North Staffordshire Combined Healthcare NHS Trust

MEETING OF THE TRUST BOARD

TO BE HELD IN PUBLIC
ON Thursday 24th May 2018, 10:00AM,
BOARDROOM, LAWTON HOUSE, TRUST HEADQUARTERS,
BELLRINGER ROAD, TRENTHAM LAKES SOUTH,
STOKE ON TRENT, ST4 8HH

	AGENDA	
1.	**APOLOGIES FOR ABSENCE** *To NOTE any apologies for absence*	Note
2.	**DECLARATIONS OF INTEREST RELATING TO AGENDA ITEMS**	Note
3.	**MINUTES OF THE OPEN AGENDA – 18th APRIL 2018** *To APPROVE the minutes of the meeting held on 18th April 2018*	Approve Enclosure 2
4.	**ACTION MONITORING SCHEDULE & MATTERS ARISING FROM THE MINUTES** *To CONSIDER any matters arising from the minutes*	Note Enclosure 3
5.	**CHIEF EXECUTIVE'S REPORT** *To RECEIVE a report from the Chief Executive*	Note Enclosure 4
6.	**CHAIR'S REPORT** *To RECEIVE a verbal report from the Chair*	Note
7.	**STAFF RETIREMENTS** *To EXPRESS our gratitude and recognize staff who are retiring* *To be introduced by the Chief Executive and presented by the Chair*	Verbal
8.	**REACH RECOGNITION TEAM AWARD ON EXCELLENCE** *To PRESENT the REACH Recognition Team Award to the Towards Outstanding Engagement Team* To be introduced by the Chief Executive and presented by the Chair	Verbal/ Presentation

	QUESTIONS FROM MEMBERS OF THE PUBLIC	
9	*To RECEIVE questions from members of the public*	Verbal
	TO ENHANCE SERVICE USER AND CARER INVOLVEMENT	
10	**SERVICE USER AND CARER COUNCIL** *To RECEIVE an update from, Wendy Dutton, Chair of the Service User and Carer Council*	Assurance Enclosure 5
	ENCOURAGE, INSPIRE AND IMPLEMENT RESEARCH AND INNOVATION AT ALL LEVELS	
11.	**INTERNATIONAL NURSING DAY- LEADING CHANGE ADDING VALUE CONFERENCE** *To RECEIVE an update from the Leading Change Adding Value Conference from Maria Nelligan, Executive Director of Nursing & Quality*	Assurance Verbal
	TO PROVIDE THE HIGHEST QUALITY SERVICES	
12	**NURSE STAFFING MONTHLY REPORT - MARCH 2018** *To RECEIVE the Nurse Staffing Monthly Report from Maria Nelligan, Executive Director of Nursing & Quality*	Assurance Enclosure 6
13	**QUARTER 4 SERIOUS INCIDENT REPORT** *To RECEIVE the Quarter 4 Serious Incident Report from Dr Buki Adeyemo, Executive Medical Director*	Assurance Enclosure 7
14	**LEARNING FROM DEATHS QUARTERLY REPORT** *To RECEIVE the Learning From Deaths Quarterly Report from Dr Buki Adeyemo, Executive Medical Director*	Assurance Enclosure 8
15	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 12** *To RECEIVE the Month 12 Performance Report from Suzanne Robinson, Director of Finance, Performance and Digital*	Approval Enclosure 9
	CREATE A LEARNING CULTURE TO CONTINUALLY IMPROVE	
16	**Received as Items 10 and 11 within Closed Trust Board**	

	MAXIMISE AND USE OUR RESOURCES INTELLIGENTLY AND EFFICIENTLY	
17	**FINANCE REPORT – MONTH 12 (2017/18)** *To RECEIVE for discussion the Month 12 Financial position from Suzanne Robinson, Director of Finance, Performance and Digital*	Approval Enclosure 10
18.	**ASSURANCE REPORT FROM THE FINANCE, PERFORMANCE & DIGITAL COMMITTEE** *To RECEIVE the Finance, Performance & Digital Committee Assurance report from the meetings held 10th May 2018 from Tony Gadsby, Chair/Non-Executive Director*	Assurance Enclosure 11
19	**SELF CERTIFICATION G6 & FT4 (PROVIDER LICENSE)** *To RECEIVE the Self Certification G6 & FT4 from Laurie Wrench, Associate Director of Governance*	Approval Enclosure 12
20	**GENERAL DATA PROTECTION REGULATIONS UPDATE** *To RECEIVE for discussion the General Data Protection Regulations Update from Suzanne Robinson, Director of Finance, Performance and Digital*	Assurance Enclosure 13
	ATTRACT AND INSPIRE THE BEST PEOPLE TO WORK HERE	
21	**ASSURANCE REPORT FROM THE AUDIT COMMITTEE** *To RECEIVE the Audit Committee Assurance report from the meeting held 23rd April 2018 from Gan Mahadea, Non-Executive Director*	Assurance Enclosure 14
22	**ASSURANCE REPORT FROM THE PEOPLE & CULTURE DEVELOPMENT COMMITTEE** *To RECEIVE the People and Culture Development Committee Assurance report from the meeting held 14th May 2018 from Lorien Barber, Non-Executive Director*	Assurance Enclosure 15
	CONTINUALLY IMPROVE OUR PARTNERSHIP WORKING	
23	**WORK PROGRAMME FOR ALLIANCE BOARD** *To RECEIVE a presentation on the Work Programme for Alliance Board from Andrew Hughes, Joint Director of Strategy and Development (NSCHT/GP Federation)*	Assurance Presentation
	CONSENT AGENDA ITEMS	
24	**CYBER SECURITY UPDATE** *To RECEIVE for discussion the Cyber Security Update from Suzanne Robinson, Director of Finance, Performance and Digital*	Information Enclosure 16
	ANY OTHER BUSINESS	

	The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday 21st June 2018 at 10:00am.	
	MOTION TO EXCLUDE THE PUBLIC *To APPROVE the resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admissions to Meetings) Act 1960)*	

THE REMAINDER OF THE MEETING WILL BE IN PRIVATE

	DECLARATIONS OF INTEREST	Note
	DECLARATIONS OF ANY OTHER BUSINESS	Note
	SERIOUS INCIDENTS	Assurance
	BUSINESS PLAN UPDATE	Approve
	LEADERSHIP & WORKFORCE REPORT AND SERVICE REVIEW	Assurance
	ANY OTHER BUSINESS	

TRUST BOARD

Minutes of the open section of the North Staffordshire Combined Healthcare NHS Trust Board meeting held on Wednesday 18th April 2018 At 10:00am in the Boardroom, Trust Headquarters, Lawton House Bellringer Road, Trentham, Stoke on Trent, ST4 8HH

Present:

Chairman:

David Rogers
Chairman

Directors:

Caroline Donovan
Chief Executive

Dr Buki Adeyemo
Medical Director

Maria Nelligan
Executive Director of Nursing and Quality

Joan Walley
Non-Executive Director

Suzanne Robinson
Director of Finance, Performance and Digital

Ganeshan Mahadea
Non-Executive Director

Alex Brett
Executive Director of Workforce, Organisational Development and Communications

Dr Keith Tattum
GP Associate

Patrick Sullivan [part]
Non-Executive Director

Jonathan O'Brien
Director of Operations

Lorien Barber
Non-Executive Director

Tony Gadsby
Non-Executive Director

In attendance:

Laurie Wrench
Associate Director of Governance

Lisa Wilkinson
Acting Corporate Governance Manager (minutes)

Wendy Dutton
Chair of Service User and Carer Council

Joe McCrea
Associate Director of Communications

Members of the public:
Jason Sax – O2 Client Management
Rachel Wingfield – East Midlands Leadership Academy
Julie Anne Murray – Deputy Director of Nursing
Veronica Emlyn – Patient Experience Lead
Simon Voiels – Service User
Geoff Yardley – Project Coordinator Growthpoint
Dave Smith – Team Manager Community
Michael Fenwick – CQC
Lydia Merriman - CQC

Retirees
Gillian Lea – Psychological Therapist
Carolyn Wilkes – Team Leader

REACH Individual Recognition Award
Julie Richardson – Residential and Resettlement Coordinator
Members of the Team Residential and Resettlement Team in support
Narissa Meredith
Jill Dale
Chris Malbon

The meeting commenced at 10:00am.

80/2018	**Apologies for Absence** Patrick Sullivan Non-Executive Director [part], Jenny Harvey Staff Side Representative and Andrew Hughes, Joint Director of Strategy and Development Jonathan O Brien, Director of Operations was welcomed to the Trust board.	**Action**
81/2018	**Declaration of Interest relating to agenda items** There were no declarations of interest relating to agenda items.	
82/2018	**Minutes of the Open Agenda – 22nd March 2018** The minutes of the open session of the meeting held on 22nd March 2018 were approved.	
83/2018	**Matters arising** The Board reviewed the action monitoring schedule and agreed the following:- ***830/2017 – Safer Staffing Nursing Report*** *– Agenda item* ***865/2017*** *–* ***PCD Assurance Report Communications Strategy*** *– Agenda item* ***12/2018 – R & D Partnership with Keele*** *– Agenda item* ***65/2018 – Director of Infection Prevention and Control (DIPC) –*** *Maria has e-mailed* ***4672018 – BAME Story – Staff Survey Results –*** *Agenda item for May Trust Board.*	
84/2018	**Chief Executive's Report** Caroline Donovan, Chief Executive, presented this report which provides an update on the activities undertaken since the last meeting and draws the	

Board's attention to any other issues of significance or interest.

OUR JOURNEY OF IMPROVEMENT FEATURES IN NEW CQC REPORT

The Trust is delighted to share that it is among just a handful of organisations to feature in a new CQC report showcasing how mental health trusts have led by example in raising standards.

The CQC's 'Driving Improvement' report focusses on a select few mental health trusts that, like Combined, have achieved significant improvement in their CQC ratings.

The report states that "the trusts featured in this publication show how good leadership can drive significant improvements, in some cases in a relatively short time. We want to encourage others to look at and learn from these case studies to help them in their own improvement work".

In order to produce the report, the CQC interviewed people throughout the Trust, including our Chair David Rogers, myself, other Executives, managers and frontline staff. They also spoke with a number of partners and stakeholders about how they are working with Combined to improve services.

Driving Improvement chronicles the story of how the Trust has transformed starting with the development of our SPAR quality priorities and Proud to CARE values. The developing culture of the organisation, with an emphasis on supporting staff and enabling clinicians to lead has been highlighted by the CQC, as has our improved governance. Our Raising our Service Excellence (ROSE) electronic patient record and Valuemakers initiative were both featured in the report as examples of real improvement.

In addition, the CQC praised excellent partnership working supporting the coordination and integration of its services across the local health and care system – highlighting the ongoing partnership between Combined and the North Staffordshire GP Federation.

HSJ VALUE AWARDS

Congratulations to the Combined Healthcare services and initiatives that have been shortlisted in the 2018 HSJ Value Awards. The Trust has been chosen as a finalist in no less than four awards for the prestigious national awards. The innovative Valuemakers programme will be representing Combined in the Improving Value through Innovative Financial Management or Procurement category.

In the Mental Health category the CAMHS in Schools team has been shortlisted, as has the Meir Partnership Care Hub service the Trust provides with Stoke-on-Trent City Council and a number of other partners. The Trust has also been nominated in the Pharmacy and Medicine's Optimisation category for medication reduction in a learning disability inpatient service.

Each of the teams will now have to go and present to a panel of judges before finding out if they are the national winners at the award ceremony on Thursday 7 June 2018 when the awards are held in Manchester.

COMBINED SERVICES SHORTLISTED FOR PATIENT SAFETY AWARDS

The Trust is delighted that the High Volume User Service and Learning Disability Service, following an announcement last week that they have been shortlisted in the 2018 Patient Safety Awards.

Now in its 10th year, the Patient Safety Awards recognise and reward outstanding practice within the NHS and independent healthcare organisations. Both services will be representing Combined in the Mental Health and Learning Disabilities Category. The High Volume User Service has been commended for “working to reduce A & E attendance” and the Learning Disability Service, for “medication reduction.

COMBINED HEALTHCARE THE FIRST MENTAL HEALTH TRUST TO SIGN THE DYING TO WORK CHARTER

The Trust welcomed Shadow Secretary of State for Health and Social Care, John Ashworth MP, to witness the signing of the charter, the Trust is proud to have become the first mental health trust in the country to sign up to the Charter, which sets out the following commitment for how staff will be supported, protected an guided throughout their employment, following a terminal diagnosis.

As well as being present for the signing, John also discussed his own approach to mental health policy and delivery and went on to visit the fabulous Growthpoint service and was really impressed by what he saw.

CONTINUING TO ENGAGE AS WE MOVE TOWARDS LOCALITY WORKING

Plans to introduce new integrated locality-based structures within Combined Healthcare continue apace.

The newly launched website provides more information on the project, which aims to bring together all age community services by geography, provide better services to local communities, brings together all specialist services (wider than the North Staffs catchment), and urgent care pathways to align with inpatient wards, create a Primary Care directorate to support developments between the Trust and primary care, develop a robust and integrated professional structure, and strengthen clinical leadership at a pathway level.

The Trust is also continuing to hold engagement forums with staff groups and stakeholders to share details of the project and welcome feedback.

NOMINATIONS NOW OPEN FOR REACH AWARDS

The Recognising Excellence and Achievement in Combined Healthcare (REACH) Awards are an annual celebration of staff and teams who go above and beyond in delivering excellent services. To mark the NHS 70 celebrations, this year's REACH will take place on Thursday 5 July at the Stoke-on-Trent Moat House. Nominations will open on Monday 26 March and the Trust is hoping to beat last year's record-breaking total of 290 nominations. This year's awards will recognise outstanding achievements in the following categories:

1. Leading with Compassion Award
2. Rising Star Award
3. Volunteer/Service User Representative of the Year Award
4. Innovation Award
5. Valuemaker Award
6. Developing People Award
7. Partnership Award
8. Service User and Carer Council Award (decided by the Service User and Carer Council)
9. Unsung Hero Award
10. Proud to CARE Award
11. Team of the Year Award
12. Chairman's Award (decided by the Chair)

RESEARCH RECRUITMENT BOOSTER

One of the Trust's key strategic objectives is to 'Encourage, inspire and implement research and innovation at all levels'. The Research Team have been working hard with staff and teams to boost research throughout the Trust and have launched a new campaign in the lead up to Easter to increase the number of patients, staff and carers participating in the mental health and dementia research studies we are involved with.

Teams have been increasing the exposure of research studies by displaying literature and speaking to their service users to see if they would be interested in taking part.

ALLIANCE OUTCOME FRAMEWORK DEVELOPED

This exciting development follows the Trust's work with the Alliance Board on 21 March 2018, led by AQUA. The Alliance Outcome Framework focuses on how the Trust can ensure its teams are motivated and working to their full potential and will allow the Trust to truly work collaboratively across organisations.

STP LEADERS HOLD KEY MILESTONE EVENT

Leaders and clinicians from organisations representing the Together We're Better partnership met at the end of March to focus on the work that has

taken place over the previous 12 months as well as using the opportunity to share their emerging thinking on future plans.

Simon Whitehouse, Together We're Better Director, reflected on the progress that has been made in across a number of key areas including:

- the prevention agenda,
- improving local primary and community care,
- increasing the effectiveness and efficiency of planned care,
- work to develop a simplified urgent and emergency care system,
- further improving local mental health services, and
- improving children, young peoples' and maternity services.

He also highlighted the work that has taken place to strengthen leadership and accountability within the partnership. He went on to stress the importance of continued collaboration and recognised that there remained a significant amount of work still to do.

Dr Paul Roberts, Director of North Staffs GP Federation spoke about the progress in developing local, community based primary care – including the successful Meir Partnership Care Hub that has seen NHS, local authority, independent and primary care colleagues work more closely together to improve health and care services for the local community.

Together We're Better's Independent Chairman, Sir Neil McKay, shared some of the emerging thinking taking place within the partnership, including an ambition for swift progress to be delivered in a number of areas.

These include implementing a greater number of integrated care teams across the area. These would build on the work being done in places like Meir to bring together a range of physical and mental health services alongside social care professionals and the voluntary and community sector to enable a coordinated approach to improving population health.

CCGS ENTER PRE-CONSULTATION PHASE TO REDESIGN LOCAL HEALTH SERVICES IN STOKE-ON-TRENT AND NORTH STAFFORDSHIRE

An update has been provided from Stoke-on-Trent and North Staffordshire CCGs about the work to design future local health services in Stoke-on-Trent and North Staffordshire.

The CCGs are in the process of gathering the views of local people in the design of high quality, accessible and affordable local health services that meet your needs in and around the Community Hospitals. They are in the process of working with local stakeholders to develop a pre-consultation business case with viable scenarios for each location on which will have formal consultation later in the year.

DAVID ROGERS WRITES BLOG ON "THE ROLE OF THE NHS CHAIR"

Our Chair, David Rogers, has written a fascinating blog on the PWC website on the changing role of an NHS Chair during times of transformation. In his blog, David says "In the new age, transformation is the only way to sustainability. And the currency of transformation is trust. Trust between collaborating organisations to best serve a local population. Trust does not just happen – it has to be generated by contact, by respect and by understanding. Chairs are central to this process"

NATIONAL UPDATE

KIRKUP REVIEW INTO LIVERPOOL COMMUNITY HEALTH

The independent review was commissioned by NHS Improvement (NHSI) following concerns raised about care delivered at Liverpool Community Health NHS Trust (LCH) during November 2010 to December 2014. The trust experienced significant failings in care quality, including an inexperienced management and director team. The Trust was also seen to be overly focussed on its pursuit of Foundation Trust (FT) status and achieving very significant cost savings required by its commissioners. In addition, organisational structures were seen to change radically and responsibilities moved to new organisations.

CQC PUBLISHES MONITORING THE MENTAL HEALTH ACT IN 2016/17 REPORT

The CQC publishes its Monitoring the Mental Health Act in 2016/17 report, which concludes that not enough is being done to consistently ensure patient rights are respected against the Mental Health Act.

Although the report found examples of good practice, it concludes that mental health services are not doing enough to ensure that people whose liberty has been restricted under the Mental Health Act are able to exercise their rights; and that this situation is not improving. The report comes as an independent review of the Mental Health Act is underway, led by Professor Sir Simon Wessely.

Combined Mental Health Act compliance visit action plans are monitored through various forums; on a monthly basis through the Exec led Performance Review meetings and bimonthly at the Quality Committee.

NHS ENGLAND WRITE TO CCGS TO BOOST MENTAL HEALTH FUNDS

The Guardian reports that NHS England has written to all 207 CCGs to warn that they must deliver on a key NHS-wide funding pledge in order to meet the rising demand for mental health services. In the letter, Claire Murdoch, NHS England's National Mental Health Director, has advised and

encouraged CCGs to ensure they boost spending on mental health by more than the size of their overall annual budget increase. She also states that all CCGs must meet the mental health investment standard (MHIS) during the new NHS financial year.

NHS STAFF ON AGENDA FOR CHANGE CONTRACT RECEIVE PAY RISE OF AT LEAST 6.5% OVER THREE YEARS

Ministers and unions have agreed a pay deal that will see all staff on an Agenda for Change contract expect a pay rise of at least 6.5% over three years. The pay rises will be worth between 29% and 6% for NHS staff, with the highest rises going to those on the lowest rates of pay. The Health and Social Care Secretary, Jeremy Hunt, announced that the NHS starting salary will go up from around £15,000 to more than £18,000. The proposal, currently being consulted on, does not include any changes to annual leave entitlements or unsocial hours payments. The proposed deal will be fully funded by the Treasury.

NHS ENGLAND AND NHS IMPROVEMENT ANNOUNCE INTENTION FOR CLOSER JOINT WORKING

On 27th March, NHS England and NHS Improvement announced plans for "working closer together". The two organisations jointly said

We have one NHS: commissioners and providers in each part of the country are serving the same people, and we need to use the resources that Parliament gives the NHS to greater benefit for local patients. This requires a much stronger focus on collaboration and joint working nationally as well as in local health systems. Subject to our boards' approval of more detailed proposals, we will begin to establish the following working arrangements from September 2018:

- increased integration and alignment of national programmes and activities – one team where possible
- integration of NHS England and NHS Improvement regional teams, to be led in each case by one regional director working for both organisations, and a move to seven regional teams to underpin this new approach.

A more joined-up approach across NHS England and NHS Improvement will enable us to:

- **work much more effectively with** commissioners and providers in **local health systems** to break down traditional boundaries between different parts of the NHS and between health and social care
- **speak with one voice**, setting clear, consistent expectations for providers, commissioners and local health systems
- **use NHS England and NHS Improvement's collective resources** more effectively and efficiently to support local health

	systems and the patients they serve • **remove unnecessary duplication and improve the impact** from our work, delivering more for the NHS together than we do by working separately. NHS England and NHS Improvement still have distinctive statutory responsibilities and accountabilities and nothing we are proposing cuts across these. The legislation also means that a formal merger between our organisations is not possible, instead they propose to combine forces for those functions where we can better work as one. **Received**	
85/2018	**Chair's Report** David Rogers, Chairman provided an update. The Annual Report on Safer Staffing is an important milestone in what the Trust is doing, where it is going and what challenges it faces. There is an increasing role in relation to the Health Economy, at large it is a greater demand on the Trusts capacity as an organisation to participate in the wider planning as a whole. A lot of the people within the Trust Board are involved in this quite heavily. It is more and more a feature of our working lives. The Trust is playing the role it always wanted; to be part of the solution of where things are moving to in North Staffordshire and it has developed the capacity and confidence to be part of this and influence change. CQC inspections – Executives have been involved in recent inspections nationally. The Trust would like to think its involvement is having a positive influence on activity, what is very obvious is it is feeding and enriching the discussions had as a Board. So many people have on board the experience of how other organisations are dealing with issues and how they are resolving them. It is a privilege and delight to be part of these teams. David referred to his Chairs Blog. Sometimes dealing with local authority colleagues means the Trust has the ability to recognise the level of accountability they have to deal with on day to day basis which is much higher than the level we have to deal with within the NHS. What is important is the accountability that flows via many avenues. It is very valuable and important in the Trust Board's open session we deal with the good and bad and we are open about what we do. David advised he will be looking where he can to develop the attendance of the public Trust Board. ***Noted***	
86/2018	**Staff Retirements**	

Gillian Lea – Psychological Therapist

Gillian originally trained as a Beauty Therapist and after too many conversations about make up decided to become a nurse at age 18 years old. In 1982 Gill applied to train in Macclesfield as an SEN in mental health. At first Gill worked as a manager privately for a year, managing care workers caring for people with physical health.

Gill started in the NHS in this Trust in the early 80's on the Acute wards -the old 90's block at City General Hospital working with Dr Crisp and Professor Cox. A lot of the patients had had babies out of wedlock and become institutionalised in what had originally been the workhouse. It was then that Gill developed an interest in group therapy as she became a co-therapist, learning on the job. Just after this Gill converted to RMN.

In the 1990's Gillian developed an interest in complementary and alternative therapies, training in acupuncture. Gillian became the Lead for the Trust in complimentary therapies, training and offering a service to clients and staff.
In 2005 Gill went onto a two day post at the School of Nursing at Keele University as an Honorary Lecturer. At the same time Gill trained 40 professionals in complimentary therapies across the Trust. At this time, she was invited to join a Mindfulness group and experience it for herself and go onto train as a Mindfulness Teacher at Bangor University. For the last five years Gill has run Mindfulness groups across the Trust.

In 2011 Gill joined with Dr Joanna Woolliscoft to run a Systemic service on the wards enabling families to plan and manage their own discharge home.
Gillian has been a dedicated member of staff, well respected by her colleagues and will be greatly missed. We wish her the very best in her retirement.

Gillian was presented with the Trusts Nursing Badge.

Carolyn Wilkes – Team Leader

Carolyn commenced working for Combined Healthcare in 2001 starting on a rotational post as a Basic Grade Occupational Therapist. Carolyn spent 6 months working at Lyme Brook CMHT and 6 months at Cheadle Hospital before being offered a permanent position in 2002 working within a community setting based at Hillcrest under the supervision of Don Walsh. During Carolyn`s time at Hillcrest she completed her MSc in OT and was also appointed an Approved Mental Health Practitioner one of the first few OT's in the country to practice working in this role.

In 2012 Carolyn was part of the formation and development of the very successful Step-On employment service before moving to Florence House in 2014 taking up the position of Ward Manager.

In 2015 Carolyn took over the joint role as Manager of Summers View alongside Florence House, ensuring a streamlined rehabilitation service provision.

	Carolyn is a highly respected leader and colleague to service users, carers and staff across the Trust. Her colleagues at Summers View and Florence House said; "Carolyn has been the making of Rehabilitation as it stands today, as a manager she is supportive, a team player and a person you know that you can go to. Carolyn never pre-judges a person; she encourages and nurtures her team to grow in their own progression and learning, not only benefiting themselves but also the service and client group. Carolyn is very patient focused and will put 150% into their care. Feedback from clients is that she is "lovely lady" who talks to them as a person. Carolyn is forward thinking, and is always looking at new ways to improve/grow the service to the benefit of Clients and staff alike, making the Rehabilitation Service and its future a place that provides a pathway forward for all." An extremely humble and unassuming individual ,Carolyn should be rightly proud nonetheless of leading her service to be recognised for their person centred, high quality, recovery focussed and can do approach quite rightly recognised with its achievement of an Outstanding rating in the 2017 CQC Well Led inspection; a fitting tribute to the vision and commitment Carolyn embodies. We are delighted that Carolyn will be returning on a part time basis to provide joint leadership into the future. On behalf of the Trust, we wish you a happy retirement. ***Received***	
87/2018	**REACH Individual Recognition Award April 2018** **Julie Richardson, Residential and Resettlement Coordinator** Julie fully deserves this REACH Individual Award for her creative and innovative 'can do' approach which has resulted in positive outcomes for our service users. Julie leads the Recovery and Resettlement Team - a service that provides a positive care pathway and step down for people who are assessed as ready for discharge and no longer requiring an acute bed. Since the unit became operational in August last year, over 30 people have been successfully supported with the majority of people returning to their own homes or supported by the team to secure alternative accommodation. This has seen excellent outcomes in terms of the reduction in the use of out of area beds. Julie has also supported the introduction of a Mental Health Support Group for adults who are deaf or hard of hearing. Led by a service user and a support worker from the team, the pair work closely with Deaflinks and the	

	deaf community to ensure continued success. Julie has encouraged the team to work creatively to develop effective ways of supporting people with a diagnosis of personality disorder which has resulted in a reduction in hospital admissions and a significant reduction in incidents of self-harm. Julie demonstrates our Trust values of being compassionate, approachable, responsible and excellent. Julie stated, "It is nothing special - we just believe in treating people with respect and we focus upon individual strengths rather than deficits. Our mantra is saying how 'we can' rather than saying we can't." Julie was presented with the Trusts Nursing badge **Received**	
88/2018	**Patient Story** Maria Nelligan, Executive Director of Nursing & Quality introduced Simon Voiels Service User and Veronica Emlyn, Patient Experience Lead. The Board watched a video whereby Simon talked about his experience working with Growthpoint during his recovery. Maria felt it was a very positive and successful story. Simon confirmed he was happy to answer questions. Caroline Donovan advised it would be brilliant to use the video more widely and asked in terms of how often Simon attended Growthpoint each week if he supported other service users whilst there. Simon confirmed he now visits one day a week. 'I don't directly support others but we all support each other anyway. The staff are always there to help. It's like a self-supporting group'. Dr Tattum commented that Growthpoint is a fantastic organisation and it breaches the gulf between illness and recovery. Dr Tattum highlighted that he has had patients 'stuck at the bridge that could not get across' so as a practitioner it is a very useful service. Dr Adeyemo thanked Simon for his support at the Smoke Free Task and Finish group and asked from a learning point of view what his experience was in terms of his change in diagnosis. Simon advised he was so ill and lost within a whirlwind and unable to articulate and admitted he did not know what to say to parents as a teenager and felt unwell. Simon thought he would have gone to prison and stated that Mental Health services in the 1980's were a lot less evolved than they are now. Simon added that it is difficult to diagnose with a limited amount of time it's about asking the right questions and answers that might reveal where they are going. Simon stated that Schizophrenia and Bi polar are very similar in presentation.	

	Geoff Yardley advised when Simon came to Growthpoint he had repeatedly lapsed in illness whenever the team thought he was taking on too much they would challenge it. Simons involved with Growthpoint this year and his role is within the landscaping group but all interviewing and work he undertakes on Ward 6 the team support him with to ensure he does not take on too much and they have been doing so for the last 8-9 years and during that time Simon has not had a hospital admission. Joe McCrea added this presentation reinforced comments received from MP John Ashworth following his recent visit to Growthpoint whereby he was praising the team at Growthpoint and the imaginative approach adopted by them. Dave Smith added in terms of the future and locality working the team are about to expand into a Growthpoint at the Meir site set up in partnership with the Police. There is an event that will be communicated soon. The idea of smaller Growthpoints is now taking off. David thanked Simon for his presentation.	
88/2018	**QUESTIONS FROM MEMBERS OF THE PUBLIC** There were no questions / comments from the public.	
89/2018	**SERVICE USER AND CARER COUNCIL** Wendy Dutton, Chair of the Service User Carer Council provided an update. **Integrated Locality Working Presentation by Julie Anne Murray** The Service User Carer Council responded favourably to the proposed new way of working however concerns were expressed regarding services for those with rare conditions where there may be only one or two service users per locality as to whether these patients will still have to travel or will localised services be available. There were also concerns that for these conditions the support provided would be the top of the list for removal due to funding restraints in the future. **Citizens Jury Update** The contents of the report were discussed and it was agreed that the report should be circulated to the Service User Carer Council for further comment. **Service User Carer Council Workshops** It was agreed that a change of time and venue should be trialled for the workshop meetings of the Service User Carer Council. As of April the workshops will be held on the same date from 5pm - 7pm at the Harplands to try to allow those who work or study to attend meetings at a more accessible location. This will be reviewed by the Service User Carer Council to measure the success and whether to implement the change more permanently. The business meetings will remain the same. ***Received***	

90/2018	**RESEARCH AND DEVELOPMENT STRATEGIC ENGAGEMENT WITH KEELE UNIVERSITY** Dr Adeyemo, Executive Medical Director presented the report and highlighted the following: Trust Board approved the updated R&D strategy at its meeting in October 2017. This document provides a 6 month update on progress against the key objectives There has been major enthusiasm with staff within the Trust for Research and Development. The research forum continues to take place on a bi-monthly basis. The programme has included presentations on a range of research-relevant subjects and there are a number of regular attendees. The membership of the R&D Steering group has been reviewed and some work to look at the roles and expectations of the directorate representatives initiated. It is recognised that the research strategy requires the support of the directorates in order to be implemented effectively and efficiently. There have been two further Nurse Consultants appointed within the Trust (Learning disability services and CYP directorate) and contact made regarding research opportunities. 8 new staff have completed GCP training this year. Professor Tadros was invited to speak at the academic seminar giving a presentation entitled “Why Medics should become a PI (Principal Investigator)”. The R&D team continue to work with clinical teams to support the above. Examples include working with the substance misuse team to evaluate aspects of their services and supporting the vascular wellbeing team with the development and evaluation of the ‘Be Able’ app. The team has built upon the partnership with Staffs University and is working towards streamlining the approval process. A memorandum of understanding was signed in September 2017 between the University of Staffordshire and Combined Healthcare. This lead to the submission of a joint funding bid in October 2017 for lottery funding for the Make Every Adult Matter (MEAM) programme. Considerable work has been undertaken to forge links with Keele University. A joint meeting between Keele and Combined took place in August 2017. Since then, the University has agreed to offer Honorary appointments at Professor and Senior Lecturer level to senior clinicians within the Trust in the Department of Primary Care Research, facilitated via Professor Christian Mallen. Professor Mallen is in possession of the CVs of relevant clinicians for ratification later this month followed by formal interviews. Senior psychiatric trainees (ST 4 and above) are being encouraged to undertake higher degrees within the faculty. One trainee is ready to sign up for an MPhil degree for which the faculty will provide supervision.	

	The proposal for the re-launch of Dragons Den is currently being progressed. The team has increased the amount of commercial income generated last to achieve 143% of the annual target (£16242). Recruitment into NIHR portfolio studies currently stands at 106. Last year the team recruited 118 subjects into NIHR sponsored trials. Going forward the team intends to focus recruitment activities on the simpler studies available (such as the NCMH study) to improve on this. The Trust's original recruitment target (set by NIHR) for this year was 96 i.e. the team has exceeded the objective; however, the target has recently been revised by NIHR without consultation and now sits at 293. Joan Walley highlighted the importance of the Trust working with Higher Education and using this as an extra arm of what the Trust can do. It is important we do not lose sight of what more Keele can do in terms of their own forward planning with the link to our services. The Trust needs to look at strategic partnerships with other organisations and how it can pursue their own initiatives and embed with the Trusts own working patterns and whether it is time to have a follow up meeting with a the Vice Chancellor to ensure it is a priority for them . Tony Gadsby referred to the memorandum of understanding the Trust has with Staffordshire University although the relationship is very much in its infancy compared to Keele Staffordshire University is the top university for computing in the country and links to the Trusts digital relationship which would be beneficial to the Trust. Caroline Donovan agreed the Trust could do more from an organisational perspective, from an STP perspective workshops and discussions have taken place with Staffordshire University and Staffordshire County Council with regards to digital work. Alex Brett highlighted the Workforce Strategy is central to this in terms of developing academic links. One of the things the professional groups are saying loud and clear is that the academic elements, attracting people to jobs and having a specialist academic profile is attractive but the Trust needs to build on the strengths of staff we already have with those links. Maria Nelligan advised meetings have taken place with the Dean of Staffordshire University on a regular basis to see if they can support the Trust innovatively around training. Maria will feed into with the next report as it links to annual staffing. Work is being undertaken to look at honorary contracts and understand how the Trust can contribute to education for nurses it is something we need to be more cited on and bring though the Research & Development innovation work. Staffordshire University have offered to increase their mental health recruitment by 20% to support the Trust with staffing in return Julie Anne Murray, Deputy Director of Nursing has been working on increasing placements with Staffordshire University	

	students. Lorien Barber asked what the impact would be of not being able to recruit to recruitment target. It was confirmed that previously there would have been a penalty but it has been acknowledged as it was mid-year there is no sanction. David Rogers commented that the Trust is blessed with two universities close by. There are so many ambitions the Trust can build on. It is an opportunity not to be missed. ***Received***	
91/2018	**NURSE STAFFING MONTHLY REPORT – FEBRUARY 2018** Maria Nelligan, Executive Director of Nursing & Quality presented the report and highlighted the following: The paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during February 2018 in line with the National Quality Board requirements. The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during 2018 was 83% for registered staff and 96% for care staff on day shifts and 84% and 104% respectively on night shifts. Overall a 92% fill rate was achieved. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward manager supporting clinical duties. The data reflects that Ward Managers are staffing their wards to meet increasing patient needs as necessary. There were no incidents of harm to patients as a result of staffing The registered nurse fill rate has slightly increased over the last 12 months. This increasing trend is continuing to be built upon and the following actions have been taken to strengthen Registered Nurse staffing: • Twenty six third year Keele nursing students have accepted a conditional offer to commence with the Trust in Oct 2018 • Shift patterns have been altered in response to staff feedback • Recruitment opportunities for RNs continue to be advertised (including bank) • Increased the presence of Duty Senior Nurses (DSN), Nurse Practitioners and WM on wards • The Trust has joined the NHSI MH recruitment and retention programme • Recruitment campaign launched for PICU The Trust Board is asked to:- • Receive the report • Note the challenges with recruitment and mitigations/action in place	

	• Note the challenge in filling shifts • Be assured that safe staffing levels are maintained Tony Gadsby enquired if the temporary increase in beds on ward 4 is still in place. Caroline Donovan advised the Trust has received mixed messages from Commissioners; middle level commissioners gave notice which we challenged. The agreement is no beds will be reduced before June 2018 this year. We are also talking to Commissioners re: the opening and closing of Ward 4. David Rogers noted the Trust is under established in relation to Registered Nurses on Ward 1 on nights but make up with care staff and asked if this is causing any particular stress on the ward. Maria Nelligan confirmed it is a challenge the target was increased last year when we had one registered nurse on the wards we increased this to two. The challenge is meeting that all the time. Shift patterns have been changed with consultation with staff which has resulted in two long days and two half days which has provided more full time equivalents therefore the fill rate should start to increase. The Trust acknowledges its vacancies and there are new registered nurses coming to the Trust in October 2018. David Rogers asked if the Darwin centre 98% occupancy is another challenge. Maria Nelligan advised the comprehensive review undertaken does highlight high occupancy on most wards the occupancy and acuity has an impact on day to day staffing required. Patrick Sullivan highlighted that these reports are scrutinised at the Quality Committee. Ward 4 is a real issue and has been a real challenge. The number of vacancies is also a real challenge. This has been discussed on a number of occasions where there are real issues around acuity and staffing but generally there are not major shortages on these wards. Maria Nelligan confirmed there are other people supporting the registered nurses and HCSW's we have activity workers and other allied health professionals who are part of the team that are not counted in figures. ***Received***	
92/2018	**ANNUAL SAFER STAFFING REPORT** Julie Anne Murray, Deputy Director of Nursing was present for this item. Maria Nelligan, Executive Director of Nursing & Quality presented the report and highlighted the following: Maria delivered a presentation. Since 2014 the Trust has been required to monitor nurse staffing within in-patient wards to ensure that safe staffing levels are maintained. This monitoring comprises monthly reporting to the Board and NHS England	

	and an annual strategic staffing review; followed 6 months later by a comprehensive review focused on safer staffing workforce plans. To enable the Board to meet this requirement this review has: • Identified the progress made since the previous safer staffing review in January 2017 • Examined current staffing levels • Reviewed the MDT and skill mix; exploring new roles and training requirements • Benchmarked with other MH trusts using Care Hours per Patient Day (CHPPD) data • Considered the impact of the management of change in relation to shift patterns • Highlighted areas of best practice and quality improvement undertaken by wards to ensure efficient and effective use of resources • Reviewed safe staffing within Access & Home Treatment • Provided recommendations that include practice, workforce and establishments There were 23 recommendations made to Board regarding Wards 1,2, 5, 6 and 7, Darwin, Summers View, Access and Home Treatment. Achievements of E-Rostering and temporary staffing service were and staffing recommendations were discussed: • Enablers for safe staffing uplifts discussed. Change in shift patterns has reduced WTE requirements and released resources to fund the uplift set out in the review • All Ward 5 staff chose to remain on 5 short shifts; this means that no efficiencies were released in relation to the MoC of shift patterns. In line with the rest of the Trust, if all Ward 5 staff moved to mixed shifts the WTE required would reduce and their safer staffing establishments would be met (£111k). • There will still be a balance of £11k to find after these mitigations. Following this review, work has taken place with the finance team to look at how the recommendations may be resourced within existing budget. The cost of implementing recommendations of the safer staffing review is £122k. There are 2 potential risks that need to be considered and these include: • The financial implications of the A4C pay review, have not been finalised • The change of shift patterns which were implemented in January 2018 will be reviewed, as agreed, in January 2019 and any changes will be have to be managed within existing resource Caroline Donovan thanked Maria, Julie Anne and finance for the paper. This will help the wards to run on a sustainable basis and from a Commissioning	

	perspective the only area we received acuity income for is Learning Disabilities therefore this may help us to monitor closely the acuity as it continues to increase.
	
	Jonathan O'Brien felt it was very useful to see in terms of a quality / safety perspective. Looking forward at increased mental health spending we have had investments in some services and we really need to keep an eye on this as we expand our investments will place increasing demands on our workforce. As people move between services we need to keep a trust-wide oversight on how we look at different roles as we progress.
	
	Alex Brett highlighted this demonstrates the whole multi-disciplinary team development which is positive. Maximising what we have in terms of working different in different roles.
	
	Tony Gadsby highlighted the potential impact of £122K adding without flexibility there is a gap. Directorates who have a net reduction in budget resource will be able to recognise this as delivered CIP. Suzanne Robinson explained as structures currently stand we cannot recognise from a directorate perspective how this affects their CIP target. We need make sure it is recognised. Tony added the CIP will be recognised as a saving in the directorate but how can this be recognised as additional CIP in another directorate. Suzanne confirmed moving to a new structure we will be achieving CIP through different mechanisms but we cannot not recognise it at this time. It will be a realignment in budget but overall as a Trust the CIP target will remain the same. Directorates in the future will not be the directorates we currently know. The increase in establishment to be sustainable was being established through shift patterns.
	
	The Board was asked to:
	• Note the progress in implementing safer staffing
	• Note further recommendations detailed in Section 13 of the report
	• Approve the recommendations to realign budgets in line with the findings of the safer staffing review from 1st July 2018. This will be dependent on:
	  • Ward 5 changing shift patterns from short shifts to mixed shifts
	  • The opening of PICU
	• Note the principals set out regarding CIP
	
	Board approved.
	
	Approved / Received	

93/2018	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 11** Suzanne Robinson, Executive Director of Finance, Performance and Digital, presented the report highlighting key points. Performance highlights:	

	• Delayed Transfers of Care has significantly reduced • Emergency readmissions continue to improve to 4.5% (target 7.5%). • 98.0% of service users referred to IAPT services are treated within 6 weeks of referral (target 75%) and 65.6% of people accessing IAPT services moved to recovery (again a 50% target). • Performance continues to improve for service users on a Care Programme Approach for at least 12 months (NHSI metric) who has received a review (98% against a target of 95%). In Month 11 there are 3 targets related metrics rated as Red and 2 targets related metrics rated as Amber. Exceptions: • Care Programme Approach (CPA) 93.9% at M11 from 95.7% at M10. 2 patients (out of 33 in total) were not followed up within the timescale. o 1 patient did not attend their follow up appointment and was not seen at all. They refused to engage despite numerous attempts to follow up o 1 patient was discharged to residential care and the breach was associated with communication issues between the ward and community team Both patients were subsequently followed up and there were no clinical issues arising from the delays. Wards and teams have been reminded of the requirements of the SOP. • Agency Spend 28.5% at M11 from 28.8% at M10 • Waiting Times 91.3% at M11 from 92.1% at M10. Jonathan O'Brien advised work is being undertaken with teams to ensure there is a clear recovery plan in place. • Under 18 Admissions 1.0 at M11 from 0.0 at M10. A 17 year old female was admitted on a S136 and transferred to Ward 3 out of hours. It was assessed as the most appropriate placement for the young person at the time of admission. Commissioners and CQC were informed and NHSE who commission CAMHS beds nationally identified a suitable alternative the following day. This is the first 16-17 year old admission into an Adult Acute bed in 2017/18. In such cases the decision to admit is approved by the Executive Nursing Director in hours and Executive Director on call out of hours. Patrick Sullivan advised this should be a never event and shared his concern. Maria Nelligan gave assurance that this is being looked into.	

	• Bed Occupancy Trust excl. AMH IP – 91.6% at M11 from 93.8% at M10 The Board were asked to receive the Trust reported performance, management action and committee oversight on the Month 11 position. ***Received / Approved***	
94/2018	**NHS PROVIDERS: REVIEW OF CHILDREN AND YOUNG PEOPLES MENTAL HEALTH SERVICES** Laurie Wrench, Associate Director of Governance presented the report and highlighted the following. On 8th March 2018, NHS providers issued a briefing of the CQC's review of CAMHS services. The CQC report titled 'Are we listening?' builds on phase 1 of their review. This briefing provides an overview of phase 1 highlights and outlines the key findings and recommendations from phase 2 of the review. The briefing also provides details of recent CQC findings with regards to the trust's community CAMHS services. What the CQC said about our services February 2018: • Parents of young people told us they felt involved in their care and the staff they worked with had a good understanding of the young people's needs. • There were processes in place to ensure each young person open to the service could be tracked through their pathway and deterioration in their mental health could be responded to quickly. • There were no long waiting lists for all children and young people open to the service. There had been a significant improvement in the reduction of waiting lists since the last inspection. There were no children and young people waiting longer than the national target of 18 weeks to be seen. • There was a good range of evidence based psychological therapies offered by a range of staff disciplines and routine outcome measures were used to monitor the effectiveness of treatment • There was a clear criterion for which young people would be offered a service • There were weekly multidisciplinary team meetings and evidence of joint working with external organisations • All staff spoke positively about their managers and service director. They felt valued and supported by senior staff.	

	• The Community CAMHS team has made significant improvements originally receiving a rating of 'inadequate' from the CQC in 2015 to receiving 'good' for all domains in 2017. This follows investment from commissioners in recognition of growing demand and under resourcing in addition to improving the quality of care plans, risk assessment and waiting list management. • The directorate are part of a digital exemplar programme to improve access to services and continue to strengthen partnerships, streamline clinical pathways and enhance service user and carer involvement. Lorien Barber asked if the CQC report was based on community CAMHS. Laurie Wrench confirmed it was. David Rogers highlighted that CAMHS was our most challenged area for some time and really has made improvement there are still places to go but the Trust should be proud of this achievement. ***Received***	
95/2018	**ANNOUNCED AND UNNANNOUNCED ASSURACE VISITS Q3 REPORT** Maria Nelligan, Executive Director of Nursing & Quality presented the report and highlighted the following: The paper summarises the Trusts Unannounced visits plans to strengthen the action plan assurance and the plans to roll 2018/19 visits out into the Community services. The paper also provides the annual schedule for both the Trusts Unannounced and Exec engagement sessions. Seeking approval from executive meeting to go to the Quality Committee 5th April 2018. The paper • Describes amendments made to the action plan 'sign off ' • Describes the roll out process into the community services. • Provides the schedule for Trust unannounced and Executive engagement sessions for 2018/19. ***Received***	
96/2018	**FINANCE REPORT MONTH 11 (2017/18)** Suzanne Robinson, Executive Director of Finance, Performance and Digital, presented the report highlighting key points. • The end of year position was discussed the Trust is confident it will deliver. • The reported year to date surplus of £1,385k against a planned surplus of £1,203k. This is a favourable variance to plan of £182k. • The M11 CIP achievement. YTD achievement of £1,863k (66%); an adverse variance of £960k;	

	• 2017/18 forecast CIP delivery of £2,282k (71%) based on schemes identified so far; an adverse variance of £915k to plan; • The recurrent forecast delivery at month 11 of £2,413k representing a recurrent variance to plan of £784k. • A risk adjusted recurrent forecast delivery of £2,288k (72%) • The cash position of the Trust as at 28th February 2018 with a balance of £5,524k; £263k better than plan • Agency forecast is currently £577k above ceiling (£2,068k) • Year to date Capital receipts for 2017/18 is £1,519k compared to a net planned capital expenditure of £2,025k • The original operating plan submitted to NHSI in December 2016 planned net capital expenditure of £2,979k by Month 11. • Based on the NHSi plan the forecast underspend would be £727k. • Use of resource rating of 2 against a plan of 2. The Board were asked to Approve: • The month 11 position reported to NHSI. • Approve the forecast Agency Ceiling breach of £577k. Suzanne Robinson discussed the budgeting of capital schemes advising the Trust is maturing now in its approach to this. Future capital projects the Trust will be more confident with and more responsive to address capital shortfalls. David Rogers asked if the Trust was carrying a backlog in maintenance. Suzanne confirmed there is an element of PFI which has a lifecycle element to that but with the expertise of the newer team more scrutiny is being applied and a comprehensive programme developed that is risk rated and provided on need. ***Approved / Received***	
97/2018	**ASSURANCE REPORT FROM THE FINANCE, PERFORMANCE & DIGITAL COMMITTEE** Gan Mahadea Non-Executive Director and Vice Chair of the Finance, Performance and Digital Committee presented the report for assurance from the meeting that took place on 5th April 2018. The following updates were given by the Executive Director of Finance, Performance and Digital to the Committee: • The FPD team have been working in conjunction with 'AOB Financial Solutions Ltd' to develop a web based software solution to track specialist Out of Area Placements across the STP. Given the transferability to similar projects across the UK, the FPD team have recognised the commercial potential and are working to agree terms around royalty payments for Intellectual Property, in the event of external sales. • An expression of interest (EOI) has been submitted for 'NHS Digital	

	Test Beds' which if successful, provides national funding to support collaboration between public and private partners to address digital solutions. The trust is working with BT on a proof of concept to develop a framework which will support digital change and transformation across the alliance footprint. The EOI has been successful and the trust has moved to the next stage. • An update around North Staffordshire Combined 2018/19 contribution to the STP. Given the level of resource in kind put forward to work on STP work streams; it will result in a net repayment to the trust. • An update around the financial risk associated with the Estates Agency Contract with SSOTP and planned mitigations. The contract ceased on 1 April 2018. The Committee received an update for Cost Improvement for month 11 and were concerned that the total identified was still significantly short of the target. £2.413m is currently forecast to be recurrently delivered against the £3.197m target. This is a recurrent shortfall of £784k. A risk adjusted forecast was presented, considering any schemes that are included in the forecast position but not transacted, which highlighted a c£0.125m risk in the forecast CIP position. The Committee were assured that there was sufficient focus being placed on Cost Improvement but given the shortfall forecast for 2017/18, noted concern around delivery of the 2018/19 target. This is enforced by the fact CIP plans were not yet fully worked up for 2018/19. The M11 Agency report showed a forecast breach in the Agency ceiling of £550k, mainly due to Medical Locums and Lorenzo Agency. The committee noted that given the outturn for 2017/18, it is likely the trust will deliver within its £1.9m agency ceiling for 2018/19 in absence of Lorenzo. The Committee expressed concern around the long term nature of medical locums and financial risk associated with the national shortfall, however were assured that the trust were placing an appropriate level of focus on attracting substantive medical consultants. There has been an improvement in the cluster 99 data which has reduced from 57% to 55.1%, however the committee expressed concern around the pace of the improvement. A task and finish group, chaired by the Executive Director of Finance, Performance and Digital, meets monthly to provide a targeted approach to address issues around data quality and recording with clinical colleagues. Patrick Sullivan asked if there is an issue with the CIP towards the end of this year if this would be carried into next year. Suzanne Robinson highlighted as previously presented the budget for 18/19 had a slight adjustment on stretch target therefore original plan was maintained. Patrick asked if the Trust would be in the same position next year as this year. Suzanne confirmed a lot of work has been undertaken with regards to PiDs early in the year therefore the Trust should hit the ground running in April there is more embedding in Valuemakers around transformation with Jonathan O'Brien joining the Trust this will hold more impetus. The	

	restructure of the organisation will provide an opportunity to look at how teams can be developed in different ways. There are also trust-wide schemes to look at. Suzanne highlighted technology is not a material but an example where the Trust have developed in-house technology generating income for the Trust that we can ring-fence for team use. It's a way to develop the transformation funding pot to get schemes off the ground. ***Received***	
98/2018	**ASSURANCE REPORT FROM THE QUALITY COMMITTEE** Patrick Sullivan, Non-Executive Director and Chair of the Quality Committee presented the report for assurance from the meeting that took place on 18th April 2018. The Committee received the latest safer staffing report. Reporting of Registered Nurse (R/N) and non-registered nurse staffing levels is a key requirement to ensure the Trust complies with National Quality Board standards. Policy Report - the recommendations supported by the Committee for ratification of policies by the Trust Board (approval for 3 years otherwise stated) as follows:- • Policy for Searching Patients and their Property • Resuscitation • Towards Smoke Free • MHA02 Allocating a responsible Clinician and Selecting Second Professionals Each Directorate presented in detail their performance as part of the new reporting arrangements to the Committee. Committee members continue to feel that this new style of reporting, capturing information from performance reviews enables a much more focussed discussion around cross cutting issues. The focus of the discussion centred on good practice and achievements, new developments and innovations, current and potential challenges. In addition to the report Patrick highlighted a detailed discussion took place regarding the provider action statement to the Darwin Centre Mental Health Act review report and there were a series of actions identified in the action plan. ***Received***	
99/2018	**COMBINED CONNECTED – COMMUNICATIONS STRATEGIC PLAN 2018** Joe McCrea, Associate Director of Communications presented the report highlighting the following;	

	The document contains a Communications Delivery Plan 2018-20 for North Staffordshire Combined Healthcare NHS Trust. The Delivery Plan sets out how we will continue implementation of the Communications Strategy and Communications Objectives agreed by the Trust Board in May 2016 and building on implementation progressed during 2017 and actioned into 2018. Public affairs and engagement were discussed. The department has now recruited to two posts in the Communications Team which brings the team back up to establishment. 29 people applied for the 18 month secondment. David Rogers added this last year has been spectacular. The quality of the relationships being developed locally is excellent. This form of relationship building is critical at the moment. Tony Gadsby highlighted one of the Trusts communication challenges is with local authorities and asked if there are ways the Trust can target communication a level below and approach councillors? Elections are coming up should the Trust have a tritely that is pitched at the counsellors? Joe confirmed this will ebb part of the public affairs section, one of the core things the Trust wants to achieve. The team is also successfully building relationships with other Communications teams which helps in terms of sharing our own Trust messages. ***Received***	
100/2018	**STAFF SURVEY RESULTS (DIRECTORATE ACTION PLANS)** Alex Brett, Director of Workforce, Organisational Development and Communications presented the report highlighting the following: The Trust has been benchmarked against all other comparable mental health trusts and is above average performance against peers and a more positive trend year on year. The Trust is pleased to see improvements to our 'Staff recommendation of the organisation as a place to work or receive treatment' scores. As a result of the action plans developed to address the themes from the 2016 staff survey, a paper was presented to the board and actions plans developed to address our areas requiring improvement. The Trust is currently feeding back results to first cohort of teams. Reducing stress at work - Health and wellbeing strategy has been developed and interventions offered to all staff and all teams. Weekly Pilates sessions are provided for staff. Monthly Feel good Friday events - 7 health and wellbeing topics are promoted. Staff support and counselling	

	service have further strengthened their offers within the organisation and have recently being nominated for national HSJ and HPMA awards Listening into action and staff satisfaction. Maria Nelligan and Dr Adeyemo have undertaken a raft of work around listening events with staff. Career progression and promotion - Apprenticeships in Healthcare have been introduced and promoted enabling staff to develop their careers from healthcare support worker to move onto an apprenticeship as a nursing associate and pre-registration nurse. A nursing associate pilot has been developed in partnership with UHNM, which will go live in Sept 2018. Recognition awards - The estates team and various CYP teams were part of the Towards Outstanding Engagement programme. All teams in these directorates saw significant improvements in their staff engagement scores through targeted team level interventions. There have been significant improvements in our CAMHs CQC results and numerous national award nominations. Despite our estates team going through a management of change re-structure and TUPE, they have had some major achievements and have raised their profile internally in the Trust and started developing external business. PDRs and response rates have seen an improvement which is a positive. Clinical incidents and lessons learnt - Directorates have continued to highlight the importance of reporting clinical incidents within directorate meetings and supporting staff to attend lesson learnt events. A corporate action plan has been developed to address trust-wide issues focussing on our lowest scoring 2017 staff survey results and will form the focus of our action plan for 2018/19. Regarding reporting on safe clinical practice the Trust is strengthening its approach around freedom to speak up there are a number of mechanisms where people are encouraged to speak up. The Freedom to Speak Up Guardian role will be going to expressions of interest this week 4 professional groups with the lowest scores, scored considerably lower than the Trust average of 3.76. A professional group specific action plan has also been developed in response to this. The Board are asked to: • Receive this report • Note the priority areas for improvement • Approve the proposed actions. Tony Gadsby highlighted the Trust is potentially going through a restructure which will affect the organisation this year therefore we should condition ourselves to see the effect of that in next year's report. Caroline Donovan added the whole approach to improvement will be using	

	the listening into action approach which will be built into the whole changes process. Alex confirmed this has been flagged as a risk and added to risk registers. We will support teams through the changes. Caroline stated that the WRES data is a priority for the Trust and a lot more work needs to be undertaken. As an Executive team we will be focussing on this. ***Approved / Received***	
101/2018	**Date and time of next meeting** The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday 24th May 2018 at 10:00am, in the Boardroom, Lawton House, Trust HQ.	
102/2018	*** Motion to Exclude the Public** The Board approved a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted.	

The meeting closed at 1.15pm

Signed: _____ Date_____
Chairman

Board Action Monitoring Schedule (Open Section)

Trust Board - Action monitoring schedule (Open)					
Meeting Date	Minute No	Action Description	Responsible Officer	Target Date	Progress / Comment
22-Mar-18	67/2018	BAME Story - Staff Survey Results A moving story was received from a member of staff who attended People and Culture Committee this time which we will bring back to a future Board.	Alex Brett	24-May-18	Agenda item
22-Mar-18	76/2018	Dying to Work Campaign -Ideas to be shared with John Ashworth as part of ongoing relationship with politicians	Joe McCrea and David Rogers	24-May-18	Draft has been shared with the Chair David Rogers

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REPORT TO TRUST BOARD

Enclosure No:

Date of Meeting:	24th May 2018		
Title of Report:	CEO Board Report		
Presented by:	Caroline Donovan, Chief Executive		
Author:	Caroline Donovan, Chief Executive		
Executive Lead Name:	Caroline Donovan, Chief Executive	**Approved by Exec**	☐

Executive Summary:		**Purpose of report**	
This report updates the Board on activities undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest.		**Approval**	☐
		Information	☒
		Discussion	☒
		Assurance	☐
Seen at:	SLT Execs Date:	Document Version No.	
Committee Approval / Review	• Quality Committee • Finance & Performance Committee • Audit Committee • People & Culture Development Committee • Charitable Funds Committee • Business Development Committee • Digital by Choice Board		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. 2. To provide the highest quality services 3. Create a learning culture to continually improve. 4. Encourage, inspire and implement research & innovation at all levels. 5. Maximise and use our resources intelligently and efficiently. 6. Attract and inspire the best people to work here. 7. Continually improve our partnership working.		
Risk / legal implications: Risk Register Ref	N/A		

Resource Implications: Funding Source:	N/A
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	N/A
Recommendations:	1. To receive

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Chief Executive's Report to the Trust Board
24 May 2018

PURPOSE OF THE REPORT

This report updates the Board on activities undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest.

LOCAL UPDATE

1. CELEBRATING OUR CQC RESULTS AND TEAMS

On May Day we celebrated our journey of improvement to date and kept up the pace and trajectory towards outstanding we started over four years ago. Our live celebration at Harplands Hospital of our fantastic CQC results was attended by staff, service users and stakeholders. Many thanks for all those who attended.

Hosted by myself and our Chairman, David Rogers - the event was livestreamed across social media and included links to our Outstanding Services - our Adult Rehab Teams at Summers View and Florence House hosted by our Medical Director, Dr Buki Adeyemo. We also live streamed our Community CAMHS Team at Dragon Square hosted by our Director of Nursing and Quality, Maria Nelligan, celebrating that everyone of their 5 CQC domains are rated Good, this is a fantastic achievement and gives confidence to our community on the quality of services provided.

The full proceedings and a highlights package of a great event - including a special CQC Celebration Film featuring staff and management talking about their achievement - have been made available via our YouTube channel, where they have received over 800 views to date.

2. TOWARDS OUTSTANDING ENGAGEMENT EVENT HIGHLIGHTS SUCCESSES OF ITS FIRST COHORT

On Tuesday 8 May the first cohort of our staff went through our Towards Outstanding Engagement Programme. The event was shared across the Trust's social media channels and showed the fantastic achievement and dedication from our staff.

The event was attended by our Chair, David Rogers, our Non-Executive Directors Lorien Barber and Joan Walley - and chaired jointly by our Executive Director of Workforce, OD and Communications Alex Brett and our Executive Director of Operations, Jonathan O'Brien. It shows the strong commitment of our senior leadership team to the programme.

The Towards Outstanding Engagement Programme is carefully designed and structured to allow teams across the Trust to really understand and own their own improvement in a robust and planned way. By assessing their own strengths and development areas both at the outset of their journey and at its completion, they are able to plan a tailored improvement journey that really means something to them and is built on their own reality.

The average increase in engagement scores across the teams was 5.6%, with some teams seeing improvements as large as 12.8% increase in their engagement scores. Each team is at a different stage and are all being supported to continue their work to improve staff engagement - it's clear that the programme is being owned, valued and embraced by the full range of services and operations we provide, with some amazing results that were shared and celebrated.

3. STP DIGITAL WORKSTREAM GATHERS PACE

A full day meeting took place with the four potential suppliers who may be providing our new Integrated Care Record as part of our STP Digital Programme. It was a really positive day with many people including clinicians attending to hear from the suppliers about how they would work with us and what they could do. This will really progress our plans for clinical information to be able to be shared across organisations.

The really exciting thing for me was the potential for patients to be in control of their record and having access to their own information and in some instances being able to choose which professionals/ organisations would have access to their information. This would have the potential to really change the balance of power between the professional and the patient and enable a stronger focus on people taking responsibility for their own health.

The day was only part of the procurement process which will also include some site visits and detailed analysis of the business cases submitted. The site visits will take place during May and the plan is to have a supplier in place by July.

The workstream also held a celebratory and sharing event to recognise the great achievements of our range of healthcare teams who have deployed technology enabled care. The event had a packed agenda, focusing on people's experience of telehealth, video consultation, mobile apps, Patient Online and online clinical consultation triage.

An afternoon session looked a variety of uses of Facebook- whether in public settings or closed groups for example in UHNM. It also looked at social media use in GP practices, Patient Participation Groups, as part of screening and within maternity services.

Almost 100 people across the day saw a range of presenters, and there was lots of interest and discussion and reflections on how others can adopt and share the learning; a massive thank-you and well done to Dr Ruth Chambers - Chair of Stoke-on -Trent CCG and lead for Technology Enabled Care workstream as part of our Digital STP Programme.

4. LISTENING INTO ACTION EVENT FOCUSES ON DEVELOPING OUR SUPPORT FOR BAME STAFF

I was really pleased to be leading a special Listening into Action event this month, particularly focusing on our continuing efforts to support and develop our Black, Asian, Minority Ethnic (BAME) staff. Lots of our BAME staff attended as did our Medical Director Dr Buki Adeyemo, Executive Director of Nursing and Quality, Maria Nelligan, Director of Workforce Organisational Development and Communications, Alex Brett, and Non-Executive Director Gan Mahadea. It was great to hear the personal stories from our staff about their experiences, but our WRES scores also indicate that we have more to do. The LIA event produced some great ideas on what would make a difference, which will be taken forward with support from our great staff.

This will build on the progress we have started this past year, including:

- the Trust identified as an NHS Employers Diversity and Inclusion Partners Programme Champion;
- being commended by the CQC for progress on developing our approach to Diversity and Inclusion;
- holding our first Trust BAME Focus Groups for service users and staff with Yvonne Coghill, national Programme Director from the NHS England Workforce Race Equality Scheme (WRES); and
- launching our Trust BAME Staff Network, led by Cherelle Laryea, Trainee Clinical Psychologist

5. SECOND ANNUAL NURSING CONFERENCE

As a nurse by clinical background myself, I know just how central our nurses are to what we do. So it was simply wonderful to be able to kick off our celebrations of Nurses Day with our second Annual Nursing Conference. Congratulations are due to Maria Nelligan, Julie Anne Murray, Amanda Miskell and the working group for putting on a fantastic day-long celebration of everything our nurses do and what they achieve.

We were pleased to welcome Siobhan Heathfield, Regional Nurse for NHS Improvement and the inspirational Tommy Whitelaw, who is a great friend to the Trust and a national champion for Dementia.

The day featured workshops on such diverse topics as suicide awareness, understanding health inequalities and asylum-seeking. It also gave our team across the Trust the opportunity to show off a range of Pledge Trees produced to show what they have done to date and what they commit to do in the coming year. I was immensely impressed with the massive amount of poster presentations from so many teams. This really demonstrated the amazing work that they do day in day out. So many teams had articulated the improvements and changes they were making for service users and carers with a real evidence base.

We live streamed the main session for the event, which can be watched via our Facebook page. The day was rounded off by every one of our attendees being presented with our Combined Nursing Badge and delivering a Happy Nurses Day message via Twitter to their colleagues across the NHS

6. PREPARATIONS FOR PICU

I am delighted that our new Psychiatric Intensive Care Unit (PICU) building is now complete which will be a pleasant well designed environment for service users and carers. Massive thanks to Andrew Hughes, Geoff Neild and Ian Ball for their work on overseeing the design and build of the unit. Also a big thank you to Carol Sylvester, Natalie Larvin, Maxine Tilstone, Jackie Clowes and our clinical staff who have done a superb job working with service users and staff to ensure the clinical plans are fit for purpose

Our biggest challenge now is being able to recruit registered nurses. We have a scheme running whereby anyone introducing a doctor or trained nurse in a patient facing role at the Trust can be awarded an Amazon voucher. We are also running another series of One Stop Shops to quickly recruit nurses in where staff can walk away on the same day with a job offer - subject to ID and other appropriate checks.

This will be the first time ever that our local communities will have access to such a facility preventing people from having to travel out of area to receive treatment.

A team from across HR and Comms have produced a series of films on our social media as part of a rolling series, including a walk-around of the new PICU featuring Natalie Larvin and Maxine Tilstone which has received over 500 views on YouTube, as well as other communications products including leaflets, job adverts and media promotion and advertising widely in various newspapers and publications.

We are also working with the Stoke Sentinel on an extended piece in the newspaper on the PICU and the job opportunities available there.

7. CQC SYSTEM IMPROVEMENT AND STP

We have been working together as a system for some months on our improvement plan for the STP and some really great improvements are now being delivered. The Stoke Council Delayed Transfers of Care have reduced significantly and the Council's ranking in the country has gone from close to the bottom to the top third. The innovative collaborative care homes project led by the GP Federation in partnership with SSOTP, Combined and Douglas Macmillan hospice is showing a 16% reduction in attendances to A&E - really well done to everyone.

As part of the Staffordshire STP, OD and System Leadership workstream which I chair, we commissioned a Primary Care Leadership Development Programme. This was facilitated externally with input from a range of Combined staff, including Neil Clarke and Jane Rook from our OD team.

The programme is aimed at developing leadership capability amongst primary care across the whole of Staffordshire and Stoke-on-Trent, with a particular emphasis on developing new models of care.

I was delighted to attend the final workshop of the first Cohort on the programme involving a range of colleagues from across primary care, together with our Director of Workforce, OD and Communications, Alex Brett and the STP Director Simon Whitehouse. It was a great event, with lots of debate and insight into the innovations, improved ways of working and development of effective working relationships that are catalysing change and improvement across Staffordshire. Each participant had led the development of a project which was really impressive – collectively there has been such improvement.

I chaired the Midlands and East STP Board this month which had a real focus on growing the workforce, which will be one of the biggest challenges facing us as we move to implement the STP vision.

8. CONTINUING TO ENGAGE AS WE MOVE TOWARDS LOCALITY WORKING

Our plans to introduce new integrated locality-based structures within Combined Healthcare continue apace. We have held a series of engagement forums with staff groups and our stakeholders, while members of the Executive team have been out and about meeting Trust teams to seek their views on the proposals.

The driving principle of this new way of working is to strengthen how our wider community teams work across primary care, social care and community services.

We propose to implement Integrated Locality Working in a phased approach.

- Phase 1 – Reconfiguration of Clinical Directors, Associate Directors (HODs), Deputy Director of Operations - Go Live 2 July 2018
- Phase 2 – Configuration of Trust-wide Professional Heads- Go Live 16 July 2018
- Phase 3 – Configuration of Associate Clinical Directors & Clinical Leads, and all Service, AHP and Psychology Leads and Matron/Quality Leads - Go Live 27 August 2018
- Phase 4 – Transformation and redesign of clinical teams - Go Live 3 September 2018

Corporate structures (e.g. Finance, HR) will be aligned by July in order to report in line with new Directorates.

These new proposals, we feel, will enable us to be even more responsive and effective in delivering compassionate care to our local service users, their carers and families. We will be holding further engagement forums over the course of the next six to eight weeks and will continue to involve frontline staff and teams across the Trust.

We want to continue the conversations with everyone as we move to this new way of working, including finalising a new web microsite we will be introducing to enable everyone to keep fully informed about our plans and progress, ask questions of us and see answers to questions asked by others. All staff are encouraged to get involved in the conversations about this exciting development in how we deliver our services.

9. NOMINATIONS FOR OUR REACH 2018 AWARDS DRAW TO A CLOSE

The Recognising Excellence and Achievement in Combined Healthcare (REACH) Awards are an annual celebration of our staff and teams who go above and beyond in delivering excellent services. To mark the NHS 70 celebrations, this year's REACH will take place on Thursday 5 July at the Stoke-on-Trent Moat House. Nominations will open on Monday 26 March and we are hoping to beat last year's record-breaking total of 290 nominations. This year's awards will recognise outstanding achievements in the following categories:

1. Leading with Compassion Award
2. Rising Star Award
3. Volunteer/Service User Representative of the Year Award
4. Innovation Award
5. Valuemaker Award
6. Developing People Award
7. Partnership Award

8. Service User and Carer Council Award (decided by the Service User and Carer Council)
9. Unsung Hero Award
10. Proud to CARE Award
11. Team of the Year Award
12. Chairman's Award (decided by the Chair)

For more information about the awards, including how to nominate, please visit our REACH website www.reachawards.org/nscht.

10. FINALISTS IN NATIONAL PATIENT SAFETY AWARDS

During the month, we were delighted that two of our teams travelled to London to present their excellent work around Patient Safety. The Trust has been nominated twice in the category of Mental Health and Learning Disabilities in the national Patient Safety Awards.

The Learning Disabilities team presented to a judging panel of eight national experts on the programme of medication reduction in the Learning Disability Inpatient Service, whilst a second team presented on the work of the High Volume User Service, which operates in collaboration with the British Red Cross and University Hospitals of North Midlands in supporting people who use services intensively. I would like to extend congratulations to both teams for their efforts and for representing Combined Healthcare and the North Staffordshire System at these prestigious awards and I look forward to hearing the outcome from the awards celebrations, which are being held for finalists in Manchester on 9 July 2018.

11. TOWARDS SMOKEFREE

Together we have made significant steps collaboratively in stopping smoking across our wards and gardens, as part of our overall ambition to become smoke free this year, we are offering smoking cessation advice and Nicotine Replacement Therapy to anyone who needs it. Thank you to all our patients, visitors and staff that have worked tremendously hard in supporting our journey.

We have recognised that patients are leaving the wards at Harplands to smoke, and congregating outside reception. The signs at key points at Harplands will be reinforced and revised reminding patients and visitors that we are now a smoke free site. It will also sign post where to get advice and support with regards to stopping smoking. Staff are also asking visitors and patients to move away from the area to smoke and we all have a part to play in this.

We are all committed to making our hospital and grounds a pleasant and healthier environment, and ask that staff, patients and visitors are tolerant as we move forward with this significant change. Together we have made significant steps collaboratively in stopping smoking in wards and gardens, and offering smoking cessation advice and Nicotine Replacement Therapy. Thank you to all our patients, visitors and staff that have worked tremendously hard in supporting our journey.

12. FLYING THE FLAG FOR COMBINED AT THE POSITIVE PRACTICE MENTAL HEALTH COLLABORATIVE

I was pleased to attend the Positive Practice CEO dinner and national conference with our Director of Nursing and Quality, Maria Nelligan. The National Positive Practice Mental Health Collaborative is a user-led, multi-agency collaborative of 75 organisations, including NHS Trusts, CCGs, Police Forces, third sector providers, front line charities and service user groups. Its aim is to identify and disseminate positive practice in mental health services by working together across organisations and sectors, to facilitate shared learning and to raise the profile of mental health with politicians and policy makers.

We're strong supporters and active members of the Collaborative, and it was great to be able to attend the first ever Collaborative Convention and Learn and share with other mental health organisations. We have been asked to start a national substance misuse collaborative which Dr Derrett Watts our Clinical Director for substance misuse will be leading. Some of the Executive Team have also been asked to be on the judging panel for the positive practice awards.

13. LEADERSHIP ACADEMY FOCUSES ON APPRENTICESHIPS

Our latest Leadership Academy featured an interactive and informative session, updating knowledge, understanding and perceptions about apprenticeships in a bid to encourage our senior managers to think differently about how to access and utilise the apprenticeship levy in developing our future workforce. We also had a guest speaker, Anne Longbottom, Development Manager from Staffordshire University discuss updates and opportunities for higher level apprenticeships.

We offer a range of apprenticeships and apprentice qualifications at different levels to enhance skills with the Trust, support talent management and draw maximum benefit from the funding available. We understand our current staff qualification levels to further enhance the skills of the workforce through apprentice qualifications and are developing new roles and pathways to enable staff to progress their career.

14. WOLVERHAMPTON UNIVERSITY

Our medical director Dr Buki Adeyemo has been invited to sit on the board of the University of Wolverhampton as an independent governor. This is great news for the Medical Director and the Trust and further enhances our growing relationships with our education partners.

15. HEALTH AND WELLBEING BOARD

On 18 April 2018 the Stoke-on-Trent Health and Well-Being Board met for the first time in its reconstituted form following the Stoke-on-Trent CQC System Review. The Board agreed a shared determination to provide system leadership as described in the CQC report. As a first demonstration of this commitment, the Board approved the Joint Commissioning Strategy prepared by the CCGs on behalf of health, social care and public health commissioners

NATIONAL UPDATE

16. HEALTH AND SOCIAL CARE COMMITTEE AND EDUCATION COMMITTEE PUBLISH REPORT ON 'THE GOVERNMENT GREEN PAPER ON MENTAL HEALTH'

A report on the government's mental health green paper, titled ***The government's green paper on mental health: failing a generation.*** The committees argue that the green paper which looks at children and young people's mental health provision lacks ambition and will provide no help to the majority of those children who desperately need it.

We have delivered significant improvements in our CAMHS services in the recent past, including significant progress on waiting times and quality of services, which were significant factors in the CQC's decision to rate our CAMHS Community and CAMHS Inpatient services as 'Good' – up from Inadequate and Requires Improvement respectively only 2 years ago.

We have also won national awards and been shortlisted for others in recognition both of the quality of our CAMHS Leadership and pioneering new models of care in partnership with Stoke-on-Trent schools."

17. RECENT REPORTS ON MENTAL HEALTH AND LEARNING DISABILITIES PROVISION

Three significant reports have been published in the last week with a focus on mental health and learning disabilities, but with relevance to all NHS foundation trusts and trusts. This overview briefing provides a summary of each and NHS Providers' view. The reports are:

- The Government's Green Paper on mental health: failing a generation – a joint report by the Health and Social Care Select Committee and the Education Select Committee
- The Learning Disabilities Mortality Review (LeDeR) Programme – the annual report by the Healthcare Quality Improvement Partnership, on behalf of NHS England
- The interim report of the Independent Review of the Mental Health Act – the review being chaired by Professor Sir Simon Wessely and commissioned by the Department of Health and Social Care

http://nhsproviders.org/media/4788/recent-reports-on-mental-health-and-learning-disabilities-nhs-providers-on-the-day-briefing-may-2018.pdf

REPORT TO: OPEN TRUST BOARD

Enclosure No: 5

Date of Meeting:	24th May 2018		
Title of Report:	Service User & Carer Council Report		
Presented by:	Wendy Dutton, Chair, Service User & Carer Council		
Author:	Wendy Dutton, Service User & Carer Council		
Executive Lead Name:	Maria Nelligan, Executive Director of Nursing & Quality	Approved by Exec	☒

Executive Summary:		Purpose of report	
This report has been prepared to provide an update to Trust Board of the Service User & Carer Council since the last meeting.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐	Date:	
	Execs ☐	Date:	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. ☐ 2. To provide the highest quality services. ☒ 3. Create a learning culture to continually improve. ☐ 4. Encourage, inspire and implement research & innovation at all levels. ☐ 5. Maximise and use our resources intelligently and efficiently. ☐ 6. Attract and inspire the best people to work here. ☐ 7. Continually improve our partnership working. ☒		
Risk / legal implications: Risk Register Ref	None identified		
Resource Implications: Funding Source:	None identified		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	The Service User & Carer Council supported the principle of increasing representation across the Protected Characteristics when reviewing the Diversity and Inclusion Strategy. They also committed to supporting inclusive services and workforce in their review of the Strategy.		
Recommendations:	The Trust Board receives the update for information and assurance.		

Version	Name/group	Date issued

North Staffordshire Combined Healthcare NHS Trust

SERVICE USER AND CARER COUNCIL UPDATE
FOR TRUST BOARD ON 24th May 2018

1 Workshop 25th April 2018

- Trial of alternative time to 5pm and venue to support attendance from the Young People Council and Volunteers and specific invites and reminders have been sent.
- 1 additional volunteer attended. Agreed to trial 2 further workshops.
- There was a lively debate on person centredness which resulted in good ideas and thoughts for progressing this work. Notes will be collated and shared with those at the workshop before being forwarded to the remainder of the Service User & Carer Council membership.

2 Business Meetings

To review agenda`s, prioritise and ensure that were are able to give items due regard. To discuss re-introducing a break.

3 Citizens Jury Update

Several members of Service User & Carer Council attended the Citizens Jury review of Mental Health Services. There was a disappointing and obvious lack of involvement from 3rd sector workers and current Mental Health service providers. The next step is to develop an action plan to review recommendations and their possible implementation. This is on the agenda for the next Service User & Carer Council Business meeting on 30 May 2018.

4 Continued Service User & Carer Council membership involvement

- Trust Board meetings
- Interviews
- PLACE Assessment
- SUEEG Meetings
- Business Meetings
- People and Development
- Inductions
- Access Meetings
- Adult In-patient meetings
- Ward and Admin Volunteers and more!

Wendy Dutton
Chair, Service User & Carer Council
4 May 2018

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO: TRUST BOARD

Enclosure No: 6

Date of Meeting:	24 May 2018		
Title of Report:	March 2018 Monthly Safer Staffing Report		
Presented by:	Maria Nelligan, Executive Director of Nursing & Quality		
Author:	Julie Anne Murray, Deputy Director of Nursing, AHP & Quality		
Executive Lead Name:	Maria Nelligan, Executive Director of Nursing & Quality	Approved by Exec	☒

Executive Summary:		Purpose of report	
This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during March 2018 in line with the National Quality Board requirements. The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during 2018 was 83% for registered staff and 96% or care staff on day shifts and 83% and 105% respectively on night shifts. Overall a 93% fill rate was achieved. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward manager supporting clinical duties. The data reflects that Ward Managers are staffing their wards to meet increasing patient needs as necessary.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐	Date:	
	Execs ☒	Date:	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. ☐ 2. To provide the highest quality services. ☒ 3. Create a learning culture to continually improve. ☐ 4. Encourage, inspire and implement research & innovation at all levels. ☐ 5. Maximise and use our resources intelligently and efficiently. ☒ 6. Attract and inspire the best people to work here. ☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	Delivery of safe nurse staffing levels is a key requirement to ensuring that the Trust complies with National Quality Board standards.		
Resource Implications: Funding Source:	Temporary staffing costs. Budgeted establishment and temporary staffing spend.		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None		
Recommendations:	To receive the report for assurance and information		

Version	Name/group	Date issued
1	Maria Nelligan	30 April 2018
2	Execs	08 May 2018

1 Introduction

This report details the ward daily staffing levels during the month of March 2018 following the reporting of the planned and actual hours of both Registered Nurses (RN) and Health Care Support Workers (Care Staff) to Unify. Appendix 1 details the establishment hours in comparison to planned and actual hours.

2 Background

The monthly reporting of safer staffing levels is a requirement of NHS England and the National Quality Board in order to inform the Board and the public of staffing levels within in-patient units.

In addition to the monthly reporting requirements the Executive Director of Nursing & Quality is required to review ward staffing on a 6 monthly basis and report the outcome of the review to the Trust Board of Directors. The 6 monthly review covering January to June 2017 was originally planned to be reported to November 2017 Board. However, due to the management of change (MoC) relating to shift patterns, it was agreed at October 2017 Quality Committee to delay the report in order to capture the outcome of the MoC. Due to the timeline of the MoC, the 2 six monthly reports (January-June and July-December 2017) were amalgamated into a comprehensive annual report for 2017. This was presented to April 2018 Board and the recommendations agreed.

3 Trust Performance

During March 2018 the Trust achieved a staffing fill rate of 83% for registered staff and 96% for care staff on day shifts and 83% and 105% respectively on night shifts. Taking skill mix adjustments into account an overall fill-rate of 93% fill was achieved. Where 100% fill rate was not achieved, staffing safety was maintained on in-patient wards by nurses working additional unplanned hours, cross cover, Ward Managers (WMs) and the multi-disciplinary team (MDT) supporting clinical duties and the prioritising of direct and non-direct care activities. Established, planned (clinically required) and actual hours alongside details of vacancies, bed occupancy and actions taken to maintain safer staffing are provided in Appendix 2. A summary from WMs of issues, patient safety, patient experience, staff experience and mitigating actions is set out below.

The Safer Staffing Group oversees the safer staffing work plan on a monthly basis, the plan which sets out the actions and recommendations from staffing reviews.

4 Impact

WMs report the impact of unfilled shifts on a shift by shift basis. Staffing issues contributing to fill rates are summarised in Appendix 2.

4.1 Impact on Patient Safety

There were no incidents reported during March 2018 relating to patient safety and nurse staffing issues.

4.2 Impact on Patient Experience

Staff prioritise patient experience and direct patient care. During March 2018 it was reported that 13 activities were cancelled or shortened (and not rearranged) due to nurse staffing levels. All of these cancellations were on Darwin where staffing levels have been challenging.

4.3 Impact on Staff Experience

In order to maintain safer staffing the following actions were taken by the Ward Manager during March 2018:

- 106 staff breaks were cancelled (equivalent to approximately 2.2% of breaks)
- 7 staff breaks were shortened equivalent to approximately >1% of breaks)
- 11 hrs of ward cross cover (nursing staff were reallocated to cover shortfall within other clinical areas).

4.4 Mitigating Actions

Ward Managers and members of the multi-disciplinary team have clinically supported day shifts to ensure safe patient care. Skill mix has been altered to backfill shortfalls. A total of 138 RN shifts were covered by HCSW where RN temporary staffing was unavailable. A total of 37 HCSW shifts were covered by RN staff where HCSW temporary staffing was unavailable. Additionally, as outlined in section 4.3, staff breaks have been shortened or not taken (time is given in lieu) and wards have cross covered to support safe staffing levels.

4.5 RN Staffing Trend

The RN fill-rate 12 month trendline is demonstrating a slight increasing trend:

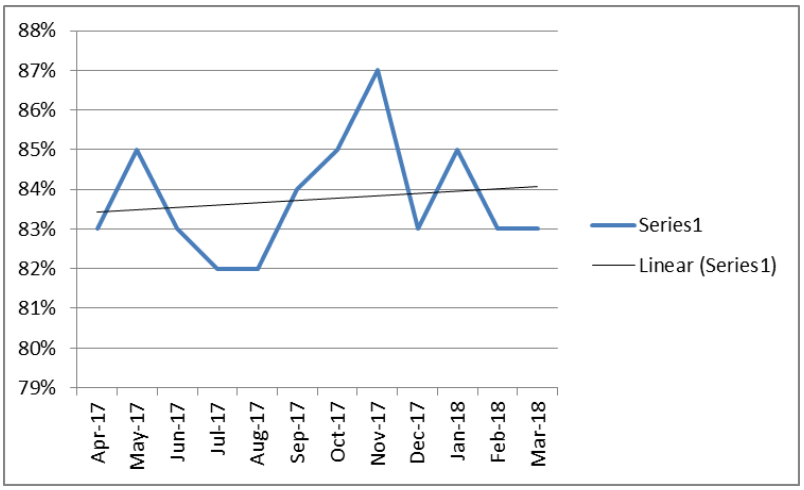

Figure 1 Twelve month RN fill rate trend line

This increasing trend is continuing to be built upon and the following actions have been taken to strengthen RN staffing:

- Twenty six third year Keele nursing students have accepted a conditional offer to commence with Trust in Oct 2018
- Shift patterns have been altered in response to staff feedback
- Recruitment opportunities for RNs continue to be advertised (including bank)
- The Trust has joined the NHSI MH recruitment and retention programme
- Recruitment campaign launched for PICU

5. Summary

Safe staffing reporting indicated challenges in staffing wards during March 2018. A significant number of RN vacancies have been filled by newly qualified RNs during October 2017; these nurses are coming to the end of their period of preceptorship. The Board should note the further challenges associated with the temporary increase of beds on Ward 4 in the response to the winter pressure in the health economy. During 2018 it is anticipated that challenges will also be experienced with the planned opening of PICU, therefore the 2017 annual nurse staffing review will make recommendations in relation to this. The Trust continues to employ alternate strategies with the support of the HR and communication teams to attract RNs during this national shortage.

The trust have joined the NHSI Retention Support Programme. A project team is being identified to deliver this programme and a visit from NHSI is being arranged.

6. Recommendations

The Trust Board is asked to:-

- Receive the report
- Note the challenges with recruitment and mitigations/action in place
- Note the challenge in filling shifts
- Be assured that safe staffing levels are maintained

Appendix 1 March 2018 Safer Staffing

Mar-18	DAY						NIGHT						DAY		NIGHT					
	Registered nurses			Care staff			Registered nurses			Care staff										
Ward name	Establishment Hours	Clinically required Hours	Total monthly actual hours	Establishment Hours	Clinically required	Total monthly actual hours	Establishment Hours	Clinically required	Total monthly actual hours	Establishment Hours	Clinically required	Total monthly actual staff hours	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Safe staffing was maintained by:	RN Vacancies	HCSW Vacancies	Bed occupancy	Movement
Ward 1	1553	1163	1120	1395	1178	1222	665	688	400	665	707	977	96%	104%	58%	138%	Nurses working additional unplanned hours and altering skill mix.	2.40	2.41	94%	↑
Ward 2	1500	1365	924	1395	1465	1574	646	686	555	665	1032	1066	68%	107%	81%	103%	Nurses working additional unplanned hours and altering skill mix.	5.20	1.21	89%	↓
Ward 3	1410	1284	1092	1260	1154	1184	600	622	355	600	666	932	85%	103%	57%	140%	Nurses working additional unplanned hours	2.80	2.04	84%	↑
Ward 4	1560	1560	1309	1860	1860	1580	688	688	537	1032	1032	1017	84%	85%	78%	99%	MDT supporting nursing team, altering skill mix	4.90	3.00	95%	↑
Ward 5	1039	1488	1064	900	1350	1428	281	315	315	843	945	885	72%	106%	100%	94%	Altering skill mix	1.50	-0.20	103%	↑
Ward 6	1095	1163	1076	2093	2197	2123	344	344	389	1376	1376	1388	93%	97%	113%	101%	Nurses working additional unplanned hours, MDT supporting nursing team	3.30	2.55	96%	↑
Ward 7	1095	1090	982	1395	1674	1580	290	344	344	581	1232	1187	90%	94%	100%	96%	MDT supporting nursing team, altering skill mix	1.80	0.00	95%	↑
A&T	956	900	923	1395	1382	1261	688	688	500	688	1032	1109	103%	91%	73%	107%	Altering skill mix	3.63	3.31	75%	↑
Edward Myers	1058	1022	901	930	837	828	291	344	343	581	688	681	88%	99%	100%	99%	Nurses working additional unplanned hours and altering skill mix. Cross cover was provided to other wards.	1.94	0.88	89%	↑
Darwin Centre	1328	1328	877	1163	1373	1392	344	344	344	688	810	812	66%	101%	100%	100%	Nurses working additional unplanned hours, altering skills mix, MDT supporting nursing team, cancelling of some activities.	3.00	0.20	90%	↓
Summers View	1013	990	783	930	930	854	332	332	323	665	654	632	79%	92%	97%	97%	MDt supporting the nursing team	1.40	0.00	91%	↓
Florence House	548	525	523	930	930	626	332	332	332	332	332	332	100%	67%	100%	100%	MDt supporting the nursing team	0.00	1.53	97%	↓
Trust total	**14152**	**13876**	**11573**	**15645**	**16329**	**15652**	**5502**	**5728**	**4736**	**8717**	**10508**	**11018**	**83%**	**96%**	**83%**	**105%**					

Appendix 2 Staffing Issues

- There have been challenges and limited success in recruiting band 5 adult RNs to Ward 4 therefore the team are seeking to recruit RNs from other fields who have physical health experience, this will be supported by an education programme. An Advanced Nurse Practitioner has been recruited and will commence in May2018.

- There are currently 46.4 WTE RN vacancies in in-patients (31.9 WTE current in-patient wards and 14.5 WTE for PICU). Of the 31.9 WTE vacancies in current in-patient wards (ie excluding PICU), a significant number are in the recruitment process (including the newly qualified University of Keele nurses who are due to join the Trust in October 2018). We continue to advertise for the remainder and a series of one-stop-shops are planned over the next few months.

- There are currently 17 WTE HCSW vacancies reported within in-patient wards. The majority of these are in the recruitment process.

- Ward 2 and 4 have the highest RN vacancies of 5.2 and 4.9 WTE respectively; the majority of these have been recruited to. The remaining posts have been advertised externally and have been included within the recruitment events with limited success. Therefore we are reviewing skill mix and shift patterns.

- Ward teams are supported by Modern Matrons and a Duty Senior Nurse who are further supported by an on-call manager out of hours.

- RN night shift cover remains challenging. This is a result of increasing night cover to 2 RNs on the acute wards (1, 2 and 3) however the number of vacancies on these wards has made this challenging to achieve consistently.

- High occupancy and increased acuity have also contributed to shortfalls, in the fill rate.

REPORT TO OPEN TRUST BOARD

Enclosure No 7

Date of Meeting:	24th May 2018		
Title of Report:	Q4 Serious Incident Report		
Presented by:	Dr Buki Adeyemo. Executive Medical Director		
Author:	Jackie Wilshaw. Head of Patient and Organisational Safety		
Executive Lead Name:	Dr Buki Adeyemo	Approved by Exec	☒

Executive Summary:		Purpose of report	
This report provides analysis of Serious Incidents which occurred during January to March 2018. It is noted that the number of serious incidents in this quarter has increased; alcohol and drug misuse continues to be a factor in the deaths reported.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☒	Date: 15TH May 2018	
	Execs ☐	Date:	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. ☐ 2. To provide the highest quality services. ☐ 3. Create a learning culture to continually improve. ☐ 4. Encourage, inspire and implement research & innovation at all levels. ☐ 5. Maximise and use our resources intelligently and efficiently. ☐ 6. Attract and inspire the best people to work here. ☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	Nil identified		
Resource Implications: Funding Source:	Nil identified		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	No issues with regards to protected characteristics have been identified during the analysis of the Q4 SI data		
Recommendations:			

Version	Name/group	Date issued
1	Dr O Adeyemo	10/04/2018
2	Dr O Adeyemo	15/05/2018

1. Purpose of the report

This report provides assurance to the Quality Committee of the Trust processes relating to Serious Incidents (SIs) and Duty of Candour. The report covers the period from 1st January 2018 to 31st March 2018 (Quarter 4, 2017/18) and details the following:

- The status of SIs currently open and trend data for Q3 2017/18 and Q4 2017/18.
- Serious Incidents by category reported by quarter.
- Themes learning and change arising from Serious Incident investigations.
- The quarterly Duty of Candour report.

2. Serious Incidents Q4

Serious Incident investigations are undertaken following incidents involving people in receipt of services or who have been in receipt of services in the previous 12 months. This does not include those service users whose deaths are determined by HM Coroner to be as a result of natural causes. The table below illustrates the total number of SIs reported by quarter for the period April 2016 to March 2018

Table 1

Incident category	Q1	Q2	Q3	Q4	**Total 2016/17**	Q1	Q2	Q3	Q4	**Total 2017/18 YTD**
Slip, trip, fall	2	0	1	2	**5**	2	6	3	3	**14**
Pending review – Unexpected/potentially avoidable death	0	10	7	6	**23**	4	10	8	11	**33**
Apparent/actual/suspected self-inflicted harm meeting SI criteria	0	1	1	1	**3**	1	0	2	2	**5**
Disruptive, aggressive behaviour meeting SI criteria	1	0	0	0	**1**	0	0	0	0	**0**
Apparent/actual/suspected self-inflicted harm meeting SI criteria (suspected suicide)	7	11	4	2	**24**	3	6	2	5	**16**
Unexpected/potentially avoidable injury causing harm	0	1	0	0	**1**	0	0	0	0	**0**
Apparent/actual abuse	0	0	0	0	**0**	0	1	2	2	**5**
Total	10	23	13	11	**57**	10	23	17	23	**73**

The increase in reported SIs between 2016/17 and 2017/18, demonstrated above, will be analysed within the Annual SI report, which will be submitted to Quality Committee in June 2018.

The table below shows the SIs by month for each directorate for Q4 2018:

Team	January	February	March	Total
AMH Community	2	2	5	9
AMH Inpatient	2	1		3
NOAP	3		1	4
Substance Misuse Services are shown below				
One Recovery Staffordshire	2		1	3
One Recovery Newcastle	1		1	2
Stoke CDAS	2			2

During Q4, 23 incidents were reported onto StEIS and have undergone or are in the process of undergoing SI investigation.

The main points to note are:

- There were 7 unexpected deaths in the Substance Misuse Directorate.
- In the Adult Mental Health-Community Directorate there were 8 unexpected deaths and 1 incident of violence and aggression (abuse) against community staff which will be investigated as a Serious Incident.
- In the NOAP Directorate, there were 2 incidents of fractures caused through falling, 1 incident of a lapsed section/illegal detention and 1 suspected suicide within the directorate.
- Within the Adult In-Patient Directorate, there were 2 incidents of patients inflicting serious self-harm, sadly one of these incidents later resulted in the person's death. One person also suffered a fracture following a fall.

3. Themes and Trends

There is an increase in SIs reported during the later weeks of Q3 and during January 2018 in Q4. The majority of these investigations are on-going at the time of report, early indications show that substance misuse featured in 7 out of the 12 SIs reported in January 2018.

Throughout Q4, there were 17 SIs relating to unexpected deaths and of these, 5 were deaths where suicide was suspected. There were 7 deaths in the Substance Misuse Services however throughout the quarter, substance misuse was suspected as a contributory factor in 12 of the 17 deaths.

As previously reported, the addition of Stoke Community Drug and Alcohol Services (CDAS) has made an impact on the number of SIs reported from substance misuse services. During Q4, CDAS deaths account for 40% of deaths since this services was acquired by directorate.

In this quarter, there were 2 incidents of serious self-harm which occurred in the in-patient wards. One incident resulted in the person requiring surgical repair of the wound inflicted. The investigation into this incident is ongoing but the initial findings indicate that the incident could not have been foreseen and there were reasonable measures in place to prevent access to items which may be used to self-harm.

As previously reported, the outcome of the second incident of serious self-harm was the death of the person, following a period in medical intensive care. This incident is currently undergoing investigation utilising a new approach for the Trust; that of a review panel which includes an external panel member from another NHS Trust. This approach is being piloted in recognition that external scrutiny and challenge assists the Trust in identifying and learning lessons. Additionally, it is recognised that the RCA approach (Root, Cause Analysis) can cause significant distress to staff. The aim of investigating SIs and other incidents is to learn from these to decrease the likelihood of future occurrences. Therefore an approach that supports a culture of openness and learning, allowing staff to speak up when things go wrong, is essential. It is anticipated that the review panel approach will mitigate against any potential feeling amongst the staff of a 'blame culture' and also bring a greater depth to investigations through the promotion of a group/team reflective approach. Evaluations of the more traditional RCA approach have also shown that SIs rarely occur due to the actions of one person and are more likely to result from systems issues, therefore an approach which facilitates questions around the wider care delivery systems is appropriate. This approach is also supported by the latest NHSI publication '*A just culture guide'* (NHSI March 2018).

SIs arising from slips, trips and falls are showing an increasing trend over the last 12 months however in Q3 and in Q4 there has been a reduction in the number of falls meeting SI criteria. Actions to address issues relating to falls from the falls rapid improvement group and the AQuA (Advancing Quality Alliance) initiatives are ongoing and under current review.

4. Learning from Serious Incidents

Recommendations and learning from investigations are disseminated on completion of the SI investigation. The learning that was found from the previous quarter and early Q4 investigations is outlined below:

- A need to improve the documentation around mental capacity assessments and the person's capacity to participate in decision making was noted. This is being monitored through case supervision and management processes. This work is also part of the ongoing Lorenzo development activity and will be monitored through the Inpatient and Community Safety Matrices
- Staff knowledge regarding the use of the Threshold Assessment Grid (TAG) has been strengthened through ongoing discussions/feedback and is currently being monitored by caseload supervision, management and audit.
- Practice observations and reflective feedback sessions have been facilitated by team leaders in order to provide assurance around general community team practice.
- The substance misuse services were reminded to ensure that all prescriptions were clearly written and to complete welfare checks on those people prescribed high dose opiate substitution treatments, where additional illicit drug-taking is suspected. This will be monitored through Team Leaders.
- Training will be provided to all regular bank staff on the NOAP wards in relation to the falls risk assessments and the post falls assessment process. This is in order to ensure that all falls assessments are accurately documented and that action to support people post falls is completed in a timely manner. Furthermore falls awareness relating to policy and process will be included in local induction.

As in previous reports there were a number of investigations where no recommendations for practice were made. However areas of good practice were identified, these include:

- Examples of good communication between community mental health and prison services and between substance misuse and prison services

During Q4, the Patient and Organisational Safety Team (P+OS Team) have worked with the Governance Leads to strengthen the Trust ability to demonstrate that the implementation of learning from investigations is embedded into practice and that changes can be evidenced. A new database has been produced, which allows the P+OS Team and the directorate governance leads to see at a glance all of the current action plans, progress made against completion of the action plans and evidence of progress made/maintained at the following 6 and 12 month periods. The progress made against these action plans will be monitored through quarterly reports to the Clinical Safety Improvement Group (CSIG) and onwards to QCRM

5. Duty of Candour (Quarter 4 report)

The Trust continues to strive for open and transparent practice in our delivery of mental health and learning disability services. All reported incidents are scrutinised at the weekly incident review meeting. This meeting is facilitated by the Patient and Organisational Safety team and aims to provide secondary monitoring and identification of all incidents which may potentially meet the criteria as Duty of Candour reportable incidents.

In the cases of the SI investigations, it is not always possible to determine which, if any of the deaths under investigation meet the Duty of Candour requirements. However should any investigation identify causal links between patient harm and service delivered, the Duty of Candour process would be initiated and a letter outlining the issues sent to the patient or next of kin. As the mortality surveillance process continues to develop, the group responsible for overseeing this have incorporated a review of SI deaths into the process. This is to ensure that Duty of Candour is considered during the SI investigation, in the governance processes for the report ratification and recorded within the mortality surveillance process.

The table below shows the number of Duty of Candour incidents for Q4:

Month	PSI identified as moderate or above	PSI downgraded following review	Meets DoC requirements	Managed through the SI policy	Moderate incident but not DoC
January	21	10	1	8	2
February	14	9	0	2	3
March	17	4	0	7	6
Total	52	23	1	17	11

The Duty of Candour incident in January was in relation to a tissue viability incident. This incident was investigated and at the time of this upon review the damage was thought to have been avoidable and therefore meets the DoC criteria. The ward manager has met with the person and apologised for the lapse in care provided. In line with the DoC requirements, a written response to the patient was also provided.

6. Conclusion

- The trust continues to monitor all incidents on a weekly basis and this report demonstrates compliance with Trust policies and processes.

- It is noted that the number of SIs within this quarter has increased. The initial findings of investigations do not show any causal or contributory link beyond an increase in the number of incidents where drugs or alcohol were taken prior to the death of the person.

REPORT TO OPEN TRUST BOARD

Enclosure No:8

Date of Meeting:	24th May 2018		
Title of Report:	Mortality Surveillance Activity Report		
Presented by:	Dr Buki Adeyemo, Executive Medical Director		
Author:	Jackie Wilshaw, Head of Patient and Organisational Safety		
Executive Lead Name:	Dr Buki Adeyemo	Approved by Exec	☐

Executive Summary:		Purpose of report	
This report provides a review of the unexpected deaths from Serious Incident Investigations and 'natural cause' deaths of service users which occurred during January to March 2018 and also provides an overview of the development of the process and incidents reported since the publication of Learning from Deaths (March 2017). This report has previously been included in the Serious Incident quarterly reports but in response to the national Learning from Deaths guidance, this analysis is now provided as a separate report.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☒	Date:15/05/2018	
	Execs ☐	Date:	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. ☐ 2. To provide the highest quality services. ☒ 3. Create a learning culture to continually improve. ☒ 4. Encourage, inspire and implement research & innovation at all levels. ☐ 5. Maximise and use our resources intelligently and efficiently. ☐ 6. Attract and inspire the best people to work here. ☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	Nil identified		
Resource Implications: Funding Source:	Nil identified		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	The analysis of deaths investigated has not revealed any issues with regards to the protected characteristics of the people reviewed under the mortality surveillance process.		
Recommendations:	The Trust is asked to accept this report as assurance that mortality surveillance processes are in place.		

Version	Name/group	Date issued
1	Dr O Adeyemo	19 April 2018
2	Dr O Adeyemo	15th May 2018

1. Introduction

Following the publication of Learning from Deaths (National Quality Board, March 2017) and Learning, candour and accountability (CQC December 2016), from April 2017 the Trust has been required to publish a quarterly account of specified information on deaths. The paper requires Trusts to examine all specified deaths of service users. This report provides information on unexpected deaths which have been determined to be due to 'natural causes' and therefore not investigated under the Serious Incident (SI) policy. However the Trust also considers the care of people whose deaths were investigated under the SI policy in order to provide the Trust with a complete understanding of all service user deaths. This report will be published on the public facing area of the Trust website.

The Trust receives information with regards to unexpected deaths from the North Staffordshire Coroner's Office. If the deceased person is in receipt of mental health or learning disability services or had been in receipt of services in the preceding 12 months **and** is determined by HM Coroner to have died unnaturally, the Trust will complete an investigation through the Serious Incident process. There is robust governance in place around this process and areas for action are monitored by the directorates responsible. The learning from these deaths is disseminated throughout the Trust as part of the Learning Lessons framework. This process was subject to review by the Trust auditors RSM and the Trust received assurance with regards to the strength of the process (September 2017).

Natural cause deaths of patients (where the person is open to services at the time of death) as identified by HM Coroner, do not meet the requirement for SI investigation. The Trust undertakes local investigations as set out in 'Learning, candour and accountability' in order to ensure that there are no gaps/omissions in service delivery or missed opportunities for learning. These investigations include those people whose deaths are related to excessive alcohol use.

The scope for mortality surveillance investigations will cover the following criteria:

- Deaths of people open to mental health services, where the person has a diagnosis of Serious Mental Illness and has died at an age which may be reasonably considered to be premature.The deaths of people over the age of 75 will not be included in mortality surveillance investigations.
- Deaths of people open to Substance Misuse Services, where alcohol abuse is considered to be a factor.

2. Mortality Surveillance Group activity

A Trust Mortality Surveillance (MS) Group was established in November 2017 and meet at 4-6 weekly intervals. The group reviews aspects of care such as assessment and care plan review dates, any delays in planned care, consideration of physical health needs and any safeguarding issues. The group take into account the cause of death* as determined by HM Coroner and are asked to consider a number of questions based on determining the quality of care provided and if the person's death could have been due to issues in care provided by the Trust. Following the review, any learning and actions identified will be shared with teams/directorates as necessary.

**not all deaths are reported to HM Coroner and the death certificate may be provided by the GP or acute hospital where the deceased was last known. In this case, the cause of death may not be known to the Trust.*

During this reporting timeframe 6 unexpected deaths have been reviewed by the MS group. These were the deaths of people in our patient population which were cleared as natural cause deaths and did not meet the criteria for investigation under the SI policy. Mortality review reports have been requested for all deaths meeting the set criteria. Some of the reports are yet to be reviewed due to the timings of the deaths. The group reviewed the care of people whose deaths had been confirmed as natural causes and which had occurred in the period. The table below details the review findings.

Patient identifier	**Standard of care**	**Code**	**Outcome of review.**
A12	Good	EN1	No issues with mental healthcare
B13	Good	UN1	No issues with mental healthcare
C31	Adequate	EU	No issues with mental healthcare
D32	Good	EN1	No issues with mental healthcare
E35	Good	EU	No issues with mental healthcare
E36	Adequate	EN1	No issues with mental healthcare

Code definitions:

- UN1 unexpected natural death – death from a natural cause – such as a sudden cardiac event/ CVA
- EN1 EN1Expected Natural- deaths that were expected to occur in an expected timeframe e.g. Terminal illness. Unlikely to be preventable
- EU Expected Unnatural - deaths that are expected but not from the cause expected or timescale e.g. misuse of drugs, alcohol dependant, eating disorder

Of the 6 deaths investigated, issues related to drugs or alcohol featured in the deaths of 4 people. The causes of death included lung cancer, sudden cardiac arrest and respiratory disorders. When considering the 'on balance' question of whether or not the death occurred as a result of problems in healthcare, the MS group concluded that none of the people died as a result of problems in mental healthcare. In all of the cases reviewed the care provided by our clinical teams was felt to be adequate to excellent. It was provided in a timely manner and appropriate for the mental health care of the person.

The group also reviewed the care of 6 people whose deaths had been reported and investigated under the SI framework. This was to provide completeness with regards to the Trust understanding of the 'on balance' question. The table below details the review findings.

Patient identifier	**Standard of care**	**Code**	**Outcome of review.**
S15	Good	UU	No issues with mental healthcare
SI23	Good	UN2	No issues with mental healthcare
SI27	Adequate	UU	No issues with mental healthcare
SI28	Good	UU	No issues with mental healthcare
SI38	Adequate	UN2	No issues with

			mental healthcare
SI39	Good	UN2	No issues with mental healthcare

Code definitions:

- UU – Unexpected Unnatural – suicide, homicide, abuse/neglect – preventable, investigated under the SI policy
- UN2 unexpected natural death – death from a natural cause but didn't have to be e.g. alcohol or drug dependency/care concerns – may have been preventable

This review found that the care provided by our clinical teams was robust and that issues in care did not contribute to the deaths.

3. Unexpected deaths in Quarter 4 2017/18

The table below shows the total number of deaths reported during January to March 2018.

	Reported as SI	Open to services at time of death- natural causes	Substance Misuse deaths			LD Deaths
			North Staffs	Stoke	Staffs	
Jan	9	4	1	2	2	1
Feb	5	3	1	0	1	0
Mar	3	5	3	0	0	2

The deaths shown above will be reviewed at the Mortality Surveillance group once the investigation reports have been completed however initial reports not indicate any issues of concern.
Deaths of people with Learning Disabilities are managed through the LeDeR process. Deaths are reported to a national central point and are then allocated to the appropriate region for local investigators. The care is reviewed and report back to the regional coordinators and the relevant Trusts. The Patient and Organisational Safety team are awaiting feedback on the deaths reported during Q2 and Q3 2017/18.

4. Conclusion.

The Trust has established a process to undertake mortality surveillance in line with national guidance. Deaths which meet the criteria for SI investigation and natural cause deaths are identified and processes are in place to monitor the care provided by the Trust clinical teams. It is recognised that the input and effectiveness of primary and secondary physical health care provision is not available to the reviewers but as far as is practicable, the mortality surveillance group identify the physical health aspects of care required and determine if the support offered by our clinical teams is person-centred and holistic in its approach. There were 12 deaths examined by the MS Group during quarter 4 (6 natural cause and 6 subject to SI Investigation). It was concluded that issues related to mental health care did not contribute to any of these deaths. Therefore the Trust is asked to accept this report as assurance that mortality surveillance processes are in place.

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REPORT TO Trust Board

Enclosure No: 9

Date of Meeting:	24 May 2018		
Title of Report:	Performance & Quality Management Framework Month 12		
Presented by:	Suzanne Robinson, Director of Finance, Performance & Digital		
Author:	Vicky Boswell, Associate Director of Performance		
Executive Lead Name:	Suzanne Robinson, Director of Finance, Performance & Digital	**Approved by Exec**	☒

Executive Summary:	**Purpose of report**	
The report provides an overview of performance for March 2018 covering Contracted Key Performance Indicators (KPIs) and Reporting Requirements. In Month 12 there are 2 target related metrics rated as Red and 1 target related metric as Amber; all other indicators are within expected tolerances. In addition to the performance dashboards a full database (Divisional Drill-Down) has been made available to Directorate Heads of Service and Clinical Directors to enable them to interrogate the supporting data and drive directorate improvement. This is summarised in the supporting PQMF dashboard.	**Approval**	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☒ Execs ☐ Date: 1 May 2018	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☒ • Audit Committee ☐ • People & Culture Development Committee ☒ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☒ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	All areas of underperformance are separately risk assessed and a rectification plan is developed, overseen by the relevant sub-committee of the Trust Board.		
Resource Implications: Funding Source:	There are potential contractual penalties if the Trust is not able to meet reporting requirements or performance standards. There have been significant improvements in data completeness and data quality following Lorenzo implementation which have mitigated the risk in year. There are plans to address remaining issues and to support further developments in the Data Quality Improvement Plan agreed with commissioners.		

Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	The PQMF includes monitoring of ethnicity as a key national requirement. The Trust is seeking to ensure that all Directorates are recording in a timely way the protected characteristics of all service users to enable monitoring of service access and utilisation by all groups in relation to the local population.
Recommendations:	The committee is asked to • Receive the Trust reported performance, management action and committee oversight on the Month 12 position.

PERFORMANCE & QUALITY MANAGEMENT FRAMEWORK
REPORT TO TRUST BOARD

Date of meeting:	24 May 2018
Report title:	**Performance & Quality Management Framework** **Performance Report – Month 12 2017/18**
Executive Lead:	Suzanne Robinson, Director of Finance, Performance & Digital
Prepared by:	Vicky Boswell, Associate Director of Performance
Presented by:	Suzanne Robinson, Director of Finance, Performance & Digital

1 Introduction to Performance Management Report

The report provides an overview of performance for March 2018 covering Contracted Key Performance Indicators (KPIs) and Reporting Requirements.

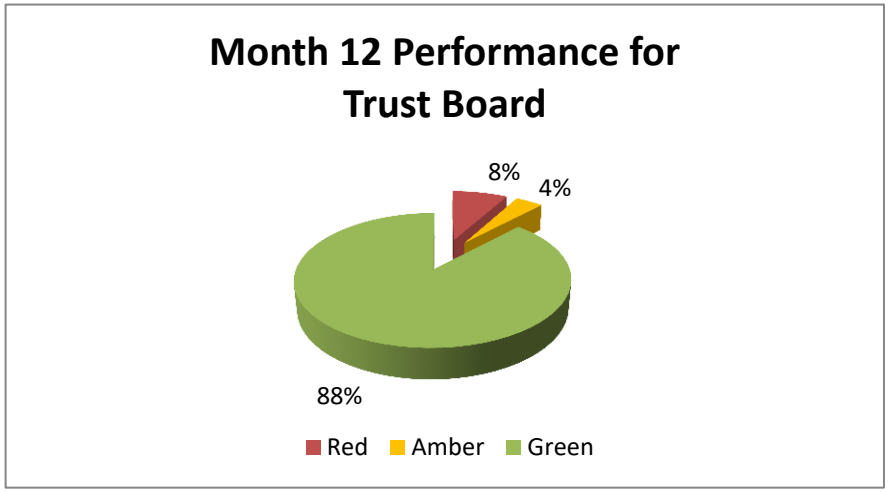
In addition to the performance dashboards a full database (Divisional Drill-Down) has been made available to Directorate Heads of Service and Clinical Directors to enable them to interrogate the supporting data and drive directorate improvement. This is summarised in Appendix 1.

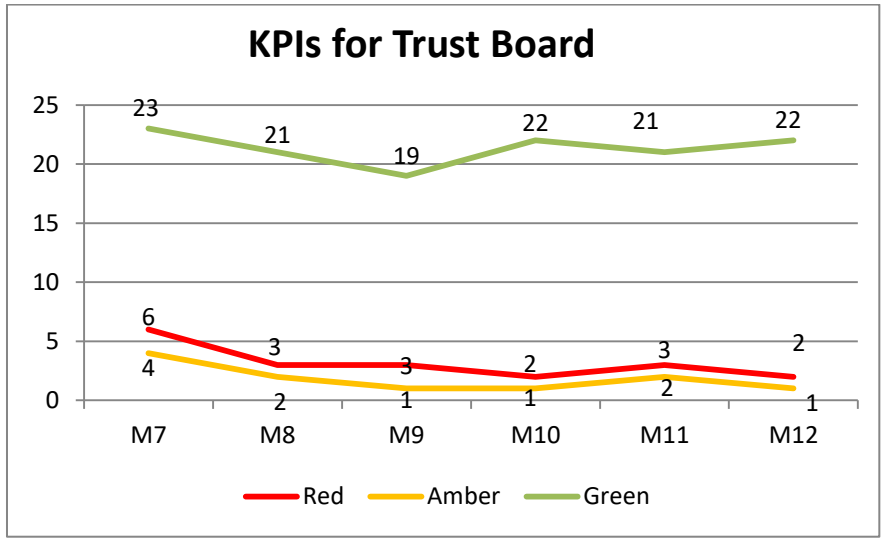
2 Executive Summary – Exception Reporting

The following performance highlights should be noted:

- 93.6% of patients have received treatment within 18 weeks of referral against a target of 92%
- 100% of inpatient admissions have been gate kept by the crisis resolution/home treatment team against a target of 95%
- 96.1% of people on a care programme approach have been followed up within 7 days after discharge (target 95%)

In Month 12 there are **2** targets related metrics rated as **Red** and **1** target related metrics rated as **Amber**; all other indicators are within expected tolerances.



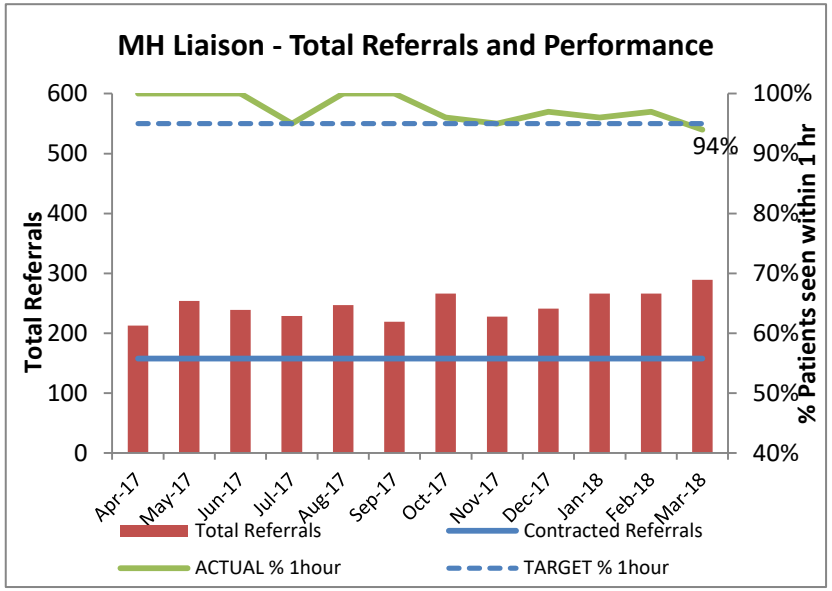


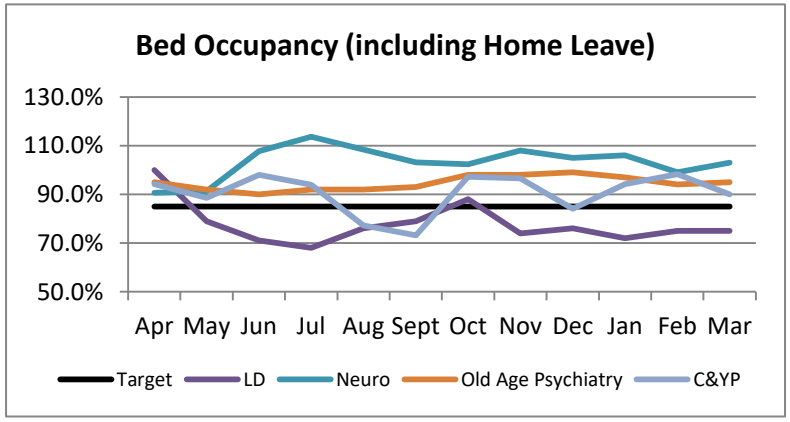
3 Updated metrics and targets

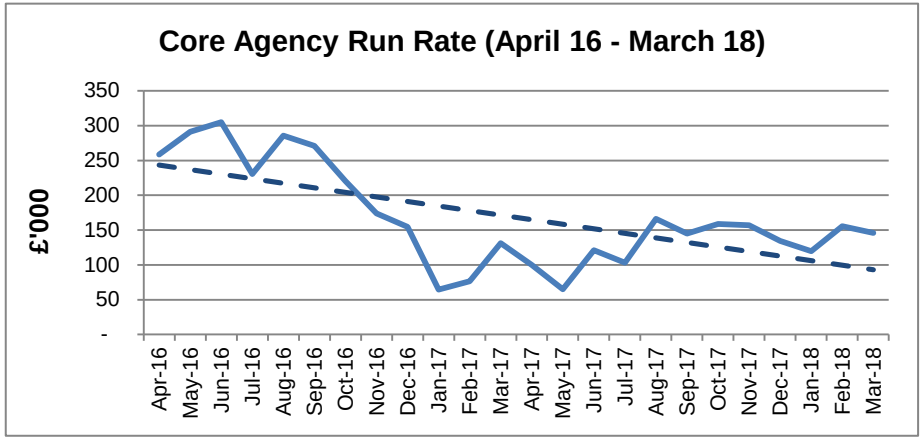
The following measures and targets have been updated for Month 12:

- Sickness Absence percentage figures for December confirmed, provisional data received for January, February and March 2018.

4 Exceptions - Month 12

KPI Classification	Metric	Exec/Op Lead	Target	M11	M12	Trend	Commentary
CCG	**MH Liaison:** Response to AE referrals within 1 hour	Dir of Ops	**95.0%**	**GREEN** **97.0%**	**AMBER** **94.0%**	↘	**94.0% at M12 from 97.0% at M11** In month 12 there was an increase in referrals which has had an impact on achieving the 1 hour standard in month. 
CCG	**Bed Occupancy:** Bed Occupancy (including home	Dir of Ops		**RED**	**RED**	↗	Bed occupancy across all wards (excluding Adult inpatient which has a 90% target) is 92.6% in month 12 from 92.5% in month 11. The highest occupancy rates are on Darwin ward (CY&P) and NOAP ward, whilst LD remains below target.

KPI Classification	Metric	Exec/Op Lead	Target	M11	M12	Trend	Commentary
	leave) All wards (excl AMH IP)		**85.0%**	**92.5%**	**92.6%**		High bed occupancy levels are impacted by the levels of admissions and may reflect pressures across the health and social care system. 
NHSI	**Agency Spend:** % year to date agency spend compared to year to date agency ceiling	Dir of Workforce and Leadership	**Zero**	**RED** **28.5%**	**RED** **27.9%**	↘	**27.9% at M12 from 28.5% at M11** Ward 4 – 7.7% at M12 from 7.1% at M11 Core – 14.4% at M12 from 14.8% at M11 The annual agency ceiling is £2,068k against actual of £2,645k - £577k worse than plan (27.9%) The main drivers of the negative variances are: • ROSE: £143k: The Trust extended the use of additional agency staff as part of the implementation of the ROSE project to ensure a safe transition. The use of agency has now ceased on this project. • Medical Locums - £363k: This reflects the national shortage of medics. A paper was presented to the March Board which reported a number

KPI Classification	Metric	Exec/Op Lead	Target	M11	M12	Trend	Commentary
							of initiatives that the Trust is exploring to attract and retain Medical Bank. Additionally the Trust is working to expand the medical bank. 

5 Recommendations

The Trust Board are asked to;

- Receive the Trust reported performance, management action and committee oversight on the Month 12 position

Month: **March**
12
Key:-

PQMF Report to Trust Board

North Staffordshire Combined Healthcare NHS Trust

CCG	NHS Standard Contract Reporting
National	NHS Improvement metric (Unify)
Trust Measure	Locally monitored metric

↗	Trend up (positive)	↘	Trend down (negative)
↘	Trend Down (positive)	↗	Trend Up (negative)
↔	No change	↘	Trend Down (Neutral)
		↗	Trend Up (Neutral)

	Metric	Frequency	Target (2016/17) Red= 17/18 target	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
NHSI	Early Intervention in Psychosis - A maximum of 2 week waits for referral to treatment (Target-17/18-50%, 18/19-53%)	Monthly	50%	76.9%	81.8%	63.6%	100.0%	70.0%	50.0%	62.5%	61.5%	72.7%	70.0%	75.0%	57.1%
CCG	Compliance with 18 week waits (Referral to Treatment or Intervention)	Monthly	92%	93.5%		82.4%	94.3%	95.1%	94.9%	92.5%	93.6%	94.2%	92.1%	91.3%	93.6%
CCG	AMH IP	Monthly	92%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
CCG	AMH Community	Monthly	92%	89.0%		77.5%	91.9%	94.9%	95.9%	95.6%	91.6%	93.5%	89.5%	87.8%	94.1%
CCG	Substance Misuse	Monthly	92%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
CCG	LD	Monthly	92%	100.0%		85.2%	100.0%	94.1%	92.3%	91.9%	90.0%	92.3%	92.1%	94.7%	90.9%
CCG	NOAP	Monthly	92%	97.4%		82.3%	94.3%	94.9%	95.4%	90.5%	95.3%	95.4%	95.7%	96.2%	96.6%
CCG	C&YP	Monthly	92%	100.0%		93.7%	100.0%	95.4%	90.3%	93.1%	92.2%	93.0%	85.7%	80.2%	84.0%
CCG	Zero tolerance RTT waits over 52 weeks for incomplete pathways	Monthly	0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CCG	MH Liaison Team response to A&E referrals within 1 hour	Monthly	95%	94.0%	94.0%	97.0%	96.0%	98.0%	97.0%	96.0%	95.0%	97.0%	96.0%	97.0%	94.0%
CCG	Patients will be assessed within 12 weeks of referral to the Memory Assessment service	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
CCG	Number of people seen for crisis assessment within 4 hours of referral	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
National	Percentage of inpatient admissions that have been gate kept by crisis resolution/ home treatment team	Monthly	95%	100.0%	98.5%	95.9%	97.2%	97.8%	98.6%	97.5%	100.0%	100.0%	100.0%	100.0%	100.0%
National/CCG	Overall safe staffing fill rate	Monthly	No Target	95.2%	95.3%	94.8%	93.4%	91.2%	90.4%	91.8%	94.3%	91.0%	94.9%	92.5%	92.5%
National	Mental health delayed transfers of care (target NHSI) (M1-4.7%, M2-4.5%, M3-4.2%, M4-4.0%, M5-3.7%, M6-3.5%) Target revised to 7.0% in M3	Monthly	7.5%	11.0%	8.4%	13.0%	12.7%	10.8%	8.8%	13.5%	12.5%	10.2%	7.8%	2.9%	3.7%
CCG	Emergency Readmission rate (30 days). Percentage of patients readmitted within 30 days of discharge.	Monthly	7.5%	15.0%	5.2%	5.1%	5.0%	4.7%	3.0%	6.9%	4.1%	3.9%	6.6%	4.5%	5.2%
NHSI	Total bed days patients have been Out of Area	Monthly	No target	0.0	0.0	160.0	295.0	259.0	22.0	1.0	28.0	150.0	68.0	149.0	61.0
Trust Measure	Adult	Monthly	No target	0.0	0.0	160.0	295.0	259.0	22.0	1.0	16.0	118.0	43.0	149.0	55.0
Trust Measure	Older Adult	Monthly	No target								12.0	32.0	68.0	0.0	6.0
NHSI	Ratio of days Out of Area to baseline (Baseline set at M9 2017/18 figure of 150 bed days, as per SOF guidance, shown as 100%. The ratio of days each month to this baseline figure is then expressed as a percentage.)	Monthly	<100%									100.0%	45.3%	99.3%	40.7%
Trust Measure	Total patients Out of Area	Monthly	No target	4.0	1.0	12.0	16.0	9.0	2.0	1.0	4.0	14.0	7.0	13.0	2.0
Trust Measure	Adult	Monthly	No target	4.0	1.0	12.0	16.0	9.0	2.0	1.0	2.0	12.0	5.0	13.0	1.0
Trust Measure	Older Adult	Monthly	No target								2.0	2.0	2.0	0.0	1.0
Trust Measure	Total bed days - PICU	Monthly	No target	21.0	65.0	73.0	176.0	125.0	121.0	104.0	99.0	94.0	213.0	112.0	159.0
Trust Measure	Total patients - PICU	Monthly	No target	4.0	2.0	3.0	8.0	1.0	2.0	3.0	2.0	3.0	7.0	2.0	5.0
SAFE															
CCG	Number of patients 16/17 years old admitted to Adult Psychiatric wards	Monthly	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0
NHSI	Admission to adult facilities of U16s	Monthly	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CCG	Bed Occupancy (Including Home Leave)	Monthly	85%	93.6%	89.4%	92.9%	92.6%	92.3%	90.0%	93.1%	93.3%	94.9%	93.8%	92.5%	92.6%
CCG	AMH IP	Monthly	90%	94.0%	89.0%	97.0%	93.0%	96.0%	89.0%	86.0%	89.0%	96.0%	91.0%	90.0%	89.0%
CCG	LD	Monthly	85%	100.0%	79.0%	71.0%	68.0%	76.0%	79.0%	88.0%	74.0%	76.0%	72.0%	75.0%	75.0%
CCG	Neuro	Monthly	85%	90.6%	91.3%	107.7%	113.7%	108.4%	103.1%	102.3%	108.0%	105.0%	106.0%	99.0%	103.0%
CCG	Old Age Psychiatry	Monthly	85%	95.0%	92.0%	90.0%	92.0%	92.0%	93.0%	98.0%	98.0%	99.0%	97.0%	94.0%	95.0%
CCG	C&YP	Monthly	85%	94.2%	88.6%	98.0%	93.9%	77.2%	73.1%	97.2%	96.6%	84.1%	94.2%	98.3%	90.0%
CCG	IAPT: The proportion of people who have depression and/or anxiety disorders who receive psychological therapies (Target: 3.75% per quarter, 1.25% p/month)	Monthly	3.75% quarterly (1.25% monthly)	1.05%	1.28%	1.21%	1.29%	1.30%	1.25%	1.5%	1.3%	0.9%	1.3%	1.3%	1.5%
NHSI / CCG	IAPT : The number of people who are moving to recovery. Divided by the number of people who have completed treatment minus the number of people who have completed treatment that were not at caseness at initial assessment	Monthly	50%	67.1%	68.5%	65.1%	65.9%	69.5%	64.9%	60.8%	66.3%	60.8%	67.2%	65.6%	70.6%
NHSI / CCG	Improving Access to Psychological Therapies (IAPT) Programme: the percentage of service users referred to an IAPT programme who are treated within 6 weeks of referral	Monthly	75%	99.7%	99.3%	100.0%	100.0%	100.0%	99.7%	100.0%	99.0%	100.0%	98.0%	98.0%	99.0%

	Metric	Frequency	Target (2016/17) Red= 17/18 target	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
NHSI / CCG	Improving Access to Psychological Therapies (IAPT) Programme: the percentage of service users referred to an IAPT programme who are treated within 18 weeks of referral	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%	100.0%	99.0%
CCG	S136 (Place of Safety) Assessments	Monthly	No Target	23.0	33.0	35.0	43.0	22.0	20.0	28.0	21.0	12.0	16.0	15.0	20.0
National	The proportion of those on Care Programme Approach (CPA) for at least 12mnths having formal review within 12mnths *NHSI*	Monthly	95%	94.3%	93.9%	91.5%	91.8%	94.5%	92.2%	90.3%	94.1%	95.9%	97.5%	98.0%	95.3%
NHSI	The proportion of those on Care Programme Approach (CPA) receiving follow-up contact within 7 days of discharge	Monthly	95%	100.0%	96.9%	94.1%	93.1%	86.7%	97.4%	92.9%	97.4%	90.9%	95.7%	93.9%	96.1%
NHSI/CCG	Never Events	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
National	Patient Safety Alerts not completed by deadline	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CCG	Mixed Sex Accommodation Breach	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CARING															
National	Inpatient Scores from Friends and Family Test – % positive	Monthly	No Target	89.0%	88.0%	83.0%	83.0%	85.9%	85.9%	93.8%	93.6%	85.9%	93.9%	91.3%	89.7%
National	Staff Friends and Family Test - % recommended - care	Quarterly	No Target			60.2%			66.7%			61.0%			65.7%
National	Percentage of complaints responded to in line with timescale agreed with complainant	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
National	Written complaints rate	Quarterly	No Target			2.4%			9.4%			9.3%			
CCG	Duty of Candour Each failure to notify the Relevant Person of a suspected or actual Reportable Patient Safety Incident	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
ORGANISATIONAL HEALTH															
National	% Year to Date Agency Spend compared to Year to Date Agency Ceiling	Monthly	0%		7.0%	20.0%	10.0%	26.0%	24.0%	28.0%	30.0%	29.7%	28.8%	28.5%	27.9%
National	Sickness Absence Percentage: Days lost	Monthly	4.95%	4.20%	3.95%	3.95%	4.20%	4.90%	4.88%	4.85%	4.71%	5.05%	5.24%	4.4%	3.2%
National	Staff Turnover (% FTE)	Monthly	>10%	0.9%	1.1%	0.6%	0.6%	1.5%	1.4%	0.7%	0.3%	1.0%	0.6%	0.8%	1.5%

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO Trust Board

Enclosure No:10

Date of Meeting:	24/05/2018		
Title of Report:	Finance Position Month 12		
Presented by:	Suzanne Robinson - Executive Director of Finance, Performance and Digital		
Author:	M Newton - Deputy Director of Finance		
Executive Lead Name:	Suzanne Robinson - Executive Director of Finance, Performance and Digital	Approved by Exec	☒

Executive Summary:	Purpose of report	
The report summarises the finance position at month 12 (March 2018)	Approval	☒
	Information	☐
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs x Date:	Document Version No.	

Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee X • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently. X 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐
Risk / legal implications: Risk Register Ref	None applicable
Resource Implications: Funding Source:	None directly from the report None applicable
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	There is no direct impact on the protected characteristics as part of the completion of this report.
Recommendations:	The Trust Board is asked to: Note: The reported 2017/18 surplus of £3,683k against a planned surplus of £1,400k. This is a favourable variance to plan of £2,283k.

	The M12 CIP achievement: o Achievement of £3,206k (100%); a favourable variance of £9k; o The recurrent CIP delivery of £2,311k representing a recurrent adverse variance to plan of £886k. The cash position of the Trust as at 31st March 2018 with a balance of £6,633k; £390k better than plan Total Agency for 2017/18 is £577k above ceiling (£2,068k) Capital payments for 2017/18 of £2,995k compared to planned capital expenditure of £3,130k; Use of resource rating of 1 against a plan of 2. Approve: The month 12 position reported to NHSI. Approve the actual Agency Ceiling breach of £577k.

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Financial Overview as at 31st March 2018

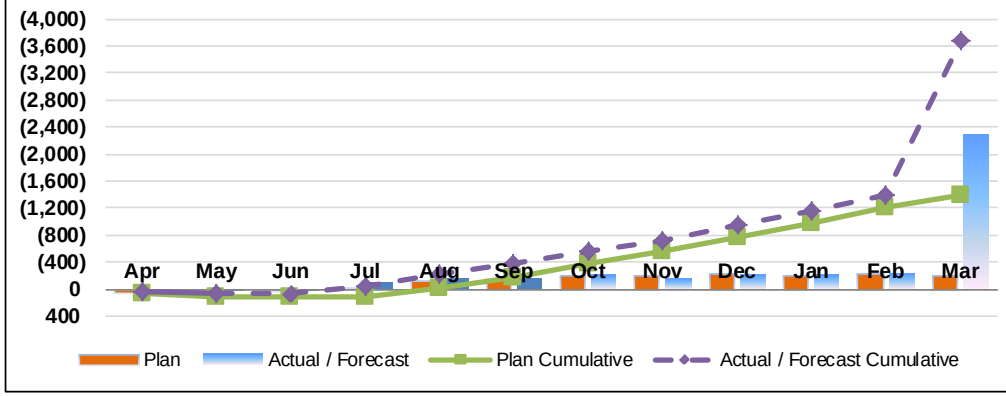
Income & Expenditure - Control Total (Surplus) / Deficit

£000	Plan	Actual	Var	%	RAG
YTD	(1,400)	(3,683)	(2,283)	(163)	G

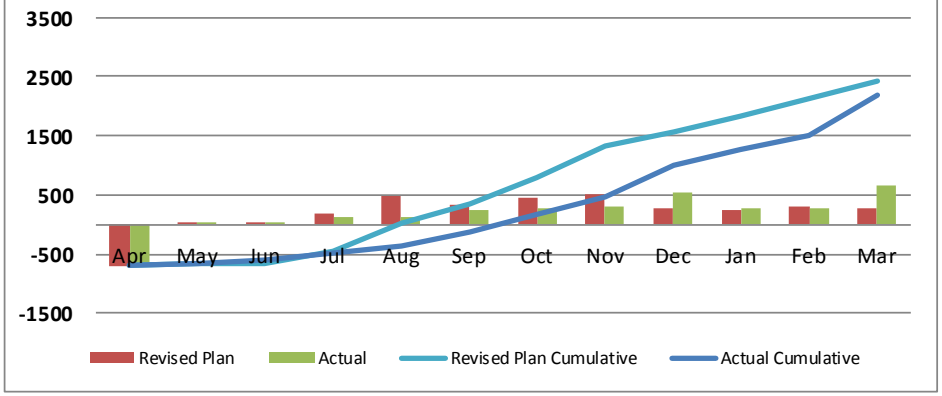
Charge to CRL

£000	Plan	Actual	Var	%	RAG
YTD	3,130	2,995	(135)	96	A

Retained (Surplus) / Deficit Run Rate 2017/18



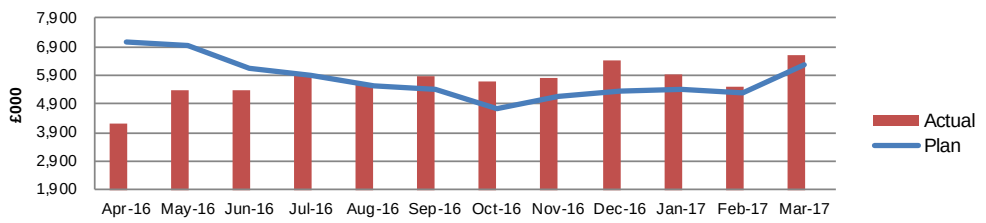
Net Capital Expenditure - Plan / Forecast 2017/18



Cash Balances

£000	Plan	Actual	Var	%	RAG
YTD	6,243	6,633	390	6	G

Cash Balances - Actual/Forecast against Plan 2017/18



Cost Improvement

£000	Plan	Actual	Var	%	Rec Var	RAG
Clinical	2,547	2,557	10	0	(517)	R
Corporate	650	649	(1)	(0)	(369)	R
Total	3,197	3,206	9	0	(886)	R

Use of Resource	Plan	Actual
Overall Risk Rating	2	1
Liquidity Ratio	1	1
Capital Servicing Capacity	2	1
I& E Margin	1	1
I&E Margin Variance to Plan	1	1
Agency Spend	1	3

1. Introduction:

The Trust's 2017/18 financial plan was to deliver a trading position of £0.9m surplus. The Trust accepted the Control Total from NHS Improvement (NHSI) of £1.4m surplus which included £0.5m from the Sustainability & Transformation Fund. For 2017/18 the Trust had a Control Total surplus of £3,683k against the original plan of £1.4m; **a £2,283k over performance against control.**

1.1 2017/18 Performance Overview

In Month 10, NSCHT Trust Board agreed to improve the 2017/18 forecast outturn position by £0.2m, increasing the trading surplus for 2017/18 to £1.1m. This allowed the Trust to attract an additional £0.2m STF funding, to deliver a forecast surplus of £1.8m for 2017/18:

- Trusts that agreed to improve beyond the control surplus attracted a pound for pound additional incentive payment.
- Trusts that overachieved against control also receive a share of any remaining national STF funding at the end of the financial year. In 2017/18 NSCHT received £1,671k of the bonus STF Incentive Scheme.

	2017/18 Plan Control (£m)	M9 Agreed Improvement (£m)	2017/18 Forecast Outturn (£m)	Further surplus improvement M12 (£m)	"Bonus" STF Funding (£m)	2017/18 Outturn (£m)
Trading Surplus	0.9	0.2	1.1	0.2		1.3
Sustainability and Transformation Funding	0.5	0.2	0.7		1.7	2.4
Surplus/Deficit	**1.4**	**0.4**	**1.8**	**0.2**	**1.7**	**3.7**

2. Income & Expenditure (I&E) Performance

Table 1 below summarises the Trust financial position in the Statement of Comprehensive Income (SOCI):

- The Trust has a final trading position of £1,494k surplus for 2017/18 against a plan of £900k surplus; **a favourable variance to plan of £594k**. After Sustainability and Transformation Funding of £2,371k, the Trust has a surplus of £3,865k against a planned surplus of £1,400k; **a favourable variance to plan of £2,465k**.

- To arrive at the final performance against control total, the surplus is adjusted for the impairment reversals (£190k) and non-cash element of LGPS pension (£8k) to give the **Adjusted Financial Performance of £3,683k;** a £2,283k surplus to control.

Table 1: Summary Performance	Annual Budget £'000	Month 12			Final Outturn		
		Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
Income	(82,772)	(7,219)	(7,050)	169	(82,772)	(82,708)	64
Pay	61,866	4,627	4,827	200	61,866	59,058	(2,808)
Non Pay	17,343	2,238	1,645	(593)	17,343	19,650	2,307
EBITDA	**(3,563)**	**(354)**	**(578)**	**(224)**	**(3,563)**	**(4,000)**	**(437)**
Other Non-Op Costs	2,664	216	29	(187)	2,664	2,506	(157)
Trading Surplus	**(900)**	**(138)**	**(549)**	**(411)**	**(900)**	**(1,494)**	**(594)**
Sustainability & Transformational Funding	(500)	(59)	(1,930)	(1,871)	(500)	(2,371)	(1,871)
(Surplus)/Deficit for the year	**(1,400)**	**(197)**	**(2,479)**	**(2,282)**	**(1,400)**	**(3,865)**	**(2,465)**
Add back for control total purposes:							
Reversal of Impairments		0	190	190	0	190	190
Non Cash Element of LGPS Pension		0	(8)	(8)	0	(8)	(8)
Adjusted Financial Performance (Control)	**(1,400)**	**(197)**	**(2,297)**	**(2,100)**	**(1,400)**	**(3,683)**	**(2,283)**

3. Income

Table 2 below shows the Trust income position by contract:

- The NHS Stoke-on-Trent CCG and NHS North Staffordshire CCG contracts are set on a block basis.
- £103k under recovery on Associate CCG's income due to a reduction in activity levels compared to original plan.
- STF for 2017/18 is the original core STF of £500k plus a further £200k for the Month 9 agreed improvement, and then a further £1,671k share of the remaining national STF funding.

		Month 12			Final Outturn		
Table 2: Income	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
NHS Stoke-on-Trent CCG	(35,382)	(2,843)	(2,843)	0	(35,382)	(35,382)	(0)
NHS North Staffordshire CCG	(24,297)	(2,147)	(2,147)	0	(24,297)	(24,297)	(0)
Specialised Services	(3,298)	(321)	(332)	(12)	(3,298)	(3,387)	(89)
Stoke-on-Trent CC s75	(3,947)	(329)	(329)	0	(3,947)	(3,948)	(0)
Staffordshire CC s75	(1,056)	(88)	(88)	0	(1,056)	(1,056)	0
Stoke-on-Trent Public Health	(1,284)	(25)	(16)	9	(1,284)	(1,263)	21
Staffordshire Public Health	(613)	(51)	(51)	0	(613)	(613)	0
ADS/One Recovery	(1,467)	(122)	(122)	0	(1,467)	(1,467)	0
Associates	(756)	(54)	(37)	17	(756)	(652)	103
OATS	(785)	(88)	(146)	(58)	(785)	(745)	39
Total Clinical Income	**(72,884)**	**(6,068)**	**(6,112)**	**(44)**	**(72,884)**	**(72,810)**	**75**
Other Income	(9,888)	(1,151)	(938)	213	(9,888)	(9,899)	(11)
Total Income	**(82,772)**	**(7,219)**	**(7,050)**	**169**	**(82,772)**	**(82,708)**	**64**
Sustainability Transformation Funding	(500)	(59)	(1,930)	(1,871)	(500)	(2,371)	(1,871)
Total Income Incl. STF	**(83,272)**	**(7,278)**	**(8,980)**	**(1,702)**	**(83,272)**	**(85,079)**	**(1,807)**

4. Expenditure

Table 3 below shows the Trust's expenditure split between pay, non-pay and non-operating cost categories.

Table 3: Expenditure	Annual Budget £'000	Month 12 Budget £'000	Month 12 Actual £'000	Month 12 Variance £'000	Final Outturn Budget £'000	Final Outturn Actual £'000	Final Outturn Variance £'000
Medical	7,536	639	409	(230)	7,536	6,414	(1,122)
Nursing	27,831	2,098	2,263	165	27,831	26,837	(995)
Other Clinical	14,502	988	1,067	78	14,502	12,858	(1,644)
Non-Clinical	10,924	879	901	22	10,924	10,091	(833)
Apprenticeship Lewy	214	18	18	(0)	214	213	(0)
Non-NHS	858	5	169	163	858	2,645	1,786
Total Pay	**61,866**	**4,627**	**4,827**	**200**	**61,866**	**59,058**	**(2,808)**
Drugs & Clinical Supplies	2,179	73	158	85	2,179	2,158	(21)
Establishment Costs	1,642	93	155	62	1,642	1,540	(101)
Information Technology	581	36	134	98	581	812	231
Premises Costs	2,097	165	307	141	2,097	2,361	264
Private Finance Initiative	4,087	341	352	12	4,087	4,242	156
Services Received	3,315	297	342	46	3,315	3,591	276
Residential Payments	1,708	142	174	32	1,708	2,000	292
Consultancy & Prof Fees	280	(6)	94	100	280	531	251
External Audit Fees	65	5	5	(0)	65	62	(3)
Legal Fees	65	5	8	3	65	65	0
Unacheived CIP	(60)	966	0	(966)	6	0	(6)
Other	1,384	120	(86)	(205)	1,318	2,286	968
Total Non-Pay	**17,343**	**2,238**	**1,645**	**(593)**	**17,343**	**19,650**	**2,307**
Finance Costs	1,293	108	108	0	1,293	1,293	0
Local Government Pension Scheme	0	0	8	8	0	8	8
Unwinding of Discounts	0	0	7	7	0	7	7
Dividends Payable on PDC	561	47	29	(18)	561	561	0
Investment Revenue	(14)	(1)	(2)	(1)	(14)	(15)	(1)
Fixed Asset Impairment	0	0	(190)	(190)	0	(190)	(190)
Depreciation (excludes IFRIC 12)	824	63	70	7	824	843	19
Total Non-op. Costs	**2,664**	**216**	**29**	**(187)**	**2,664**	**2,506**	**(157)**
Total Expenditure	**81,872**	**7,081**	**6,501**	**(580)**	**81,872**	**81,214**	**(658)**

4. Directorate Summary

Table 4 below summarises Pay, Non Pay and Income by Directorate:

Table 4: YTD Expenditure	Pay			Non Pay			Income			Total		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
AMH Community	17,037	16,052	(985)	4,647	4,776	129	(2,129)	(2,125)	4	19,555	18,703	(853)
AMH Inpatients	6,471	6,524	53	54	394	340	(164)	(147)	17	6,362	6,771	409
Children's Services	6,342	5,763	(579)	638	752	114	(633)	(636)	(3)	6,348	5,879	(469)
Substance Misuse	2,906	2,784	(122)	855	769	(86)	(503)	(399)	104	3,257	3,154	(103)
Learning Disabilities	4,989	4,793	(196)	588	391	(197)	(55)	(41)	14	5,522	5,142	(379)
Neuro & Old Age Psychiatry	11,362	11,094	(268)	747	730	(16)	(1,008)	(1,051)	(43)	11,101	10,773	(328)
Corporate	12,758	12,049	(709)	12,478	14,345	1,867	(78,781)	(80,681)	(1,900)	(53,544)	(54,287)	(742)
Total	**61,866**	**59,058**	**(2,808)**	**20,007**	**22,157**	**2,150**	**(83,272)**	**(85,079)**	**(1,807)**	**(1,400)**	**(3,865)**	**(2,465)**

- AMH Community is underspent on pay due to a vacancies not fully covered by Agency and Bank. The adverse variance on Non Pay results from overspends against residential payments.

- AMH Inpatient is overspent on pay mainly due to vacancies on medics being covered by Agency at a premium cost. Overspends on Non Pay are driven by under achievement of CIP against the plan.

5. Cost Improvement Programme

The Trust target for the year is £3.197m, as reported to NHSI. This takes into account the requirement to deliver a £1.4m control surplus for 2017/18. The table below shows the achievement by Directorate towards individual targets at M12. The Trust wide CIP achievement is 100% at M12 compared to plan

		YTD M12			Forecast					
CIP Delivery	Annual CIP Target 2017/18	Plan	Transacted	(Under)/Over Achievement	Plan	Total Schemes	(Under)/Over Achievement	RAG	Recurrent Transacted	Recurrent Position
	£'000	£'000	£'000	£'000	£'000	£'000	£'000		£'000	£'000
Clinical										
AMH Community	1,084	1,084	1,155	71	1,084	1,155	71	107%	873	873
AMH Inpatients	379	379	41	(338)	379	41	(338)	11%	69	69
Children's Services	333	333	333	(0)	333	333	(0)	100%	333	333
Learning Disabilities	256	256	533	277	256	533	277	208%	260	260
NOAP	495	495	495	(0)	495	495	(0)	100%	495	495
Total Clinical	**2,547**	**2,547**	**2,557**	**10**	**2,547**	**2,557**	**10**	**100%**	**2,030**	**2,030**
Corporate										
CEO	26	26	8	(18)	26	8	(18)	31%	8	8
Finance, Performance & Digital	61	61	69	8	61	69	8	112%	71	71
MACE	62	62	20	(42)	62	20	(42)	33%	91	91
Operations	29	29	34	5	29	34	5	116%	35	35
Quality & Nursing	13	13	14	1	13	14	1	107%	14	14
Strategy (Core)	10	10	17	7	10	17	7	168%	20	20
Trustwide	388	388	381	(7)	388	381	(7)	98%	1	1
Workforce & OD	61	61	107	46	61	107	46	176%	41	41
Total Corporate	**650**	**650**	**649**	**(1)**	**650**	**649**	**(1)**	100%	**281**	**281**
Total	**3,197**	**3,197**	**3,206**	**9**	**3,197**	**3,206**	**9**	**100%**	**2,311**	**2,311**

Below 75%	
Below 90%	

Target	3,197
Variance	(886)

- The recurrent position as at M12 is £2,311k (72%), which represents a recurrent shortfall against the target of £886k (28%).
- In month 12 Cost Improvement schemes were transacted non-recurrently to deliver the 2017/18 target.
- The recurrent shortfall is £886k; however this includes a £400k target for OOA which the CCG have agreed to transfer into the 2018/19 contract. The shortfall carried forward into 2018/19 is £486k.

6. Statement of Financial Position

Table 6 below shows the Statement Financial Position of the Trust.

Table 6: SOFP	31/03/2017 £'000	31/01/2018 £'000	28/02/2018 £'000	31/03/2018 £'000
Non-Current Assets				
Property, Plant and Equipment	28,037	29,371	29,558	31,026
Intangible Assets	222	263	264	277
NCA Trade and Other Receivables	1,426	608	608	608
Other Financial Assets	897	897	897	1,089
Total Non-Current Assets	**30,581**	**31,139**	**31,327**	**33,000**
Current Assets				
Inventories	88	84	76	79
Trade and Other Receivables	5,146	7,122	7,235	7,347
Cash and Cash Equivalents	6,964	5,932	5,525	6,633
Non-Current Assets Held For Sale	0	0	0	0
Total Current Assets	**12,198**	**13,138**	**12,837**	**14,058**
Current Liabilities				
Trade and Other Payables	(7,472)	(8,305)	(7,995)	(7,166)
Provisions	(333)	(228)	(226)	(621)
Borrowings	(457)	(633)	(633)	(633)
Total Current Liabilities	**(8,262)**	**(9,166)**	**(8,854)**	**(8,420)**
Net Current Assets / (Liabilities)	**3,937**	**3,972**	**3,982**	**5,639**
Total Assets less Current Liabilities	**34,518**	**35,110**	**35,309**	**38,639**
Non Current Liabilities				
Provisions	(474)	(474)	(474)	(458)
Borrowings	(12,189)	(11,632)	(11,594)	(11,557)
Total Non-Current Liabilities	**(12,663)**	**(12,106)**	**(12,068)**	**(12,015)**
Total Assets Employed	**21,855**	**23,004**	**23,241**	**26,624**
Financed by Taxpayers' Equity				
Public Dividend Capital	7,648	7,648	7,648	7,648
Retained Earnings reserve	4,884	6,033	6,270	9,032
Revaluation Reserve	9,323	9,323	9,323	9,944
Total Taxpayers' Equity	**21,855**	**23,004**	**23,241**	**26,624**

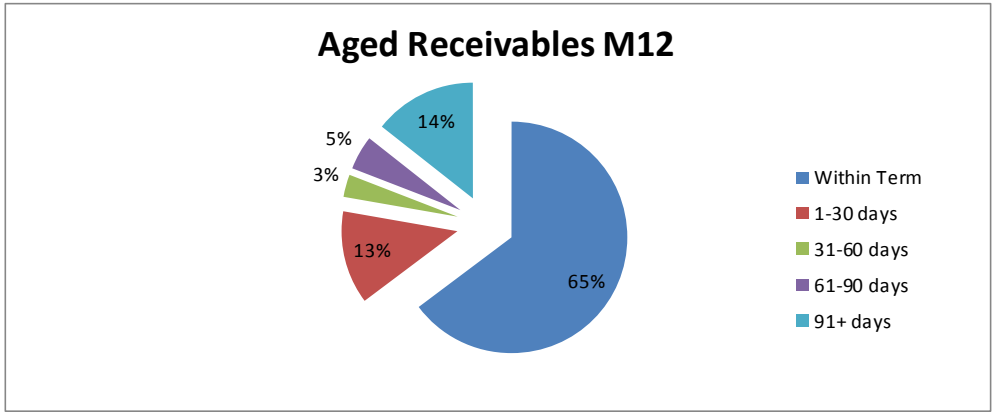
Current receivables are £7,347k, of whicn:

- £4,210k is based on accruals (not yet invoiced) and relates to income accruals for services invoiced retrospectively at the end of every quarter. This includes STF funding £2,046k, Bucknall Sale £713k, Staffs CC S75 £602k and VAT £174k.
- £3,137k in awaiting payment of invoice. (£2,031k within terms)

£698k is overdue by 31 Days or more and therefore subject to routine credit control processes;

- £3k has been escalated to management /solicitors;
- £695k has not been formally disputed and full payment is anticipated.

		Days Overdue				
Table 6.1 Aged Receivables/Payables	Within Term £'000	1-30 Days £'000	31-60 Days £'000	61-90 Days £'000	91+ Days £'000	Total £'000
Receivables Non NHS	1,088	279	41	42	201	1,651
Receivables NHS	943	129	57	107	250	1,486
Payables Non NHS	640	122	20	1	37	820
Payables NHS	1,374	49	28	2	8	1,461

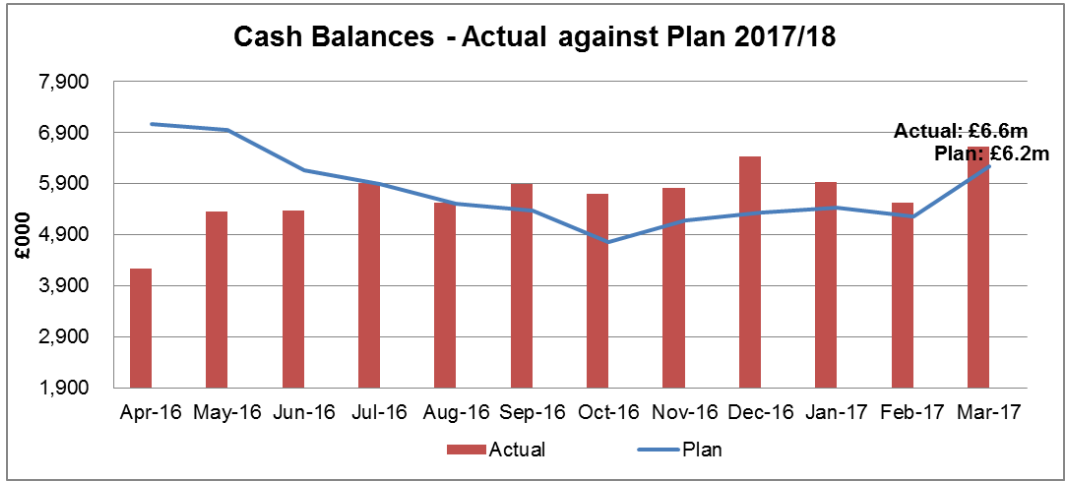


7. Cash Flow Statement

The cash balance at 31st March 2018 has increased by £1,109k to £6,633k, mainly due to cash receipts from Health Education England at £982k and Local Authority quarterly receipts £581k, partly offset by an increase in capital expenditure in March. The Trust cash position at 31st March 2018 is **£390k higher than planned** as a result of slippage on the Trust's capital plan**.**

Table 7 below shows the Trust's cash flow for the financial year:

Table 7: Statement of Cash Flows	Apr-17 £'000	May-17 £'000	Jun-17 £'000	Jul-17 £'000	Aug-17 £'000	Sep-17 £'000	Oct-17 £'000	Nov-17 £'000	Dec-17 £'000	Jan-18 £'000	Feb-18 £'000	Mar-18 £'000	Annual £'000
Net Inflows/(Outflow) from Operating Activities	(2,674)	1,184	116	702	(221)	635	121	479	1,201	(128)	(111)	1,051	**2,355**
Net Inflows/(Outflow) from Investing Activities	(21)	(31)	(45)	(120)	(134)	(237)	(279)	(311)	(554)	(334)	(259)	96	**(2,229)**
Net Inflows/(Outflow) from Financing Activities	(38)	(38)	(38)	(38)	(38)	(38)	(38)	(38)	(39)	(38)	(38)	(38)	**(457)**
Net Increase/(Decrease)	**(2,732)**	**1,115**	**32**	**544**	**(393)**	**360**	**(196)**	**130**	**608**	**(500)**	**(408)**	**1,109**	**(331)**
Opening Cash & Cash Equivalents	**6,964**	**4,232**	**5,346**	**5,379**	**5,923**	**5,530**	**5,890**	**5,694**	**5,824**	**6,432**	**5,932**	**5,524**	
Closing Cash & Cash Equivalents	**4,232**	**5,346**	**5,379**	**5,923**	**5,530**	**5,890**	**5,694**	**5,824**	**6,432**	**5,932**	**5,524**	**6,633**	
Plan	7,064	6,964	6,164	5,889	5,517	5,381	4,756	5,185	5,331	5,430	5,261	6,243	
Variance	**2,832**	**1,618**	**785**	**(34)**	**(13)**	**(509)**	**(938)**	**(639)**	**(1,101)**	**(502)**	**(263)**	**(390)**	



8. Capital Expenditure

The Trust's permitted capital expenditure agreed within the 2017/18 plan is £3,130k. Table 8 below shows the actual capital expenditure for 2017/18 as submitted to NHSI.

		Final Outturn		
Capital Expenditure	**Original Plan £'000**	**Plan £'000**	**Actual £'000**	**Variance £'000**
A&T Refurbishment	400	0	0	0
Hazelhurst Unit Development	325	0	0	0
Substance Misuse Additional Beds	125	0	0	0
Place of Safety	0	100	11	(89)
Temporary Place of Safety	0	94	7	(87)
Psychiatric Intensive Care Unit	2,120	2,153	1,821	(332)
E-rostering	102	102	117	15
Information Technology	50	235	243	8
Environmental Improvements (backlog)	120	120	112	(8)
Reduced Ligature Risks	300	200	7	(193)
Equipment	50	0	0	0
Darwin	0	26	116	90
Ward 4	0	30	13	(17)
Lymebrook MHRC	0	43	33	(10)
NOAP Airlock	0	27	0	(27)
VAT Recovery on 2016/17 Schemes	0	0	(1)	(1)
Dementia Pods	0	0	23	23
BitJam	0	0	0	0
Contingency	100	0	0	0
Fire Alarm System	0	0	34	34
A&T Unit BMS	0	0	13	13
Trust HQ BMS	0	0	12	12
Generator	0	0	27	27
Defibrillators	0	0	36	36
Estates Software System	0	0	57	57
ECT Maintenance	0	0	40	40
LD Beds	0	0	10	10
Upgrade Greenfields Reception	0	0	4	4
AMH Community Vehicle	0	0	24	24
Building Improvement Broom Street	0	0	0	0
Ward 4 Beds	0	0	32	32
Information Technology	0	0	204	204
Total Gross Capital Expenditure	**3,692**	**3,130**	**2,995**	**(135)**
Bucknall Hospital (Part)	(713)	(818)	(818)	0
Total Capital Receipts	**(713)**	**(818)**	**(818)**	**0**
Total Charge Against CRL	**2,979**	**2,312**	**2,177**	**(135)**

- The Operating Plan as reported to NHSI forecast that there would be a total charge against the CRL of £2,979k by month 12, including (£713k) Capital Receipts for the sale of Bucknall Hospital and £3,692k Capital Expenditure.
- Actual Capital Expenditure as at month 12 is £2,995k against a revised plan of £3,130k.
- A number of new schemes were identified at month 9 through the Capital Investment Group to maximise the use of the capital allocation. All schemes were chosen with the consideration of value for money and deliverability within 2017/18 in mind.

9. Use of Resource Metrics

The Framework covers 5 themes, quality of care, finance and use of resource, operational performance, strategic change, leadership and improvement capability. The metrics below will be used to assess the Trust's financial performance.

Table 9: Use of Resource	Year to Date Plan	Year to Date Actual	RAG Rating
Liquidity Ratio (days)			
Working Capital Balance (£000)		5,574	
Annual Operating Expenses (£000)		78,708	
Liquidity Ratio days		26	
Liquidity Ratio Metric	1	1	
Capital Servicing Capacity (times)			
Revenue Available for Debt Service (£000)		6,372	
Annual Debt Service (£000)		2,314	
Capital Servicing Capacity (times)		3	
Capital Servicing Capacity Metric	2	1	
I&E Margin			
Normalised Surplus/(Deficit) (£000)		3,683	
Total Income (£000)		85,079	
I&E Margin		4.33%	
I&E Margin Rating	1	1	
I&E Margin Variance from Plan			
I&E Margin Variance		2.58%	
I&E Margin Variance From Plan	1	1	
Agency Spend			
Providers Cap (£000)		2,068	
Agency Spend (£000)		2,645	
Agency %		28	
Agency Spend Metric	1	3	
Use of Resource	2	1	

Table 9.1: Use of Resource Framework Parameters				
Rating	**1**	**2**	**3**	**4**
Liquidity Ratio (days)	0	(7)	(14)	<(14)
Capital Servicing Capacity (times	2.50	1.75	1.25	<1.25
I&E Margin	1%	0%	-1%	<=(1%)
I&E Margin Variance	0%	-1%	-2%	<=(2%)
Agency Spend	0	25	50	>50

10. Better Payment Practice Code

The Trust's target is to pay at least 95% of invoices in terms of number and value within 30 days for NHS and Non-NHS suppliers.

In 2017/18 the Trust has under-performed against this target, having paid 87% within target based on the total number of invoices, and 94% based on the value of invoices.

Table 10 below shows the Trust's BPPC performance split between NHS and non-NHS suppliers.

	2016/17			2017/18 Month 12			2017/18 YTD		
Table 10: Better Payment Practice Code	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**
Number of Invoices									
Total Paid	508	13,183	13,691	55	1,045	1,100	659	10,933	11,592
Total Paid within Target	459	11,610	12,069	54	842	896	575	9,527	10,102
% Number of Invoices Paid	90%	88%	88%	98%	81%	81%	87%	87%	87%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-4.6%**	**-6.9%**	**-6.8%**	**3.2%**	**-14.4%**	**-13.5%**	**-7.7%**	**-7.9%**	**-7.9%**
Value of Invoices									
Total Value Paid (£000s)	6,860	29,380	36,240	654	3,281	3,935	7,164	33,211	40,374
Total Value Paid within Target (£000s)	6,385	27,914	34,299	653	3,150	3,804	6,258	31,653	37,911
% Value of Invoices Paid	93%	95%	95%	100%	96%	97%	87%	95%	94%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-1.9%**	**0.0%**	**-0.4%**	**4.8%**	**1.0%**	**1.7%**	**-7.6%**	**0.3%**	**-1.1%**

- There is performance of 97% in month 12 based on value on both NHS and Non NHS invoices, but 81% based on the number of invoices.

11. Recommendations

Trust Board are asked to:

Note:

- The reported 2017/18 adjusted retained surplus of **£3,683k against a planned surplus of £1,400k**. This is a favourable variance to plan of £2,283k.
- The M12 CIP achievement:
  - Achievement of £3,206k (100%); **a favourable variance of £9k**; (this includes £1,223k Non Recurrent CIP Recognised in Month 12)
  - The recurrent CIP delivery of £2,311k representing a **recurrent adverse variance to plan of £886k**.
- The cash position of the Trust as at 31st March 2018 with a **balance of £6,633k**; £390k better than plan
- Total Agency for 2017/18 is £577k above ceiling (£2,068k)
- Capital payments for 2017/18 of £2,995k compared to planned capital expenditure of £3,130k;
- Use of resource rating of **1** against a plan of 2.

Approve:

- The month 12 position reported to NHSI.
- Approve the forecast Agency Ceiling breach of £577k.

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO Public Trust Board

Enclosure No:11

Date of Meeting:	24TH MAY 2018		
Title of Report:	Finance, Performance and Digital Committee Assurance Report		
Presented by:	Chair of Finance, Performance and Digital Committee		
Author:	Mike Newton - Deputy Director of Finance		
Executive Lead Name:	Suzanne Robinson – Executive Director of Finance, Performance and Digital	Approved by Exec	☒

Executive Summary:	Purpose of report	
This paper details the issues discussed at the Finance, Performance and Digital Committee meeting on the 10TH May 2018. The meeting was quorate with minutes approved from the previous meeting on the 5th April 2018. Progress was reviewed and actions confirmed from previous meetings.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs X Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee X • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services X☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.X 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	Oversees the risk relevant to the Finance & Performance Committee		
Resource Implications: Funding Source:	None applicable directly from this report		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	There are no direct impact of this report on the 10 protected characteristic of the Equality Act		
Recommendations:	The Trust Board is asked to note the contents of this report and take assurance from the review and challenge evidenced in the Committee.		

Assurance Report to the Trust Board
Thursday 24th May 2018

Finance, Performance and Digital Committee Report to the Trust Board – 24th May 2018.

This paper details the issues discussed at the Finance, Performance and Digital Committee meeting on the 10th May 2018. The meeting was quorate with minutes approved from the previous meeting on the 5th April 2018. Progress was reviewed and actions confirmed from previous meetings.

Executive Director of Finance, Performance and Digital Update

The following updates were given by the Executive Director of Finance, Performance and Digital;

- The FPD team have been working in conjunction with 'AOB Financial Solutions Ltd' to develop a web based software solution to track specialist Out of Area Placements across the STP. Given the transferability to similar projects across the UK, the FPD team have recognised the commercial potential and are working to agree terms around royalty payments for Intellectual Property, in the event of external sales.

- An update around North Staffordshire Combined 2018/19 contribution to the STP. Given the level of resource in kind put forward to work on STP work streams; it will result in a net repayment to the trust.

- An update around the construction of the Trust Psychiatric Intensive Care Unit, outlining agreed funding, cost and workforce implications, as well as an update around the final Capital expenditure. The committee requested a more detailed review to be provided at the June FPD Committee.

Finance

- **Monthly Finance Report – Month 12**

The Finance position was presented, showing £2.3m better than plan. This includes £0.4m surplus improvement and £1.9m additional share of Sustainability and Transformation funding.

CIP was fully delivered in the year through transacting non recurrent schemes in M12. The recurrent shortfall on CIP carried into 2018/19 targets is £486k.

Performance:

- **Activity Report**

The report detailed M12 activity against plan using traditional reporting methods and care clustering. The SLA and PbR activity reports are within contract tolerances.

The Committee expressed concern around the pace of improvement around reporting Cluster 99s and therefore is unable to give assurance around the quality of activity reported.

A task and finish group, chaired by the Executive Director of Finance, Performance and Digital, meets monthly to provide a targeted approach to address issues around data quality and recording with clinical colleagues. This is expected to support improvement.

The Committee requested that the report and action plan is presented on a quarterly basis.

- **CAMHs Waiting Times**

Due to concerns raised previously by the Committee around the deterioration in performance against CAMHS waiting list targets; an update report was presented in M12.

Following the presentation of the report and action plan, assertions from the Director of Operations and assurance that dedicated resource was being allocated to support; the committee are assured that sufficient focus is being placed on CAMHs waits to deliver recovery trajectories.

The Committee requested an update report tracking progress against recovery trajectories to be presented at the end of Q1.

Digital:

- **Action Plan GDPR**

The action plan was presented updating on the progress in delivering GDPR standards by 25th May 2018. The committee are assured that enough progress has been made to satisfy the requirements of the Information Commissioners Office (ICO.)

- **Cyber Security Requirements**

The Trust compliance against the 10 data and cyber security standards (DSPR) was presented ahead of the 11th May submission deadline. The committee approved the submission, which was subsequently circulated to Trust Board.

- **Lorenzo Digital Exemplar**

The Chief Information Office presented headline slides summarising the outline business case for the Lorenzo Digital Exemplar (LDE.) The committee agreed in principal, however have requested further information around resources, functionality and efficiencies at the next committee.

Realignment of Operational Directorates:

- **Assurance on Key Systems, Reporting and Finance**

The report outlined the impact of the restructure on Trust systems, reporting and finances. In addition, the report outlined the timeframes, the role of the corporate task and finish group and provided an assessment of the trust capability to report in line with each of the project phases.

The committee were assured that the Trust will be able to report on the new structure and meet external reporting requirements from 1st July 2018. Further detail around the financial impact was requested and will be included in the June committee.

Other Reports and Updates

The Committee received additional assurance reports as follows:

- 2018/19 Forward Plan – Apprentice Levy Presentation
- Performance Report (PQMF)
- Finance, Performance and Digital Risk Register 2017/18
- Board Assurance Framework Objectives 2017/18 for FPD
- Board Assurance Framework Objectives 2018/19 for FPD
- Cost Improvement Programme (CIP) – Month 12 (*for information*)
- Agency Utilisation M12 (*for information)*
- Partnerships and Contracting Q4 (*for information*)
- Capital Reporting and Capital Affordability Update Q4 (*for information*)
- Treasury Report (*for information*)
- Lorenzo Digital Exemplar outline business case (*for information)*
- Business Opportunities (*for information)*
- FPD Monitoring Schedule (*for information*)
- Cycle of Business 2017/18 and 2018/19 (*for information*)

Recommendation

The Board is asked to receive the contents of this report and take assurance from the review and challenge evidenced in the Committee.

On Behalf of Tony Gadsby
Chair of Finance, Performance and Digital Committee

NHS
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REPORT TO Trust Board

Enclosure No: 12

Date of Meeting:	24.05.18		
Title of Report:	Trust Self Certification – Condition G6 – The provider has taken all precautions necessary to comply with the license, NHS Acts and NHS Constitution.		
Presented by:	Laurie Wrench		
Author:	Laurie Wrench		
Executive Lead Name:	Caroline Donovan	Approved by Exec	☐

Executive Summary:	Purpose of report	
Although NHS trusts are exempt from needing the provider licence, directions from the Secretary of State require the NHS Trust Development Authority to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate. The Single Oversight Framework (SOF) bases its oversight on the NHS provider licence. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions. NHS trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements. Trust Board must self-certify and confirm compliance against condition G6 by 31st May 2018	Approval	☒
	Information	☐
	Discussion	☐
	Assurance	☐

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	1
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently ☐ 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		

Risk / legal implications: Risk Register Ref	The Single Oversight Framework (SOF) bases its oversight on the NHS provider licence. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions
Resource Implications: Funding Source:	None
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	
Recommendations:	That the Board approve the self-certification.

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	**Confirmed**

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	David Rogers	**Name**	Caroline Donovan
Capacity	Chair	**Capacity**	Chief Executive
Date	24th May 2018	**Date**	24th May 2018

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

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NHS
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REPORT TO Trust Board

Enclosure No:12B

Date of Meeting:	24th May 2018		
Title of Report:	Self-Certification – Condition FT4		
Presented by:	Laurie Wrench		
Author:	Laurie Wrench		
Executive Lead Name:	Caroline Donovan	Approved by Exec	☒

Executive Summary:	Purpose of report	
Although NHS trusts are exempt from needing the provider licence, directions from the Secretary of State require the NHS Trust Development Authority to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate. The Single Oversight Framework (SOF) bases its oversight on the NHS provider licence. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions. NHS trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements. Trust Board must self-certify and confirm compliance against condition FT4 by 30th June 2018	Approval	☒
	Information	☐
	Discussion	☐
	Assurance	☐

Seen at:	SLT ☐ Execs ☒ Date:	Document Version No.	1
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☒ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☐ 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		

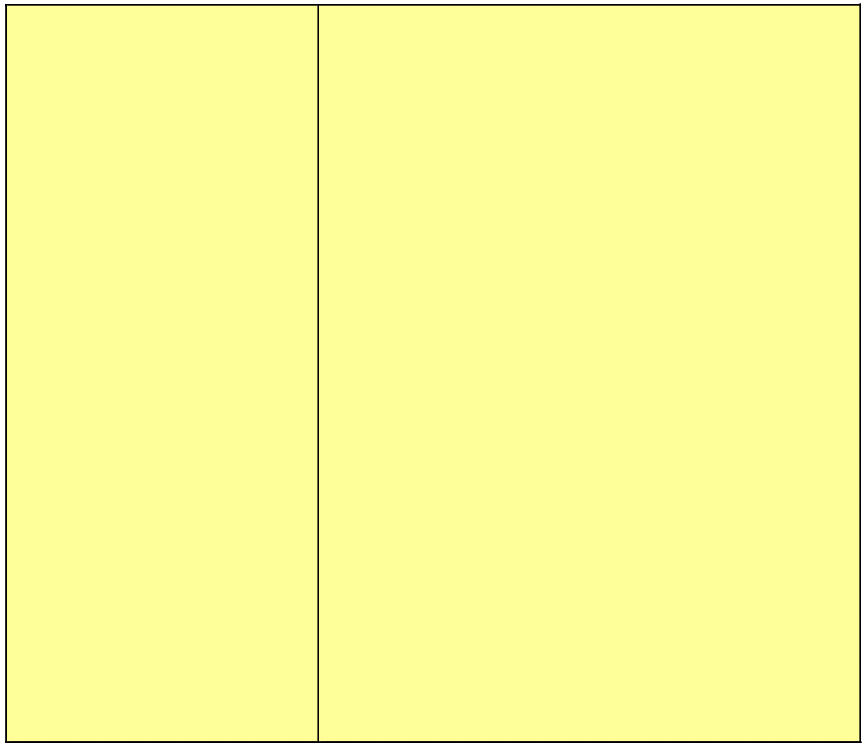
Risk / legal implications: Risk Register Ref	The Single Oversight Framework (SOF) bases its oversight on the NHS provider licence. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions
Resource Implications: Funding Source:	N/A
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	N/A
Recommendations:	The Board approve the self-certification for condition FT4

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1 Corporate Governance Statement	Response	Controls and Assurances
1 The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	**Confirmed**	Risk is mitigated through the following mechanisms: • Statement of Internal Audit Assurance within the Annual Governance Statement (AGS) • Regular review of the Board Assurance Framework (BAF) • Regular review of Committee and Board Effectiveness • Register of Declarations of Interest • Freedom of Information responses • Risk Management processes and reporting • Board Development • Fit and Proper Persons • CQC rating of 'good' for well led • Internal, external and counter fraud work programme • Affiliation with AQUA • Adherence to Standards of Business Conduct
2 The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	**Confirmed**	Mitigation of Risk: • Single Oversight Framework Category 2 • Affiliation with AQUA as recommended by NHSI • NHSI IDM Meetings

3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	**Confirmed** Risk is mitigated through: • A review of Board and Committee effectiveness undertaken including Committee Terms of Reference, frequency of meetings, membership of sub committees, ongoing Board development, sub group reporting arrangements • Committee structure review including sub-committees
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on	**Confirmed** Risk is mitigated through: • Financial balance • Finance, Performance and Digital committee reporting to Board • CQC rating of 'good' • Robust Performance Management Framework and rectification plans • Purchase order processes • Investment policy • Delegated authority limits1, 2 and 5 year business plans • CIP plans

such plans and their delivery; and
(h) To ensure compliance with all applicable legal requirements.



5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	**Confirmed**	Risk is mitigated through: • Executive Director leadership for quality by Director of Nursing and Quality and Medical Director • Board developments topics in quality • Board to team unannounced quality assurance visits • Announced quality assurance visits with CCG, service users / carers and Healthwatch • Involvement of service user and carer council • QIA on CIP • Quality Account • Quality Committee reports to Board • Scrutiny of the Performance Management Framework at committee and Board • Rectification plans for metrics where target not achieved, including actions and trajectory for improvement • Quality priorities – Safe, Personalise, Accessible and Recovery Focussed (SPAR) • Strategic objectives relate to quality measured through the BAF • CQC overall rating of good (October 2017)

6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed**	• Declaration of good character • Fit and Proper Persons • Declarations of Interest • NHSI led process re appointment of Chair and Non-Executive Directors

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____

Name David Rogers

Signature _____

Name Caroline Donovan

NHS
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NHS Trust

REPORT TO Trust Board

Enclosure No:13

Date of Meeting:	24/05/2018		
Title of Report:	General Data Protection Regulations Report		
Presented by:	Karen Armistead – Head of Portfolio Management and Data Protection Officer		
Author:	Karen Armistead – Head of Portfolio Management and Data Protection Officer		
Executive Lead Name:	Suzanne Robinson – Director of Finance, Performance and Digital	Approved by Exec	☒

Executive Summary:	Purpose of report	
General Data Protection Regulation (GDPR) was approved by the EU in April 2016; and will apply in the UK from 25 May 2018. The main legislation that previously regulated the use of personal data was the Data Protection Act 1998 and the Privacy and Electronic Communications Regulations 2003. RSM were commissioned in 2017/18 to produce a gap analysis around the Trusts compliance with the new GDPR regulations. The purpose of this report is provide assurance around the trust progress around resolving areas of non compliance.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☒ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	The General Data Protecton Regulations are a legal requirement. Regulators will be able to issue fines of up to 4% of turnover. Additionally individuals can sue you for compensation to recover both material damage and nonmaterial damage (e.g. distress).		
Resource Implications:	The GDPR will place an extra work burden on the Trust as a number of previous recommendations are becoming mandatory. The increased Monitoring compliance requirements of the GDPR and the requirement to appoint a Data Protection Officer and resources to allow them to fulfil their		

Funding Source:	role effectively. This has been resourced in order to meet this requirement. Funding for the DPO has been confirmed
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	No Diversity & Inclusion Implications
Recommendations:	The Trust Board are asked to: • Receive the action plan noting the progress to date;

Trust Board
GDPR Action Plan
24th May 2018

1) Introduction

General Data Protection Regulation (GDPR) was approved by the EU in April 2016; and will apply in the UK from 25 May 2018. The main legislation that previously regulated the use of personal data was the Data Protection Act 1998 and the Privacy and Electronic Communications Regulations 2003.

RSM were commissioned in 2017/18 to produce a gap analysis around the Trusts compliance with the new GDPR regulations. The purpose of this report is provide assurance around the trust progress around resolving areas of non compliance.

2) Background

The purpose of GDPR is to redress the power imbalance between organisations holding data and the individuals whose data is held. In 2010, the Information Commissioner's Office (ICO) was given the power to prosecute and impose monetary penalties on organisations for serious breaches of the Data Protection Act 1998 but GDPR requires compliance with far tighter regulations in all areas where personal data is stored, used and disclosed to third parties, not just in marketing and fundraising.

Service users have the right to confidentiality and privacy and expect professionals to keep their data safe and secure. Clinicians and care providers also have a legal duty and professional obligation to respect privacy and keep information confidential in the course of care delivery. Therefore there must be a lawful basis to process service user data.

'Lawful' means complying with various regulatory requirements which are imposed by law regarding sharing information, with the DPA currently being the principle statute regulating the sharing of information. As a general rule, if sharing complies with DPA (or GDPR from May 2018 onwards) it will be lawful.

The common law duty of confidence and Article 8 of the European Convention of Human Rights (a right to respect for a private life) also need to be taken into account. The legal basis, justifications and implications discussed below are for consideration for the purposes of direct care only.

3) Key Changes as a Result of New Standards

- The proposed legal basis which patient level data would be collected by the Trust would be for the purposes of direct care only.

- Under GDPR the identification of a legal basis is needed before you start processing data and Privacy Impact Assessments are mandatory for high risk projects. A PIA process has been developed and a requirement outline will be included in all business cases.

- Patients have the right to know what you are doing with their data and any action that fails to achieve this could potentially end up in a prosecution. The Trust Service User Information leaflet is being updated to cover new rights in relation to GDPR.

- The Information Security and Data Protection policy will form the central repository for Data Protection Guidance and all policies are due to be updated to refer to this policy.

- The GDPR will place an extra work burden on the Trust as a number of previous recommendations are becoming mandatory. The increased Monitoring compliance requirements of the GDPR and the requirement to appoint a Data Protection Officer and resources to allow them to fulfil their role effectively. This has been resourced in order to meet this requirement.

4) GDPR Action Plan

RSM were commissioned in 2017/18 to produce a gap analysis around the Trusts compliance with the new GDPR regulations. The audit report identified 10 areas of non compliance which the trust is working towards implementing prior to the introduction of GDPR.

The trust is anticipating it will be compliant in all areas before the introduction of GDPR.

The full action plan and progress is shown in appendix 1.

5) Recommendations

The Trust Board are asked to:

- Receive the action plan noting the progress to date;

Appendix 1: GDPR Action Plan

Action Plan

Ref	Internal Audit Findings	Actions	Progress	Timescales	Responsible Owner	RAG
1.	Through discussions with the Information Security Manager, we noted that there is no high-level information sharing map, where a database of data, external party, access, direction of data, method of transfer, etc. is held. There is a risk that the Trust has a lack of understanding regarding the inflows and outflows of personal data, how data is accessed by third parties and who has access to which systems. The Trust may be incapable of completely documenting data processing activities thereby increasing the risk of non-compliance. There is also a risk that the Trust will be unable to inform third parties when the need to correct or erase data regarding a data subject arises.	The Trust will be required to fully document all personal data flows – both internally and data shared externally. To achieve this, the Trust should perform a data discovery and mapping exercise, using system owners to identify flows of personal data	Lorenzo contains details of the majority of dataflows within the trust and maps for these already exist. High level Data flow maps have been shared with internal and external partners to confirm that all personal dataflows have been captured. Information Asset owners are in the process of completing lower level flows.	25.5.18	Mr D Hewitt Mr D Hewitt Information Asset Owner	

Ref	Internal Audit Findings	Actions	Progress	Timescales	Responsible Owner	Delivery RAG
2.	We noted that whilst there is an account lockout threshold of 5 invalid attempts, there is no account lockout duration and therefore the lockout procedure is redundant. There is a risk that an unauthorised individual can gain access to the Trust's network, using a brute force attack.	The Trust will need to implement an account lockout duration, of at least 30 minutes, to prevent unauthorised individuals accessing the network using a brute force attack.	The Trust has implemented a lockout procedure which was agreed with partner organisations at the SSHIS Intelligent Customer Forum (ICF.) These details consider a balance of security and functionality.	Complete	Mr D Hewitt	
3.	We noted, through confirmation with the Information Security Manager, that the Trust does not employ any data classification scheme in order to categorise data by its sensitivity. This therefore means that additional security measures are not placed on data assets which are deemed more sensitive. There is a risk that the Trust is not employing sufficiently robust security measures on sensitive data assets.	The Trust will need to formally document and employ a Data Classification Policy. All data assets should fall under one of the data classifications and the security measures to be employed for specific classifications should be detailed within the policy.	Data Classification has been written in draft for approval following the Information Steering Group on 18/5/2018. Data classifications and security measures employed are detailed in the policy.	25.5.18	Ms K Armistead	

Ref	Internal Audit Findings	Actions	Progress	Timescales	Responsible Owner	Delivery RAG
4.	We noted through review of the Trust's policies, that they currently make references to the DPA and therefore do not comply with GDPR. The rights of individuals within the policies reflect their rights under the DPA and there are numerous references to the 8 principles of data protection, which are in line with the DPA and not the GDPRs principles of data protection. With out of date Trust policies, which refer frequently to the DPA, there is a risk that the Trust will not be compliant with new requirements stated in the GDPR.	The Trust will need to review all of its policies and ensure that the policies and procedures are updated to reflect their respective requirements under the GDPR. These should be ready for approval and implementation once GDPR becomes the legal requirement. Policies which require review include, but are not limited to: • Information Security Policy & Data Protection Policy Any areas which list the rights and principles of data protection under the DPA, should be replaced.	The Information Security & Data Protection policy has now been reviewed and all other policies to be amended to reference this policy in relation to Data Protection. All Information Governance work stream leads to review their area's policies and the policies refer to the Information Security & Data Protection policy. (Standard text to be shared)	25.5.18 25.5.18	Mrs L Forrester All Work Stream Leads	

Ref	Internal Audit Findings	Actions	Progress	Timescales	Responsible Owner	Delivery RAG
5.	We noted, through discussions with the Information Security Manager, that we were unable to find any job description which assigned responsibility for safeguarding staff data to an appropriately senior individual, such as the Head of HR. We were therefore unable to find evidence that staff data is safeguarded by a sufficiently senior individual within the Trust. This increases the risk that staff data is not safeguarded to the same standard as patient data. The Trust should ensure that this is rectified as priority as the GDPR legislation applies to all personal data including data belonging to employees as well as service users, suppliers and partners.	The Trust will need to ensure that responsibility for safeguarding staff assets and data is assigned to a sufficiently senior individual who has clearly identified responsibility for	To be added into the Associate Director of Workforce job description.	25.5.18	Mrs K Smith	

Ref	Internal Audit Findings	Actions	Progress	Timescales	Responsible Owner	Delivery RAG
6.	Through discussions with the Chief Information Officer (CIO), we confirmed that the Trust's executives have agreed to make the CIO the Data Protection Officer (DPO). However, the responsibilities of a DPO have not yet been added to his job description. Without completing and approving the DPOs job description, there is a risk that the Trust will not be compliant with GDPR requirements.	The Trust will be required to add the Data Protection Officer's responsibilities to the Chief Information Officer's job description and have this formally approved. Furthermore, the Trust may need to demonstrate that the CIO is sufficiently experienced and trained to take on the role of DPO under the requirements of the GDPR.	Role of Data Protection Officer has been added to the job description of the Head of Portfolio Management. DPO has been appointed in post since the 1 April 2018. DPO and IG Team have attended basic GDPR training to support the new functions. It is expected that official accreditation will be available post GDPR implementation.	Complete Complete	Mr D Hewitt Ms K Armistead/Mrs B Haslehurst / Mrs L Forrester	

Ref	Internal Audit Findings	Actions	Progress	Timescales	Responsible Owner	Delivery RAG
7.	We noted that the Access to Health and Employee Records Policy does not comply with the GDPRs requirements for subject access requests, and allows for 40 days to comply and a fee to be charged. With subject access requests being complied within 40 days with the possibility of a fee, there is a risk that the Trust will not be compliant with the GDPR.	The Trust will be required to change the policies and procedures regarding subject access requests to reflect the rules under the GDPR. The Access to Health and Employee records and the Privacy Policy in particular must have their content changed so that compliance to a subject access request occurs within 30 days and is at no cost to the data subject, with the exceptions listed within the GDPR. Procedures should be put in place by the Trust to comply with the new requirements.	Policy has been reviewed and will be circulated to the relevant governance group.	25.5.18	Mrs L Forrester	

Ref	Internal Audit Findings	Actions	Progress	Timescales	Responsible Owner	Delivery RAG
8.	We noted that the Access to Health and Employee Records Policy lays out an informal procedure for data subjects to request rectification of data they feel is inaccurate. It is important that the Trust puts in place formal procedures for data subjects to correct data inaccuracies kept on their record. Without a formal process for data subjects to correct inaccuracies in data being held about them, there is a risk that the Trust will not be compliant with GDPR.	The Trust will be required to create a formal and documented process and procedure for data subjects to request changes to the data held on them, for the purpose of rectification. This should be reflected within the Access to Health and Employee Records Policy.	Formal documented processes and procedure is being developed within the Subject Access Request policy and is on target to be completed by the 25th May 2018.	25.5.18	Mrs L Forrester	

Ref	Internal Audit Findings	Actions	Progress	Timescales	Responsible Owner	Delivery RAG
9.	There are no policies which inform data subjects regarding their right to erasure, restrain processing or object to their personal data being held or processed under the GDPR. This information was missing from the Privacy Policy given to patients. There are also no formal procedures to accommodate for these new rights of individuals under the GDPR. The current Information Security Policy contains information regarding the rights under the DPA, and required the subjects to apply to the court. Without policies and procedures to uphold the rights of all individuals under the GDPR, there is a risk that the Trust will not be compliant with the new legislation.	The Trust will need to employ formal policies to inform and uphold the rights of data subjects under the GDPR. Wording should be included within the Privacy Policy and Information Security Policy, at least, so that the Trust is able to comply with right to erasure, data portability, restrain processing or object under the GDPR. Procedures should also be put in place to uphold these rights.	The following actions are in progress and will be completed by 25.5.18: • Update the service user confidentiality leaflet. With reference to what we are doing under article 9 (direct patient care). • Implement the Privacy Notice. (complete) • Review policies to include standard text referring to SAR (use of information and subject rights.) • Develop information on the Trust Website.	25.5.18	Mrs L Forrester Mrs L Forrester Work Stream Leads Mr J McCrea/Mrs L Forrester	

Ref	Internal Audit Findings	Actions	Progress	Timescales	Responsible Owner	Delivery RAG
10.	We noted during our discussions with the Information Security Manager, that we were unable to locate any process in place to capture or obtain explicit consent for the processing, sharing and storage of data of patients. We also noted in the Employment Contract template, that there is no section under which employees are informed about the processing, storage or sharing of their data and therefore no consent is given upon the signing of the contract, as there is no mention of data processing. Without the capture of explicit consent for the processing, use and sharing of patient and employee data, there is a risk that the Trust will not have a documented legal basis for processing data and therefore risk non-compliance with the requirements under the GDPR.	The Trust will need to employ formal policies and procedures so that explicit consent is obtained by patients for the use, processing and sharing of their personal data. The Trust will need to include information regarding the use and processing of personal data within employment contracts, so that employees are aware of the purpose for which their data is being obtained, processed and shared and give explicit consent for these activities to take place. In both instances the Trust will need to clearly state how long the data will be retained for (which should be consistent with the Trust's data retention policies).	This action is covered by existing processes: Service user data will be collected under article 9 of the GDPR, direct patient care. Under this article there is no requirement for explicit consent on the basis that all information captured directly relates to the delivery of care to the service user. Where information is going to be processed or shared for no direct patient care then explicit consent needs to be sought and recorded. This applies to existing processes which will continue to be used following the implementation of GDPR. The Trust Records Management policy contains the data retention table. The Trust also collects and stores data relevant to external stakeholders,	Complete	Mrs C Bentley/Mr G Sargeant	

			voluntary sector partners and other external organisations and individuals who have previously been identified as potentially having an active interest in the work of the Trust. The Trust Communications team will be contacting each person/organisation to confirm explicit consent.			

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REPORT TO TRUST BOARD

Enclosure No:14

Date of Meeting:	22nd March 2018		
Title of Report:	Summary of the Audit Committee held on 23rd April 2018 - Presentation of the Draft Annual Accounts		
Presented by:	Gan Mahadea, Chair / Non Executive		
Author:	Laurie Wrench, Associate Director of Governance		
Executive Lead Name:	Suzanne Robinson	Approved by Exec	☒

Executive Summary:		Purpose of report	
This report provides a summary of the key headlines from the Audit Committee held on the 23rd March 2018. The full papers are available as required to members.		Approval	☒
		Information	☐
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☒ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☒ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☒ 4. Encourage, inspire and implement research & innovation at all levels.☒ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☒ 7. Continually improve our partnership working. ☒		
Risk / legal implications: Risk Register Ref	To ensure that the committee meets its terms of reference by receiving reports of the work of its sub groups		
Resource Implications: Funding Source:	n/a n/a		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	n/a		
Recommendations:	Receive the report for assurance and ratification that the Trust is a going concern as recommended by members of the Audit Committee		

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Assurance Report of the Audit Committee – Presentation of the Draft Annual Accounts

23rd April 2018

Going Concern

Mike Newton, Deputy Director of Finance, presented this report which is a fundamental principle in the preparation of the financial statements. Members recommended that the Trust is a going concern which requires ratification by the Trust Board.

Draft Annual Accounts

Mike Newton, Deputy Director of Finance, presented the Draft Annual Accounts. It was noted that this is the Trust's 19th Consecutive year of achieving financial balance and is the highest in year position of the last 9 years. Members of the Audit Committee approved the draft Annual Accounts for submission following delegated authority from the Trust Board

Final Annual Accounts

The Audit Committee request delegated authority from the Trust Board to submit the Final Annual Accounts 29th May 2018

RSM Internal Audit

The following reports were received:

- Data Quality - DTOC – partial assurance
- Consent Audit Report – partial assurance
- Mobile Phone Policy – partial assurance

2018-19 Internal Audit Strategic and Operational Plan

Andrew Bostock, Head of Internal Audit, KPMG, presented the plan which had been agreed and discussed by the Executive Team and subsequently approved by the Audit Committee. There has been an additional item included; HR Governance Review.

Draft Annual Governance Statement

Laurie Wrench, Associate Director of Governance, presented the draft Annual Governance Statement 2017/18 which is a statement about the system of integrated governance, risk management and internal control, across the whole of the Trust's activities. The Trust is obliged to declare any significant internal control issues in its disclosure statement.

Laurie Wrench

Associate Director of Governance on behalf of

Mr Gan Mahadea, Chair and Non-Executive Director

11th May 2018

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REPORT TO TRUST BOARD

Enclosure No:15

Date of Meeting:	24th May 2018		
Title of Report:	PCD Summary		
Presented by:	Lorien Barber, Non-Executive Director		
Author:	Alex Brett, Executive Director of Workforce, OD and Communications		
Executive Lead Name:	Alex Brett	Approved by Exec	☒

Executive Summary:	Purpose of report	
A summary of the People & Culture Development Committee meeting held on Monday 14th May 2018 and chaired by Mrs Lorien Barber. It received a number of reports for assurance and approval including: • Staff Story • Refreshed Terms of Reference and Cycle of Business • Director of Workforce, OD & Communications Update • Locality Working • Board Assurance Framework • Workforce & OD Risks • Performance Report • Staff Survey Action Plan • Towards Outstanding Engagement • Being Open • Retention & Exit Interviews • Workforce Race Equality Standard • Medical Revalidation Annual Organisational Audit • Clinical Excellence Awards • Pay Award • Lorenzo Digital Exemplar • Apprentice Projections/Draft Apprenticeship Plan • Policies for approval	Approval	☒
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☒ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. ☒ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve. ☒ 4. Encourage, inspire and implement research & innovation at all levels. ☐ 5. Maximise and use our resources intelligently and efficiently ☒ 6. Attract and inspire the best people to work here ☒ 7. Continually improve our partnership working. ☐		

Risk / legal implications: Risk Register Ref	A number of risks are monitored and reviewed through the Committee. The current risks identified and mitigation plans in place are: Risk 12 – There is a risk that there is insufficient staff to deliver appropriate care to patients because of staffing vacancies and increased referrals. This has a consequence of potential failure to achieve performance targets, inability to deliver service user expectations and increase pressure upon existing staff. Risk 868 – There is a risk that the Trust will breach its Agency cap for the use of temporary staffing with a consequence of increased spend and reputational harm due to reduced segmentation by NHSi. Risk 900 – There is a risk that the Trust does not provide inclusive services that recognise the diverse nature of our service users, therefore services may not be accessible or of sufficient quality. relating to temporary staffing Risk 901 - There is a risk that the Trust does not have an inclusive and diverse workforce impacting on our ability to support the needs of diverse communities and ability to attract and retain staff Risk 1034 – There is a risk that staff are not effectively engaged, do not have sufficient clarity of purpose and do not realise their potential through not having an up to date PDR. This can adversely affect their ability to work efficiently and effectively and impacting upon delivery of services. Risk 1072 – There is a risk that staff may not be accessing clinical supervision on a regular basis to ensure that professional responsibilities and as a result may not feel supported in practice. NEW Risk 1111 – There is a risk that staff engagement scores, turnover and retention for the Trust will be impacted on as a result of the change and transition to implement the integrated locality working structure. Risk rating 12. It was noted that there is no budget for Health & Wellbeing in the Trust which is also a CQUIN, the consequence of this is that the Trust could forfeit circa £62k next year for the Staff Engagement element of the CQUIN. The Committee also agreed the addition of a separate risk around clinical supervision reporting.
Resource Implications: Funding Source:	There is no identified budget for Health & Wellbeing in the Trust which is also a CQUIN, the consequence of this is that the Trust could forfeit circa £62k next year for the Staff Engagement element of the CQUIN if this is not achieved.
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	The Committee plays a significant role in actions and assurance related to Diversity and Inclusion and the oversight of the Public Sector Equality Duty under the Equalities Act. This duty requires the Trust to • Eliminate unlawful discrimination • Advance equality of opportunity • Foster good relations
Recommendations:	The Board are asked to approve the policies identified for ratification and those for extension and receive the summary for assurance purposes.

Summary to Trust Board
People & Culture Development Committee
Monday 14th May 2018, 9.30 – 12.40pm

The meeting was chaired by Mrs Lorien Barber.

1. Staff Story

The Committee received a presentation from a staff member who had experienced over four months of severe and debilitating back pain. After personally funded visits to a chiropractor and a decline in motivation, positivity and work output, a chance remark from a work colleague started a journey of Trust support. This support in the form of 16 physiotherapy appointments; a workplace assessment, new chair, new table and weekly Pilates sessions, ensured that the staff member had maintained their attendance at work, and was again motivated and positive. Whilst the Trust does have a wealth of staff support on offer it was noted that this is not always well publicised and this will be addressed, a roadshow will also be going out to areas shortly, predominately the community areas to illustrate what can be put in place to support staff health and wellbeing.

2. Refreshed Terms of Reference and Cycle of Business

Following the AQuA Well-Led Development review late last year the Terms of Reference and Cycle of Business had been refreshed and revised. The Committee approved the refresh subject to a couple of changes to the cycle of business.

3. Director of Workforce, OD and Communications Update

The Committee was updated on the following issues:

- STP
- Workforce 5 Year Forward Plan

4. Locality Working

The Committee was informed that the Locality Working Phase 1 Management of Change involving both Heads of Directorate and Clinical Directors had been launched, and would close on May 30th. Staff-side has been engaged in the discussions, and will continue to support staff as required. The Trust has initiated a publically accessible web-site to guide staff through the process. The Committee will continue to monitor the Management of Change as a standing agenda item.

5. Board Assurance Framework

The Committee reviewed the performance against the 2017/18 BAF at Quarter 4 and the new 2018/19 metrics.

The 2017/18 Q4 BAF was approved by the Committee as they noted:
There remain some challenges on delivery at Quarter 4 for apprentices and engaging and retaining staff. Work continues to embed and strengthen the values and behaviours framework, and favourable progress has been made with social media engagement. The Values and Behaviours framework has altered from green to amber as the Trust is not assured that these are fully embedded in practice. Apprenticeships has also moved to amber as the target of 33 apprentices has not been met, with only 15 commencing with the Trust; a robust plan around apprentices is in place to meet the levy. Attraction and Retention remains at red, and whilst the workforce plans are in place these are not currently competency-based. The D&I inclusion rate had altered to red to reflect the recent WRES findings. Turnover continues to be a challenge. The Communications Plan is amber as it was delayed being approved at Board to meet the assurance timescales; and there is a medical leadership programme planned for next year. Staff survey results are amber as

there is steady state in results with the WRES scores deteriorating. Talent Management remains red; however there are plans to address this moving forward.

The 2018/19 BAF is quite detailed with very similar themes and areas of work as in 2017/18. Included in the areas for review include both the Board and Executives undergoing a 360^{o} feedback programme; and apprenticeships will continue to feature highly with a need to meet the levy. Digital workforce is a new entry and will impact on phase 4 of the locality working programme. Recruitment remains a high focus with the retention programme with NHSI key. BAME staff and WRES will also remain a high priority.

6. Workforce & OD Risks

A number of risks are monitored and reviewed through the Committee. The current risks have been identified and mitigation plans are in place for:

Risk 12 – There is a risk that there is insufficient staff to deliver appropriate care to patients because of staffing vacancies and increased referrals. This has a consequence of potential failure to achieve performance targets, inability to deliver service user expectations and increase pressure upon existing staff. Risk to remain at 16 until a more stable period ensues.

Risk 868 – There is a risk that the Trust will breach its Agency cap for the use of temporary staffing with a consequence of increased spend and reputational harm due to reduced segmentation by NHSi. Risk to remain at 12.

Risk 900 – There is a risk that the Trust does not provide inclusive services that recognise the diverse nature of our service users, therefore services may not be accessible or of sufficient quality. Risk to remain at 12.

Risk 901 - There is a risk that the Trust does not have an inclusive and diverse workforce impacting on our ability to support the needs of diverse communities and ability to attract and retain staff. Risk to remain at 12.

Risk 1034 – There is a risk that staff are not effectively engaged, do not have sufficient clarity of purpose and do not realise their potential through not having an up to date PDR. This can adversely affect their ability to work efficiently and effectively and impacting upon delivery of services. Risk to remain at 12.

Risk 1072 – There is a risk that staff may not be accessing clinical supervision on a regular basis to ensure that professional responsibilities and as a result may not feel supported in practice. Risk to remain at 12.

The following new risk has been added:
Risk 1111 – There is a risk that staff engagement scores, turnover and retention for the Trust will be impacted on as a result of the change and transition to implement the integrated locality working structure. Risk rating 12.

It was noted that there is no budget for Health & Wellbeing in the Trust which is also a CQUIN, the consequence of this is that the Trust could forfeit circa £62k next year for the Staff Engagement element of the CQUIN.

The Committee also agreed the addition of a separate risk on clinical supervision reporting which was currently proving an issue with the onus on individuals to record this.

7. Performance Reports

The Performance metrics at Month 12 were reviewed by the Committee.

In month 12 there were 4 target related metrics rated as red:

- Agency Spend – the main drivers are ROSE and Medical Locums
- Use of Locums – up at M12 to 23.6% from 21.5% at M11, this is particularly in CAMHS and Community Adult MH
- Vacancy Rate – reduced slightly from 10.7% at M11 to 9.8% at M12, although this figure mitigates to 4.4%, there is real activity around recruitment specifically for PICU
- Clinical Supervision- decreased from 86.1% at M11 to 77.7% at M12, this remains on the risk register and rectification plans are reviewed at the Performance meetings. Recording continues to be an issue and this is the onus of the individual.

8. Workforce Metrics

The Committee was updated by exception. Sickness absence is reducing, and falls below the target of 5%, the highest reason for absence is stress and anxiety with a robust system in place to monitor sickness absence; the policy has also been updated and ratified to help support attendance at work.

There continue to be challenges with stat/mand training compliance and PDR recording which is currently at 86%. DBS continues to be monitored. There are no major changes with overtime and agency, and turnover is just over 10% (some Trusts are looking at 30% target for turnover. For the last seven months we have had more starters than leavers, and work has been undertaken to reduce the time to recruit. The Trust is looking at retention initiatives as a lot of staff will be due to retire over the next few years. Nursing-wise there will be trigger points in the next few years; there remain challenges locally as the Universities are providing LD training, and few Universities support return to practice courses. There is also a large amount of medics due to retire over the next few years. The Trust has managed to retain a large proportion of student nurses, and is looking to work with areas further afield, Manchester and London have been tried, but incentives with other Trusts are substantially more than we currently offer. The market remains tight and we need to think creatively in order to attract staff.

9. Staff Survey Action Plans

The Committee noted the Staff Survey action plans and theses will continue to be monitored and reviewed.

10. Towards Outstanding Engagement

The Committee received an update on Towards Outstanding Engagement and the recent Celebration Event held on May 8th. The event showcased the excellent results achieved by the teams with a need to ensure the teams from Cohort 1 remain engaged. Cohort 2 will follow the locality based changes to the structure. The survey results will be reviewed by the Committee again in November 2018.

11. Being Open

The Committee received the report that illustrated the collective activity of all the mechanisms including themes, trends and patterns of raising concerns, with a full summary of activity covering a 12 month period for April 2017 – March 2018 and a detailed quarterly review for the period of January 2018 – March 2018.

It was noted that the Trust is currently out to advert for a new Freedom to Speak Up Guardian the role would be revised to one day per week and be aimed at those band 8A and above.

12. Retention & Exit Interviews

The Committee reviewed the latest findings of the exit interviews up to the end of December. Whilst the response rate was low at 12%, the themes and narrative are useful for discussion.

The paper will also be submitted to Trust Board in May.

13. Workforce Race Equality Standard (WRES)

The Committee received the update paper detailing the significant progress on the WRES agenda over the last nine months. A further report will be prepared for the June Committee containing the full WRES action plan update; feedback from the BAME staff Listening into Action session on May 9th, and the Trust's 2018 WRES raw data.

14. Medical Revalidation Annual Organisational Audit

The Committee received the annual audit. It was noted that there was one missed appraisal which had been due to a misunderstanding of the process; as a result monthly reporting has been introduced to actively monitor compliance.

15. Clinical Excellence Awards

The Committee received the update report with regards to NHSI's negotiations concerning the Local Clinical Excellence Awards with financial annual implications of between £46,000 and £92,000. The Government is negotiating the consultant contract. Following discussion the Committee agreed the 3-year option, and will be taken forward at the next JLNC meeting.

16. Pay Award

The pay award remains out to consultation with a proposed sign-off toward the end of July 2018 and once agreed will be resubmitted to the Committee.

17. Lorenzo Digital Exemplar

A presentation was given regarding the Trust's ambition to become a Digital by Choice organisation, with a national reputation as a leader in the use of digital technology to improve services as a whole organsiation. The vision for service users is a dramatic change in the number of steps required to confirm diagnosis or support via access to a portal.

The implications for culture change, leadership, staff engagement and new ways of working were discussed with the Committee noting the OD support required for this programme of work.

18. Apprentice Projections/Draft Apprenticeship Plan

The Committee received the plan and projections going forward for assurance purposes.

19. Policies

The following policies were approved by the Committee and the Trust Board are requested to approve them:

- Dress Code Policy
- Job Evaluation Policy

The following policy was agreed an extension to July 9th 2018:

- Learning & Development Review Policy

The following policies were agreed a six-month extension:

- Personal Relationships at Work
- Performance Improvement Policy
- PDR Policy

20. Date & Time of Next Meeting

- Monday 9th July 2018, at 9.30 am, Boardroom, Trust HQ, Lawton House, Trentham

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REPORT TO OPEN TRUST BOARD

Enclosure No:16

Date of Meeting:	24/05/2018		
Title of Report:	Cyber Security Requirements		
Presented by:	Suzanne Robinson, Director of Finance, Performance and Digital		
Author:	David Hewitt, Chief Information Officer		
Executive Lead Name:	Suzanne Robinson, Director of Finance, Performance and Digital	Approved by Exec	☒

Executive Summary:	Purpose of report	
To improve data security and protection for health and care organisations, the Department of Health and Social Care, NHS England and NHS Improvement published a set of 10 data and cyber security standards called the 2017/18 data security protection requirements (DSPR) that all providers of health and care must comply with. The 2017/18 DSPR standards are based on recommendations by Dame Fiona Caldicott, the National Data Guardian (NDG) for health and care and confirmed by the government in July 2017.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☒ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	The increased risk from cyber attack since the WannaCry attack in 2017 has required organisations to tighten controls and increased the monitoring and assessment requirements.		
Resource Implications: Funding Source:	None currently identified.		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	No Diversity & Inclusion Implications		
Recommendations:	The Trust Board are asked to receive the report and:		

	• note the progress around implementing DSPR Standards. • note the implementation of the 10 standards on 11th May 2018.

Trust Board (Private)
Cyber Security Requirements
24th May 2017

1) Introduction

To improve data security and protection for health and care organisations, the Department of Health and Social Care, NHS England and NHS Improvement published a set of 10 data and cyber security standards called the 2017/18 **data security protection requirements (DSPR)** that all providers of health and care must comply with. This commitment came about following the WannaCry cyber attack in May 2017.

The 2017/18 DSPR standards are based on recommendations by Dame Fiona Caldicott, the National Data Guardian (NDG) for Health and Care.

NHS England have requested NHS providers to confirm by Friday 11 May whether you have implemented (fully, partially or not) the 10 standards outlined in the 2017/18 DSPR.

2) Question response details

	Standard	Response	Details
1	There must be a named senior executive responsible for data and cyber security in your organisation. Ideally this person will also be your senior information risk owner (SIRO), and where applicable a member of your organisation's board.	**Fully Implemented** The organisation has a named senior executive who reports to the board who is responsible for data and cyber security and this person is also the SIRO	Suzanne Robinson Director of Finance, Performance and Digital North Staffordshire Combined NHS Trust Suzanne.Robinson@combined.nhs.uk 01782 275122
2	By 31 March 2018 organisations are required to achieve at least level 2 on the Information Governance (IG) toolkit. More information about the IG toolkit v14.1 can be found here: www.igt.hscic.gov.uk/help.aspx	**Fully Implemented** The organisation has completed the IG toolkit, submitted its results to NHS Digital and obtained either level 2 or 3.	Results submitted at level 2
3	The beta version of the Data Security and Protection toolkit was released in February 2018 and will help organisations understand what actions they need to take to implement the General Data Protection Regulation (GDPR) which comes into effect in May 2018.	**Fully Implemented** By May 2018, the organisation will have an approved plan to detail how it will achieve compliance with the GDPR. This will have board-level sponsorship and approval.	GDPR action plan developed and in progress. Board level sponsorship from Director of Finance, Performance and Digital.
4	All staff must complete appropriate annual data security and protection training. As per the IG toolkit, staff are defined as: all staff, including new starters, locums, temporary, students and staff contracted to work in the organisation.	**Fully Implemented** At least 95% of staff have completed either the previous IG training or the new training in the last twelve months.	95% achieved.

	Standard	Response	Details
5	Organisations must: • Identify a primary point of contact for your organisation to receive and co-ordinate your organisation's response to CareCERT advisories, and provide this information through CareCERT Collect	**Fully Implemented** The organisation has in post a primary point of contact who is responsible for receiving and co-ordinating CareCERT advisories.	Primary point of contact is the CIO
	• act on CareCERT advisories where relevant to your organisation	**Fully Implemented** The Organisation has registered for CareCERT Collect **No -** the organisation does not have plans in place for all CareCERT advisories up to 31/3/2018 that are applicable to the organisation	Care Certs are registered and recorded on the S&SHIS call logging system and actioned by the S&SHIS, when they relate to Training or Communications we send them via the Communications team.
	• confirm within 48 hours that plans are in place to act on High Severity CareCERT advisories, and evidence this through CareCERT Collect	**Fully Implemented** The organisation has clear processes in place that allow it to confirm within 48 hours of a High Severity CareCERT advisory being issued that a plan is in place.	The high alerts are delivered to the CIO.
6	Comprehensive business continuity plans must be in place to support the organisation's response to data and cyber security incidents.	**Partially Implemented** The organisation is developing a business continuity plan(s) for data and cyber security incidents. The plan(s) will take into account the potential impact of any loss of services on external organisations in the health and care system. The business continuity plan for cyber security incidents in has been tested in 2017/18.	Business Continuity Plans are in place for directorates/services for loss of IT and disaster recovery plans in relation to IT services provided. S&SHIS test annually.
7	Staff across the organisation must report data security incidents and near misses, and incidents should be reported to CareCERT in line with reporting guidelines.	**Fully Implemented** The organisation has a process or working procedure in place for staff to report data security incidents and near misses	The incident reporting process is in place via safeguard system.
8	Your organisation must: • identify unsupported systems (including software, hardware and applications)	**Partially Implemented** The organisation has reviewed all its systems and any unsupported systems have been identified but not logged on the organisation's relevant risk register.	We have replaced most of the systems but not telephony, which is currently being reviewed.
	• have a plan in place by April 2018 to remove, replace or actively mitigate or manage the risks associated with unsupported systems.	**Fully Implemented** By May 2018 the organisation will have developed a plan to remove, replace or actively mitigate or manage the risks associated with unsupported systems.	

	Standard	Response	Details
9	Your organisation must: • have undertaken or have signed up to an on-site cyber and data security assessment by NHS Digital	**Partially Implemented** Prior to 31 March 2018 the organisation signed up to undergo an NHS Digital on-site cyber and data security assessment.	The Trust have signed up for this and is waiting for a scheduled assessment with NHS Digital.
	• act on the outcome of that assessment, including any recommendations, and share the outcome of the assessment with your commissioner.	**Not Implemented** The organisation does not yet have an improvement plan in place on the basis of the findings of the assessment, and has not yet shared the outcome with the relevant commissioner(s)	No response recived regarding a visit so there are no findings to share.
		No The organisation has not used an external vendor to audit the organisation's data and cyber security risks	The Trust have not had a separate cyber audit.
10	Organisation should ensure that any supplier of critical IT systems that could impact on the delivery of care, or process personal identifiable data, has the appropriate certification (suppliers may include other health and care organisations).	**Not Implemented** The organisation has not checked whether its suppliers of IT systems have appropriate certification.	This is place with all DXC suppliers for Lorenzo. An active process will be implemented for all suppliers.

3) Recommendations

The Trust Board are asked to receive the report and:

- note the progress around implementing DSPR Standards.
- note the implementation of the 10 standards 11th May 2018.