North Staffordshire Combined Healthcare NHS
NHS Trust

MEETING OF THE TRUST BOARD

TO BE HELD IN PUBLIC ON THURSDAY 24 September 2015, 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.	**DECLARATION OF INTEREST RELATING TO AGENDA ITEMS**	Note
3.	**DECLARATIONS OF INTERESTS RELATING TO ANY OTHER BUSINESS**	Note
4.	**MINUTES OF THE OPEN AGENDA – 30 JULY 2015** *To APPROVE the minutes of the meeting held on 30 July 2015*	Approve Enclosure 2
5.	**ACTION MONITORING SCHEDULE & MATTERS ARISING FROM THE MINUTES** *To CONSIDER any matters arising from the minutes*	Note Enclosure 3
6.	**CHAIR'S REPORT** *To RECEIVE a verbal report from the Chair*	Note
7.	**CHIEF EXECUTIVE'S REPORT** *To RECEIVE a report from Mrs. C Donovan, Chief Executive*	Note Enclosure 4
	FOCUSING ON QUALITY AND SAFETY AND BEING AN EMPLOYER OF CHOICE	
8.	**SPOTLIGHT ON EXCELLENCE** *To PRESENT the Spotlight on Excellence Team and Individual Awards to staff* *To be introduced by the Chief Executive and presented by the Chair*	Verbal
9.	**PRESENTATION FROM TRUST'S OLDER PEOPLE'S MENTAL HEALTH CITY TEAM** *Presentation from Jane Munton-Davies, Head of Neuro and Older People's Directorate*	Verbal
10.	**STAFF RETIREMENTS** *To EXPRESS our gratitude and recognise staff who are retiring.* *To be introduced and presented by the Chair*	Verbal

11.	**QUALITY COMMITTEE REPORT** *To RECEIVE the Quality Committee assurance report from the meeting held on 15 September 2015 from Mr. P Sullivan, Chair of the Quality Committee*	Assurance Enclosure 5
12.	**QUALITY COMMITTEE TERMS OF REFERENCE – Annual Review** *To APPROVE the revised Terms of Reference from Mr. P Sullivan, Chair of the Quality Committee*	Approve Enclosure 6
13.	**NURSE STAFFING MONTHLY REPORT – August 2015** *To DISCUSS and APPROVE the assurance report on the planned versus actual staff variances from Ms. C Sylvester, Acting Director of Nursing & Quality*	Assurance Enclosure 7
14.	**LISTENING & RESPONDING – PALS & COMPLAINTS ANNUAL REPORT 2014/15** *To RECEIVE the annual report from Ms. C Sylvester, Acting Director of Nursing Medical Director*	Assurance Enclosure 8
	DELIVERING OUR FINANCIAL PLAN AND ENSURING GOOD GOVERNANCE	
15.	**FINANCE REPORT – Month 5 (2015/16)** *To RECEIVE for discussion the month 5 financial position from Ms. A Harrison, Interim Director of Finance*	Assurance Enclosure 9
16.	**ASSURANCE REPORT FROM THE FINANCE & PERFORMANCE COMMITTEE CHAIR** *To RECEIVE the Finance & Performance Committee Assurance report from the Committee Chair, Mr. T Gadsby from the meeting held on 17 September 2015*	Assurance Enclosure 10 To follow
17.	**FINANCE & PERFORMANCE COMMITTEE TERMS OF REFERENCE – Annual Review** *To APPROVE the Finance & Performance Committee Terms of Reference from Mr. T Gadsby Chair of the Committee*	Approve Enclosure 11
18.	**ASSURANCE REPORT FROM THE AUDIT COMMITTEE** *To RECEIVE for assurance the Audit Committee report from Mr. D Rogers, Committee Chair, following meeting on the 14 September 2015*	Assurance Enclosure 12
19.	**AUDIT COMMITTEE TERMS OF REFERENCE – Annual Review** *To APPROVE the Audit Committee Terms of Reference from Mr. D Rogers, Committee Chair*	Approve Enclosure 13
	CONSISTENTLY MEETING STANDARDS	

20.	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 5** *To RECEIVE the month 5 Performance Report from Ms. A Harrison, Interim Director of Finance*	Assurance Enclosure 14
21.	**SELF CERTIFICATIONS FOR THE NHS TRUST DEVELOPMENT AGENCY** *To APPROVE the Self Certifications for the TDA from Ms. A Harrison, Interim Director of Finance*	Assurance Enclosure 15
	BEING AN EMPLOYER OF CHOICE, DEVELOPING ACADEMIC PARTNERSHIPS AND EDUCATION AND TRAINING INITIATIVES	
22.	**PEOPLE AND CULTURE DEVELOPMENT COMMITTEE REPORT** *To RECEIVE the People and Culture Development Committee assurance report from the meeting held on the 21 September 2015 meeting from Mr. P. O'Hagan, Committee Chair*	Assurance Enclosure 16 To follow as meeting is on 21.9.15
23.	**BETTER LEADERSHIP FOR TOMORROW – NHS LEADERSHIP REVIEW – ROSE REPORT: LOCAL IMPLICATIONS** *To RECEIVE FROM Mr. P Draycott, Director of Leadership & Workforce, report detailing local implications following the NHS Leadership Review*	Assurance Enclosure 17
24.	**To *DISCUSS* any Other Business**	
	QUESTIONS FROM MEMBERS OF THE PUBLIC	
25.	*To ANSWER questions from the public on items listed on the agenda*	
	DATE AND TIME OF THE NEXT MEETING	
	The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday 29 October 2015 at 10:00am.	
26.	**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	

A meeting of the North Staffordshire Combined Healthcare NHS Trust will take place in private at 1:00pm, in the Boardroom, Trust Headquarters.

	DECLARATIONS OF INTEREST	Note
	DECLARATIONS OF ANY OTHER BUSINESS	Note

	SERIOUS INCIDENTS	Assurance
	LEADERSHIP & DEVELOPMENT UPDATE	Note
	BUSINESS CASES & INTEGRATED BUSINESS PLAN	Note
	ANY OTHER BUSINESS	

Enclosure

North Staffordshire Combined Healthcare NHS
NHS Trust

TRUST BOARD

Minutes of the open section of the North Staffordshire Combined Healthcare NHS Trust Board meeting held on Thursday, 30 July At 10:00am in the Boardroom, Trust Headquarters, Lawton House Bellringer Road, Trentham, Stoke on Trent, ST4 8HH

Present:

Chairman:

Mr K Jarrold
Chairman

Directors:

Dr B Adeyemo
Medical Director

Ms A Harrison (part)
Interim Director of Finance

Mr T Gadsby
Non-Executive Director

Mr S Blaise (part)
Deputy Director of Finance

Mr P Sullivan
Non-Executive Director

Mr P Draycott
Director of Leadership &Workforce

Mr M Dinwiddy
Interim Director of Nursing and Quality

Mrs B Johnson
Non-Executive Director

Mr P O'Hagan
Non-Executive Director

Mr A Rogers
Director of Operations

Mr D Rogers
Non-Executive Director

In attendance:

Mrs S Storey
Trust Board Secretary/Head of Legal and Corporate Affairs

Mrs A Roberts
Head of Communications

Mrs J Scotcher
Executive PA

Team Spotlight:
Richard Powell, Caseload Manager
Darren Carr, Clinical Director

Ms J Harvey
UNISON

Individual spotlight
Arlene Copeland, Hospital Alcohol Liaison Nurse, Substance Misuse
Andy Wilshaw
Darren Bowyer, Head of Directorate Substance Misuse

Members of the public:
Hilda Johnson - North Staffs User Group
Manir Hussai, SOT CCG (observing)

The meeting commenced at 10:00am.

79/2015	**Apologies for Absence** Apologies were received from Dr Laws, Dr Tattum, and Mrs Donovan. The Chair noted that Mr Blaise was in attendance for the initial part of the meeting attending on behalf of Ms Harrison, Interim Director of Finance. He further commented that Mr Blaise had recently won the 'Lifetime Contribution Award' at the recently	**Action**

	held HFMA West Midlands Annual Conference 2015 and congratulated him on this well-deserved award. The Chair also noted that for Mr Dinwiddy, Interim Director of Nursing and Quality and Mr Hughes, Interim Director of Strategy and Business Development, this would be their final Board meeting and he thanked them both for all their hard work and leadership in helping the Trust to maintain its sustainability.	
80/2015	**Declaration of Interest relating to agenda items** There were no declarations of interest relating to agenda items.	
81/2015	**Declarations of interest relating to any other business** There were no declarations of interest.	
82/2015	**Minutes of the Open Agenda – 4 June 2015** The minutes of the open session of the meeting held on 4 June 2015 were approved as a correct record.	
83/2015	**Matters arising** The Board reviewed the action monitoring schedule and agreed the following:- **08/2015 - Priority Referral Team - CYP Directorate -** Mrs Donovan queried what was the impact from changes at Stafford on the Trust. Dr Barton stated that statistics were available from when Stafford closed A&E services. It was noted that we need to transparency for commissioners; Mr A Rogers to take forward to provide more information to the Board. ***Mr Rogers commented that this issue is slightly wider than the Priority Referral Team, it is in relation to Mid staffs activity transferring to Stoke. This has been raised at Commissioning Board and they have recognised our case in this regard. This is ongoing and will bring back to the September meeting to provide the Board with a further update.*** **11/2015 - Safe Staffing Monthly Report -** Mr Sullivan was pleased to hear that community teams would be included and welcomed the increased data and metrics. He further noted that he would like to see complaints and incidents contained within the report. ***Mr Dinwiddy commented that with regard to the community metrics the work is ongoing to finalise the methodology for collating this information. It was noted that the six monthly report would be submitted***	**Mr A Rogers**

	to next month's Trust Board in July 2015 - On today's agenda – remove from schedule **11/2015 - Safe Staffing Monthly Report -** The Chair requested that the Board receive a regular report on recruitment. Mr Draycott to take forward. ***Mr Draycott gave an update regarding the initial recruitment campaign. The Trust has appointed 12 Health Care Support Workers and additionally 23 Registered nurses. Unfortunately, the last round of interviews, there were a number of appointments offered but not accepted and some non-attendees for interview. He further noted that mental health is a challenging environment in terms of nurse recruitment and the Trust is doing well to attract additional staff. The directorates will continue with the recruitment campaign. The Chair noted this is very encouraging and safe staffing levels are most important, it was also good to have commissioner support and to see that is now being translated into recruitment. However, it will take time for the wards to feel the benefit – remove from schedule*** **12/2015 - Assurance Report - Finance and Performance Committee - 23 April 2015 -** - It was proposed to write thank you letters to all those concerned for the impressive year end position – this is in hand with letters planned for completion by the end of the week. ***Mrs Storey noted that this had been completed and this was agreed by the Chairman – remove from schedule*** ***44/2015 - CEO report - the Chairman suggested that it may be beneficial to have staff stories as well as patient stories at Board-*** Mr Draycott and the Chair have met and this is being progressed ***– remove from schedule*** ***48/2015 Safe Staffing Monthly report –*** Mr A Rogers also noted that the Trust occupancy levels are based on home/leave measures ie Darwin showing 100% whereas 8 out of 10 filled due to 2 on home leave. Mr Dinwiddy to pick this matter up with Dr Adeyemo for further consideration with the data. Ms Harrison confirmed that the Trust is in the process of completing a bed capacity model and would work with Mr Dinwiddy in this respect ie patients sleeping out. Mr Dinwiddy stated that we need to reflect those numbers. ***This will be captured in the Safer Staffing model and will be addressed in the next six monthly report Remove from schedule***	

	Safer Staffing monthly report – Mrs H Johnson commented that the boards in respect of staffing levels on the wards are not always being completed. ***Mr Dinwiddy confirmed he had taken action in this area, although Mrs H Johnson commented there a still a few wards not completing. Mr Dinwiddy to speak to Mrs H Johnson to follow up further– remove from schedule.*** ***Financial Performance Month 1*** – Ms Harrison further noted the financial performance to-date is on plan. It was further noted that the Cost Improvement Schemes have not yet been put into budgets but this will be actioned by Month 2. ***Mr Blaise commented that this has been actioned – remove from schedule***	
84/2015	**Chair's Report** The last few weeks have been a time of major policy development in the NHS. The number and speed of announcements has been astonishing. In the first few weeks after the election it was clear that the focus of national policy was on getting the financial position under control - it was all about the money - and that remains a huge challenge for the NHS. However we now have an emerging policy framework that builds on the 5 Year Forward View with its strong emphasis on integration. There are six main themes. ***First transparency***. The intention is that there will be less reliance on targets more reliance on openness about problems and the publication of information about the quality of services and about outcomes. The core assumption is that a system t with the confidence to be honest about failings is a system that does something to put them right. ***Second learning not blaming*** including the establishment of the Patient Safety Investigation Service, learning from the Virginia Mason Hospital system in Seattle, a culture of openness, honesty and candour, listening to patients, families and staff and supporting staff who speak out against poor quality. ***Third the bringing together of Monitor and the Trust Development Authority***, under new leadership, to create NHS Improvement with the objective of focusing on learning about,	

	and improving, efficiency and quality. It is no exaggeration to say that the selection of the Chief Executive for the new joint organisation is one of the most important decisions facing the NHS. ***Fourth a commitment to patient power*** enabled by electronic health records, health apps, the provision of information about services and a new electronic booking service. ***Fifth a wide range of initiatives designed to improve integration***, urgent and emergency care and 7 day working. ***Sixth the Rose review on leadership and management*** with 19 recommendations designed to make people better qualified to manage and lead. It is the best report on this topic since the publication of Better Management, Better Health in the 1980s. This policy framework will, he believed, command widespread support in the NHS. The main challenge is implementation at a time of great financial pressure. ***Received***	
85/2015	**Chief Executive's Report** Dr Adeyemo presented the report on behalf of Mrs Donovan, Chief Executive, which provides an update on the activities undertaken since the last meeting in June 2015 and draws the Board's attention to any other issues of significance or interest. **Quality Assurance** As the Board are aware, the CQC visit is scheduled for week commencing 7 – 11 September 2015. Teams have been preparing by undertaking self-assessments and subsequent peer reviews of the teams. This has given teams the opportunity to test areas of good practice and where any gaps may be. The feedback has been quite encouraging for teams. The clear message for staff is that the CQC inspection is an opportunity to showcase the excellent services and care we provide. **Appointments** As noted earlier in the meeting it is Mr Dinwiddy's final meeting and the Trust has now appointed Maria Nelligan, as the new Director of Nursing and Quality. She has a wealth of experience and is currently the Deputy Director of Nursing at Cheshire and Wirral. It was noted that Mrs Donovan wished to thank Mr Dinwiddy for all his support and leadership. Dr Adeyemo commented that for her, personally it has been a pleasure working with him. **Substance Misuse service**	

	New Beginnings, an independent group helping those on the path to recovery from addiction, has launched Family and Carer Support Group to provide much needed help and the opportunity for relatives and friends to talk about their experiences. The Trust values their expertise and support. Dr Adeyemo commented that in her view this was a really good example of how adversity can be turned into something good and they continue to do this with the new group. **Listening into Action Update** The Board noted that it is a pleasure to see the difference in where we were and where we are now with the Pulsecheck results and how much we have improved in the year. Staff are more engaged and feel valued in their roles and how we develop the Trust together. We have also launched several new ways for staff to engage with the senior leadership team including the weekly CEO Blog, Team Brief on the road. Dr Adeyemo commented that it is good for both her and her colleagues to see first-hand what staff face on a daily basis. The Pulsecheck results are on today's agenda for further discussion. **Garden in Bloom Competition** This is an Annual event which showcases the work of staff and patients with a variety of garden displays. For the inpatient areas at the Harplands this event provides therapy for patients and is an enjoyable opportunity for them. Mrs B Johnson commented that this was a really good event and she had the pleasure of being one of the judges. She particularly noted the display of 'Prince Charles and Camila' sitting in deck chairs! Well done to all. Mrs H Johnson also commented that unfortunately she had not been able to judge this year due to other work pressures but that this was a most enjoyable event. In particular, she noted everyone had especially enjoyed throwing wet sponges at staff on Ward 3! **Annual General Meeting** The Trust will be holding its Annual General Meeting on 22 September 2015 at 1pm - 4.30pm; members of the public are welcome to attend. ***Received***	
86/2015	**<u>Individual Spotlight Award</u>** **<u>Arlene Copland, Hospital Alcohol Liaison Nurse</u>** **<u>Substance Misuse Directorate</u>** Arlene is a Registered General Nurse, who works as a Hospital Alcohol Liaison Nurse as part of the One Recovery Staffordshire partnership. She is a highly qualified, experienced and motivated nurse who specialises in providing specialist alcohol	

harm reduction and treatment advice to patients and staff at Queens Hospital, Burton.

Arlene has been selected for the Spotlight Award because of the work she has undertaken to establish the Alcohol Liaison Service at Queens, which has included meeting with and forming professional relationships with all levels of medical and nursing colleagues as well as devising protocols, guidelines and teaching sessions.

Her passion for her work is obvious and also infectious. She demonstrates a 'can do' attitude, which has helped the management at Queens to achieve better outcomes for patients. It is without doubt that the care provided to this group of patients has become safer, more responsive and more effective.

Since taking on the role, Arlene has championed our Value of providing high quality innovative care to patients - her most notable triumph has been to get staff to utilise the Clinical Institute Withdrawal Assessment to assess alcohol withdrawal symptoms and prescribe and administer medication to counteract the effects of this.

Arlene also consistently exceeds expectations and through her commitment to educate colleagues she is gradually changing the ethos and culture of care offered to patients by staff at Queens's hospital.

Team Spotlight Award and Presentation
Moorlands Community Mental Health Team based at the Ashcombe/Brandon Centre's Adult Mental Health Community Directorate

The Moorlands Community Mental Health Team has been selected for this month's Team Spotlight Award as a result of their recent and ongoing work to modernise and develop services offered for people living in the Rural Moorlands Area. This development has progressed over the last 3 years following the merger of two existing Community Mental Health Teams. The Team prides itself on having developed an efficient service, offering an increasing number of facilities but with the ability to discharge service users back to primary care services.

Their approach to service developments are reflective of all the Trust values. Examples include their pursuance of a strategy of meeting with local GP's and development of a close working relationship, reflecting our value of Working Together for Better lives; the integration of psychological services within the team to increase access and delivery of psychological therapies and introducing dual diagnosis clinics with substance misuse services to offer joint treatment plans reflects our value of

	Providing High Quality Innovative Care. This process has been led by their management team, but these developments have been planned, delivered and monitored by every member of the Moorlands Team. Mr A Rogers noted the increased referral rate highlighted in the presentation and that this was likely to be a trend in other teams. It is really important for us as a Board and Trust to challenge and have dialogue with commissioners. Mr O'Hagan commented that he felt humbled by the presentation. He expressed concerns about where the service is located and the possibility of the team feeling isolated and the need for us as a Trust to engage with the team. Mr Powell stated that he felt it was not necessarily the Trust but the team's role to feel more integrated and get more involved. He commented that coming along to the Board meeting had helped to raise awareness and was the start of the process. Mr O'Hagan stated that if there is anything the Board can do to help Mr Powell must make them aware. Dr Adeyemo commented on the good work of the team and that this is a reflection of the Trust values and they should continue with all their hard work. With regards to medication monitoring and wellbeing; the team play a part in keeping people in primary care, providing services over and above commissioned service. She thanked Mr Powell for sharing the work of the team with the Board. Mrs B Johnson noted that she had visited the Ashcombe Centre and was very impressed. She did however, raise concerns regarding the location of the centre and whether this was the right one for the team? Mr Powell stated that the team were very happy with the location, however they realised that the location was not right for service users and that a base in Leek would be more accessable. Mr A Rogers stated that other locations have been identified and the aim is to move somewhere in Leek, but not pursued due to other issues and this was being progressed under the Estates rationalisation of the Trust. The Chair noted that the Ashcombe Centre's location was historical due to the St Edwards Hospital being nearby. He hoped that the relocation would be taken forward. Mr Powell noted that the other satellite location was the Brandon Centre and that this may benefit from becoming 'One Hub' with the Ascombe Centre.	**Mr A Rogers**

	Mr Blaise noted that being a small team does have its benefits small is fantastic and is something to be proud of. Mr Draycott noted that teams ideally should range from between 8 to 15 individuals; sometimes if the team is too big it can create difficulties with personal engagement. Dr Carr commented on the rapid transformation that the team has been through. He further noted the strong relationships the team have with other organisations and suggested the Board use the team to evaluate and innovate new services. The Chair encouraged this and suggested further discussion be held at PCD. Mrs H Johnson noted that one of her colleagues covered the Ashcombe Centre and there were good working relationships with no issues, she highlighted that community services can be forgotten. She reiterated Dr Carr's suggestion and that teams can learn and share their good practice – keep up the good work! The Chair thanked Mr Powell and his team and in particular commented on the Patient Story chosen; which was clearly a complex and difficult case and extremely challenging. However it was brave to share the story and it highlighted the real progress made and reminded the Board of the complexity of issues the team face. ***Received***	**Mr Draycott**
87/2015	**Staff Retirements** Dr Adeyemo recognised staff who are retiring this month, unfortunately these staff were not able to attend today. The 3 staff noted were Pat Rawlings, June Cantor and Denise Chapman. The Chair expressed the Board's warm wishes and thanked them for their service to the Trust. Mr Draycott commented that these staff would also be acknowledged through Team Brief. ***Received***	
88/2015	**Quality Committee Summary held on 16 June and 21 July 2015** Mr Sullivan, Non-Executive Director, presented the summaries of the Quality Committees held on 16 June and 21 July 2015 for assurance purposes.	

	The following policies were discussed on 16 June 2015 for ratification today • 5.19 Zero Tolerance and 5.07 Violence & Aggression - policies merged • Staffordshire & Stoke on Trent Interagency Section 135 • Staffordshire & Stoke on Trent Interagency Section 136 • 4.34 Intellectual Property Policy • IC8 Cleaning - approve until 31.7.2016 • IC17 Specimen Management – approve until 30.09.2016 • R05 Restricted Access and Locked Doors • 5.13 Critical Incident Stress Management - approve until 31.07.2016 • Standing Operating Procedure – Return and Replacement of Ligature Cutters – to be appended to the Ligature Risk Reduction Policy The following policies were discussed on 21 July 2015 for ratification today • MHA16 Mental Capacity Act • 7.05 One Staffordshire Information Sharing • 4.36 External Visits Policy • Policy to Manage Visits by VIP / Celebrities • 1.74 Ligature Risk Reduction – replace with Environmental Ligature Risk Assessment Policy • Palliative Care in MH and LD Services • Seclusion / Segregation – new policy • 1.35 Policy and procedure for the safe and supportive observation and engagement of patients at risk – extend for six months • 1.50 The Observation and Monitoring of Patients – withdraw as replaced with 1.35 In terms of scrutiny number of areas were reviewed ; • Nurse Staffing Performance Monthly report – May and June 2015 • Quality Impact metrics from the Quality Management	

	Framework Report (PQMF) Months 2 and 3 2015 • Serious Incidents 1 January 2015 – 31 March 2015 • Annual Programme - Infection control • Risks to Quality of Services – June 2015 • Draft Service User and Carer Experience Strategy 2015 'Caring for and about' In terms of assurances the Quality committee received; • Annual report - Infection Control • Quality Governance Framework • Kate Lampard Report on the actions of Jimmy Saville – on today's agenda • Directorate Performance reports • CQC Quality Assurance Programme Update • Domain updates around ; patient safety, clinical effectiveness, organisational safety and efficiency customer focus • Complaints report Q1 2015/16 • Eliminating Mixed Sex Accommodation – Q1 2015-16 update against Action Plan • Board to team visits Q1 2015/16 • Quarterly Report against implementation of the Institute for Innovation Improvement High Impact Actions and the Chief Nursing Officers 6 C's ; Care, Compassion, Competence, Communication, Courage, Commitment. Cs In terms of information purposes, the Quality Committee received ; • Briefing from Healthwatch England on early discharge in mental health • End of Life Care across the Health Service • New judgement in Deprivation of Liberty update	

	• Business cases for service and Capital Development • Nurse Revalidation • Board Assurance Framework – on today's agenda • Mental Health Crisis Report and what we are doing locally • Health Service Ombudsman publicises NHS Complaints Information Commissioner Led Quality Visit to the Trust' Access Team – March 2015 • Progress update regarding Service User and Carer Council • Mental Capacity Act Group - Terms of Reference Mr O'Hagan made reference to the Performance Dashboard and queried when the integrated report would be available. Mr Sullivan commented that the Quality Committee have received a number of dashboards in draft format and these were evolving to include workforce information and it was his understanding that the dashboard would be available for the September Quality Committee. Mr Sullivan further noted that the detail produced last time had shown considerable improvements. It also enabled Complaints and Serious Incidents to be drilled down further to identify emerging themes and trends. Dr Adeyemo anticipated that there would be a review of the Performance Dashboard at the next Board of Directors session. Proto-types had been shown to consultants and nursing staff and they were pleased with the information provided. Mr D Rogers commented that this was a good development with clear visibility, helping us to take a fresh look at trends. ***Received***	
89/2015	**Safe Staffing Monthly report** Mr Dinwiddy, Interim Director of Nursing and Quality, presented the assurance report. This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during the data collection period	

	Mr Dinwiddy updated the Board as follows; • Planned staffing has been RAG rated based on registered and care staff. Ward Managers have supported the data with narrative reporting with no reports of challenges to the delivery of safe care • Where the planned staffing has fallen below 90%, ward managers have used additional data such as occupancy, incidents, sickness and training to provide an overview of any challenges to safety and quality and have confirmed that there has been no impact on either as a result of staffing • The report will detail the UNIFY submission for June 2015 and will be posted on the Trust website Mr Dinwiddy commented that the report is now much more owned by all staff and importantly staff understand the metrics. Ms Harrison has also supported the development of a system which takes into account acuity, to support decisions made about staffing levels required. The third and final reiteration of the calculations will be shared with Mr Dinwiddy and Ward Managers. Other factors which have been considered include bed cost, ratio of staff, qualified to unqualified. The reallocation of budgets will be made accordingly. Mr Dinwiddy thanked Ms Harrison for making progress in this area and that it was an extremely interesting piece of work. It was noted that the figures are based around acute trusts and in reality do not fit with Mental Health. The figures are based on a 50:50 split predominately and there are other staff to be considered such as the Activity Workers and other therapists. Mr Dinwiddy noted that within the A&T Unit there are some issues around Registered nurses ; however that is being mitigated by using the Registered nurse across the unit and increased activity from unqualified ie Health Care Support Worker nurses. Ms Harvey raised staffing during the summer time with annual leave at its peak. She also commented that as well as mitigation of using Health Care Support Workers; describing as unqualified is not a reflection of their distinct role. Mr Dinwiddy stated that from a staffing perspective there is more to consider than just cold data day by day, week by week and this is how staff work together as a team. Mr Draycott noted the recent appointments made with the staff recruitment as	**Ms Harrison**

	previously mentioned. He also commented that we recognise 3 peaks of annual leave in the year; July/August, Christmas and the end of March and these factors are taken into account with staffing levels. The policy is due for dissemination. Mr D Rogers raised concerns with A&T and that staffing is still below the planned. Ms Harrison noted that occupancy is another factor that needs to be considered. Mr Dinwiddy gave some assurance and there is an issue around staff that have been excluded from this report. A Band 6 nurse who was excluded will now be included. He further noted that high sickness levels and particular issues are now being addressed and we are in a better situation. Mr Draycott also noted that has been recruitment of 2 additional nurses. Mr Dinwiddy also commented that there are issues with recruitment in Learning Disabilities. Mr Draycott noted that it is imperative that the Trust gets the right calibre of staff. Mr A Rogers noted that A&T is currently full and there is very little home leave unlike Darwin Centre. Mr Sullivan noted that Learning Disabilities is very challenging and can be a difficult area to recruit to. It is important we recognise very skilled roles for registered or non -registered and the support they need. The Chair noted that Mr Dinwiddy would take forward the developments in this area with Ms Nelligan and that she also had a background of experience in learning disability services, which would be beneficial. ***Received***	**Mr Dinwiddy /Ms Neligan**
90/2015	**Nurse Staffing Six Monthly report** Mr Dinwiddy, Interim Director of Nursing and Quality, presented the assurance report. This paper outlines the six monthly performance of the Trust in relation to planned vs actual nurse staffing levels during the data collection period It was noted that the report now includes 20% ward manager's time and this is considered reasonable. The Trust is pleased to report that the monthly UNIFY data reflects that planned staffing levels have been achieved across all the inpatient areas for the majority of the reporting period.	

	Mr Dinwiddy confirmed that work has been progressed with support from Finance, Human Resources and Operations to ensure the right people are in the right place at the right time, to ensure safety within all units. It was further noted that occupancy rates have been included within the report, broken down by directorate. Mr Sullivan raised some concerns regarding the sickness levels on Ward 2 which seem to have increased. Mr Draycott clarified there is some long term sickness in this area and Mr A Rogers confirmed this has been debated at the PMS and JNCC meetings. Mr Sullivan also commented that in respect of incorporating ward managers into staffing levels; we must also be mindful of the time required for their management duties. Mr Dinwiddy to take forward with Mr Sullivan. Mrs H Johnson stated she had noticed on Ward 2 recently the 22 beds were full with patients with a variety of needs. She also questioned sickness and this may impact on the staffing levels/loss of some of the qualified staff. In addition, she shared her experience of a visit to ward 5 in respect of annual leave in that there were no qualified members of staff in the day room; only one HCSW. She was told 2 members of staff were on annual leave and 2 were off sick this is concerning in particular on a neurological ward. Mr Dinwiddy thanked Mrs H Johnson for bringing this matter to his attention. Mr Draycott gave further assurance to Mrs H Johnson and Board members that when establishments are drawn up we do make allowances for annual leave, training and sickness and ensure there is a 'buffer' built in and that 2 staff being absent on annual leave appeared reasonable in the circumstances given the total number of workforce on the ward. . Mrs H Johnson remarked on the positive comments received about Mr Dinwiddy when he visited the wards and comments were made about him being a very nice man. Debate took place regarding staff ratios and when acuity is extremely high. Mr D Rogers noted the Darwin Centre and the number of incidents; several in one day. Mr A Rogers noted that this was perhaps connected to a particular patient. Mr Dinwiddy also commented around the logistics of managing the child and ensuring they are hydrated and fed – this is hugely challenging.	

	The Chair commented he was delighted to see improvements and thanked the Board for their scrutiny. He requested that Execs pay particular attention to 4 areas ; A&T, Ward 2, Ward 5 and the Darwin Centre. Secondly to consider Mr Sullivan's comments regarding the Ward manager's role. Thirdly to note the acuity and funding issues as expressed by Ms Harrison for further debate with our commissioners. ***Received***	**Exec Team**
91/205	**Quality Account 2014/15** Dr Adeyemo, Medical Director, presented the Quality Account 2014/15. The Quality Account is produced annually to report to the public about the quality of services. The Board approved and accepted the final version and noted that a summary version will be produced in preparation for the Annual General meeting in September 2015. The Board formally recognised and thanked all those involved in producing this work. ***Approved***	
92/2015	**Integrated Quality Report Q4 2014.15** Dr Adeyemo, Medical Director, presented the summary of the Integrated Quality Report Q4 2014/15 for information and assurance purposes. The Trust has delivered the majority of its key performance metrics. There are a number of areas of good practice and where performance has been identified as needing to be improved, the Trust has put measures in place to achieve this. As noted previously, the report has also been received at the Quality Committee. Dr Adeyemo commented that the report focuses on key trends and lessons learnt. It was also noted that the CQUIN milestones for quarter 4 had been delivered. Mr Sullivan raised concern that the report appeared to be saying that incidents had not reduced when taking Chebsey Close out of the equation. Dr Adeyemo noted that she would clarify the situation but understood that there had been an overall reduction. ***Received***	**Dr Adeyemo**

93/2015	**Service User and Carer Council** Mr Dinwiddy, Interim Director of Nursing, presented this paper to inform the Trust Board of the work undertaken to develop a Service User and Carer Council (the Council). The Inaugural meeting of the Council is due to take place on 20 August 2015. Unfortunately, Mr Dinwiddy commented that he would have left the Trust by then. There has been an appointment of a new patient experience lead Veronica Emlyn, and this was welcomed. The Council will be supported by the Trust but predominately run by service users and carers themselves and will share their experiences with the Trust Board. All directorates will be represented on the Council The chair of the Council will attend Open and Closed Board meeting, anticipated from October or November 2015. The Council will be asked to drive The Service User Standards and to hold the Trust accountable for the implementation of The Service User standards. These standards have been drafted by Mrs Stronach and she was acknowledged for her work in this regard. The Chair noted that this was a hugely important development for the Trust which he welcomed.. ***Received***	
94/2015	**Themes and Lessons learnt from NHS investigations into matters relating to Jimmy Savile** Mr Dinwiddy, Interim Director of Nursing and Quality, presented this report into the actions and learning from the investigations into Jimmy Savile. The recommendations have been highlighted by Kate Lampard QC and the Trust has drawn up their action plan in response to these recommendations, which provides assurance on 9 out of 14 themes which apply to us. The action plan is self-explanatory and is in respect of safeguarding, volunteers, VIPs visiting trusts etc. ***Received***	
95/2015	**Board to team Visits Q1 2015/16** Mr Dinwiddy, Interim Director of Nursing and Quality, presented this report which provides a summary of Board to Team visits conducted during Q1 2015/16. This was one of the recommendations from the Francis Inquiry into Mid Staffordshire Hospital NHS Trust was that '*the trust make Board members more visible across the organisation a priority'.*	

	This report basically gives us the findings from the reporting schedules given. It is somewhat disappointing that we have not undertaken as many as we had planned; there have been 6 visits conducted out of 21 planned. It was further noted for assurance purposes that the Trust has implemented 'Grandfather' roles whereby Executive Directors undertake shadowing exercises with staff'. Mrs B Johnson commented that the Board to Team visits recorded may not be entirely accurate as she noted one of her visits was not listed. Mr Dinwiddy requested that all Board members notify Mrs Smith, Executive PA, in order that the log be updated appropriately. Mr Gadsby commented that the Trust is making good progress in this area, however he felt that any issues that are identified there is no mechanism for feeding back and ensuring issues are closed off. Mr Draycott agreed that through the Quality Committee there is a process of updates on actions. Mrs B Johnson asked whether we feedback to areas we have visited. Mr Draycott confirmed this was feedback but not consistently and this was being looked at. The Chair noted that he welcomed the report and was pleased that the visit programme has been revived. However, he asked for the process to be strengthened in view of comments made by Mr Gadsby and Mrs B Johnson. Mrs B Johnson also stated that it would be helpful to have sight of the last report of the Board to team visit beforehand and a high level brief on the service before the visit. Mr Dinwiddy to take forward with Mrs Stronach. Received	**Mr Dinwiddy /Ms Nelligan**
96/2015	**Financial Performance – Month 1** Ms A Harrison, Interim Director of Finance, presented this report and highlighted the headline performance for the period to the end of 30 June 2015. The headlines are as follows; The Trusts financial performance is a retained deficit of £0.343m against a planned deficit of £0.368m, a favourable variance of £0.025m. The in-year cost improvement target is £2.66m with a year to date performance of £0.04m behind plan. The cash balance as at 30 June 2015 was £7.13m.	

	The capital expenditure is £0.04m, which is slightly behind the Plan of £0.14m. The Continuity of Service risk rating is reported as 3 in line with the plan Ms Harrison gave assurance to the Board that the Trust is very close to plan on all financial aspects and this is forecasted to continue. With regard to Capital, there is now a capital commitment contract set up to inform the Trust on funds committed but not yet subject to an order or invoice. This will be reviewed at the Capital Investment Committee and Finance and Performance Committee. This is one of the Trust's Big Ticket items and will be kept under scrutiny. It was further noted that the there are several Business Cases which will be discussed in the closed session of the Trust Board led by Mr Hughes. ***Received***	
97/2015	**Assurance Report - Finance and Performance Committee Report – 18 June and 23 July 2015** Mr Gadsby, Non-Executive Director, presented the assurance reports to the Trust Board from the Finance and Performance Committees held on 18 June and 23 July 2015. Mr Gadsby reiterated Ms Harrison's comments, that the Trust is in a reasonably good financial position. However, he did express caution to Board members as this could change very quickly and we still have to maintain clear focus and control. At the meeting on 18 June 2015, the Finance and Performance Committee received a report detailing the Trust's costing processes and systems used in the production of the Trust's Reference Cost return. The committee took assurance that a robust process is in place as evidenced by the quality and data checks detailed within the paper. The Finance and Performance Committee received a verbal update on the completion and agreement of the Service level agreements both clinical and non-clinical; the Trust is now in a much better position than 12 months ago. As previously mentioned, the Capital control information now	

	gives visibility of capital costs going forward thanks to Ms Harrison. He reiterated that the Business cases would be discussed in the closed session of the Trust Board. ***Received***	
98/2015	**NHS England – Five year Forward View** Mr Hughes, Interim Director of Strategy and Development, presented the Five Year Forward View – Time to Deliver published in June 2015 and provides an update on progress to date from NHS organisations to deliver the vision for 2020. Mr Hughes noted that the document reinforces 3 gaps – quality, health, efficiency and funding. However, it is disappointing to note there is no explicit reference to mental health. The document is in line with our Integrated Business Plan and Annual Plan. ***Received***	
99/2015	**Performance and Quality Management Framework Report (PQMF) Month 1** Ms Harrison, Interim Director of Finance, presented this report. The report provides the Board with a summary of performance to the end of Month 3. A range of metrics is in place to monitor performance, quality and outcomes. The indicators are those set by our commissioners and local trust targets and aligned to the relevant Trust objectives. Performance against these KPIs has been reviewed by the Finance & Performance Committee prior to this report being presented to Trust Board In month 3 there is 1 metric rated as Red, 6 rated as Amber and 54 rated as Green; ratings for the 26 unrated metrics will be determined once technical guidance is received from the TDA. Ms Harrison noted that there are no additional metrics to report, however, some of the forecast positions are going to be reviewed. It has become apparent that in some areas even if we achieve targets quarterly, the time left available it is not mathematically possible to score 100%. As previously mentioned, Ms Harrison confirmed a Performance Dashboard has been developed where additional investment has been made, which will be submitted to Finance and Performance Committee and will be presented to the	

	September Trust Board. There is currently some challenge with the visual format; the plan is to make this timely and pictorially presentable. Mr D Rogers welcomed this development and stated this would give the board further assurance and understanding. ***Received***	**Ms Harrison**
100/2015	**Self-Certifications for the NHS Trust Development Agency** Mrs Harrison, Interim Director of Finance, presented the executive summary. The summary indicates that the Executive Team have reviewed the declarations, with no change from last month's position of compliance The Trust is continuing to be compliant. ***Received***	
101/2015	**Board Assurance Framework Q1 2015/16** Dr Adeyemo, Medical Director presented the Board Assurance Framework for assurance progress against the Trust's Principal Objectives and Risk Treatment Plans. It was noted that the Board Assurance Framework (BAF) has been significantly developed over the last few months, aligning the Trust Strategic Objectives to our quality priorities and key risks including the Board's level of risk appetite. The BAF provides an update and RAG rating for those actions due during Q1 and provides an update against further actions including gaps and challenges to be addressed. Dr Adeyemo thanked Ms Roberts, Head of Communications, for adding the new SPAR design.. Mr D Rogers suggested that this may be best placed higher on the agenda for the next Trust Board. The Chair agreed and noted there would be a further discussion at the Board of Directors session on the BAF. Mrs Storey also noted that the BAF is helping to further inform the Work plan for each committee going forward. ***Received***	**Mrs Storey**

102/2015	**People and Culture Development Committee Report** Mr Sullivan, Vice Chair of the PCD Committee/Non-Executive Director, presented this report which is a summary from the People and Culture Development Committee meetings which took place on 22 June and 20 July 2015. The PCD Committee approved the • Equality of Opportunity Policy • Performance Improvement Policy • Leave Policy • Medical Appraisal Policy ***Ratified*** For assurance purposes the committee received; Dashboard on Workforce - reviewed by directorates Workforce and organisation risks reviewed Other issues of note ; Information around Staff Profile Productive Workforce metrics Action plan to improve E-learning across the Trust Dragon's Den ; scheduled to take place in the Autumn 2015 – update at next meeting. – Pulsecheck results which are on today's Board agenda Healthcare Support Worker Learning Programme Progress Report – again on today's Board agenda Learning Disabilities Service proposed joint management structure – verbal update on closed session Mr Draycott highlighted the extension of the E-learning approach which aims to ensure maximum use of this mode of learning throughout the Trust and to benefit training status for individuals. In relation to benchmarking of productive workforce metrics, Mr Draycott remarked that the Trust's benchmarked position overall is 8th out of 29 across the West Midlands Provider Trusts and is worthy of note.. With regard to GMC National Trainee Survey 2015 – there were no issues for the Trust in respect of GMC trainees and that the quality of the placements were good. ***Received***	

103/2015	**Staff Engagement (Pulsecheck results)** Mr Draycott, Executive Director of Leadership and Workforce presented this report which provides a comparative analysis between the LiA Pulsecheck results 2014 – 2015 and the NHS Staff Survey results 2013 – 2014 and offers assurance about action being taken and progress made in response to the feedback obtained. Mr Draycott confirmed that had been discussed at the PCD meeting held on 20 July 2015 and noted the results suggest that real progress is being made in improving staff perceptions of the Trust as an employer and provider of services. Mr Draycott asked members of the Board to review Appendix 1 on page 7 (Survey One and Survey Two compared) and to note the improvements in these areas and progress made as an organisation, however not to be complacent. He further noted that in all 15 areas there has been a minimum of 10% increase in comparison to the original results. On page 8 this gave a pictorial image of how we benchmark against other NHS organisations and out of 15 areas we were favourable in 14 areas. Members of the Board noted this was very encouraging. The Chair was very pleased with the results and this is of real importance for the Trust. ***Received***	
104/2015	**Health Care Support Worker Development Programme** Mr Draycott, Executive Director of Leadership and Workforce presented this report to review our current position against Widening Participation and Development for the support workforce including Health Care Support Worker learning programme progress report. In addition to the report was the correspondence from NHS England in relation to Talent for Care; Get in – opportunities for people to start their career in a support role Get on – supporting people to be the best they can be in the job they do Go further – providing opportunities for career progression including into registered professions; which the Trust has committed to.	

	The report is here for assurance purposes to the Board and Mr Draycott noted a new lead has been identified with the Workforce Directorate. The programmes focuses on Bands 1 – 4 and the next cohort is due to start in October 2015 with the introduction of the Care Certificate which helps to give our HCSWs skills, knowledge and experience The Chair remarked this is of huge importance and support workers are a very significant part of our workforce. Ms Harvey also remarked on the importance of this and the good focus for Bands 1 – 4. She recalled a really good scheme which was available to Trust employees sometime ago entitled *'Life long learning scheme'* which gave funding to staff for a specific subject not necessarily relating to their role. It may be worthwhile developing staff further in their roles and to encourage additional learning. She urged that this be reconsidered. Mrs Harvey stated that she needed to invigorate staff side learning representatives. Mr Draycott said that this was previously a regional funded approach, but that the Trust hoped to be able to provide opportunities such as these in the future. The Chair commented on the Life Long Learning scheme and agreed this was rewarding for staff and he also recognised the impact the trade unions have made to life long learning. ***Received***	**Mr Draycott**
105/2015	**Any other business** Mrs H Johnson commented that one of the NSUG members had completed the community mental health certificate and is now working on the Bank which was to be acknowledged and commended	
106/2015	**Date and time of next meeting** The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday, 24 September 2015 at 10:00am, in the Boardroom, Lawton House, Trust HQ.	
107/2015	*** 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 12.30 pm

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
30-Apr-15	08/2015	Priority Referral Team - CYP Directorate - Mrs Donovan queried what was the impact from Stafford or Mid Staffs.. Dr Barton stated that statistics were available from when Stafford closed A&E. It was noted that we need to transparency for commissioners ;Mr A Rogers to take forward to provide more information to the Board.	Mr A Rogers	24-Sep-15	Mr Rogers commented that this issue is slightly wider than the Priority Referral Team, it is in relation to Mid staffs activity transferring to Stoke. This has been raised at Commissioning Board and they have recognised our case. This is ongoing and will bring back a further update for September meeting.
30-Jul-15	86/2015	Spotlight - Moorlands Community MH Team based at Ashcombe/Brandon - Mr A Rogers stated that other locations have been identified and the aim is to move somewhere in Leek, but not pursued due to other issues and this was being progressed under the Estates rationalisation of the Trust.	Mr A Rogers	29-Oct-15	part of rationaliation plan - update on progress in October 2015
30-Jul-15	86/2015	Spotlight - Moorlands Community MH Team based at Ashcombe/Brandon Dr Carr commented on the rapid transformation that the team has been through with very little collateral damage. He further noted the strong relationships the team have with other organisations and suggested the Board use the team to evaluate and innovate new services. The Chair encouraged this and suggested further discussion be held at PCD.	Mr Draycott	24-Sep-15	On the People and Culture Development Committee agenda - remove from schedule
30-Jul-15	89/2015	Safe Staffing Monthly report - Ms Harrison has also supported Mr Dinwiddy in this area. Each ward has been mathematically calculated taking into account a number of factors and a number of decisions about acuity. The third and final reiteration of the calculations will be shared with Mr Dinwiddy and Ward Managers. There may be some challenge and if necessary we can remodel, other factors which have been considered ie what does each bed cost, what ratio of staff, qualified to unqualified. The reallocation of budgets will be made accordingly.	Ms Harrison	24-Sep-15	final agreement incorporating ward managers suggestions will be agreed by the Executive and the budget allocaton will take place at M6. Complete remove from schedule

Board Action Monitoring Schedule (Open Section)

Meeting Date	Minute No	Action Description	Responsible Officer	Target Date	Progress / Comment
30-Jul-15	90/2015	Safe Staffing Six Monthly report - Mr Sullivan also commented that in respect of incorporating ward managers into staffing levels; we must also be mindful of the time required for their management duties. Mr Dinwiddy to take forward with Mr Sullivan.	Ms Sylvester/Mr Sullivan	24-Sep-15	Verbal update at meeting
30-Jul-15	104/2015	HCSW Development programme - Ms Harvey also remarked on the importance of this and the good focus for Bands 1 – 4. She recalled a brilliant scheme which was available to Trust employees sometime ago *'Life long learning scheme'* which gave funding to staff for a specific subject not necessarily relating to their role.	Mr Draycott	24-Sep-15	Remove - part of the People & Culture Development Committee agenda

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: Open Trust Board

Date of Meeting:	Thursday 24 September 2015
Title of Report:	Chief Executive's Report to the Trust Board
Presented by:	Mrs Caroline Donovan
Author of Report: **Name:** **Date:** **Email:**	Caroline Donovan, Chief Executive Caroline Donovan 15 September 2015 Caroline.donovan@northstaffs.nhs.uk
Purpose / Intent of Report:	• For Information
Executive Summary:	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.
Which Strategy Priority does this relate to: **How does this impact on patients or the public?**	• Customer Focus Strategy • Clinical Strategy • ~~IM and T Strategy~~ • Governance Strategy • ~~Innovation Strategy~~ • ~~Workforce Strategy~~ • ~~Financial Strategy~~ • ~~Estates Strategy~~
Relationship with Annual Objectives:	To ensure safe provision of clinical services
Risk / Legal Implications:	N/A
Resource Implications:	N/A
Equality and Diversity Implications:	N/A
Relationship with Assurance Framework [Risk, Control and Assurance]	N/A
Recommendations:	To receive this report for information

North Staffordshire Combined Healthcare Trust

Chief Executive's Report to the Board of Directors
24 September 2015

1. 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

2. QUALITY ASSURANCE

The Trust are coming to the end of our Comprehensive CQC Inspection which started on the 7th September 2015 with the inspection team being present on site for that week. As part of the inspection, the CQC have met with key clinical staff groups, commissioners and wider partners.

The inspection – which is carried out by a mixture of inspectors, clinicians and Experts by Experience – will assess whether the service overall is: safe, effective, caring, responsive to people's needs and well-led. Following the inspection, each provider will receive an overall rating of either: Outstanding, Good, Requires Improvement or Inadequate.

The process continues with the potential for further visits to teams and information being requested up until the 25th September 2015.

Initial high-level feedback from the CQC Inspection Team is that we have some examples of great practice of which we should be proud. Of course, there were also areas highlighted which need improvement; the detail of this will be shared in our inspection report, which is due in December.

3. APPOINTMENTS

I'm delighted to welcome to Dr Hardeep Uppal, who joins us as Consultant Psychiatrist in the LD Directorate. Dr Uppal, who is a specialist in ADHD, has an interest in digital technology and will be joining our Digital by Choice Group.

Veronica Emlyn joins us this month as our new Service User and Carer Engagement Lead. Veronica joins us with a wealth of experience and will lead on the development of our Patient, Service User and Carer Council.

Dr Swathi Theegala has joined the Trust as a Consultant Psychiatrist on Ward 3 at Harplands. Dr Theegala has a specialist interest in ECT.

Rob Cragg has been appointed as our Health Economy Director of Leadership and Transformation. This is a post that will work across the trusts and social care providers across our health and social care economy and will lead on supporting the cultural change that we need to see. Rob used to work here a few years ago; he is coming from

Wrightington Wigan and Leigh NHS Foundation Trust, where he has supported the Trust to significantly improve the way staff feel about being engaged and listened to which has been recognised through various national awards.

Tom Thornber also takes up his post as our new substantive Director of Strategy & Development. Tom joins us from The Christie NHS Foundation Trust in Manchester.

Andy Oakes is taking up a new role of Head of Partnerships and Social Care. Whilst this is an existing part of Andy's current role as Head of the Adult Mental Health Community Directorate, it is an area that is expanding rapidly given the Trust's focus on the wider health economy and integrated care. We have advertised for a new Head of AMH Community Directorate with interviews planned for late 28th September and Claire Holmes, CQC Project Lead, will act up as Interim Head of Directorate from Monday 28 September until the substantive post is recruited.

Congratulations to all staff who have taken up new appointments within the organisation this month.

4. CRISIS CARE PROGRAMME

Crisis care programme reduces use of police cells as a 'place of safety' by more than 50% for people experiencing a mental health crisis.

The Crisis Care Concordat, a national programme to improve standards in mental health crisis care across the country, has also led to almost 10,000 people receiving emergency attention from mental health nurses working alongside police officers. These are known as street triage schemes.

Since it was launched in February 2014, the Concordat has resulted in:

- a 55% reduction in England in the use of police cells as a place of safety for people detained under the Mental Health Act since 2011/12 and a 34% reduction since 2013/14
- more than 9,350 people helped by street triage schemes in just 12 months in the 9 areas where pilots have been running - a further 17 areas now have street triage schemes following this success
- 10 ambulance trusts signing up to 30 minute targets for paramedics to respond to mental health crises where the police have been the first to the scene - previously these were not routinely treated as emergencies

Locally we have seen a significant reduction in the number of people who have been taken to a police cell since the introduction of our Community Triage Team. During April to July last year we had 29 occasions where someone has not been seen in a Place of Safety in comparison to 2 in the same period this year. We believe that this is still 2 people too many and we are working with partners to reduce this further.

5. BALANCED SCORECARD

The Trust has introduced a Balanced Scorecard, comprising local and national objectives and targets in an easy-to-read dashboard. Development of the Balanced Scorecard is an ongoing

process and work will continue throughout the year to further refine the indicators and enablers.

The Balanced Scorecard is split into the following four domains:

- Workforce
- Finance
- Quality
- Performance

Within each domain are a number of indicators, grouped under our SPAR quality objectives. Each domain is rated across a spectrum of Red Amber and Green (RAG), with a set of thresholds specific to that domain determining the final RAG-rating. The Balanced Scorecard will be brought to Board on a monthly basis.

6. LISTENING INTO ACTION UPDATE

As reported at previous Trust Board meetings, our Listening into Action (LiA) programme is putting power in the hands of staff, to deliver the changes needed to the way Trust services are run.

The second wave of LiA teams are working hard to deliver on their objectives to make a difference to services across the Trust.

The second "Pass It On" event is planned for 23rd October 2015 at the Britannia Stadium where all of the teams will showcase their work and pass on the progress made. We will also then start to identify themes for our next LiA teams.

7. ANNUAL GENERAL MEETING

Our Annual General Meeting took place on Tuesday 22 September this year, from 1pm – 4.30pm. The AGM provides an opportunity not only for the Trust's accounts to be formally presented publically, but also for people with an interest in mental health services to come along and find out more about the excellent services delivered every day by staff and volunteers across our organisation.

Many thanks to the staff who supported the event and to those who came along to find out more about our Trust.

8. NHS TECHNOLOGY

The Health Secretary has announced that patients will be able to access and interact with their GP record online within 12 months.

The Health Secretary has challenged the NHS to make better use of technology so that patients can be empowered to manage their own healthcare needs, while ensuring that their data remains safe at all times.

Mr Hunt made clear that by 2016 all patients should be able to access their own GP electronic record online in full, seeing not just a summary of their allergies and medication

but blood test results, appointment records and medical histories. By 2018 this record will include information from all their health and care interactions.

As we have reported in previous months, the Trust is moving forward with our Digital by Choice strategy to support greater use of technology to ensure delivery of safe, personalised, accessible and recovery focussed services.

9. MENTAL HEALTH CHAMPION FOR SCHOOLS

The Department for Education's (DfE) first ever mental health champion for schools will help to raise awareness and reduce the stigma around young people's mental health.

Natasha Devon MBE - who works as a television pundit and writer - was chosen for the role following her extensive work with young people. This includes launching two organisations which give young people practical tips on dealing with mental health and body image concerns. As founder of the Self-Esteem Team and the Body Gossip education programme, Natasha has delivered classes to more than 50,000 teenagers, as well as their parents and teachers.

The move comes as part of a wider government commitment to improve children and young people's mental health - including the way these services work with schools - with £1.25 billion to be invested specifically in young people's mental health over the next 5 years. This money will transform local services so that every organisation involved with caring for children and young people works together to support them with their mental health, not just the NHS.

Alongside this, the Department of Health, working with NHS England, is investing £150 million to improve eating disorder services, backed up by a new standard so that young people who need help can be seen within 4 weeks or 1 week for urgent cases by 2020. The very worst emergency cases should find support within 24 hours. The funding will be used to improve community-based services so patients are helped earlier and fewer need in-patient care.

Caroline Donovan
Chief Executive
Thursday 24 September 2015

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: **Open Trust Board**

Date of Meeting:	24 September 2015
Title of Report:	Summary of the Quality Committee meeting held on the 15 September 2015
Presented by:	Mr Patrick Sullivan, Non Executive Director Chair of Quality Committee
Author of Report: Name: Date: Email:	Sandra Storey, Trust Secretary, Head of Corporate and Legal Affairs 17 September 2015 sandraj.storey@northstaffs.nhs.uk
Purpose / Intent of Report:	• For decision / assurance
Executive Summary:	This report provides a high level summary of the key headlines from the Quality Committee meeting held on the 15 September 2015. The full papers are available as required to Trust Board members
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Customer Focus Strategy • Clinical Strategy - • Governance Strategy
Relationship with Annual Objectives:	Ensure provision of safe clinical services
Risk / Legal Implications:	N/A
Resource Implications:	N/A
Equality and Diversity Implications:	N/A
Relationship with Assurance Framework [Risk, Control and Assurance]	The Quality Committee has an integral relationship with Improving Quality/ Registration.
Recommendations:	• To note the contents of the report • Ratify the policies highlighted in the report

Key points from the Quality Committee meeting held on 15 September 2015 for the Trust Board meeting on the 24 September 2015

1. **Introduction**

   This is the regular report to the Trust Board that has been produced following the last meeting of the Quality Committee.

   The Chair welcomed Maria Nelligan as an observer to the meeting. Maria will be taking up post as Director of Nursing & Quality from October 2015. Carol Sylvester was also welcomed to the meeting in her new capacity as Acting Director of Nursing & Quality.

2. **Director of Quality Report**

   The report updates the committee on activities undertaken since the last meeting and draws the committee's attention to any other issues, local or national, or of significance or interest. Notable items as follows:

- **The Professional duty of candour: new guidance for doctors, nurses and midwives –** the new guidance is the latest in a series of reforms following the well publicised public inquiry into Mid Staffordshire NHS Foundation Trust. The new guidance will sit alongside the statutory duty of candour which came into force for NHS providers in November 2014. It is worth remembering though that all healthcare professionals have long had a professional responsibility to be honest with people in their care when things go wrong. The overarching guidance for doctors is the GMC's Good Medical Practice, while for nurses and midwives it is the Code: Professional standards of practice and behaviour for nurses and midwives; both of which cover fundamental aspects of the healthcare professional's roles.

  In terms of what is happening in the Trust, work has been undertaken to refresh the Trust policy with clear support and guidance for staff.

- **This Week Next Week July 17 July 2015 report**
  – a survey found that more than 1 in 3 of those requiring assistance reported they did not always receive it, with those aged 80 most affected.
  In terms of what is happening at the Trust, the committee received information on the person centred approach that the Older people's Team has taken in relation to diet, fluid, screening and assessments.

  - Lord Crisp's Review Highlight demand for mental health services
  Work is ongoing locally with key stakeholders to help respond to this issue. Staff in the Trust has been analysing data on delayed transfers of care and early indications have found that there is a significant increase in particular in Older Peoples service from 2013. The most common reasons for Older Peoples services was access to care home placements and in Adults of working age was accommodation issues. The committee will receive further information in due course.

- **Report of the Chief Coroner to the Lord Chancellor – second annual report: 2014/15**
  The Chief Coroner has fulfilled his obligatory reporting duties under section 36 of the Act and used the report as an opportunity to outline his visions for future reforms to the coronial service across

England and Wales. The report also noted the unanticipated rise in the work from Deprivation of Liberty Safeguards (DoLS) and hints at the likelihood of statutory reforms in this area. The Chief Coroner's office is working towards and alert system so that subscribers can be sent relevant Prevention of Future Death Reports as they are published. This would help to share any learning and education in terms of practices and procedures.

One of the key reforms to the coronial system was an emphasis on alleviating the stress and anxiety of bereaved families by completing inquests in a timely manner. In terms of what has been happening locally, since the reforms it is pleasing to note that all reports have been completed on time. The Coroner has commended the Trust on the timeliness but also the quality of reports though this requires an ongoing commitment by those involved.

3. Policy Review

The committee received information on policies that had been reviewed and made recommendations for withdrawal, extension or approval. The recommendations were supported by the committee for ratification of the policies by the Trust Board for a period of 3 years as follows:

- Serious Incident Policy 5.32
- Incident Reporting Policy 5.01

The committee also reviewed the Forward Look Policy report and noted that this is an ongoing piece of work.

Currently all policies that fall under the jurisdiction of the committee are within their review date with a small number of policies requiring review by the end of October 2015.

4. Quality Impact Assessment of Cost Improvement Schemes (CIPs)

Dr Adeyemo noted that there were no new schemes to report since the last meeting. All individual CIP schemes have been quality impact assessed. Two new CIP developments have been reviewed accordingly with no impact on quality of service indicated.

5. Quality Committee Terms of Reference

The Quality Committee are required to review its Terms of Reference at least annually and these were considered by the Committee at its meeting. It was proposed that there should be a refocus for the committee particularly aligning quality priorities to SPAR (Safe, Personalised, Accessible, Recovery focused) alongside development of the Trust's Board Assurance Framework and assurances that require reporting to the committee.

A third Non Executive Director, namely Bridget Johnson, has been added to the membership of the committee. Bridget is the link Non Executive Director to the Service User & Carer Council. It was noted that as the work of the Council develops over the coming months this will help to inform any changes to the committee's Terms of Reference. The committee will also undertake a review of its effectiveness, also taking account of the feedback from the CQC inspection to help develop the Terms of Reference and indeed the future work plan for the committee.

6. Nurse Staffing Performance monthly report – August 2015

The committee received the nursing staff performance on a shift by shift basis for the month of August 2015. While there are still some ongoing challenges a proposed model has been presented to the Executive which included ward managers commencing 20% clinical shifts to provide enhanced leadership. It was noted that almost all vacancies based on the current establishment have been filled. There has been a skill mix review and it is proposed that all adult acute inpatient wards will be staffed to a 50:50 ratio.

7. **Quality Metrics from the Performance Quality Management Framework Report (PQMF) month 5 2015/16**

The committee reviewed the quality metrics extracted from the wider PQMF. As noted previously, the role of the committee is to consider the impact of metrics potentially going off track. Of the total 73 metrics at month 5, 2 quality metrics were noted to be rated as red and 3 rated as amber. These relate to compliance with Personal Development Review (PDR) targets, the percentage of staff compliant with mandatory training, compliance with 18 week referral to treatment (ASD) and RAID response times. The committee discussed the mitigation plans to improve performance.

Committee members also reviewed the further developed Balance Scorecard that will be adopted by the committee going forward. This document, presented using the quality objectives, was well received by the committee and further enhancements were discussed and agreed. It is intended that this will reduce the number of reports that are presented to the committee in the future and the scorecard captures a significant amount of this information such as performance by Trust and Directorate level in respect to key metrics, benchmarking, nurse staffing, patient experience and so on.

8. **Annual Report on PALS & Complaints 2014/15**

This report covered the performance of the PALS and Complaints Team, including details of compliments received for the period 2014/15. The report describes initiatives during the year including a reintroduction of the complaints and PALS training for staff, development of a new improving the patient experience literature and investigating officers complaints handling training. It was noted that work is being undertaken to develop the annual report going forward with the intention that this is much more detailed and informative for the reader.

9. **Report following the TDA infection prevention and control visit to the Harplands Hospital**

This report summarised the key themes identified by representatives from the TDA on their visit to the Trust on the 7 August 2015. The TDA performed their last visit to the Harplands Hospital in September 2014 and offered to perform a follow up visit as a precursor to the forthcoming inspection by the CQC. A number of positive themes and observations were highlighted for the Trust in particular praise for a whole health economy approach and collaborative working with other providers. Action points were also raised to further raise standards and it was noted that the Trust had responded positively to these recommendations. The action plan will remain live until all actions are addressed and progress will be monitored by the committee.

10. **Leadership and Workforce Update**

The committee received a report summarising current raising concern cases, including details of the nature of the concerns raised, investigating manager, progress, planned completion date and

outcome. The report outlined one new case since the last meeting.

11. Letter to the Trust CEO from the Quality Surveillance Group – July 2015

NHS England uses a Surveillance Rating System. The letter indicates that the Trust is rated Green which indicates Regular Surveillance, no specific concerns, but watching eye on any dips in performance.

12. National Confidential Inquiry into Suicide and Homicide by people with mental illness (NCISH) Annual Report July 2015.

This report by the University of Manchester's National Confidential Inquiry into Suicide and Homicide by People with Mental Illness uses data from across the UK for the period 2003 – 2013. During this time there has been a 29% rise among men who die by suicide while under the care of mental health services. The largest rise was seen in middle aged men 45-54 years old which may be driven by increases in risk factors such as alcohol and economic pressures. Concern is raised over the increase in the number of suicides of people following discharge from out of areas admissions as the findings suggest that it is more difficult to care plan for people and so increase the suicide risk for this group of people; a recommendation to end all out of area admissions is made.

The report is being considered in the Trust. Staff are aware from anecdotal evidence that the search for out of area beds has been much greater than the actual out of area beds located and used, though the Trust has not experienced increased incidents relating to this.

13. Restraint report Q3 & Q4 2014-15 and Q1 2015-16

This report gives a comparison for the period highlighted evidencing the use of all physical restraint in all clinical areas giving the committee an opportunity to understand the levels of and reasons for the use of physical restraint. In the period Q1, the findings highlight how the challenges presented by one client can influence the figures.

It is noted that the use of physical restraint should be the last resort after all other means of managing a situation has been tried or the risk is so immediate that physical restraint is the least restrictive way of reducing and/or managing the risk.

14. Seclusion report Quarter 1 2015/16

The committee received a report showing the recorded use of seclusion highlighting the clinical areas using this intervention, length of time the patient was subject to seclusion and compliance with the Mental Health Act Code of Practice when a patient has been secluded. Considerable time and effort has been devoted to ensuring that the Trust can, as far as possible, comply with the guidance in the new MHA Code of Practice around the use of seclusion. This is an ongoing process and work is ongoing in terms of monitoring arrangements ensuring that provision of seclusion areas fit the correct specification. The Seclusion Policy has also been reviewed and updated to comply with the 2015 MHA Code of Practice.

15. Overview of Safeguarding Activity

The committee received a paper outlining the current case reviews for both Adult and Safeguarding investigations, information on trends and themes arising from safeguarding within the Trust, and change to leadership arrangements within the Safeguarding Team. The report also identified the training that is provided and how local lessons are disseminated.

16. **Patient Led Assessment Care Environment (PLACE) 2015**

The Trust PLACE assessments have been completed in accordance with national guidelines and target dates given for each location with at least 50% patient representation and independent validator on each assessment. The Trust has received high scores with improvements noted by our Patient Representatives across the organisation which is reflected in the results.

17. **Directorate Performance Reports**

The Committee received the monthly performance reports from each of the Directorates including information on key risks, serious incidents and complaints. Committee members also spent time considering the draft Performance Balanced Scorecard, noted earlier in this report. This dashboard will continue to evolve over time in order to give the information and assurance required by the teams and committee.

18. **Risk to Quality of Services M5 2015/16**

Committee members considered the report for quality risks, noting the risk treatment plans in place. Of note is the lack of PICU availability which means there is a risk that patients are not supported in an appropriate environment. It was noted that a business case has been developed and is being considered by commissioners. A protocol has also been developed to support higher risk situations supporting patients in the Ward 1 Annexe. This and the other risks to the provision of quality services are being monitored by the committee.

19. **Ward 2 CQC Unannounced Mental Health Act Visit to Ward 2 – July 2015**

The committee received a report following the visit to the ward in July 2015. It was noted to be generally a positive visit but some learning identified with regards to record keeping and environmental changes.

20. **CQC Quality Assurance Programme Update**

The committee received a verbal update summarising the progress made by the Quality Assurance Programme Board noting that the Trust is in the second week of the three week inspection. It was noted that Mrs Holmes was moving into a new job to support the community teams and she was thanked for her contributions in respect to this programme of work.

21. **Domain Updates**

The committee received each of the domain reports for assurance purposes in respect to:

- **Patient safety** , **Clinical effectiveness, Organisational safety and efficiency** , **Customer focus**

22. **Next meeting: 20 October 2015**

On behalf of the Committee Chair, Mr Patrick Sullivan, Non Executive Director
Sandra Storey
Trust Secretary / Head of Corporate and Legal Affairs
17 September 2015

North Staffordshire Combined Healthcare NHS
NHS Trust

Encl. 6

REPORT TO: Trust Board

Date of Meeting:	24 September 2015
Title of Report:	Terms of Reference for the Quality Committee
Presented by:	Patrick Sullivan, Chair of the Quality Committee
Author of Report: Name: Date: Email:	Sandra Storey, Trust Secretary / Head of Corporate and Legal Affairs 08 September 2015 Sandraj.storey@northstaffs.nhs.uk
Purpose / Intent of Report:	• For Review and Approval
Executive Summary:	The Quality Committee are required to review its Terms of Reference at least annually. These were last considered by the Committee at its meeting on the September 2015. The proposed changes relate to a refocus for the committee particularly in respect to its quality priorities aligned to SPAR and development of the Trust's Board Assurance Framework. A third Non Executive Director, named Bridget Johnson has been added to the membership of the committee who is the link Non Executive Director to the Service User & Carer Council. As the work of the Council develops over the coming months this will help to inform any changes to the committee's Terms of Reference. The committee will be undertaking a review of its effectiveness in the coming months and this will also help to inform the review of the Terms of Reference.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Clinical Strategy • Customer Focus • Governance Strategy
Relationship with Annual Objectives:	Review of Terms of Reference is part of the Trust's integrated governance arrangements
Risk / Legal Implications:	N/A
Resource Implications:	N/A
Equality and Diversity Implications:	N/A
Relationship with Assurance Framework [Risk, Control and Assurance]	Review of Terms of Reference is part of the Trust's integrated governance arrangements and helps inform the Trust Annual Governance Statement
Recommendations:	It is recommended that the Trust Board approve the revised terms of reference for the committee for a 12 months period, taking account of the fact that the terms of reference will be developed further in light of developments and represented to the Trust Board accordingly.

North Staffordshire Combined Healthcare NHS
NHS Trust

QUALITY COMMITTEE

TERMS OF REFERENCE

Membership	• Three Non-Executive Directors • CEO • Medical Director • Director of Nursing & Quality • Director of Operations • Director of Leadership and Workforce • Clinical Director (or their nominated deputy) for each Clinical Directorate • Associate Director of Governance • Associate Director of Medical and Clinical Effectiveness
Quorum	• Four members including at least one executive director, one a non-executive director and one a clinical director (or nominated deputy)
In Attendance	• Trust Board Secretariat • Co-opted members as required:
Frequency of Meetings	• No less than six meetings per year
Accountability and Reporting	• Accountable to the Trust Board • Report to the Trust Board after each meeting • Minutes of meetings available to all Trust Board members on request • Annual report to Trust Board on actions taken to comply with terms of reference
Date of Approval by Trust Board	• 24 September 2015
Review Date by:	• 30 September 2016

QUALITY COMMITTEE

TERMS OF REFERENCE

1. Constitution

The Trust Board hereby resolves to establish a Committee of the Trust Board to be known as the Quality Committee (hereafter referred to as the Committee).

2. Membership

The Committee shall be appointed by the Trust Board from amongst the directors of the Trust and shall consist of not less than three members. One of the non-executive director members will be appointed Chair of the Committee by the Trust Board. In the absence of the Chair appointed by the Trust Board one of the other non-executive directors will be elected by those present to Chair the meeting.

3. Quorum, Frequency of Meetings and Required Frequency of Attendance

No business shall be transacted unless four members are present, of whom at least one shall be an executive director, one a non-executive director and one a clinical director (or nominated deputy who has authority to make decisions in their absence).

The committee shall meet at least monthly or six weekly to effectively manage matters such as performance and quality. Meetings will be called more frequently when vacancies arise or meetings can be called at the discretion of the Chair. There will be no less than six meetings per year.

Members of the Committee should attend regularly and should not be absent for more than two consecutive meetings.

4. In Attendance

Only the Committee Chairman and relevant members are entitled to be present at a meeting of the Committee, but others may attend by invitation of the Committee.

Any service user representative from the Service User and Carer Council invited by the Committee will be allocated a ‘buddy’ from the membership of the Committee by the Chair, to offer support before, during and after the Committee meeting, should this be required.

5. Authority

The committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek information it requires from any employee and all employees are directed to co-operate with any request made by the committee. The committee is authorised to obtain outside or legal advice or other professional advice and to secure the

attendance of outsiders with relevant experience if it considers this necessary.

6. Duties

To provide assurance to the Trust Board on the quality and safety of healthcare provided by the Trust by developing and reviewing the Trust's Quality and Clinical strategy and plans.

Quality Governance

The Committee will report and provide assurance to the Trust Board on the quality of healthcare provided by the Trust through the monitoring of the Trust's quality objectives that are called SPAR:

Our services will be consistently *Safe*
Our care will be *Personalised*
Our processes and structures will guarantee *Access*
Our focus will be on *Recovery*

The Committee will have domains reporting into it, each led by a director. The Domain leads, aligned to SPAR, will ensure a report of the activities and progress of the groups within their domain is fed into the Committee:

- Patient Safety Domain
- Clinical Effectiveness Domain (Patient Outcomes)
- Customer Focus Domain (Patient Experience)
- Organisational Safety and Efficiency Domain)

The Committee will oversee the planning and development of quality and governance activities in the Trust in line with NHS Executive Guidance: Clinical Governance: Quality in the New NHS (HSC 1999/065). This is a statutory duty on all NHS trusts, which requires them to put and keep in place arrangements for monitoring and improving the quality of health care they provide.

The Committee will set the Trust's strategy for quality and ensure the development of the Trust's clinical, quality and governance plans.

The committee will oversee the delivery of Directoratel quality and governance plans.

The Committee will ensure that accountability for the delivery of high quality service to patients is with Directorates.

The Committee will encourage and foster greater awareness of quality and governance throughout the organisation at all levels.

The Committee will ensure the development and ratification of clinical policy and procedure.
The Service User and Carer Council will be a conduit of information regarding patient and carer issues which will be shared through Directorate reporting arrangements through to the Senior Leadership Team and Quality Committee meetings, as appropriate.

The Committee will approve any new clinical or interventional procedure.

The Committee will approve research and development and audit plans in line with strategic objectives.

The Committee will ensure the development of the strategy for CQUINs with commissioners and oversee the monitoring and reporting process.

The Committee will oversee the development of Quality Accounts and oversee the monitoring and reporting process, giving assurance to the Audit Committee in this regard.

The Committee will monitor the Quality Indicators (QIs) as defined in the Trust's Performance & Quality Management Framework (PQMF).

The Committee will monitor the Trust's performance via review of the Performance Balanced Scorecard.

The Committee will receive assurance on the quality impact assessment of proposed Cost Improvement Programmes.

The Committee will receive information and assurance on staffing levels.

The Committee will monitor and guide trust activity in relation to compliance with core standards and will also oversee the Trust's Registration and ongoing accreditation under the Health and Social Care Act.

The Committee will monitor the system and process for capturing and responding to service user and carer feedback.

The Committee will receive information in relation to Medicine's management and monitor any issues or concerns.

Risk Management Function

The Committee via the Risk Review Group will ensure that operational and clinical risks are identified, measured and adequate controls are in place. There will be a quarterly review of the Trust's Board Assurance Framework and the assurances that fall under the responsibility of the Quality Committee.

While the Audit Committee will give assurance to the Board that the overall system for risk management is in place and is effective, operational responsibility for the management of risk to quality of services lies with the Quality Committee supported by the Risk review Group.

7. Accountability and Reporting Arrangements

The minutes of Committee meetings shall be formally recorded by the administrator for the committee. Copies of the minutes of Committee meetings shall be available to all Trust Board members on request.

The Associate Director of Medical and Clinical Effectiveness shall prepare a report to the Trust Board for the Chair after each meeting of the Committee. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Trust Board.

8. Sub-Committees and Reporting Arrangements

The Committee shall have the power to establish sub-committees for the purpose of addressing specific tasks or areas of responsibility. In accordance with paragraph 4.5 of the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee unless expressly authorised by the Trust Board.

The terms of reference, including the reporting procedures of any sub-committees must be approved by the Committee and regularly reviewed.

9. Compliance and Effectiveness

The Committee must produce an annual report to the Trust Board on the actions taken by the Committee to comply with its terms of reference. This will include information in respect to how the committee has reviewed its effectiveness and its relationship with other committees, in particular the Finance and Performance Committee, People and Culture Development Committee and Audit Committee, ensuring that there are is no unnecessary duplication or gaps in business across the committees.

The annual report will include information about compliance with the requirement that members should attend regularly and should not be absent for more than two consecutive meetings. The annual report will also include information about the reporting arrangements into the Committee from any sub-committees.

10. Administration

The Associate Director of Medical and Clinical Effectiveness will

- Agree the agenda with the Chairman and Quality Directors and ensure the collation of the papers and minutes are taken by the committee administrator;
- Ensure that a record is kept of matters arising and issues to be carried forward;
- Devise and maintain a schedule of matters and cycle of business for the Committee;
- Prepare reports to the Trust Board after each meeting of the Committee; and
- Advise the Committee on pertinent areas.

11. Requirement for Review

The Terms of Reference will be reviewed at least annually by the committee for Trust Board approval and the next review must take place before end of September 2016.

North Staffordshire Combined Healthcare NHS
NHS Trust

Report to: Quality Committee Enclosure 7

Date of Meeting:	24 September 2015
Title of Report:	Nurse Staffing Performance on a shift-by-shift basis
Presented by:	Carol Sylvester, Acting Director of Nursing and Quality
Author of Report: Date: E-mail:	Carol Sylvester, Acting Director of Nursing and Quality 18 September 2015
Purpose / Intent of Report:	• For Assurance
Executive Summary:	This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during the data collection period (1st – 31st August 2015) in line with the National Quality Board expectation that: *"The Board:* *• Receives an update containing details and summary of planned and actual staffing on a shift-by-shift basis* *• Is advised about those wards where staffing falls short of what is required to provide quality care, the reasons for the gap, the impact and the actions being taken to address the gap* *• Evaluates risks associated with staffing issues* *• Seeks assurances regarding contingency planning, mitigating actions and incident reporting* *• Ensures that the Executive Team is supported to take decisive action to protect patient safety and experience* *• Publishes the report in a form accessible to patients and the public on their Trust website (which could be supplemented by a dedicated patient friendly 'safe staffing' area on a Trust website)".* • The performance relating to the fill rate (actual numbers of staff deployed vs numbers planned) on the wards for March was 97.87%: being a total fill rate of 96.02% for registered nurses and 99.0%for HCSWs. The position reflects that ward managers are effectively deploying additional staff to meet increasing patient needs as necessary. The Board is asked to: Receive the monthly nurse staffing report
Which Strategy Priority does this relate to? How does this impact on patients or the public?	• Customer Focus Strategy • Clinical Strategy • Governance Strategy • Workforce Strategy • Financial Strategy
Relationship with Annual Objectives	Supports the delivery of the Trust's Annual Objectives and the delivery of high quality care

Risk / Legal Implications:	Delivery of safe nurse staffing levels is a key requirement to ensuring that the Trust complies with National Policy direction
Resource Implications:	Further assessment of the use of bank and agency staff is planned to inform a review of baseline establishments against the current level of acuity

North Staffordshire Combined Healthcare NHS
NHS Trust

In patient safer staffing metrics-August 2015

RAG rating **>90% GREEN** **<90% AMBER** **<80% RED**

Ward	Performance (% planned vs actual)				Overall fill rate%	Bed Occupancy % (including home leave)	Sickness %	Mand Training %	PDR %	Incident Rate	SI`s	Complaints
	Day %		Night %									
	Reg`d	Care	Reg`d	Care								
Ward One	123%	90%	112%	121%	111.4%	107 ↑	10.66 ↓	84 ↑	92.5 ↑	33 ↑	0 ↔	1↑

Ward Manager narrative:

- Five Band 5 vacancies filled
- Band 2 and Band 6 advertised
- Increased occupancy and high levels of observation required additional temporary staffing
- Reduction in sickness although remain elevated.
- 6 DSN shifts undertaken
- All training attended as planned
- PDR`s for registered staff completed, outstanding care staff dates arranged

Ward Two	96%	94%	106%	144%	110.2%	104%↑	4.11↓	78↓	92↑	8↓	0 ↔	0↔
Ward Manager narrative: • Three band 5 vacancies filled • 1 band 5 and 1 band 6 vacancy to be recruited to in September • Over occupancy during the month • 21 DSN shifts • Aim to cover a rota of 6/6/4 due to patient acuity-temporary staffing utilised plus ward manager covered under filled shifts as needed												
Ward Three	96%	99%	116%	151%	115.4%	96%↓	11.12 ↑	82↑	80↓	50 ↑	0 ↔	0↔
Ward Manager narrative: • Band 5 vacancies x 1.6 filled • Band 6 vacancy due to be interviewed September • Increase in sickness has seen additional pressures to use temporary staffing • No occupancy pressures with reduced occupancy from July • 21 DSN shifts covered by band 7 &6												
Ward Four	119%	54%	71%	114%	89.3%	92↓	0.95 ↔	94↓	84.7 ↑	31 ↑	0↔	0↔
Ward Manager narrative: • Issues continued with cancellation of bank staff –addressed with HR colleagues for review and management • Reduction in occupancy and acuity and therefore no reported impact on quality from reduced staffing • Registered night cover supported by movement from other clinical areas • Continue to utilise block booking of agency where available												

Ward Five	87%	116%	102%	138%	110.8%	87% ↓	3.11↓	88↑	96.4 ↑	5 ↓	0↔	0↔
Ward Manager narrative: • Although a reduction in sickness, some registered nurse sickness required ward manager to provide registered cover • Reduced occupancy and acuity in August • No safety or quality issues reported												
Ward Six	80%	101%	100%	88%	92.05%	90% ↓	8.62 ↑	90↑	100 ↑	26 ↓	0↔	0↔
Ward Manager narrative: • 2 band 5 vacancies recruited and remaining vacancy advertised • 6 DSN shifts covered in August • No over occupancy • Mentorship, preceptorship and scheduled training all delivered • PDR programme completed												
Ward Seven	89%	103%	100%	100%	97.9%	85%↓	3.94 ↓*	94↔	96↑	9↓	0↓	0↔
Ward Manager narrative: • No staffing or occupancy issues to raise • Decrease in sickness/absence • All training delivered as scheduled • Shortfall in registered staff covered by ward manager as required												
EMC	94%	91%	100%	100%	96%	95%↑	8.85↑*	97↑	80.9 ↓	24↑	0↔	0↔
Ward Manager narrative: • 2 band 5 vacancies filled ,band 6 vacancy to be advertised • 6 DSN shifts covered • Ward Manger appointed												

• No occupancy pressures												
A&T	72%	110%	100%	100%	95.3%	80↔	3.91 ↓	94↔	92.8 ↔	22↑	0↔	0↔
Ward Manager narrative (combined A&T and Telford): • 1 band 3 and 1 band 5 vacancies. Currently utilising temporary staffing to cover underfill • No occupancy pressures • No unusual acuity • 18 DSN shifts covered • Cross cover provided between the two units with ward manager cover as and when needed.												
Telford	83%	71%	100%	100%	88.4%	100↔	5.87↑	97↑	100 ↔	13 ↓	0↔	0↔
As above												
Summers View	96%	102%	100%	100%	99.4%	91↓	4.88 ↓*	80↑	95.2 ↓	8 ↓	0↔	0↔
Ward Manager narrative: • I band 5 and 1 band 3 vacancies out to advert • 3 WTE sickness • No occupancy pressures • Reduced acuity (levels of high observation) • 4 DSN shifts covered												
F` House	97%	103%	100%	100%	99.9%	98% ↑	0.00↓*	93↓	93↑	14 ↔	0↔	0↔

Ward Manager narrative: • No occupancy pressures • Staffing levels satisfactory for patient need • All training undertaken as planned												
Darwin	95%	80%	86%	130%	97.5%	76% ↓	1.43↓	89↓	97.3 ↑	22↓	0↔	0↔
Ward Manager narrative: • 1 band 3 and 1 band 5 vacancy out to advert • Reduced occupancy and acuity • Reducing sickness • Due to above, no impact to quality from underfill												
D`Square	110%	89%	100%	100%	99.65%	81% ↓	0.00↔ *	91↑	95↑	4 ↑	0↔	0↔
Ward Manager narrative: • Increase in sickness-awaiting completed data • Shifts covered by excess hours with regular staff as needed												

Key points to note

- Safer Staffing review summary paper with proposed model to Executive meeting September 22nd detailing the following :
- Wards 2,3,6 will receive an uplift in establishment
- Duty Senior Nurse advertisement closed and successful recruitment to the post lessening the impact of ward manager DSN shifts. Further discussions to increase DSN post to further reduce impact at ward level
- Almost all vacancies based on current establishment filled
- Ward Managers will commence 20% clinical shifts to provide enhanced leadership
- Skill Mix reviewed-all adult acute inpatient wards will be staffed to 50:50 ratio

Unify data August 2015

- Total Trust fill rate Registered Nurse for August 2015 is 96.02%
- Total Trust fill rate Care Staff for August 2015 is 99.0%
- Overall Fill rate for August is 97.87%

Unify return August 2015

Inpatient area	Day				Night			
	Registered nurses		Care staff		Registered nurses		Care staff	
	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual
Ward 1	930.00	1147.95	1860.00	1670.45	333.12	372.45	996.45	1201.89
Ward 2	930.00	890.50	1395.00	1317.55	332.32	353.73	664.33	953.78
Ward 3	930.00	888.72	1395.00	1385.12	332.32	385.85	664.33	1004.15
Ward 4	1390.00	1654.50	1860.00	994.50	571.95	406.94	870.47	991.17
Ward 5	930.00	809.50	1395.00	1618.50	290.47	296.28	580.94	804.08
Ward 6	1087.50	870.00	1850.00	1860.00	290.47	290.47	1068.18	937.02
Ward 7	870.00	773.00	1305.00	1348.50	269.37	269.37	544.15	544.15
A&T	930.00	668.75	1221.40	1337.00	172.00	172.00	1139.75	1139.75
Telford	793.60	656.75	1240.00	880.00	161.25	161.25	505.25	505.25
Edward Myers	930.00	870.00	930.00	843.50	290.47	290.47	580.94	580.94
Darwin Centre	1462.50	1390.00	1387.50	1102.50	481.25	412.25	752.50	979.55
Summers View	982.50	940.00	982.50	1002.50	302.40	302.40	837.60	837.60
Florence House	465.00	449.50	930.00	957.50	323.33	323.33	323.33	323.33
Dragon Square	478.00	524.00	1152.00	1026.00	64.75	64.75	64.75	64.75
TOTALS	**13109.10**	**12533.17**	**18903.40**	**17343.62**	**4215.47**	**4101.54**	**9592.97**	**10867.41**

Encl. 8

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO THE TRUST BOARD – Open

Date of Meeting:	24 September 2015
Title of Report:	Annual PAL & Complaints report 2014/15
Presented by:	Carol Sylvester, Acting Director of Nursing
Author of Report: Name: Date: Email:	Lesley Whittaker Interim Complaints Manager 11/9/15 Lesleyp.whittaker@northstaffs.nhs.uk
Purpose / Intent of Report:	• **For Information and assurance**
Executive Summary:	North Staffordshire Combined Healthcare NHS Trust Annual complaints, compliments and PALS report 2014/15. The report details the number of complaints over 2014/15 (65 in total) showing a decrease of 29 complaints from the previous year 2013/14. The report describes initiatives during 2014/15 including the re commencement of the Listening and Responding training, development of new improving the patient experience literature and investigating officers complaints handling training.

Which Strategy Priority does this relate to:	• **Customer Focus Strategy** • **Clinical Strategy** • **Governance Strategy** • Innovation Strategy • Workforce Strategy • **Patient Safety**
How does this impact on patients or the public?	To provide assurance of the delivery of high quality, safe and responsive services for people who access our services

Relationship with Annual Objectives:	Provide safe care for people who access our service.
Risk / Legal Implications:	Failure to respond to service user concerns

Resource Implications:	Not directly as a result of this report
Equality and Diversity Implications:	Not directly as a result of this report
Relationship with Assurance Framework [Risk, Control and Assurance]	
Recommendations:	That the Trust Board receives assurance that the Trust have robust systems in place to respond to service user feedback including complaints, PALs and compliments

North Staffordshire Combined Healthcare NHS
NHS Trust

Annual Report
PALS & Complaints 2014/15

Listening, Responding and Improving

We're here to help:
How we will respond to your questions, compliments, comments and complaints

Contents

Page

Foreword

Welcome to the 2014/ 15 Annual Report of North Staffordshire Combined Healthcare NHS Trust's Patient Advice and Liaison Service (PALS) and Complaints Team. This report summarises the four quarterly reports published by the Trust during the course of 2014/15 and supplements information contained within the Trust's Statutory Annual Report.

In addition, those elements of the report that are specific to complaints handled under the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (the Regulations), are presented in accordance with the requirements of the Regulations.

North Staffordshire Combined Healthcare NHS Trust is always keen to listen and respond to questions, requests, comments and concerns. We value the feedback and points of view of the people who use our services, their carer's and loved ones and we take pride in the ways in which we work alongside people to resolve complaints and learn lessons. During the year 2014/15 our staff provided services to thousands of people and is pleased that only a very small fraction expressed dissatisfaction by making a complaint, see page 8 for details.

We hope this annual report will provide you with a good insight into the number and types of enquiries, concerns, comments and complaints responded to by our PALS and Complaints staff during the course of the year.

Every concern or compliment we receive is taken seriously and is see as an opportunity to improve care.

We hope this report demonstrates this commitment and provides examples of how we listen, respond and learn.

The report is published on the Trust's website **www.combined.nhs.uk** and issued to:

- Stoke on Trent and North Staffordshire Clinical Commissioning Groups NHS England and Independent Complaints Advocacy Services (ICAS);
- The Local Healthwatch and POhWER organisations; and
- Local user groups and organisations, advocacy services and other voluntary sector organisations.

If you would like a copy of this report, please contact our team by:

- FREEPHONE: 0800 389 9676
- Mobile: 0771 8971123 (Text and Speech)
- Email: PatientExperienceTeam@northstaffs.nhs.uk
- Post: Patient Experience Team

FREEPOST RSRS—YTLU—UBBY
North Staffordshire Combined Healthcare NHS Trust
PALS and Complaints Department
Harplands Hospital, Hilton Road
Stoke on Trent, ST4 6TH

Please advise us if you need this report in another language/format or you need assistance with reading this report.

Lesley Whittaker
Interim Complaints Manager

John Coleman
PALS Advisor

North Staffordshire Combined Healthcare NHS Trust

Overview

North Staffordshire Combined Healthcare NHS Trust has a single point of access to PALS and Complaints through the Patient Experience Team. This approach provides service users, relatives, carers and the general public with access to PALS and Complaints via:

- Single Freephone telephone number - 0800 389 9676
- Freepost address
- Dedicated text phone
- Email - PatientExperienceTeam@northstaffs.nhs.uk

This joined-up service offers clients easy access whether they wish to offer a comment, pass on a compliment, make an enquiry, get support when navigating services, or make a complaint.

Making the feedback process easier to understand

Promotion of this service and our staff response to any type of feedback is included in the Trust's Listening, Responding and Improving Leaflet.

In line with the Care Quality Commission's (CQC) best practice "Complaint Matters" report this service was reviewed earlier in 2015. The aim of the review was to make the feedback / complaints process simple and clearer to follow and the leaflet was also re-designed in an easy to understand format. The new leaflet called "improving the patient experience" has been designed with support from all Directorates and North Staffs Users Group. In addition to the leaflets, there will also be posters for all of the Teams and postcard size feedback forms for community patients to utilise. The new design leaflets will be distributed in September 2015.

Listening and Responding Training

The Trust's listening and responding training was reviewed in May 2015 and brought up to date with the best practice from the Parliamentary and Health Service Ombudsman, with regard to staff managing complaints and how we listen to and deal with concerns.

By ensuring staff are aware of how to deal with issues as they arise offers patients a seamless and consistent response from the Trust and ensures we are making the best use of available resources.

Complaints

During the course of the year 65 complaints were investigated by the Trust and each client received a response that was personally reviewed and signed by our Chief Executive.

In the majority of these complaints a face to face meeting was offered with the Investigating Officer during the review of the complaint, and a meeting with a Senior Manager to discuss any outstanding issues if appropriate.

North Staffordshire Combined Healthcare NHS
NHS Trust

PALS — We are here to help

The PALS team offers advice, help and support for patients, their relatives, carers and friends at times of need. We expect all staff to be open and responsive to concerns when issues are raised by those who come into contact or use our services. We hope this demonstrates our commitment to providing the best service possible and that we are keen to learn and improve. We believe that all our staff have a duty to listen and respond to the best of our ability in order to assist patients.

Contacts with our team

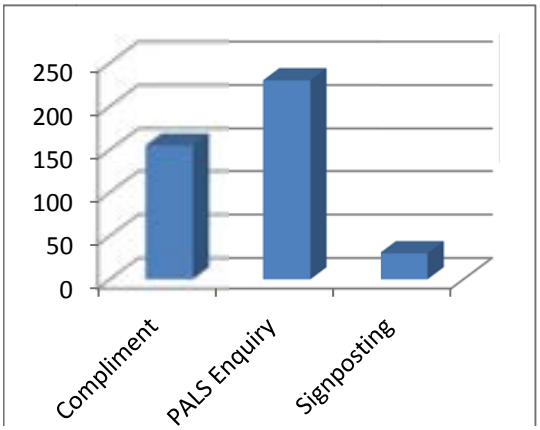
There may be times when patients may prefer to talk to someone external to their care team because they do not want to complain or they are not sure who to ask. Listening and responding is a key role in PALS.

Patients Advice & Liaison (PALS) and Compliments

We welcome and encourage feedback from patients, their relatives, carers and friends about their experiences of our services and listening is at the centre of our ethos. The majority of feedback to the Trust is received directly by care teams; nevertheless, there are times when comments and compliments are made via PALS within the Patient Experience Team. PALS received 169 contacts during 2014/15. People who contact this service often have several concerns or requests. We rely on your feedback to drive improvement. We listen to your voice.

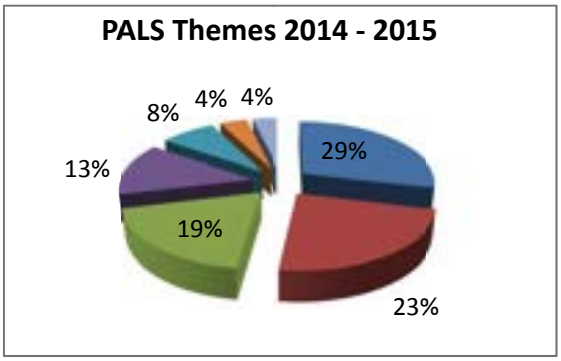
Each issue is categorised and documented individually and the 415 issues raised are summarised as follows:

Total recorded PALS activities by type



Themes

General issues raised in the last year relate to:



Key

29% Compliments
23% Building Closer Relationships
19% Safe High Quality Co-ordinated Car
13% Access & Waiting
8% Information and Choice
4% Signposting
4% Environments

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Compliments

We are pleased to have recorded 155 compliments over the year via thank you cards, comments, letters and cards which we collate and share within the Trust. Examples Include;

From a family member regarding Dragon Square:

“My son accesses respite care at dragon square. He is severely disabled and requires 24 hour care. I cannot tell you how valuable this service is, we as a family, would not function without the ongoing support from this unit. Life is very hard this service provides my child with exceptional care and for us as parents know that the staff who care for our son are wonderful professional individuals which makes time with our other children a little bit more normal. Once again this unit is not recognised enough and hope that even just this message recognises how much this service is needed and appreciated.”

Local press article by a former -patient about Ward 2, Harplands Hospital:

"I am writing to express my sincere thanks and appreciation for the treatment and support I received recently as an inpatient at Harplands Hospital. The staff were very professional and considerate, treating me with kindness, courtesy and respect. The food was delicious and nutritious. My stay at the hospital was a positive experience and I am most grateful to all those involved with my care.”

Service user comments about Ward 1:

“Compliment to all staff on Ward 1, very welcoming, offer loads of support and are easy to talk to and respectful of your condition and needs”

Service user comments about Ward 7:

“Patient said they had been on the ward for 3 months and thinks the ward is very clean and tidy, all the staff are fantastic and she feels very safe and well looked after.”

Family member’s comments about Ward 6:

“To all the team, what a fantastic team you all are. What magic you all work, with treatment, care and friendliness you have transformed our mum to her usual happy self, thank you.”

Service user compliment regarding Older Persons Outreach Team:

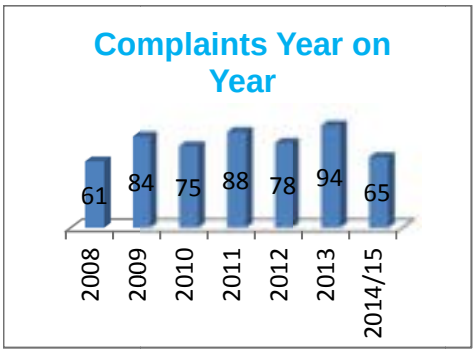
"The Grand Canyon is a mile deep, and they've brought me up to level ground."

Compliment about a staff member at Lymebrook Centre:

“Your support has made a difference.”

Highlighting when we get things right is as important to us as when we highlight areas we could improve.

Listening to Complaints



This part of the report focuses on those complaints received by the Trust which were handled in accordance with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

It summarises the information provided on a quarterly basis throughout the year to our Quality Committee.

During the year, the Chief Executive responded to 65 complaints investigated by the Trust. This was a reduction of 29 complaints from the previous year.

The Trust noted last year's PALS contacts which have increased and may demonstrate more issues have been dealt with informally via the PALS route.

Patient Focused Response

The complaints regulations stipulate that arrangements for dealing with complaints must be such as to ensure that:

- Complaints are dealt with efficiently and proportionately
- Complaints are properly investigated
- Complainants are treated with respect and courtesy
- Complainants receive, so far as is reasonably practical, assistance to enable them to understand the procedure in relation to complaints; or advice on where they may obtain such assistance
- Complainants receive a timely and appropriate response
- Complainants are told the outcome of the investigation of their complaints; and
- Action is taken if necessary in the light of the outcome of a complaint".

In addition, the Regulations require that the Trust must "offer to discuss with the complainant the manner in which the complaint is to be handled; and the period within which the investigation of the complaint is likely to be completed; and the response is likely to be sent."

Whilst providing a timely response is very important, our commitment to provide the complainant with a full and fair investigation continues to be the over-riding factor in the complaints process. This involves providing the complainant with the opportunity, where appropriate, to meet with staff from within the Trust to discuss their concerns further and to provide a satisfactory written response.

Learning from Complaints

The Trust has facilitated a Learning Lesson's programme since 2011.This programme includes Learning Lessons Sessions for all staff to meet and share the learning from both complaints and incidents.

A Learning Lessons bulletin is also sent out to all staff on a quarterly basis, this bulletin shares best practice and learning in a confidential way.

Additionally the Trust also now monitors any complaint "actions" in the monthly Directorate meetings. This review and examination of the outcomes of investigations enables senior Managers and clinical staff to reflect on the complaints and the Trust's findings.

The Trust has also identified "Learning Lessons Leads" within each Team. This nominated person is responsible for sharing any learning within the Team and gathering feedback.

The Learning Lessons programme is open for any Patients or family to contribute to either via attendance at the meetings, or involvement in the bulletins by telling their story.

Patient Association Standards – review of the standards by the Trust

In 2013, the Patients Association published 12 NHS good practice standards for complaints handling (Please click here to view the Patients Association website).

For the purpose of this Annual Report the Trust has completed a review against these 12 standards, to demonstrate assurance that the Trusts complaints process is in line with the Associations recommended best practice.

Standard 1
The Complainant has a single point of contact in the Organisation and is placed at the centre of the process. The nature of their complaint and the outcome they are seeking is established at the outset.

- ✓ Trust response – each complaint is allocated an Investigating Officer who makes contact with the Complainant. The Complaints Manager or Investigating Officer determines the outcome that is required by the Complainant.

Standard 2
The complaint undergoes initial assessment and any necessary immediate action is taken. A lead investigator is identified.

- ✓ Trust response – each complaint is screened by the Complaints Manager/ Deputy and escalated to other Departments as required, if there is any evidence of risk or harm.

Standard 3
Investigations are thorough (Regulation 3 (2) (b) and Regulation 14 (1)), where appropriate obtain independent evidence and opinion, and are carried out in accordance with local procedures, national guidance and within legal frameworks.

- ✓ Trust response – each investigation once completed is reviewed by the Complaints Manager, Governance Lead, Head of Directorate, Director of Nursing and Chief Executive. Each complaint is allocated an Investigating Officer who has no clinical relationship with the complainant.

Standard 4
The investigator reviews, organises and evaluates the investigative findings.

- ✓ Trust response – the Investigating Officer produces a written report collating any review of the notes, interviews and meetings with the complainant/others.

Standard 5
The judgement reached by the decision maker is transparent, reasonable and based on the evidence available.

- ✓ Trust response –our processes demonstrate a thorough scrutiny of the report by at Directorate and Executive level in the Trust.

Standard 6
The complaint documentation is accurate and complete. The investigation is formally recorded, the level of detail appropriate to the nature and seriousness of the complaint.

- ✓ Trust response – the Trust has invested in an I.T web based incident/complaint management system called Safeguard. All contacts, letters, emails and reports are stored securely to provide an easily accessible audit trail.

Standard 7
Both the complainant and those complained about are responded to adequately. (Regulation 14, investigation and response).

- ✓ Trust response – If appropriate, the Complainant is offered a face to face meeting to share findings in addition to a written response. At the closure of the complaint the Directorate is provided with a copy of the response to share with relevant staff/ persons.

Standard 8
The investigation of the complaint is complete, impartial and fair.

- ✓ Trust response – following submission of the Investigating Officer's report additional assurances are in place via the directorate and executive's review. This further ensures both a fair investigation and thorough response with strategic oversight of any emerging themes.

Standard 9

The organisation records, analyses and reports complaints information throughout the organisation and to external audiences.

✓ Trust response – please see the Annual Report circulation list on page 3.

Standard 10
Learning lessons from complaints occurs throughout the organisation.

✓ Trust response – please see above regards learning lessons on page 8.

Standard 11
Governance arrangements regarding complaints handling are robust.

✓ Trust response – Our Trust policy outlines the governance arrangements and points 3, 6 and 8 detail the review and scrutiny processes.

Standard 12
Individuals assigned to play a part in a complaint investigation have the necessary competencies

✓ Trust response –Investigating Officers are allocated by the Directorate's Governance Lead. The Investigating Officer will have received training in investigations or be supervised by an appropriate other person. The Trust is facilitating additional complaint management training in September 2015 to ensure that competencies for undertaking comprehensive and robust investigations are demonstrable.

A more detailed review of these standards will be carried out in November 2015 and will be uploaded to the Trust website.

Where we are going

Improving the patient experience

The Patient Experience Team was involved in a new trust wide initiative called “Listening into Action” (LIA) in 2014/5.

This LIA work focused on learning lessons from complaints and incidents and included a staff survey to assess how learning could be improved after any complaints were made. Following this each team identified a Learning Lessons Lead who is responsible for sharing learning and publicising any Learning Lessons events.

Patient Experience Facilitator

A new development for 2015 is the recruitment of a new post holder dedicated to enhancing our patient’s experience via service user and carer involvement development.

Patient, Service User and Carer Council 2015

The Trust was delighted to launch the Patient, Service User and Carer Council in early 2015. The opening event attracted more 60 service users, carers and representatives from local organisations, including Healthwatch and it has gone from strength to strength. The council’s purpose is to build on the Trust’s good record of service user and carer engagement, listen to views on how service users and carers can more effectively influence how the Trust is run, and help the Trust to continually improve. The name of the group is currently under review by the group, but has agreed its aspirations of how it will lead the way together with our experts by experience.

Links with Directorates, improving the ownership of complaints

The Patient Experience Team will continue to work with each of the Directorates directly to ensure that actions plans following complaints are monitored and learning is shared.

Contact us

The team welcomes the involvement of service users/carers, staff and other stakeholders in support of further improvements to the way we listen and respond to people’s experiences and points of view.

If you would like to get involved, please contact us for more information or to arrange a meeting. For our contact details, see page 3.

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO TRUST BOARD (OPEN)

Date of Meeting:	24 September 2015
Title of Report:	Monthly Finance Reporting Suite – August 2015
Presented by:	Ann Harrison, Interim Director of Finance
Author of Report: Name: Date: Email:	 Andy Turnock 14 September 2015 andrew.turnock@northstaffs.nhs.uk
Purpose / Intent of Report:	Performance monitoring
Executive Summary:	The attached report contains the financial position to 31 August 2015. The Trusts financial performance is a retained deficit of £0.526m against a planned deficit of £0.544m, a favourable variance of £0.018m. The in-year cost improvement target is £2.66m with a year to date performance of £0.011m behind plan. The cash balance as at 31 August 2015 was £7.36m. The net capital expenditure is a negative (£0.129m) which is behind the Plan of £0.125m, an under spend of £0.254m. The Continuity of Service risk rating is reported as 3 in line with the plan.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Financial Strategy
Relationship with Annual Objectives:	Financial Reporting
Risk / Legal Implications:	n/a
Resource Implications:	As above.
Equality and Diversity Implications:	n/a
Relationship with Assurance Framework [Risk, Control and	

Assurance]	
Recommendations:	***The Board is asked to:*** • ***note that the financial performance to date is on plan, with a favourable variance reported of £0.018m*** • ***note the in-year cost improvement target is £2.66m and a year to date performance slightly behind Plan*** • ***note the cash position of the Trust as at 31 August 2015 of £7.36m*** • ***note the net capital expenditure position as at 31 August 2015 is an under spend against Plan of £0.254m*** • ***note the year to date Continuity of Service risk rating of 3***

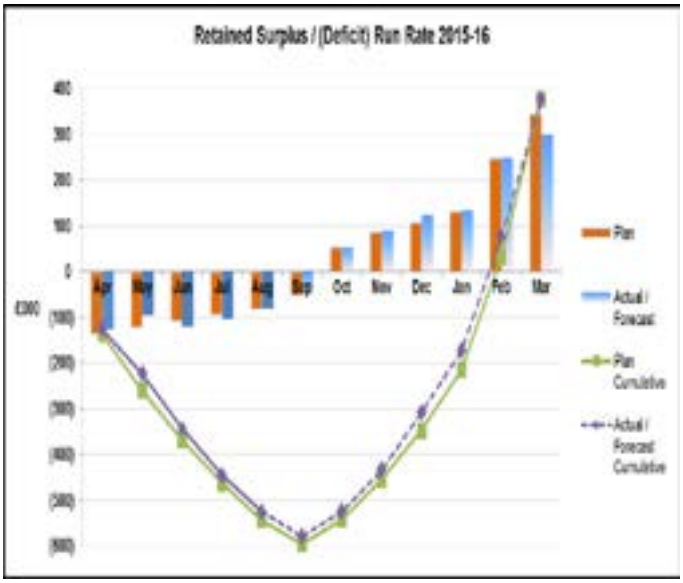
DRAFT FINANCIAL OVERVIEW as at 31 August 2015

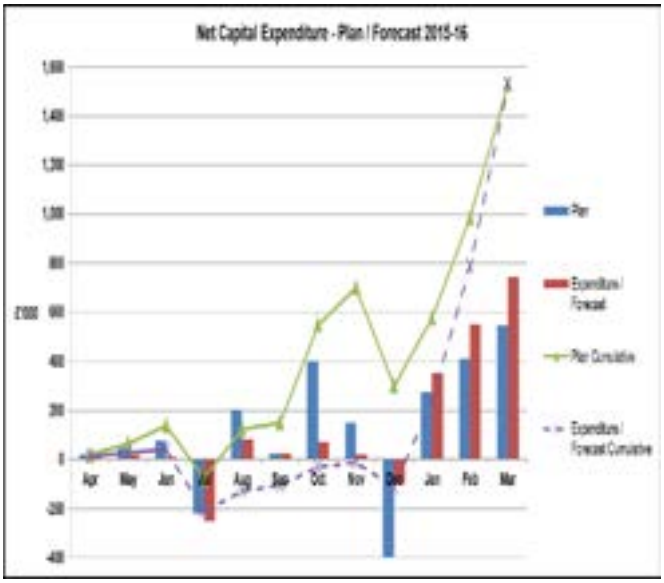
Income & Expenditure - Retained Surplus / (Deficit)

£000	Plan	Actual	Var	%	RAG
YTD	(544)	(526)	18	3	G
Forecast	377	377	0	0	G

Net Capital Expenditure

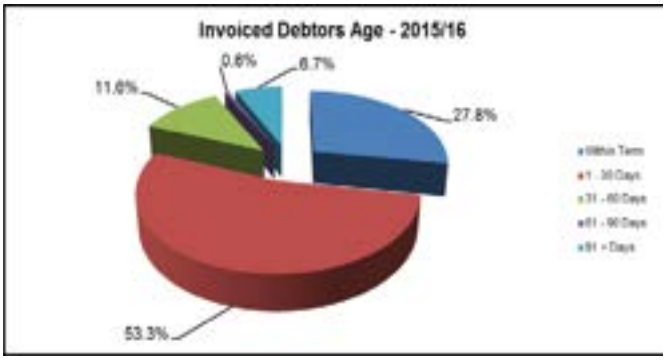
£000	Plan	Actual	Var	%	RAG
YTD	125	(129)	(254)	(203)	A
Forecast	1,530	1,530	0	0	G





Cash Balances

£m	Plan	Actual	Var	%	RAG
YTD	6.5	7.4	0.8	13	G



Continuity of Service Risk Rating

	YTD Plan	YTD Act	FOT
Overall Risk Rating	3	3	3
Metrics:			
Liquidity Ratio	4	4	4
Capital Servicing Capacity	1	1	2

Notes

Risks:
- Non achievement of income targets
- Non delivery of CIP requirement
- Managing cost pressures
- Under performance against activity targets

Assumptions:
- Clinical income targets are predominately achieved.
- Charges against provisions provided for last year do not exceed the value provided.

1. Financial Position

1.1 Introduction

The Trusts financial Plan submission to the National Trust Development Authority (NTDA) showed a retained surplus position of £0.227m and an 'adjusted financial performance' of £0.750m (£0.227m plus IFRIC 12 adjustment of £0.523m).

The Trust has recently submitted a revised financial Plan which shows an increase of £0.150m to the surplus, resulting in an 'adjusted financial position' of £0.900m. This amendment follows the directive issued from the NTDA for provider Trusts to improve their forecast position.

This report details the Trust's performance against the revised Plan for the period ending 31 August 2015.

1.2 Income & Expenditure (I&E) Performance at Month 5

At the end of Month 5, the Trusts budgeted plan was a retained deficit of £0.544m (£0.324m deficit at adjusted financial performance level). The reported retained position is a deficit of £0.526m, giving a favourable variance of £0.018m against plan.

Table 1 below shows this position in the Statement of Comprehensive Income (SOCI) for the Trust. A more detailed SOCI is shown in Appendix A, page 1.

Table 1: Statement of Comprehensive Income

Detail	Full Year Annual Budget £000	Current Month £000			Year to Date £000		
		Budget	Actual	Variance	Budget	Actual	Variance
Income	75,949	6,214	6,164	(49)	30,592	30,842	250
Pay	(56,202)	(4,808)	(4,565)	243	(23,824)	(22,838)	986
Non pay	(16,247)	(1,214)	(1,407)	(193)	(5,948)	(7,212)	(1,264)
EBITDA	**3,500**	**192**	**192**	**1**	**820**	**792**	**(27)**
Other Costs	(2,750)	(228)	(227)	1	(1,144)	(1,098)	46
Adjusted Financial Performance	**750**	**(36)**	**(35)**	**1**	**(324)**	**(306)**	**18**
IFRIC 12 Expenditure	(523)	(45)	(45)	0	(220)	(220)	0
Retained Surplus / (Deficit) prior to Impairment	**227**	**(81)**	**(80)**	**1**	**(544)**	**(526)**	**18**
Fixed Asset Impairment	0	0	0	0	0	0	0
Retained Surplus / (Deficit)	**227**	**(81)**	**(80)**	**1**	**(544)**	**(526)**	**18**

Contained within non-pay budgets are the CIP targets for directorates, many have been reduced and transacted in budgets of the various schemes across the Trust.

Also contained within non-pay, specific budgets have been set and held centrally. Table 2 shows these central reserves forecast budgets which equate to £1.942m, against which the Trust is forecasting expenditure of £0.596m. This highlights that the Trusts achievement of the forecast retained surplus of £0.377m is predicated on the support to the operational position from reserves of £1.346m.

Table 2: Reserves Held Centrally

Description	Forecast Annual Budget (£000)	Committed within FOT (£000)
Contingency	153	0
Cleanliness in Hospitals	15	15
Quality & Reform	382	150
QNIC	49	0
Other Earmarked reserves	1,344	432
Total	**1,942**	**596**

1.3 Forecast Year End Performance

Following the finalisation of the month 5 position, a worked up forecast outturn has been undertaken which supports the revised retained surplus of £0.377m (£0.900m at adjusted financial performance level) which is in line with the revised Plan. This outturn position is dependent on achieving the cost improvement programme as well as managing cost pressures, existing or arising, during the financial year. The Trust's forecast position will be shared with the NTDA as part of their financial monitoring regime.

1.4 Cost Improvement Programme

The in-year target for the year and reported to the NTDA is £2.66m and takes into account the requirement to deliver the revised surplus referred to above.

As at month 5, the performance against the planned schemes on a year to date basis is slightly behind plan, with £0.655m being achieved against the target of £0.812m. However, additional schemes have been identified which have delivered £0.146m on a year to date basis resulting in an overall performance of £0.801m, and therefore a £0.011m under achievement. This is shown in table 3 below.

Table 3: CIP Delivery – Year to Date

	Plan £000	Delivered £000	Variance £000
Original schemes	812	655	(157)
New schemes	0	146	146
Total schemes	**812**	**801**	**(11)**

2. Summary of Financial Position

A Statement of Financial Position is shown in Appendix A, page 2.

2.1 Fixed Assets

Property, Plant & Equipment and Intangible assets balances of the Trust have remained relatively static.

2.2 Cash

As at 31 August 2015, the Trust's cash position was £7.36m which represents an increase during the month of £0.533m. A monthly cash flow forecast is shown in Appendix A, page 3 which demonstrates the cash movements.

2.3 Other Working Balances

There has been little change in the working balances during the month, with an overall net increase of circa £0.4m. This is a result of an increase in creditors of £0.5m and a decrease of debtors of £0.1m.

Within the overall debtors value, £2.1m relates to invoiced debt. Invoiced debt is summarised by age in Appendix A, page 4, along with the analysis of the stage of recovery.

3. Capital Expenditure and Programme

The Trust's permitted capital expenditure in 2015/16 is £2.3m; this is the combination of the Trust's £1.53m Capital Resource Limit (CRL) and its predicted asset sales of £0.77m. The capital expenditure for the year as at 31 August 2015 is a negative £0.129m, made up of £0.141m of expenditure and (£0.270m) from the disposal of the former Learning Disability property Meadow View. This represents a variance against the profiled net capital expenditure of £0.254m shown in the Plan submitted to the NTDA.

Appendix A, page 5 details the expenditure to date and the forecast outturn including a graph to show both the actual and projected performance against Plan.

4. Continuity of Services Risk Rating Risk Rating

As reported in the Plan, the Trust is planning to achieve a Continuity of Service Risk Rating of 3 by the end of the financial year. As at month 5, this is calculated as 3. The forecast outturn rating is also 3, in line with the planned rating previously mentioned.

Appendix A, page 6 shows in detail the separate metrics, the outputs, and the various components used to calculate the specific metrics.

5. Recommendations

The Board is asked to:

- ***note that the financial performance to date is predominately on plan, with a favourable variance reported of £0.018m***
- ***note the cash position of the Trust as at 31 August 2015 of £7.36m***
- ***note the net capital expenditure position as at 31 August 2015 is an underspend against plan of £0.254m***
- ***note the year to date Continuity of Service Risk Rating of 3 and also a forecast rating of 3.***

Statement of Comprehensive Income including Forecast Outturn – Trust Wide

	Full Year	< < < Current Month > > >			< < < Year to Date > > >			< < < Forecast Outturn > > >		
	Budget £000	Actual £000	Budget £000	Variance £000	Actual £000	Budget £000	Variance £000	Actual £000	Budget £000	Variance £000
Income:										
Revenue from Patient Care Activities	67,338	5,530	5,553	-24	27,183	27,029	155	68,557	68,526	31
Other Operating Revenue	8,610	635	660	-26	3,659	3,563	96	8,222	8,610	-388
	75,949	6,164	6,214	-49	30,842	30,592	250	76,779	77,136	-357
Expenses:										
Pay										
Medical	-6,756	-492	-567	75	-2,412	-2,814	402	-6,117	-6,756	639
Nursing	-25,921	-2,138	-2,255	117	-10,783	-11,099	316	-26,290	-26,903	614
Other clinical	-13,422	-1,004	-1,074	70	-5,049	-5,630	580	-12,532	-13,538	1,006
Non-clinical	-9,511	-712	-817	105	-3,498	-3,942	445	-8,805	-9,507	702
Non-NHS	-593	-220	-95	-125	-1,096	-339	-757	-2,205	-853	-1,352
Cost Improvement	0	0	0	0	0	0	0	0	0	0
	-56,202	-4,565	-4,808	243	-22,838	-23,824	986	-55,948	-57,557	1,609
Non Pay										
Drugs & clinical supplies	-1,884	-182	-162	-20	-955	-800	-155	-2,266	-1,906	-360
Establishment costs	-1,726	-99	-145	46	-598	-716	118	-1,470	-1,741	270
Premises costs	-1,970	-200	-168	-32	-1,049	-892	-157	-2,723	-1,971	-752
Private Finance Initiative	-3,865	-332	-322	-10	-1,660	-1,610	-50	-3,981	-3,865	-117
Other (including unallocated CIP)	-5,332	-593	-417	-176	-2,949	-1,930	-1,019	-6,231	-4,544	-1,687
Central Funds	-1,470	0	0	0	0	0	0	-596	-1,942	1,346
	-16,247	-1,407	-1,214	-193	-7,212	-5,948	-1,264	-17,268	-15,969	-1,299
EBITDA *	**3,500**	**192**	**192**	**1**	**792**	**820**	**-27**	**3,563**	**3,610**	**-47**
Depreciation (excludes IFRIC 12 impact and donated income)	-797	-65	-65	0	-330	-330	0	-797	-797	0
Investment Revenue	12	2	1	1	8	5	3	16	12	4
Other Gains & (Losses)	0	0	0	0	42	0	42	42	0	42
Local Government Pension Scheme	0	0	0	0	0	0	0	0	0	0
Finance Costs	-1,364	-114	-114	0	-568	-568	0	-1,364	-1,364	0
Unwinding of Discounts	0	0	0	0	0	0	0	0	0	0
Dividends Payable on PDC	-601	-50	-50	0	-250	-250	0	-561	-561	0
Adjusted Financial Performance - Surplus / (Deficit) for the Financial Year **	**750**	**-35**	**-36**	**1**	**-306**	**-324**	**18**	**900**	**900**	**0**
IFRIC 12 Expenditure ***	-523	-45	-45	0	-220	-220	0	-523	-523	0
Retained Surplus / (Deficit) for the Year	**227**	**-80**	**-81**	**1**	**-526**	**-544**	**18**	**377**	**377**	**0**

* EBITDA - earnings before interest, tax, depreciation and amortisation

** NTDA expected surplus or deficit against w hich the Trust is measured

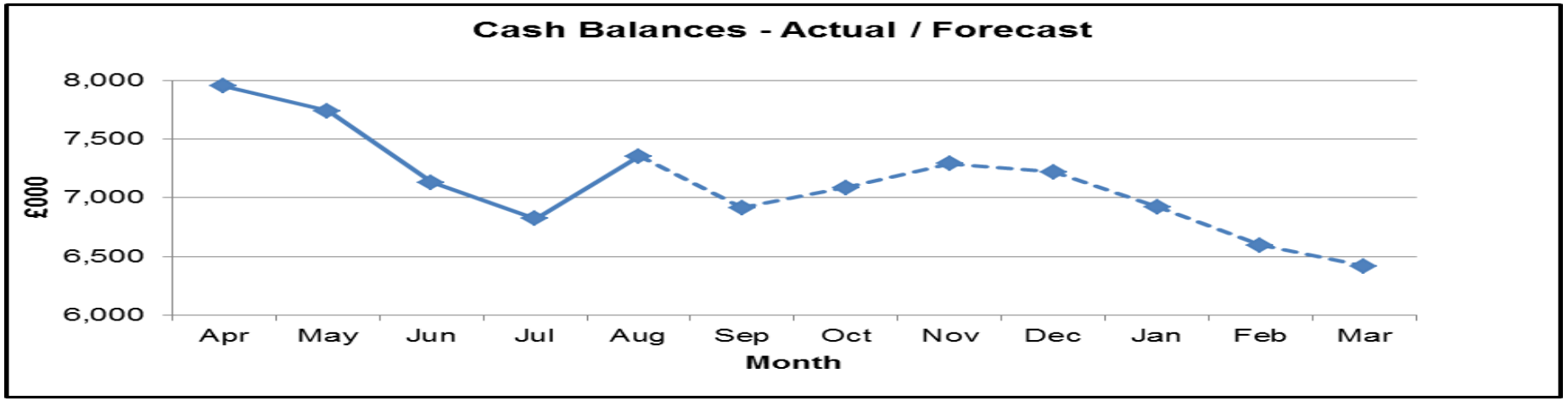
*** Additional costs in respect of the Trust's PFI scheme follow ing the introduction of IFRS, classed as technical adjustments.

Statement of Financial Position – including forecast

Detail	Period End Dates 31/03/2015 £000	31/05/2015 £000	30/06/2015 £000	31/07/2015 £000	31/08/2015 £000	Forecast 31/03/2016 £000
NON-CURRENT ASSETS:						
Property, Plant and Equipment	30,863	30,668	30,573	30,493	30,466	31,799
Intangible Assets	52	52	40	40	40	66
Trade and Other Receivables	0	0	0	0	0	0
TOTAL NON-CURRENT ASSETS	30,915	30,720	30,613	30,533	30,506	31,865
CURRENT ASSETS:						
Inventories	86	84	82	90	82	86
Trade and Other Receivables	3,017	4,469	5,570	5,801	5,728	3,298
Cash and cash equivalents	6,805	7,743	7,130	6,822	7,355	6,416
SUB TOTAL CURRENT ASSETS	9,908	12,296	12,782	12,713	13,165	9,800
Non-current assets held for sale	2,520	2,520	2,520	2,250	2,250	1,750
TOTAL ASSETS	**43,343**	**45,536**	**45,915**	**45,496**	**45,921**	**43,415**
CURRENT LIABILITIES:						
NHS Trade Payables	-864	-1,047	-1,065	-769	-772	-676
Non-NHS Trade Payables	-4,374	-6,680	-7,222	-7,319	-7,871	-5,607
Borrowings	-351	-351	-351	-351	-351	-346
Provisions for Liabilities and Charges	-1,682	-1,667	-1,636	-1,546	-1,526	-882
TOTAL CURRENT LIABILITIES	-7,271	-9,745	-10,274	-9,985	-10,520	-7,511
NET CURRENT ASSETS/(LIABILITIES)	5,157	5,071	5,028	4,978	4,895	4,039
TOTAL ASSETS LESS CURRENT LIABILITIES	**36,072**	**35,791**	**35,641**	**35,511**	**35,401**	**35,904**
NON-CURRENT LIABILITIES						
Borrowings	-12,992	-12,934	-12,904	-12,876	-12,846	-12,647
Trade & Other Payables	-558	-558	-558	-558	-558	-558
Provisions for Liabilities and Charges	-604	-604	-604	-604	-604	-404
TOTAL NON- CURRENT LIABILITIES	-14,154	-14,096	-14,066	-14,038	-14,008	-13,609
TOTAL ASSETS EMPLOYED	**21,918**	**21,695**	**21,575**	**21,473**	**21,393**	**22,295**
FINANCED BY TAXPAYERS EQUITY:						
Public Dividend Capital	7,998	7,998	7,998	7,998	7,998	7,998
Retained Earnings	814	591	471	369	289	1,191
Revaluation Reserve	13,664	13,664	13,664	13,664	13,664	13,664
Other reserves	-558	-558	-558	-558	-558	-558
TOTAL TAXPAYERS EQUITY	**21,918**	**21,695**	**21,575**	**21,473**	**21,393**	**22,295**

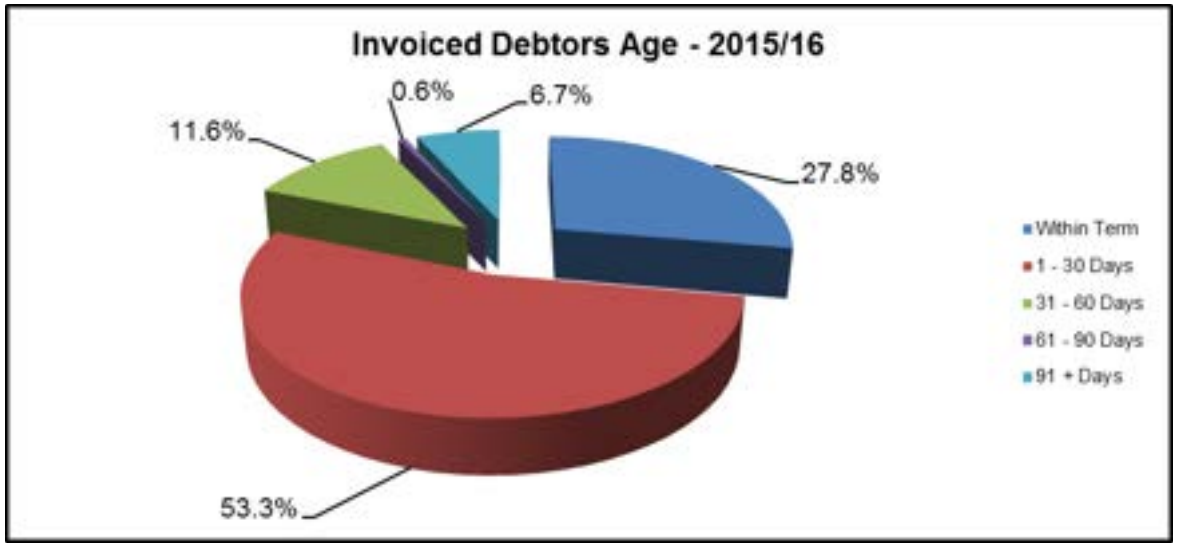
Cash-flow Forecast

Statement of Cash Flows (CF)	Actual Apr 15 £000	Actual May 15 £000	Actual Jun 15 £000	Actual Jul 15 £000	Actual Aug 15 £000	Forecast Sep 15 £000	Forecast Oct 15 £000	Forecast Nov 15 £000	Forecast Dec 15 £000	Forecast Jan 16 £000	Forecast Feb 16 £000	Forecast Mar 16 £000	2015/2016 Full Year £000
Cash Flows from Operating Activities													
Operating Surplus / (Deficit)	35	66	42	17	82	161	216	242	263	285	344	491	**2,244**
Depreciation and Amortisation	113	112	117	98	110	111	111	111	111	109	109	108	**1,320**
Impairments and Reversals	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Interest Paid	-114	-114	-114	-114	-114	-114	-114	-114	-113	-113	-113	-113	**-1,364**
Dividend Paid	0	0	0	0	0	-300	0	0	0	0	0	-261	**-561**
Inflow / (Outflow) prior to Working Capital	**34**	**64**	**45**	**1**	**78**	**-142**	**213**	**239**	**261**	**281**	**340**	**225**	**1,639**
(Increase) / Decrease in Inventories	0	-7	2	8	8	-10	0	0	0	0	0	-1	**0**
(Increase) / Decrease in Trade and Other Receivables	-658	-794	-1,101	-231	-73	507	297	486	235	382	290	402	**-258**
Increase / (Decrease) in Trade and Other Payables	1,817	581	509	-265	650	-295	-211	-795	-615	-306	-120	143	**1,093**
Provisions (Utilised) / Arising	-3	-12	-31	-90	-20	-446	-30	-25	-25	-275	-213	-458	**-1,628**
Increase/(Decrease) in Movement in non Cash Provisions	0	0	0	0	0	0	0	350	0	0	0	280	**630**
Inflow / (Outflow) from Working Capital	**1,156**	**-232**	**-621**	**-578**	**565**	**-244**	**56**	**16**	**-405**	**-199**	**-43**	**366**	**-163**
Net Cash Inflow / (Outflow) from Operating Activities	**1,190**	**-168**	**-576**	**-577**	**643**	**-386**	**269**	**255**	**-144**	**82**	**297**	**591**	**1,476**
Cash Flows from Investing Activities													
Interest Received	2	2	2	1	2	1	1	1	1	1	1	1	**16**
(Payments) for Property, Plant and Equipment	-12	-18	-10	-18	-83	-25	-72	-20	-100	-350	-595	-742	**-2,045**
Proceeds of disposal of assets held for sale (PPE)	0	0	0	315	0	0	0	0	200	0	0	0	**515**
Net Cash Inflow / (Outflow) from Investing Activities	**-10**	**-16**	**-8**	**298**	**-81**	**-24**	**-71**	**-19**	**101**	**-349**	**-594**	**-741**	**-1,514**
NET CASH INFLOW / (OUTFLOW) BEFORE FINANCING	**1,180**	**-184**	**-584**	**-279**	**562**	**-410**	**198**	**236**	**-43**	**-267**	**-297**	**-150**	**-38**
Cash Flows from Financing Activities													
Capital Element of Payments in Respect of Finance Leases PFI	-29	-29	-29	-29	-29	-29	-29	-29	-29	-30	-30	-30	**-351**
Net Cash Inflow/(Outflow) from Financing Activities	**-29**	**-29**	**-29**	**-29**	**-29**	**-29**	**-29**	**-29**	**-29**	**-30**	**-30**	**-30**	**-351**
NET INCREASE / (DECREASE) IN CASH AND CASH EQUIVALENTS	**1,151**	**-213**	**-613**	**-308**	**533**	**-439**	**169**	**207**	**-72**	**-297**	**-327**	**-180**	**-389**
Cash and Cash Equivalents (and Bank Overdraft)	**7,956**	**7,743**	**7,130**	**6,822**	**7,355**	**6,916**	**7,085**	**7,292**	**7,220**	**6,923**	**6,596**	**6,416**	



Aged Debtor Analysis

Analysed as	Within Term £000	1 - 30 Days £000	31 - 60 Days £000	61 - 90 Days £000	91 + £000	Overall Balance £000
NHS	441	145	242	12	89	**930**
Local Authorities	104	242	0	1	1	**348**
Other Debtors	40	737	3	0	50	**830**
Total	**586**	**1,124**	**245**	**13**	**140**	**2,109**

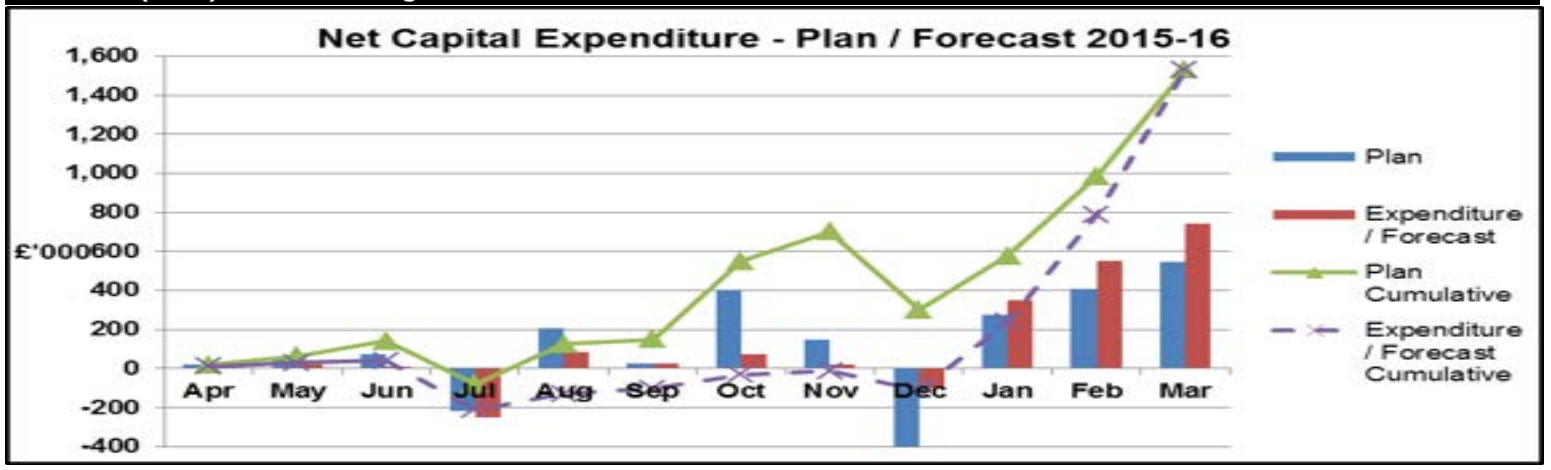


Analysed by Credit Control Stage	Within Term £000	1 - 30 Days £000	31 - 60 Days £000	61 - 90 Days £000	91 + £000	Overall Balance £000
No formal dispute received - full payment anticipated	586	1,124	245	13	108	**2,077**
Routine credit control processes activated	0	0	0	0	22	**22**
Resolved - Awaiting Credit Note to be issued	0	0	0	0	0	**0**
Escalated to Management / Solicitors	0	0	0	0	10	**10**
Total	**586**	**1,124**	**245**	**13**	**140**	**2,109**

Capital Programme and Expenditure

Scheme	Detail	2015/16 Original Scheme Value £000	2015/16 Revision - Post Business case approval £000	Year to Date £000	Forecast Outturn £000
Psychiatric Intensive Care Unit	awaiting business case approval	400	0	0	10
Low Secure unit with rehabilitation	awaiting business case approval	500	0	0	10
Assessment & Treatment and Telfold Unit	business case approved	600	500	0	500
Dragon Square Upgrade	business case approved	250	550	22	550
Darwin Upgrade	business case approved	0	700	13	550
Information Technology	various	100	100	71	150
Equipment	various	80	80	0	30
Other		270	270	35	100
Environmental Improvements	numerous sites	100	100	0	100
Total Expenditure		**2,300**	**2,300**	**141**	**2,000**
Disposals					
Former Learning Disability property	Meadow View	-270	-270	-270	-270
Bucknall Hospital (part)	staged receipts	-500	-500	0	-200
Net Expenditure		**1,530**	**1,530**	**-129**	**1,530**

Capital Allocations	£000
Initial CRL (per NTDA Plan submission)	**1,530**
Revisions to Plan:	
None	-
Final CRL	**1,530**
Value of Schemes Forecast Outturn as at 31/08/15	**1,530**
Potential (Over) / Undershoot against CRL	**0**



Continuity of Service Risk Rating

Continuity of Services Risk Rating		YTD Actual £000	Forecast Plan £000	Forecast Actual £000
Liquidity Ratio	**Working Capital:**			
	Total Current Assets	15,415	11,550	11,550
	Total Current Liabilities	-10,250	-7,661	-7,511
	Inventories	82	86	86
	Non Current Assets Held for Sale	2,520	1,750	1,750
	Working Capital Balance	**2,563**	**2,053**	**2,203**
	Annual Operating Expenses:			
	Operating Expenses	30,600	72,680	74,535
	Add back:			
	Depreciation & Amortisation	-550	-1,350	-1,320
	Impairments	0	0	0
	Annual Operating Expenses:	**30,050**	**71,330**	**73,215**
	Liquidity Ratio (Working capital balance / Annual operating expenses)	13.0	10.4	11.0
	Liquidity Ratio Metric	**4.0**	**4.0**	**4.0**
Capital Servicing Capacity	**Revenue Available for Debt Service:**			
	EBITDA	792	3,486	3,563
	Interest Receivable	-8	-16	-16
	Revenue Available for Debt Service	**800**	**3,502**	**3,579**
	Annual Debt Service:			
	Finance Costs (including interest on PFIs and Finance Leases)	568	1,364	1,364
	Dividends	250	561	561
	Capital element of payments relating to PFI, LIFT Schemes and finance leases	145	351	351
	Annual Debt Service	**963**	**2,276**	**2,276**
	Capital Servicing Capacity (times) (Revenue available for Debt Service / Annual Debt Service)	0.8	1.5	1.6
	Capital Servicing Capacity metric	**1.0**	**2.0**	**2.0**
Continuity of Services Risk Rating for the Trust		**3.0**	**3.0**	**3.0**

Risk Assessment Framework Parameters					
Liquidity Ratio (days)					50% Weighting
Rating	4	3	2	1	
Tolerance	0	-7	-14	<-14	
Capital Servicing Capacity					50% Weighting
Rating	4	3	2	1	
Tolerance	2.5	1.75	1.25	<1.25	

North Staffordshire Combined Healthcare NHS
NHS Trust

Enclosure 11

REPORT TO: Trust Board

Date of Meeting:	24 September 2015
Title of Report:	Finance and Performance Committee Terms of Reference
Presented by:	Ann Harrison Interim Director of Finance
Author of Report: Name: Date: Email:	Sandra Storey, Trust Secretary & Head of Corporate and Legal Affairs 11 September 2015 Sandraj.storey@northstaffs.nhs.uk
Purpose / Intent of Report:	• For approval
Executive Summary:	The Finance & Performance Committee are required to review its Terms of Reference at least annually. These were reviewed at the last meeting of the Committee held on 17 September 2015. There are minor amendments that will be completed as noted in the summary from the meeting and the Terms of Reference will be updated accordingly.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Governance Strategy • Finance Strategy
Relationship with Annual Objectives:	Cuts across all objectives to ensure that the Trust has an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities.
Risk / Legal Implications:	To ensure that the Trust is complying with its Standing Orders
Resource Implications:	None identified as a result of this report
Equality and Diversity Implications:	None identified as a result of this report
Relationship with Assurance Framework [Risk, Control and Assurance]	Provides assurances that appropriate governance arrangements are in place
Recommendations:	For ratification by the Trust Board

FINANCE & PERFORMANCE COMMITTEE

TERMS OF REFERENCE

Membership	• Non Executive Director (Chair) • One other Non Executive Director • Chief Executive • Director of Finance (or Deputy) • Director of Leadership & Workforce • Director of Operations • Director of Nursing & Quality ▪ Trust Secretary ▪ Head of Performance & Information ▪ Director of Strategy & Development
Quorum	▪ Three members (one of whom to be from Finance) including at least one Executive Director and one Non-Executive Director
In Attendance/As Required/ Invited	▪ Medical Director ▪ Deputy Director of Finance or Assistant Director of Finance ▪ PA to take minutes ▪ Associate Director of Strategy and Business Development ▪ Head of Estates ▪ Head of Costing and Contracts ▪
Frequency of Meetings	▪ Monthly
Accountability and Reporting	▪ Accountable to the Trust Board ▪ Assurance Report to the Trust Board after each meeting ▪ Minutes of meetings available to all Trust Board members on request ▪ Annual report to Trust Board on actions taken to comply with Terms of Reference
Date of Approval by Trust Board	▪ 25 September 2014
Review Date	▪ By 25 September 2015

FINANCE AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. Constitution

The Trust Board hereby resolves to establish a Committee of the Trust Board to be known as the Finance and Performance Committee (The Committee). Its principal aim is to provide advice and assurance to the Trust Board on performance and financial risk management and on the achievement of the Trust financial strategy.

The Committee has no executive powers other than those specifically delegated in these terms of reference.

2. Membership

The Chairman and Non-Executive members of the Committee shall be appointed by the Trust Board and the Executive members by the CEO. The Trust Board should satisfy itself that at least one Non-Executive member of the Committee has recent and relevant financial experience.

In the absence of the Chair being appointed by the Trust Board, one of the Non-Executive directors will be elected by those present to Chair the meeting.

3. Quorum, Frequency of Meetings and Required Frequency of Attendance

No business shall be transacted unless three members of the Committee are present. This must include not less than one Non Executive Board Member and one Executive Director, and in the event that this is not the Executive Director of Finance, then one representative from the Finance Function.

The Committee will meet as monthly, but not less than quarterly to review financial performance including performance against the TDA compliance framework and key national targets. Members of the committee are required to attend a minimum of 80% of the meetings held each financial year and not be absent for two consecutive meetings.

4. In attendance

In addition to the agreed membership, other Board members shall have the right to attend. Other directors and officers of the Trust may be asked to attend at the request of the Chairman. Only the Committee Chairman and

relevant members are entitled to be present at a meeting of the Committee, but others may attend by invitation of the Chairman.

5. Authority

The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Trust Board to request the Chief Executive or Director of Finance to obtain reasonable outside legal or other independent professional advice but it has no delegated financial authority.

6. Duties

To monitor the Trust's performance and the achievement of its financial plans (including the Cost Improvement Programme) and ensure that the Trust's financial strategy is aligned with the Integrated Business Plan and in line with changing NHS systems and financial performance requirements:

- To review and recommend to the Trust Board the annual financial plan / budget, including workforce, and the associated financial budget with targets set in terms of key performance indicators including CIP.

- To recommend to the Trust Board the Long Term Financial Plan included in the Five year Integrated Business Plan.

- To receive and review regular updates, as a minimum on a quarterly basis, on the financial performance of the Trust versus the Monitor group framework dashboard, and to ensure that effective action is taken to enable the Trust to achieve its key statutory and performance targets. Review the form of financial reporting, includes related workforce reports, and make recommendations thereon.

- To monitor performance against the TDA compliance framework and key national targets to ensure indicators are on target.

- To ensure the Trust Board is provided with regular reports on the financial performance of the Trust including forecast performance and associated risks and make recommendations to the Trust Board on remedial actions aimed at ensuring that the Trust's financial budget and plans are achieved.

- To receive and consider the annual medium term capital plan prior to submission for approval to the Trust Board and to receive progress reports on the management of the capital programme from the Capital Investment Group (CIG) as reported within the monthly finance reporting suite along with copies of minutes of the CIG meetings.

- To be the approval body for Capital expenditure items in accordance with the Scheme of Delegation (*for items over £100,000 and up to £250,000 in value)*

following the production and approval of suitable business cases via the Executive Group and the Capital Investment Group.

- To consider proposals for asset sales prior to a recommendation (to agree to dispose of such assets) to the Trust Board.

- To keep under review issues such as reference costs and to benchmark activity and performance and to act on any learning or remedial action required.

- To ensure that sound business cases are provided in relation to new service provision, commercial developments, partnerships, licensing and make recommendations as appropriate to the Trust Board including business opportunities or tenders over £250k.

- To monitor the development and implementation of Service Line Management and Reporting and the move towards patient level costing.

Information Governance

The Committee will review the Trust's policies and management arrangements covering all aspects of information governance, i.e:

- Openness
- Legal Compliance
- Information Security
- Information Quality Assurance / Data Quality

The Committee will receive and consider annual assessments and audits of information governance policies and management arrangements.

In monitoring compliance with the IG toolkit, the Committee will receive and consider an annual Information Governance Improvement Plan and monitor the implementation of that plan.

The Committee will receive and consider reports into breaches of confidentiality and security and where appropriate undertake or recommend remedial action giving assurance to the Audit Committee about the robustness of the processes in place

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Risk Management Function

- To review the Trust's exposure to financial risk of all natures which might affect resources and the achievement of strategic objectives, and to ensure that policy decisions are taken with a full awareness of risk and to the Trust's Risk Management Committee as appropriate.

- The Committee will receive information in relation to financial risk via the Executive Group.

- Will make recommendations on the mitigation or acceptance of identified financial, business development or related workforce risks and provide assurance on financial risk to the Risk Management Committee. The Risk Management Committee will provide assurance to the Audit Committee on the robustness of the Trust's risk management arrangements.

7. Accountability and Reporting Arrangements

The minutes of the Committee meetings shall be formally recorded by the PA to the Executive Director of Finance. Copies of the minutes of Committee meetings shall be available to all Trust Board members on request.

The Director of Finance or delegate shall prepare a report, to be presented by the Chair of the Committee, to the Trust Board after each meeting of the Committee.

The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Trust Board, or require executive action whilst the Board are considering the information included within the monthly finance reporting suite and report back issues relating to financial risk to the Chair of the Risk Management Committee.

8. Sub-Committees and Reporting Arrangements

The Committee shall have the power to establish sub-committees for the purpose of addressing specific tasks or areas of responsibility. In accordance with paragraph 4.5 of the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee unless expressly authorised by the Trust Board.

The terms of reference, including the reporting procedures of any sub-committees must be approved by the Committee and regularly reviewed.

9. Compliance and Effectiveness

The Committee must produce an annual report to the Trust Board on the actions taken by the Committee to comply with its terms of reference.

The annual report will include information about compliance with the requirement that members should attend regularly and should not be absent for more than two consecutive meetings. The annual report will also include information about the reporting arrangements into the Committee from any sub-committees.

10. Administration

The Committee shall be supported administratively by the PA to the Director of Finance whose duties in this respect will include:

- Agreement of the agenda with the Chairman and attendees and collation of papers;
- Taking and issuing the minutes and preparing action lists in a timely way;
- Keeping a record of matters arising and issues to be carried forward.

11. Requirement for Review

The Terms of Reference will be reviewed at least annually and the next review must take place before 25 September 2015.

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: **Open Trust Board**

Date of Meeting:	24 September 2015
Title of Report:	Audit Committee Report
Presented by:	Mr D Rogers, Non Executive Director Chair of Audit Committee
Author of Report: Name: Date: Email:	Sandra Storey, Trust Secretary / Head of Corporate & Legal Affairs/ Sandra Storey 16 September 2015 sandraj.storey@northstaffs.nhs.uk
Purpose / Intent of Report:	• For Information & Performance Monitoring
Executive Summary:	This report provides a high level summary of the recent meeting of the Audit Committee held on the 14 September 2015. The report describes our new external audit arrangements with Ernest & Young. In October 2015, our internal auditors will change their name from Baker Tilly to RSM (given that they are a member of RSM international. Trust Board members are reminded that the full minutes and papers are available for inspection from the Trust Secretary / Head of Corporate and Legal Affairs.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Governance Strategy • Finance Strategy • Customer Focus
Relationship with Annual Objectives:	Relates to all annual objectives
Risk / Legal Implications:	N/A
Resource Implications:	N/A
Equality and Diversity Implications:	N/A
Relationship with Assurance Framework [Risk, Control and Assurance]	The Assurance Framework provides the Board with evidence to support the Statement of Internal Control.
Recommendations:	The Board is asked to • Receive and note the contents of this report

Summary of the 14 September 2015 Audit Committee meeting To Trust Board meeting 24 September 2015

1. Welcome

The Chair welcomed Hassan Rohimun, Director and Mike Green, Manager from Ernest & Young who have been appointed by the Audit Commission as the Trust's External Auditors. 2015/16 is their first audit year with the Trust. Their contract will be overseen by the Public Sector Audit Appointments Ltd (PSAA), an independent company set up by the Local Government Association.

2. Principal Risk Register Assurance Report

The report reflected on the work undertaken around risk management arrangements, particularly the use of the Safeguard system for reporting and managing risk, changes to the leadership, the role of the Risk Review Group and reasons for disbanding the Trust's Risk Management Committee. The report also described the training that is being provided to Directorate staff to improve awareness, understanding and consistency in the approach to managing risk throughout the Trust.

A 3 month pilot of team level risk management and risk registers has commenced with teams participating from each Directorate with the plan to roll this out to all teams upon completion of the pilot.

As requested by the committee, future reports in respect to the Principal Risk Register will provide information on the number of principal risks, their ratings and mitigation to give the required assurance to the committee about the robustness of the framework in place for the management of the Trust's principal risks.

3. Risk Management Policy and Strategy – Assurance on process

The report provided an overview of the changes to the Risk Management Strategy and Policy since the last update to the committee. It was noted that changes to the Trust's risk management processes have taken place which have resulted in an earlier review of the strategy and policy. Executive responsibility for risk now falls within the portfolio of the Chief Executive. As noted at point 2, a pilot is currently underway and is likely to inform changes to the strategy and policy. It is anticipated that the work on the strategy and policy will be completed by December 2015.

4. Information Governance Incidents April – August 2015

All Trust's are expected to report on lapses in data security. The committee received a report on information governance incidents for the period April 2015 – August 2015. This provided the committee with assurance that there is a process in place for the reporting and management of information governance incidents.

It was noted that no breaches have occurred in accordance with legislation and that no significant control issues have been highlighted following a review of the incidents. The committee were assured with the remedial action that had been taken in order to reduce the risk of similar occurrences. The main themes related to staff needing to be more vigilant when dealing with information. The Committee also noted that the

Quality Committee receive more detailed reports on information governance including incidents as part of the Organisational Safety and Efficiency Domain and their role is to focus on learning and action from the issues raised. The Audit Committee gives assurance to the Board with regards to the reporting and management processes in place in respect to information governance incidents which help to inform the Trust's Annual Governance Statement and Annual Report.

5. Audit Committee Terms of Reference – Annual Review

The Audit Committee are required to review its terms of reference at least annually. The committee considered its terms of reference and wish to advise the board that there are no significant changes proposed at this time. The committee will undertake a review of its effectiveness in the coming months and this, alongside any further changes to the management of risk, will help to inform any changes.

6. Internal Audit Progress Report – Baker Tilly

The committee received a report detailing the audit assignments that have been completed and the impacts of those findings since the last Audit Committee. Auditors asked the committee to ensure that the recommendations are given due consideration and that the timescales agreed with Trust Managers are adhered to.

The report also noted that audits scheduled over the coming months. Auditors will discuss with the appropriate leads if the planned audits remain applicable. It was noted that some audits could be deferred or replaced with other work depending on any learning or action identified from the CQC inspection currently underway.

The committee reviewed the report on the follow up of high, medium and low priority recommendations. Concern was raised with the low number of recommendations closed on the recommendations tracking system and others being only partly implemented. Committee members sought assurance from the Finance Director that this would be raised outside of the meeting and action taken to address the outstanding recommendations. While it was acknowledged that there had been some staff changes that impacted on progressing this work, it was agreed that a review of the process would take place to reduce the risk of similar occurrences.

Auditors noted that on the 26 October 2015, their name will change from Baker Tilly to RSM given their membership of RSM International. All existing Baker Tilly contacts and relationships will remain unchanged.

7. Local Counter Fraud Service (LCFS) Progress Report

The committee received a briefing from auditors detailing the work that has been completed since the last meeting and following approval by the committee of their 2015/16 audit plan.

It was noted that a review of HR files had been undertaken which identified areas where improvements could be made with additional controls that will further promote compliance with best practice. A Fraud Risk Assessment was also undertaken in the Trust during August 2015 and the findings will be reported to the next meeting of the committee.

Fraud awareness and training sessions have continued including review of a number of policies and procedures to ensure they remain fit for purpose.

Auditors noted that a national exercise will be undertaken across the Baker Tilly client base during 2015/16 considering the emerging risk area of cyber fraud. The LCFS will assess the Trust's policies and procedures in place and awareness presentations and webinars will be delivered to key employees.

8. External Auditors Ernest & Young Annual Audit Fee 2015/16

The committee received the Annual Audit Fee letter for 2015/16 setting out the proposed external audit fees for the 2015/16 financial year. The audit is the first for the Trust provided by Ernest & Young and the first they will undertake following the closure of the Audit Commission on 31 March 2015. The audit fee covers the audit of the Trust's financial statements, accounts and value for money conclusion. Their Audit Plan will be issued in December 2015 and the auditors will communicate any significant financial statement risks identified, planned audit procedures to respond to those risks and any changes in fee. It will also set out any significant risks identified in relation to the value for money conclusion.

The committee also discussed the auditor's health sector audit committee briefing. Of note was the series of questions that they consider Audit Committee's should be asking themselves. The Trust Secretary suggested that this should be brought back to the committee when members undertake a mid-year review of its effectiveness. This will be included on the agenda for the next meeting.

9. Cost Improvement Programme (CIP)

Committee members were reminded of the process in place to assess the quality impact on services in respect to proposed cost improvement schemes. Quality metrics are well established and are monitored by the Quality Committee. It was noted by the Finance Director that the committee can take assurance with the process in place. CIP will be shortly be subject of an audit and the findings will be reported to the next meeting of the committee.

10. Review of Single Tender Actions

The committee received a detailed report on competition waivers that have occurred during the period 2014/15. Of the total of 37, 19 related to annual contracts with half being single specification suppliers. It was noted that the management of single tender actions would be kept under review and further reports would be made to the committee in order to provide further information and assurance on the process.

11. Review of the Business of other Board Committees

The committee received the following summary business reports:

- *Quality Committee* meetings – 19 May 2015, 16 June 2015 & 21 July 2015;
- *Finance & Performance Committee* meetings – 28 May 2015, 18 June 2015 and 23 July 2015;
- *People and Culture Development Committee meetings* – 18 May 2015, 22 June 2015, January, 20 July 2015.

Members noted the importance of reviewing the business of other Board committees, particularly in terms of ensuring no gaps or unnecessary duplication in business.

12. Next meeting of the Audit Committee

19 November 2015 1.00pm

On behalf of the Committee Chair Mr David Rogers
Sandra Storey
Trust Secretary / Head of Corporate and Legal Affairs
16 September 2015

North Staffordshire Combined Healthcare NHS
NHS Trust

Encl 13

REPORT TO: Trust Board

Date of Meeting:	24 September 2015
Title of Report:	Audit Committee Terms of Reference
Presented by:	David Rogers, Non Executive Director Chair of the Audit Committee
Author of Report: Name: Date: Email:	 Sandra Storey 3 September 2015 Sandraj.storey@northstaffs.nhs.uk
Purpose / Intent of Report:	• For Decision
Executive Summary:	The Audit Committee are required to review its Terms of Reference at least annually. The last review took place at its meeting on the 14 September 2015. There are no significant changes proposed to the Committee's Terms of Reference The Trust Board is asked to agree the Terms of Reference for the next 12 months. In the meantime, a review of the committee's effectiveness is planned. In addition, the Board Assurance Framework and approach to risk is being embedded and the committee agreed that this work will also help to inform a further review of the terms of reference over the coming months.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Governance Strategy
Relationship with Annual Objectives:	Governance
Risk / Legal Implications:	To ensure that the Trust is complying with its Standing Orders
Resource Implications:	None identified as a result of this report
Equality and Diversity Implications:	None identified as a result of this report
Relationship with Assurance Framework [Risk, Control and Assurance]	Provides assurances that appropriate governance arrangements are in place
Recommendations:	To present to Trust Board for approval

AUDIT COMMITTEE

TERMS OF REFERENCE

Membership	▪ No less than three Non-Executive Directors
Quorum	▪ Two Members
In Attendance	▪ Director of Finance ▪ External Audit ▪ Internal Audit ▪ Associate Director of Governance
Frequency of Meetings	▪ At least five meetings per year
Accountability and Reporting	▪ Accountable to the Trust Board ▪ Report to the Trust Board after each meeting ▪ Minutes of meetings available to all Trust Board members on request ▪ Annual report to Trust Board on actions taken to comply with terms of reference
Date of Approval by Trust Board	▪ 24 September 2015
Review Date	▪ By 30 September 2016

AUDIT COMMITTEE

TERMS OF REFERENCE

1. Constitution

The Trust Board hereby resolves to establish a Committee of the Trust Board to be known as the Audit Committee (The Committee). The Committee is a non-executive committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference.

2. Membership

The Committee shall be appointed by the Trust Board from amongst the non-executive directors of the Trust and shall consist of not less than three members. The Trust Board should satisfy itself that at least one member of the Committee has recent and relevant financial experience.

One of the members will be appointed Chair of the Committee by the Trust Board. In the absence of the Chair appointed by the Trust Board one of the non-executive directors will be elected by those present to Chair the meeting.

The Chairman of the organisation shall not be a member of the Committee.

3. Quorum, Frequency of Meetings and Required Frequency of Attendance

No business shall be transacted unless two members of the Committee are present.

In accordance with best practice as identified in the NHS Audit Committee Handbook, meetings shall be held no less than five times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

Members of the Committee should attend regularly and should not be absent for more than two consecutive meetings.

4. In Attendance

Only the Committee Chairman and relevant members are entitled to be present at a meeting of the Committee, but others may attend by invitation of the Committee.

The Director of Finance, Associate Director of Governance and appropriate Internal and External Audit representatives shall normally attend meetings. However, at least once a year the Committee will meet privately with the External and Internal Auditors.

The Chief Executive and other executive directors may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director. The Chief Executive should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

5. Authority

The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Trust Board to obtain reasonable outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

6. Duties

Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the organisation's strategic and annual objectives.

In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with Registration under the Health and Social Care Act, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Trust Board;
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, assurance from the respective Committees on the effectiveness and robustness of the management of principal risks in relation to strategic and annual objectives and the appropriateness of the above disclosure statements;
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements; and
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

The Committee shall ensure that the Trust has an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Trust Board. This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal of auditors;
- review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organization as identified in the Assurance Framework;
- consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources;
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation; and
- annual review of the effectiveness of internal audit.

External Audit

The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work.

The Committee shall review the performance of the External Auditor. This will be achieved by:

- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy;
- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and any associated impact on the audit fee; and
- review all External Audit reports, including agreement of the annual audit letter before submission to the Trust Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

Other Assurance Functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the Trust.

These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will include the Finance and Performance Committee, People and Cultural Development Committee, Quality Committee and the Business Development and Investment Committee.

In reviewing the work of the Quality Committee, and issues around clinical risk management, the Audit Committee will wish to be satisfied that assurance can be gained from the clinical audit function. Similarly, in reviewing the robustness of the Trust's system for risk management, the Audit Committee will wish to be satisfied that assurance can be gained from the work of each of the respective committees in managing their risks to achieving the Trust's strategic and annual objectives.

Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting

The Audit Committee shall review the Annual Report and Financial Statements before submission to the Trust Board, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee;
- changes in, and compliance with, accounting policies and practices;
- unadjusted misstatements in the financial statements;
- approval of charitable funds annual accounts and report;
- major judgemental areas; and
- significant adjustments resulting from the audit.

The Committee should also ensure that the systems for financial reporting to the Trust Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Trust Board.

7. Accountability and Reporting Arrangements

The minutes of Committee meetings shall be formally recorded by the Associate Director of Governance or administrator for the committee.. Copies of the minutes of Committee meetings shall be available to all Trust Board members on request.

The Associate Director of Governance shall prepare a report to the Trust Board after each meeting of the Committee. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Trust Board, or require executive action.

The Committee will report to the Trust Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and ensuring the Trust continues to meet the requirements of Registration under the Health and Social Care Act 2008.

8. Sub-Committees and Reporting Arrangements

The Committee shall have the power to establish sub-committees for the purpose of addressing specific tasks or areas of responsibility. In accordance with paragraph 4.5 of the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee unless expressly authorised by the Trust Board.

The terms of reference, including the reporting procedures of any sub-committees must be approved by the Committee and regularly reviewed.

9. Compliance and Effectiveness

The Committee must produce an annual report to the Trust Board on the actions taken by the Committee to comply with its terms of reference.

The annual report will include information about compliance with the requirement that members should attend regularly and should not be absent for more than two consecutive meetings. The annual report will also include information about the reporting arrangements into the Committee from any sub-committees.

10. Administration

The Committee shall be supported administratively by the Associate Director of Governance whose duties in this respect will include:

- Agreement of agenda with Chairman and attendees and collation of papers;
- Ensuring appropriate administrative support is in place to take the minutes;
- Keeping a record of matters arising and issues to be carried forward;
- Preparing reports to the Trust Board after each meeting of the Committee; and
- Advising the Committee on pertinent areas.

11. Requirement for Review

The Terms of Reference will be reviewed at least annually by the committee for approval by the Trust Board and the next review must take place before 30 September 2016.

North Staffordshire Combined Healthcare NHS
NHS Trust

Enclosure 14

REPORT TO: TRUST BOARD

Date of Meeting:	24 September 2015
Title of Report:	Performance Report – Month 5 2015/16
Presented by:	Ann Harrison, Interim Director of Finance
Author of Report: Name: Date: Email:	 Kevin Daley 18/09/15 Kevin.Daley@northstaffs.nhs.uk
Purpose / Intent of Report:	• Performance monitoring
Executive Summary:	This report provides the Board with a summary of performance to the end of Month 5 (August 2015). Performance against the TDA metrics and key National Targets is included within the report. A range of metrics is in place to monitor performance, quality and outcomes. The indicators are those set by our commissioners and local trust targets and aligned to the relevant Trust objectives. Performance against these KPIs has been reviewed by the Finance & Performance Committee prior to this report being presented to Trust Board At month 5 there is 1 metric rated as Red and 2 rated as Amber; the attached exception report expands on these areas. Executive leads will provide a verbal update at the meeting, where appropriate.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Governance Strategy The Performance & Quality Management Framework measures performance across National and local indicators, presented against the Trust's enabling strategies, commissioning contract and the TDA's proposed assurance framework.
Relationship with Annual Objectives:	The Performance & Quality Management Framework measures performance across all annual objectives
Risk / Legal Implications:	All areas of underperformance are separately risk assessed and added to the risk register dependent

	on the outcome of the risk assessments.
Resource Implications:	Not directly as a result of this report
Equality and Diversity Implications:	Not directly as a result of this report
Relationship with Assurance Framework [Risk, Control and Assurance]	The Performance & Quality Management Framework is a key control within the Assurance Framework
Recommendations:	The Board is asked to • Consider and discuss reported performance with particular emphasis on areas of underperformance • Confirm sufficient detail and assurance is provided

PERFORMANCE MANAGEMENT REPORT TO TRUST BOARD

Date of meeting:	24 September 2015
Report title:	**Performance & Quality Management Framework** **Performance Report – Month 5 2015/16**
Executive Lead:	Interim Director of Finance
Prepared by:	Kevin Daley, Performance Development Manager
Presented by:	Glen Sargeant, Head of Performance & Information

1 Introduction to Performance Management Report

The report includes TDA metrics, targets where agreed, trends and revised RAG rating

- An Executive Summary (this report)
- Overall performance of metrics with targets (App A)

In addition to the attached appendices a full database (Divisional Drill-Down) has been made available to Directorate Heads of Service and Clinical Directors to enable them to scrutinise / check the supporting data and drive improvements based on that data.

2 Executive Summary – Exception Reporting

This section presents an overview and performance by exception across all Key Performance Indicators in place to measure performance, quality and outcomes.

In month 5 there is 1 metric rated as Red and 2 as Amber; targets for the unrated metrics will be updated once 2015/16 technical guidance is received from the TDA.

	Month 5			
Metric Driver	**Red**	**Amber**	**Green**	**Unrated**
Exceptions – Month 5	**1**	**2**	**55**	**26**

3 Exceptions - Month 5

Metric	Exec/Op Lead	Target	M5 Perf	YTD Perf	Forecast Outturn	Trend	Commentary
TRAINING: % staff compliant with mandatory training	Workforce Dir Op Lead B Dawson	**95%**	**AMBER** **90%**	**AMBER** **90%**	**AMBER**	↔	**90% @ month 5 same as month 4** Month 5 breakdown Corporate Services = 87% AMH Community = 91% AMH In Patient = 86% Substance Misuse = 92% CYP = 87% Learning Disabilities = 93% NOAP = 92% Trust is proactively taking action with teams to ensure that all staff attend statutory & mandatory training and maintain their compliance.
APPRAISAL: Annual appraisal and personal development plan % - All staff	Workforce Dir Op Lead	**90%**	**RED** **77%**	**RED** **77%**	**GREEN**	↘	**77% @ month 5 from 80% @ month 4** Trust is proactively taking action with teams to ensure that all staff have an appraisal and PDR. The PDR figure is currently subject to validation as it appears that a number of PDRs have taken place but have not been recorded..
CPA: The proportion of those on Care Programme Approach(CPA) for at least 12 months Having formal review within 12 months	Dir of Ops Op Lead tbc	**95%**	**AMBER** **92.8%**	**AMBER** **92.8%**	**GREEN**	↗	**New method of calculation which now reflects the TDA monitoring process 92.8% @ M5 from 90.81% @ M4** Initiative being implemented to ensure that all reviews are undertaken within the appropriate timescale and input within 72 hours. Teams being targeted with weekly reports identifying patients whose review is due within the forthcoming 6 to 8 weeks.

							The majority of current underperformance is related to the Greenfield Centre, Head of Directorate copied in on weekly reports. To be addressed via PMS session.

4 Risk Ratings

The TDA measures Trust performance in five categories:
At month 5 we have maintained our rating of **Level 4** (out of 1 to 5), where 5 is best.

5 Recommendations

- Consider and discuss reported performance with particular emphasis on areas of underperformance
- Confirm sufficient detail and assurance is provided

The following metric is formally monitored during 2015/16; it will be live from 2016/17:

Metric	Exec/Op Lead	Target	M5 Perf	YTD Perf	Forecast Outturn	Trend	Commentary
Early Intervention: % of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks.	Dir of Ops Op Lead S Wilson	**50%**	**RED** **20%**	**RED** **20%**	**GREEN**	↔	**20% @ month 5 same as month 4** These figures relate to current working practice, where allocations onto caseload are through the weekly team meeting – the Operational Lead is reviewing processes and an action plan is in place to close the gap.

REPORT TO TRUST BOARD

Enclosure 15

Date of Meeting:	24 September 2015
Title of Report:	NHS Trust Development Authority (NTDA) Monthly Self Certifications.
Presented by:	Ann Harrison, Interim Director of Finance
Author of Report: Name: Date: Email:	Glen Sargeant, Head of Performance and Information 14 September 2015 glen.sargeant@northstaffs.nhs.uk
Purpose / Intent of Report:	Information and approval
Executive Summary:	This paper confirms that the monthly NTDA self-certification documents have been reviewed by the executive team and are ready to be submitted. Declarations include: • Fit & proper directors • Registration with CQC • Compliance with TDA Accountability Framework In all there are 26 self-certification declarations and these form part of the NTDA Oversight and Escalation Process. There is no change from last month's position to report, which confirms non-compliance with Board Statement 11 (Governance) - *The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.* Several IG Toolkit requirements were changed when version 13 was launched in June 2015 and the Trust was unable to evidence full compliance against one of prior to the 31 July 2015 baseline submission. An action plan (attached) is in place to address this, implemented by the IG Steering Group, which will be reported to Quality Committee. It is anticipated that the Trust will be able to declare full compliance at the October 2015 update

	submission. Based on August 2015 data, the Trust is therefore declaring non-compliance with one TDA requirement.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Clinical, Finance and Governance. There is no direct impact on patients or the public.
Relationship with Annual Objectives:	5: Robust plans delivering quality and sustainable services
Risk / Legal Implications:	None
Resource Implications:	None identified
Equality and Diversity Implications:	None identified
Relationship with Assurance Framework [Risk, Control and Assurance]	Supports the wider framework
Recommendations:	Board members are asked to : • Approve the submission for August 2015 data declaring non-compliance with one TDA requirement. This is to be sent to the NTDA on or before the last working day of September 2015.

North Staffordshire Combined Healthcare NHS
NHS Trust

Encl 17

REPORT TO: **Trust Board**

Date of Meeting:	24th September 2015
Title of Report:	Rose Report Local Implications
Presented by:	Paul Draycott
Author of Report: Name: Date: Email:	Beverley Dawson Training Manager 7/9/15 Beverley.dawson@northstaffs.nhs.uk
Purpose / Intent of Report:	For Information
Executive Summary:	The Rose Report makes far-reaching recommendations which are set largely within the national context. The local relevance of these recommendations is outlined in this paper. It is recommended that the Trust: Specific local recommendations are outlined and in general it is recommended that the Trust use the local applications as part of the Trust approach to leadership development and build these recommendations into the wider OD strategy for the Trust.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Workforce Strategy High Quality leadership is an essential skill set from which to take the Trust forward. This report focuses on the need to continually develop, refresh and renew our leadership capability in order to keep abreast of the complex and changing healthcare provider environment.
Relationship with Annual Objectives:	Supports governance through effective leadership and management
Risk / Legal Implications:	The risks of poor quality leadership are multi-factorial affecting quality, governance, productivity, staff wellbeing and service user outcomes.
Resource Implications:	
Equality and Diversity Implications:	
Relationship with Assurance Framework [Risk, Control and Assurance]	
Recommendations:	It is recommended that the Board receives the information contained within this report to inform future practice.

Better Leadership For Tomorrow – NHS Leadership Review – Local Implications

Lord Rose

8/25/2015

Dawn Thompson

Beverley Dawson

Introduction

At the back end of June 2015, Lord Stuart Rose published his long-awaited review into NHS leadership, commissioned by the Secretary of State in 2014.

The Rose Review was deliberately practical in its enquiry and recommendations. It builds on themes uncovered in the 2013 Mid-Staffordshire NHS Foundation Trust Inquiry (Francis Report) and on other more recent reviews (Dalton 20144, King's Fund 2014 and 2015) and the Five Year Forward View (NHS 2015); 19 recommendations were highlighted in five themes described below:

The aim of this report is to review the recommendations of 'Better Leadership For Tomorrow' and to draw out local implications.

Context

Better Leadership for Tomorrow 2015 set out to:

- review what needed to be done to develop talent from inside and outside the health sector into NHS leadership positions
- recommend how strong leadership might transform the NHS
- Equip clinical commissioning groups to deliver the 5 year forward view.

It was written at a time of massive change for the NHS and takes into account the need of leaders to effectively manage in this changing environment

5 themes emerged

Lack of Shared NHS vision

- Lack of single vision for the NHS and increasing fragmentation of provision into provider and foundation trusts means that leaders are distracted from the common aim

Leadership Training

- Insufficient leadership and management capability to deal with the change agenda that has been set out in the 5 year forward view
- Need for national accredited leadership training at all levels – Qualifications in leadership
- NHS leadership academy to be merged with Health Education England to increase authority to create leadership training and to do so in very timely way (90 day cycle)
- Increase graduate training scheme ten fold
- Increase opportunities to learn from outside the NHS and from other areas of the NHS

Performance Management

- Lack of competency frameworks against which to manage leadership performance
- Performance management seen in negative terms rather than as a tool to support leadership development
- Leadership performance management not well used
- Lack of leadership career structure and career support

- Appraisal system for managers needs to be improved

Bureaucracy

- Too much focus on targets not enough focus on culture
- Rationalisation of regulatory bodies
- All trusts encouraged to review and simplify their data returns

Management support

- Short tenure of senior managers needs to change and minimum term contracts be introduced
- NEDs and lay member training needs to improve
- Boards and senior managers need additional development and support

Local Application

A significant proportion of the Rose review recommendations are aimed at national reform and review. However, it is possible to localise the themes and recommendations that are presented and to think about how we can prepare as an organisation for these changes as shown in the table below.

Rose Report Recommendations	Local Application
R1 form a single service-wide communication strategy within the NHS to cascade and broadcast good (and sometimes less good) news and information as well as best practice to NHS staff, Trusts and CCG's	• Celebrate our successes, recognise and acknowledge it. • Take an appreciative perspective that begins by focusing on what is good, what we want more of and what we can improve on, and what we can celebrate rather than what's wrong, what's missing, what's broken. • Continue to review Trust values to reflect NHS constitution • Trust mission linked to NHS mission • NHS awareness included in induction training • Explore how we can make NHS best practice more explicit and part of everyday work eg: how do we promote and use NICE guidance • Add in something about North Transformational group and the work happening here??
R2 create a short NHS handbook / passport / map summarising in short and or visual form the NHS core values to be published broadcast and implemented throughout the NHS	• NHS handbook when it becomes available to be part of our induction pack • Ensure our current handbook is reflecting NHS constitution and values • Use the NHS infographs in a more proactive way. For example recent info graph on mental health at work and one on NHS key figures

R3 Charge HEE to coordinate the content, progress and quality of all NHS training including responsibility for the coordination and measurement of all management training in the NHS. At the core of this is a 90 day action cycle.	• Ensure the Trust prioritises national leadership programmes as they become available. • Ensure that management qualifications are included in Trust recruitment strategy for management posts • PDR for managers/leaders to include PDP about management/leadership training needs
R4 Move sponsorship of the NHS leadership academy from NHS England to Health Education England	
R5 Include accredited /nominated training establishments as part of a divers training effort	• Develop skills in collective and action learning within our organisation and across the patch • Engage with local accredited and nominated training providers as they become known. • Engage in multi sector training where this has been accredited or nominated to meet NHS leadership needs
R6 Review, refresh and extend (x10) the NHS graduate scheme; establish career pathways, a greater variety of placements and guaranteed job after three years training (quality and assessment permitting)	• Increase awareness of the NHS graduate scheme locally • Identify a lead person within the Trust to identify potential graduate placements and to ensure the Trust is actively considered for graduate placements • Pro-actively recruit NHS graduates
R7 Refresh middle management by training a more porous approach both from within the NHS and externally (recruitment from, and secondment to, other sectors)	• Pro-actively approach local businesses with a good reputation for leadership and management training with the aim of forming mutual learning opportunities • Actively seek talent match opportunities across local NHS and other public sector organisations offering secondments and job shadowing opportunities for our managers to learn from other sectors • Work with charitable organisations to provide secondment opportunities for managers and leaders • Embed Aston Training • Set up pan Staffordshire and Shropshire job swaps for 6 months for posts that can easily do this? i.e. HR •
R8 Require senior managers to attend accredited courses for a qualification to show consistent levels of experience and training have been reached across the NHS. On completion of this course they enter a senior management talent pool open to all Trusts	• Develop our talent match approach across the West Midlands • Continue to support, develop, train, appraise, promote and engage our most resources.

	• Continue spot great talent, train them, develop them, support them and promote them. • Have a succession plan in all areas • Add in North Transformational Group actions?? • The Trusts continues to develop, recognise and reward appropriately leadership qualities across the Trust and these are celebrated across all disciplines and job grades within our Reach programme. • Managers to attend the NHS accredited courses once these become available • Ensure all managers in the Trust hold a management qualification of some sort. • Include as an essential in recruitment to future management positions
R9 Set, teach and embed core management competencies and associated expected behaviours at each management level.	• Promote core management competencies through the healthcare leadership framework on all leadership programmes and through conversations at management and leadership PDR processes • Build management competencies into performance framework.
R10 establish a mechanism for providing on-going career support for all those in a management role allowing individuals to increasingly take charge and identify their own developmental needs.	• Promote talent management and career conversations as part of our PDR process. • Promote self directed learning for all individuals, encouraging them to plan their developmental journey. • Provide support to staff at all points of their career in relation to career progression
R11 Establish and embed an NHS system of simple, rational appraisal (a balanced scorecard for individual) supported by a regular course in giving and receiving appraisals as part of the core provision of the single training body. At a senior level, these appraisals should be standardised across the NHS	• Until a common NHS appraisal system is available ensure that all Trust staff receive training in the principles of good appraisal including the soft skills associated with giving and receiving feedback, setting and achieving goals. • Ensure that the Trust's appraisal process is simple to understand and includes measurement of managerial and leadership competencies • Embed the new balance score card across the Trust.
R12 Review the data demands of regulators and oversight bodies; these can then be rationalised and harmonised in order to produce consistent, clear and simple reporting that does not distract staff from patient care.	• Work with appropriate regulatory bodies locally to review their data needs and to determine the most cost effective way that this can be provided • Agree with appropriate regulatory bodies that any new requests for information will be mutually negotiated; with the use of existing datasets being the preferred course

	of action wherever this is possible.
R13 Merge oversight bodies, the NHS Trust Development Authority and Monitor	• Respond to merged regulatory bodies as appropriate at the time
R14 Spend time on a regular basis at all levels of the NHS to review the need for each data return being requested and to feed any findings to the executive and non executive teams to review	• Conduct an in-house housekeeping process to review all data requests and determine if information can be rationalised or used in a more effective way • Reduce the number of new data demands unless there is a proven business justification for their introduction • Encourage staff to make use of the data that is available by increasing their access to data (dashboard) and their confidence in analysing and using the data that they have at their disposal • Ensure that ESR is embedded
R15 Establish and maintain a clearer system of simple rational appraisal (balanced scorecard for the organisation)	• Identify and articulate clearly what good and poor leadership looks like based on NHS leadership competency framework • Promote clarity about this to leaders and managers across the Trust • Enable all leaders and managers to undertake 360 degree feedback to gain a depth of understanding about their own competence level against this framework • All managers and leaders to have a development plan which corresponds to the 360 assessment and to include discussion of this plan at their PDR
R16 Health and social care information centre to develop an easily accessible burden impact assessment template and protocol	• Work with TDA to determine our own estimate of burden impact assessment whilst waiting for the national tool to be developed
R17 Create NHS wide comment boards, Websites and supporting technology to be designed and implemented to share best practice.	• In the interim the Trust could develop its own best practice web page – building on the LiA innovation project. • Include the lessons learned outcomes in communicating best practice through comment boards etc • Actively promote the NHS wide comment board once this is available including creative ways of doing this such as messages to mobile phones, wallpaper on PC's and laptops, Flash mobs in key sites etc
R18 Set minimum term centrally held contracts for some very senior managers subject to assessment and appraisal	• Review our recruitment process for senior posts and consider the use of minimum term contracts. • Ensure that this is backed up by an explicit performance assessment and appraisal process that allows performance to be supported and managed as appropriate.

R19 formally review NED and CCG lay member activity (including competence and remuneration) in line with CQC well led initiative; and establish a system of volunteer NEDS from other sectors.	• Encourage robust NED development programme on recruitment • Continue to provide a comprehensive development programme for NEDS in uni and cross organisational settings to allow the development of wider set of networks and competency development • Encourage CPD for all NEDS in line with the competence requirements that will be issued nationally.
Other aspects to consider	
	• Recognise the impact of constant change and to what extent changes are allowed to embed to create the intended outcome.
	• Continue to embed "no change about me without me". Equipping managers and teams to flourish through change. For managers be prepared to lead themselves and their teams through MOC with elegance and creativity.

The Trust is making sure its programmes such as LiA and effective team development help us to continue to build strong leadership communities, and as a Trust we are also sharing this practice more widely across the Northern Transformation Group which will help to tackle some of the issues raised in the review.

Conclusion and Recommendations

The Rose Report makes far-reaching recommendations which are set largely within the national context. The local relevance of these recommendations is outlined in this paper.

It is recommended that the Trust:

- Use the local applications as part of the Trust approach to leadership development
- Build these recommendations into the wider OD strategy for the Trust.