North Staffordshire Combined Healthcare NHS
NHS Trust

MEETING OF THE TRUST BOARD

TO BE HELD IN PUBLIC ON THURSDAY 25 FEBRUARY 2016, 10:00AM, BOARDROOM, 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 – 28 JANUARY 2016** *To APPROVE the minutes of the meeting held on 28 January 2016*	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 the Chief Executive*	Note Enclosure 4
	TO DELIVER HIGH QUALITY PERSON CENTRED MODELS OF CARE (Strategic Goal)	
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 SPOTLIGHT TEAM** *TO RECEIVE an introduction to the corporate team by Mr. P. Draycott in respect of the Executive PA Team*	Verbal
10.	**STAFF RETIREMENTS** *To EXPRESS our gratitude and recognize staff who are retiring* *To be introduced and presented by the Chair*	Verbal

11.	**ASSURANCE REPORT FROM THE QUALITY COMMITTEE REPORT** *To RECEIVE the Quality Committee assurance report from the meeting held on 16 February 2016 from Mr. P Sullivan, Chair of the Quality Committee*	Assurance Enclosure 5
12.	**NURSE STAFFING MONTHLY REPORT – January 2016** *To DISCUSS and APPROVE the assurance report on the planned versus actual staff variances from Ms. M. Nelligan, Director of Nursing & Quality*	Assurance Enclosure 6
13.	**NHS TRUST DEVELOPMENT AUTHORITY (NTDA)** **Monthly Self Certifications** *To RECEIVE this paper which confirms that the monthly NTDA self-certification documents are no longer required from Mrs. C. Donovan, Chief Executive*	Assurance Enclosure 7
14.	**BOARD TO TEAMS VISIT REPORT Q2 AND Q3 2015/16** *To RECEIVE for assurance an analysis of Board to Team Visits from Ms. M. Nelligan, Director of Nursing & Quality*	Assurance Enclosure 8
	TO BE ONE OF THE MOST EFFICIENT PROVIDERS (Strategic Goal)	
15.	**FINANCE REPORT – Month 10 (2015/16)** *To RECEIVE for discussion the month 10 financial position from Mrs. 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 18 February 2016*	Assurance Enclosure 10
17.	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 10** *To RECEIVE the month 10 Performance Report from Mrs. A Harrison, Interim Director of Finance*	Assurance Enclosure 11
18.	**ASSURANCE REPORT FROM THE AUDIT COMMITTEE** *To RECEIVE the Audit Committee Assurance report from Mr. D Rogers, Chair of the Audit Committee, from the meeting held on 18 February 2016*	Note Enclosure 12
19.	**COMMITTEE EFFECTIVENESS UPDATE** *To RECEIVE the Committee Effectiveness Update from Mrs L Wrench, Associate Director of Governance*	Assurance Enclosure 13 ***To follow***
	TO BE A DYNAMIC ORGANISATION DRIVEN BY INNOVATION (Strategic Goal)	

20.	**ASSURANCE REPORT FROM THE PEOPLE AND CULTURE DEVELOPMENT COMMITTEE REPORT** *To RECEIVE the People and Culture Development Committee assurance report from the meeting held on the 22 February 2016 from Mr. P. O'Hagan, Chair of the People and Culture Development Committee Report*	Assurance Enclosure 14 ***To follow***
21.	**5 YEAR FORWARD VIEW FOR THE MENTAL HEALTH STRATEGY** *To RECEIVE a report for the 5-Year Forward view for the Mental Health Strategy from Mr. T. Thornber, Director of Strategy and Planning*	Assurance Enclosure 15
22.	**To *DISCUSS* any Other Business**	
	QUESTIONS FROM MEMBERS OF THE PUBLIC	
23.	*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 31 March 2016 at 10:00am.	
24.	**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
	BUSINESS PLAN UPDATE	Approve
	LEADERSHIP & WORKFORCE REPORT AND SERVICE REVIEW	Assurance
	ANY OTHER BUSINESS	

North Staffordshire Combined Healthcare NHS Trust

TRUST BOARD

Minutes of the open section of the North Staffordshire Combined Healthcare NHS Trust Board meeting held on Thursday, 28 January 2016 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:

Mrs C Donovan
Chief Executive

Mr P O'Hagan
Non-Executive Director

Dr B Adeyemo
Medical Director

Mr P Sullivan
Non-Executive Director

Mr D Rogers
Non-Executive Director

Ms A Harrison
Interim Director of Finance

Mr P Draycott
Executive Director of Leadership &Workforce

Dr K Tattum
GP Associate Director

Mr T Gadsby
Non-Executive Director

Ms M Nelligan
Executive Director of Nursing and Quality

Dr I Laws
GP Associate Director

Mr T Thornber
Director of Strategy and Development

Mrs B Johnson
Non-Executive Director

In attendance:

Mrs L Wrench
Associate Director of Governance

Mrs J Scotcher
Executive PA

Ms J Harvey
UNISON

Mrs A Roberts
Head of Communications

Team Spotlight:
Recovery Hub – Substance Misuse
Sue Parkes
Kelly Parker
Johnathon Mclean

Individual spotlight:
Sandra Huczok

Mr A Cotterill
Chair – Service User Council

Members of the public:
Alice Dair
Shirley Perkins
Grant Williams

Ms W Dutton
Vice Chair – Service user council

The meeting commenced at 10:00am.

247/2016	**Apologies for Absence** Apologies were received from Mr A Rogers, Director of Operations, and Hilda Johnson, North Staffs User Group.	**Action**

	The Chair gave a warm welcome to Andrew Cotterill and Wendy Dutton who have recently been elected as Chair and Vice chair of the Service User and Patient Council. The Chair commented that he was delighted to see them at today's meeting and looked forward to seeing them at future meetings of the Board. Dr Laws offered his resignation as GP Associate due to recent health problems and a move to Worcestershire. The Chair thanked him for his valuable contribution and said that he would be greatly missed.	
248/2016	**Declaration of Interest relating to agenda items** There were no declarations of interest relating to agenda items.	
249/2016	**Declarations of interest relating to any other business** There were no declarations of interest to any other business.	
250/2016	**Minutes of the Open Agenda – 26 November 2015** The minutes of the open session of the meeting held on 26 November 2015 were approved as a correct record	
251/2016	**Matters arising** The Board reviewed the action monitoring schedule and agreed the following:- ***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. Part of rationalisation plan – Mr A Rogers confirmed that this will be addressed with the Estates Strategy due to be submitted to the Trust Board in January 2016. ***Presentation has taken place at the January Board of Directors' session, further work up and presentation at February Board of Directors session.*** ***Mr Thornber confirmed that the Estates Optimisation paper will to come to the Trust Board in February 2016. The Chair clarified that the issue with the Ashcombe Centre, is that it is not based in the centre of town and is not easily assessable to our service users.***	**Mr Thornber**

	134/2015 Balanced Scorecard - Mr O'Hagan queried when the Board would have sight of the scorecard. Ms Harrison gave assurance that this would be in December; there are some formatting issues at present. He also noted the requirement for being 'paperless'. Ms Harrison also noted that the Balanced Scorecard would be presented to the Trust Board in January 2016. The Chair noted that this would provide the Board with a much more clearer and interactive way of receiving information ***On today's agenda*** ***216/2015 - Team Spotlight Community Learning Disability Team -*** Mr O'Hagan commended the role of the Enablement Worker and how could this be captured and broadcast to promote their excellent work. Mr Draycott stated that the Trust may have the capacity through U-tube ***This is being progressed. Mr Draycott confirmed there has been a slight issue with Internet Explorer 11 not being accessible on all PCs, this should be rectified and rolled out end of March 2016.*** **– remove from schedule** ***216/2015 - Team Spotlight Community Learning Disability Team*** Dr Tattum queried how this is accessible? Sarah stated that the team had assumed all GPs had been made aware and that all referrals are redirected to the community team. However, Dr Tattum stated GPs had not been notified. It was agreed to highlight this change in the GP newsletter and that team members would be setting up appointments to meet with all GPs. ***Actioned going forward and the article will be in the next edition – remove from schedule*** ***216/2015 Team Spotlight Community Learning Disability Team -***, Mrs H Johnson expressed her great admiration for the LD teams and although NSUG do not cover this, she liked the words enablement. She did note however, when the Activity Workers came to Trust Board and presented they were asked what would help improve their work and this has not been materialised. Mrs Donovan agreed to take forward. ***This is being followed up – remove from schedule***	

	218/2015 - Safe Staffing Monthly Report - The Board will be aware of a staffing review in line with national quality expectations, the dates have been set before Christmas for Wards 1, 2, 3, Rehab and CAMHS. The findings of the review will be reported to the Board in January 2016, with a view to address the other wards, Learning Disabilities and Older people going forward. ***Deferred – Ms Nelligan confirmed that a six month review is underway but not yet complete; this will be presented to the Trust Board in March.*** ***218/2015 - Safe staffing Monthly Report -*** Mrs H Johnson raised her concerns regarding Summers View staffing levels. This is due to some long term sickness, a suspension and a vacancy. This is having an impact and she did raise a complaint made by a service user who requires escorting when she goes out. Ms Nelligan agreed to review this after today's meeting. Mr Sullivan also noted that there have recently been 3 members of staff who have left and this is also about leadership and skill mix. ***Ms Nelligan noted she had reviewed the vacancy concerns at Summers View, these posts are being recruited to and this will continue to be monitored – remove from schedule*** ***219/2015 - Serious Incidents Quarterly Report July-Sept 2015*** Mr Sullivan raised concerns, in particular with the information on pages 4 and 5 and whether this should be in the public domain, as this could be identifiable. Mrs Donovan noted this going forward. She also requested that the report should provide more narrative on teams for the future. In addition, she requested more visibility around breaches within the timescales for investigations, in particular if the delay is out of our control ie with commissioners. ***Actioned going forward, this will be in the next quarterly report – remove from schedule*** ***227/2015 People and Culture Development Committee Assurance Report -*** Ms Nelligan informed the Board that she would be working with Mr Draycott to implement Compassionate Leadership in the Trust. She also made reference to a recent article published in the Nursing Times highlighting her work in her previous role. The Chair requested a copy of this article.	**Ms Nelligan**

	Ms Nelligan noted that work is progressing in this area with support from the Listening into Action (Lia) looking at values, involving West Midlands with our programme and it was anticipated that implementation of the training would begin in March 2016 as a pilot. The Chair and Mr Sullivan also complimented Ms Nelligan on the article published in the Nursing Times - remove from schedule	
252/2016	**Chair's Report** This month the Chair drew attention to a really important initiative launched by the Guardian newspaper and talked about a recent report from the Kings Fund on NHS resources. The Guardian have launched a fascinating initiative called "This is the NHS", which can be followed on line. It is a month long focus on the NHS and it can be shaped by sharing personal experiences. A wide range of topics have already been covered. One of yesterday's themes was "Tools for growing up: the case for improving children's mental health". The Chair stated that he hoped members would enjoy it as much as he was enjoying it. The King's Fund has just published another very important piece of work by John Appleby their Chief Economist. John points out that in 2000 the current spending on health care in the UK was 6.3% of GDP - Gross Domestic Product. The European average was 8.5%. Even though spending on the NHS increased substantially and rose to 8.8% of GDP in 2009 there was still a gap with the European average which had risen to 10.1%. The very worrying thing is that since then the gap has started to widen and looks set to widen further. By 2020 the spending is forecast to be only 6.6% in 2020/2021 – just above where it was in 2000. For the UK to match the OECD – Organisation for Economic Co-operation and Development - countries average – even excluding the USA because of their very high figures – would require spending to increase by £21billion above current spending plans. The NHS is, in the memorable words of Sir John Oldham, "*the greatest gift that the British people have ever given themselves"*. Those of us who share his view had better take note of John Appleby's warning and contribute to the debate.	

	If we want the NHS to flourish it will have to be paid for. As John says the question is increasingly not so much whether it is sustainable to spend more, after all many countries manage that, rather it is whether it is sustainable for spending to remain so low given the improvements we want and reasonably expect. ***Received***	
253/2016	**Chief Executive's Report** Mrs Donovan, Chief Executive, presented this report which provides an update on the activities undertaken since the last meeting in November 2015 and draws the Board's attention to any other issues of significance or interest. **Quality Assurance** The Trust is continuing to work on the CQC improvement plans post our inspection in September 2015. The draft report has been sent back in terms of factual accuracy and this remains confidential. The Quality Summit is planned for 9 February 2016 and we will be able to share this with our stakeholders with support from the TDA. **Business Plans** The Trust is in the process of developing a draft ***One Year Plan.*** It was noted that the guidance was only received approximately 10 days ago and the first draft is due back on 8 February 2016, with a further submission by 11 April 2015. The plan will be the focus of the Board of Directors' session in February 2016. The next stage will then be to develop a ***5 Year Plan*** by June 2016, aligned with our sustainability plan, taking into account Pan Staffordshire ***'Together we are better'***. **Appointments** The Trust has successfully appointed Suzanne Robinson, as the new Director of Finance. She joins us on 24 March 2016 from Christies Hospital. Suzanne has broad experience with provider and commissioner backgrounds. Major thanks go to Ann Harrison, Interim Director of Finance, who has done a superb job in supporting us as Interim Director of Finance. Dr Nasreen Fazal-Short has been appointed as the Clinical Director for the Adult Mental Health Inpatient Directorate. Dr Sgouros is stepping down, but continuing to work with us as a Consultant Psychiatrist and will be supporting Nasreen.	

	Rapid Assessment Interface and Discharge (RAID) The Trust has been working closely with our partners in the local health economy to prepare for the winter. The Rapid Assessment Interface and Discharge (RAID) supports both the University Hospitals of North Midlands NHS Trust (UHNM) and the community hospitals. Improvements to the service were noted in that 95% of service users are seen within one hour, in the emergency portals. The Trust has also received funding for RAID to operate a 24 hours service as a pilot until the end of March 2016. **Estates Optimisation** The Trust has started a review of our Estates provision, to see how we can best use our estate more efficiently for both our staff and service users. We will be working with our partners in order to co-locate if appropriate. There are currently 37 premises across North Staffordshire. **Dear Caroline** The 'Dear Caroline' website was launched 12 months ago to enable staff to raise concerns without fear of negative consequence. The website also continues to get positive comments with increasing staff leaving their names. **Dragon's Den** The Trust held a Dragons' Den event on 18 January 2016, via our People and Culture Development Committee. There were approximately 20 applicaticants who pitched their innovative ideas for consideration by the panel. **Growthpoint re-covered** The innovative Growthpoint team of staff and service users have come up with a new project to develop alternative skills and bring old furniture to life. The team is now looking for donations of old pieces of wooden furniture in order to transform them. For all donations contact Tracey Mace or Geoff Yardley. **Service user and Carer Council** As noted earlier Andrew Cotterill was voted in as Chair and Wendy Dutton as Vice Chair of the Service User and Carer Council. The Chief Executive was delighted to welcome them today and was looking forward to their membership of the Trust Board in February 2016. **Time to talk** The next Time to Talk day will be on Thursday, 4 February 2016. The Trust will be supporting this national event in a number of our centres and at Harplands Hospital. Further details will be available on the Trust website.	

Quality and Finance
A joint letter from Jim Mackey and Professor Sir Mike Richard has been sent to all Trusts asking them to consider quality and finances on equal footing in their planning decisions. The letter sets out how NHS Improvement and the CQC will be working together to jointly design the approach the CQC will use to assess trusts' use of resources and how the CQC can use the financial data NHS improvement holds and use the expertise of NHS improvement staff in reaching its judgements on use of resources.

Agency Costs
New guidance has been received from NHS Improvement on agency usage with restrictions imposed nationally in order to try to maximise productivity and expenditure. A report has been prepared and is on today's agenda.

£1.8Bn Sustainability Fund
Individual letters have been sent by NHS Improvement to Trusts to highlight their indicative share of the £1.8BN sustainability fund. However, it was noted that the priority trusts will be those with a deficit and therefore the Trust will not be benefiting.

Preliminary Recommendations from Lord Carter's Review into Operational Productivity
Lord Carter has sent his recommendations to the Secretary of State with re-emphasis that the NHS will be able to generate £5bn of efficiency savings by the end of parliament.

Prime Minister pledges action on Mental Health
The Prime Minister has pledged increased investment over the next five years as follows:

- Targeted support for new mothers and improved access to mental health services,
- Mental health support in Emergency Departments, 24 hours a day 365 days a year.
- New Waiting time measures for people with eating disorders
- New targets for Psychosis by 2020, seen within 2 weeks
- £400m funding for crisis resolution home treatment teams

Ms Harvey commented on the increased investment and taskforce which seems a sensible approach; however she stated this would need alignment with social services. The Chair echoed these comments.

	Ms Harvey stated that in respect of the new guidance for Agency costs, we have seen a rise in the number of staff choosing not to work substantively and who prefer to work for an agency. This helps them balance their home life and career and this needs to be taken into account. Mr Draycott noted Ms Harvey's points and commented that the Trust is working with Staff Side in respect of staff choosing agency as career choice. It is proposed to attract more staff via recruitment and he would be working with Ms Nelligan to take this forward. A recruitment drive is ongoing at present. The Chair made reference to the joint letter from Jim Mackey and its importance to have some sense of perspective, in that there was a time when Finance was king and Foundation Trust status was the priority. He further commented that we have seen the extreme effects and damage to quality of services with Stafford Hospital. However, consequently following the Francis report, some organisations, not this one, responded in a dramatic way outside of their resources available to them. What Jim Mackey's letter reminds us, it that we need to do both. The Trust is trying to be financial stable whilst providing quality, within the resources available to us and that it is the responsibility of an organisation to keep control of its money. ***Received***	
254/2016	**Individual Spotlight -** **Sandra Huczok, Receptionist, Hope Centre** **Adult Community Directorate** Sandra is a receptionist at the Hope Centre, providing a service mainly to the Access Team. Sandra always has a smile on her face and welcomes clients, staff and visitors warmly. She regularly brings in newspapers and flowers to keep the area nice and welcoming for all Since joining the team Sandra has also been responsible for new systems and ways of working ensuring the smooth running of the area. On a daily basis, Sandra lives the Trust values by valuing people as individuals, and regularly exceeds the expectations of her role.	

255/2016	**Staff Retirements** Mrs Donovan recognised staff who are retiring this month as follows, **Phil Leese (Volunteer - North Staffs Users Group)** Phil was a service user at St Edwards Hospital a number of years ago, where he first met a member of North Staffs Users Group. This later inspired him to become a member of North Staffs Users Group and a volunteer User Rep at various resource centres and bungalows across the Trust. His role as a User Rep, was to talk to service users about the services they received, raising their concerns to staff to help resolve any issues and representing service users' views at numerous meetings. Phil has also delivered Mental Health Awareness training to staff at Combined Healthcare, Social Care and the Police and supported PEAT and PLACE inspections across the Trust. Phil became a trustee for North Staffs Users Group over 8 years ago and served as Chair of Trustees for 4 years, before retiring as a Trustee. During that time, Phil was an excellent Ambassador for North Staffs Users Group and for service users' rights to receive the best Mental Health services. More recently he has been part of the Psychosis Pathway Working Group at Combined Healthcare working with staff and other service users. Phil has gained the trust and respect of service users and staff who he has worked with over the years. Hilda Johnson commented that,' ***It has been a privilege and an honour to work with Phil over the years, firstly as a volunteer herself and more recently as a staff member for North Staffs Users Group. She has learnt a lot from Phil over the years and will miss him as a member and volunteer for North Staffs Users Group.*** ***Received***	
256/2016	**Team Spotlight Award and Presentation** **Recovery Hub Team** **Substance Misuse Directorate** The directorates' number one priority for 2015 was to re-secure the two major long term contracts which were out for tender. The team put in many hours of hard work and were successful in their endeavours.	

	The Recovery Hub Team support people who have experienced substance misuse issues with the aim of rebuilding the service user's life post-substance misuse. The Recovery Hub is an extension of the wider local treatment services available to people who experience substance misuse issues. They offer a holistic approach aiming to rebuild a service user's life post substance misuse. The team, in partnership with Changes – Mental Health service, deliver services which develop employee skills and support with developing IT skills. In addition the team runs group work, peer support, coaching and mentoring among many other areas. Following a development of provision within Stafford over 150 people have linked with the service since December 2015. The team have worked tirelessly to develop a welcoming environment that is supported by a staffing team who are motivated to provide recovery support service that is truly welcomed and embedded into the One Recovery Staffordshire Treatment Model. Sue Parkes delivered the presentation to the Board with support from Johnathon McClean who gave a pictorial presentation of the Staffordshire Recovery Hub rooms. It was noted the recovery movement service is real and visible and growing in Staffordshire. Johnathon commented he was very proud to be part of the service. Helen, a service user, a mother and a wife, delivered the very moving patient story. She spoke of her personal journey, suffering with bad anxiety, depression, acrophobia and her issues with alcohol. Helen stated that she had undergone 3 medical detoxes at home, however there had been no aftercare and this is when she struggled. However, on the third detox a new system had been put in place referring her to Access and Choices. She attended weekly appointments with Kerry who tried to introduce her to the Recovery Hub. Initially, Helen was resistant and felt it was not for her however, after some persuasion she went to the Recovery Hub it turned out to be the best thing she had ever done.	

	She increased her visits and got involved with the allotment project and found this a very good way to open up and talk to people with the same problems she had. She undertook the Wellbeing programme twice and felt she always learnt something different about herself. Helen has also completed an 'A' level in 17 weeks and it is now able to co-ordinate meetings. Helen commented that it has changed the way she has deal with her addiction. Mr D Rogers thanked the team very much, especially Helen and he commented that he had visited the team over a year ago and noted the improvements they have made since. He noted some of the challenges back then, with the trust and integration with IT and records. Sue Parkes stated that this is work in progress and that IT systems are now much better and that in terms of working together things have massively improved. Mr Thornber endorsed Mr Rogers' comments and congratulated the team for retaining their contracts and their innovation and engagement with third parties. Dr Laws drew on his experience as a GP over the last 20 years, and that those people undertaking a medical detox had no recovery plan and would then struggle to get employment, so this is crucial to their treatment. Mrs Donovan commended the team and well done to Helen in particular, this had been a moving and inspirational story. She further commented that this service is a role model of what the Trust can achieve and it hallmarks the quality working actively with service users and partners. She noted the diligence of Kerry in Helen's case and that it takes hard work, the key is how we can spread this. Mr Sullivan thanked all the presenters for their great presentation and this was a very courageous thing to do. He asked the team whether there is anything the Board can help them with? Mr McClean stated that the Board could help the team by coming to visit the team, to see what we are doing and get a better understanding.	

	A member of the public, Shirley Perkins commented that she had stumbled on the Newcastle hub and had been invited in – it was a wonderful experience She stated that she could not compliment the hub enough and has in fact been back several times and particularly likes the book exchange. She further commented that she was meeting ordinary, everyday folks that are in recovery and urged for other people to visit and try to get rid of the stigma and realise the benefits the social hub provides. Sue Parkes commented that it is about recognising dual experience of both mental health and substance misuse and supporting joint working across Staffordshire. Mr Gadsby also commented that both he and Dr Adeyemo had visited the Hub in Newcastle, whereby the team took them through their journey and how it had evolved. In some respects the team were getting ahead of commissioners and that it is important that commissioners provide financial support. Sue Parkes stated that the process is still under different commissioners ie Clinical Commissioning Groups commission Mental Health and Substance Misuse is commissioned by Public Health. It was noted that Matt Russell is the lead on community resources, there is some way to go yet. The Commissioners are very clear on a holistic approach to normalise recovery. The Chair thanked the team and in particular Helen and he quoted ' *'Real change occurs when people who are not used to speaking out are heard by people not used to listening'* ***Received***	
257/2016	**Quality Committee Summary held on 19 January 2016** Mr Sullivan, Chair of the Quality Committee/Non-Executive Director, presented the summary of the Quality Committee held on 19 January 2016 for assurance purposes. The following policies were supported by the committee for ratification by the Trust Board 5.39 CCTV 1.62 Physical Assessment 5.04 Moving and Handling 5.11 Security Policy ***Ratified*** In terms of committee, a number of reports were received ;	

	• ***Incident Debrief*** - Update in relation to an incident occurred with a gentlemen from London in police custody within our services. The Board were made aware of this at the time and the committee received a further briefing and lessons learnt from that. • ***Adult Mental Health Shift Pattern changes*** – there were no concerns about the impact on quality. • ***Service User and Carer Council*** - Update on work of the Service User and Carer Council, as mentioned previously Andrew Cotterill and Wendy Dutton are here today and very welcome. • ***Director of Quality Report*** - which raises 4 important issues ; 1. *Review of Southern Health NHS Foundation Trust of which there is a paper on today's agenda* 2. *Health Ombudsman calls for patient complaints overhaul* 3. *CQC monitoring the Deprivation of Liberty Safeguards DOLs 2014/15 report* 4. *Confidential Enquiry into Maternal Deaths at the University of Oxford* The committee received for assurance ; • ***Quality Impact assessment of Cost Improvement Schemes (CIPs)****,* awaiting information regarding the next financial year 2016/17. • ***Nurse Staffing Performance Monthly Report*** – November and December 2016 – on today's agenda • ***Performance Balanced Scorecard 2015/16 and Performance Management Quality Report M9*** • ***Unannounced Commissioner visit to Access Team*** • ***The Winterbourne Medicines Programme: NHS improving Quality (IQ) Summary report and LD Directorate Update and Action Plan*** • ***An overview of Trust arrangements for the reporting***	

	and management of serious incidents in response to failings in serious incident management at Southern Health NHS Foundation Trust • ***Restraint Report Q3 and Q4 2014/15 and Q1 and Q2 2015/16*** • ***Quarterly Seclusion Report Q1 and Q2 2015/16*** • ***Q3 Update against the Infection Prevention and Control*** • ***Risk to Quality of Services – January 2016*** • ***Directorate Performance Reports*** – as expected pressures in the Children's division with waiting times and waiting lists – some issues have been addressed following the CQC visit There were a number of concerns regarding pressures in adult services noted and the Board will discuss this later today. There remains some challenges in terms of Cost Improvement Programme which is being reviewed at present, together with the balancing of resources available and what we are able to provide. Mr O'Hagan commented on the summary and the key themes breakdown on page 1 into SPAR quality domains, however he noted that the rest of the report is not presented in that way. Mr Sullivan noted that Dr Adeyemo deserves compliments for this in respect of the Director of Quality report. Mrs Donovan stated this may be beneficial going forward using the SPAR themes. Ms Harvey highlighted the Adult Mental Health Shift Pattern changes, whereby the proposal has been agreed to move away from long days to 7.5 hours as a standard shift for earlies and lates within Adult Mental Health. She noted that this has been the third time to her knowledge that shift patterns have changed. She understood the reasoning behind this, in terms of handover for staff, how tired staff can be, however some staff do prefer the longer shifts. Ms Nelligan acknowledged this, but stated that the Trust has gone through a formal consultation process and the general consensus is in favour of the change. She further added that this a national debate in respect of shorter shifts being better for patients.	

	Ms Harrison commented that the Trust has put in extra funding for safe staffing on a 3 shift basis in order to understand the costs. This does have an impact on handover and cost generally, we will not be changing the 3 shift pattern, but may look at the handover period. Mr Sullivan made an observation from his personal experience, in that there will be pro's and con's to each option and not everyone will be 100% in agreement. The changes are happening nationally, but circumstances change and the service has driven this, it has not been imposed Mr Draycott stated that this was important for staff in terms of their Performance Development Reviews (PDR), supervision, etc Ms Dutton queried were the changing shifts across the whole Trust? Mrs Donovan confirmed this was just Adult Inpatient services. Ms Dutton further queried in terms of family friendly whether there were any options to opt in or out? Ms Nelligan clarified that each Ward Manager will be flexible and balance the shifts accordingly, also accommodating the twilight shifts. The primary focus is about patient care and patient safety, this will be monitored going forward. She further clarified that there were very few people who were not in agreement and there is general support from staff. The Chair thanked members for their comments and suggested that further debate takes place regarding the Adult Wards later on today's agenda. ***Received***	
258/2016	**Safe Staffing Monthly report** Ms M Nelligan, Executive 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 (November and December 2015) in line with the National Quality Board expectation. Ms Nelligan updated the Board and made reference to the changes in the reporting format. From 1 November 2016, Ward Managers report the impact of unfilled shifts on a shift by shift basis. The themes are summarised within the report.	

	During November 2015, the Trust achieved staffing levels of 96.7% for registered staff and 91.5% for care staff on day shifts and 98.7% and 101% nights respectively. Ms Nelligan confirmed that Ward Managers are using the procedure when they need to escalate where there are no staff and they need to use bank/additional hours or agency. As the Board are aware Ward Managers are supernumerary and work within the numbers. In terms of process, staff are encouraged to do incident reports when we have not got shifts filled. There were no incidents relating to staff in November 2015. However, on 2 occasions incident forms were completed when staffing levels have fallen below those required which impact on therapeutic activities. A number of staff breaks have been shortened or not taken. Training has also been cancelled to ensure safe staffing levels. Ms Nelligan clarified that the March report to the Board will be an in-depth report which will include the staffing review, together with information about our vacancies, recruitment and bank staff. In terms of the December report, the Trust achieved staffing levels of 94.1% for registered staff and 91.5% for care staff on day shifts and 98.7% and 101% nights respectively. Again, in Section 5 of the report it sets out the themes. There were staffing gaps identified as relating to vacancies unfilled and high acuity on acute inpatient wards due to increased levels of observation. Trust-wide recruitment drive ongoing with some vacant posts filled and awaiting start dates however challenges remain in filling all posts. Again on 2 occasions patient activity was cancelled on ward 2 due to reduced staffing levels unable to be filled by bank/agency.cross-cover. A number of staff breaks have been shortened or not taken to ensure wards are safe. Mrs Donovan requested that in respect of the issues for staff not being able to take their breaks, could we monitor that and raise as an incident? Ms Nelligan to take forward. Ms Harvey agreed that would be useful to monitor. She also noted that it is the period in the year, when staff need to take their remaining annual leave for the end of the year and that this may have an impact with staffing levels over the next few months.	**Ms Nelligan** **Ms Nelligan**

	Mr Draycott gave assurance that the Trust is bridging the gaps in terms of notice periods and with recruitment. Ms Nelligan commented that the Trust intends to implement electronic rostering (E-rostering) in the near future. Ms Harrison supported this and confirmed that establishments can be calculated on an electronic rota, which will also be linked to the balanced scorecard. Ms Harvey raised some concerns with E-rostering and that she had both good and bad experiences. Ms Nelligan also gave assurance that E-rostering reviews annual leave, this is saving time as otherwise this would be done manually. Ms Harrison also gave assurance that staff would be trained with the appropriate IT skills and that the Trust has allowed for 24% cover in the budget. Mrs B Johnson queried whether annual leave dates needed to be 1 April – 31 March as a rule and whether the Trust use staff commencement dates instead to ease the pressure. Mr Draycott clarified that this was not a rule and could be considered, however the challenge is around the accrual process. Ms Harvey noted that this has been suggested previously and definitely has benefits. Further discussion may take place at JNCC. Mr Sullivan supported E-rostering and that the Trust would benefit from this. He also thanked Ms Nelligan for the informative report and appreciated the level of detail gathered to inform the Board. Mr Sullivan did question where we are with community staffing and caseloads? Ms Nelligan confirmed this is a not a national requirement. However, the Trust is having discussions with the Clinical Quality Review Meeting (CQRM). The Trust needs to set out a plan for this work and consider how this will be taken forward together with the resources required. Ms Harrison confirmed that caseloads will be visible through the Balanced Scorecard. The Chair noted that had Mrs H Johnson (NSUG) been present today, she would also have raised her concerns with staffing levels on the Adult Mental Health wards.	

	The Chair also noticed that for the first time we have had many references to the unavailability of bank staff and was this a growing issue? Mr Draycott commented that it is an issue, but this has been visible for the last 12 months. ***Received***	
259/2016	**Board Assurance Framework – Q3 Update** Mrs Wrench, Associate Director of Governance, presented the Board Assurance Framework updates as at Quarter 3 2015/16. The Board Assurance Framework (BAF) aligns the Trust strategic objectives to our quality priorities and key risks including the Board's level or risk appetite. The BAF provides an update and RAG rating for those actions due during quarter 3 and provides an update against future actions including gaps and challenges to be addressed. Mrs Wrench drew attention to the following : ***Objective 6 - Developing Academic Partnership and Education and Training Initiatives*** - this objective retains a high target risk. ***Objective 8 - Hosting a CQC inspection*** – further assurances and actions have been added to this objective ***Objective 1 - Focusing on quality and safety 1.5 Raise the service user voice across the Trust*** - (Family and Friends) this is currently rated red, Ms Nelligan commented that the Patient Experience Lead is undertaking a mapping exercise regarding feedback with friends and family questions. Also during the final quarter this will be linked with the Service User and Patient Council for further improvement. ***Objective 9 - Becoming Digital by Choice –*** Mr O'Hagan commented that the 'on target' and 'end year' status should be red not amber. ***Objective 12 - Delivering our Financial Plan - 12.4 Reducing Drugs overspend by 50%*** - Ms Harrison commented that the Trust is negotiating with the Clinical Commissioning Groups for ADHD drugs raised at Commissioning Board and we are making progress in this areas. It was noted that there are some issues with the current Shared Care Protocol. Dr Adeyemo clarified that it is critical for the patient, that whoever is delivering the care gets the correct resources to manage this and that some of our partners are struggling to work with GPs. Suffice to say	

	there will be further discussions with our GPs colleagues as this is not sustainable. The Chair summarised and noted the developments we are progressing with in particular, Mr Thornber developing partnerships, entering the digital area. He also commented that the Board Assurance Framework was a step forward in terms of governance for the Trust and he thanked Board members for the comments. ***Received***	
260/2016	**Finance Report – Month 9 (2015/16)** Ms Harrison, Interim Director of Finance, presented this report and highlighted the headline performance for the period 31 December 2015. The Month 9 financial results show a year to date retained deficit of £0.325m against a plan deficit of £0.347m, a favourable variance of £0.022m. At the end of Month 9 the detailed forecast indicates an achievement of a retained surplus of £0.727m (£1.250m surplus at adjusted financial performance level), representing breakeven against the revised plan after the agreed capital to revenue transfer. The Trust continues to target a £2.66m efficiency programme as part of the current financial plan. More detail is reported separately. The cash balance at the end of month 9 was £6.1m. Net capital expenditure to date is £0.420m, which is ahead of the planned profile to date. The year-end forecast is a charge against the Capital Resource Limit of £1.180m which is in line with Plan after the agreed revenue to capital transfer. The Continuity of service Risk Rating is reported as 2. The forecast outturn rating is 3, which is in line with the planned rating. Ms Harrison reported there are no significant changes to the Trust plan to achieve the stretched target. It was noted that there is currently a small overspend on capital expenditure. Firstly, due to to Bucknall monies of £65,000 which	

	were delayed over Christmas. The Board noted that planning had gone through unopposed. Secondly, there was a reduction in cash during the Christmas period, the Trust continued to make our credited payments, whereas other trusts took a Christmas break. This has now balanced in January 2016. ***Received***	
261/2016	**Finance and Performance Committee Assurance Report – 21 January 2016** Mr Gadsby, Non-Executive Director, presented the assurance report to the Trust Board from the Finance and Performance Committee held on 21 January 2016. The Board were assured that the Trust is in a good position and we will deliver our targets, supported by reserves. Mr Gadsby commented in respect of Bucknall planning, this has been based on a larger number of houses being built and therefore there will be an overage benefit, which the Trust will receive at an appropriate time. The Finance and Performance Committee received the following: • ***Payment by Results (PBR)*** - the Board has previously been advised that there are two proposed commissioning processes and it was noted that the episode approach (cluster month) be adopted. • ***Contract negotiations report*** – this was presented and concerns raised regarding the slow process as the Trust have to date not received a financial offer for next year despite developing a baseline which has been submitted, no agreement or feedback has been received. • ***Cost Improvement Programme*** – there is a need to continue to deliver 2015/16 schemes and to now focus on developing PIDs for 2016/17 saving schemes. A report will be submitted to February's Finance and Performance Committee in terms of projected position in 2016/17. The Chair summarised and noted the good news with Bucknall. He further noted the importance of retaining the focus on CIPS for the current year and forthcoming year.	**Ms Harrison**

	Mr O'Hagan reminded the Board of Section 106. Ms Harrison is taking this forward. ***Received***	**Ms Harrison**
262/2016	**Business Development Committee Assurance Report – 5 January 2016** Mr D Rogers, Non-Executive Director, presented the summary of the Business Development Committee meeting held on 5 January 2016. Mr D Rogers stated the summary is quite condensed compared to the amount of papers received at the committee. Historically, there have been concerns regarding business cases not moving forward and not aligned to our ambitions. However, he noted that this was one of the responsibilities of the Business Development Committee and to give assurance that these Business cases are in line with our objectives. Furthermore, he noted that the summary would include details in terms of timings and money for ease of reference. In respect of the ***One Year Plan***, the Business Development Committee received a briefing paper on the process and timelines to be adopted. This is on today's agenda. Mr Thornber noted that for the next Trust Board a more detailed version of the One Year Plan will be submitted. He further noted the key drivers to our plan are to link into Pan Staffordshire, Specialist Mental Health, patients and service users that go out of area and how we can bridge any gaps. The ***PICU Business Case*** was on today's Closed Trust Board for approval. Mr Gadsby commented that we need to update all Terms of Reference in respect of our committees. Mrs Wrench noted that this work would be reviewed for the February Trust Board. The Chair thanked Mr D Rogers and Mr Thornber and asked the Board to acknowledge that this is a new committee that it is developing. ***Received***	**Mrs Wrench**
263/2016	**Performance and Quality Management Framework Report (PQMF) Month 9** Ms Harrison, Interim Director of Finance, presented this report. The report provides the Board with a summary of performance to the end of Month 9.	

	Ms Harrison reported on two changes; • The narrative has been written by the appropriate Director; • We have split 18 weeks into the two factors both first referral and internal referral, to see the difference of performance in two areas. It was noted that RAID has slightly decreased from 91% at month 8 to 88% at month 9 in respect of all referrals seen on same day or within 24 hours, according to the narrative. ***Received***	
264/2016	**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 ***Approved***	
265/2016	**Register of documents subject to the Trust's Official Seal** Mrs Wrench, Associate Director of Governance, presented the Register of documents subject to the Trust's Official Seal during the period 1 January 2015 – 31 December 2015. ***Received***	
266/2016	**NHS Preparedness for Major Incident** Mr Thornber, Director of Strategy and Planning, presented this paper for assurance in respect of NHS England's request to review Emergency Preparedness following the Paris terrorist attacks. It was noted that there is some additional work focussing on reception at the Harplands site in respect of 'lockdown' facility. ***Received***	
267/2015	**People and Culture Development Committee Report** Mr O'Hagan, Chair of the PCD Committee/Non-Executive Director, presented this report which is a summary from the People and Culture Development Committee meeting which took place on 20 January 2016.	

	The People and Culture Development Committee held their 3rd Annual Dragon's Den event at their January meeting. Mr O'Hagan thanked all who had sat on the panel which was a combination of Executive Directors, Staff Side and Service User representatives. All pitches were creative and innovative with a number for technology or creating environments where we support people more effectively. It was also suggested that a new post may be of benefit in order to help streamline these ideas in the form of a Trust Innovation Manager. Other pitches focussed on commercial and revenue aspects ie the *Dementia Training package*. Mrs B Johnson suggested that the Trust may wish to contact Marks and Spencers,as they are Dementia Champions and there may be opportunities for the Trust to link into that. Darryl Gwinnett is currently pursuing this. Overall the day was very positive and it is proposed to feedback by the end of February 2015. The Chair thanked Mr O'Hagan and all who were involved at this event and it was great to see such good ideas. ***Received***	
268/2016	**Junior Doctors** Mr Draycott, Executive Director of Leadership and Workforce, presented this summary which provides information related to the planned Industrial Action by Junior Doctors, the action taken, the impact and potential future action. It was noted that the strike action for 26 – 28 January 2016 had been suspended in a hope that a national settlement can be reached. The next proposed date is planned for 10 February 2016. However, on 12 January 2016, 13 junior doctors participated in the industrial action. All essential services were staffed appropriately and no detrimental impact has been reported to date. Two morning clinics in the NOAP Directorate were cancelled; this affected 11 service users all of which have been contacted to arrange alternative appointments. The Chair commented that the Trust hopes this will be resolved as soon as possible. ***Received***	
269/2015	**Agency Briefing Paper**	

	Mr Draycott, Executive Director of Leadership and Workforce presented this briefing paper following the short consultation in November 2015 regarding Agency Price Caps. Monitor/TDA confirmed that all Agency Price caps will apply across all staff groups – doctors, nurses and all other clinical and non-clinical staff. The Trust is required to report on a weekly basis to the TDA when we exceed the price caps or not on a framework. The Trust has had 4 breaches, the contracts were engaged prior to the requirement being implemented; 3 breaches were not on the framework with 1 price cap breach. It was noted that the Trust has plans going forward, however there maybe some additional challenges. The Chair thanked Mr Draycott for the briefing and acknowledged that he understood the Government's desire to reduce the deficit. However at the end of the day we have to have safe staffing. ***Received***	
270/2016	**Briefing on 'The State of Health Care and Adult Social Care in England – Care Quality Commission'** Mrs Wrench, Associate Director of Governance, presented this briefing which is a summary of the CQC report on the State of Health Care and Adult Social Care in England. The report was produced in October 2015, the summary highlighted the key findings and this is very much along the lines of our Internal Peer Review and draft CQC reports. A further paper will demonstrate progress against the recommendations made in the CQC report. ***Received***	
271/2016	**Southern Healthcare Review** Ms Nelligan, Executive Director of Nursing and Quality, presented an overview of Trust arrangements for the reporting and management of serious incidents in response to failings in serious incident management in Southern Health NHS Foundation Trust. The report has been compiled in response to the publication of an investigation report commissioned by NHS England and undertaken by Mazars in respect of the management and investigation of service user deaths reported within Southern	

	Healthcare NHS Foundation Trust. The report by Mazars was commissioned after failings were identified in both care and the management of reporting and investigating unexpected deaths within Southern Healthcare following the death of Connor Sparrowhawk. The investigation makes a number of recommendations to improve the processes for reporting, investigating and reviewing unexpected deaths. This report seeks to assure the Board that the Trust has policies, procedures and review systems internally and externally for the management of unexpected death incidents; that these arrangements have been reviewed; gaps in assurance identified and recommendations made where gaps exist, with continued scrutiny with our commissioners The Trust has reviewed the number of unexpected deaths for a time period, highlighting Learning Disabilities service users and this then led us to look at our systems. Currently we have two systems running in parallel; the CHIPS system speaks to Safeguarding system which interlink. In the meantime, a manual review of those that meet the criteria for unexpected deaths, will take place for Learning Disability service users known to us. Within the time period, there has only been one individual (Learning Disabilities) who died of natural causes. A further report will be submitted to Quality Committee for assurance. ***Received***	
272/2016	**Any other business** Mr Grant Williams, member of the public raised his concerns regarding the delay for the work to the Midway car park in Newcastle-under-lyme. Mrs B Johnson commented that she had spoken with Mrs H Johnson who confirmed that work would be starting shortly. However this is in the control of the Council and not the Trust. Annie Roberts also clarified that work had started on level 5 of the Midway car park however this is still not addressing the concerns regarding higher car park levels. . Mr Williams appreciated the feedback and thanked Mr Jarrold, the Chair, for all his hard work and support during his time with the Trust and everything he had done for the Trust.	

	The Chair thanked Mr Williams for his comments. The Chair pointed out that the Board had been able to spend the majority of the time on items in relation to the individual and Team spotlights, the presentation, staffing and quality. This was only possible because the finance and performance position was sound. If finance and performance were not good the Board would not be able to spend as much time on services and quality	
273/2016	**Date and time of next meeting** The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday, 25 February 2016 at 10:00am, in the Boardroom, Lawton House, Trust HQ.	
274/2016	*** 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
26-Nov-15	218/2015	**Safe Staffing Monthly report -** The Board will be aware of a staffing review in line with national quality expectations, the dates have been set before Christmas for Wards 1, 2, 3, Rehab and CAMHS. The findings of the review will be reported to the Board in January 2016, with a view to address the other wards, Learning Disabilities and Older people going forward.	Ms Nelligan	31-Mar-16	***Deferred- Ms Nelligan confirmed that a six month review is underway but not yet complete, this will be presented to the Trust Board in March 2016.***
28-Jan-16	258/2016	**Safe Staffing Monthly Report** - Ms Nelligan clarified that the March report to the Board will be an indepth report which will include the staffing review, together with information about our vacancies, recruitment and bank staff.	Ms Nelligan	31-Mar-16	
28-Jan-16	258/2016	**Safe Staffing Monthly Report -** Mrs Donovan requested that in respect of the issues for staff not being able to take their breaks, could we monitor that and raise as an incident. Ms Nelligan to take forward.	Ms Nelligan	31-Mar-16	
28-Jan-16	261/2016	**Finance and Performance Assurance Report - 21 January 2016 - Cost Improvement Programme** – there is a need to continue to deliver 2015/16 schemes and to now focus on developing PIDs for 2016/17 saving schemes. A report will be submitted to February's Finance and Performance Committee in terms of projected position in 2016/17. Mr O'Hagan reminded the Board of Section 106. Ms Harrison is taking this forward.	Ms Harrison	18-Feb-16	Complete
28-Jan-16	262/2016	**Business Development Committee Assurance Report - 5 January 2016** - Mr Gadsby commented that we need to update all Terms of Reference in respect of our committees. Mrs Wrench noted that this work would be reviewed for the February Trust Board.	Mrs Wrench	25-Feb-16	

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: Trust Board

Date of Meeting:	Thursday 25 February 2016
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 16 February 2016 Caroline.donovan@northstaffs.nhs.uk
Committee Approval/Received prior to Trust Board:	• Quality Committee • Finance and Performance Committee • Audit Committee • People and Culture Development Committee • Charitable Funds Committee • Business Development and Investment Committee
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 & T Strategy • Governance Strategy • Innovation Strategy • Workforce Strategy • Financial Strategy • Estates Strategy
Relationship with Annual Objectives:	**n/a**
Risk / Legal Implications:	**n/a**
Resource Implications:	**n/a**
Equality and Diversity Implications:	**n/a**
Relationship with the Board Assurance Framework	1. Focusing on quality and safety 2. Consistently meeting standards 3. Protecting our core services 4. Growing our specialised services 5. Innovating in the delivery of care 6. Developing academic partnerships and education and training initiatives 7. Being an employer of choice 8. Hosting a successful CQC inspection 9. Becoming digital by choice 10. Reviewing and rationalising our estate 11. Devolving accountability through local decision making that is clinically led assuring governance arrangements. 12. Delivering our financial plan
Recommendations:	**To receive this report for information**

North Staffordshire Combined Healthcare NHS Trust

Chief Executive's Report to the Board of Directors
25 February 2016

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

LOCAL UPDATE

1. QUALITY ASSURANCE

The CQC Quality Summit scheduled for the 9th February unfortunately needed to be postponed for the second time. The reason was due to a delay in the Trust receiving the reports following the factual accuracy process. The Trust is working closely with the CQC and we are hoping the report will be finalised very soon. The Quality Summit is likely to be held in March with publication of the reports. In the meantime, the Trust is continuing to work on our action plans to progress continual improvements.

2. APPOINTMENTS

I am pleased to share that Natalie Larvin has been appointed as the Head of Directorate for our Adult Mental Health Inpatient Directorate and will join us from Cheshire and Wirral Partnership NHS Foundation Trust. She is a senior clinician with extensive management experience and will be a great asset to the Directorate.

We are delighted to have appointed Dr Mark Williams as Clinical Director for Primary Care at the Trust. Mark has great experience as a local GP and will support our vision to work more closely in support of Primary Care

The recruitment process is now well underway to replace the Chairman, Ken Jarrold CBE, with interviews scheduled for the end of February. The Stakeholder part of this process was held on 17th February which involved service users and carers, partners, staff and Board members.

3. PRIDE

One of the Listening into Action programmes in the current wave is to support equality and inclusion. I'm delighted to share that the Trust will be screening a special film to raise Lesbian, Gay, Bisexual and Trans (LGBT) awareness.

The Trust has joined with UNISON to host a screening of the BAFTA-award winning 2014 film Pride (certificate 15) on Wednesday 24 February at 7pm at the Potteries Museum and Art Gallery, Bethesda Street, Hanley, ST1 3DW.

The film night forms part of the Trust's diversity and inclusion programme and is being held during LGBT History Month, which works to challenge homophobia, biphobia and transphobia.

Pride is based on the true story of the formation of the Lesbians and Gays Support the Miners campaign and the support it provided to the families of a Welsh mining village affected by the Miners' Strike of 1984-5.

The film features a host of British acting talent, including Bill Nighy, Imelda Staunton, Paddy Considine, Dominic West and Andrew Scott and won a BAFTA and British Independent Film Awards, among other accolades.

Tickets are just £2 and are available via email at diversity@northstaffs.nhs.uk or by phone on 0300 123 1535 (ext 2814).

4. MEMORY SERVICES

The City Community Mental Health Team (CMHT) and Memory Service are due to relocate from their current premises in Abbots House to Marrow House, Forrister Street, Stoke-on-Trent, ST3 1SQ on Monday 29 February.

This is part of working more closely with Social Care colleagues and improving the facilities for patients and staff.

The telephone number for both the City CMHT and Memory Service will change as of Monday 29 February to 0300 123 0893

5. DIGITAL BY CHOICE

Clinical leads from all Trust Directorates and project support staff have been supporting the design of a test version of the new Electronic Patient Record (EPR). Staff are currently trialling with the test system in order to better understand how it can best meet the needs of the Trust to improve services for service users and carers.

This will continue over the next few months and from this we will adjust and redesign processes to ensure the system meets our needs before we go live with the EPR early in 2017.

6. FLU

We continue to focus on offering the flu vaccine across the Trust. We continue to hold drop-in flu clinics as part of our flu immunisation programme for 2015/16.

Flu is a viral illness that has the potential to cause very serious complications; even death. Many patients and service users will be vulnerable in terms of their ability to combat infection and staff are busy getting the vaccine to protect themselves, their patients/service users, family and colleagues from the virus.

A series of clinics have been held over the past few months to enable staff to receive the jab, while its team of Flu Champions have been offering a 'roving' service administering the vaccine to clinical areas based on the Harplands site and spreading the message to staff to get the jab and become flu fighters.

7. TIME TO TALK

One in four of us experience mental ill health every year, yet many are afraid to talk about how they are feeling due to the stigma that still exists in society surrounding mental health.

Time to Talk Day on February 4 sought to break the silence by encouraging as many of us as possible to take time out to have a conversation with friends, family and colleagues about mental health.

Teams across the Trust showed their support for Time to Talk Day by displaying bunting and posters in wards 1 and 5 and other areas, while staff took time out to talk about mental health with service users, carers and colleagues.

The day forms part of the work of Time to Change, an anti-stigma campaign run by the charities Mind and Rethink Mental Illness which the Trust is supporting

NATIONAL UPDATE

8. LORD CARTER REPORT

Lord Carter was asked in the summer of 2014 by the health secretary to assess what efficiency improvements could be generated in hospitals across England. The review looked at productivity and efficiency in English non-specialist acute hospitals which account for half the total health budget. The conclusion was that there is significant variation across the main resource areas with a £5bn efficiency opportunity by improving workforce costs, medicines optimisation, estates and procurement management.

At the beginning of February, Lord Carter published his final report into hospital efficiency. Although not mental health focussed, there are areas for improvement indicated for the Trust which will be integrated into our 5 year plans.

9. HEALTH EDUCATION ENGLAND (HEE) CONSULTATION

HEE has launched a consultation seeking views on the scope and design of a new nursing support role to work alongside care assistants and graduate registered nurses to deliver hands on care, focusing on ensuring patients continue to get the compassionate care they deserve.

The Shape of Caring review, led by Lord Willis of Knaresborough (published in March 2015), recommended developing this role because of an NHS and social care need. The aim is to

create a new type of care worker with a higher skill set to assist, support and complement the care given by registered nurses.

Over the next few weeks, HEE is looking for help in answering some important questions on key aspects of this role including the title and whether the new role should be regulated – I will be sharing my views with HEE on this important issue and am encouraging colleagues and networks to do the same.

The consultation document is now available on the HEE website: https://hee.nhs.uk/our-work/developing-our-workforce/nursing/have-your-say-new-role-nursing

The consultation will close at 12 midnight on Friday 11 March 2016 and I will be encouraging people to respond to the consultation

10. CQC CONSULTATION ON 2016-21 STRATEGY

The CQC has launched the final stage of consultation on its 2016-21 strategy. The consultation period will run for seven weeks, closing on 14 March 2016.

This follows ten months of engagement on how the CQC intends to develop its regulatory model, to ensure that it is flexible, responsive and efficient. This started with the publication of *Shaping the Future* in March 2015, followed by *Building on Strong Foundations* published last October.

Respond to the consultation via www.cqc.org.uk/2016strategyconsultation
or email strategyconsultation@cqc.org.uk by 14 March 2016. Again this is something I would a encourage people to engage in

11. THE FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH

The Five Year Forward View for Mental Health was published on 15th February 2016. The report was produced by a mental health taskforce established by NHS England, led by Paul Farmer, Chief Executive, MIND.

The report provides a comprehensive account of the challenges facing the provision of mental healthcare in the NHS and sets out a strategy for change based on the key themes that emerged during the Taskforce's engagement work: prevention, access, integration, quality and a positive experience of care. Three are 58 recommendations designed to:

- align the priorities and activities of six NHS arm's length bodies to achieve parity of esteem between mental and physical health for children, young people, adults and older people
- solicit wider involvement across other national and local agencies to improve the social care, housing and
- employment offer for people with mental health problems
- focus on tackling mental health inequalities a t local and national level experienced by people living in poverty, who are unemployed and who are already marginalised.

The Executive summary is followed by thematic chapters containing the context and basis for the 58 recommendations. Annexes contain recommended principles for payment approaches for mental health set out the full recommendations organised by each national body responsible for delivery.

Priority actions for the NHS by 2020/21 include:-

- *A 7-day NHS* providing the right care, a t right time, a t right quality including crisis care seven days a week, out of area placements reduced and eliminated as quickly as possible, liaison psychiatry, treatment times for first episode psychosis within two weeks of referral, expanding community based services for those with severe mental health problems, reducing suicide by 10 percent.
- *Integrated mental and physical health* approach including expanding access to perinatal mental health, meeting the physical health needs of people living with severe mental health problems and increasing access to psychological therapies
- *Promoting good mental health and preventing poor mental health*, including expanding access for more children and young people to access high-quality mental health care when they need it, supporting more people to find or stay in work with access to psychological therapies, a focus on creating mental healthy communities including housing and support for those in the criminal justice system, and finally building a better future with research and a data revolution.

We welcome the report which provides higher priority for investment in mental health. We will be working through the detail in partnership with our Commissioners and expect to see increased investment in Mental Health services for our local committees.

Caroline Donovan
Chief Executive Thursday 25 February 2016

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: **Open Trust Board**

Date of Meeting:	25 February 2016
Title of Report:	Summary of the Quality Committee meeting held on the 16 February 2016
Presented by:	Mr Patrick Sullivan, Chair of Quality Committee
Author of Report: Name: Date: Email:	Sandra Storey, Associate Director of Medical and Clinical Effectiveness 17 February 2016 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 16 February 2016. 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 as highlighted in the report

Key points from the Quality Committee meeting held on 16 February 2016 for the Trust Board meeting on the 25 February 2016

1. Introduction

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

2. Director of Quality Report

The committee received the Director of Quality Report with notable items:

- **"Do not Resuscitate" landmark ruling on DNAR notices and consultation in patients lacking capacity**
  The decision is likely to have wide ramifications as it clarifies that the rules requiring consultation apply to patients who lack capacity. The Trust has established palliative care guidelines and resuscitation policy that makes reference to the Mental Capacity Act and its key principles. However, the newly established Mental Health Law Governance Group will review this and ensure trust wide awareness and compliance.
- **Confidentiality – changing GMC guidance**
  The GMC guidance on confidentiality was published in 2009 and they are now consulting on a revised version which closes mid-February 2016. The committee will receive further briefings following developments in this area.

3. Policy Review

The recommendations were supported by the committee for ratification of policies by the Trust Board, as follows:

- 1.42 NICE and National Confidential Enquiries – for 12 months
- 1.52a & 1.52b Research Policy and Strategy – until 30 June 2016
- 1.71 Multi Agency Public Protection Arrangements (MAPPA) – until 30 June 2016

4. Nurse Staffing Performance monthly report – January 2016

The committee received the nursing staff performance on a shift by shift basis for the month of January 2016. During this period the Trust achieved staffing levels of 93.5% for registered staff and 92.1% for care staff on day shifts and 103.2% and 99.6% respectively on nights. The committee were assured that safety was maintained by the use of additional hours, cross cover and ward manager supporting clinical duties. The nursing team are working hard to deliver safe staffing on the wards which is a challenge as a result of vacancies. A recurrent programme is in place and Matrons are supporting ward managers with recruitment.

5. Performance Balance Scorecard 2015/16 & Performance and Management Quality Report M10

The committee reviewed the scorecard and noted that this continued to be developing well with on-going input from the Directorates. Members considered the key performance indicators and noted that there were 4 quality metrics rated as red and 5 rated as amber. Detailed discussion with

information and assurance given on action being taken to improve performance where possible, particularly in respect to statutory and mandatory training, personal review, referral time to treatment and complaint response times

6. Safeguarding report Q3 2015/16

The Committee received a report detailing current case reviews, themes and trends in safeguarding, and pertinent issues from the Safeguarding Team.

7. Adult Safeguarding Self-Assessment

The committee received the completed adult self-assessment and assurance framework for in place for healthcare providers. The purpose of the framework is to help providers meet safeguarding adult responsibilities and achieve improved outcomes in preventing harm occurring and effective, patient centred responses where harm has occurred.

Members discussed the completed assessment and respective scoring. The managing allegations process and internal incident review process were highlighted as good practice. It was noted that there is work underway to roll out revised training following a change in the law in this area. Quarterly safeguarding meetings will also be rearranged to bi-monthly meetings to raise the profile of safeguarding.

8. Annual reports for Adult and Children Safeguarding 2015

The committee received these reports for information which provided detail of the referral rates, training compliance and the key priorities and achievements for the year.

9. Eliminating Mixed Sex Accommodation Q3 progress against 2015/16 action plan

The committee noted the progress against the action plan and the areas rated as on-going or completed. It was noted that the CQC had identified a potential breach which related to one particular patient and their preferred choice of accommodation. A reassessment of the ward configuration is currently underway to address any on-going issues.

10. Q2 2015/16 submission paper for CQUIN goal 4: embedding a safety culture

The Committee received information on work completed during Q2 2015/16, detailing activities undertaken and progress made against the key quarter milestones. The Chair asked for the team to be commended for their work in this regard.

11. Section 136 North Locality 2014/15 report and update on action plan The

The 2014/15 Section 136 North Locality report provides annual data on the use of Section 136 in North Staffordshire. It showed a decreasing use of Section 136 and significant reductions in the use of Police Custody as a place of safety. The committee reviewed the locality meeting action plan which showed the key areas the group is working on. The group is made up of stakeholders from a number of external organisations and is focused on monitoring and developing practice and respective services related to the use of Section 136. The Chair also commended the work undertaken around Section 136, noting that there had been significant developments.

12. Review of deaths of people with a learning disability

Following the publication of the Independent Review of deaths of people with a learning disability or mental health problem in contact with Southern Health NHS FT, the Trust has undertaken a review of all of the people who have died since 2014. The committee received a report giving assurance that all unexpected deaths (which the HM Coroner concluded as natural causes) are reported and investigated appropriately.

13. Directorate Performance Reports

Members discussed in detail the risks that were identified and assurances received, particularly in relation to meeting cost improvement targets, improving access and waiting times, and ensuring sufficient capacity to manage increased activity. Improving compliance with statutory and mandatory training, timely completing of personal reviews, undertaking clinical supervision and risk management training, and improving sickness absence were other areas of note.

14. Risk to Quality of Services - February 2016

Committee members considered the report for quality risks, particularly those scoring 12, which have been reported to the committee previously. Members discussed the risk treatment plans in place and sought assurance about the actions being taken. The information also reflects and informs the feedback from and to the Risk Review Group. Of note was the lack of local Psychiatric Intensive Care Unit (PICU) availability and the progress with the business case to address this.

15. Quality Account 2015/16 Project Plan

The committee received the project plan setting out the key milestones to ensure its publication by the 30 June 2016. The Associate Director of Governance will lead on the development of the plan supported by the Associate Director of MACE. Given the timing of the publication, the committee as previous will have delegated authority from the Trust Board to approve the final version, unless the Trust Board decides otherwise.

16. CQC Inspection Update

The committee received an update on the progress and position following the CQC comprehensive inspection in September 2015.

17. CQC Annual Reports 2014/15 – Monitoring of the Mental Health Act and Monitoring of the Deprivation of Liberty Safeguards

The committee received summary reports on the key findings from the CQC Annual Reports. The summaries provided information and assurance about how the Trust is meeting its regulatory requirements as well as continuous cycle of development in respect to policy and training. The newly established Mental Health Law Governance Group will oversee this work.

18. Mental Health Law Governance Group – Terms of Reference

The committee received and approved the proposed terms of reference for the newly established Mental Health Law Governance Group. This brings together the Mental Capacity Act Group and

Mental Health Law Group. In recognition of this important area of work and to raise its profile, the group with be chaired by the Trust's Medical Director.

19. Adult Community Mental Health Survey Action Plan

The committee received the action plan with comparator scores from 2014 to 2015, and the actions being taken to improve the position.

20. National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (NCISH)

The Trust has been invited to participate in the development of a national scorecard by the University of Manchester and the Centre for Suicide Prevention. The scorecard is currently being developed with the aim of helping Trusts to understand their data in order to improve services delivered.

21. Consent Audit – RSM Tenon – Phase One

The committee received the findings from the first phase of their audit of the consent process. This has helped to inform work already on-going in this area and is part of the work plan of the Mental Health Law Governance Group.

22. 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**

23. Effectiveness Review

Committee members considered its effectiveness in respect to meeting its Terms of Reference and reporting to the Trust Board.

Members discussed quality priorities and how this should inform the agenda going forward. It was felt that the business of the committee should focus more on the quality plan and monitoring quality metrics that underpin the quality structure. Members also discussed revising reporting arrangements and rationalising reports to ensure that they are much more succinct in terms of drawing out the key issues for the committee. It was agreed that the four domain reports would be brought together into a single report that provides a summary output of the work of its groups by exception. This is a means by which the committee is alerted to any emerging issues, learning and action being taken and future work plans of the reporting groups.

It was proposed that the committee should move to a bi-monthly cycle of business meetings and that this would improve its effectiveness in terms of quality of reports and completion of actions. There will be a move to circulating more information electronically, with the introduction of virtual discussions during the intervening months where appropriate.

The outputs of this discussion will help inform the wider review being undertaken of the committees and the Trust Board.

24. Next meeting: 15 March 2016

On behalf of the Committee Chair, Mr Patrick Sullivan, Non-Executive Director
Sandra Storey Associate Director of Medical and Clinical Effectiveness, 17 February 2016

Enclosure 6

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: **Trust Board**

Date of Meeting:	25 February 2016
Title of Report:	Nurse Staffing Monthly Report – January 2016
Presented by:	Maria Nelligan Executive Director of Nursing & Quality
Author of Report:	Carol Sylvester Deputy Director of Nursing
Purpose / Intent of Report:	• For Information / Assurance
Management Oversight prior to Committee	• Quality Committee
Executive Summary:	The attached reports provides summaries of the ward daily staffing levels during the month of January 2016
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:	As noted below under the Board Assurance Framework
Risk / Legal Implications:	Implications re gaps or unnecessary duplications in business
Resource Implications:	Will reduce the number of meetings
Equality & Diversity:	N/A
Relationship with the Board Assurance Framework	1. Focusing on quality and safety 2. Consistently meeting standards
Recommendations:	For the Trust Board to discuss the Trust's performance and any areas of issue / concern

Enc. 6

North Staffordshire Combined Healthcare NHS
NHS Trust

Report subject:	**Ward Daily Staffing Levels January 2016**
Report to:	**Quality Committee**
Action required:	**Information and Assurance**
Date of meeting:	**Tuesday 16th February 2016**
Prepared by:	**Carol Sylvester, Deputy Director of Nursing**
Presented by:	**Maria Nelligan, Executive Director of Nursing and Quality**

1 Summary

This report details the ward daily staffing levels during the month of January 2016 following submission of the planned and actual hours of both Registered Nurses (RN) and Health Care Support workers (Care) to Unify (Appendix 1).

The themes arising within this report reflect previous reporting and are reflected following the table below.

2 Background

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

In addition to the monthly reporting requirements, the Executive Director and Deputy Director of Nursing are finalising a six monthly comprehensive review of ward staffing levels in adult inpatient and children`s tier 4 and children`s respite services during December 2015 and February 2016 in line with NQB requirements.

3 Trust Performance

During January the Trust achieved staffing levels of 93.5% for registered staff and 92.1%for care staff on day shifts and 103.2% and 99.6% nights respectively. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover, Ward Manager supporting clinical duties. Incident forms completed where shortfalls remained despite escalation to temporary staffing backfill and unavailability of cross cover.

Ward	Performance (% planned vs actual)						Ward Manager Summary	Bed Occupancy % (including home leave)
	Day %		Total %	Night %		Total %		
	R/N	Care		R/N	Care			
Ward 1	79.0	99.4	**89.2**	153.2	113.5	**133.3**	Additional RN planned to meet high acuity predominantly due to level 3 observation level. Unable to fill all planned day shifts due to bank unavailability and vacancies No patient activity cancelled. 2 staff supervision sessions and 2 statutory and mandatory training sessions cancelled. Total of 6 staff breaks not taken, 3 shifts staff moved to cross cover, 2 occasions MDT cover required, 3 occasions with staff working additional, unplanned hours and 6 occasions of HCSW covering RN planned shifts	107 ↑
Ward 2	89.5	94.0	**91.7**	103.2	82.6	**92.9**	Planned RN and HCSW staffing levels not consistently met due to vacancies and unavailability of bank staff. No patient activities were cancelled in January, 16 staff breaks not taken, short term cross cover provided on 16 occasions, 2 supervision sessions were cancelled and 24 planned RN shifts were covered by HCSW	107 ↑
Ward 3	97.7	100.1	**98.8**	109.6	94.6	**102.1**	Planned RN staffing levels not consistently met due to current vacancy rate and unavailability of bank staff. No patient activities were cancelled. 28 staff breaks not taken, cross cover provided on 5 occasions from 1 hour to full shift. MDT cover required on 2 occasions, unplanned additional hours worked on 2 occasions and 2 planned RN shifts covered by HCSW	104 ↑
Ward 4	92.0	95.3	**93.6**	83.8	116.9	**100.3**	Under filled planned day HCSW and RN shifts covered by use of bank and agency where available however, limited availability continues. Night shifts planned for 2 RN, under fill rate due to unavailability of RN bank. No patient activities cancelled, no staff breaks lost, cross cover to other wards provided on 3 occasions, MDT cover required on 3 occasions, planned RN shifts covered by HCSW on 7 occasions	95 ↓
Ward 5	107	96.2	**101.6**	102.6	119.8	**111.2**	Actual fill rates higher than planned due to complex patient requiring high levels of intervention and observation with additional support required on night shifts Five patient activities were cancelled, 2 staff breaks not taken, cross cover required on 1 occasion, RN shifts covered on 4 occasions by HCSW	88 ↓

Ward	Performance (% planned vs actual)						Ward Manager Summary	Bed Occupancy % (including home leave)
	Day %		Total %	Night %		Total %		
	R/N	Care		R/N	Care			
Ward 6	100.7	99.5	**99.7**	103.5	88.5	**96**	Shortfall on night HCSW shifts reported no direct impact on patient care with cross cover from wards arranged as needed. Shortfall due to short term sickness and increased observation. Four patient activities cancelled due to short notice increase in activity but rearranged. Eight staff breaks not taken and 3 breaks shortened , MDT cover required on 1 occasion	99 ↔
Ward 7	86.1	90.9	**88.0**	100	100	**100**	Planned day RN and HCSW levels not consistently met due to short term sickness and lack of bank availability. WM provided additional cover as required to maintain safe staffing levels. Increase in harm falls but no indication due to under filled shifts. RCA underway	95 ↓
A&T	81.6	94.9	**88.2**	100	100	**100**	Planned RN day shifts not filled due to vacancies, short term sickness and additionally increase in observation level of new admission. Cross cover ongoing between Telford and A&T overseen by Unit Manager. No cancelled activities, no cancelled breaks	80 ↔
Telford	90.3	86.8	**88.0**	100	91.1	**95.5**	Planned RN day shift unmet due to vacancy (1 x Band 5) and unavailability of bank/agency. Under fill of HCSW due to short term sickness and unavailable temporary staffing cover. Cross cover arrangements for A&T and Telford detailed above. No cancelled activities, no cancelled breaks	75 ↑
EMC	105	66.0	**85.5**	102.1	102.2	**102.2**	Under filled planned day HCSW shifts covered by use of additional RN hours however, a high number of shifts remained unfilled. Additional cover provided by ward manager and also IOU staff when no IOU admissions. One patient activity cancelled, 4 staff breaks cancelled.	82 ↑
Darwin	100	97.1	**98.5**	100	100	**100**	Planned shifts have been met with the exception of short term HCSW sickness. No cancelled activities, no cancelled breaks	87 ↓

Ward	Performance (% planned vs actual)						Ward Manager Summary	Bed Occupancy % (including home leave)
	Day %		Total %	Night %		Total %		
	R/N	Care		R/N	Care			
Summ View	95.6	85.6	**90.6**	99.9	98.6	**99.2**	Under-fill of planned HCSW day staff due to vacancy and unavailability of additional hours/bank. No reported cancelled patient activity, breaks, training	86 ↑
Flor House	109.6	65.4	**87.5**	100	100	**100**	HCSW day shift part filled by use of RN additional hours. Shortfall of HCSW due to long term sickness and maternity leave. Recruitment in progress. Total of 10 staff breaks not taken	75 ↓
Dragon Square	100	95.9	**97.9**	95.2	95.2	**95.2**	Planned closure of unit for respite care for one week in January. All stat and mand training undertaken during this week including bespoke MAPA course based on patient group.	59 ↑
TOTAL	93.53	92.1	**92.7**	103.2	99.6	**95.5**		

4 Issues leading to Staffing Gaps

The Trust continues to face challenges in successfully recruiting to vacant Registered Nursing positions across the Trust but specifically so within the Adult Acute Inpatient wards.

A rolling programme of recruitment is on-going however, applications remain low with a number of applicants shortlisted subsequently not interviewed due to non-attendance.

Additionally, a number of applicants were unsuccessful at interview.

A review of recruitment to vacant positions is underway with planning for strengthening of advertisement via media, building additional registered bank capacity and streamlining recruitment processes to reduce length of time from interview to commencement of employment.

Non–registered recruitment has proved to be successful with the majority of vacant posts filled and awaiting commencement of employment.

5 Impact on Patient Safety

A total of 14 incident forms have been submitted during January detailing insufficient staffing on the wards.

Twelve relate to inpatient services and cover adult acute inpatient, NOAP, Substance Misuse and Learning Disability. The remaining incident forms relate to community services.

All incidents were recorded as no harm incidents and relate to insufficient staff to meet activity on a shift due to sickness, increase in acuity and inability to cover with temporary staffing.

Two incident forms relate to vacant posts in inpatient wards that, despite a programme of recruitment, remain unfilled.

6 Impact on Patient Experience

A total of 10 patient activities have been cancelled in January with 2 rearranged.
There have been no reports of local or formal concerns/complaints raised by service users at this time.

7 Impact on Staff Experience

A total of 74 staff breaks have not been taken in January due to unfilled shifts coupled with high levels of acuity and activity. Cross cover arrangements have taken place on 23 occasions ranging from a meal break cover to full shift cover. MDT cover has been required on 8 occasions.

Pre-arranged supervision sessions have been cancelled on 4 occasions and training on 2 occasions.

Unplanned hours have been worked on 7 occasions ranging from short term cover to complete tasks to full shift cover when unable to cover unplanned increase in activity.

8 Summary

The Nursing Team are working hard to deliver safe staffing on the wards which is a challenge as a result of vacancies. A recurrent programme is in place and Matrons are supporting Ward Managers with recruitment.

Appendix 1
Unify return January 2016

MONTH: January 2016

Inpatient area	Day				Night				Performance (planned vs actual)					
	Registered nurses		Care staff		Registered nurses		Care staff		Registered nurses	Care staff	Registered Day	Care day	Registered Night	Care Night
	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	%	%				
Ward 1	1736.80	1373.30	1775.30	1765.30	323.33	495.61	1318.12	1496.18	91	105	79.07%	99.44%	153.28%	113.51%
Ward 2	1395.00	1246.50	1395.00	1311.50	332.32	343.03	996.65	823.71	92	89	89.35%	94.01%	103.22%	82.65%
Ward 3	1230.00	1205.00	1655.00	1658.00	332.32	364.46	1143.78	1082.59	100	98	97.97%	100.18%	109.67%	94.65%
Ward 4	1395.00	1284.00	1627.50	1551.00	581.25	487.43	609.33	712.38	90	101	92.04%	95.30%	83.86%	116.91%
Ward 5	930.00	951.00	1395.00	1342.00	290.47	298.03	581.57	697.24	102	103	102.26%	96.20%	102.60%	119.89%
Ward 6	945.00	952.50	1679.70	1672.50	262.36	271.73	984.13	871.56	101	96	100.79%	99.57%	103.57%	88.56%
Ward 7	930.00	801.30	1395.00	1269.00	290.47	290.47	581.25	581.25	89	94	86.16%	90.97%	100.00%	100.00%
A&T	697.50	569.30	1550.00	1471.10	129.05	129.05	1204.10	1204.10	84	97	81.62%	94.91%	100.00%	100.00%
Telford	697.50	630.00	1337.50	1161.30	204.60	204.60	967.60	881.80	93	89	90.32%	86.83%	100.00%	91.13%
Edward Myers	930.00	976.50	930.00	614.25	290.47	296.77	581.20	594.25	104	80	105.00%	66.05%	102.17%	102.25%
Darwin Centre	1195.00	1195.00	942.00	915.50	331.70	331.70	666.50	666.50	100	98	100.00%	97.19%	100.00%	100.00%
Summers View	930.00	889.55	930.00	796.60	323.33	323.03	667.80	659.06	97	91	95.65%	85.66%	99.91%	98.69%
Florence House	465.00	510.00	930.00	608.50	323.33	323.33	323.22	323.33	106	74	109.68%	65.43%	100.00%	100.03%
Dragon Square	315.00	316.00	660.00	633.00	194.25	185.00	194.25	185.00	98	96	100.32%	95.91%	95.24%	95.24%
TOTALS	**13791.80**	**12899.95**	**18202.00**	**16769.55**	**4209.25**	**4344.24**	**10819.50**	**10778.95**	**1348.20**	**1311.42**	93.53%	92.13%	103.21%	99.63%

North Staffordshire Combined Healthcare NHS
NHS Trust

Enclosure 7

REPORT TO: TRUST BOARD

Date of Meeting:	25 February 2016
Title of Report:	NHS Trust Development Authority (NTDA) Monthly Self Certifications.
Presented by:	Ann Harrison, Interim Director of Finance
Author of Report:	Glen Sargeant, Head of Performance and Information
Purpose / Intent of Report:	• For Information •
Management Oversight prior to Committee	• Executive Meeting •
Executive Summary:	This paper confirms that the monthly NTDA self-certification documents are no longer required. Trusts have received confirmation from the NTDA that since the Self Certification process has not been updated in accordance with the Accountability Framework and is no longer in line with Monitor reporting requirements, it have decided to stop this collection with immediate effect until further notice. The NTDA thanks all who have taken the time to submit the collection all these months. It will keep Trusts informed as and when new reporting requirements evolve.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Clinical Strategy • Governance Strategy • Financial Strategy 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 identified
Resource Implications:	None identified
Equality & Diversity:	None identified
Relationship with the Board Assurance Framework	Supports the wider framework
Recommendations:	Board members are asked to : • Note that the monthly NTDA self-certification documents are no longer required.

Enc. 8

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: **Trust Board**

Date of Meeting:	25 February 2016
Title of Report:	Summary of Board to Team visits undertaken in Q2 and 3 - 2015/16
Presented by:	Maria Nelligan, Executive Director of Nursing and Quality
Author of Report:	Carol Sylvester, Deputy Director of Nursing
Purpose / Intent of Report:	• For Decision / Approval • Performance monitoring • **For Information**
Management Oversight prior to Committee	• Executive Meeting • Senior Leadership Team Meeting • Quality Committee
Executive Summary:	Several High profile inquiries into serious failings at NHS Hospitals have reported Boards being insufficiently concerned about patient safety and their understanding of patient and staff experience. Board members did not engage with service users or staff on the frontline, consequently Board members were not known outside of the Boardroom or Committee circuit. A recommendation of the Francis Inquiry into Mid Staffordshire Hospital NHS Trust was that "the Trusts make Board members visibility across the organisation a priority". The Trust Chairman made it a requirement for all Board members to carry out planned visits across the trust frontline clinical areas. This initiative strengthens the Boards visibility and ability to see and hear about the everyday experiences of service users, carers and staff. The report provides a summary of Board to Team visits undertaken in Q2 and 3 2015/16. The report provides summary detail of the key positives, challenges raised and actions agreed. A number of challenges are identified however, there are many positive messages and themes detailed within the visit feedback.

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:	
Risk / Legal Implications:	
Resource Implications:	
Equality & Diversity:	
Relationship with the Board Assurance Framework	1. Focusing on quality and safety 2. Consistently meeting standards 3. Protecting our core services 4. Growing our specialised services 5. Innovating in the delivery of care 6. Developing academic partnerships and education and training initiatives 7. Being an employer of choice 8. Hosting a successful CQC inspection 9. Becoming digital by choice 10. Reviewing and rationalising our estate 11. Devolving accountability through local decision making that is clinically led assuring governance arrangements. 12. Delivering our financial plan
Recommendations:	The Trust Board receive the report for information

North Staffordshire Combined Healthcare NHS
NHS Trust

Quarter 2 and 3 Summary Report - Board to Team (B2T) Visits 2015/16

Introduction

Several High profile inquiries into serious failings at NHS Hospitals have reported Boards being insufficiently concerned about patient safety and their understanding of patient and staff experience. Board members did not engage with service users or staff on the frontline, consequently Board members were not known outside of the Boardroom or Committee circuit.

Background

A recommendation of the Francis Inquiry into Mid Staffordshire Hospital NHS Trust was that "the Trusts make Board members visibility across the organisation a priority".

The Trust Chairman made it a requirement for all board members to carry out planned visits across the trust frontline clinical areas. This initiative strengthens the Boards visibility and ability to see and hear about the everyday experiences of service users, carers and staff.

The Board to Team visits are also a key component of the Trust commitment to monitoring and improving quality, service user and staff experience. Key outcomes associated with the board to team programme will be:

- To raise the profile of the board with service uses and staff so that they can understand the Board's role and how it exists to ensure effective quality.
- To ensure that service users, carers and staff have the opportunity to meet and discuss services with board members those who are responsible for them
- To increase engagement with service users, carers and staff
- To enhance board members connection from Board to 'ward/team' To provide board members with a range of experience of services that is provided
- To provide board members with one perspective of service quality that compliments the other information that is routinely reported to board meetings
- To report on and escalate any issues that service users or staff have raised with board members for action.

Method

In March 2015 a revised scheduled programme of visits to all clinical areas was devised, pairing an Executive Director and a non-Executive Director to undertake allocated visits throughout the year.

This report provides a summary of visits undertaken during quarters 2 and 3 2015/16.

A total of 14 visits were scheduled during Q2 and 14 in Q3, each to different trust services.

A total of 13 visits were completed and a written summary report was submitted.

It is acknowledged that at times it has been difficult to maintain the planned schedule of visits and, wherever possible, visits have been re-scheduled.

The table below provides a summary of visits undertaken in Q2 and Q3, general themes and any actions arising from the visit.

Date	Service	Summary	Positives	Challenges	Actions
16th July 2015	**Lymebrook CMHT**	Arrived and immediately invited to MDT meeting Later met with staff for open discussion	✓ Positive and productive MDT working and integration ✓ Appropriate staffing levels and use of temporary staffing to backfill long term sickness to maintain standards ✓ Dedicated and committed team ✓ Recovery focussed practice ✓ Positive reports re commencement of Autism service	! Waiting times from psychology referral initial assessment to treatment ! Depth of information from Access referrals ! Potential impact on good Service User experience from multiple assessments within treatment pathway	No immediate actions and Team Manager actioning issues raised
17th August 2015	**Adult Psychology Team** The Service works with teams in both adult community Rehabilitation and Inpatient services As MDT members help to manage interventions that require	Met with Head of Service, Trainees, Admin Staff to discuss general and specific themes	✓ MDT working ✓ Team inclusion and working for better service user outcomes ✓ Creation of post to bridge inpatient to community pathway ✓ Increased use of evidence based practice and measurable outcomes	! Access to rooms inhibiting ability to deliver services closer to Service Users and within MDT. ! Need for an electronic patient record solution to support service ! Lengthy recruitment	All actions identified recorded a lead person and actions fed back accordingly. Visiting Exec recorded visit through CEO Blog

	psychological input, particularly complex needs and highly specialised service		✓ Deploying right skills to service user need increasing positive experiences and improving efficiency ✓ Delivered goals set out in psychological services review ✓ Head of Service published paper on Emotional Intelligence and using across the trust ✓ Purchase of IT equipment to improve efficiency ✓ Increasing number of high calibre applicants to recruitment	process !Ensuring staff know that they are appreciated ! Leadership development and the importance of psychological support	
July 9th 2015	**Healthy Minds IAPT service** Healthy Minds is based at the Hope Centre in Hanley. Work in partnership with two voluntary sector partners (Changes and Mind)	Visiting team met with Senior Practitioner, eight practitioners and five admin staff	✓ Secured extra funding in recognition of underfunding following an NHS England review. Gains evidenced in improvements in KPI's. ✓ Passionate Staff ✓ Increased access and flexibility	! High volume of referrals has caused staff stress !Communication in and across team needs improvement !Room availability to undertake assessments and therapy	All actions identified recorded a lead person and actions fed back accordingly. Visiting Exec recorded visit through CEO Blog

	providing range of psychological interventions to people accessing services in primary care.		through evening clinics ✓ Positives with co-location with Access Team to screen referrals ✓ Strong clinical supervision programme ✓ Access to WiFi	!Reception area in need of improved décor to increase feel of welcome	
27th July 2015	**Edward Myers Centre** Based on Harplands Hospital site part of the Substance Misuse Directorate Provides seven day service for supported detoxification. Maximum 3 week wait sooner based on need Treatment and therefore length of stay lasts between 7 and 14 days.	Met with staff including Acting Manager, MDT, Housekeeper, Service Users	✓ Excellent environment, clean and welcoming ✓ Proud and passionate staff ✓ Excellent service user feedback ✓ Good quality and appropriate leaflets, signage ✓ Improved activities programme ✓ Very positive regard for New Beginnings Group ✓ Good quality meals ✓ Commercial approach to service ✓ Staff able to articulate the purpose and values of the unit and wider trust ✓ Manager very proud of the service overall	! Location of the unit can cause some isolation to the wider Harplands community	No actions identified by ward or visiting team

23rd July 2015	**Parent and Baby Unit** Based in Hanley, provides a seven day service support for women, children and families of expectant mothers of over 20 weeks pregnant to mothers who are 12 months post delivery of their child.	Visiting Team met with 3 staff on duty. No service users were present	✓ Well utilised, clean and welcoming unit ✓ Welcoming, enthusiastic staff ✓ Future unit development opportunity ideas ✓ Strong emphasis on staff education and training ✓ Strong clinical supervision programme ✓ Student placement of the year 2014 ✓	! Lack of opportunity for regular Team Manager and Service Manager communication/supervision ! No Wi-Fi Lack of staff engagement with reconfigured medical post ! Feeling that psychological services could be delivered in a more effective way	Visiting Exec Director provided a schedule of dates and leads for actions outlined .
13th Oct 2015	**Broom street Community Learning Disabilities Team**	Met with the Team Leader and held a general discussion about the provision of services	✓ Passionate professional staff ✓ Positive about the increasing move to digital systems for patient information recording	! Challenges in duplication of information held on paper and digital systems ! Estate not suitable and accessible for service to be provided, general condition and modernisation priority	No actions identified from the visit
5th Oct 2015	**Dragon Square Community Learning Disability Unit**	Met with the Team Leader and held a general discussion about the service	✓ Imminent move of CAMHS service to Dragon Square as part of estates rationalisation will help with	! Further health promotion work to undertake to ensure service users receive the appropriate	No actions identified from the visit

			team communication and closer working ✓ Improving clarity on the direction of travel for the service as a whole ✓ Development of clinical pathway work to ensure service users get the right service at the right time	level and type of service, not necessarily LD services where there is an LD diagnosis !Consideration of better use of physiotherapy services to improve service user health and wellbeing	
13th Oct 2015	**RAID/Liaison Psychiatry Team**	✓ Visiting team met with 8 staff members during their visit to explore general and specific thoughts	✓ Enthusiastic team passionate about the quality of their roles and responsibilities ✓ New opportunities to extend and develop services ✓ Close working relationships with UHNM ✓ Very positive approach to change	! Physical space at UHNM limiting Phone signals poor and no Wi-Fi in certain areas ! Chasing two IT departments for IT issues !Some lengthy hold ups in recruitment to vacant posts	No actions identified that are not already being actioned from this visit
24th July 2015	**Ward 4 Harplands Hospital** Dual Care Ward opened in January 2015 due to capacity issues in UHNM with staff	The visiting team met with the ward manager, Advanced Nurse Practitioner and Service User	✓ Passionate , committed and ambitious team ✓ Great model for integration ✓ Sense of strong leadership and ambition ✓ Developing stronger and	! Some uncertainty about the future commissioning intentions !Which leads to issues associated with temporary	Agreed that several actions would be followed up by the team and the Executive Director including: Scoping for a conservatory to increase the available space

	provided from NSCHT, UHNM and agency staff. Despite being opened within 3 days the ward has been uniformly praised, not only for supporting the initial capacity issue but also for the quality of care provision. There have been a number of evaluations of the ward, all of which have been positive. As the ward was initially a short term solution, the ward was initially and remains staffed with a higher than optimal degree of Bank and Agency staff. The Trust is in the process of finalising a business case in respect of long term commissioni		future links for integration ✓ Positive programme of activities ✓ Happy, well care for patients with positive feedback ✓	staffing !Length of stay has increased due to lack of available placements	Follow up on the business case progress Work with the Head of Directorate to review processes to address delayed discharges Consider publication of the service model

	ng of the ward, which it is hoped will resolve this with an opportunity to recruit a substantive establishmen t				
22nd July 2015	**Early Intervention Team**	The visiting team met with a number of the team to enable a two way discussion relating to positive and challenging service delivery	✓ Enthusiastic and positive staff ✓ Expanding service with additional national funding ✓ QIA process addressed potential CIP programme to merge team with CMHT`s ✓	! Ensuring full staff engagement in any potential service redesign ! Challenges to recruitment to additionally funded post and embedding processes ! Access and waiting times being carefully monitored	Actions agreed and followed up by the Exec Director include: Reviewing management of team budgets and harmonising separate budgets Developing a progress sheet to monitor targets following additional investment
2nd Oct 2015	**Sutherland Centre CMHT**	Visiting Team met with the Centre Manager	✓ Caseload management processes improved with Band 6 practitioners now undertaking improving capacity and quality ✓ Psychology input embedded in MDT ✓ Weekly case	! Consultant waiting times increased due to increased volume of referrals ! Capacity to accommodate members of the recently integrated Assertive Outreach Team	No immediate actions identified from the visit Waiting times are kept under close review via performance metrics and reporting

			note audit developed with emphasis on quality improvement and effective communication ✓ Care plans updated on CHIPS rather than paper based ✓ Established service user self-help group ✓ Good use of the space within the building		
22nd July 2015	**Criminal Justice Mental Health Team**	Visiting team met with staff members to provide an opportunity for 2 way dialogue of the positives and challenges within the service	✓ Excellent partnership working with police ✓ Street Triage scheme reduced Place of Safety referrals ✓ Street Triage scheme nominated for HSJ award ✓ Close working relationship with acute teams ✓ Team Leader developing in to LIA lead role with acting up opportunity created	! Need additional admin time to reduce admin burden on clinical staff and create more space for clinical activity !Improvement in incident management, data and analysis	No actions identified from this visit
9th July 2015	**Ward 1** Ward 1 is a 14 bedded ward and place of	Visiting team met with Deputy Ward Manager and staff nurse and ward manager	✓ Pleasant and welcoming staff ✓ Good level of	! Changes in senior leadership created some	Agreed to escalate concerns regarding

	safety Annexe.		therapeutic engagement with service users ✓ Respectful and unobtrusive application of observation ✓ Staff consulted and engaged with PICU development planning	initial difficulties but team recognise they are now stronger for it ! Recruitment to vacant posts delayed by Shared Service processes.	Shared Service delays to the Director of Leadership and Workforce for action.

Themes and conclusion

In summary there are many positive observations and comments made by the visiting Board members particularly around staff and service user satisfaction, environmental cleanliness, staff engagement with service users and positive feedback from service users about their experiences. Activity programmes had been prioritised across services and staff valued the investment in IT hardware and Wi-Fi service.

Integration of psychology personnel in to MDT working was a particular feature valued by the MDT although challenges to psychological therapy via waiting lists cited as an issue.

A real sense of service user collaboration and recovery was evident in many visits and a positive emphasis on the benefits of service user feedback and measurable outcomes.

Challenges consisted of poor environments, and, at times, digital technology however, it would appear that such IT issues have been priority actions for resolution of which staff were positive about.

Recruitment delays remain an issue of frustration although an acknowledgement of the work to progress this through the LIA initiative was well recognised and valued.

It is very pleasing to see that where challenges were identified suggested improvement actions were discussed during the visit, or have subsequently been followed up with relevant staff to take forward.

It is positive to note that that actions identified during Board visits are communicated to the relevant clinical team and Directorate management team to ensure improvements are made in a timely manner and that the visits reflected across the trust via the CEO Blog.

Recommendation

The committee is requested to receive the report for information.

Carol Sylvester

Deputy Director of Nursing

February 2016

Enclosure 9

REPORT TO TRUST BOARD (OPEN)

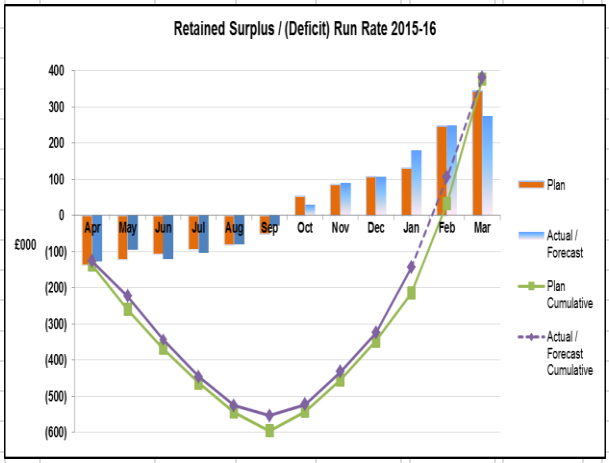
Date of Meeting:	25 February 2016
Title of Report:	Monthly Finance Reporting Suite – January 2016
Presented by:	Ann Harrison, Interim Director of Finance
Author of Report: Name: Date: Email:	 Steve Blaise 19 February 2016 Steve.blaise@northstaffs.nhs.uk
Committee Approval/Received prior to Trust Board:	Finance and Performance Committee
Purpose / Intent of Report:	Performance monitoring
Executive Summary:	The attached report contains the financial position to 31 January 2016 The Trusts financial performance is a retained deficit of £0.144m against a planned deficit of £0.227m, a favourable variance of £0.083m. The in-year cost improvement target is £2.658m with a year to date performance of £0.04m behind plan. The cash balance as at 31 January 2016 was £6.4m. The net capital expenditure is £0.434m which is behind the Plan of £0.575m, an under spend of £0.141m. 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	n/a

Implications:	
Relationship with the Board Assurance Framework	Delivering our financial plan
Recommendations:	***The Board is asked to:*** • ***note that the financial performance to date is on plan, with a favourable variance reported of £0.083m*** • ***note the cash position of the Trust as at 31 January 2016 of £6.4m*** • ***note the net capital expenditure position as at 31 January 2016 is an under spend against Plan of £0.141m*** • ***note the year to date Continuity of Service risk rating of 3***

FINANCIAL OVERVIEW as at 31 January 2016

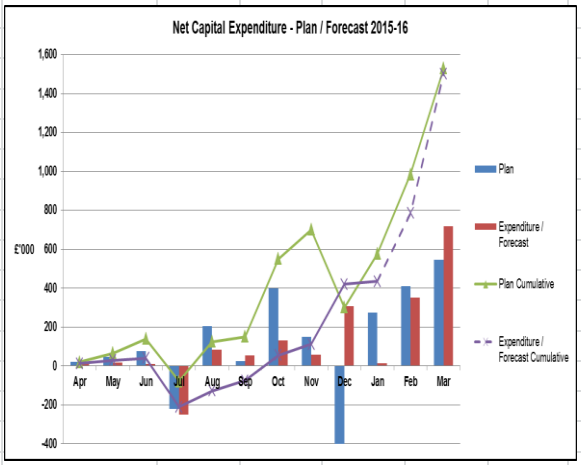
Income & Expenditure - Retained Surplus / (Deficit)

£000	Plan	Actual	Var	%	RAG
YTD	(227)	(144)	83	37	G
Forecast	377	727	350	93	G



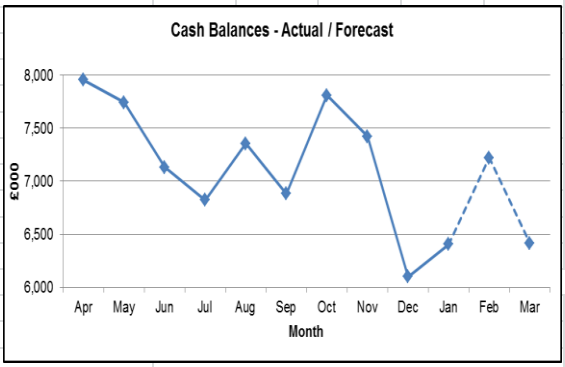
Net Capital Expenditure

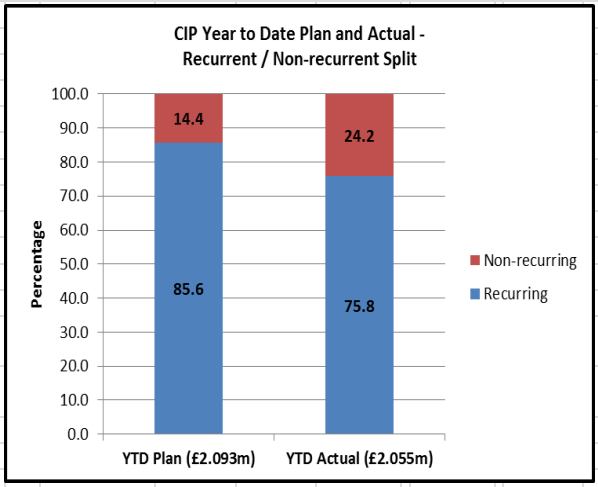
£000	Plan	Actual	Var	%	RAG
YTD	575	434	(141)	(25)	A
Forecast	1,530	1,180	(350)	(23)	G



Cash Balances

£m	Plan	Actual	Var	%	RAG
YTD	6.4	6.4	0.0	0	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	2	2	2

Notes

Risks:	Non achievement of income targets
	Non delivery of CIP requirement & increasing delivery of CIP's on a non recurrent basis.
	Managing cost pressures including no additional commitments to further cost pressures.
	Under performance against activity targets
Assumptions:	Clinical income targets for the main clinicial contracts are 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 Trust Development Authority (TDA) 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).

In September 2015 the Trust submitted a revised financial Plan which showed 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.

In late 2015 the TDA announced that NHS Trusts that were forecasting an undershoot against its 2015/16 Capital Resource Limit were to be given an opportunity to transfer this underspend from its Capital allocation into to its revenue position. Any value agreed as part of this transfer by the TDA would be paid to the Trust as Income who would then be required to increase its surplus (or reduce its deficit) by the same value.

Following a capital forecast review in December this Trust offered to transfer £350k. In January 2016 the Trust were informed that this transfer was to be transacted. Consequently the Trust financial reports and forecasts detailed below and in the attached schedules reflect this change including the increase to its forecast 2015/16 year end surplus.

1.2 Income & Expenditure (I&E) Performance at Month 10

At the end of Month 10, the Trusts budgeted plan was a retained deficit of £0.227m (£0.212m surplus at adjusted financial performance level). The reported retained position is a deficit of £0.144m (£0.295m surplus at adjusted level), giving a favourable variance of £0.083m 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	77,394	6,575	6,657	81	63,145	63,646	501
Pay	(57,799)	(4,926)	(4,836)	91	(48,221)	(46,491)	1,731
Non pay	(16,096)	(1,256)	(1,368)	(112)	(12,423)	(14,583)	(2,160)
EBITDA	**3,500**	**393**	**453**	**60**	**2,501**	**2,572**	**71**
Other Costs	(2,750)	(230)	(229)	0	(2,289)	(2,277)	12
Adjusted Financial Performance	**750**	**163**	**224**	**61**	**212**	**295**	**83**
IFRIC 12 Expenditure	(523)	(43)	(43)	0	(439)	(439)	0
Retained Surplus / (Deficit) prior to Impairment	**227**	**120**	**181**	**61**	**(227)**	**(144)**	**83**
Fixed Asset Impairment	0	0	0	0	0	0	0
Retained Surplus / (Deficit)	**227**	**120**	**181**	**61**	**(227)**	**(144)**	**83**

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

Also contained within non-pay, specific budgets have been set and held centrally.

It should be noted that Safer Staffing funding was allocated to Directorates in M6.

1.3 Forecast Year End Performance

Following the finalisation of the month 10 position, a worked up forecast outturn has been undertaken which supports the revised retained surplus of £0.727m (£1.250m at adjusted financial performance level). This surplus has increased from the targeted revised Plan surplus by £0.350m as a consequence of the capital to revenue transfer agreement detailed above. This outturn position is dependent on:

- The achievement of the cost improvement programme
- The management of cost pressures, existing or arising, during the remainder of the financial year
- The reserves position being in a position to support the operational position
- The identification of appropriate funding sources prior to the commitment of further costs that are not included in the current forecast position.

Included within the forecast is the envisaged over performance of circa £0.462m against planned clinical income but this includes the £0.350m the Trust will receive as a consequence of the capital to revenue transfer discussed in detail above. This forecast also includes an over performance in respect of NCA'S/OATS. The forecast is, however, negated by under performance of the Specialised Services contract in respect of Darwin, as detailed in previous reports, of £0.288m. In addition, the Trust is also predicting under performance on the two Local Authority DAT contracts.

The Trust's forecast position will be shared with the NTDA as part of their financial monitoring regime.

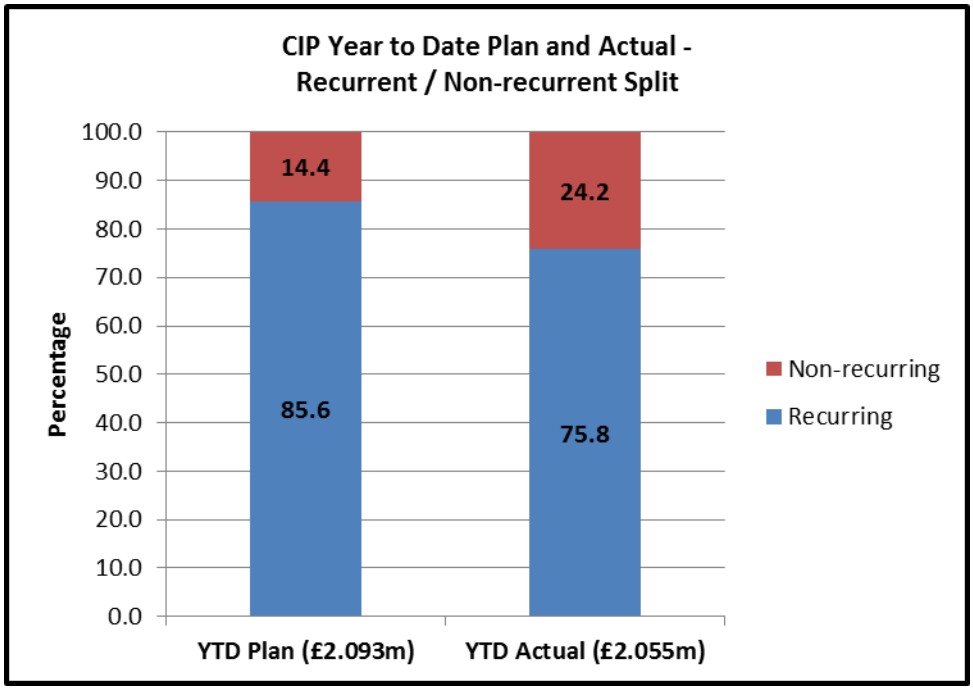
1.4 Cost Improvement Programme

The in-year target for the year and reported to the NTDA is £2.66m and takes into account the requirement to deliver the 2015/16 planned surplus referred to above.

As at month 10, the performance against the planned schemes on a year to date basis is slightly behind plan, with £2.05m being achieved against the target of £2.09m.

The split of recurrent to non-recurrent externally reported savings is reported below in table 3, showing the increased non-recurrent year to date delivery at 24%, compared to plan at 14%. The trigger for a red RAG rating on the NTDA return is when non recurrent savings exceed 25%.

Table 2: Recurrent Plan & Actual Savings



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 been revised on line with the Trusts latest forecast of capital spend and amended as a consequence of this updated forecast and the capital to revenue transfer agreement mentioned above.

2.2 Cash

As at 31 January 2016, the Trust's cash position was £6.4m which represents an increase during the month of £0.3m. A monthly cash flow forecast is shown in Appendix A, page 3 which demonstrates the cash movements.

2.3 Other Working Balances

Working balances have remained relatively static during the month. Debtors have decreased in month by £0.5m and Creditors have also decreased by £0.5m.

Within the overall debtors value, £1.9m 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 agreed within the 2015/16 plan was £2.3m; this was the combination of the Trust's £1.53m Capital Resource Limit (CRL) and its predicted asset sales of £0.77m. This has changed as a consequence of the revised forecast outturn position and the subsequent capital to revenue transfer detailed above. This change results in a forecast of £1.180m as the combination of £1.502m expenditure and in year predicted asset sales of £0.322m.

The capital expenditure for the year as at 31 January 2016 is £0.434m,made up of £0.756m of expenditure and (£0.322m) from the disposal of the former Learning Disability property Meadow View & part of Bucknall Hospital land disposal. The original Trust capital plan predicted a further Bucknall Land related disposal receipt in 2015/16. However, it is now known the next receipt relating this disposal will not now be received until 2016/17 with further larger receipts in the three following years.

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 10, 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 Committee is asked to:

- ***note that the financial performance to date is predominately on plan, with a favourable variance reported of £0.083m***
- ***note the cash position of the Trust as at 31 January 2016 of £6.4m***
- ***note the net capital expenditure position as at 31 January 2016 is an underspend against plan of £0.141m***
- ***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	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Income:										
Revenue from Patient Care Activities	68,820	6,075	6,008	68	56,554	56,436	118	69,906	69,445	462
Other Operating Revenue	8,575	581	568	14	7,092	6,709	383	8,586	8,581	5
	77,394	6,657	6,575	81	63,646	63,145	501	78,493	78,026	467
Expenses:										
Pay										
Medical	-6,883	-512	-575	63	-4,832	-5,735	902	-5,831	-6,884	1,053
Nursing	-26,796	-2,187	-2,278	90	-21,412	-22,431	1,019	-25,800	-27,153	1,353
Other clinical	-13,654	-1,052	-1,178	126	-10,272	-11,316	1,044	-12,415	-13,650	1,235
Non-clinical	-9,668	-733	-821	88	-7,225	-8,014	789	-8,752	-9,672	920
Non-NHS	-797	-352	-75	-277	-2,750	-726	-2,024	-3,428	-880	-2,548
Cost Improvement	0	0	0	0	0	0	0	0	0	0
	-57,799	-4,836	-4,926	91	-46,491	-48,221	1,731	-56,227	-58,240	2,013
Non Pay										
Drugs & clinical supplies	-2,006	-162	-166	4	-1,837	-1,684	-153	-2,189	-2,012	-177
Establishment costs	-1,711	-131	-143	12	-1,318	-1,425	107	-1,601	-1,722	120
Premises costs	-2,101	-246	-179	-67	-2,492	-1,800	-692	-3,125	-2,102	-1,023
Private Finance Initiative	-3,865	-332	-322	-10	-3,320	-3,221	-99	-3,984	-3,865	-119
Other (including unallocated CIP)	-6,219	-497	-505	8	-5,618	-4,864	-753	-6,792	-6,211	-581
Central Funds	-194	0	59	-59	0	571	-571	-614	-215	-399
	-16,096	-1,368	-1,256	-112	-14,583	-12,423	-2,160	-18,305	-16,126	-2,179
EBITDA *	**3,500**	**453**	**393**	**60**	**2,572**	**2,501**	**71**	**3,961**	**3,660**	**301**
Depreciation (excludes IFRIC 12 impact and donated income)	-797	-67	-67	0	-698	-661	-37	-844	-797	-47
Investment Revenue	12	1	1	0	17	10	7	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	-1,137	-1,137	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	-501	-501	0	-561	-611	50
Adjusted Financial Performance - Surplus / (Deficit) for the Financial Year **	**750**	**224**	**163**	**61**	**295**	**212**	**83**	**1,250**	**900**	**350**
IFRIC 12 Expenditure ***	-523	-43	-43	0	-439	-439	0	-523	-523	0
Retained Surplus / (Deficit) for the Year	**227**	**181**	**120**	**61**	**-144**	**-227**	**83**	**727**	**377**	**350**

* 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.

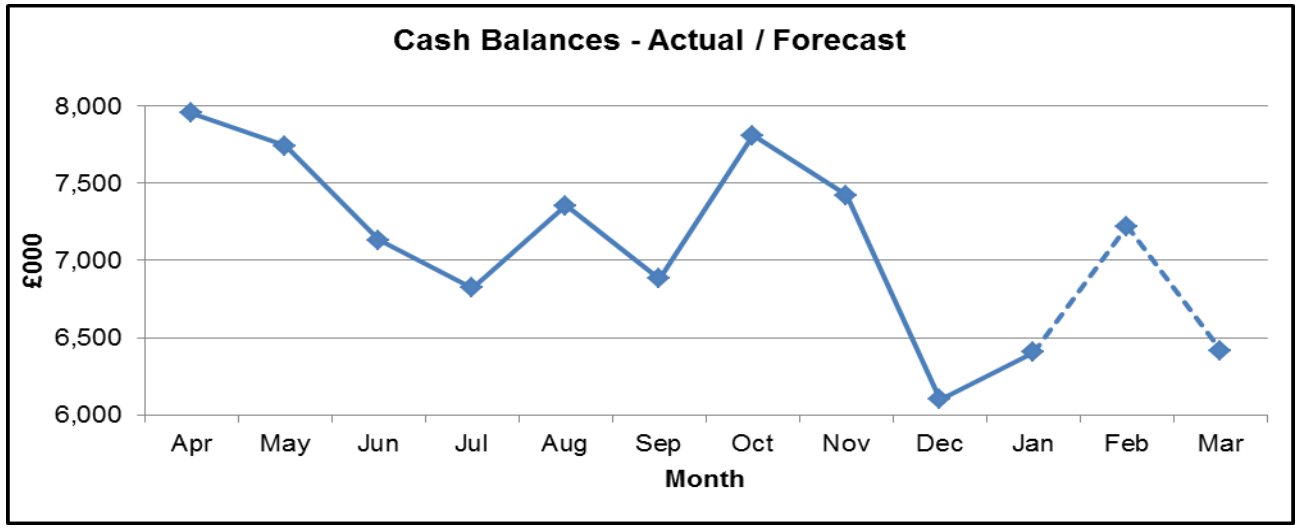
Appendix A – Page: 2

Statement of Financial Position – including forecast

Detail	Period End Date 31/03/2015 £000	31/08/2015 £000	30/09/2015 £000	31/10/2015 £000	30/11/2015 £000	31/12/2015 £000	31/01/2016 £000	Forecast 31/03/2016 £000
NON-CURRENT ASSETS:								
Property, Plant and Equipment	30,863	30,466	30,397	30,415	30,441	30,607	30,512	31,177
Intangible Assets	52	40	28	28	28	22	22	66
Trade and Other Receivables	0	0	0	0	0	0		0
TOTAL NON-CURRENT ASSETS	30,915	30,506	30,425	30,443	30,469	30,629	30,534	31,243
CURRENT ASSETS:								
Inventories	86	82	75	66	81	74	78	86
Trade and Other Receivables	3,017	5,728	6,213	4,995	5,021	6,292	5,756	3,298
Cash and cash equivalents	6,805	7,355	6,883	7,811	7,423	6,104	6,407	6,416
SUB TOTAL CURRENT ASSETS	9,908	13,165	13,171	12,872	12,525	12,470	12,241	9,800
Non-current assets held for sale	2,520	2,250	2,250	2,250	2,198	2,198	2,198	2,005
TOTAL ASSETS	**43,343**	**45,921**	**45,846**	**45,565**	**45,192**	**45,297**	**44,973**	**43,048**
CURRENT LIABILITIES:								
NHS Trade Payables	-864	-772	-1,056	-930	-875	-850	-775	-676
Non-NHS Trade Payables	-4,374	-7,871	-7,581	-7,511	-9,164	-7,248	-6,866	-5,240
Borrowings	-351	-351	-351	-351	-351	-351	-351	-346
Provisions for Liabilities and Charges	-1,682	-1,526	-1,515	-1,429	604	-1,364	-1,346	-882
TOTAL CURRENT LIABILITIES	-7,271	-10,520	-10,503	-10,221	-9,786	-9,813	-9,338	-7,144
NET CURRENT ASSETS/(LIABILITIES)	5,157	4,895	4,918	4,901	4,937	4,855	5,101	4,661
TOTAL ASSETS LESS CURRENT LIABILITIES	**36,072**	**35,401**	**35,343**	**35,344**	**35,406**	**35,484**	**35,635**	**35,904**
NON-CURRENT LIABILITIES								
Borrowings	-12,992	-12,846	-12,817	-12,787	-12,758	-12,729	-12,699	-12,647
Trade & Other Payables	-558	-558	-558	-558	-558	-558	-558	-558
Provisions for Liabilities and Charges	-604	-604	-604	-604	-604	-604	-604	-404
TOTAL NON- CURRENT LIABILITIES	-14,154	-14,008	-13,979	-13,949	-13,920	-13,891	-13,861	-13,609
TOTAL ASSETS EMPLOYED	**21,918**	**21,393**	**21,364**	**21,395**	**21,486**	**21,593**	**21,774**	**22,295**
FINANCED BY TAXPAYERS EQUITY:								
Public Dividend Capital	7,998	7,998	7,998	7,998	7,998	7,998	7,998	7,648
Retained Earnings	814	289	260	291	382	489	670	1,541
Revaluation Reserve	13,664	13,664	13,664	13,664	13,664	13,664	13,664	13,664
Other reserves	-558	-558	-558	-558	-558	-558	-558	-558
TOTAL TAXPAYERS EQUITY	**21,918**	**21,393**	**21,364**	**21,395**	**21,486**	**21,593**	**21,774**	**22,295**

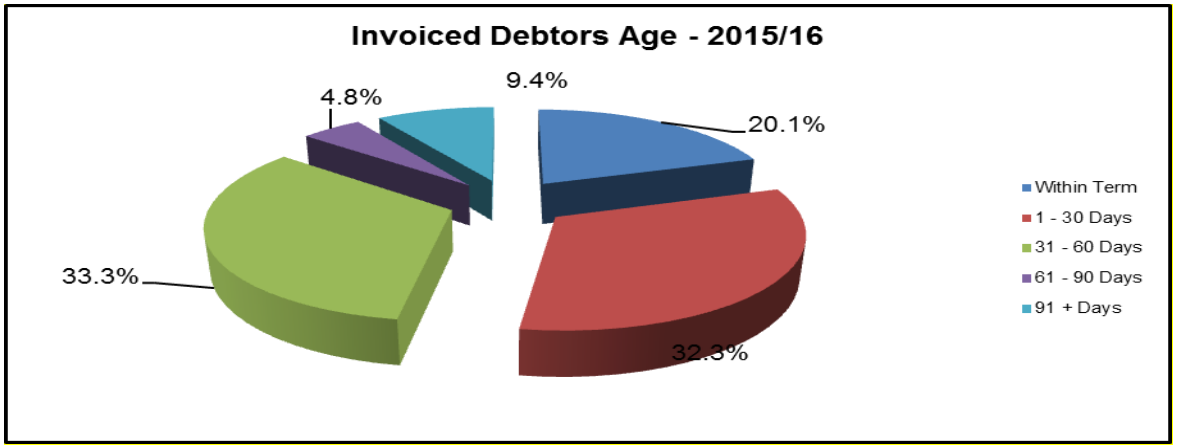
Cash-flow Forecast

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	Actual Sep 15 £000	Actual Oct 15 £000	Actual 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	134	193	253	*270*	*343*	*374*	*785*	**2,594**
Depreciation and Amortisation	113	112	117	98	110	134	112	115	*114*	*112*	*114*	*116*	**1,367**
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*	*-112*	*-113*	*-114*	**-1,364**
Dividend Paid	0	0	0	0	0	-256	0	0	*0*	*0*	*0*	*-305*	**-561**
Inflow / (Outflow) prior to Working Capital	**34**	**64**	**45**	**1**	**78**	**-102**	**191**	**254**	***271***	***343***	***375***	***482***	**2,036**
(Increase) / Decrease in Inventories	0	-7	2	8	8	7	9	-16	*-3*	*0*	*-9*	*1*	**0**
(Increase) / Decrease in Trade and Other Receivables	-658	-794	-1,101	-231	-73	-485	1,218	-7	*-1,141*	*557*	*1,240*	*1,218*	**-257**
Increase / (Decrease) in Trade and Other Payables	1,817	581	509	-265	650	199	-247	-514	*-65*	*-531*	*-245*	*-1,235*	**654**
Provisions (Utilised) / Arising	-3	-12	-31	-90	-20	-11	-86	-19	*-46*	*-18*	*-269*	*-675*	**-1,280**
Increase/(Decrease) in Movement in non Cash Provisions	0	0	0	0	0	0	0	0		*0*	*0*	*280*	**280**
Inflow / (Outflow) from Working Capital	**1,156**	**-232**	**-621**	**-578**	**565**	**-290**	**894**	**-556**	***-1,255***	***8***	***717***	***-411***	**-603**
Net Cash Inflow / (Outflow) from Operating Activities	**1,190**	**-168**	**-576**	**-577**	**643**	**-392**	**1,085**	**-302**	***-984***	***351***	***1,092***	***71***	**1,433**
Cash Flows from Investing Activities													
Interest Received	2	2	2	1	2	2	2	1	*1*	*2*	*1*	*0*	**18**
(Payments) for Property, Plant and Equipment	-12	-18	-10	-18	-83	-53	-130	-110	*-308*	*-18*	*-250*	*-496*	**-1,506**
Proceeds of disposal of assets held for sale (PPE)	0	0	0	315	0	0	0	52	*0*	*0*	*0*	*0*	**367**
Net Cash Inflow / (Outflow) from Investing Activities	**-10**	**-16**	**-8**	**298**	**-81**	**-51**	**-128**	***-57***	***-307***	***-16***	***-249***	***-496***	**-1,121**
NET CASH INFLOW / (OUTFLOW) BEFORE FINANCING	**1,180**	**-184**	**-584**	**-279**	**562**	**-443**	**957**	**-359**	***-1,291***	***335***	***843***	***-425***	**312**
Cash Flows from Financing Activities													
Capital Element of Payments in Respect of Finance Leases PFI	-29	-29	-29	-29	-29	-29	-29	-29	*-31*	*-29*	*-30*	*-29*	**-351**
PDC Repayment linked to Capital to Revenue transfer	0	0	0	0	0	0	0	0	*0*	*0*	*0*	*-350*	**-350**
Net Cash Inflow/(Outflow) from Financing Activities	**-29**	**-29**	**-29**	**-29**	**-29**	**-29**	**-29**	**-29**	***-31***	***-29***	***-30***	***-379***	**-701**
NET INCREASE / (DECREASE) IN CASH AND CASH EQUIVALENTS	**1,151**	**-213**	**-613**	**-308**	**533**	**-472**	**928**	**-388**	***-1,322***	***306***	***813***	***-804***	**-389**
Cash and Cash Equivalents (and Bank Overdraft)	**7,956**	**7,743**	**7,130**	**6,822**	**7,355**	**6,883**	**7,811**	**7,423**	***6,101***	***6,407***	***7,220***	***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	344	568	393	74	144	**1,523**
Local Authorities	7	26	230	17	0	**280**
Other Debtors	25	12	1	0	31	**70**
Total	**377**	**606**	**624**	**91**	**176**	**1,873**

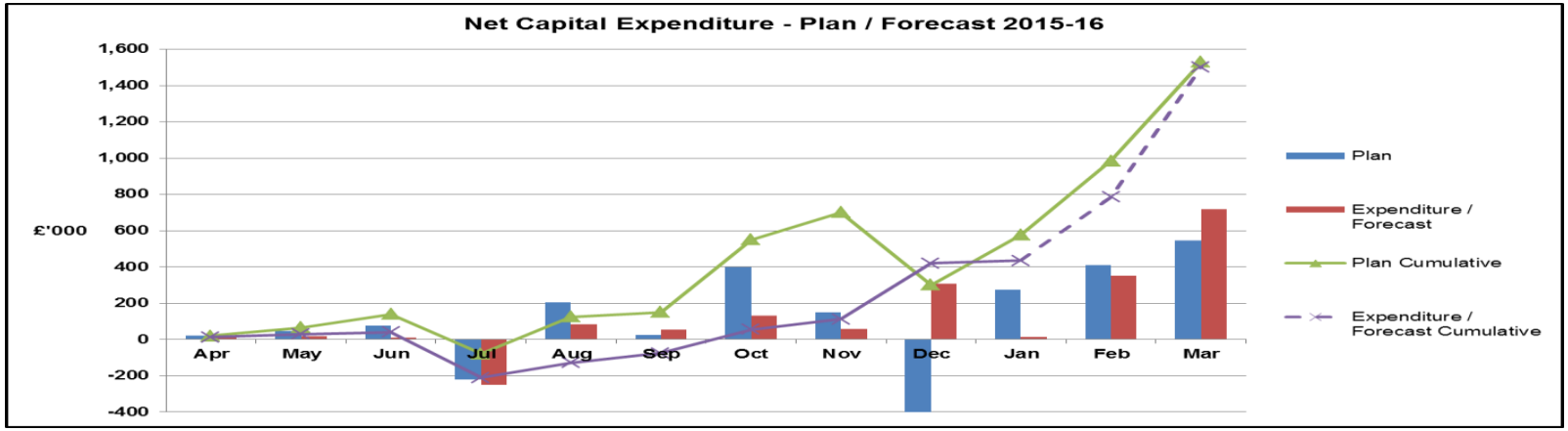


Analysed by Credit Control Stage	Within Term £000	1 - 30 Days £000	31 - 60 Days £000	61 - 90 Days £000	91 + £000	Overall Balance £000
No formal dispute received - full payment anticipated	377	606	624	91	144	**1,842**
Routine credit control processes activated	0	0	0	0	22	**22**
Resolved - Awaiting Credit Note to be issued	0	0	0	0	0	**0**
Escalated to Management / Solicitors	0	0	0	0	10	**10**
Total	**377**	**606**	**624**	**91**	**176**	**1,874**

Capital Programme and Expenditure

Scheme	Detail	2015/16 Original Scheme Value £000	2015/16 Revision £000	Year to Date £000	Forecast Outturn £000
Psychiatric Intensive Care Unit	awaiting business case approval	400	0	22	22
Low Secure unit with rehabilitation	awaiting business case approval	500	0	0	0
Assessment & Treatment and Telfold Unit	business case approved	600	500	25	500
Dragon Square Upgrade	business case approved	250	500	499	500
Darwin Upgrade	business case approved	0	680	33	60
Information Technology	various	100	100	71	150
Equipment	various	80	80	0	30
Other		270	270	106	160
Environmental Improvements	numerous sites	100	100	0	80
Total Expenditure		**2,300**	**2,230**	**756**	**1,502**
Disposals					
Former Learning Disability property	Meadow View	-270	-270	-270	-270
Bucknall Hospital (part)	staged receipts	-500	-500	-52	-52
Net Expenditure		**1,530**	**1,460**	**434**	**1,180**

Capital Allocations	£000
Initial CRL (per NTDA Plan submission)	**1,530**
Revisions to Plan:	
Capital to revenue transfer	-350
Final CRL	**1,180**
Value of Schemes Forecast Outturn as at 30/11/15	**1,180**
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	14,439	11,550	11,805
	Total Current Liabilities	-9,338	-7,661	-7,144
	Inventories	78	86	86
	Non Current Assets Held for Sale	2,198	1,750	2,005
	Working Capital Balance	**2,825**	**2,053**	**2,570**
	Annual Operating Expenses:			
	Operating Expenses	62,212	72,680	75,899
	Add back:			
	Depreciation & Amortisation	-1,137	-1,350	-1,367
	Impairments	0	0	0
	Annual Operating Expenses:	**61,075**	**71,330**	**74,532**
	Liquidity Ratio (Working capital balance / Annual operating expenses)	14.2	10.4	12.6
	Liquidity Ratio Metric	**4.0**	**4.0**	**4.0**
Capital Servicing Capacity	**Revenue Available for Debt Service:**			
	EBITDA	2,572	3,486	3,961
	Interest Receivable	-17	-16	-16
	Revenue Available for Debt Service	**2,589**	**3,502**	**3,977**
	Annual Debt Service:			
	Finance Costs (including interest on PFIs and Finance Leases)	1,137	1,364	1,364
	Dividends	501	561	561
	Capital element of payments relating to PFI, LIFT Schemes and finance leases	292	351	351
	Annual Debt Service	**1,930**	**2,276**	**2,276**
	Capital Servicing Capacity (times) (Revenue available for Debt Service / Annual Debt Service)	1.3	1.5	1.7
	Capital Servicing Capacity metric	**2.0**	**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	

Enclosure 10

REPORT TO TRUST BOARD

Date of Meeting:	25 February 2016
Title of Report:	Finance and Performance Committee Report – Committee Meeting 18 February 2016
Presented by:	Tony Gadsby – Committee Chairman
Author of Report: Name: Date: Email:	 Steve Blaise 18 February 2016 steve.blaise@northstaffs.nhs.uk
Committee Approval/Received prior to Trust Board:	n/a
Purpose / Intent of Report:	Performance monitoring For information
Executive Summary:	The attached reports provides a summary of the Committee meeting held on the 18 February 2016 and provides assurance to the Board over the level of review and challenge provided by the Committee of financial and other reporting as well as forecasting.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Financial Strategy Workforce Strategy Governance Strategy IM&T Strategy
Relationship with Annual Objectives:	Financial Reporting
Risk / Legal Implications:	n/a
Resource Implications:	As above
Equality and Diversity Implications:	n/a
Relationship with the Board Assurance Framework	Provides assurance over the Trust's arrangements for sound financial stewardship and risk management.

Recommendations:	**The Trust Board are asked to:** • ***Note the contents of the report and take assurance from the review and challenge evidenced in the Committee*** • ***Delegates the approval of the Trust 2015/16 Annual Accounts to the Audit Committee at its meeting on 31st May 2016.***

North Staffordshire Combined Healthcare NHS Trust

Assurance Report to the Trust Board – Thursday, 25 February 2016

Finance and Performance (F&P) Committee Report to the Trust Board – 18 February 2016

This paper details the issues discussed at the Finance and Activity Committee meeting on 18 February 2016

The meeting was quorate, approved the minutes from the meeting on the 21 January 2016 and reviewed the progress and actions taken from previous meetings.

The Committee received the financial update for month 10 (January 2016) 2015/16.

The income and expenditure position to Month 8 was ahead of plan at a deficit of £0.144m (£0.295m surplus at "adjusted financial performance" level) against a plan deficit of £0.227m, a favourable variance of £0.083m against plan. The paper also reported that the year-end forecast was in line with the revised planned position of £0.727m surplus, equating to a £1.250m surplus at adjusted financial performance level. This position would represent an underspend performance against a revised plan in line with capital to revenue transfer adjustment reported last month.

The Trust's cash balance at the end of January was £6.4m against the plan balance of £6.4m.

Capital Expenditure for the year as at 31 January 2016 is £0.434m which is slightly behind plan. The revised target for 2015/16 is now, following the recent capital to revenue transfer, £1.180m.

It was noted that the Trust continued to report a Continuity of Service overall risk rating of level 3 at January 2016. Additionally, the Trust is also reporting a forecast year end overall rating of level 3. This level 3 rating is achieved primarily as a result of the Trusts healthy liquidity ratio.

Other Reports and Updates

The Committee received additional reports and verbal updates as follows:

- The verbal report from the Director of Finance included reference to the Transformation agenda and the on-going contractual negotiations. The contracting report presented highlighted the difficult financial position of the contracts with the local authority sector.

- A Service Line Reporting/Payment by Results report updating the Committee of the progress to date in meeting the contractual requirements whilst securing the Trusts future income levels.

- A report updating the Committee on the Trust's current tender activity. It was noted that the GPST Employer Lead tender was not included within the list of potential tenders.

- The Committee received, for information, the minutes and report from the Trusts Capital Investment Group (CPU).

- A report providing a summary of the progress and plan of the Trusts 2016-17 budget setting exercise.

- A Performance Management report including TDA metrics, agreed targets, trends and a revised RAG rating. The reported noted that, at month 10, there were 3 metric's rated as Red and 6 rated as Amber. The Committee were briefed on the issues within these areas.

- The Committee received a paper detailing the key milestones and deadlines associated with the production of the Trusts 2015/16 Annual Accounts. It was noted that the June Trust Board date to approve the Accounts was set on the date that the Accounts should be posted with the DH. It was agreed to recommend to the Board that the formal approval of the Trusts Accounts is delegated to the Audit Committee at its meeting on 31st May 2016.

- A report on the CIP position for the Trust against the planned programme which showed a small forecast over achievement against the revised total target. It was noted that there was still work to do to minimise the amount of CIP achieved non-recurrently in 2015/16 and that there needs to be a greater emphasis on developing the 2016/17 efficiency programme.

- Key Risks to finance and performance. A schedule was provided which described the key risks appertaining to the 2015/16 financial plan.

- The month 9 and year to date Better Payment Practice Code performance was tabled showing the Trust performance in settling its creditors. This information demonstrated a high level of performance with all year to date results being in excess or equal to the 95% target.

Recommendation

- The Board is asked to note the contents of this report and take assurance from the review and challenge evidenced in the Committee.
- The Board delegates the responsibility for the formal approval of the Trusts 2015/16 Annual Accounts to the Audit Committee to take place on 31st May 2016

On Behalf of Tony Gadsby – Chair of Finance and Performance Committee

Steve Blaise – Deputy Director of Finance

18 February 2016

Enclosure 11

REPORT TO TRUST BOARD

Date of Meeting:	25 February 2016
Title of Report:	Performance Report – Month 10 2015/16
Presented by:	Ann Harrison, Interim Director of Finance
Author of Report: Name: Date: Email:	Clare Dockerty 18 February 2016 Clare.Dockerty@northstaffs.nhs.uk
Committee Approval/Received prior to Trust Board:	• Finance and Performance Committee
Purpose / Intent of Report:	Performance Monitoring
Executive Summary:	This report provides the Board with a summary of performance to the end of Month 10 (January 2016) 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. At month 10 there are 3 metrics rated as Red and 6 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 contracts and the TDA's assurance framework compliance 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 the Board Assurance Framework	1. Focusing on quality and safety 2. Consistently meeting standards 3. Delivering our financial plan

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.

North Staffordshire Combined Healthcare NHS
NHS Trust

PERFORMANCE MANAGEMENT REPORT TO TRUST BOARD

Date of meeting:	25 February 2016
Report title:	**Performance & Quality Management Framework** **Performance Report – Month 10** **2015/16**
Executive Lead:	Interim Director of Finance
Prepared by:	Performance & Information Team
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 10 there are 3 metrics rated as Red and 6 as Amber; targets for the unrated metrics will be updated once 2015/16 technical guidance is received from the TDA. Figures for exceptions against internal targets are also provided in the table below.

	Month 10			
Metric Driver	**Red**	**Amber**	**Green**	**Unrated**
Exceptions – Month 10	**3**	**6**	**52**	**21**

3 Exceptions - Month 10

Metric	Exec/Op Lead	Target	M10 Perf	YTD Perf	Forecast Outturn	Trend	Commentary
TRAINING: % staff compliant with mandatory training	Workforce Dir Op Lead S Slater	**95%***	AMBER **88%**	AMBER **88%**	AMBER	↔	**88% @ month 10 same as month 9** Month 10 breakdown Corporate Services = 85% AMH Community = 87% AMH In Patient = 86% Substance Misuse = 87% CYP = 85% Learning Disabilities = 93% NOAP = 90% Each Directorate has plans which are being reviewed again to ensure that staff have the appropriate mandatory training. There has also been a move to provide access to increased e-learning packages to support access and compliance. *Commissioners have advised that this target can reduce to 90%; awaiting written confirmation.
APPRAISAL: Annual appraisal and personal development plan % - All staff	Workforce Dir Op Lead A Garside	**90%**	AMBER **89%**	AMBER **89%**	GREEN	↗	**89% @ month 10 from 85% @ month 9** Most Directorates achieved 90% and the remaining Directorates have trajectories in place to achieve minimum 90%. Adult community has the largest challenge and a detailed plan for people to complete their PDRs.
18 WEEKS (1): Compliance with 18 week RTT (**all**	Dir of Ops	**95%**	AMBER **93%**	AMBER **93%**	GREEN	↗	**93% @ month 10 from 92% @ month 9** Month 10 breakdown

referrals, i.e. initial *and* subsequent internal referrals)	Op Lead Head of Dir						AMH Community = 94% @ M10 from 91% @ M9 (Longest 52 weeks) AMH In Patient = 100%@ M10 same as M9 Substance Misuse = 100%@ M10 same as M9 CYP = 87%@ M10 from 88% @ M9 (Longest 53 weeks) Learning Disabilities = 100%@ M10 same as M9 NOAP = 98%@ M10 from 97% @ M9 (Longest 51 weeks) Data validation / cleansing is being undertaken by directorates in relation to longest waits. Completion by end of Q4.
Metric	**Exec/Op Lead**	**Target**	**M10 Perf**	**YTD Perf**	**Forecast Outturn**	**Trend**	**Commentary**
18 WEEKS (2): Compliance with 18 week RTT (**initial referrals only**)	Dir of Ops Op Lead Head of Dir	**95%**	**AMBER** **91%**	**AMBER** **91%**	**AMBER**	↗	**91% @ month 10 from 90% @ month 9** AMH Community = 90% @ M10 from 88% @ M9 (Longest 54 weeks) AMH In Patient = 100%@ M10 same as M9 Substance Misuse = 100%@ M10 same as M9 CYP = 89%@ M10 from 89% @ M9 (Longest 53 weeks) Learning Disabilities = 100%@ M10 same as @ M9 NOAP = 99%@ M10 from 96% @ M9 (Longest 52 weeks) Data validation / cleansing is being undertaken by directorates in relation to longest waits. Completion by end of Q4.
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 Head of Dir	**95%**	**AMBER** **94.8%**	**AMBER** **94.8%**	**GREEN**	↗	**94.8% @ month 10 from 94.2% @ month 9** Directorates are being given Performance Rectification Plans (which include trajectories) in order to achieve this target. These plans will be monitored closely by the Director of Operations.

Metric	Exec/Op Lead	Target	M10 Perf	YTD Perf	Forecast Outturn	Trend	Commentary
RAID: A&E Emergency Portal referrals seen within 1 hour	Dir of Ops Op Lead D Carr	**95%**	AMBER **91%**	AMBER **91%**	AMBER	↘	**91% @ month 10 from 95% @ month 9** - A&E Emergency Portal referrals seen within 1 hour Completion of induction training for new members of staff covering night shifts has impacted on efficiency. This will be completed in February 2016.
RAID: All other referrals seen on same day or within 24 hours	Dir of Ops Op Lead D Carr	**100%**	RED **90%**	RED **90%**	AMBER	↗	**90% @ month 10 from 88% @ month 9** - all other referrals seen on same day or within 24 hours Given the growth of Urgent Care activity at UHNM, the service has increasingly been picking up out of area activity. NSCHT is currently in discussion with commissioners via the RAID steering group to agree response targets, which will be added as agreed. Contract target of 100% is being discussed at the Contracting Group and will be escalated to the Commissioning Board, requesting a reduction to 95% in line with the 1hr and 4hr targets. There are a very large number of inappropriate referrals reaching the RAID team, often relating to patients who are referred as medically fit but are found not to be when RAID attend to assess. The RAID team are collecting data but have not yet been able to agree a strategy with UHNM to reduce this trend. The RAID team report that it takes less time to physically attend and triage the referral in situ than to triage over the

							phone at point of referral. This is leading to the service being stretched. Discussion is ongoing to develop a strategy but, as the issue is complex and not constrained to any individual referral source, there is some delay.
Metric	**Exec/Op Lead**	**Target**	**M10 Perf**	**YTD Perf**	**Forecast Outturn**	**Trend**	**Commentary**
Vacancy Rate: Staff in Post vs Budgeted Establishment	Workforce Dir Op Lead	**5%**	**RED** **5.51%**	**RED** **5.51%**	**RED**	↗	**5.51% @ month 10 from 5.08% @ month 9** AMH In Patient = 5.96% AMH Community = 8.20% Children and Young People = 9.11% Learning Disabilities = 3.28% Neuro & Old Age Psychiatry = 2.90% Substance Misuse = 6.95% Corporate = 5.05% There has been an increase in establishment which has contributed to this position. There are also a number of vacancies out to recruitment and a number that have been difficult to fill. These are being supplemented by a planned recruitment campaign utilising traditional and social media over a wide geography.
Nursing agency usage: Total spend against total nursing paybill	Workforce Dir Op Lead	**3%**	**RED** **6.15%**	**RED** **6.15%**	**RED**	↗	**6.15% @ month 10 from 5.24% @ month 9** AMH In Patient = 1.01% AMH Community = 1.28% Children and Young People = 0.54% Learning Disabilities = 0% Neuro & Old Age Psychiatry = 2.73% Substance Misuse = 0.23%

							Ops = 0.34% The agency spend reflects both some of the challenges with recruitment such as sickness (Adult Community) and also services where we have actively utilised temporary staffing to support services. These include areas such as Ward 4 and CYP. We are actively looking to expand our Bank to reduce this reliance. We are also undertaking a review of agency processes & spend to assure ourselves that we are doing all we can to reduce reliance on agency. This will be mitigated with current recruitment activities.

4 Recommendations

- Note the contents of the report.

Enclosure 12

REPORT TO TRUST BOARD

Date of Meeting:	18th February 2016
Title of Report:	Audit Committee Report
Presented by:	Mr D Rogers, Non Executive Director Chair of Audit Committee
Author of Report: Name: Date: Email:	 Jo Lloyd (on behalf of Laurie Wrench) 18th February 2016 Jo.lloyd@northstaffs.nhs.uk
Committee Approval/Received prior to Trust Board:	• **Audit Committee**
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 18th February2016. The Trust Board members are reminded that the full minutes and papers are available for inspection from the Associate Director of Governance, Laurie Wrench.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Governance • Financial • Customer Focus
Relationship with Annual Objectives:	Aligns to all annual objectives.
Risk / Legal Implications:	n/a
Resource Implications:	n/a
Equality and Diversity Implications:	n/a
Relationship with the Board Assurance Framework	**1. Focusing on quality and safety** **2. Consistently meeting standards** ~~3. Protecting our core services~~ ~~4. Growing our specialised services~~ ~~5. Innovating in the delivery of care~~ ~~6. Developing academic partnerships and education and training initiatives~~ 7. Being an employer of choice **8. Hosting a successful CQC inspection** ~~9. Becoming digital by choice~~ ~~10. Reviewing and rationalising our estate~~ **11. Devolving accountability through local decision making that is clinically led assuring governance arrangements.** 12. **Delivering our financial plan**
Recommendations:	The Board is asked to : Receive and note the contents of this report.

Summary of the 18th February 2016 Audit Committee meeting to Trust Board Meeting on 25th February 2016

1. Risk Management Policy and Strategy

The Audit Committee were assured that these were now fit for purpose. The documents were presented to the Risk Review Group held on 16th February 2016 and agreement gained. The Policy will now progress to the Policy Working Group for corporate review. Following this it will then be presented at the Quality Committee before finally being ratified by The Trust Board in March 2016.

2. Healthcare Quality Standards Assurance Report / CQC Inspection update

The Committee received a report outlining the current progress made and work was currently being undertaken within the Trust around some factual accuracy and challenging of some areas within the report. The Quality Summit scheduled for the 9th February 2016 has been postponed and it is hoped this will take place in March 2016.

The final report has not yet been publicised and it was noted that once the report is published the Trust have a 6 month window in which to improve their rating without the need for further inspection.

3. Board Assurance Framework – Q3

This report for quarter 3 was received for information and update purposes and it was noted that this has been received by relevant sub committees throughout January 2016 – Quality, Finance and Performance and Business Development.

This was the first time an integrated BAF metrics had been produced. In helping to be more streamlined and focused it was noted there were 12 strategic objectives last year and moving forward there would be 7. The basic principles within the BAF are good and RSM are working with the Trust to strengthen this further.

The Committee agreed that in future, management by the Audit Committee will be by exception only, in terms of assurance before going to the Trust Board.

4. Quality Account Project Plan

The Committee were assured through the presentation of a report enclosing data and information that key milestones for services were being delivered which would influence the Quality Account. The Quality Committee will be responsible for overseeing the Quality Account due for publication by June 2016.

5. Audit Recommendations – Progress report

As recognised at the previous meeting assurances will be embedded into the new Board Assurance Framework (BAF) once objectives and metrics have been finalised. This was discussed at the Senior Leadership Team (SLT) meeting on 16th February 2016. The Executive Team will explore and look to implement the metrics during March 2016.

The progress report was presented to the Committee and some good examples of practice were noted. The format/layout of the report will be amended for the future to enable easier understanding. There were 4 finalised reports 1) General ledger 2) Information Governance 3) Payroll 4) LCFS.

Of note there is still work ongoing around the Access Policy and the Safer Staffing Policy.

6. RSM – internal audit progress report

The report presented detailed agreed action plans included within the final report summarising the work completed to date.

A number of assignments remain "in progress" and it is anticipated all action plans will be completed by the agreed end date of 31st March 2016. There is one change proposed to the plan and this was to defer the work around *consent* to quarter 1 for 2016/2017. This was agreed.

7. Ernst and Young – external annual audit plan

The Committee were presented with the annual audit plan for the audit of the Trust's financial statements and value for money conclusion. The report took account of various changes within the Trust's finance team and it was noted there was a contingency plan in place.

Ernst and Young felt assured there were no significant risks but there were some key areas of focus for the Trust. In terms of financial performance – the trust is continuing to work pan Staffordshire and supporting the move forward with some initiatives.

8. Ernst and Young – update paper

This quarterly paper was presented for information providing an update on relevant key themes.

9. Segmental reporting

This report was not too dissimilar to previous years and it was recognised and accepted that NHS Trusts have similar operating characteristics in line with local requirements. In essence the type of customer and the method used to provide services are predominantly the same. The Committee accepted the recommendation that the Trust have should report one "provision of healthcare".

10. Committee Effectiveness Review

This overview is currently in the process of being plotted. This will then need to come to the Audit Committee as part of the assurance process.

11. Charities consolidation

The Committee were asked to consider this paper which incorporates the Department of Health Guidance on the consolidation of Charitable Funds into Trust financial accounts. It was agreed that the current level of funds fell below the level of materiality for the organisation.

12. CIP process verbal update

The first stage of the 2016/17 plan had begun its roll out and was being strengthened using a bottom up approach. Six weekly finance meetings had been introduced in December 2015 to discuss detail, presentations to Board and Execs had taken place and future planning of CIP was being deep rooted. A PID has been produced to incorporate

the CIP and also the Quality Impact assessment.

Attention needs to focus around schemes for recurrent funding in the future.

Summaries of various Committees – these were presented for information only.

REPORT TO: Trust Board Enclosure 15

Date of Meeting:	**25 February 2016**
Title of Report:	Overview of the report from the independent Mental Health Taskforce NHS England February 2016 (Five Year Forward View).
Presented by:	**Tom Thornber Director of Strategy and Planning**
Author of Report:	Tom Thornber, Director of Strategy and Planning
Purpose / Intent of Report:	• For Decision / Approval • For Information
Management Oversight prior to Committee	
Executive Summary:	**The report commissioned by the Five year Forward View identifies key recommendations for NHS England and Department of Health to take forward which will significantly influence our 1 year Operating Plan and 5 year Integrated Business Plan refresh.**
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Across all strategy priorities.
Relationship with Annual Objectives:	Supports delivery of our 1 year and 5 year plan.
Risk / Legal Implications:	**N/A**
Resource Implications:	N/A
Equality & Diversity:	N/A
Relationship with the Board Assurance Framework	Supports the 1 year and 5 year plans which links to the annual objectives that helps inform the Trust compliance with the Board Assurance Framework and annual governance statement.
Recommendations:	The document is for debate and review to support the development of our 1 year operational and 5 year Integrated Business Development refresh to deliver against the recommendations proposed in the report.

North Staffordshire Combined Healthcare NHS
NHS Trust

To: Trust Board

From: Tom Thornber, Director of Strategy and Planning

Date: 25 February 2016

SUBJECT: Final Report from the Independent Mental Health Taskforce NHS England.

Introduction

An independent mental health taskforce, commissioned as part of the NHS *Five year forward view*, published its final report February 2016 chaired by Mind Chief Executive Paul Farmer. The Executive Summary ***Appendix 1*** attached.

The taskforce explored the variation in access to and quality of care and support across England; looked at outcomes for people who are and aren't able to access these, and considered ways to tackle the prevention of mental health problems.

Mental health statistics

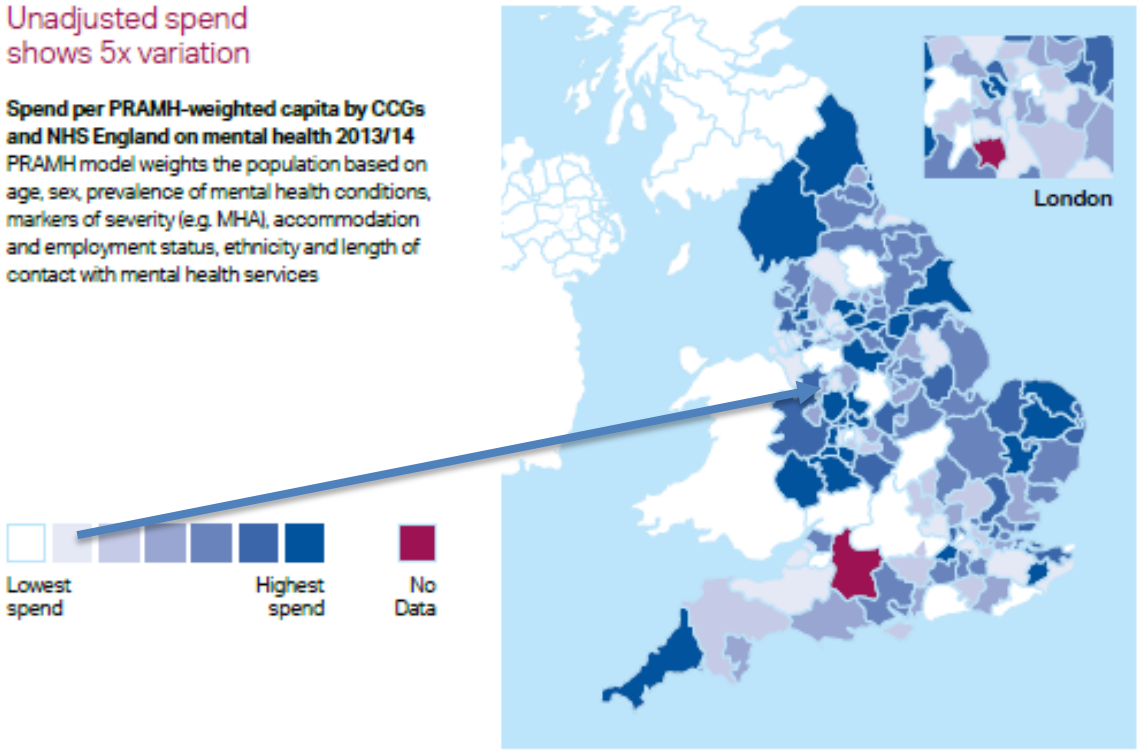
- 1 in 4 people in the UK will experience a mental health problem each year
- 3 children in every classroom have a diagnosable mental health condition
- only a quarter of people with a common mental health problem get treatment, mostly in the form of medication
- 90% of prisoners have at least one mental health disorder, including personality disorder, psychosis, neurosis, alcohol misuse and drug dependence
- 2.3 million people with a mental health condition are out of work and mental health conditions are the primary reason for claiming health related benefits
- mental illness costs the country as much as £100 billion each year through lost working days, benefits and treating preventable illness
- the most common mental health problem is depression which is experienced by 8 to 12% of the population

The taskforce set out a number of recommendations, including improving access to talking therapies and crisis care See **Appendix 2**, together with a proposed development and infrastructure of mental health pathways **Appendix 3.**

The government has accepted the recommendations and pledged to treat a million more people by 2020 with £1 billion of funding. However, the funding will need to be found from the £8.4 billion the government has promised to the NHS this parliament.

This report provides important focus on what service users and patients experiencing every type of mental ill health need – an ambitious programme of support and greater access to services.

Locally the graph below indicates the significant underspend within Stoke on Trent comparative to North and South Staffordshire.



Among the key recommendations are:

By 2020/21, one million extra people will be provided with support for their mental health problem.

People facing a crisis should have access to mental health care 24/7.

People's mental and physical health should be treated equally – including people with severe mental health problems, women in the perinatal period, children and young people.

Commenting in response to the report, Saffron Cordery, Director of policy and strategy at NHS Providers, said:

"Everyone in the mental health community should welcome this report. It provides important focus on what service users and patients experiencing every type of mental ill health need – an ambitious

programme of support and greater access to services.

"However, against the backdrop of extensive financial challenge in the NHS, it remains to be seen whether the proposals set out in the report are genuinely affordable. It is notable that there is no additional upfront investment to help deliver what is an ambitious agenda outlined in the report. In acute services we are seeing substantial investment in transformation – it would be helpful to follow suit in mental health and community services."

Recommendations to the Board

The Board Directors are asked to:

• **RECEIVE** The Executive summary and overview of the report.

• **DEBATE** its content, **CONFIRM** that it aligns with expectations both in our 1 year Operational Plan and future refresh of the 5- Year Integrated Business Plan.

Appendix 1

EXECUTIVE SUMMARY

THE CURRENT STATE OF MENTAL HEALTH

"The NHS needs a far more proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services".

Mental health problems are widespread, at times disabling, yet often hidden. People who would go to their GP with chest pains will suffer depression or anxiety in silence. **One in four adults** experiences at least one diagnosable mental health problem in any given year. People in all walks of life can be affected and at any point in their lives, including new mothers, children, teenagers, adults and older people. Mental health problems represent the largest single cause of disability in the UK. The cost to the economy is estimated at £105 billion a year – roughly the cost of the entire NHS.

POLICY CONTEXT

There has been a **transformation in mental health** over the last 50 years. Advances in care, the development of anti-psychotic and mood stabilising drugs, and greater emphasis on human rights led to the growth of community based mental health services. In the 1990s, the Care Programme Approach was developed to provide more intensive support to people with severe and enduring mental illness. There was a new emphasis on promoting public mental health and developing services for children and homeless people. In 1999, the National Service Framework for Mental Health was launched to establish a comprehensive evidence based service. This was followed by the NHS Plan in 2000 which set targets and provided funding to make the Framework a reality. A National Service Framework for Children, Young People and Maternity Services was then launched in 2004.

In 2011, the Coalition government published a **mental health strategy** setting six objectives, including improvement in the outcomes, physical health and experience of care of people with mental health problems, and a reduction in avoidable harm and stigma. The strategy was widely welcomed. However, despite these initiatives, challenges with system wide implementation coupled with an increase in people using mental health services has led to inadequate provision and worsening outcomes in recent years, including a rise in the number of people taking their own lives.

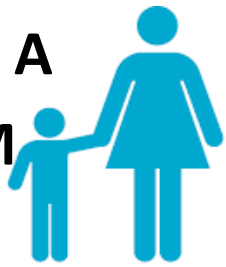
Yet, over the last five years, public attitudes towards mental health have improved, in part due to the Time to Change campaign. In turn, this increased awareness has heightened understanding of an urgent need to act on improving the experiences of people with mental health problems, both within and beyond the NHS. There is now a need to **re-energise and improve mental health care across the NHS** to meet increased demand and improve outcomes.

In this context, NHS England and the Department of Health **published Future in Mind** in 2015, which articulated a clear consensus about the way in which we can make it easier for children and young people to access high quality mental health care when they need it. This strategy builds on these strong foundations.
Mental health has not had the priority awarded to physical health, has been short of qualified staff and has been deprived of funds. We must provide equal status to mental and physical health, equal status to mental health staff and equal funding for mental health services as part of a triple approach to improve mental health care – a fresh mindset for mental health within the NHS and beyond.

MENTAL HEALTH PROBLEMS IN THE POPULATION

Half of all mental health problems have been established by the age of 14, rising to 75 per cent by age 24. **One in ten children** aged 5 – 16 has a diagnosable problem such as conduct disorder (6 per cent), anxiety disorder (3 per cent), attention deficit hyperactivity disorder (ADHD) (2 per cent) or depression (2 per cent). Children from low income families are at highest risk, three times that of those from the highest. Those with conduct disorder - persistent, disobedient, disruptive and aggressive behaviour - are twice as likely to leave school without any qualifications, three times more likely to become a teenage parent, four times more likely to become dependent on drugs and 20 times more likely to end up in prison. Yet most children and young people get no support. Even for those that do the average wait for routine appointments for psychological therapy was 32 weeks in 2015/16. A small group need inpatient services but, owing to inequity in provision, they may be sent anywhere in the country, requiring their families to travel long distances.

1 IN 10 CHILDREN AGED 5-16 YEARS HAVE A DIAGNOSABLE MENTAL HEALTH PROBLEM



One in five mothers suffers from depression, anxiety or in some cases psychosis during pregnancy or in the first year after childbirth. Suicide is the second leading cause of maternal death, after cardiovascular disease. Mental health problems not only affect the health of mothers but can also have long-standing effects on children's emotional, social and cognitive development. Costs of perinatal mental ill health are estimated at £8.1 billion for each annual birth cohort, or almost £10,000 per birth. Yet fewer than 15 per cent of localities provide effective specialist community perinatal services for women with severe or complex conditions, and more than 40 per cent provide no service at all.
Physical and mental health are closely linked – **people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people** – one of the greatest health inequalities in England.

Two thirds of these deaths are from avoidable physical illnesses, including heart disease and cancer, many caused by smoking. There is also a lack of access to physical healthcare for people with mental health problems – less than a third of people with schizophrenia in hospital received the recommended assessment of cardiovascular risk in the previous 12 months.

In addition, **people with long term physical illnesses suffer more complications if they also develop mental health problems,** increasing the cost of care by an average of 45 per cent. Yet much of the time this goes unaddressed. There is good evidence that dedicated mental health provision as part of an integrated service can substantially reduce these poor outcomes. For example, in the case of Type 2 diabetes, £1.8 billion of additional costs can be attributed to poor mental health. Yet fewer than 15 per cent of people with diabetes have access to psychological support. Pilot schemes show providing such support improves health and cuts costs by 25 per cent.

Stable employment and housing are both factors contributing to someone being able to maintain good mental health and are important outcomes for their recovery if they have developed a mental health problem. Between 60–70 per cent of people with common mental health problems are in work, yet few employees have access to specialist occupational health services. For people being supported by secondary mental health services, there is a 65 per cent employment gap compared with the general population. People with mental health problems are also often overrepresented in high-turnover, low-pay and often part-time or temporary work. Common mental health problems are over twice as high among people who are homeless compared with the general population, and psychosis is up to 15 times as high. Children living in poor housing have increased chances of experiencing stress, anxiety and depression.

Only **half of veterans of the armed forces** experiencing mental health problems like Post Traumatic Stress Disorder seek help from the NHS and those that do are rarely referred to the right specialist care. NHS England is currently consulting on the future of mental health support for this group and it is essential that more is done to ensure their needs are identified early and they are supported to access specialist care swiftly.

One in five older people living in the community and 40 per cent of older people living in care homes are affected by depression. Diagnosing depressive symptoms can be difficult, and we know that some clinicians believe treatment for depression is less effective in older people, despite evidence to the contrary.

40 PER CENT OF OLDER PEOPLE LIVING IN CARE HOMES ARE AFFECTED BY DEPRESSION

People in **marginalised groups** are at greater risk, including black, Asian and minority ethnic (BAME) people, lesbian, gay, bisexual and transgender people, disabled people, and people who have had contact with the criminal justice system, among others. BAME households are more likely to live in poorer or over-crowded conditions, increasing the risks of developing mental health problems.
People of all ages who have experienced traumatic events, poor housing or homelessness, or who have multiple needs such as a learning disability or autism are also at higher risk.

As many as **nine out of ten people in prison** have a mental health, drug or alcohol problem.

Suicide is rising, after many years of decline. Suicide rates in England have increased steadily in recent years, peaking at 4,882 deaths in 2014. The rise is most marked amongst middle aged men. Suicide is now the leading cause of death for men aged 15–49. Men are three times more likely than women to take their own lives - they accounted for four out of five suicides in 2013. A quarter of people who took their own life had been in contact with a health professional, usually their GP, in the last week before they died. Most were in contact within a month before their death.

More than a quarter (28 per cent) of suicides were amongst people who had been in contact with mental health services within 12 months before their death, amounting to almost 14,000 people in the ten years from 2003-2013. However, suicides amongst inpatients in mental hospitals have significantly declined over the same period, as a result of better safety precautions.

CURRENT EXPERIENCES OF MENTAL HEALTH CARE

Nearly two million adults were in contact with **specialist mental health and learning disability services** at some point in 2014/15 – though we know little about the quality of their care and there remains extensive unmet need for mental health care. Three quarters of people with mental health problems receive no support at all. Among those who are helped, too few have access to the full range of interventions recommended by National Institute for Health and Care Excellence (NICE), including properly prescribed medication and psychological therapy.

Nine out of ten adults with mental health problems are supported in primary care. There has been a significant expansion in access to psychological therapies, following the introduction of the national IAPT programme (Improving Access to Psychological Therapies). However, there is considerable variation in services, with a waiting time of just over six days in the best performing areas and 124 days in the worst performing areas in 2014-15.

Of those adults with more **severe mental health problems** 90 per cent are supported by community services. However, within these services there are very long waits for some of the key interventions recommended by NICE, such as psychological therapy, and many people never have access to these interventions. One-quarter of people using secondary mental health services do not know who is responsible for coordinating their care, and the same number have not agreed what care they would receive with a clinician. Almost one-fifth of people with care coordinated through the Care Programme Approach (for people with more severe or complex needs) have not had a formal meeting to review their care in the previous 12 months.

NINE OUT OF TEN ADULTS WITH MENTAL HEALTH PROBLEMS ARE SUPPORTED IN PRIMARY CARE

In its recent review of **crisis care**, the Care Quality Commission found that only 14 per cent of adults surveyed felt they were provided with the right response when in crisis, and that only around half of community teams were able to offer an adequate 24/7 crisis service. Only a minority of hospital Accident & Emergency (A&E) departments has 24/7 cover from a liaison mental health service, even though the peak hours for mental health crisis presentations to A&E are between 11pm and 7am. Too often, people in mental health crisis are still accessing mental health care via contact with the police. The inquiry found that while adults were seen promptly where liaison mental health services were available in an A&E department and there were clear pathways through to community services, those aged under 16 were referred directly to children and young people's services but seen only when services were open during office hours. This could involve waiting a full weekend and lead to a significant variation in the quality of care on the basis of someone's age.

Admissions to **inpatient care** have remained stable for the past three years for adults but the severity of need and the number of people being detained under the Mental Health Act continues to increase, suggesting opportunities to intervene earlier are being missed. Men of African and Caribbean heritage are up to 6.6 times more likely to be admitted as inpatients or detained under the Mental Health Act, indicating a systemic failure to provide effective crisis care for these groups.

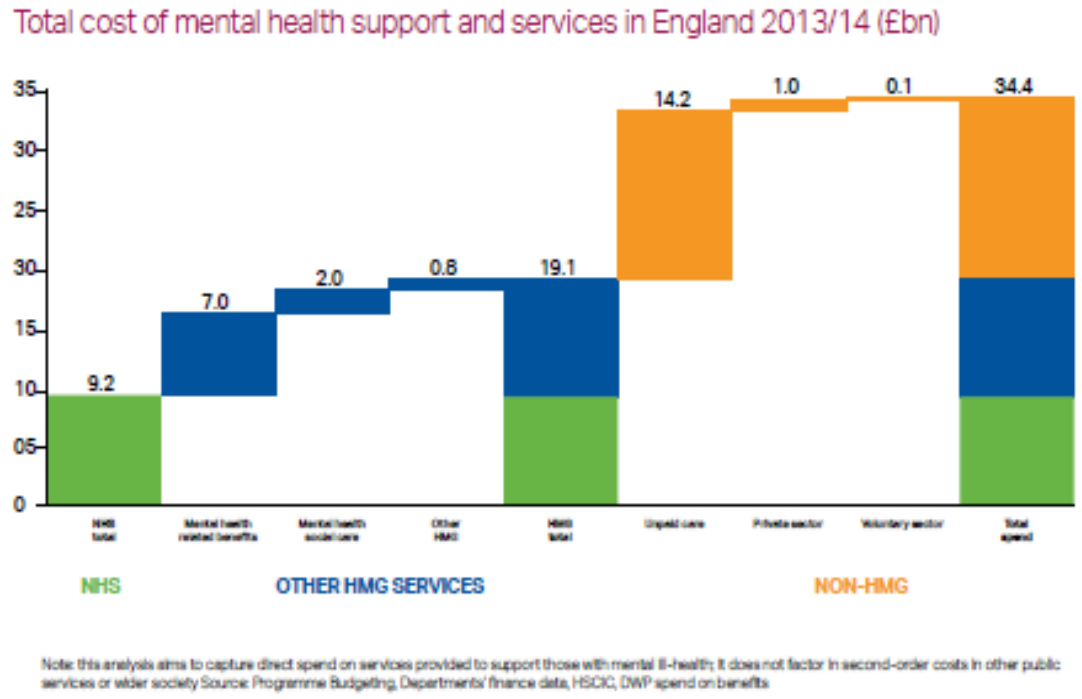
The number of adult inpatient psychiatric beds reduced by 39 per cent overall in the years between 1998 and 2012. For children and young people, average admissions per provider increased from 94 in 2013/14 to 106 in 2014/15. **Bed occupancy** has risen for the fourth consecutive year to 94 per cent. Many acute wards are not always safe, therapeutic or conducive to recovery. Pressure on beds has been exacerbated by a lack of early intervention and crisis care, and the resulting shortage leads to people being transferred long distances **outside of their area**.

Mental health accounts for 23 per cent of NHS activity but NHS **spending** on secondary mental health services is equivalent to just half of this. Years of low prioritisation have led to Clinical Commissioning Groups (CCGs) underinvesting in mental health services relative to physical health services but the degree of the disparity has largely been obscured by the way spending on mental health conditions is grouped together and reported, unlike spend on physical health care, which is disaggregated by specific conditions. Spending per capita across CCGs varies almost two-fold in relation to underlying need.

£34 BILLION EACH YEAR SPENT

ON MENTAL HEALTH

Poor mental health carries an **economic and social cost of £105 billion a year** in England. Analysis commissioned by NHS England found that the national cost of dedicated mental health support and services across government departments in England totals £34 billion each year, excluding dementia and substance use [1].



Note: this analysis aims to capture direct spend on services provided to support those with mental ill-health; it does not factor in second-order costs in other public services or wider society Source: Programme Budgeting, Departments' finance data, HSCIC, DWP spend on benefits

£19 billion of this is made up of government spend, though there is little or no national data available for how up to 67 per cent of mental health funding is used at a local level. Most of the remainder (£14bn) is for the support provided by unpaid carers, plus a relatively small share that is funded through the private and voluntary sectors.
Given chronic underinvestment in mental health care across the NHS in recent years, efficiencies made through achieving better value for money should be **re-invested to meet the significant unmet mental health needs** of people of all ages across England, and to improve their experiences and outcomes.

WHAT NEEDS TO HAPPEN - A FRESH MINDSET

"We should have fewer cases where people are unable to get physical care due to mental health problems affecting engagement and attendance (and vice versa). And we need provision of mental health support in physical health care settings - especially primary care."

People told us that their mental health needs should be treated with equal importance to their physical health needs, whatever NHS service they are using – this is a fundamental principle of the Taskforce recommendations.

All too often people living with mental health problems still experience stigma and discrimination, many people struggle to get the right help at the right time and evidence-based care is significantly underfunded. The human cost is unacceptable and the financial cost to government and society is unsustainable.

Leaders across the system must take decisive steps to break down barriers in the way services are provided to reshape how care is delivered, increase access to the right care at the right time, drive down variations in the quality of care on offer, and improve outcomes.

Our ambition is to deliver rapid improvements in outcomes by 2020//21 through ensuring that 1 million more people with mental health problems are accessing high quality care. In the context of a challenging Spending Review, **we have identified the need to invest an additional £1 billion in 2020/21**, which will generate significant savings. It builds on the £280 million investment each year already committed to drive improvements in children and young people's mental health, and perinatal care.

PRIORITY ACTIONS FOR THE NHS BY 2020/21

1. A 7 day NHS – right care, right time, right quality

"If you feel unwell in the evening, during the night or at the weekends and bank holidays there is no choice but to go to A&E. There's no support out there during these times. It's crucial that this is changed for the benefit of service users, their families and carers."

People facing a crisis should have access to mental health care **7 days a week** and 24 hours a day in the same way that they are able to get access to urgent physical health care. Getting the right care in the right place at the right time is vital. Failure to provide care early on means that the acute end of mental health care is under immense pressure. Better access to support was one of the top priorities identified by people in our engagement work. Early intervention services provided by dedicated teams are highly effective in improving outcomes and reducing costs.

The Care Quality Commission (CQC) found that just half of Community Mental Health Teams (CMHTs) are able to offer a 24/7 crisis service today. By 2020/21, NHS England should ensure that a 24/7 community-based mental health crisis response is available in all areas across England and that services are adequately resourced to offer intensive home treatment as an alternative to acute inpatient admission. For adults, NHS England should invest to expand Crisis Resolution and Home Treatment Teams (CRHTTs); for children and young people, an equivalent model of care should be developed within this expansion programme. **Out of area placements for acute care should be reduced and eliminated as quickly as possible.**

Good liaison mental health care is also needed in acute hospitals across the country, providing a 24/7 urgent and emergency mental health response for people attending A&E or admitted as inpatients to acute hospitals. Only a minority of A&E departments have 24/7 liaison mental health services that reach minimum quality standards, even though peak hours for people presenting to A&E with mental health crises are 11pm-7am. By 2020/21 no acute hospital should be without all-age mental health liaison services in emergency departments and inpatient wards, and at least 50 per cent of acute hospitals should be meeting the 'core 24' service standard as a minimum.
People experiencing a first episode of psychosis should have access to a NICE-approved care package within 2 weeks of referral. Delay in providing care can lead to poorer clinical and social outcomes. The NHS should ensure that by April 2016 more than 50 per cent of this group have access to Early Intervention in Psychosis services, rising to at least 60 per cent by 2020/21.

People want care in the least restrictive setting that is appropriate to meet their individual needs, at any age, and is close to home. People living with severe mental health problems, such as schizophrenia or personality disorder, should not be held in restrictive settings for longer than they need to be. **The NHS should expand proven community-based services for people of all ages with severe mental health problems who need support to live safely as close to home as possible.**

More 'step-down' help should be provided from secure care, such as residential rehabilitation, supported housing and forensic or assertive outreach teams. By April 2017, population-based budgets should be in place for those CCGs who wish to commission specialised services for people of all ages, in partnership with local government and national specialised commissioners. The Taskforce welcomes the invitation set out in NHS England Planning Guidance 2016/17 – 2020/21 for providers of secondary mental health services to manage budgets for tertiary (specialised) services, to reduce fragmented commissioning and improve full community and inpatient care pathways.

Improving the 7 day crisis response service across the NHS will help save lives as part of a major drive to **reduce suicide by 10 per cent by 2020/21.** Every area must develop a multi-agency suicide prevention plan that demonstrates how they will implement interventions targeting high-risk locations and supporting high-risk groups within their population.

Some people experience unacceptably poor access to or quality of care. There has been no improvement in race inequalities relating to mental health care since the end of the 5-year Delivering Race Equality programme in 2010. **Inequalities in access** to early intervention and crisis care, rates of detentions under the Mental Health Act 1983 and lengths of stay in secure services persist.

National and local commissioners must show leadership in tackling unwarranted variations in care. The Department of Health should address race equality as a priority and appoint a new equalities champion to drive change.

Measures must be taken to ensure all deaths across NHS-funded inpatient mental health services are properly investigated, and learned from to improve services and prevent repeat events. By April 2017, the Department of Health should establish an independent system for the assurance of the quality of investigations of all deaths in inpatient mental health services and to ensure a national approach to applying learning to service improvement.

2. An integrated mental and physical health approach
"Making physical and mental health care equally important means that someone with a disability or health problem won't just have that treated, they will also be offered advice and help to ensure their recovery is as smooth as possible, or in the case of physical illness a person cannot recover from, more should be done for their mental wellbeing as this is a huge part of learning to cope or manage a physical illness."

People told us that mental health support should be made easily available across the NHS - for mums to be, children, young adults visiting their GP, people worried about stress at work, older people with long-term physical conditions and people receiving care for cancer or diabetes. People with existing mental health problems told us that services should be integrated - for example, physical health checks and smoking cessation programmes should be made available for everyone with a severe mental illness.

The impact of mental health problems experienced by women in pregnancy and during the first year following the birth of their child can be devastating for both mother and baby, as well as their families. **By 2020/21, NHS England should support at least 30,000 more women each year to access evidence-based specialist mental health care during the perinatal period.** This should include access to psychological therapies and the right range of specialist community or inpatient care so that comprehensive, high-quality services are in place across England.

By 2020/21, at least 280,000 people living with severe mental health problems should have their physical health needs met. They should be offered screening and secondary prevention reflecting their higher risk of poor physical health. This will reduce the health inequalities gap. We know there is low take up of information, tests and interventions relating to physical activity, smoking, alcohol problems, obesity, diabetes, heart disease and cancer. In England there are over 490,000 people with severe mental illness registered with a GP. The proportion receiving an annual physical health check ranges from 62 per cent to 82 per cent (this data does not include any information about how many people are being supported to access evidence based interventions as a result of these checks). People with a long standing mental health problem are twice as likely to smoke, with the highest rates among people with psychosis or bipolar disorder. Current incentive schemes for GPs to encourage monitoring of physical health should continue and extra efforts should be made to reduce smoking - one of the most significant causes of poorer physical health for this group. Mental health inpatient services should be smoke free by 2018.

The provision of psychological therapies for people with common mental health problems has expanded hugely in recent years. But it is still meeting only 15 per cent of need for adults. NHS England should **increase access to evidence-based psychological therapies to reach 25 per cent of need so that at least 600,000 more adults with anxiety and depression can access care (and 350,000 complete treatment) each year by 2020/21.** There should be a focus on helping people who are living with long-term physical health conditions or who are unemployed. There must also be investment to increase access to psychological therapies for people with psychosis, bipolar disorder and personality disorder.

3. Promoting good mental health and preventing poor mental health– helping people lead better lives as equal citizens

"If I'd had the help in my teens that I finally got in my thirties, I wouldn't have lost my twenties."

Prevention matters - it's the only way that lasting change can be achieved. Helping people lead fulfilled, productive lives is not the remit of the NHS alone. It involves good parenting and school support during the early years, decent housing, good work, supportive communities and the opportunity to forge satisfying relationships. These span across national and local government, so the Taskforce has a set of recommendations to build on the Prime Minister's commitment to a "mental health revolution."

Prevention at key moments in life

Children and young people are a priority group for mental health promotion and prevention, and we are calling for the Future in Mind recommendations to be implemented in full. Early intervention and quick access to good quality care is vital – especially for children and young people. Waiting times should be substantially reduced, significant inequalities in access should be addressed and support should be offered while people are waiting for care.

By 2020/21, at least 70,000 more children and young people should have access to high-quality mental health care when they need it. This will require a fundamental change in the way services are commissioned, placing greater emphasis on prevention, early identification and evidence-based care. NHS England should continue to work with partners to fund and implement the whole system approach described in Future in Mind, building capacity and capability across the system so that by 2020/21 we will secure measurable improvements in children and young people's mental health outcomes. We need to ensure that good quality local transformation

plans are put into action, invest in training to ensure that all those working with children and young people can identify mental health problems and know what to do, complete the roll-out of the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme across England by 2018 and develop an access standard for Child and Adolescent Mental Health Services (CAMHS) by the end of 2016/17. This should build on the standard for children and young people with eating disorders announced in July 2015.

BY 2020/21 AT LEAST 70,000 MORE CHILDREN AND YOUNG PEOPLE SHOULD HAVE ACCESS TO HIGH-QUALITY MENTAL HEALTH CARE

In addition, some children are particularly vulnerable to developing mental health problems - including those who are looked after or adopted, care leavers, victims of abuse or exploitation, those with disabilities or long term conditions, or who are within the justice system. The Departments of Health and Education should establish an expert group to examine their complex needs and how they should best be met, including through the provision of personalised budgets. The Government should also review the best way to ensure that the significant expansion of parenting programmes announced by the Prime Minister builds on the strong-evidence base that already exists and is integrated with Local Transformation Plans for Children and Young People's mental health services.

The **employment rate for adults** with mental health problems remains unacceptably low: 43 per cent of all people with mental health problems are in employment, compared to 74 per cent of the general population and 65 per cent of people with other health conditions. Of people with 'mental and behavioural disorders' supported by the Work Programme, only 9.5 per cent have been supported into employment, a lower proportion than for some proven programmes. There is a 65 per cent point gap between the employment rates of people being supported by specialist mental health services who have more severe health problems and the general population.
Employment and health form a virtuous circle: suitable work can be good for your health, and good health means that you are more likely to be employed.
By 2020/21, each year up to 29,000 more people living with mental health problems should be supported to find or stay in work through increasing access to psychological therapies for common mental health problems and expanding access to Individual Placement and Support (IPS).

Employment is vital to health and should be recognised as a health outcome. The NHS must play a greater role in supporting people to find or keep a job. Access to psychological support must be expanded to reach at least a quarter of all people who need it. There must be a doubling of access to Individual Placement and Support programmes to reach an extra 30,000 people living with severe mental illness (so that at least 9,000 are in employment), and the new Work and Health Programme should prioritise investment in health-led interventions that are proven to work for people with mental health problems.

Creating mentally healthy communities
We heard from many people about the importance of the role of Local Government in the promotion and prevention agenda. Building on the success of local Crisis Care Concordat Plans, we recommend the creation of local Mental Health Prevention Plans, based on high quality evidence.

Housing is critical to the prevention of mental health problems and the promotion of recovery. The Department of Health, the Department of Communities and Local Government, NHS England, HM Treasury and other agencies should work with local authorities to build the evidence base for specialist housing support for vulnerable people with mental health problems and explore the case for using NHS land to make more supported housing available for this group.

In relation to the proposed Housing Benefit cap to Local Housing Allowance levels, the Department of Work and Pensions should use evidence to ensure that the right levels of protection are in place for people with mental health problems who require specialist supported housing. The Ministry of Justice, Home Office, Department of Health, NHS England and Public Health England should work together to **support those in the criminal justice system experiencing mental health problems** by expanding- liaison and diversion schemes nationally, increasing support for Blue Light services, and for the 90 per cent of people in prison with mental health problems, drug or alcohol problems.
Ending the **stigma** around mental ill health is vital.

The Department of Health and Public Health England should continue to help local communities build a grass roots social movement to raise awareness of good physical and mental health and support people to seek help when they need it.

Building a better future
"There should be even greater emphasis put on people's experience and how experts-by-experience can be seen as real assets to design and develop services."

The next five years will build the foundations for the next generation.
The UK should be a world leader in the development and application of new **mental health research**. The Department of Health, working with relevant partners, should publish a ten year strategy for mental health research one year from now including a co-ordinated plan for strengthening the research pipeline on identified priorities, and promoting implementation of research evidence.

A **data and transparency revolution** is required to ensure greater consistency in the availability and quality of NHS-funded services across the country. The information gathered by the NHS should reflect social as well as clinical outcomes – e.g. education, employment and housing - that matter to people with mental health problems. This requires better data linkage across the NHS, public health, education and other sectors, with absolute transparency on spending in relation to prevalence, access, experience and outcomes. **By 2020/21, CCGs should be required to publish a range of benchmarking data to provide transparency about mental health spending and performance.**

DELIVERING THIS STRATEGY

"Being both a junior doctor training in psychiatry, and a patient with mental health problems, enables me to experience both sides of the NHS, and I feel this gives me a great advantage and insight. Whilst a lot of the work I experience on both sides is very positive, I am frequently amazed by the heavy workloads of my colleagues and those treating me. And I know that for me, this can in fact contribute to deterioration in my own mental health."

Mental health services have been chronically underfunded. We know that the presence of poor mental health can drive a 50 per cent increase in costs in physical care. The Taskforce considers it a point of basic parity between physical and mental health that types of care and therapies shown to lead to improved mental health outcomes and found to be cost-effective should be made available to people with mental health problems. Without upfront investment it will not be possible to implement this strategy and deliver much-needed improvements to people's lives, as well as savings to the public purse.

Over the next five years additional funding should allow NHS England to expand access to effective interventions. The priority areas we have identified would require an additional £1 billion investment in 2020/21, which will contribute to plugging critical gaps in the care the NHS is currently unable to provide. Our expectation is that savings and efficiencies generated by improved mental health care e.g. through a strengthened approach to prevention and early intervention, and through new models of care, will be re-invested in mental health services.

To deliver these commitments and realise the associated savings NHS England must be able to target investment and ensure there is sufficient transparency and accountability for putting them into action. Both the current Mandate priorities and those set out in this report should specifically be reflected in the local Sustainability and Transformation plans that areas will need to produce by June 2016, in how those plans are assessed and in the processes for allocating and assuring funds.

We recommend eight principles to underpin reform:

Decisions must be locally led
Care must be based on the best available evidence

Services must be designed in partnership with people who have mental health problems and with carers

- Inequalities must be reduced to ensure all needs are met, across all ages
- Care must be integrated – spanning people's physical, mental and social needs
- Prevention and early intervention must be prioritised
- Care must be safe, effective and personal, and delivered in the least restrictive setting
- The right data must be collected and used to drive and evaluate progress

We make specific recommendations on the need to develop and support the mental health workforce, making it a career option of choice across medicine, social care, the allied health professions and the voluntary sector. We encourage the further development of personalised care, giving people choice in their own care, and the expansion of peer support.

We make a series of fundamental recommendations to hardwire mental health into how care is commissioned, funded, and inspected, across the whole NHS. These should enable mental health to be fully embedded in NHS planning and operations for the duration of the Five Year Forward View.

Co-production with experts-by-experience should also be a standard approach to commissioning and service design, with Arm's Length Bodies (ALBs) leading by example and supporting this practice in local areas. We recommend the creation of a Mental Health Advisory Board reporting to the Five Year Forward View Board, publicly updating on progress against our recommended outcomes. We also encourage the Cabinet Office and Department of Health to put in place cross-government oversight of the wider actions we are recommending the Government should take, in addition to those being led by the NHS.

Conclusion

A summary of our recommendations can be found in the second annex of this report. Delivery of these recommendations is everybody's business - for the NHS, for health and social care professionals, for providers, employers, across government and communities.

But the critical element of success will be to put the individual with their own lived experience of mental health at the heart of each and every decision which is made. We have much to be proud of in the progress that has been made in empowering people to make their own decisions, and for services to be co-designed. We now have to go a step further and truly produce services which are led by the needs of the individual, not the system.

Appendix 2

FULL RECOMMENDATIONS

Recommendations are listed by lead or joint lead agency for the NHS arms-length bodies

NHS ENGLAND	Future in Mind	NHS England should continue to work with HEE, PHE, Government and other key partners to resource and implement Future in Mind, building on the 2015/16 Local Transformation Plans and going further to drive system-wide transformation of the local offer to children and young people so that we secure measurable improvements in their mental health within the next four years. This must include helping at least 70,000 more children and young people each year to access high-quality mental health care when they need it by 2020/21. The CYP Local Transformation Plans should be refreshed and integrated into the forthcoming Sustainability and Transformation Plans (STPs), which cover all health and care in the local geography, and should include evidence about how local areas are ensuring a joined up approach that is consistent with the existing statutory framework for children and young people.
	Access standards and care pathways	By 2020/21, NHS England should complete work with ALB partners to develop and publish a clear and comprehensive set of care pathways, with accompanying quality standards and guidance, for the full range of mental health conditions based on the timetable set out in this report. These standards should incorporate relevant physical health care interventions and the principles of coproduced care planning, balancing clinical and non-clinical outcomes (such as improved wellbeing and employment). Implementation should be supported by: • Use of available levers and incentives to enable the delivery of the new standards, including the development of aligned payment models (NHS England and NHS Improvement) • Alignment of approaches to mental health provider regulation (NHS Improvement and CQC) • Comprehensive workforce development programmes to ensure that the right staff with the right skills are available to deliver care in line with NICE recommendations as the norm (HEE) • Ensuring that the relevant public health expertise informs the development of the new standards and that they are aligned with the new co-existing mental health and alcohol and/or drug misuse services guidance being developed for commissioners and providers of alcohol and/or drug misuse services. (PHE)

NHS ENGLAND	Perinatal mental healthcare	NHS England should invest to ensure that by 2020/21 at least 30,000 more women each year access evidence-based specialist mental health care during the perinatal period. This should include access to psychological therapies and the right range of specialist community or inpatient care so that comprehensive, high-quality services are in place across England.
	Psychological therapies for people with long term conditions	NHS England should invest to increase access to integrated evidence-based psychological therapies for an additional 600,000 adults with anxiety and depression each year by 2020/21 (resulting in at least 350,000 completing treatment), with a focus on people living with long-term physical health conditions and supporting people into employment. There must also be investment to increase access to psychological therapies for people with psychosis, bipolar disorder and personality disorder.
	Employment support	By 2020/21, NHS England and the Joint Unit for Work and Health should ensure that up to 29,000 more people per year living with mental health problems should be supported to find or stay in work through increasing access to psychological therapies for common mental health problems (see above) and doubling the reach of Individual Placement and Support (IPS). NHS England should seek to match this investment in IPS by exploring a Social Impact Bond or other social finance options.
	Early Intervention in Psychosis	NHS England should ensure that by April 2016 50 per cent of people experiencing a first episode of psychosis have access to a NICE–approved care package within two weeks of referral, rising to at least 60 per cent by 2020/21.
	Crisis services	By 2020/21, NHS England should expand Crisis Resolution and Home Treatment Teams (CRHTTs) across England to ensure that a 24/7 community-based mental health crisis response is available in all areas and that these teams are adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission. For children and young people, an equivalent model of care should be developed within this expansion programme.
	Acute liaison	By 2020/21 no acute hospital should be without all-age mental health liaison services in emergency departments and inpatient wards, and at least 50 per cent of acute hospitals should be meeting the 'core 24' service standard as a minimum.

NHS ENGLAND	Least restrictive acute care	In 2016, NHS England and relevant partners should set out how they will ensure that standards – co-produced with experts by experience, clinicians, housing and social care leads – are introduced for acute care services over the next five years. Integral to the standards should be the expectation that acute mental health care is provided in the least restrictive manner and as close to home as possible, with the practice of sending people out of area for acute inpatient care due to local acute bed pressures eliminated entirely by no later than 2020/21. Plans for introduction of the standards should form part of a full response to the Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, by no later than end 2016/17. NHS England and NHS Improvement should also ensure that use of the Mental Health Act is closely monitored at both local and national level, and rates of detention are reduced by 2020/21 through the provision of earlier intervention. Plans should include specific actions to substantially reduce Mental Health Act detentions and targeted work should be undertaken to reduce the current significant over-representation of BAME and any other disadvantaged groups in acute care.
	Secure care pathway	NHS England should lead a comprehensive programme of work to increase access to high quality care that prevents avoidable admissions and supports recovery and 'step down' for people of all ages who have severe mental health problems and significant risk or safety issues in the least restrictive setting, as close to home as possible. This should seek to address existing fragmented pathways in secure care, increase provision of community based services such as residential rehabilitation, supported housing and forensic or assertive outreach teams and identify new co-commissioning, funding and service models. This work should also tackle inequalities for groups shown to be over-represented in detentions and lengthy stays, and seek to ensure that out of area placements are substantially reduced. The programme should identify where and how efficiencies could be realised within the system and reinvested, and include recommendations on the wider reforms required to make this happen, including changes to legal processes. NHS England should also roll out the proven model of teams delivering community forensic CAMHS and complex need services nationally from 2016.
	Using and sharing data	By 2020/21, NHS England and NHS Improvement should work with the HSCIC and with Government to ensure rapid using and sharing of data with other agencies. The Department of Health should hold the HSCIC to account for its performance, and consult to set minimum service expectations for turning around new datasets or changes to existing datasets by no later than summer 2016.
	Vanguards	MCP, PACS, UEC vanguards and the Integrated Personalised Commissioning programme should be supported to ensure that the inclusion of payment for routine integrated care adequately reflects the mental health needs of people with long-term physical health conditions within new care model programmes. Vanguard sites should also provide greater access to personal budgets for people of all ages, including children and young people who have multiple and complex needs, to provide more choice and control over how and when they access different services.

NHS ENGLAND	Physical health outcomes in people with mental illness	NHS England should undertake work to define a quantified national reduction in premature mortality among people with severe mental illness, and an operational plan to begin achieving it from 2017/18. NHS England should also lead work to ensure that by 2020/21, 280,000 more people living with severe mental illness have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention. This will involve developing, evaluating and implementing models of primary care whereby GPs and practice nurses take responsibility for delivering the full suite of physical care screenings, outreach, carer training and onward interventions or referrals, in line with NICE guidelines. This model should include outreach workers or carer training to support people to access primary care because many people with psychosis struggle to access services, and give GPs and practice nurses the training and time they need to deliver NICE-concordant screening and care.
	Older age specialist services	NHS England should ensure that people being supported in specialist older-age acute physical health services have access to liaison mental health teams – including expertise in psychiatry of older adults – as part of their package of care, incentivised through the introduction of a new national CQUIN or alternative incentive payments and embedded through the vanguard programmes.
	Trialling population based budgets	NHS England should ensure that by April 2017 population-based budgets are in place which give CCGs or other local partners the opportunity to collaboratively commission the majority of specialised services across the life course. In 2016/17 NHS England should also trial new models through a Vanguard programme that allow secondary providers of these services to manage care budgets for tertiary (specialised) mental health services to improve outcomes and reduce out of area placements. We recommend testing this at scale, with a particular focus on secure care commissioning, perinatal and specialised CAMHS services.
	Co-production evaluation	NHS England should work with NHS Improvement to run pilots to develop evidence based approaches to co-production in commissioning by April 2018.
	CCG inequalities – funding	NHS England should disaggregate the inequalities adjustment from the baseline funding allocation for CCGs and Primary Care, making the value of this adjustment more visible and requiring areas to publicly report on how they are addressing unmet mental health need and mental health inequalities.
	NHS staff mental health	NHS England should ensure current health and wellbeing support to NHS organisations extends to include good practice in the management of mental health in the workplace, and provision of occupational mental health expertise and effective workplace interventions from 2016 onwards.

NHS ENGLAND	Navigators	NHS England and NHS Improvement should encourage providers to ensure that 'navigators' are available to people who need specialist care from diagnosis onwards, to guide them through options for their care and ensure they receive appropriate information and support. In parallel, NHS England and HEE should work with voluntary and community sector organisations, experts-by-experience and carers to develop and evaluate the role of 'navigators' in enabling more people-centred care to be provided.
	Trialling acute care models or 16-25s	NHS England should work with CCGs, local authorities and other partners to develop and trial a new model of acute inpatient care for young adults aged 16–25 in 2016, working with Vanguard sites. This should evaluate: developmentally and age-appropriate inpatient services for this group; supporting young people in an environment that maximises opportunities for rehabilitation and return to education, training or employment; viewing the young person within their social context; and enlisting the support of families or carers. This should build on the existing trials of new models of 'transitional' services for those aged 0–25.
	NHS staff awareness	NHS England should develop and introduce measures of staff awareness and confidence in dealing with mental health into annual NHS staff surveys across all settings.
	Staff health & wellbeing	NHS England should introduce a CQUIN or alternative incentive payment relating to NHS staff health and wellbeing under the NHS Standard Contract by 2017.
	Data stocktake	NHS England and the HSCIC should work to identify unnecessary data collection requirements, and then engage with NHS Improvement to prioritise persistent non-compliance in data collection and submission to the MHSDS, and take regulatory action where necessary. For the most important data items (including inequalities data), commissioners should use NHS standard contract sanctions (financial penalty) for a data breach where there is persistent non-return of data. Commissioners should be required to use national data flows where they exist and not place undue pressure on providers by asking for local data that duplicates national data.
	Payment system	NHS England and NHS Improvement should together lead on costing, developing and introducing a revised payment system by 2017/18 to drive the whole system to improve outcomes that are of value to people with mental health problems and encourage local health economies to take action in line with the aims of this strategy. This approach should be put in place for children and young people's services as soon as possible.
	Governance	NHS England, the Department of Health and the Cabinet Office should confirm what governance arrangements will be put in place to support the delivery of this strategy. This should include arrangements for reporting publicly on how progress is being made against recommendations for the rest of government and wider system partners.

Public Health England	Mental Health Intelligence Network	During 2016 NHS England and Public Health England should set a clear plan to develop and support the Mental Health Intelligence Network over the next five years, so that it supports data linkage across public agencies, effective commissioning and the implementation of new clinical pathways and standards as they come online.
	Preventing poor physical health outcomes	Public Health England should prioritise ensuring that people with mental health problems who are at greater risk of poor physical health get access to prevention and screening programmes. This includes primary and secondary prevention through screening and NHS Health Checks, as well as interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. As part of this, NHS England and PHE should support all mental health inpatient units and facilities (for adults, children and young people) to be smoke-free by 2018.
	Preventing mental ill health	PHE should develop a national Prevention Concordat programme that will support all Health and Wellbeing Boards (along with CCGs) to put in place updated JSNA and joint prevention plans that include mental health and comorbid alcohol and drug misuse, parenting programmes, and housing, by no later than 2017.
Care Quality Commission	Integrated regulation of CYP services	The CQC should work with Ofsted, Her Majesty's Inspectorate of Constabulary and Her Majesty's Inspectorate of Probation to undertake a Joint Targeted Area Inspection to assess how the health, education and social care systems are working together to improve children and young people's mental health outcomes.
	Quality inspection across settings	The CQC should develop regulation and inspection of NHS-funded services to include mental health as part of its planned approach to assessing the quality of care along pathways and in population groups, beyond the inspection of providers. Within its strategy for 2016–2020, the CQC should also set out how it will strengthen its approach to: • How it inspects primary medical services, acute and adult social care services, so that it assesses whether these services are providing high-quality care for people with mental health problems • Inspect providers on the quality of co-production in individual care planning, carer involvement and in working in partnership with communities to develop and improve mental health services (drawing on good practice such as the 4PI principles) • Ensure that, from 2016, inspections of all specialist mental health services reflect the extent to which the provider ensures that people have an outcomes-focused recovery path that includes discharge and future planning and is integrated with other services, incorporating housing and other social needs - Ensure (with support from the Department of Health) that data captured about experience of inpatient mental health services is represented in a form which allows comparison and improvement monitoring at national level • Incorporates good practice in information sharing with other providers and with mental health carers, to address complex issues relating to how patient confidentiality rules apply in the care of people with mental health problems.

NHS Improvement	Learning from deaths by suicide	NHS Improvement and NHS England, with support from Public Health England, should identify what steps services should take to ensure that all deaths by suicide across NHS-funded mental health settings, including out-of-area placements are learned from to prevent repeat events. This should build on insights through learning from never events, serious incident investigations and human factors approaches. The CQC should then embed this information into its inspection regime.
Health Education England	Workforce planning and development across settings	HEE should work with NHS England, PHE, professional bodies, charities, experts-by-experience and others to develop a costed, multi-disciplinary workforce strategy for the future shape and skill mix of the workforce required to deliver both this strategy and the workforce recommendations set out in Future in Mind. This review should address training needs for both new and existing NHS-funded staff and should report by no later than the end of 2016. This workforce strategy should include: • Clear projections for required staff numbers to 2020/21 and what action will be taken to plug any gaps • Core training in basic mental health awareness and knowledge, understanding of mental health law, public mental health, compassion and communication skills • For professions involved in the care and support of people with mental health problems, tailored curricula with competencies in dealing with the common physical health problems people may present with, shared decision-making, mental health prevention (including suicide), empowering people to understand their own strengths and self-manage, carer involvement and information sharing. Drawing on the best available evidence, this should also ensure that professionals are equipped to provide age-appropriate care and reduce inequalities. HEE and PHE should develop an action plan so that by 2020/21 validated courses are available in mental health promotion and prevention for the public health workforce (including primary care).
	Prescribing standards	HEE should work with the Academy of Medical Royal Colleges to develop standards for all prescribing health professionals that include discussion of the risks and benefits of medication, take into account people's personal preferences, include preventative physical health support and the provision of accessible information to support informed decision-making. This should be completed in collaboration with relevant stakeholders by April 2017 and subject to regular review.

Recommendation for Government

Cabinet office	Co-morbid mental health and substance misuse problems	The Cabinet Office should ensure that the new Life Chances Fund of up to £30m for outcomes-based interventions to tackle alcoholism and drug addiction requires local areas to demonstrate how they will integrate assessment, care and support to people with co-morbid substance misuse and mental health problems, and make a funding contribution themselves. It should also be clear about the funding contribution required from local commissioners to pay for the outcomes that are being sought.
Department of Health	Research	The UK should aspire to be a world leader in the development and application of new mental health research. The Department of Health, working with all relevant parts of government, the NHS ALBs, research charities, independent experts, industry and experts-by-experience, should publish a report one year from now, setting out a 10-year strategy for mental health research. This should include a co-ordinated plan for strengthening and developing the research pipeline on identified priorities, and promoting implementation of research evidence.
	Equalities	The Department of Health should appoint a new equalities champion with a specific remit to tackle health inequalities amongst people with mental health problems and carers across the health and social care system and through cross-government action. This role should include responsibility for advising on operational activity within the NHS to reduce discrimination for people found to be at particular risk, including but not limited to those with characteristics protected by the Equalities Act. The Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, makes a recommendation that a Patients and Carers Race Equality Standard should be piloted in mental health and this should form part of the remit of the new role-holder.
	Suicide prevention	The Department of Health, PHE and NHS England should support all local areas to have multi-agency suicide prevention plans in place by 2017, contributing to a 10 per cent reduction in suicide nationally. These plans should set out targeted actions in line with the National Suicide Prevention Strategy and new evidence around suicide, and include a strong focus on primary care, alcohol and drug misuse. Each plan should demonstrate how areas will implement evidence-based preventative interventions that target high-risk locations and support high-risk groups (including young people who self-harm) within their population, drawing on localised real time data. Updates should be provided in the Department of Health's annual report on suicide.
	Mental Health Act	The Department of Health should work with a wide range of stakeholders to review whether the Mental Health Act (and relevant Code of Practice) in its current form should be revised in parts, to ensure stronger protection of people's autonomy, and greater scrutiny and protection where the views of individuals with mental capacity to make healthcare decisions may be overridden to enforce treatment against their will.

Department of Health	Social work	The Department of Health should continue to support the expansion of programmes that train people to qualify as social workers and contribute to ensuring the workforce is ready to provide high quality social work services in mental health. This should include expanding 'Think Ahead' to provide at least an additional 300 places.
	Supported housing	The Department of Health, Communities and Local Government, NHS England, HM-Treasury and other agencies should work with local authorities to build the evidence base for specialist housing support for vulnerable people with mental health problems and explore the case for using NHS land to make more supported housing available for this group.
	Health and Justice care pathway	The Ministry of Justice, Home Office, Department of Health, NHS England and PHE should work together to develop a complete health and justice pathway to deliver integrated health and justice interventions in the least restrictive setting, appropriate to the crime which has been committed. This should build on the national roll out of Liaison and Diversion schemes (including for children and young people) across England by 2020/21 and the increased uptake of Mental Health Treatment Requirements (diversion through court order to access community based treatment) as part of community sentences for everyone who can benefit from them. It should also improve mental health services in prison and the interface with the secure care system, with continuity of care on release, to support offenders to return to the community.
	Data improvement	The Department of Health, NHS England, PHE and the HSCIC should develop a 5-year plan to: address the need for substantially improved data on prevention, prevalence, access, quality, outcomes and spend across mental health services; set out responsibilities for each agency in providing the necessary legal, commissioning, and quality and safety information required; design and develop new datasets, linking physical health, mental health, social care and employment datasets, while ensuring that information governance adequately protects people's rights; include mental health measures in all physical care datasets, including emergency care. The HSCIC should act as a data system leader and set new minimum service expectations for turning around new datasets or changes to existing datasets. The Department of Health, NHS England, HSCIC and NHS Improvement should publish a summary progress report by the end of 2016 setting out how the specific actions on data, information sharing and digital capability identified in this report and the National Information Board's Strategy are being implemented.
	Children and Young People metrics	The Department of Health should develop national metrics to support improvements in children and young people's mental health outcomes, drawing on data sources from across the whole system, including NHS, public health, local authority children's services and education, to report with proposals by 2017.

Department of Health	Greater transparency	The Department of Health, HSCIC and MyNHS, working with NHS England, should improve transparency in data to promote choice, efficiency, access and quality in mental health care, ensuring that all NHS-commissioned mental health data are transparent (including where data quality is poor) to drive improvements in services. The CCG Performance and Assessment Framework should include a robust basket of indicators to provide a clear picture of the quality of commissioning for mental health. To complement this, NHS England should lead work on producing a Mental Health FYFV Dashboard by the summer of 2016 that identifies metrics for monitoring key performance and outcomes data that will allow us to hold national and local bodies to account for implementing this strategy. The Dashboard should include health and social outcomes including employment and settled housing outcomes for people with mental health problems.
	Prevalence surveys	The Department of Health should commission regular prevalence surveys for children, young people and adults of all ages that are updated not less than every 7 years.
	CCG transparency	The Department of Health and NHS England should require CCGs to publish data on levels of mental health spend in their Annual Report and Accounts, by condition and per capita, including for Children and Adolescent Mental Health Services, from 2017/18 onwards. They should require CCGs to report on investment in mental health to demonstrate the commitment that commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall allocation increase. For children and young people, this should be broken down initially into spend in the community, on emergency, urgent and routine treatment, and for inpatient care.
	Parity for mental health in Health & Social Care Act regulations	The Department of Health should carry out a review of existing regulations of the Health and Social Care Act to identify disparities and gaps between provisions relating to physical and mental health services. This should include considering how to ensure that existing regulations extend rights equally to people experiencing mental health problems (e.g. to types of intervention that are mandated or to access care within maximum waiting times).
	Deaths in inpatient settings	The Department of Health should ensure that the scope of the new Healthcare Safety Investigation Branch includes a clear focus on deaths from all causes in inpatient mental health settings, including independent scrutiny of the quality of investigation, analysis of local and national trends, and evidence that learning is resulting in service improvement. This should include the involvement of families, and build on the models and experiences of the Independent Police Complaints Commission and the Prisons and Probation Ombudsman. The Department should also work with the CQC to establish a methodology for inspecting the quality of learning from all deaths in inpatient mental health services, including introducing greater transparency around the cause of deaths within each provider.

Department of Health	Challenging stigma	The Department of Health should work with PHE to continue to support proven behaviour change interventions, such as Time to Change, and to establish Mental Health Champions in each community, to contribute to improving attitudes to mental health by at least a further 5 per cent by 2020/21.
	Innovation fund for devolved areas	The Department of Health and the Department for Work and Pensions, working with NHS England and PHE, should identify how the £40 million innovation fund announced at the Spending Review and other investment streams should be used to support devolved areas to jointly commission more services that have been proven to improve mental health and employment outcomes, and test how the principles of these services could be applied to other population groups and new funding mechanisms (e.g. social finance).
	Digital	The Department of Health, through the National Information Board, should ensure there is sufficient investment in the necessary digital infrastructure to realise the priorities identified in this strategy. Each ALB should optimise the use of digital channels to communicate key messages and make services more readily available online, where appropriate, drawing on user insight. Building on trial findings, NHS England should expand work on NHS Choices to raise awareness and direct people to effective digital mental health products by integrating them into the website and promoting them through social marketing channels from 2016 onwards.
	New GPs	The Department of Health and NHS England should work with the RCGP and HEE to ensure that by 2020/21 all GPs, including the 5,000 joining the workforce by 2020/21, receive core mental health training, and to develop a new role of GPs with an extended Scope of Practice (GPwER) in Mental Health, with at least 700 in practice within 5 years.
	Regulation of psychological therapies	The Department of Health should consider how to introduce the regulation of psychological therapy services, which are not currently inspected unless provided within secondary mental health services.
	Better Care Fund	To drive and scale improvements in integration, the Department of Health and relevant partners should ensure that future updates to the Better Care Fund include mental health. This might include making an element of payment for outcomes contingent on reducing acute admission through requiring all hospitals to comply with Crisis Care Concordat and NICE standards on liaison and crisis mental health care.
	Summary Care Records	The Department of Health and HSCIC should advocate adoption of data-rich Summary Care Records that include vital mental health information, where individuals consent for information to be shared, by 2016/17.

Department for Work & Pensions	Employment support	The Department for Work and Pensions should ensure that when it tenders the Health and Work Programme it directs funds currently used to support people on Employment Support Allowance to commission evidence-based health-led interventions that are proven to deliver improved employment outcomes – as well as improved health outcomes – at a greater rate than under current Work Programme contracts. The Department of Work and Pensions should also invest to ensure that qualified employment advisers are fully integrated into expanded psychological therapies services.
	Housing Benefit cap	The Department of Work and Pensions should, based on the outcome of the "Supported Housing" review in relation to the proposed Housing Benefit cap to Local Housing Allowance levels, use the evidence to ensure the right levels of protection are in place for people with mental health problems who require specialist supported housing.
Department for Education / Department of Health / Department for Work and Pensions	Parenting programmes and support for children with complex needs	The Departments of Education and Health should establish an expert group to examine the needs of children who are particularly vulnerable to developing mental health problems and how their needs should best be met, including through the provision of personalised budgets. The Government should also review the best way to ensure that the significant expansion of parenting programmes announced by the Prime Minister builds on the strong-evidence base that already exists and is integrated with Local Transformation Plans for Children and Young People's mental health services.
HEFCE	Research	HEFCE should review funding requirements and criteria for decision-making to support parity through the Research Excellence Framework and take action to ensure that clinical academics in mental health (including in psychiatry and neuroscience) are not disadvantaged relative to other areas of health research, starting in 2016/17.
ACRA	Inequalities and funding allocation formula	ACRA should review NHS funding allocation formulas, including the inequalities adjustment, to ensure it supports parity between physical and mental health in 2016/17. They should also be reviewed to ensure they correctly estimate the prevalence and incidence of conditions across the mental health spectrum. Membership of ACRA should be revisited with the specific goal of ensuring that mental health expertise is adequately represented across the disciplines involved, e.g. clinical, academic, policy and providers.

Appendix 3

Proposed mental health pathway and infrastructure development programme