North Staffordshire Combined Healthcare NHS Trust

MEETING OF THE TRUST BOARD

TO BE HELD IN PUBLIC ON THURSDAY, 25 SEPTEMBER 2014, 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 – 24 JULY 2014** *To APPROVE the minutes of the meeting held on 24 JULY 2014*	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.	**TEAM SPOTLIGHT - PRESENTATION FROM THE FINANCE TEAM** *To RECEIVE a presentation from the Trust's Finance Team, led by Mr. Steve Blaise, Acting Deputy Director of Finance*	Verbal
10.	**QUALITY COMMITTEE REPORT** *To REVIEW the Quality Committee assurance report from the meeting held on 16 September 2014 from Mr. P Sullivan, Chair of the Quality Committee*	Assurance Enclosure 5

11.	**SAFE STAFFING MONTHLY REPORT** *To DISCUSS the assurance report on the planned versus actual staff variances from Ms. K Wilson, Director of Nursing and Quality*	Assurance Enclosure 6 *To follow*
12.	**RISK MANAGEMENT COMMITTEE REPORT** *To REVIEW the assurance summary from the Risk Management Committee meeting held on the 13 August 2014 from Mrs. B Johnson, Committee Chair*	Assurance Enclosure 7
13.	**Q2 PRINCIPAL RISK REGISTER REPORT 2014/15** *To APPROVE the Q2 Principal Risk Register from Ms. K Wilson, Director of Nursing & Quality*	Approve Enclosure 8
14.	**INFECTION CONTROL ANNUAL HYGIENE DECLARATION** *To APPROVE the Infection Control Annual Hygiene Declaration from Ms. K Wilson, Director of Nursing & Quality*	Approve Enclosure 9
15.	**PATIENT EXPERIENCE REPORT QUARTER 1 REPORT 2014/15** *To REVIEW for assurance purposes an analysis of PALS and complaints contacts from Ms. K Wilson, Director of Nursing & Quality*	Assurance 10
	TO BE ONE OF THE MOST EFFICIENT PROVIDERS (Strategic Goal)	
16.	**FINANCE & ACTIVITY COMMITTEE REPORT** *To RECEIVE for assurance the Finance & Activity Committee report of the meeting held on 18 September 2014 from Mr. T Gadsby, Committee Chair*	Assurance Enclosure 11
17.	**FINANCE REPORT – Month 5 (2014/15)** *To RECEIVE the month 5 financial position from Mr. C Calkin, Interim Director of Finance*	Approve Enclosure 12
18.	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 5** *To DISCUSS the month 5, Performance Report from Ms. K Wilson, Director of Nursing & Quality*	Assurance Enclosure 13
19.	**SELF CERTIFICATIONS FOR THE NHS TRUST DEVELOPMENT AGENCY** *To APPROVE the Self Certifications for the TDA from Mr. C Calkin, Interim Director of Finance* **NHS TRUST DEVELOPMENT AUTHORITY – Oversight Ratings and Guidance** *To receive the Oversight ratings and guidance from Mr. C Calkin, Interim Director of Finance*	Approve Enclosure 14 Note Enclosure 14.1
20.	**AUDIT COMMITTEE REPORT** *To RECEIVE for assurance the Audit Committee report of the meeting held on the 11 September 2014 from Mrs. B Johnson, Acting Committee Chair*	Assurance Enclosure 15
21.	**AUDIT COMMITTEE ANNUAL REPORT 2013/14** *To RECEIVE for assurance the Audit Committee Annual Report 2013/14 from Mrs. B Johnson, Acting Committee Chair*	Assurance Enclosure 16

22.	**AUDIT COMMITTEE TERMS OF REFERENCE** *To APPROVE the Audit Committee Terms of Reference, presented by the Audit Committee Acting Chair, Mrs. B Johnson*	Approve Enclosure 17
23.	**ANNUAL AUDIT LETTER 2013/14** *To RECEIVE for information the 2013/14 Annual Audit Letter from KPMG, presented by Mr. C Calkin, Interim Director of Finance*	Assurance Enclosure 18
24.	**DIGITAL BY CHOICE PROGRAMME** *To RECEIVE a briefing report on the Digital by Choice Programme from Mr A. Hughes, Interim Director of Strategy & Development*	Note Enclosure 19
25.	**NHS COMPLIANCE WITH EMERGENCY PLANNING, RESILIENCE AND RESPONSE (EPRR) SELF ASSESSMENT OF CORE STANDARDS** *To APPROVE the self assessment from Mr. A Roger, Director of Operations*	Approve Enclosure 20
	TO BE A DYNAMIC ORGANISATION DRIVEN BY INNOVATION (Strategic Goal)	
26.	**PEOPLE AND CULTURE DEVELOPMENT COMMITTEE REPORT** *To RECEIVE the People and Culture Development Committee report from the meeting held on 18 August 2014 from Mr. P O'Hagan, Committee Chair*	Assurance Enclosure 21
27.	**STAFF RETIREMENTS** *To RECEIVE a paper from Mr. P Draycott, Acting Director of Leadership & Workforce on process for recognizing staff retirements*	Approval Enclosure 22
28.	**LEARNING & DEVELOPMENT APPROACHES FOR HEALTH CARE SUPPORT WORKERS** *To RECEIVE a progress report from Mr. P Draycott, Acting Director of Leadership & Workforce on the development plan for Health Care Support Workers*	Assurance Enclosure 23
29.	**To *DISCUSS* any Other Business**	
	QUESTIONS FROM MEMBERS OF THE PUBLIC	
30.	*To ANSWER questions from the public on items listed on the agenda*	
	DATE AND TIME OF THE NEXT MEETING	
31.	*The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday 30 October 2014 at 10:00am.*	
32.	**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.

	SERIOUS INCIDENTS	
	LEADERSHIP & WORKFORCE UPDATE, including STAKEHOLDER ENGAGEMENT	
	CHEBSEY CLOSE	
	BOARD DEVELOPMENT and TRUST DEVELOPMENT PLAN	

Enclosure

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, 31 July 2014 At 10:00am in the Boardroom, Trust Headquarters, Bellringer Road, Trentham, Stoke on Trent, ST4 8HH

Present:

Chairman:

Mr K Jarrold
Chairman

Directors:

Ms B Johnson
Non-Executive Director

Mrs C Donovan
Acting Chief Executive

Mr P O'Hagan
Vice Chair

Dr K Tattum
GP Associate Director

Mr P Sullivan
Non-Executive Director

Mr C Calkin
Interim Director of Finance

Ms K Wilson
Executive Director of Nursing and Quality

Mr P Draycott
Acting Director of Leadership & Workforce

Mr A Rogers
Director of Operations (non- voting)

Dr D Sheppard
GP Associate Director

Mr D Rogers
Non-Executive Director

Mr A Hughes
Interim Director of Strategy and Development (non- voting)

In attendance:

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

Mrs P Smith
Executive PA

Ms J Harvey
UNISON

Team Spotlight:
Central Referral Hub
Cathy Regan, Amy Poole
Sharon Lees and Paula Pawson

Individual Spotlight:
Dawn Burston
CPN - Criminal Justice Team

Members of Public:

Mr B Goodfellow

Mr J Gould

Mr C King

Mr I Syme

Mr D Blackhurst

Mrs H Johnson

The meeting commenced at 10:00am.

		ACTION
184/2014	**APOLOGIES FOR ABSENCE** Apologies were received from Mr Gadsby, Non-Executive Director, Dr Adeyemo, Executive Medical Director.	
	The Chair welcomed all attendees to the meeting. The Chair offered his condolences to the family and friends of Mr Roger Carder who sadly passed away recently and said how much Roger's contribution as a Non-Executive Director had been appreciated. Mr David Rogers, newly appointed Non Executive Director, was welcomed and would be in attendance to observe the Board meeting today. David will start in post on the 1 August for a 2 year term of office and will Chair the Trust's Audit Committee. The Chair offered his thanks to Mrs Bridget Johnson, Non Executive Director for taking on the role as acting Chair of the Audit Committee during Roger's absence. Mr Peter O'Hagan and Mr Bridget Johnson were noted to have been successfully reappointed for a further 2 year term of office. The Chair welcomed Mr Chris Calkin, Interim Director of Finance to his first Trust Board meeting. Mr Kieran Lappin, former Director of Finance was thanked for his contributions to the Trust. Mr Andrew Hughes, Interim Director of Strategy and Development (non-voting), was welcomed to his first board meeting.	
185/2014	**DECLARATION OF INTEREST RELATING TO AGENDA ITEMS** There were no declarations of interest.	
186/2014	**DECLARATIONS OF INTEREST RELATING TO ANY OTHER BUSINESS** There were no declarations of any other business	
187/2014	**MINUTES OF THE OPEN AGENDA - 31 JULY 2014** The minutes of the open agenda of the meeting held on 5 June 2014 were approved as a correct record.	

188/2014	**MATTERS ARISING**	
	The Board reviewed the action monitoring schedule and agreed the following:- ***85/2014 PALS / Complaints report*** - consideration to be given to bringing together various sources of information. It was agreed that this issue will be addressed and brought back in due course via the Quality Committee - A proposal will be presented to the July meeting of the Quality Committee meeting and then at the Trust Board in September 2014. To leave this action on the schedule. ***127/14 – F&A Committee Report – 17 April 2014 (Annual accounts) Mr Gadsby commented that he had now received the Annual Accounts, but had yet to give them scrutiny. A meeting was due to be held with Mr Gadsby, Mr Lappin and Mr Blaise to go through the accounts in more detail.*** In the absence of Mr Gadsby, Mr Sullivan advised that a meeting to discuss the cost improvement programme had been arranged for the following week. *To leave action on the schedule.* ***147/2014 - Chief Executive`s Report: Choice of Mental Health Provider at First Outpatient Appointment.*** Ms Wilson advised that some work is being organised with Healthwatch of Stoke-on-Trent and Staffordshire and that a scoping meeting with all user groups will be set up. A progress report on the programme will be submitted to the Trust Board going forward. ***To remove from schedule*** ***152/2014 - Financial Performance - Month 1*** Business cases - Mr Rogers noted that these were on the agenda summarised under the Quality Committee and Finance and Activity Reports. ***To remove from schedule*** ***166/2014 - Improving staff Engagement - Listening in Action process*** Mr Draycott advised that the `Big Conversation` is planned for September. Two Co-ordinators have been appointed and further information is included in the Chief Executive`s Report. ***To remove from schedule***	**Ms Wilson** **Mr Sullivan/ Mr Gasby**

189/2014	**CHAIR`S REPORT** The Chair reminded everyone that the Trust's Annual General Meeting will take place on the 24 September 2014. The Chair noted that he welcomed people's attendance to this important occasion. The Chair welcomed the stability that the recent appointment and reappointment of Non-Executive Directors gives to the Board. There are now three Non-Executive Directors who have terms of office to July and August 2016 with every reason to believe that as the other NEDs' terms of office come to an end they will also be extended. The Chair further added that this stability is very welcome because so much else is changing. It is increasingly clear that the provider policy of the NHS is changing and that Foundation Trust status is not the only option, making reference to the Dalton review of provider options. It was also noted that Norman Lamb was asking for bids to explore mutual status through a Mutual Pathfinder Programme. It has been reported that a major acute Trust is exploring a future as a social enterprise. It feels as if the NHS is entering a very different and more varied world of provider futures. This week has also seen a very significant statement of major staffing reductions at NHS England. It has been suggested that there will be a major restructure of the Local Area Teams as a result of the job losses. It was noted the possibility of major change likely both in provider futures and in the structure of commissioning. The Chair closed his remarks by noting that as we find our way through this time of change it is pleasing that there is continuity and stability with our Non-Executive Directors of the Board. ***RECEIVED***	
190/2014	**CHIEF EXECUTIVE`S REPORT** Mrs Donovan, Acting Chief Executive, updated the Board on activities since the last meeting. **Clinical Pathways Redesign Project Update** There are 8 clinical pathway work schemes being led by one of the senior clinicians and it was noted that it was pleasing that they have been making very good progress. The event in June was very successful and 110 people attended from across 21 partner organisations, which showed the real commitment from	

	everyone. The event also featured a series of engagement and feedback sessions which focused on how existing services can be further improved for service users. The focus of the programme has always been on finding the very best solution for the delivery of high quality care for our service users and the event very much reinforced this. A video is available of the event.	
	Executive Director Team Appointments Mrs Donovan announced two appointments to the Executive Team, Mr Hughes and Mr Calkin, as noted earlier in the meeting by the Chairman. Chris Calkin is a former Director of Finance/Deputy Chief Executive at the UHNS and has extensive local knowledge and experience and is a resident of Stoke-on-Trent. The Trust bid farewell to Kieran Lappin, Director of Finance on the 20 June and he was thanked for his contribution to the Trust. Andrew Hughes has taken up post of the Interim Director of Strategy & Development for the next six months. He joins us for three days per week and is based at Trust HQ. Andrew is responsible for revising our clinical strategy to reflect the work that has been undertaken in the eight clinical pathway groups and will work with teams to develop business cases for Commissioner investment and will also oversee the work of the Programme Management Office and will be lead Director for development of the Digital by Choice Strategy; our strategic vision for IT and informatics. Andrew will also be supporting the development of the Trust's Estates Strategy, using the clinical strategy and Digital by Choice as drivers for change. Andrew has experience as an Executive Director in an acute provider and now has a portfolio career in consultancy and project leadership and holds other roles as Non-Executive Director at Burton Hospitals NHS Foundation Trust, a Trustee of Teenage Cancer Trust and a Clinical Tutor at Warwick Medical School.	
	Trust Community Triage Team visited by Norwegian Visitors Earlier in June mental health colleagues from Scandinavia were welcomed to the Trust. The came to the Trust to fact find in respect to an innovative scheme that involves mental health professionals supporting local police to respond to calls more effectively from people who are mentally unwell.	

	The Triage team is based at the Northern Area Custody facility in Etruria and is made up of three Community Psychiatric Nurses, who work with frontline officer seven days a week to provide support in responses to calls from members of the public with mental health issues. The nurses also follow this up by working with the individual concerned to ensure they receive the right care at the right time in the right please. The visitors also learned more about the Trust`s Criminal Justice Mental Health team (CJMJT) which manages the triage team.	
	**Trust Consultant`s Research Paper to be published in Mental Health Journal** A research paper jointly written by one of the Trust`s Consultant Psychiatrists, Dr Ravi Belgamwar, which examined whether work experience placements influence students attitudes towards mental illness, will receive national recognition and is due to be published in an upcoming edition of The Psychiatric Bulletin, published by the Royal College of Psychiatrists.	
	Listening into Action Two Nurses have been appointed to lead the project which is commencing in September 2014. The Trust is really trying to change the culture about what would make the difference within the clinical services. We have asked all staff to take a `pulse check` which will help us to understand how engaged and valued staff feel right now before we roll out the programme and then we can take a further check. **Quality Governance Framework** An external review of the Trust's quality governance arrangements was undertaken across the Trust by KPMG. The domains reviewed included Strategy, Capabilities and Culture, Processes and Structures and Measurement. The audit concluded that the Trust meets Monitor`s governance requirements with a favourable score of 2.5, which shows a continued improvement from the last independent assessment of 3.5. A rating of less than 4 is required to progress through the Monitor process. The Quality Committee will take forward the findings from this audit and will report back to the Trust Board in the coming months. **GMC Supervisor Recognition Project** Following consultation, the General Medical Council has put in place new arrangements for the formal recognition and approval of clinical and education supervisors which applies to all Doctors, including Staff and Associate Specialist (SAS) Doctors.	

	All the Trust`s supervising clinicians are fully compliant with the Health Education West Midland GMC Supervisor Recognition Project ahead of the 21 July deadline. We are one of only four Trusts in the West Midlands who are fully compliant. Thanks to Dr Ravi Belgamwar. **Brighter Futures Artwork Event** Mrs Donovan noted that at the beginning of July 2014 she attended an event at the New Vic Theatre in Newcastle - `Hidden Talents`. There was a very impressive display of excellent artwork that service users from Brighter Futures have produced. Workshops are delivered across the City in a range of accessible locations. **NHS England Chief Offers Local government Leaders Radical New Health And Social Care Integration Option** NHS England announced at the beginning of July that local Councils will be offering a new option to people accessing health and social care support, which gives them the ability to control their own blended NHS and community care, in partnership with the voluntary sector. The new integrated commissioning programme which will provide real opportunities for services to be clinically devised around service users. Mental Health and Learning Disabilities are going to be two of the user groups which are going to be targeted going forward. Mrs Donovan noted that colleagues in the Trust will look carefully at the implications of this for our organisation and those who use our services. The Chair concluded the discussion by stating that one of the important things about being responsible for any organisation is the signs of health in the organisation. A healthy organisation is about really good communication at every level and our staff are encouraged and that is what the LiA and Aston Team Leaders is all about. The Quality Governance Framework is another way of delivering and providing assurance that we have these signs of health. It is very important to focus on these areas not just the finances. ***RECEIVED***	
191/2014	**SPOTLIGHT ON EXCELLENCE AWARDS** The Chair presented the individual and team spotlight award to: **Dawn Burston, Criminal Justice Mental Health Team.** Dawn is a CPN Caseload Manager who has multiple roles within the Criminal Justice Mental Health Team. She has responsibility for caseload management to a team who support offenders with mental health difficulties who find themselves in the Criminal Justice system and also deputises for the Team Manager.	

	Dawn has been instrumental in the implementation of the Community Triage Team pilot, which commenced at the end of November 2013. This team was developed in partnership with the Police and Crime Commissioners office (PCC) in response to a report commissioned by them evidencing that local Police officers were engaged in supporting members of the public, either in their home or a public place, with mental health difficulties, for which they had no expertise or knowledge of service provision. There was a higher than average number of 136 detentions implemented by Police officers as this was the only option open to them for the safe transfer of a person in distress or crisis. Dawn has built on existing positive relationships and partnership arrangements and has worked tirelessly to develop the service, train staff (including Police officers in common mental health issues), implement the service, kept it under constant review, responded to issues as they arise, monitored the outcomes of the service and has shown great leadership abilities. The success of the pilot so far is in no small part due to Dawn's commitment to high standards of care. ***RECEIVED***	
192/2014	**TEAM SPOTLIGHT AWARD PRESENTATION** This month's team spotlight Award and presentation was from the Children's Community Emotional and Mental Health Service Line and is for the Central Referral Hub. The Central Referral Hub has just celebrated its 1 year anniversary as a single point of entry for all referrals of children and young people into the CONNECT service. The Central Referral Hub was designed to streamline how incoming referrals are handled, increase consistency and reduce duplication across teams. The CRH works by operating as a single entry point for all referrals, whether from workers, parents and carers or young people themselves. These are considered at the Central Referral Hub by a dedicated admin team and a rota of duty clinicians. In the past year the CRH has dealt with 2665 referrals from initial contact, acceptance and signposting through to offering and booking first appointments. The Central Referral Hub is an incredibly busy environment with a dedicated staff group working closely to meet the needs of Children and Young People at this first point of contact.	

	The Central Referral Hub makes first contact with our service more straight forward for referrers: one phone number, one fax and one address for all referrals rather than working out which of 3 teams to contact. It is a central resource of knowledge about other services which improves our ability to signpost. Dr Tattum, Associate GP advised that this service has significantly improved in terms of its responsiveness. It was further noted that there is a very empathic feel which gets across to patients and staff demonstrate a very much \`can do\` attitude. It was suggested that perhaps it could be improved slightly if users could access the hub direct because sometimes they get lost but that might impact on the capacity of the team. Mr Rogers advised that he spent last week having conversations with Commissioners about the service the team provides and some of the impact; there is a difference in referral and signposting. Mr Rogers stated that he will further pick this up with the team and discuss outside of the meeting. Mr Hughes raised discussions around how we manage 17-18 year olds for onward referral to adult services and how quickly is the service going to expand to 9am to 5pm and will that be 7 days per week? Mr Rogers advised that more staff will be needed for a 7 day service and Commissioners are aware that the Hub are taking referrals for the pathway and that there is an indication from them that there may be a resource for that. Cathy Regan advised that in terms of the transition, every young person that comes into the service when they reach 17 years old have a transition programme so if they continue with our services into adulthood there are joint appointments with adult services to help with the transition. The Chairman thanked both Cathy Regan and Amy Poole and emphasised the importance of continually improving access and the responsiveness of our services. ***RECEIVED***	
193/2014	**SUMMARY OF THE QUALITY COMMITTEE MEETING HELD ON 17 JUNE 2014 AND 15 JULY 2014** Mr Sullivan, Non-Executive Director, provided the Board with a summary report from the meeting held on the 17 June 2014 and 15 July 2014.	

	The Policy Review proposals were supported by the Committee for ratification of the policies by the Trust Board for a period of 3 years or be extended as follows:- • **S136 guidelines for physical healthcare of S136 service users and protocol for the management of S136 patients at Harplands Hospital.** • **Personal Searches Policy -** approve for 12 months. • **Purchasing of Electrical plant equipment/guidance for the purchases of equipment, materials and substances -** rescind policy as part of the Health & Safety Policy. • **Gas escapes procedure** • **Mercury guidance.** • **New and expectant mothers - risk assessment checklist.** • **Sharps procedure.** • **Unsafe gas appliances.** • **Managing allegations of abuse** - extend until 30 September 2014. • **Records Management Policy** • **Attendance at Coroners Court** • **Food Waste Guidelines** • **Safe Use and Purchase of Electrical Equipment** • **Health & Safety Audit Procedure.** The Board ratified the above policies.	
	Mr Sullivan noted the committee received information on the process in place to quality impact assess CIP schemes. It is a helpful reflection of the high quality process within the Trust and improvements that have been made. A meeting will take place with the Non-Executive Director members of the Quality Committee in order to look further at the rationale around some of the cost improvement schemes and for the Directors to feel assured about the robustness of the scrutiny process (which is based on the Monitor guidance). The Prone Restraint Report has been received from the last quarter. There are changes in the advice relating to the management of violence and aggression, particularly around physical interventions and it is a positive for the Trust that there is such a close monitoring of restraint, in particular prone restraint. Commissioners have recently undertaken a visit to Ward 4 at Harplands Hospital to review the quality of service provision. Some positive and constructive feedback had initially been shared ahead of their full report. An initial report and action plan	**Mr Sullivan/ Mr Gadbsy**

	on the work is being undertaken. A Quality Impact Assessment of the Business Cases has taken place and will be supported when significant work has been provided. The Quality Committee received information around the Patient Safety Campaign which is a national initiative that the Trust will participate in. Launched in June 2014 the mission is to strengthen patient safety in the NHS. Work is underway with the TDA to provide support to organisations in their plans to further reduce harm to patients. The Committee agreed that this would be helpful given the national focus and our commitment to patient safety. The Committee received reports from the Director of Quality and the individual Quality & Safety reports from the Divisions. Mr Sullivan made reference to the KPMG independent review of the Trust's Quality Governance arrangements. The report will be helpful in some development work at the next meeting of the committee in September where members will spend part of the meeting to review its effectiveness and progressing the recommendations in the KPMG report. The Chair agreed that reviewing the function and effectiveness of the Quality Committee will be an important process of assurance on behalf of the organisation as a whole but even when we receive very satisfactory external reviews; we should not be complacent as should see this as an opportunity for continual improvement. ***RECEIVED and APPROVED***	**Mr Sullivan**
194/2014	**QUALITY ACCOUNT 2013/14**	
	Ms Wilson presented the above for information purposes in the absence of Dr Adeyemo. All organisations are required to develop and publish a Quality Account by the 30 June 2014. Given the timing of the Board meeting, the Quality Committee were given delegated authority to review and approved the Quality Account on behalf of the Board. Ms Wilson advised that achievements in terms of our improvement in quality can be found on pages 5 & 6.	
	To note particular achievements around CQUINs and work that has been positively engaged in with partner organisations around the Clinical Pathway development.	

	In context of the safer staffing review, Ms Wilson stated that we have received accreditation from the Royal College of Psychiatrists that some of our inpatient services are delivering some of the clinical standards which demonstrates our improvements. Also some of the work being undertaken around recovery which is to support service users. Mr O`Hagan advised that the Quality Account is very well presented and very easy to read. On behalf of the Trust Board, the Chairman asked for congratulations to be forwarded to Mrs Wrench who overseen the publication of the document. ***RECEIVED***	
195/2014	**SAFE STAFFING MONTHLY REPORT**	
	Ms Wilson, Executive Director of Nursing and Quality, presented this report which outlines the performance of the Trust in relation to the National Quality Board expectations. It was noted that the Board will receive a more detailed report on the work in November 2014. The planned activity levels are based on ward establishments and also using the outputs from the safer staffing tool and professional judgement from the teams who are engaged in the review. Further work needs to be done around the granularity around some of the figures. Mr Hughes observed that clearly it is important to look at these in the round but also other indicators around incidents, acuity, etc are all issues that creates a balanced picture that assures us of safety.	
	Ms Harvey advised that the paper is really useful given that it is sometimes difficult to see what this means. Ms Harvey confirmed that this has been discussed within the Trust and the Union supports the national staffing levels. A standard day however, is not necessarily a standard day. Would this give an indication of where the extra staff is needed, for outings etc, to give service users the support they may need? Ms Wilson advised that it really is about the levels and numbers you plan to have on a shift and how many you are actually able to have on duty. It is not intended to give any other information at this time. However, there is a programme of work to develop this information further.	

	Following discussion the Chair pointed out that we know that the safe staffing review is here because of some dreadful events elsewhere in the NHS. It is very encouraging that national attention is much more focused on safe staffing issues than previously but as staff have said, this is only the beginning of us really understanding the key issues. How many staff do we need given the workload, complexity of our patients, how many staff can we afford and how many staff do we actually deploy? All the above is crucial and we are all aware that by taking on this programme we are inviting staff themselves into this debate so we need to be ready for that because obviously their views will be crucial on what it feels like for them. We need to listen to staff and respond to their concerns. Mrs Donovan noted that there is an escalation process to the Executive Team for additional staffing requirements needed The Trust Board agreed to:- • Note the contents of the report • Approve the approach taken. ***RECEIVED, NOTED AND APPROVED***	
196/2014	**FINANCE REPORT - MONTH 3 (2014/15)** Mr Calkin, Interim Director of Finance, presented the above which summarised the financial performance for the period to the end of June 2014.Headline performance:- • A retained deficit of £0.44m, giving a favourable variance against plan of £0.01m. • A year-end forecast that shows a breakeven position against the submitted plan (adjusted financial performance of a retained surplus of £0.268m). • A year to date Continuity of Service Risk Rating of 3, with a year-end forecast rating of 3. • CIP target of £4.08m, with a forecast delivery. • Capital expenditure of £0.016m to date and a forecast gross expenditure of £2.64m. • A cash balance of £5.2m at the end of June 2014. Cost Improvement Programme is ahead of where we anticipated we would be at this time of year, however this has been supported by the additional of a number of non-recurring schemes.	

	Cash Balances is more positive than planned because we are behind with the capital plan. We can meet our financial obligations. Overall Risk Rating is at 3 which is where we had planned to be. Capital Servicing capacity is down from where we anticipated it to be. This will right itself as we move through the year and start to deliver the planned surplus. . Ahead on income and we do not anticipate any major changes in the forthcoming months but hope to maintain the current position. Cost Improvements - forecast delivery there is currently about £700k unidentified CIP and work is ongoing within the Directorates, including Corporate areas, to address this. Workforce Analysis - Level of bank nursing in June reduced significantly although this is yet to be investigated to determine if it is either a delay in time sheet submission or reduced demand. Mr Calkin noted that he is working with Mr Draycott on systems and processes to improve the accounting and reporting on the use of Bank staff. The progress around the closure of Chebsey Close was noted and the work ongoing to address some of the financial issues. Mrs Donovan advised that stronger focus is required on the split between non-recurring and recurring needs to be shown in the report. Mr Calkin advised that while there is always going to be an element of non-recurring, the report will be updated going forward. Following discussion the Chair advised that clearly the Trust is in a good financial position but we are very well aware that the current position is dependent on achieving the CIP programme.	**Mr Calkin/ Mr Draycott**
197/2014	**ASSURANCE REPORT FROM THE FINANCE & ACTIVITY COMMITTEE**	
	In the absence of Mr Gadsby, Mr Calkin presented the above report which provides a summary of the Committee meetings held on the 26 June and 24 July 2014. The summary provides assurance to the Board regarding the the level of review and challenge provided by the Committee on financial and other reporting as follows:-	

	Financial update for Month 2 (May 2014) 2014/15 received, this was the first month of the 2014/15 year to include the full set of supporting schedules. Income and expenditure position to Month 2 was ahead of plan at a deficit of £0.434m against a plan deficit of £0.449m showing a favourable variance of £0.015m. The year-end forecast was in line with the planned positon of £0.268m surplus. The Trust`s cash balance at end of April was £6.1m which is £0.9m higher than the position at the end of April 2014. Capital Resource Limit (CRL) for 2014/15 is £1.5m. Month 2 report also included a trading account detailing the costs and income associated with Chebsey Close and showed a trading surplus of circa £0.07m. This will continue to be updated on a monthly basis. Cost Improvement Programme (CIP) for Month 2 received which incorporated elements of the Workforce paper linked to CIP schemes. The paper highlighted the requirement to deliver £4.08m of CIP with plans in place to deliver £3.87m and also showed a year to date position of £0.6m delivery against the plan of £0.5m. The deliverability rating provided by Divisions remains high (97% rated green or amber). The Finance team will test this rating more thoroughly over the coming weeks. Drug cost movements for 2013/14 is being analysed. There is a significant reduction in Dementia drugs in generic prescribing. It has not indicated any changes in prescribing habits. A paper which explained the Continuity of Services Risk Rating which replaces the Financial Risk Rating on 1 April 2014, was received by the committee. It was noted that the Long Term Financial Model (LTFM) recently submitted to the TDA is being reviewed by them linked to the Integrated Business Plan A report on issues and options available to improve car parking at both Harplands and Trust HQ to provide additional parking at both sites. The committee recommended to the Board to approve the proposal to give notice on the car park F lease Disposal of Bucknall Hospital and related issues were discussed.	

	The Board noted the contents of this report and will take assurance from the review and challenge evidence in the Committee. Additionally the committee proposed to the Board to approve the submission of the Trust`s Reference Cost return in line with the national deadline. ***RECEIVED and APPROVED***	
198/2014	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) - Month 3**	
	Mr Calkin presented the report which provides the Board with a summary of performance to the end of Month 3 (June 2014). There are 122 metrics at Month 3 to monitor performance, quality and outcomes. It was noted that Key Trust Target (KT01) is under-performing (status red) and requires improvement. There is a proposal coming from the TDA on how we might be subject in the future, to performance management. The purpose for including this is to give the Board some assurance that we are aware of these issues and prepare ourselves to move to the new system. We still have not received the final guidance. This will be shared when we have more information about the new system coming in and we will continue to drive forward improvements, where appropriate, in terms of our presentation of data. It was noted that the Trust's did not attend (DNA) rate is improving. Work is also ongoing in terms of how we offer appointments and what further can be done to reduce the number of DNAs. Similarly, with re-admission rates; it was noted the work that is ongoing to ensure the correct definition is being applied. If the patient is re-admitted as part of the care plan that that should not be included as a readmission. The definition is currently being checked because there is a need to focus on the true re-admission definition. The Board discussed the IAPT target in respect to the proportion of people who have depression and/or anxiety disorders who receive psychological therapies. This is a service that is delivered in partnership with MIND and Changes and is being closely monitored with some issues around recruitment and significant demand issues which Commissioners have recognised and given additional funding.	

	It was noted that an action plan meeting has been set up to look at the key issues that we need to address over the next six months to get ready for Payment by Results (PbR). Mandatory Training target is 95% against the Trust`s current achievement of 91%. Action is being taken to address this. Annual Appraisals target is currently 80% at Month 3 from 89% at Month 2. This however will improve given the current cascade system in operation. Dr Tattum advised on the Psychological Therapies high incidents of DNA, noting that part of the problem may be the amount of time people have to wait for an appointment. The Chair said that clearly we are moving in the right direction but a lot more needs to be done to get us in the right place. Ms Wilson advised that this will be part of the Choice agenda which could address some of the issues around waiting. Mr Rogers advised that a meeting with the service is taking place this week. It is also noted that there are many more people accessing the service than was originally forecast. Commissioners recognise that there is a funding issue and they have requested for a robust plan going forward. Mrs Donovan advised the complexity of the partnership arrangement and the fact that we did inherit this serviced from Rethink. The partnership is now with ourselves North Staffs MIND and Changes. Staff from Re-think have been transferred. ***RECEIVED***	
199/2014	**NHS TRUST DEVELOPMENT AUTHORITY (NTDA) MONTHLY SELF CERTIFICATIONS**	
	Mr Calkin advised on the above report which presents the monthly NTDA self-certification documents for Board approval. These self-certification declarations forms part of the Oversight and Escalation Process and based on June 2014 data, the Trust is declaring compliance with all requirements. ***RECEIVED AND APPROVED***	
200/2014	**ANNUAL REPORT AND FINANCIAL STATEMENTS 2013/14**	
	Mrs Donovan presented the above which provides an update position statement in respect to the Annual Report, which will be presented at the Trust`s Annual General Meeting in September 2014. In particular, it provides assurance that the Annual Report 2013/14, which includes the full financial statements and accounts for 2013/14, has been produced in line with the national guidelines - the Manual for Accounts.	

	This report has been reviewed by the Executive Team, Audit Committee and had sign off from the Trust auditors. The introduction to the report from Mr Jarrold, Chairman of the Trust will be developed in due course following collation of all the key information and important messages. Mrs Donovan thanked both Mrs Storey and Mrs Roberts for all their hard work in pulling together this report. Mrs Storey added that external auditors provided good feedback on the report. The report will form a suite of documents for presentation the AGM, which will include the Quality Account and summary versions of the Annual Report. Mrs Roberts thanked everyone for their contributions to the report. The Chair emphasised that what really matters in an annual report is that it is believable. It is absolutely right to celebrate success however, it is also important to recognise difficulties and challenges. At the AGM it is hoped that we will achieve this important balance through presentations of patient stories. Mrs Storey noted that we are not having a further open Trust Board meeting until the 25 September which is the day after the AGM. Once the introduction has been added a copy will be circulated to Board members prior to the AGM. ***RECEIVED and APPROVED***	**Mrs Storey**
201/2014	**KPMG ANNUAL AUDIT LETTER 2013/14**	
	Mr Calkin presented the above for information which summarises the key issues arising from KPMG (external auditors) 2013/14 audit at the Trust. This report will be published on the Trust`s website. The audit concluded that the Trust has in place proper arrangements to secure economy, efficiency and effectiveness in its uses of resources. The organisation can be really proud of itself given some of the turbulence the Trust has been through. Mr Calkin thanks all those who have been involved in the Audit Committee. Mrs Storey noted the focused work of the Audit Committee that has helped deliver this positive report, in particular drilling down to get the right information to be able to report their full assurance to the Trust Board. Mrs Donovan acknowledged the work of the Committee and advised that she has written thanking all members for their contribution around this piece of work.	

202/2014	**PEOPLE AND CULTURE DEVELOPMENT COMMITTEE REPORT**	
	Mr O`Hagan advised on the above report which provides a summary of the meetings that took place on the 16 June and 21 July 2014. The report highlights key points discussed and agreed outcomes. The Committee is split into two different business functions, (a) How are we doing and how are the staff doing; (b) Development. The meeting in June looked at staff sickness levels and how we might be better able to support our staff. We have a number of staff who are clearly anxious and concerned which can manifest itself into stress. The committee discussed trust leaders providing the right framework of support. We do have a very good support team for our staff once they reach that critical point. How do we support those staff before we reach that critical point? It was noted that committee members discussed improving the various processes and interventions we have across the organisation from the Staff Counselling Service right through to being pro-active in trying to avoid stress occurring in the first place. Jan Summerfield, Staff Counselling Service will be undertaking a presentation at the committee's next development session in October 2014 and this would specifically focus on the Manager`s response to stress. Ms Harvey advised that we do have some interventions in place and we are getting better, we have a really good Staff Counselling Service but we need to be doing better. There has always been a bad culture generally within the NHS and the staff feel that they have to keep coping until it gets better. We do know the organisation is undergoing a great deal of change as well as finance constraints. The `time to talk` campaign is really important that we talk about mental health within the Trust. We are happy to talk about physical problems but are we comfortable in a group like this to talk about staff who are experiencing mental health problems due to work. We are not there yet and leaders need to think about it in those terms. Staff tend not to talk about it because it may be seen as a weakness. Discussion took place around the appraisal process and opening up the conversation around stress and anxiety at work. Mr O`Hagan pointed out that we have lifted the lid, so let us start to make it part of the 'big' conversation. **Policies:** There were 7 policies that the Committee considered	

	which had been approved by the Joint Negotiation and Consultation Committee (JNCC) and the Trust`s Policy Working Group. They were supported by the Committee for onward ratification for 3 years by the Trust Board. **GMC Survey Results/Student Placement Feedback -** Mr Sullivan advised that in his opinion the best feedback we ever receive is from service users and carers. It is also very important to receive good feedback from our staff but some of the most objective feedback you get is from staff that are on placement. This was a positive report. **Workforce Service Line Performance** – the committee received a detailed workforce service line performance report and discussed a couple of other important issues. It was noted that safe staffing was discussed in more detail at the Quality Committee. The committee discussed information relevant to the People and Culture Development committee in terms of human resources and staff training. **Operational Structure Restructure –** The committee discussed the proposed operational structure. **Revalidation** – it was noted that the committee received a report which showed good progress in medical appraisal and re-validation. Ms Harvey commented on pay progression in terms of performance and competencies and that it is right that there should be a policy. However, there are some staff groups within the NHS that have not had a pay rise in the last 3-4 years and this is unsatisfactory. ***RECEIVED***	
203/2014	**REPORT ON MEDICAL APPRAISAL AND REVALIDATION**	
	Dr Adeyemo presented the above and as previously advised by Mr Sullivan, this has been discussed at the People and Culture Development committee and is being presented here for assurance to the Board on our progress against Revalidation. Revalidation is a national process by which all Doctors will satisfy the FMC (at 5 yearly intervals) that they are fit to practice and should retain their licence. The report sets out our progress for the last financial year 2013/2014 and demonstrates that the Trust is fully compliant. Dr Sheppard confirmed that both he and Dr Tattum have been revalidated.	

	Ms Wilson advised that revalidation is going to be extended across other professionals, including nursing. The Board supported the ongoing management and governance of the work to continue Revalidation. ***RECEIVED FOR INFORMATION***	
204/2014	**ANY OTHER BUSINESS**	
	Renaming of the Trust Headquarters	
	The Chair presented a paper proposing to rename the Trust Headquarters in honour of a lady who dedicated 49 years to NHS service. Miss Lawton started work at what was then Cheddleton County Asylum in 1915 assisting with medical case records at a time when there was a large influx of patients from other mental hospitals, evacuated for military purposes. Miss Lawton served as St. Edward`s secretary and Deputy Clerk before being appointed Clerk in 1931, the only woman at the time to hold such an office in the country. The Chair wished to thank Mrs Roberts, Head of Communications and Mr Blackhurst, Evening Sentinel because as a result of their news/media release, we have managed to trace Miss Lawton`s nephew who has been very helpful and is aware of the proposal to re-name Trust HQ to Lawton House. The Chair further noted that it is important to honour those people on whose shoulders we stand, further commenting on his interest in reading about previous Consultant Psychiatrists who had worked within the Trust, e.g. Professor John Cox, and acknowledging their contributions. The Trust Board agreed to support the proposed renaming of Trust HQ to Lawton House. ***NOTED AND APPROVED***	
205/2014	**QUESTIONS FROM MEMBERS OF THE PUBLIC**	**ACTION**
(a)	*Mr Goodfellow* Commented on mental illness in the workplace and how this can affect your work. In terms of performance, what would it take to get this Trust above 2.8, what areas are actually failing? Mr Calkin advised that our liquidities are fine, just slight tweaks	

	to get us up to a full 3. If we achieve our cost improvements, and as there seems to be good budgetary control elsewhere, activity, income and delivering CIP is key, this will get us to a full 3.	
(b)	I am involved in taking patients out. If there is an incident at Harplands Hospital with a medical situation, is there a medical team or do they go straight up to A&E? Ms Wilson advised that if people have physical healthcare needs whilst they are an inpatient at Harplands, we have very strong communications with our partners at the UHNS where we can give patients physical healthcare. We have also got a number of nurses who are physical health trained so if somebody collapses they would know how to respond.	
(c)	Can the Trust do anything on site to help ease A&E pressure on beds? Ms Wilson advised that some of our Trust Nurses can respond to some of those medical emergencies but obviously where there is a need for surgery for example, it would be appropriate for them to be cared for at the UHNS. The Chair thanked Mr Goodfellow for his comments.	
(d)	*Mrs H Johnson* **Staffing Levels** Because I am based at the Harplands Hospital, we do go out to wards, in particular 1, 2 & 3. Safe staffing levels is a good thing and we have been picking up on extra activity workers. It is nice to come on the wards when we see them engaged. Unfortunately when the activity workers are taken ill and have annual leave, then staff haven`t got the time to do those activities.  When people have been told they can have a day out from the wards; some times staff haven`t been able to offer because of staffing levels. It doesn`t have to be a Staff Nurse but a Healthcare Support Worker, can the Trust look at that? I have asked if the Consultant can be a bit more flexible given staff availability. Ms Wilson responded by saying that as part of the work this is ongoing we are trying to capture where activity is affected and relate that to staffing levels. The Chair thanked Mrs Johnson for her comments.	
(e)	*Mr I Syme* What is the status of the future of RAID, the service used by	

	UHNS? Mr Rogers advised that RAID supports people in an acute setting across the UHNS and the focus is A&E. We also have an Intoxication Observation Unit (IOU) working with those people who may have alcohol problems. There is a resource challenge around RAID. Commissioners have said that RAID will be really beneficial across community hospitals and we are working with them in order to work through how that resource gets through. It may mean that some of the resource moves across the pathway. Winter funding, we have not got any of the money out of the process but we are having those conversations, it is more about how we then use resources more effectively across the local health economy. Mr Syme asked about timescales in relation to this please? Mr Rogers advised that the Commissioners have said April 2015.	
(f)	On reading SSOTP performance reports included in a recent KPMG report, we were horrified to see that one of the options is that the community hospitals transfer from the Partnership Trust to the University Hospital of North Staffordshire. As Combined used to run mental health and learning disabilities care, you also managed the community services for many years following its formation in 1994. However, they were then transferred to the former Primary Care Trust provider arm and then to SSOTP when it was ruled that Combined was too small to take them back. So would you be prepared to look at running these services in future especially as a lot of their staff are former Combined employees? You used to run the service and understand the need for integration of physical and mental health, SSOPT doesn`t seem to understand integration.  There are currently gaps that affect people transferred between services. We are getting more and more alarmed about this and we aren`t the only ones. The Chair responded by saying that any decision to change the brief of community services is a matter not for this Trust; so the first step would be for the CCGs to decide whether they wish to tender those services and to seek other bidders to provide them. All relevant parties would decide on whether or not they would wish to be considered. I would absolutely say that we would not disqualify ourselves from that but it would be a bidding process that we would go through.	

	Mrs Donovan advised that the emerging strategy is one that is really trying to integrate pathways and to try and build those up on a population basis. From a conceptual point of view we cannot argue with that, a need to drive the importance of integration of mental health and so a population based approach to building services in an integrated way we would be very keen to support. The over-arching theme is integration. Mr Syme said that we understand integration, SSoTP do not seem to really understand as yet. The hiatus can affect the smooth transition of people going from service to service. Healthwatch are getting more and more alarmed. The Chair thanked Mr Syme for his comments.	
206/2014	**ANY OTHER BUSINESS** There was no other business to be discussed.	
207/2014	**DATE AND TIME OF NEXT MEETING** The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday, 25 September 2014, at 10:00am, in the Boardroom, Trust HQ.	
208/2014	*** 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 12:30pm.

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
27-Mar-14	85/2014	***PALS / Complaints report*** - consideration to be given to bringing together various sources of information. It was agreed that this issue will be addressed and brought back in due course via the Quality Cte	Karen Wilson	25-Sep-14	A proposal will be presented to the July meeting of the Quality Committee meeting and then at the Trust Board in September 2014. To leave this action on the schedule.
24-Apr-14	127/2014	***127/14 – F&A Committee Report – 17 April 2014 (Annual accounts)*** Mr Gadsby commented that he had now received the Annual Accounts, but had yet to give them scrutiny. A meeting was due to be held with Mr Gadsby, Mr Lappin and Mr Blaise to go through the accounts in more detail. In the absence of Mr Gadsby, Mr Sullivan advised that a meeting to discuss the cost improvement programme had been arranged for the following week	Mr Sullivan/Mr Gadbsy	25-Sep-14	
31-Jul-14	193/2014	***Summary of Quality Cte meeting held on 17 June 2014 and 15 July 2014*** - A meeting will take place with the Non-Executive Director members of the Quality Committee in order to look further at the rationale around some of the cost improvement schemes and for the Directors to feel assured about the robustness of the scrutiny process.	Mr Sullivan/Mr Gadsby	25-Sep-14	To provide update at Sept meeting
31-Jul-14	193/2014	***Summary of Quality Cte meeting held on 17 June 2014 and 15 July 2014*** - Mr Sullivan made reference to the KPMG independent review of the Trust's Quality Governance arrangements. The report will be helpful in some development work at the next meeting of the committee in September where members will spend part of the meeting to review its effectiveness and progressing the recommendations in the KPMG report.	Mr Sullivan	25-Sep-14	On Sept agenda as part of the feedback from the Quality Committee meeting held on 16.9.14
31-Jul-14	196/2014	***Finance Report - Month 3 (2014/15)-*** Workforce Analysis - Level of bank nursing in June reduced significantly although this is yet to be investigated to determine if it is either a delay in time sheet submission or reduced demand. Mr Calkin noted that he is working with Mr Draycott s on systems and processes to improve the accounting and reporting on the use of Bank staff.	Mr Calkin/Mr Draycott	25-Sep-14	On Sept agenda as part of the Finance Report
31-Jul-14	200/2014	***Annual Report and Financial Statements 2013/14*** *- Mrs Storey added that external auditors provided good feedback on the report. The report will form a suite of documents for presentation the AGM, which will include the Quality Account and summary versions of the Annual Report.*	Mr Storey D9	25-Sep-14	On Sept agenda as part of the Finance Report

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: Open Trust Board

Date of Meeting:	Thursday 25 September 2014
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 18 September 2014 Caroline.donovan@northstaffs.nhs.uk
Purpose / Intent of Report:	• For Information
Executive Summary:	This report updates the Board on activities undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest.
Which Strategy Priority does this relate to: **How does this impact on patients or the public?**	• Customer Focus Strategy • Clinical Strategy ~~• IM and T Strategy~~ • Governance Strategy ~~• Innovation Strategy~~ ~~• Workforce Strategy~~ ~~• Financial Strategy~~ • ~~Estates Strategy~~
Relationship with Annual Objectives:	To ensure safe provision of clinical services
Risk / Legal Implications:	N/A
Resource Implications:	N/A
Equality and Diversity Implications:	N/A
Relationship with Assurance Framework [Risk, Control and Assurance]	N/A
Recommendations:	To receive this report for information

North Staffordshire Combined Healthcare Trust

Chief Executive's Report to the Board of Directors
25 September 2014

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

LOCAL UPDATE

2. CHIEF EXECUTIVE APPOINTMENT
I am delighted to be able to present this as my first Chief Executive Report, having been appointed to the substantive post on 17 September 2014. I'd like to formally acknowledge my thanks to all those who gave their time to be involved in the appointment process.

I have been overwhelmed by the support shown to me so far and I am grateful for the opportunity to be able to continue to work with our immensely dedicated staff, who inspire me on a daily basis.

3. NSCHT ANNUAL GENERAL MEETING
As I deliver this report, this year's Trust Annual General Meeting (AGM) will have taken place on Wednesday 24th September at the Medical Institute.

As most of the Board will have been in attendance, you will hopefully have enjoyed the series of interesting, thought-provoking and heart-warming videos focussing on how the lives of patients and carers have improved through the use of NSCHT's services.

We also showed a separate video marking the progress of a partnership programme working to further improve the integration of mental health and learning disability services with physical healthcare and social care, covered below in item 2.

As part of our statutory requirements, the Trust's Quality Account, Annual Report and Annual Accounts were also presented. Most importantly, there was an excellent opportunity for members of the public to ask questions of our senior team and clinical staff as well as networking time both before and after the event.

Many thanks to all the staff who supported the AGM and took time out to share with those who attended the wonderful work delivered by our clinical teams during 2013/14.

4. CLINICAL PATHWAYS REDESIGN PROJECT UPDATE
The clinical and commissioning leads for the eight pathways presented to the CCGs' Commissioning Board on 27 August. The presentations were well received.

We have created a strong case for local delivery of mental health and learning disability services in partnership and I would like to pass on my personal thanks to all those who have been involved.

5. ORGANISATIONAL STRUCTURES
During July and August, we carried out a consultation with divisional staff regarding the management structures within our clinical services. This consultation is now complete and the outcome has been shared with all affected staff. The aim of the consultation was to promote autonomy and speed decision-making. The key components of the new structure are as follows:

I. The new service groups will be known as Directorates
II. The new structure will be based around six Directorates:
   - Adult Mental Health Inpatient
   - Adult Mental Health Community
   - Neuropsychiatry and Old Age Psychiatry
   - Learning Disabilities
   - Child and Adolescent Mental Health Services
   - Substance Misuse
III. Each Directorate will be led by a Clinical Director
IV. There will be a new post of Associate Director of Transformation to focus on key developmental and transformational programmes. This post will be ring fenced to existing Business Managers
V. There will be a new post of Associate Medical Director reporting to the Medical Director to provide additional clinical leadership and capacity
VI. There will be a creation of an Adult Board across the two AMH Divisions to ensure services are appropriately co-ordinated and patients can move through the pathway
VII. Each Directorate will have a Head of Service
VIII. Professional leadership will be supported across all of the Directorates.

6. LISTENING INTO ACTION
In early July we launched the Listening into Action Pulse Check to all our staff. The Pulse Check is a survey, which helps us to understand how engaged and valued staff feel ‘right now’. I’m pleased to report that, of our Cohort of six trusts nationally, we received the highest return rate on our survey – 624 responses were received which is around 43% of our organisation. This is a fantastic starting point for our LiA Journey and gives us a strong benchmark moving forwards.

Over the course of September, we have held six 'Big Conversations' inviting staff across the entire organisation to ask them what gets in the way of them delivering the very best care for our patients and what changes they think would make the biggest impact. The events have been energetic and some fantastic ideas have been shared.

It’s now essential that we act on the feedback provided from the events; we have appreciated the time people have given to the Big Conversations and the way in which managers have supported their staff to attend. We have given a commitment that the key themes will be shared with staff by mid-October and that we will be taking forwards the top ideas from staff to resolve the issues they raised through pioneer groups, made up of people who have an interest in the theme and the drive to make change happen.

7. IMPROVING MENTAL HEALTH SERVICES FOR YOUNG PEOPLE IN NORTH STAFFORDSHIRE
During August, we launched a new forum giving children and young people a much greater involvement in how mental health services are shaped and delivered.

I’m pleased to report that NSCHT has provided the funding to local user-led mental health charity Changes YP to set up the Young Persons’ Forum. The forum forms part of the Children and Young People’s Improving

Access to Psychological Therapies (CYP IAPT) programme, an NHS England-led initiative aimed at improving existing Child and Adolescent Mental Health Services (CAMHS) in the community.

Young people participating in the forum will play a key role in deciding the way CAMHS is designed, delivered and monitored, while full support, guidance and encouragement will be provided to help members have their say in how services can be enhanced for young people.

Its inaugural monthly meeting took place on 21 August at The Ashlands Centre in North Street, Newcastle. Feedback from the forum is really encouraging and the young people getting involved are enthusiastic about the opportunities offered to them.

I'd like to pass on my thanks to Dr Claire Halsey, Project Lead and her team in the Children and Young People's Division, particularly Sam Heywood, Clinical Lead, who has been key to the success of setting up the forum.

To get involved in the forum, or for more information, please contact Lois Cocker on 07935 934701.

8. SECTION 136 SUITE AT HARPLANDS HOSPITAL

At the end of August, Police and crime Commissioner, Matthew Ellis, raised a number of concerns via the local media regarding the availability of beds at Harplands Hospital for people brought to the suite under Section 136 arrangements with Staffordshire Police. The police can use section 136 of the Mental Health Act to take people to a place of safety when they are in a public place. They can do this if they think the person has a mental illness and is in need of care.

We acknowledged via the media and directly with Mr Ellis' office, that we had been in a position where, to ensure the safety of service users and staff, it had been necessary to temporarily close the 136 Suite on seven occasions between June and August.

Andy Rogers, Director of Operations for the Trust, is working closely with Staffordshire Police, the Police and Crime Commissioner's Office and the Adult Mental Health division to ensure we provide a consistent, safe, 24/7 service in line with the needs of those requiring access to our services in times of crisis, as we absolutely recognise that a police cell is not the appropriate place to care for someone who is mentally unwell.

We are also working closely with frontline officers, in order that they know how to recognise who might need detaining under a Section 136 arrangement, as not all people have been brought to the Section 136 Suite at Harplands Hospital appropriately.

To support this, the Trust has in place a Community Triage Team; three NSCHT Community Psychiatric Nurses work with frontline officers seven days a week to provide support in response to calls from members of the public with mental health issues. The nurses follow this up by working with the individual concerned to ensure they receive the right care at the right time in the right place.

We are working closely with commissioners, who fund the Section 136 facility, and with Staffordshire Police, to regularly assess the demand on the service and identify where any changes in capacity may be required.

9. PATIENT LED ENVIRONMENT ASSESSMENTS – PLACE

I welcomed the positive results of our annual Patient Led Assessment Care Environment (PLACE) report at the end of August. PLACE focuses on the environment in which care is provided with particular emphasis on cleanliness, general condition, appearance and maintenance, privacy and dignity and the provision of food and drinks. Our results show the Trust is well above the national average, according to the patient-led audit.

A key aspect of the PLACE system is the increased involvement of Patient Assessors - individuals who represent users of healthcare services rather than providers. All assessing teams must include at least two Patient Assessors, who must also comprise at least 50% of the overall team.

Assessments took place at each of NSCHT's inpatient venues at the following locations providing adult and older people mental health, learning disability and primary care services: Harplands Hospital; Dragon Square; Greenfields Centre; The Bungalows at Chebsey Close; Sutherland Centre; Darwin Centre; and Assessment & Treatment and Telford Units.

The Trust achieved the following results:

- Cleanliness – 98.99% (compared to the national average of 97.25%)
- Food and Hydration – 97.12% (compared to the national average of 88.79%)
- Privacy, Dignity and Wellbeing – 91.86% (compared to the national average of 87.73%)
- Condition, Appearance and Maintenance – 94.61% (compared to the national average of 91.97%)

Of particular note are Dragon Square and The Bungalows at Chebsey Close, which both achieved 100% for cleanliness. A big thank you to all staff involved for providing such excellent facilities for people using and delivering our services.

10. DUTY OF CANDOUR SESSIONS TO BE DELIVERED BY MILLS & REEVE

The Francis Inquiry Report into the events at Mid Staffordshire NHS Trust between 2005 and 2009 called for the establishment of a statutory duty of candour on both providers and individuals. This would require staff to disclose information to their employer where they believe poor care has resulted in death or serious injury to a patient, and make it a criminal offence for staff to try and prevent someone exercising this duty.

In responding to the Francis report, the government supported the proposal to implement a duty of candour with criminal sanctions on providers. A statutory Duty of Candour will be introduced in October 2014. It will place a formal requirement on providers of health or social care to be open with their patients when they suffer harm related to care or treatment. Its aim is to ensure that openness, transparency and candour are the norm.

In line with our commitment to openness and transparency, we will be shortly holding a Duty of Candour briefing session for staff, led by Mills & Reeve. The briefing is open to all professional disciplines to provide an understanding in terms of roles and responsibilities relating to this new statutory duty and will involve a briefing followed by time for Q&A.

Whilst there is already a contractual Duty of Candour contained in NHS Standard Contracts, this new statutory duty will apply to a wider range of providers. The session will therefore look at:

- When will the duty apply
- What is an incident?
- What are the reporting requirements?
- What are the consequences of a breach

11. ACCOUNTABILITY SESSION AT STAFFORDSHIRE COUNTY COUNCIL
On Wednesday 10 September, the Chairman and Executive Team presented to the Healthy Staffordshire Select Committee as part of its annual calendar of Accountability Sessions held with all NHS organisations across Staffordshire.

We welcomed the opportunity to provide the Select Committee members with an overview of our services and give account to them of how we had performed in a number of areas over the past 12 months. We were asked a number of challenging questions and received some positive feedback from councillors, who provide an alternative voice for people who have access to our services, which we are keen to encourage.
The session was webcast live to the public, and all staff were encouraged to view the session. It is available on the Staffordshire County Council website here - http://www.staffordshire.public-i.tv/core/portal/webcast_interactive/144919

NATIONAL UPDATES

12. KINGS FUND AND THE FOUNDATION TRUST NETWORK PUBLICATION
In February 2014, the Secretary of State appointed Sir David Dalton to undertake a review into securing the clinical and financial sustainability of providers of NHS care through offering new options for organisational forms.

The review will consider the potential for providers of NHS services to develop different organisational forms, and recommend how to incentivise the providers to work in new ways to provide better care, more efficiently, and help support struggling providers. It will fully involve acute, mental health and community service providers, both inside and outside the NHS, in the development of options.

The Kings Fund and the Foundation Trust Network have produced a paper setting out how new organisational arrangements might help drive improvements in struggling NHS organisations and services. This publication explores some of the organisational options available, including how high-performing NHS organisations might support providers in difficulty. It provides an evidence review and a range of individual perspectives on some of those new organisational arrangements, in health and other sectors, nationally and internationally – in a bid to inform the work of the Dalton review. The individual contributions highlight the benefits and challenges of different organisational models.

The full paper can be found here -
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/future-organisational-models-for-the-nhs-kingsfund-jul14.pdf

13. NHS ENGLAND CHIEF EXECUTIVE COMMITTED TO IMPROVING DEMENTIA DIAGNOSIS
NHS England is committed to pushing up dementia diagnosis rates, Chief Executive Simon Stevens has told the Alzheimer's Society Conference.

The pledge comes as NHS England publishes a new Dementia Toolkit aimed at helping GPs make more timely diagnosis of the condition and, importantly, what they can do in terms of vital post-diagnostic support.

The support covers many areas and is mainly directed at the person with the diagnosis or their carer. It relates to both emotional support and practical task-based help including specific interventions such as cognitive stimulation therapy.

The toolkit supports the ongoing work colleagues across NSCHT's Older People's Services already carry out with local GPs on early diagnosis of dementia and support available for both the patient and those involved in their care.

The toolkit can be found at http://www.england.nhs.uk/wp-content/uploads/2014/09/dementia-revealed-toolkit.pdf

14. NHS AND SOCIAL CARE BODIES TAKE NEXT STEP TOWARDS INTEGRATED HEALTH AND SOCIAL CARE FOR INDIVIDUALS

At the beginning of September, NHS England, the Local Government Association, Think Local Act Personal and the Association of Directors of Adult Social Services formally invited health and social care leaders to help build a new integrated and personalised commissioning approach for people with complex needs.

Integrated Personal Commissioning is a new voluntary approach to joining up health and social care for people with complex needs. This proposal makes a triple offer to service users, local commissioners and the voluntary sector to bring health and social care spend together at the level of the individual.

Service users will be offered power and improved support to shape care that is meaningful to them. Local authorities and NHS commissioners, and providers will be offered dedicated technical support, coupled with regulatory and financial flexibilities to enable integration. The voluntary sector will be a key partner in designing effective approaches, supporting individuals and driving cultural change.

NHS England, LGA, TLAP and ADASS have therefore published a joint prospectus inviting expressions of interest from the voluntary sector, providers and commissioners in the IPC programme. The prospectus is supported by a guide to bring people up to date on the latest developments in making care more personalised and integrated.

At NSCHT, discussions are already underway with local partners We will be promoting the personal health budgets and local authority personal budget as alternatives to residential care, whilst working with local housing providers to offer a package which provides high quality accommodation and gives service users the option to purchase their own care package.

A number of projects are currently being discussed, which will be launched in due course in a meaningful way for our service users via an information day/launch event, which will take forward the developments.

Caroline Donovan
Chief Executive
18 September 2014

North Staffordshire Combined Healthcare NHS Trust

REPORT TO: **Open Trust Board**

Date of Meeting:	25 September 2014
Title of Report:	Summary of the Quality Committee meeting held on the 16 September 2014
Presented by:	Mr Patrick Sullivan, Chair of Quality Committee
Author of Report: Name: Date: Email:	Sandra Storey, Trust Secretary, Head of Corporate and Legal Affairs 16 September 2014 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 16 September 2014. The full papers are available as required to Trust Board members
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Customer Focus Strategy • Clinical Strategy - • Governance Strategy
Relationship with Annual Objectives:	Ensure provision of safe clinical services
Risk / Legal Implications:	N/A
Resource Implications:	N/A
Equality and Diversity Implications:	N/A
Relationship with Assurance Framework [Risk, Control and Assurance]	The Quality Committee has an integral relationship with Improving Quality/ Registration.
Recommendations:	• To note the contents of the report • Ratify the policies highlighted in the report

Key points from the Quality Committee meetings held on the 16 September 2014 for the Trust Board meeting on the 25 September 2014

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

Dr Adeyemo presented the Director of Quality Report with notable items as follows:

- **Extended remit for Duty of Candour –** to ensure the Trust is responding to the statutory duty and the need to raise awareness of the duty and the responsibilities for clinicians, it was noted that a learning event has been arranged to take place on the 5 November 2014 at the North Staffs Medical Institute. Sandra Storey and Carol Sylvester are leading on this and can provide further information.
- **Clinical Pathways work –** the clinical pathways redesign board continues to focus on the design and integration of a number of care pathways that will deliver an improved experience across the wide range of mental health services. Pathway leads in conjunction with commissioners presented the latest version of pathways to an extended commissioning board on the 27 August 2014 and this was well received. Discussions are currently ongoing as to the next steps with commissioners looking to inform the Trust of their commissioning intentions late September / October 2014.
- **CQUINS 2014/15 –** Quarter 1 submissions were submitted and were achieved in full. All Quarter 2 submissions remain on track.
- **Dementia diagnoses increasing rapidly –** official figures show that the number of people diagnosed with dementia nationally has risen by 62 per cent in the last seven years. This clearly has an impact on local dementia services and the current changes proposed in the clinical pathway for dementia and older people particularly with local CCGs agreeing a target of increasing the proportion of people with dementia receiving a diagnosis while they are in the mild stages of the illness.

3. Policy Review

Mrs Storey presented the policy report on behalf of the director leads. The proposals were supported by the committee for ratification of the policies by the Trust Board for a period of 3 years or to be extended as follows:

- **Fire Policy – 5.05**
- **Information Governance Policy – 7.08**
- **Information Governance Strategy – 7.08a**
- **Safe Haven Policy - 7.14**
- **Information Sharing Protocol - 7.05 – rescind as replaced by the One Staffordshire Protocol**
- **Safeguarding Procedures – 1.12a & b**
- **Management of Pulmonary Tuberculosis – IC10**

4. Performance Quality Management Framework Report (PQMF) month 5

Committee members reviewed the month 5 report and were assured that performance against the Monitor compliance framework and key national targets, are all on target. A range of 122 metrics are in place to monitor performance. There were three areas that reported as significantly under-performing (red) and three areas as under-performing (amber). All other metrics remain green. Members discussed the report and were assured about the mitigating action plans in place to improve performance in the under-performing areas.

Committee members agreed that going forwards it seemed appropriate for the performance report to be managed by the Finance & Activity Committee. The Quality Committee will retain responsibility for monitoring quality metrics. The Finance & Activity Committee will discuss this business item as part of the Terms of Reference review at their meeting on the 18 September 2014.

5. Independent review of the Quality Governance Assurance Framework by KPMG

The committee discussed the report which showed a much improved position since the last independent review in 2011, moving from a score of 3.5 to 2.5. This means that the auditors are of the opinion that the Trust meets Monitor's requirements for quality governance. Committee members discussed how they could improve this position further and were satisfied that the action plan addressed the recommendations and was the start of this process. The Board's programme of development will also help to further inform the plan.

6. Integrated Quality Report Q1 2014/15 & PALS & Complaints Report Q1 2014/15

The committee received the high level summary extracted from the full Integrated Quality report. This report drew to the committee's attention notable items such as analysis of serious incidents, PALS and Complaints. Committee members agreed that as part of their review of the effectiveness of the committee, this report and other similar patient experience reports be re-evaluated to consider whether they could be reorganised into one report to provide a better understanding of the common themes and learning outcomes.

7. Quality Impact Assessment (QIA) – summary Business rules

Ms Wilson noted that in accordance with its Terms of Reference, the QIA Star Chamber will meet bi monthly prior to the Quality Committee. There will be a star chamber for each of the newly configured Directorates and the timings for each are being arranged.

8. Risks to Quality of Services

Committee members considered the report for quality risks as at 10 September 2014, noting the risk treatment plans in place. This was discussed alongside the two divisional reports in respect to their risks that are either emerging or require escalation.

Mr Ian Ball, Head of Estates, attended the meeting at this point to help provide information and assurance on the review that is underway to ensure that the Trust optimises levels of safety as well as ensuring the inpatient environment at Harplands Hospital is conducive to therapy. It was acknowledged that while there are significant levels of assurance already, the group would undertake a deep dive in respect to patient safety at its next meeting. It was also agreed that going forward the programme of work would form part of the agenda for the Risk Management Committee.

9. **Compliance with Emergency Planning, Resilience and Response – self assessment of Core Standards**

In line with NHS England's requirements, Boards must declare that they have plans in place and can deal with a wide range of incidents and emergencies. A self assessment against the standards was completed which resulted in 22 of the 31 standards being rated as green and 8 rated as amber with evidence of progress to achieve full compliance. The committee endorsed the report for submission to the Trust Board for approval prior to the TDA submission deadline of the 26 September 2014.

10. **Information Governance (IG) Steering Group – Terms of Reference**

The committee received for approval the revised Terms of Reference from the IG Steering Group. Members agreed that some aspects needed clarifying such as aspects relating to membership, roles and responsibilities. It was concluded that the paper would be referred back to the group in order to complete this work prior to approval by the committee.

11. **Chief Pharmacist Annual Report 2013/14 and Medicines Optimisation and Pharmaceutical Services Strategy**

The committee received these documents for review and approval prior to consideration by the Trust Board. Committee members asked for the Chief Pharmacist to be invited to the next committee meeting to talk through in person and in more detail these important documents prior to consideration by the Trust Board.

12. **Serious Incidents analysis April – June 2014**

The committee reviewed this report in detail which concluded that there are no apparent seasonal or monthly trends by incident category or by total reported incidents. It was noted that the Trust has escalated concerns regarding the delay in commissioner review of investigation reports and agreement for closure through the Clinical Quality Review meeting forum. The committee also received for information a summary report of the key findings from the publication in July of the annual National Confidential Inquiry for Suicide and Homicide.

13. **Divisional Reports**

Reports were received from the Adult Mental Health and LDNOAP Directorates. Concern was expressed by committee members that a report had not been submitted by the Children's and Young People's Service and that there was no directorate representative in attendance to provide a verbal report. Concern was also expressed that was no directorate representative in attendance to present the LDNOAP report. The Chair noted that he would raise his concerns about this outside of the meeting and that this was an area that would be discussed in more detail in the development part of the meeting under the review of the committee Terms of Reference.

14. **CQC Ward 4 Visit, Ward 6 Visit and overarching Action Plan**

The committee received a report from the CQC following their unannounced visit to Ward 4 in August 2014, The Directorate are currently considering the report and will provide a response by the deadline of the 30 September 2014. The inspectors considered past actions that had been identified and were satisfied that they have all be completely resolved. Some further points were raised such as posters reminding patients of the CQC, and these will be addressed as part of the response to the CQC.

The committee have previously been notified of the unannounced visit to Ward 6 and that the deadline for response was the 26 August 2014. This had been completed in timescale and a copy provided to the committee for information and assurance purposes.

15. Final Patient Led Assessment Care Environment (PLACE) results

The committee received the provisional results at its meeting in July 2014. It was confirmed that the results has been finalised and that there was no change from the excellent results previously presented.

16. Domain Reports

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

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

17. Review of the Effectiveness of the Quality Committee

Committee members agreed that it was timely to review its effectiveness in respect to meeting its Terms of Reference.

Members discussed quality priorities and how they translate into a quality strategy and plan. 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 there is a transformation agenda required for the committee. Building on what is working well, as concluded by the independent review of the Trust's quality governance arrangements, and what additional work is required to enhance arrangements further. Consequently, it was concluded that this important piece of work needed further discussion by members with a programme for delivering the revised agenda and Terms of Reference for the committee over the next 3 months.

The committee therefore requests that the Trust Board extend its current Terms of Reference for a period of 4 months. This will allow the committee to complete its work in December 2013 with the outputs reported to the Trust Board meeting thereafter in January 2015.

On behalf of the Committee Chair, Mr Patrick Sullivan, Non Executive Director

Sandra Storey
Trust Secretary / Head of Corporate and Legal Affairs
17 September 2014

North Staffordshire Combined Healthcare NHS Trust

Encl 7

REPORT TO: **Trust Board** (open)

Date of Meeting:	25 September 2014
Title of Report:	Report from the Risk Management Committee held on 13 August 2014
Presented by:	Mrs. B Johnson, Chair of the Risk Management Committee
Author of Report: Name: Date: Email:	Sandra Storey, Trust Secretary, Head of Corporate and Legal Affairs 2014 18 August 2014 sandraj.storey@northstaffs.nhs.uk
Purpose / Intent of Report:	• For assurance
Executive Summary:	This report provides a summary of the Risk Management Committee meeting held on the 13 August 2014
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]	Risk Management is an integral part of the Trust's Board Assurance Framework and informs the Annual Governance Statement
Recommendations:	To note the contents of the report

Risk Management Committee Summary Business Report to the Trust Board of the meeting held on 13 August 2014

1. **Welcome**

   Mr David Rogers, Non Executive Director, was welcomed to his first meeting of the committee.

2. **Report from the Risk Review Group**

   Ms Wilson, Director of Nursing & Quality presented this report which provided an update of the work of the Risk Review Group following their meetings in May and June 214.

   Ms Wilson informed the committee that the meetings had reverted from taking place quarterly to monthly meetings in order to keep an increased focus on the risk management arrangements at Directorate level. The Risk Management Committee felt assured by this level of attention given this important area of work and supported these arrangements.

   Ms Wilson also noted that there had been limited representation from some of the Directorates at recent meetings. While it was acknowledged that this was mainly as a consequence of annual leave, Directorate leads have been reminded to ensure there is representation from their service at each meeting given their ownership and accountability for local risks.

3. **Q2 2014/15 Principal Risk Register and Review of Risk Management Arrangements**

   Ms Wilson presented this paper which highlighted principal risks, their ratings and mitigating actions. It was noted that the description of some of the risks had been revised following the review of the risk register at the last committee meeting.

   Committee members reviewed the Principal Risk Register and risk treatment plans and discussed at length the significance of the risks being presented at Q2 and those going forward into Q3.

   In respect to the risk of failing to maintain clinical effectiveness and operation of safe clinical services, Committee members discussed the programme of work that is in place to ensure ongoing compliance with the CQC's standards of care and preparations for inspection. Committee members were confident with the robustness of the plans in place to manage this key area of work.

   It was noted that at the previous meeting of the Committee the narrative in respect to mitigating actions for all risks was noted to be at a very high level and this prompted discussion around the level of assurance being provided to the board and the evidence available. Ms Wilson advised that she had spoken with Mrs Bridget Johnson, Chair of the Risk Management about strengthening the presentation of risk going forward so that it more visibly aligns to the key controls within the Assurance Framework. This approach was welcomed by the Committee noting that this would increase the assurance levels around the risk management arrangements.

4. Risk Management Annual Statement 2013/14

The Committee received the annual statement which summarised the risk management arrangements and activity undertaken for the year ending 31 March 2014. This also provided a summary of the developments that had been undertaken throughout the year to further enhance arrangements. This included the Risk Review Group undertaking a review of its effectiveness and compliance with its Terms of Reference.

5. Cycle of Business

This was received by the Committee and will be further refined as work develops over the coming months.

On behalf of the Committee Chair, Bridget Johnson
Sandra Storey
Trust Secretary / Head of Corporate and Legal Affairs
28 August 2014

North Staffordshire Combined Healthcare NHS Trust

Encl 8

REPORT TO: Trust Board (open)

Date of Meeting:	25 September 2014
Title of Report:	Q2 Principal Risk Register Report 2014/15
Presented by:	Karen Wilson Executive Director of Nursing & Quality
Author of Report: Name: Date: Email:	Glen Sargeant, Head of Performance and Information 1 August 2014 Glen.sargeant@northstaffs.nhs.uk
Purpose / Intent of Report:	• For review and approval
Executive Summary:	• The enclosed short report describes the current position, future developments and recommendations for the committee to consider
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Governance Strategy Robust risk management supports the effective delivery of safe and high quality services.
Relationship with Annual Objectives:	The Risk Management Framework measures and facilitates the management of risk across all annual objectives.
Risk / Legal Implications:	Addressed by this report
Resource Implications:	Not directly as a result of this report
Equality and Diversity Implications:	Not directly as a result of this report
Relationship with Assurance Framework [Risk, Control and Assurance]	The Risk Management Framework is a key control within the Assurance Framework.
Recommendations:	To consider for assurance purposes and to approve the attached report

2014/15 Principal Risk Register - Q2 (draft v2)

Ref	Strategic Risk	Annual Objectives / Committee	Controls	Lead	Impact	Likelihood	Gross Risk	Impact	Likelihood	Residual Risk Q2	2014/15 Mitigation Plans
STRATEGIC PLANNING											
1	**Failure to maintain clinical effectiveness and operate safe clinical services:** The Trust fails to develop an outcome focus which is integral to clinical practice; Fails to implement methods to assess clinical effectiveness; Fails to assess outcomes; Fails to deliver services that improve outcomes; failure to implement robust and safe clinical services, fails to deliver a culture where patient safety is continually reviewed and improved; failure to maintain infection prevention & control: failure to safeguard children & vulnerable adults.	**1,3,4,5,6** Quality	15, 18, 20, 22, 27, 32, 34, 52, 53, 55, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 111, 124, 127,	Med Director & Dir Nursing & Quality	5	3	15	5	1	5	Trust level and Team level outcome measurement framework established and will continue to be enhanced moving forward. Full implementation of the new processes to learn from disparate quality systems in an integrated manner. External quality reports (e.g. DoH, TDA, CQC) are viewed alongside internal performance reports to ensure the Trust is on track in the key areas. Service Line Management / Reporting - Local focus on compliance and safety established. (Dir of Leadership & Workforce). Increased focus on quality & governance is in place at divisional level – e.g. Q&G leads and Q&G infrastructure built in to the wider Divisional Governance Framework Data Quality arrangements are continually monitored and enhanced where possible (Dir of Finance). As a result of the Phase 2 public consultation, investment in additional community support has been established to support more patients to be supported within the community. Home treatment team & Crisis Resolution work closely with acute wards to facilitate discharge & ensure by providing timely interventions that support admission avoidance where appropriate and embed the 'recovery model' of care for users and their carers. Significantly more robust divisional and service line risk management structures are now in place. Enhanced community teams in AMH and NOAP. Some staff have been moved from community to inpatient settings in order to reduce the need for bank usage. In NOAP enhancements to the community service have led to a reduced demand for user beds. The Trust has an integrated process for the reporting of safeguarding activity, which is embedded within the Trust incident reporting system which allows performance to be effectively managed. Further to increased incident reporting of falls across older adult services, plans for improving safety, reducing incidents and improving standards in this area are currently being implemented.
2	**Failure to jointly develop clinical pathways and develop a clinical strategy which informs the future direction of the Trust:** The Trust fails to develop appropriate and effective, or develops undeliverable, clinical pathways and a clinical strategy	**2,3** Risk Management	1, 2, 3, 4, 5, 6, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 38, 40, 43, 44, 45, 48,	Chief Executive	4	3	12	4	2	8	Within the LHE, the CELG group meet to align plans and the development of strategy across the economy with a commitment to a 'whole system' approach to service redesign and transformation. A Trust commissioning board, chaired by CCGs, meets monthly. In addition there is a sector wide QIPP board that meets quarterly. 8 clinical pathway groups established with clear clinical or commissioning leads. Terms of reference for each group established and key partners identified. Governance structure established and agreed with commissioners. Monthly Commissioning Board and monthly internal Programme Board tracks progress. Workshops undertaken in May and June 2014 to share progress internally and externally and to strengthen integration across pathways.
286	**Future organisational form is unable to deliver sustainable services:** impacting on future provision and delivery of patient care	**2,5** Risk Management	1,3,5,6,13,14,15,16, 20,25,26,40, 43,46,47,50, 56,57,58	Chief Executive	4	3	12	4	2	8	Agreement with Commissioners and TDA to refresh clinical strategy currently under way to develop robust, integrated clinical pathways that support integration with physical healthcare and social care. Clinical pathway work will inform the decision for future organisational form. 2-year plan developed and broadly supported by TDA with minimal concerns raised. 5-year plan developed and submitted in June 2014 to describe and model future services. TDA risk rating for Trust reduced from 3 to 2.
4	**Failure to maintain the confidence of commissioners and deliver outcomes together:** The Trust fails to meet the ongoing expectations of commissioners; Fails to work jointly in an effective manner to deliver agreed outcomes	**2,3** Risk Management	13, 14, 15, 20, 23, 28, 40, 41, 42, 43, 44, 45, 52, 58, 125, 126,	Dir of Operations	4	4	16	4	3	12	Clinical pathways are being established in partnership with local commissioners to jointly determine the direction of travel of this organisation. Director of Operations and Director of Nursing hold regular 1:1 meetings with the lead commissioners for Staffordshire and Stoke on Trent. Where issues do occur, items are escalated to the Commissioning Board for further discussion and agreement. At NSCHT's request the Commissioning Board's focus has been extended to include CAMHS service in order to be fully inclusive. The Commissioning Board has also been extended to include Stoke on Trent City Council. CIP and longer-term service change plans are shared and agreed with commissioners to help inform clinical pathway work.
5	**Potential impact of CIP on quality:** The Trust fails to ensure that arrangements are in place to prevent any reduction in quality of services during the delivery of the CIP.	**4,5** Quality	2, 4, 5, 15, 20, 27, 28, 29, 32, 33, 39, 60, 61, 64, 65, 66, 68, 69, 70, 71, 72, 73, 74, 75, 76, 87, 89, 124,	Med Director/Dir Nursing & Quality	4	3	12	4	2	8	Top level Board commitment to maintaining Quality is recorded in public minutes and message is disseminated through the organisation via Trust communication (plenary/ team brief etc) Review of clinical change and any negative impact by Clinical Directors/Senior Nurses at least a monthly basis . Review of incidents and specifically to see if there is any correlation with where CIP is being delivered. Consultation and scrutiny of plans (Exec Team). Continue the regular monitoring of any impact on quality as a result of delivering the CIP (SMT). Increased focus on quality & governance at divisional level - i.e. Q&G leads and Q&G infrastructure. Close scrutiny of all plans from a clinical perspective; confirm and challenge meeting held with commissioners - in year post implementation review. All CIP schemes are quality impact assessed by Clinical Directors and signed off by the Medical and Nursing Directors. The Trust Quality committee reviews CIP implementation plans on a quarterly basis to ensure that the implementation of CIP plans is monitored for their impact on quality. A new control mechanism has been introduced to strengthen the assurance requirements which will be piloted during the month of September.
287	**Failure to deliver a culture change in staff engagement and other internal / external relationships:** The Trust fails to engage staff and other internal / external partners in the planning and delivery of services; Fails to communicate its plans in a clear and compelling way that builds confidence	**3,4,6** People & Culture	15, 20, 23, 27, 28, 60, 61, 65, 75, 76, 87, 111, 124, 125, 126,	Dir Leadership & Workforce	4	3	12	4	2	8	People and Culture Development Committee in place to help promote strategic leadership and guidance. Introduction of Aston Team Based Working Programme across the Trust Introduction of Listening into Action and a dedicated lead assigned to drive forward the programme. Regular bulletins and updates for staff on SID and in staff newsletter. Monthly Chair and Chief Executive –led plenary sessions continue to engage with senior managers across the organisation (and all staff by cascade). Monthly Team Brief sessions delivered face-to-face in teams to ensure 2-way dialogue is generated. Updated Staff Friends and Family Test rolled out in Q1 2014/15, taking a structured approach to ensure that all staff (including agency, bank and locum workers) have the opportunity to feed back at least once a year in addition to the National Staff Survey. Regular programme of 'Board to Ward' visits in place to facilitate open discussion and more informal feedback. CDs, Business Managers and Service Line Managers support robust organisational leadership. Staff at all levels are empowered to influence and help deliver the strategic direction of the Trust. Identified as an organisational objective for 2014/15
280	**Failure to develop effective 5-year strategic plan:** The Trust is unable or lacks ability to develop an effective 5-year strategic plan, impacting on services and on the future form of the Trust; Trust fails to take sufficient advantage of opportunities presented by the current market environment	**5** Risk Management	1, 2, 3, 4, 5, 6, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 43, 56, 57, 58, 63, 88,	Dir of Finance	4	4	16	4	3	12	The Trust is developing its Strategic Plans with deep involvement of commissioners, particularly our host CCGs. This action will ensure both commitment from commissioners to fund the outcome of Clinical Pathway work and commitment from the Trust to deliver the outcomes aligned to the commissioners' Clinical Strategy.

Ref	Strategic Risk	Annual Objectives / Committee	Controls	Lead	Impact	Likelihood	Gross Risk	Impact	Likelihood	Residual Risk Q2	2014/15 Mitigation Plans
FINANCIAL											
288	**Insufficient funding to meet the cost base for service provision arising from the financial impact of CIP, Bucknall site and LD changes:** This could result in insufficient income to maintain service provision and to inform contract negotiations on an ongoing basis, as we progress towards a Payment by Results regime.	**5** Finance & Activity	16, 24, 26, 29, 39, 46, 47, 50, 51, 53, 54, 56, 97, 98, 109, 111, 116, 117, 121,	Dir of Finance	5	4	20	5	3	15	The Trust has developed a robust CIP regime which involves both an assurance of deliverability and a quality impact assessment to ensure appropriate quality standards are maintained. The Trust is progressing the implementation of PbR in line with national requirements and is working with commissioners to progress this agenda. Significant work has been completed in clustering activity on the patient information system in preparation for the new regime. The PLICS system provides service line information combining financial and non financial information at patient, service line, divisional and Trust level. Details are continually being refined with individual service lines. In advance of tariff being developed for Mental Health, in order to better understand the potential contribution of individual services, the Trust is currently undertaking an exercise to match costs and income by service utilising block contract data.
309	**Lack of control, management, monitoring and governance of Non Clinical Service level Agreements due to absence of agreed signed Non Clinical SLAs**	**5** Finance & Activity	2,3,4,5.26,41,45,50,53,56,58,91	Dir of Finance	3	4	12	3	3	9	Register of Non Clinical SLAs established - completed Identification of Accountable Manager – 75% completed Review of status of SLA e.g. agreed/signed to not agreed/unsigned – 75% completed Establishment of Reporting process to provide relevant high level KPIs to Finance and Activity Committee on a quarterly basis - outstanding
INFORMATION MANAGEMENT & TECHNOLOGY											
10	**Failure to develop and implement fit-for-purpose information systems that provide real-time information for patients and fully support PbR, mobile working and efficiency:** The Trust fails to develop electronic information systems, including the technical skills, which are fit for purpose; Fails to effectively manage information; Fails to develop an electronic patient record (EPR); fails to support clinicians through ensuring there are integrated electronic recording systems.	**4,6** Finance & Activity	19, 109, 111, 112, 114, 116, 117, 118, 119, 121, 122, 123,	Dir of Finance	4	5	20	4	4	16	A Director of Strategy has been appointed to help drive forward actions to mitigate this risk. The Trust has also held a series of diagnostic meetings between key staff and an external IT consultant to gain a better understanding of the issues facing staff and the potential solutions, including a full-day workshop on 3 July 2014 to agree the next steps. A data quality forum is in place to ensure quality is driven up, for current systems. Training is provided for both clinical and non-clinical staff - including clinical coding, records maintenance, system usage etc. Investment in information Technology is planned and the IM&T strategy includes plans to increase mobile and flexible working and also to identify an electronic patient record solution. In the medium term Investment in IT remains a priority for the use of the Trust's Capital Resource. In the interim a significant amount of work is being undertaken to update CHIPS. This has included rationalising coding, improving reporting. This has enabled release of significant amounts of data to support development of PBR to commissioners and mitigated the risk significantly. In addition a proposal has been written to add a patient noted function to CHIPS, which would then facilitate a functional if basic patient record system that can be used to unlock some of the efficiency possible from mobile working and discussions about the feasibility and time to implement this are ongoing with HIS. In recent years there has been little investment in IT infrastructure and hardware, largely linked to the former transaction timetable. This will also be reviewed during 2014/15 in the light of ongoing discussions in respect of organisational form. The Trust is also investing in a range of IT support systems e.g. Big Hand (voice dictation), electronic whiteboards etc.
WORKFORCE											
12	**Failure to comply with safe staffing requirements and establish safe staffing levels in clinical areas:** The Trust fails to review and implement safe and effective levels of clinical staff to meet patient needs in clinical services.	**5,6** Quality People & Culture	1, 17, 34, 35, 36, 39, 55, 97, 101, 102, 103, 128	Dir Nursing & Quality	3	3	9	3	2	6	The Trust Board is accountable in ensuring that the Trust has sufficient levels of clinical staff in place to provide safe, effective care to all its patients. The Trust has reviewed staffing levels and is implementing an action plan to strengthen arrangements. A Safer Staffing Workgroup has been established to take forward this agenda. Steps taken to assure the Trust board to date are: Ward staffing review of wards 1 -7 at the Harplands hospital, which indicated an under-establishment in some areas. Recruiting to vacancies across the Harplands site, recruiting to the Nursing Bank to ensure availability of resource when needed, reducing bed number on wards which are under occupied, improving HR process to effectively manage sickness absence. A 6-monthly overview paper and the first monthly review paper (M2 data) were presented to June 2014 Trust Board. These have also been uploaded to a dedicated page on the Trust's website with a link to the staffing level data on NHS Choices and staffing levels are clearly displayed at each inpatient site in accordance with national requirements. Monthly report on activity regarding safer staffing submitted to July Trust Board.

Ref	Strategic Risk	Annual Objectives / Committee	Controls	Lead	Impact	Likelihood	Gross Risk	Impact	Likelihood	Residual Risk Q2	2014/15 Mitigation Plans
ESCALATED FROM OPERATIONAL RISK REGISTER											
131	**Significant financial impact in 2014/15 as a result of future model of LD services**	- / Risk Review Group	-	Dir of Finance	5	4	**20**	5	3	**15**	Ongoing TUPE discussions taking place with relevant parties; support team in place to help manage process. Escalated to Trust's Principal Risk Register in view of potential cost impact. Risk has been escalated to the chair of the LD Project Board and raised with the Commissioning Board. HR 'task and finish' group and an Assertive Outreach Support Team have been established to support the care to clients through the Transaction period. Our host commissioners are supporting the Trust in securing other commissioners' 'fair share' contributions towards exit costs. (There is considerable uncertainty over whether other commissioners will pay.) The Trust has enhanced its accounting provision to align with current anticipated redundancy costs.
130	**Work undertaken in the roof spaces at Harplands may lead to potential disruption in clinical areas and / or harm to patients and staff**	- / Risk Review Group	-	Dir of Operations	5	3	**15**	5	3	**15**	Standstill agreement in place (to extend warranty period while investigation / resolution of the issues is undertaken). Legal advice sought. Practical steps taken to minimise risk of leaks through maintenance work - plastic sleeves and fluorescent tape to make valves (weak points) more obvious; isolation vale location and bleed valve placements actively highlighted in pre-briefs. Ongoing discussions between Estates, Carillion and PFI partners - Exec led by Dir of Operations. Risk escalated to PRR for wider consideration.
129	**Risk of patients using ligature points in in-patient unit at Harplands resulting in potential harm**. Previous audits had assessed this risk in areas where it was most likely (i.e. bedrooms) and concluded it to be low risk. This has been increased following a recent suicide on Ward 1 where a bedroom door handle was used as an anchorage point.	- / Risk Review Group	-	Dir of Operations	4	4	**16**	4	3	**12**	All annual risk assessments in respect to ligature points are in place and have been undertaken External review undertaken week beginning 15th July. Action plan developed and actions expedited following receipt of review. All staff have been made aware that door handles are a potential anchorage point and observation levels for service users at risk will be assessed against this potential. Environmental Risk Group established. Additional values-based sessions delivered.
258	**Failure to sign and / or effectively manage Trust's clinical SLAs**	- / Risk Review Group	-	Dir of Operations	4	3	**12**	4	3	**12**	Risk escalated to PRR in Q2 2014/15 to increase focus. (This risk supersedes the specific PFI contract risk – 279 – previously on the PRR, which has now been closed.) Full list of SLA's (including potential financial impact) being collated so that an overarching action plan can be developed.

		LIKELIHOOD				
		Rare	Unlikely	Possible	Likely	Almost Certain
IMPACT	**Rating**	**1**	**2**	**3**	**4**	**5**
Negligible/Insignificant	**1**	1	2	3	4	5
Minor	**2**	2	4	6	8	10
Moderate	**3**	3	6	9	12	15
Major	**4**	4	8	12	16	20
Catastrophic	**5**	5	10	15	20	25

Overall Risk Rating

1-3= Low
4-6= Moderate
8-12= Significant
15-25= High

Top 20 Controls for Principal Risks:
1 - On an annual basis the Board of Directors reviews and revises the strategic objectives and sets annual objectives, which are aligned with the organisation's strategic plan and with Registration requirements, and are tested against the high level governance framework.
2 - The Board ensures that there are robust risk management arrangements in place, these arrangements are set out in the Risk Management Strategy and Risk Management Policy, which are reviewed on an annual basis.
3 - The Board reviews the risks that threaten delivery of the organisation's principal objectives (principal risks) on a quarterly basis.
4 - The Board ensures that there are robust performance management arrangements in place. A balanced scorecard is in place across all of the enabling strategies, which links performance to the principal objectives.
5 - There is an Assurance Framework which maps the Trust's annual objectives; risks; controls; positive assurance; gaps in control and/or assurance and remedial action.
6 - The Board is appropriately engaged in developing and maintaining the Assurance Framework.
13 - The Trust has a comprehensive medium to long term Integrated Business Plan which is aligned to current Commissioning Intentions.
14 - The Trust has an up to date market assessment which informs the Integrated Business Plan.
15 to 22 - The Trust's Enabling Strategies, which are aligned to the Business Plan.
23 - The Board of Directors publishes an annual Summary Business Plan which sets out the Trust's purpose, values and its principal objectives for the year ahead.
43 - The Trust seeks to ensure concordance between the Trust's plans and commissioners future commissioning intentions.
58 - The Trust reviews and sets its operational plans with stakeholders on an annual basis. The Trust Board approves the operational plans in line with the principal objectives and the Trust strategic plan.
111 - The Trust has a Records Management Policy and Data Quality Strategy.

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: **TRUST BOARD**

Date of Meeting:	25 September 2014
Title of Report:	Annual Statement of compliance with The Health and Social Care Act Code of Practice on the Prevention and Control of Infections and related guidance (Department of Health 2010)
Presented by:	The Director of Infection Prevention & Control
Author of Report: Name: Date: Email:	Associate Chief Nurse (Infection Prevention) @ UHNS Emyr Phillips 16th September 2014 emyr.phillips@uhns.nhs.uk
Purpose / Intent of Report:	• For Decision√ • Performance monitoring • For Information
Executive Summary:	The Code of Practice sets out the ten criteria against which the Care Quality Commission judge a registered provider. The enclosed document provides a summary of the Trust's position benchmarked against the criteria detailed in the Code, which is required to be reported to Trust Board on an annual basis.
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:	Delivery of high quality care
Risk / Legal Implications:	Registration with the Care Quality Commission
Resource Implications:	No additional resource requirements.
Equality and Diversity Implications:	Policy and practice complies with Equality legislation.
Relationship with Assurance Framework [Risk, Control and Assurance]	Compliance with the Health & Social Care Act 2008 Code of Practice (DoH 2010) Governance arrangements are described in the code declaration under criterion 1.
Recommendations:	It is recommended that the Board accept the annual declaration of compliance with the Hygiene Code.

North Staffordshire Combined Healthcare NHS Trust

Position statement (as at 16th September 2014) of compliance with The Health and Social Care Act 2008 Code of Practice on the Prevention and Control of Infections and related guidance (Department of Health 2010)				
The assessment was benchmarked against the criteria detailed in the Code using a traffic light system of green for compliance, amber for partial compliance and red for little compliance				
Criterion		**Green (Compliance)**	**Amber (Partial compliance)**	**Red (Little compliance)**
Management, organisation and the environment				
Criterion One: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them				
1.1	Appropriate management and monitoring arrangements should ensure that: • A registered provider has an agreement within the organisation that outlines its collective responsibility for keeping to a minimum the risks of infection and the general means by which it will prevent and control such risks. • An individual is designated as the lead for infection prevention and control and be accountable directly to the registered provider • The mechanisms are in place by which the registered provider intends to ensure	All Infection Prevention and Control Policies detail roles and responsibilities within the Trust and place individual responsibility on each and every member of staff to minimise the risk of infection. All policies are located on the Trust intranet and included in the Staff Information Desk (SID). Karen Wilson, who is a Board member and the Director of Nursing and Quality is the nominated Director of Infection Prevention and Control. She is accountable to the Chief Executive and the Board. Steve Eley, the Deputy Director of Nursing is the Deputy DIPC. The Trust has an SLA with UHNS for the IP		

	that sufficient resources are available to secure the effective prevention and control of infection. • These should include the implementation of an infection prevention and control programme - infection prevention and control infrastructure and	service provision. The Trust resource for IPC complies with recommendations detailed in Section 1.8 the Health and Social Care Act 2008 Code of Practice. The Board have the opportunity to review the position following the presentation. The Infection Prevention and Control Annual Programme is approved by the Infection Prevention and Control Group (IPCG), Quality Committee and the Board. This document details the Trust's priorities, the individuals responsible and timescales. It is reviewed and updated regularly. The Trust's infrastructure includes the DIPC, Deputy DIPC, IPN, ICD (detailed below) IPC Group, incident reporting mechanisms, policy and procedure documents The Trust has a Service Level Agreements (SLAs) with - • The University Hospital of North Staffordshire (UHNS) for Infection Prevention nursing service; Pathology, microbiology advice and Infection Control Doctor (ICD) Services • Shropshire Community Health NHS Trust for Occupational Health services, which will change to Team Prevent from October 2014 • Staffordshire Housing for maintenance of		

	- the ability to detect and report infections • Relevant staff, contractors and other persons, whose normal duties are directly or indirectly concerned with providing care, receive suitable and sufficient information on, and training and supervision in, the measures required to prevent and control the risks of infection • A programme of audit is in place to ensure that key policies and practices are being implemented appropriately	learning disability properties • Carillion for support services at the Harplands Hospital • Staffordshire and Stoke-on-Trent Partnership Trust for cleaning Trust locations at Bradwell and Cheadle Hospital The Trust subscribes to the electronic surveillance system ICNet administered by the UHNS. Laboratory reports are reviewed by the IPN each day during period of duty and by the UHNS Consultant Microbiologist. Timely advice is provided to clinical teams on the appropriate management of the patient. Clinical teams report alert conditions to the IPN Infection Prevention and Control is included in Corporate Induction and in three yearly Mandatory updates for all staff. IPC Policies detail duties, roles and responsibilities. The Trust IPCN provides training to Carillion staff providing services at the Harplands Hospital. Other contractors are selected from approved lists of organisations with the necessary systems and procedures in place Clinical teams working within hospital inpatient areas undertake quarterly audits while the Trust		

	• A policy on information sharing when referring, admitting, transferring, discharging and moving service users within and between health and adult social care facilities is available • A decontamination lead is designated, where appropriate	IPCN undertakes random unannounced annual audits Monthly cleanliness audits and annual Patient Led Assessment of the Clinical Environment (PLACE) assessments are undertaken. The Trust achieved excellent results during the PLACE assessment undertaken in 2014 The Trust has an Admission and Discharge Policy which ensures that clinical information including infection prevention and control is handed over to the receiving organisation to facilitate a safe and seamless transfer. Details of MRSA, *Clostridium difficile,* resistant organisms and whether the individual has been part of an outbreak of infection should be included in discharge documents The Support Services Advisor (Cleanliness) is the Trust designated lead for decontamination of the environment.		
	Risk assessment			
1.2	A registered provider must ensure that it has: • Made a suitable and sufficient assessment of the risks to the person receiving care with respect to prevention and control of infection	Admissions to hospital inpatient locations are assessed using the Bardwin infection predictor tool. Nursing care is subsequently planned to mitigate those risks. The level of risk will determine whether a daily or weekly review is required and any change in the patient's condition prompts an urgent review. The Trust uses the Bristol Stool Form system for		

		the assessment and monitoring of diarrhoeal symptoms and subsequent reporting of potentially infectious patients to the IPCN. Trust Policies on MRSA, *Clostridium difficile* infection, outbreak prevention and management describe the assessment and management of patients with potential or identified infections. The Trust IPN provides patient specific advice to clinical teams		
	• Identified the steps that need to be taken to reduce or control those risks	In addition to the above, individuals admitted to hospital inpatient locations, who meet DoH criteria, are offered MRSA admission screening and where appropriate MRSA decolonisation		
	• Recorded its findings in relation to the first two points	Patient specific information is recorded in the patient's records and will include admission assessment documents, laboratory reports, prescription charts and any specific advice from the IPN.		
	• Implemented the steps identified and	Patients will be reviewed daily		
	• Put appropriate methods in place to monitor the risks of infection to determine whether further steps are needed to reduce or control infection	Compliance with MRSA admission screening is monitored by the IPN through weekly returns from all hospital inpatient areas. Monthly summary reports are provided to the Performance Department for inclusion in Trust reports Surveillance data, trends, variances and any potential or emerging risks are included in the agenda as a standing item for discussion at each		

		Infection Prevention and Control Group which meets four times a year. Urgent issues would be reported directly to the DIPC		
	Directors of Infection Prevention and Control (NHS Provider organisations)			
1.3	The role of the DIPC in NHS provider organisations is to: • Be accountable directly to the Chief Executive and to the Board (but not necessarily a member of the Board) • Be responsible for the organisation's infection prevention and control team (ICT) • Oversee local prevention and control of infection policies and their implementation • Be a full member of the ICT and regularly attend its infection prevention and control meetings • Report directly to the NHS board • Have the authority to challenge inappropriate practice and inappropriate antibiotic prescribing decisions	The nominated DIPC is Karen Wilson, who is a Board member and reports directly to the Chief Executive and the Board The Trust has a SLA with UHNS IP service who reports to Karen Wilson and the Deputy DIPC Steve Eley The DIPC receives an update on IPC policies and audits at each IPC Group meeting The DIPC or Deputy DIPC chairs the Infection Prevention and Control Group which meets four times a year The DIPC is also the Executive Director of Nursing and Quality. The DIPC reports to the Quality Committee which is a sub-committee of the Board and reports by exception to the Board. The Deputy DIPC is the Deputy Director of Nursing The DIPC, as a Board member, has the necessary authority to challenge poor practice. The Antimicrobial Pharmacist presents summary		

		reports to members of the Infection Prevention and Control Group at each meeting. Through this mechanism the DIPC has the opportunity to challenge inappropriate antibiotic prescribing decisions and current practice within the Trust		
	• Assess the impact of all existing and new policies on infections and make recommendations for change	The impact of existing and new policies is assessed through audit, incident reports, contract monitoring and training records.		
	• Be an integral member of the organisation's clinical governance and patient safety teams and structures and	The DIPC is a member of the Quality Committee		
	• Produce an annual report and release it publicly	The DIPC produces an annual report and releases it publicly following approval by Quality Committee and the Board		
	Assurance framework.			
1.5	Activities to demonstrate that infection prevention and control are an integral part of quality assurance should include:			
	• Regular presentations from the DIPC and/or the ICT to the NHS Board or registered provider. These should include a trend analysis for infections and compliance with audit programmes	The DIPC reports monthly IPC activity to the Quality Committee including surveillance data, trends and variances, progress, issues and emerging threats. IPC information is also reported The Board through performance dashboard and the year-end summary in the IPC Annual Report		
	• Quarterly reporting to the NHS Board or registered provider by clinical directors and matrons. Reports may include –	The DIPC reports to the Board and includes progress and issues at each meeting		

	• Monthly cleanliness scores	The Support Services Advisor provides the DIPC with monthly cleanliness scores		
	• PLACE scores	The Support Services Advisor provides the DIPC with PLACE scores following the annual assessment		
	• Contract performance measures where provision is outsourced, which will include cleanliness measures and issues of non-compliance and subsequent rectification performance	The Support Services Advisor provides the DIPC with monthly cleanliness scores including the Harplands Hospital, where cleaning is provided through a PFI contract with Carrillion.		
	• A review of statistics on alert organisms, outbreaks and SUIs.	The IPN provides monthly reports to the DIPC on alert organisms, outbreaks and SIs		
	• Evidence of appropriate action taken to deal with occurrences of infection including, where applicable root cause analysis and	All *Clostridium difficile* infections, bacteraemia and outbreaks of infection are subject to a root cause analysis investigation. The RCA investigation prompts a summary report and subsequent action plan. The plan is monitored by the clinical team and matron		
	• An audit programme to ensure that policies have been implemented	The DIPC receives details of audits in the monthly report and briefing papers submitted to the IPC Group Inpatient areas undertake a quarterly programme of audits, while the IPCN undertakes unannounced annual audits		
1.6	In accordance with health and safety requirements, where suitable and sufficient assessment of risks requires action to be taken,	The IPCN receives weekly incident reports detailing health and safety issues relevant to infection prevention and control. The IPN is also		

	evidence must be available on compliance with the regulations or, where appropriate, justification of a suitable better alternative.	a member of the Organisational Safety Group		
	Infection Prevention and Control Programme			
1.7	The programme should : • Set objectives that meet the needs of the organisation and ensure the safety of service users • Identify priorities for action • Provide evidence that relevant policies have been implemented to reduce infections • If appropriate, report progress against the objectives of the programme in the DIPC's annual report or the IPC Lead's annual statement	The IPC annual programme reflects national objectives and sets local ambitions which meet the needs of the Trust The IPC annual programme identifies priorities for action in response to issues, emerging threats and key national documents The regular programme of audits provide evidence that policies have been implemented Progress of the annual programme is reported at each IPC Group meeting four times a year		
	Infection Prevention and Control Infrastructure			
1.8	An infection prevention and control infrastructure should encompass: • An infection control nurse or another designated person who is responsible for infection prevention and control matters and has access to specialist expertise as necessary and	The Trust has a SLA with the IP nursing service at UHNS, and through this SLA has a Sister based with the Trust. Through this SLA there is a provision for telephone advice at weekends as well as cover for leave. There are close links		

	• 24 hour access to a nominated qualified infection control doctor (ICD) or consultant in health protection /communicable disease control. The registered provider should know how to access this advice.	with the Commissioners Head of IP&C and Public Health England. The Trust IPN has access to advice from the UHNS Consultant Microbiologists. The Trust nominated Infection Control Doctor is Dr Vasile Laza Stanca		
	Movement of service users			
1.9	There should be evidence of joint working between staff involved in the provision of advice relating to the prevention and control of infection; those managing bed allocation; care staff and domestic staff in planning service user referrals, admissions, transfers, discharges and movements between departments, and within and between health and adult social care facilities.	Identified and emerging risks are detailed in daily summary reports received from the UHNS, laboratory reports received through ICNet and weekly reports from Public Health England. Admission and discharge documentation facilitates the cascade of information between organisations		
1.10	A registered provider must ensure that it provides suitable and sufficient information on a service user's infection status whenever it arranges for that person to be moved from the care of one organisation to another, or from a service user's home, so that any risks to the service user and others from infection may be minimised.	Admission assessment documentation includes completion of the Bardwin Tool (Infection Predictor Tool) and MRSA admission screening. The outcome is recorded in the patients documentation and file notes Nurse to nurse communication forms provided to the receiving organisation, detail colonisation or infection and any relevant treatment		
Criterion 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				
2.1	With a view to minimising the risk of infection, a registered provider should normally ensure that: • It designates leads for environmental	The Support Services Advisor (Cleanliness) is		

	cleaning and decontamination of equipment used for diagnosis and treatment (a single individual may be designated for both areas) • In healthcare, the designated lead for cleaning involves directors of nursing, matrons and the ICT or persons of similar standing in all aspects of cleaning services, from contract negotiation and service planning to delivery at ward and clinical level. • In healthcare, matrons or persons of similar standing have personal responsibility and accountability for delivering a safe and clean care environment • The nurse or other person in charge of any patient or resident area has direct responsibility for ensuing that cleanliness standards are maintained throughout that shift • All parts of the premises from which it proves care are suitable for the purpose, kept clean and maintained in good physical repair and condition	the Trust lead for environmental cleaning. Clinical teams have a nominated Equipment Manager who takes responsibility for the safe management of patient/ nursing equipment The Trust Support Services Advisor has membership of the Infection Prevention and Control Group, chaired by the DIPC. All elements of the cleaning services are reported to the Group. The Contract Monitoring Group ensures that services are delivered to plan and issues resolved All Trust Infection Prevention and Control Policies identify the matron, ward or unit manager as the person responsible and accountable for a safe clean environment All inpatient areas have a matron, ward or unit manager responsible for cleanliness standards. Issues are discussed at monthly service line and operational meetings. Standards are monitored through monthly cleanliness audits, reported to the DIPC and members of the IPC Group Monthly cleanliness audits and annual PLACE inspections monitor cleanliness, the integrity and physical repair of Trust premises. All controlled and responsive Planned, Preventative Maintenance (PPM) and work requests are logged through database computer systems allowing and a full audit trail of all works. Maintenance through external providers have their own equivalent logging systems and audit		

		trail.		
	• The cleaning arrangements detail the standards of cleanliness required in each part of its premises and that a schedule of cleaning frequency is available on request	All locations have a support services information folder detailing the cleaning specifications and audit results which are available to members of the public on request. All cleaning schedules are displayed in a public area		
	• There is adequate provision of suitable hand washing facilities and antimicrobial hand rubs where appropriate.	All areas have hand washing facilities which reflect a balance or risk undertaken by the clinical team. All clinical staff working within or supporting clinical teams carry personal dispensers of alcohol hand rub.		
	• There are effective arrangements for the appropriate cleaning of equipment that is used at the point of care, for example hoists, beds and commodes – these should be incorporated within appropriate cleaning, disinfection and decontamination policies	Cleaning schedules are available for every item of nursing/patient equipment and the Trust has a Cleaning and Disinfection Policy. Standards are monitored through monthly cleanliness audits		
	• The supply and provision of linen and laundry are appropriate for the level and type of care	Linen and Laundry is managed through the external provider Synergy. The Trust receives regular performance reports on each element of the contracted process. The Trust audits the service through quarterly contract monitoring meetings and a twice yearly Duty of Care external audit to the Synergy Laundry.		
2.2	The environment means the totality of a service user's surrounding when in care premises or transported in a vehicle. This includes the fabric of the building, related fixtures and fittings, and services such as air and water supplies. Where	The Head of Estates ensures that infection prevention and control and cleanliness is included in all new build, refurbishment and redevelopment projects.		

	care is delivered in the service user's home, the suitability of the environment for that level of care should be considered	The Trust IPN is also a member of the Trust Water Quality Group		
	Policies on the environment			
2.3	Premises and facilities should be provided in accordance with best practice guidance. The development of local policies should take account of infection prevention and control advice given by relevant expert or advisory bodies or by the IPCT and this should include provision for liaison between members of any ICT and the persons with overall responsibility for the management of the service users environment. Policies should address but not be restricted to:	The Head of Estates ensures that infection prevention and control and cleanliness is included in all new build, refurbishment and redevelopment projects		
	• Cleaning services	Section 8 of the IPC Policy Manual is The Trust Cleaning and Disinfection Policy. This document includes information on and makes reference to the Revised Healthcare Cleaning Manual		
	• Building and refurbishment, including air-handling systems	The Trust follows current Health Technical Memorandum (HTM) documents, national guidance and evidence based practice		
	• Waste Management	The Trust Waste Management Policy is based on Health Technical Memorandum 07-01: Safe Management of healthcare waste (located in the Health and Safety Policy Folder)		
	• Laundry arrangements for used and infected linen	Section 13 of the IPC Policy Manual is The Trust Linen and Laundry Policy.		

	• Planned preventative maintenance	The assessment has deemed that a Planned Preventative Maintenance Policy is not required. Procedures are logged and processed through Wims Computer system with the automated generation of PPM work dockets		
	• Pest control	The assessment has deemed that a Pest Control Policy is not required. Pest control services are provided by an external company and the PFI provider. Contracts are monitored through the Trust Contract Monitoring Group which meets four times a year.		
	• Management of drinkable and non-drinkable water supplies	The Trust has a Legionella Policy for the management of water systems. Effectiveness is monitored by the Water Quality Group, chaired by the Head of Estates.		
	• Minimising the risk of Legionella by adhering to national guidance	The Trust and provider organisations adhere to national guidance documents L8 and HTMs 04 - 01: The control of Legionella, hygiene, safe hot water, cold water and drinking water systems. External third parties are utilised for water quality risk assessments. BS 8580.		
	• Food service, including food hygiene and food brought into the care setting by service users, staff and visitors	The Trust has a Food Safety Policy and Managing Food Safety documents based on the requirements of food safety legislation. The Nutrition Group ensures compliance with national legislation, guidance, the CQUIN Safety Thermometer and audits.		

	Cleaning services			
2.4	The arrangements for cleaning should include: Clear definition of specific roles and responsibilities for cleaning Clear, agreed and available cleaning routines Sufficient resources dedicated to keeping the environment clean and fit for purpose Consultation with IPCN on cleaning protocols when internal or external contracts are being prepared Details of how staff can request additional cleaning, both urgently and routinely	Detailed in local support services folders and cleaning schedules with roles and responsibilities publicly displayed Work schedules are displayed on notice boards in entrance areas The Support Services Advisor has a budget for and manages in house resource and monitors the effectiveness of services in maintaining standards. Cleaning is provided through an SLA with the Partnership Trust at Bradwell and Cheadle Hospital The Hospital Cleanliness Technician whose time is funded from the support services budget ensures that urgent repairs and maintenance is undertaken. Cleanliness and maintenance at the Harplands Hospital is managed through the PFI contract with Carillion The Trust IPN regularly liaises with the Support Services Advisor including services provided by the PFI Clinical teams and the Trust IPN contact the Carillion Helpdesk at the Harplands to request additional cleaning or a change to the cleaning regime during the management of a patient with an infection or during outbreaks. For community locations the Clinical Teams or the IPN would		

		contact the Trust Support Services Manager or Support Services Advisor.		
	Decontamination			
2.5	The decontamination lead should have responsibility for ensuring that they take account of best practice and national guidance. • Decontamination of the environment • Decontamination of equipment • Decontamination of reusable medical devices	 Working with planned maintenance programmes CHC estates and the Harplands PFI, clean air ventilation plants, light fittings, and electrical equipment. Radiator covers are removed prior to cleaning. by Carillion at the Harplands. In community locations, the dedicated Hospital Cleanliness Technician responds to issues identified during cleanliness audits via the support services team. The Support Services Advisor ensures that equipment is cleaned to national standards Equipment Managers, Matrons and Team Leaders ensure that reusable medical devices are cleaned after use and to national standards. Cleanliness indicator labels are used to demonstrate that the item has been cleaned		
2.6	The decontamination policy should demonstrate that: • It complies with guidance establishing essential quality requirements and a plan is in place for progression to best practice	 The Medical Devices Policy and Equipment Managers Workbook details the Trust's approach to decontamination		

	• Decontamination of reusable medical devices takes place in appropriate facilities designed to minimise the risks that are present • Appropriate procedures are followed for the acquisition, maintenance and validation of decontamination equipment • Staff are trained in cleaning and decontamination processes and hold appropriate competencies for their role • A recod keeping regime is in place to ensure that decontamination processes are fit for purpose and use the required quality systems	Hospital inpatient locations have Dirty Utility Rooms for the decontamination of reusable medical devices such as commodes. Service Level Agreement with University Hospital of North Staffordshire Clinical Technology Department All areas have a nominated Equipment Manager The role is detailed in the Medical Devices Policy Support Services Supervisors train new staff while most existing staff have NVQ Level 2 in Cleaning and Building Interiors or Support Service in Health. Equipment Managers ensure that reusable medical devices are cleaned after use and cleanliness indicator labels are used to document that the item has been cleaned		
Criterions 3. Provide suitable accurate information on infections to service users and their visitors				
3.1	Areas relevant to the provision of such information include: General principles on the prevention and control of infection and key aspects of the registered provider's policy on infection prevention and control, which take into account the communication needs of the service user	The Harplands Hospital entrance area and all wards and units have Infection Prevention and Control Notice Boards. Information racks provide leaflets and information on a range of topics including MRSA, *Clostridium difficile* and preventing outbreaks of infection		

	The roles and responsibilities of particular individuals such as carers, relative and advocates in the prevention and control of infection, to support then when visiting service users Supporting service users awareness and involvement in the safe provision of care The importance of compliance by visitors with hand hygiene The importance of compliance with the registered provider's policy on visiting Reporting failures of hygiene and cleanliness Explanations of incident/outbreak management	Members of the public are guided to and offered Trust leaflets which detail the contribution of carers and relatives During an outbreak of infection members of the public are advised to report to the nurse in charge for advice on their contribution to safe care Information is provided in the notice board in the entrance area at the Harplands and in ward information racks Members or the public are offered information on visiting, particularly during outbreaks of infection The procedure is described in the Support Services Folder or the notice board in the entrance area. Issues are escalated to the nurse in charge, the Trust Support Services Advisor, Support Services Supervisor or the Carillion Soft Services manager at the Harplands During an outbreak of infection. A poster placed on the entrance door directs members of the public to the nurse in charge for information and advice on the current position		
3.2	Information should be developed with local service user representative organisations, which include Local Involvement Networkds (LINKs) and Patient Advice and Liaison Services (PALS)	All patient information leaflets are developed in conjunction with the Patient Experience Team and service users		

Criterion 4: Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion				
4.1	A registered provider should ensure that : Accurate information is communicated in an appropriate manner This information facilitates the provision of optimum care, minimising the risk of inappropriate management and further transmission of infection Where possible, information accompanies the service user	Patient records include nurse to nurse communications. Laboratory reports are be cascaded through electronic systems Electronic information systems facilitate the rapid cascade of clinical information Nurse to nurse communication forms provide information on post discharge care		
4.2	Provision of relevant information across organisation boundaries	The electronic surveillance system ICNet allows information on alert organisms to cross organisational boundaries. The UHNS provides daily electronic updates on MRSA, *Clostridium difficile* and outbreaks of infection. Public Health England provide weekly updates for the midlands and monthly summary reports		
Criterion 5: Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people				
5.1	Registered providers should ensure that advice is received from suitably informed practitioners and that, if advised, registered providers should inform their local health protection unit of any outbreaks or serious incidents relating to infection	The Trust IPN ensures that clinical teams receive advice on reported infections and outbreak management. The IPN ensures that all outbreaks are reported to Public Health England and advice is sought if appropriate		

5.2	Arrangements to prevent and control infection should demonstrate that responsibility for infection prevention and control is effectively devolved to all groups in the organisation involved in delivering care	All policy and procedure documents place individual responsibility on each and every member of staff to minimise the risk of infection Matrons have membership of the IPCG and information is cascaded through Service Line Meetings. Senior staff in acute and home treatment also have regular meetings		
Criterion 6: Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection				
6.1	A registered provided should, so far as is reasonably practicable, ensure that its staff, contractors and others involved in the provision of care co-operate with it, and with each other, so far as is necessary to enable the registered provider to meet its obligations under the Code	Contractors used by the Trust are taken from lists of approved organisations which meet the required standards. E.g Construction Line, EBA List. Method statements, risk assessments and training records are forwarded to Estates Department		
6.2	Infection prevention and control would need to be included in the job descriptions and be included in the induction programme and staff updates of all employees (including volunteers). Contractors working in service user areas would need to be aware of any issues with regard to infection prevention and control and obtain "permission to work". Confidentiality must be maintained.	The corporate induction programme and mandatory updates for all staff include IPC. The Trust standard is that IPC is included in job descriptions Contractors are selected from lists or organisations meeting required standards. The nurse in charge would update contractors on any issues affecting the planned work programme		
6.3	When staff undertake procedures, which require skills such as aseptic technique, staff must be trained and demonstrate proficiency before being allowed to undertake these procedures independently	The Trust provides a clinical skills training programme Aseptic technique is included in registered nurse training. If updates are required, sessions are		

		provided by Keele University. Each clinical area has a clinical skills champion		
Criterion 7: Provide or secure adequate isolation facilities				
7.1	A healthcare registered provider delivering in-patient care should ensure that it is able to provide, or secure the provision of, adequate isolation precautions and facilities, as appropriate, sufficient to prevent or minimise the spread of infection. This may include facilities in a day care setting.	Trust inpatient facilities are predominantly single rooms with hand washing facilities. Wards have some rooms with en suite facilities. There are a small number of with four bedded dormitories Single rooms would be used for a patient requiring isolation.		
7.2	Policies should be in place for the allocation of patients to isolation facilities, based on a local risk assessment. The assessment could include consideration of the need for special ventilated isolation facilities. Sufficient staff should be available to care for the service users safely	The isolation policy forms Section 5 of the Infection Prevention and Control Policy Manual. This document proposes an assessment to determine a balance of risk prior to isolation. Isolation rooms are ventilated however, a patient requiring negative pressure would be transferred to the University Hospital of North Staffordshire.		
7.3	Registered providers of accommodation should ensure that they are able to provide or secure facilities to physically separate the service user from other residents in an appropriate manner in order to minimise the spread of infection	Most rooms within the Trust are single rooms. Where safe and appropriate patients can be separated from other individuals in single rooms or if necessary cohorted in four bedded bays		
7.4	Care homes (N/A)	N/A		
Criterion 8 : Secure adequate access to laboratory support as appropriate				
8.1	A registered provider should ensure that laboratories that are used to provide a microbiology service in connection with arrangements for infection prevention and control	Microbiology services are provided by the University Hospital of North Staffordshire Pathology Laboratory.		

	have in place appropriate protocols and that they operate according to the standards required by the relevant national accreditation bodies.	The laboratory is accredited		
8.2	Protocols should include: A microbiology laboratory policy for investigation and surveillance of healthcare associated infections Standard laboratory operating procedures for the examination of specimens	 The Pathology Laboratory adhere to UHNS Policies and Procedures Standard Operating Procedures are implemented		
Criterion 9: Have and adhere to policies, designed for the individual's care and provider organisations, that will help to prevent and control infections				
9.1	A registered provider should, in relation to preventing, reducing and controlling the risks of infections, have in place the appropriate policies concerning the matters mentioned in a to y below. All policies should be clearly marked with a review date	Infection Prevention and Control Policies are placed on the Trust intranet, called the Staff Information Desk (SID) following agreement and approval by Quality Committee and the Board. SID is the Trust intranet and the electronic medium for the cascade of all information All policies are subject to a programme of regular review. The front sheet is marked with the review date		
9.2	A guide is given in Table 3 as to which policies may be appropriate to the regulated activities. A decision should be made locally following a risk assessment	Trust Policies reflect the nature of the organisation i.e. mental health and learning disability services		
9.3	Any registered provider should have policies in place relevant to the regulated activity it provides. Each policy should indicate ownership(i.e. who commissioned and retains managerial	The front sheet of all Trust Policies describes ownership, responsibility for the policy and the review date.		

	responsibility) authorship and by whom the policy			
a	**Standard infection prevention and control precautions** Policy should be based on evidence based guidelines, including those on hand hygiene at the point of care and the use of personal protective equipment Policy should be accessible and be understood by all groups of staff, service users and the public	Described in Section Three of the Trust IPC Policy Manual		
b	**Aseptic technique** Where aseptic procedures are performed: Clinical procedures should be carried out in a manner that maintains and promotes the principles of asepsis Education, training and assessment in the aseptic technique should be provided to all persons undertaking such procedures The technique should be standardised across the organisation and An audit should be undertaken to monitor compliance with the technique	The assessment process has deemed that an Aseptic Technique Policy is not required, however, procedures are undertaken according to the Royal Marsden Manual Training is not provided by the Trust, however, if a training need is identified, this would be met through the Clinical Skills Tutor at Keele University Procedures outside the competencies of staff working within the Trust would be referred to the appropriate specialist. E.g. Tissue Viability Audits are undertaken on the Edward Myers substance misuse unit where intravenous cannulation is regularly undertaken. The Clinical Team use the Hand Hygiene Observation Tool (HHOT)	Systems and procedures associated with asepsis including training and assessment are being reviewed at present	

c	**Outbreaks of communicable infection** The degree of detail in the policy should reflect local circumstances. Professional advice on IPC for regulated activities may be drawn from a number of expert sources. Policies for outbreaks of communicable infection should include initial assessment, communication, management and organisation, plus investigation and control The contact details of those likely to be involved in outbreak management should be reviewed at least annually All registered providers should report significant outbreaks of infection to their local health protection unit, including outbreaks in service users who are detained under the Mental Health Act 1983, if advised to do so by suitably informed practitioners	Section 12 of the IPC Policy Manual is the Policy for the Prevention and Management of Outbreaks of Infection including viral gastro-enteritis The Trust Infection Prevention and Control Doctor provides expert advice. The Trust Policy details this information. Clinical Teams are also provided with the Trust Toolkit for the detection and management of outbreaks of infection. These toolkits have recently been reviewed and updated. Sources of advice are included in the Infection Prevention and Control Policy Manual Significant outbreaks would be reported to Public Health England as well as the local health economy		
d	**Isolation of service users with an infection** The isolation policy should be evidence based and reflect local risk assessment Indications for isolation should be included in the policy, as should procedures for the infection prevention and control management of service users in isolation Information on isolation should be easily	Section Five of the IPC Policy manual details the Trust's Isolation Policy Indications for isolation may also be included in the MRSA and *Clostridium difficile* Policies The Isolation Policy is easily accessible through		

	accessible and understood by all groups of staff, service users and the public	the Trust intranet. Alternatively, patient specific information can be sought from the Trust IPN		
e	**Safe handling and disposal of sharps** Relevant considerations include: Risk management and training in the management of mucous membrane exposure and sharps injuries and incidents Provision of medical devices that incorporate sharps protection mechanisms where there are clear indications that they will provide safe systems of working for staff A policy that is easily accessible and understood by all groups of staff Safe use, secure storage and disposal of sharps Auditing of policy compliance	Section Seven of the IPC Policy Manual Policy details the Trust Policy on the prevention and management of Occupational exposure to Blood and body fluids Sharps safety is included at Corporate Induction and in three yearly mandatory updates for all staff The policy is available on the Trust intranet The Trust IPN audits practice associated with the safe use, storage and disposal of sharps		
f	**Prevention of occupational exposure to blood borne** viruses (BBV) including prevention of sharps injuries Measures to avoid exposure to BBVs (Hep B, c and HIV) should include: Immunisation against Hep B, as se out in the Immunisation against infectious disease (The Green Book) The wearing of gloves and protective clothing	 Detailed in the Trust Policy The Occupational Health Department provide immunisation against Hep B where appropriate Detailed in the Trust Personal Protective Equipment Policy		

	The safe handling and disposal of sharps including the provision of medical devices that incorporate sharps protection where there are clear indications that they will provide safe systems of working for staff and Measures to reduce the risks during surgical procedures	Detailed in the Trust's Policy. Safety engineered devices have been implemented in accordance with the EU Sharps Directive No surgical procedures undertaken within the Trust		
g	**Management of occupational exposure to BBV and post exposure prophylaxis** Management should ensure That any member of staff who has a significant occupational exposure to blood and body fluids is aware of the immediate action required and is referred appropriately for further management and follow up Provision of clear information for staff about reporting potential occupational exposure – in particular the need for prompt action following a known or potential exposure to HIV or Hep B and Arrangements for Post-Exposure to HIV or Hep B	Detailed in the Trust Policy on Blood Borne Viruses Flow charts are included in the Trust Policy. The UHNS provide follow up for high risk injuries		
h	**Closure of rooms, wards, departments and premises to new admissions** A system should be in place for the provision of advice from the local health protection unit/DIPC?ICT for the registered provider There should be clear criteria in relation to closures and re-opening The policy should address the need for environmental decontamination prior to re-opening	Section 12 of the Trust IPC Policy Manual details the Trust's Policy for the Prevention and Management of Outbreaks of Infection including viral gastroenteritis		

i	Disinfection The use of disinfectants is a local decision, and should be based on current accepted good practice	Section Five of the IPC Policy Manual details the Trust's Cleaning and Disinfection Policy		
j	Decontamination of reusable medical devices	Section 5.35 of the H&S Manual details the Trust's Policy and Guidance on the Management of Medical Devices		
k	Single use medical devices	As above		
l	Antimicrobial prescribing Prescribing should generally be harmonised with that in the BNF. However, local guidelines may be required in certain circumstances All local guidelines should include information on a particular drug's regimen and duration Procedures should be in place to ensure prudent prescribing and antimicrobial stewardship. There should be an on- going programme of audit, revision and update. In healthcare this is usually monitored by the antimicrobial management team or local prescribing advisors	Antimicrobial Prescribing is detailed in Appendix Four of the Medicines Management Policy. Information has been harmonised with other North Staffordshire provider organisations and summarised in the Antimicrobial Prescribing Guidelines. The Antimicrobial Pharmacist monitors and provides advice on prudent antibiotic prescribing. A summary report is provided at each meeting of the IPC Group. Prescribing is monitored by the Trust Antimicrobial Prescribing Pharmacist.		
m	Reporting of infections to the Health Protection Agency or local authority	Detailed in the Trust Notifiable Diseases Policy		
n	Control of outbreaks and infections associated with specific alert organisms • MRSA This policy should make provision for	The Trust MRSA Policy details screening and decolonisation and isolation of infected patients		

	Screening of NHS patients on emergency or relevant elective admission to a unit that provides surgical diagnostic or other medical care. The arrangements for undertaking screening will be subject to local agreement Suppression regimens for colonised patients when appropriate Isolation of infected or colonised patients Transfer of infected or colonised patients within organisations or to other care facilities Antibiotic prophylaxis for surgery and Undertaking a root cause analysis on patients with MRSA bacteraemia ***Clostridium difficile*** The Policy should make provision for Surveillance of CDI Diagnostic criteria Isolation of infected service users and cohort nursing Environmental decontamination Antibiotic prescribing policies Contraindication of anti-motility agents • Glycopeptide resistant enterococci (GRE) • Acinetobacter, extended spectrum beta lactamase and other antibiotic resistant bacteria • Viral haemorrhagic fevers (VHF) • CJD	in accordance with Department of Health guidance and evidence based practice. No surgery undertaken within the Trust Any MRSA bacteraemia would be subject to a root cause analysis investigation The requirements are detailed in the Trust Policy for the prevention and management of *Clostridium difficile* infection The assessment process has determined that the following policies are not required Not required Not required		

	• Relevant policies for other specific alert organisms	Not required Not required Not required		
o	CJD/vCJD – handling of instruments and devices	Not required		
p	Safe handling and disposal of waste The risks from waste disposal should be properly controlled. In practice, in relation to waste, this involves: • Assessing risk • Developing appropriate policies • Putting arrangements in place to manage risks • Monitoring, auditing and reviewing the way in which arrangements work and • Being aware of statutory requirements and legislative change and managing compliance **Precautions in connection with handling waste should include:** • Training and information (including definition and classification of waste	The Trust waste contract is managed by the Estates Agency and Carillion at the Harplands Hospital. The Organisational Safety Department have responsibility for policies, training and audit. The Trust has policies and procedures to minimise risks. Health and Safety Audits are undertaken by the Senior Management assistant and reported to the Organisational Safety Committee. Procedures including segregation are undertaken in accordance with HTM 07-01:Safe management of healthcare waste. Training is experiential learning within clinical teams and included in local inductions.		

	• Personal Hygiene • Segregation and storage of waste • The use of appropriate personal protective equipment • Immunisation • Appropriate procedures for handling such waste • Appropriate packaging and labelling • Suitable transport on site and off site • Clear procedures for dealing with accidents, incidents and spillages and • Appropriate treatment and disposal of such wastes • Systems should be in place to ensure that the risks to service users from exposure to infections caused by waste present in the environment are properly managed and that duties under environmental law are	Hand hygiene is included in all mandatory training. Waste is segregated by clinical teams and is placed in colour coded bins compliant with HTM 07-01. The Trust provides a full range of personal protective equipment. The OH Department provides immunisation appropriate to the individual's role. Procedures are detailed in the Trust Waste Policy. Bags and waste bins are labelled in accordance with HTM 07-01. The Trust has a contract with SITA for the transport and disposal of waste. The procedure for dealing with spillages and incidents are detailed in the trust Waste Policy. The Trust contract for the treatment and disposal of waste is with SITA. The Trust Policy on Waste reflects HTM 07-01: Safe management of healthcare waste. The duties placed upon the Trust are detailed in the Trust Policy.		

	discharged. The most important of these area – • Duty of care in the management of waste • Duty to control polluting emissions to the air • Duty to control discharges to sewers • Obligations of waste managers • Collection of data and obligations to complete and retain documentation including record keeping and • Requirement to provide contingency plans and have emergency procedures in place	Documentation and records associated with the management of waste and the waste contract are retained by the Estates Agency. Not applicable Not applicable The Head of Estates is the Trust Waste Manager Documents are retained by the Estates Department. The Trust has a Major Incident Plan.		
q	Packaging, handling and delivery of laboratory specimens	Section 17 of the IPC Policy Manual if the Trust Specimen Management Policy.		
r	Care of deceased persons	The Trust does not have a policy however Procedures are undertaken in accordance with the Royal Marsden Manual.	Review the requirement for a care of the deceased policy	
s	Use and care of invasive devises	Detailed in the Medical Devices Policy		
t	Purchase, cleaning, decontamination, maintenance and disposal of equipment	Detailed in the Medical Devices Policy		
u	Surveillance and data collection	The arrangements for alert organism		

		surveillance and data collection are detailed in the relevant policies such as MRSA and *Clostridium difficile.* The number of reported infections would not justify a separate policy. Laboratory reports are received via the electronic surveillance system ICNet. On receipt of a positive laboratory report the IPN contacts the appropriate ward or unit to advise on the appropriate and safe management of a patient with an infection.		
v	Dissemination of information	Information is cascaded through electronic systems including the Trust "Staff Information Desk" (SID) and through regular bulletins Team Talk and News Round. Senior managers and Team leaders have planned meetings with their teams.		
w	Isolation facilities	Most rooms within the Trust are single rooms and some have en suite facilities. Using a balance of risk approach these may be used as isolation rooms. There are a small number of four bedded bays at the Harplands Hospital, which could be used as cohort bays.		
x	Uniform and dress code	Detailed in the Trust Dress and Appearance Policy.		
y	Immunisation of service users	As per the "Green Book"		

Criterion 10: Ensure, so far as is reasonable practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitable educated in the prevention and control of infection associated with the provision of health and social care				
10.1	Registered providers should ensure that policies and procedures are in place in relation to the prevention and control of infection such that:			
	All staff can access occupational health services or access appropriate occupational health advice	The Trust currently receives Occupational Health (OH) services through an SLA with Shropshire Community Health NHS Trust.		
	Occupational health policies on the prevention and management of communicable infection in care workers are in place	The OH nurses work to the Trust's Policy on Blood Borne Viruses. The Lead OH Nurse is a member of the Trusts Infection Prevention and Control Group.		
	Decisions on offering immunisation should be made on the basis of a local risk assessment as described in "The Green Book	Shropshire Community Health NHS trust Occupational Health Department work to national guidance including the Green Book.		
	Employers should make vaccinations available free of charge to employees if a risk assessment indicates that it is needed	Vaccinations are free to Trust employees.		
	There is a record of relevant immunisations	The OH Service uses the OPAS system of electronic records. Paper and electronic records are held for 40 years		
	The principles and practice of prevention and control of infection are included in induction and training programme for new staff. The principles include: ensuring policies are up to date; feedback from audit results; examples of good practice, and action needed to correct poor	Infection Prevention and Control is included at induction and in all mandatory updates. Feedback from audits is undertaken within clinical teams		

	practice. There is appropriate ongoing education for existing staff (including support staff, volunteers, agency/locum staff and staff employed by contractors, which should incorporate the principles and practice of prevention and control of infection There is a record of training and updates for all staff and The responsibilities of each member of staff for the prevention and control of infection are reflected in their job description and in any personal development plan or appraisal	There is an on-going programme of infection prevention and control updates through the mandatory training programme Training records are held on the electronic Oracle Learning Management (OLM) System IPN has a job description. Personal development of IPN is reviewed by the Associate Chief Nurse (Infection Prevention) at UHNS.		
10.2	Occupational health services for staff should include: Risk based screening for communicable diseases and assessment of immunity to infection after a conditional offer of employment and ongoing health surveillance Offer of relevant immunisations and Having arrangements in place for regularly reviewing the immunisation status of care workers and providing vaccinations to staff as necessary in line with "The green Book"	The Occupational Health Department undertake screening and health surveillance for new and existing staff who are changing roles within the Trust. Verbal histories are taken for MMR and varicella, while any uncertainties associated with the individual's immunisation status are confirmed through blood tests.		
10.3	Occupational health services in respect of BBVs should include: Having arrangements for identifying and	The Occupational Health Department work to the Trust's Blood Borne Virus Policy. Department of Health guidance is followed in		

	managing healthcare staff infected with hepatitis B, C or HIV and advising about fitness for work and monitoring as necessary, in line with DoH guidance Liaising with the UK Advisory Panel for Healthcare Workers infected with Blood-borne viruses when advice is needed on procedures that may be carried out by BBC infected care workers, or when advice on patient tracing, notification and offer of BBV testing may be needed A risk assessment and appropriate referral after accidental occupational exposure to blood and body fluids and Management of occupational exposure to infection, which may include provision for emergency and out of hours treatment, possibly in conjunction with accident and emergency services and on call infection prevention and control specialists. This should include a specific risk assessment following an exposure prone procedure.	situations associated with Hepatitis B, C or HIV. The Lead OH Nurse reports incidents and issues to members of the IPC Group No exposure prone procedures are undertaken within the Trust Risk assessment and procedures are detailed in the Trust Policy Emergency and out of hours assessment and treatment is provided by the UHNS Consultant Microbiologists. The Risk Assessment document and procedure are detailed in the Trust Blood Borne Virus Policy		

Enc. 10

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO Trust Board (Open)

Date of Meeting:	25 September 2014
Title of Report:	Patient Advice and Liaison Service (PALS) & Complaints Report Quarter 1 - 2014/15
Presented by:	Karen Wilson Director of Nursing & Quality
Author of Report: Name: Date: Email:	Karen Marsh – Complaints Report Leanne Cunliffe – PALS Report 11 September 2014 Karenj.marsh@northstaffs.nhs.uk Leanne.Cunliffe@northstaffs.nhs.uk
Purpose / Intent of Report:	• Performance Monitoring
Executive Summary:	The purpose of the report is to provide an updated position of the performance of the PALS and complaints processes carried out by the Patient Experience Team.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Customer Focus Strategy • Clinical • Governance
Relationship with Annual Objectives:	Directly relates to the provision of quality care and the experience of our service users and carers
Risk / Legal Implications:	None
Resource Implications:	None
Equality and Diversity Implications:	None
Relationship with Assurance Framework [Risk, Control and Assurance]	Supports the Trust Assurance framework
Recommendations:	• That the Trust Board consider and discuss for assurance purposes the current position in relation to PALS and complaints performance

North Staffordshire Combined Healthcare NHS Trust

Patient Advice and Liaison Service (PALS) and Complaints Report

Quarter 1 – 2014/2015

1. Introduction

In accordance with national, local and Trust policy and procedures for monitoring performance, this paper provides the Quality Governance Committee with information to enable a review of the Trust's performance regarding PALS and Complaints data activity during Quarter 1, 2014/2015 (April – June 2014).

2. Executive Summary

During Quarter 1, 2014/15 the Patient Advice and Liaison Service (PALS) recorded 70 contacts which raised 90 issues. Further details are provided within Section 3 of this report. This represents an increase in the number of contacts (52) and issues (52) raised during Quarter 4, 2013/14.

A total of 10 complaints were received under the NHS Complaints Regulations during Quarter 1, 2014/15. This represents a decrease from Quarter 4, 2013/14 when 21 complaints were received.

During Q1, 2013/14 the Trust was advised of 1 complaint being referred to the Parliamentary and Health Service Ombudsman for independent review (Stage 2, NHS Complaints Procedure). This complaint is being investigated by the Ombudsman and a draft report has been received by the Trust. We now await their final report and findings.

The Patient Experience Team are working hard to ensure that the most appropriate process is followed in order to respond to and address concerns and complaints, identifying and responding to emerging themes and trends and identifying learning outcomes.

3. PALS

YEAR	Q1 – 2014-15			Q2 – 2013/14			Q3 – 2013/14			Q4 2013/14		
MONTH	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
PALS Activity - Contacts	26	24	20	10	12	20	23	15	3	13	19	20
PALS Activity – Issues Raised	35	35	20	11	12	18	26	12	3	13	19	20
Type												
• Comments	**0**	**4**	**0**	0	0	0	1	0	0	1	0	1
• Compliments	**3**	**4**	**5**	0	0	0	0	3	0	0	0	0
• Help with a Problem	**23**	**22**	**11**	9	9	17	10	9	3	12	18	19
• Case passed to Complaints	**0**	**1**	**1**	0	0	0	3	0	0	0	0	0
• Information Request	**8**	**2**	**0**	1	3	2	4	0	0	0	0	0
• Signposting/Referrals	**1**	**2**	**4**	0	0	0	5	3	0	0	1	0
• Other	**0**	**0**	**0**	0	0	0	0	0	0	0	0	0
TOTAL	**35**	**35**	**20**	**10**	**12**	**19**	**23**	**15**	**3**	**13**	**19**	**20**

Division												
• AMH	25	20	13	8	7	17	12	7	2	6	13	15
• CYP	1	4	1	1	5	1	3	5	1	3	2	2
• LDNOAP	3	8	2	1	0	2	2	1	0	3	3	3
• Corporate	6	3	4	0	0	0	2	0	0	0	0	0
Service Area												
• Access & Waiting	4	7	4	2	0	0	4	4	2	3	3	1
• Information & Choice	9	0	1	4	9	19	6	3	1	9	13	16
• Building closer relationships	5	5	9	3	0	1	8	4	0	0	2	2
• Safe, high quality, co-ordinated care	16	15	5	1	3	0	0	1	0	1	1	1
• Environment	1	8	1	0	0	0	0	5	3	0	0	0

4. **Themes**

Please see table below regarding examples of emerging themes identified for this quarter.

Theme – ACCESS & WAITING	
Mother wanted to know if there was a way to expedite her son's appointment as she had been told that there was a 12 month wait.	Advised parent to contact her son's school and GP as to whether they would be able to support her in requesting that the appointment be expedited, then they should write to the team and highlight any risks.
A mother rang for advice on who to ring for support for her daughter.	Advised that given daughter's address, her local team would be located at the Sutherland Centre. If daughter was already accessing their support, she could contact them for help otherwise she could access services via Access Team and their contact details were provided.
Patient was advised to go to A&E by the Duty Professional, within working hours, in order to be assessed by the RAID team	Advised the patient of the correct protocol. Highlighted in Newsround to ensure staff were aware of the correct protocol. Advised service line managers of the incident.

Theme – INFORMATION & CHOICE	
A mother was trying to arrange for an out of area inpatient specialist stay for younger people with OCD.	GP referred this through Ashcombe Centre as they would need to prove that he could not receive the treatment locally. Assessment arranged with Centre Manager and psychologist.
Patient reports there are no patient information leaflets on the ward and detained patients are not allowed to go to the main corridor (off the ward) to the NSUG's leaflet racks.	Ward Manager has now put laminated information sheets on the wardrobe in each bedroom and has also filled the leaflet racks up.
Requested information on Patient Experience Team and how to make a complaint.	Full explanation given, followed up by posting our leaflet out to them.

Theme – BUILDING CLOSER RELATIONSHIPS	
Family concerned about the lack of deaf awareness at the Harplands, and not provided with an interpreter.	Raised as a formal complaint for a full investigation. Deaf awareness training information requested from a local charity.
Member of the public rang to advise that she keeps getting telephone calls and messages left on her voicemail for community addiction team.	All promotional and information leaflets checked and contain the correct number. Their phone number is one digit different to CAD's and so it must be down to human error.
Wanted to complain about a member of staff who she claims told her she was paranoid and telling lies, and advised that she had diagnosed herself.	Later advised that she did not wish to pursue this any further as she felt she over-reacted.

5. **Compliments**

A total of 12 compliments have been received via the Patient Advice and Liaison Service during Quarter 1. This is less than the previous quarter, where 21 were received. Some comments received are shown below:

- *Compliment for Community LD Nurse and how she assisted with a child that was experiencing distress when he arrived on the bus. She provided a prompt. Client centred service which eased the child's distress.*
- *Compliment about a member of staff at Lyme Brook, "your support has made a difference to my life, thank you"*
- *Compliment for a member of staff at the Ashcombe Centre, "Thanks for your support and looking after bluey"*
- *Compliment about the Early Intervention service "Fab, supportive and understanding"*
- *Compliment for the Early intervention Service "thank you for giving me my son back"*
- *Edward Myers Unit is "safe, supportive, non-judgemental and caring"*
- *Compliment and a thank you for the care her son received at Chebsey Close*.

All services should be encouraged to forward compliments and thank you letters to the Patient Experience Team for collation and feedback to relevant departments and divisions.

6. **Recommendations**

- To continue to promote the Patient Experience Team and its functions, including the PALS Services, through awareness raising sessions, both internal and external to the Trust.
- To forge stronger links and interface with Complaints and effective handling.
- To continue to work with team with regard to capturing feedback from service users and carers.

7. Complaint Activity Report

7.1 Complaints: Number, Type, Division, Service Area and Investigation Status

YEAR	**Q1 – 2014/15**			Q2 – 2013/14			Q3 – 2013/14			Q4 2013/14		
MONTH	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
TOTAL COMPLAINTS	**10**			**29**			**28**			**4**	**7**	**10**
Acknowledgement Rate (%)	100	100	100	100	100	100	100	100	100	100	100	100
Response Rate – Numbers responded to in timescale agreed with complainant (All timescales for responses are agreed with the complainant on an individual basis and the complainant is kept informed of progress/delays as appropriate.)												
Number responded to within **1 month**	0	0	0	0	0	0	4	0	0	0	3	4
Number responded to within **2 months**	0	1	0	0	0	0	0	0	0	1	1	0
Number responded to in over **2 months**	1	0	0	0	0	0	0	0	0	0	0	0
Responses outstanding	2	4	1	0	0	0	3	10	0	3	3	5
Complaints withdrawn	1	0	0	0	0	0	1	1	0	0	0	1
Complaints referred to the Ombudsman due to complainant dissatisfaction	0	0	1	0	0	0	0	0	0	0	1	0
Complaints upheld by the Ombudsman	0	0	0	0	0	0	0	0	0	0	0	0
Type												
• **A**dmission, discharge & transfer arrangements	0	1	0	0	0	0	2	1	0	1	0	3
• **A**ids & appliances, equipment and premises (including access)	0	0	0	0	0	1	0	0	0	1	0	0
• **A**ppointments (delay/ cancellation – outpatient)	0	0	0	1	2	3	2	2	2	0	2	0
• **A**ppointments (delay/ cancellation – inpatient)	0	0	0	0	0	0	0	1	0	0	0	0
• **A**ttitude of staff	1	0	0	2	4	5	2	2	3	2	0	3
• **A**ll aspects of clinical treatment	2	2	0	1	2	0	0	0	2	0	0	2
• **C**ommunication/ information	0	1	1	1	2	1	1	3	0	0	1	1
• **C**onsent to treatment	0	0	0	1	0	0	0	0	0	0	0	0
• **C**omplaints handling	0	0	0	0	0	0	0	0	0	0	0	0
• **P**atient privacy & dignity	0	0	0	0	1	0	0	0	0	0	0	0
• **P**atient property & expenses	0	1	0	1	0	0	1	0	0	0	0	0
• **P**ersonal records (including medical and/or complaints)	0	0	0	0	1	1	1	0	0	0	0	0
• **F**ailure to follow agreed procedures	0	0	0	0	0	0	1	1	0	0	3	2
• **P**atient status (race/ gender/age)	0	0	0	0	0	0	0	0	0	0	0	0
• **H**otel services	0	0	0	0	0	0	0	0	0	0	0	0
• **O**ther	0	0	0	0	0	1	0	0	0	0	0	0

7.2 Complaints: Statistics by Division

Please note that this has been allocated based on the predominant issues/concerns raised, where this spans more than one business division. The table illustrates the type of complaint categories used by the Department of Health in relation to the annual KO41a Return. Each year the Trust is required to complete and submit this Return in line with the pre-set categories.

In addition, whilst **10** complaints were registered, we were later contacted by one complainant who advised that although care had been provided to his relative at Harplands Hospital, the concerns he had were as a result of discussions held with the CSU and therefore the complaint was forwarded to that organisation for a response. Therefore, the complaint statistics in terms of area, etc (below) use the figure of **9**.

Business Division	**Q1 – 2014/15**	Q2 - 2013/14	Q3 - 2013/14	Q4 - 2013/14
Adult Mental Health (AMH)	5	20 (21)	21	19
Children & Young People (CYP)	2	3	1	1
Learning Disabilities, Neuropsychiatry & Old Age Psychiatry (LDNOAP)	1	2	4	1
Corporate	1	3	2	0
TOTALS	**9**	**28**	**28**	**21**

7.3 Complaints: Type by Division

CATEGORY (Type of complaint, as per KO41a)	**AMH**	**CYP**	**LDNOAP**	**CORP**	**TOTAL Q4**
Admissions, discharge & transfer arrangements	**1**	**0**	**0**	**0**	**1**
Aids & appliances, equipment & premises (including access)	**0**	**0**	**0**	**0**	**0**
Appointments (delay/cancellation) – Out-patient)	**0**	**0**	**0**	**0**	**0**
Appointments (delay/cancellation) – In-patient	**0**	**0**	**0**	**0**	**0**
Attitude of staff	**0**	**1**	**0**	**0**	**1**
All aspects of clinical treatment	**2**	**1**	**1**	**0**	**4**
Communication/information to patients (written/oral)	**1**	**0**	**0**	**1**	**2**
Consent to treatment/medication	**0**	**0**	**0**	**0**	**0**
Complaints handling	**0**	**0**	**0**	**0**	**0**
Patient privacy & dignity	**0**	**0**	**0**	**0**	**0**
Patient property & expenses	**0**	**0**	**0**	**0**	**0**
Personal records	**0**	**0**	**0**	**0**	**0**
Failure to follow agreed procedures	**1**	**0**	**0**	**0**	**1**
Patient Status (race/gender/age)	**0**	**0**	**0**	**0**	**0**
Hotel services	**0**	**0**	**0**	**0**	**0**
Other (e.g. lack of assessment)	**0**	**0**	**0**	**0**	**0**
TOTAL	**5**	**2**	**1**	**1**	**9**

7.4 Complaints: Links to Serious Incidents (SI's), Claims, Safeguarding Referrals

During Quarter 1, 2014/15 one complaint received was linked to an earlier Serious Incident.

8. Acknowledgements/Investigation Rate/Referrals to Ombudsman

A total of 10 complaints were managed under the NHS Complaints Regulations during Quarter 1. This is a decrease from 21 complaints received during Quarter 4, 2013/14.

In accordance with Complaint Regulations, all of the complaints (100%) were acknowledged no later than 3 working days after the day on which the Trust received the complaint.

During Quarter 1, the Trust was advised of 1 complaint being referred to the Parliamentary and Health Service Ombudsman for Independent Review (Stage 2, NHS Complaints Procedure). The relevant papers have been submitted to the Ombudsman and we now await confirmation as to whether or not they intend to undertake investigation or further review of this case.

9. Emerging Themes and Trends

During Quarter 1, 2014/15 the highest category of complaints has fallen within the category of **All Aspect of Clinical Treatment.** There did not appear to be any link with these complaints as all related to differing aspects of clinical care provision. Generally the spread of complaints across the divisions and service lines is proportionate to the size of the service.

10. Learning & Improvement

The following list is not exhaustive as some complaints remain ongoing. The list below provides some examples of improvements and learning points from complaints during Quarter 1 2014/15:

- Timescales for ADHD assessments to be discussed with parents at the initial assessment appointment in order that they are provided with sufficient information at the start of the process. Preferably this should be confirmed in writing.
- Following completion of the Triple P Programme there should be a process in place to discuss future care provision with the family.
- All staff working in the Mental Health Law Team are to be trained in use of the Trust's Patient Information System as a way of generating addresses directly into correspondence as opposed to manually inputting information in order to reduce the likelihood of errors occurring.
- Staff to be reminded of the importance of addressing the role of carers and the information they can provide at the point of admission.

11. Complaint Outcomes

Complaints remain a key element of discussion at the Trust's weekly Incident Review Meeting which is led by the Trust's Head of Patient Safety and attended by Divisional Governance Leads. Discussion has taken place about improving links and learning from Serious Incident investigations and complaints. As such, this regular meeting provides the opportunity to distil learning and effect improvement change from both Serious Incidents and complaints. Learning from complaints will also feature as an item within the Trust's current information flyer around cascade learning from Serious Incidents.

Further analysis and review of complaints will also be reintroduced at Divisional Meetings which will be held on a quarterly basis to ensure effective feedback and identification of any learning points, as well as ensuring that any actions are followed through accordingly. This will include a detailed review of complaint investigation outcomes, including a general discussion with the wider divisional team to establish the status of the complaint, i.e. justified, part-justified and not justified.

12. **Reviewing Detail**

It is important that the detail associated with complaints is adequately cascaded. The following provides some examples of complaint investigations and outcomes:

SUMMARY OF CONCERN RAISED	OUTCOME
Example 1: Service user repeatedly asked to board out on another ward during admission to Harplands Hospital. Complaint received from a service user who was asked to board out on a number of occasions which she felt had a negative effect on her in-patient stay.	Apologies were offered and an explanation provided as to how the decision to ask a patient to board out on another ward is reach. A number of recommendations were made. **Learning Points/Recommendations** Lockers are now available on the ward for patients to store their belongings on occasions when they are asked to board out on another ward. The decision to board out needs to be made by the ward team at the beginning of the shift including the rationale as to why a particular individual has been identified as suitable to board out.
Example 2: All Aspect of Care and Treatment A mother complaints that she had waited too long for an ASD assessment for her daughter; that an appropriate risk assessment had not been completed in response to her daughter's self-harming behaviour; attitude of the assessing clinician and the quality and timing of the report.	A detailed investigation was undertaken and following the response, further meetings took place with the Complaints Manager, Clinical Director and Investigating Officer to resolve the parent's concerns. **Learning Points/Recommendations** Letter to be sent to those on the waiting list to apologise for their wait. A duty rota to be considered to ensure a timely response to telephone enquiries to the team. Risk Assessment Proforma to be produced for use during telephone calls to help measure the level of risk where it is indicated that a child is at risk of harm. Team to consider using a post book to record post and assist in tracking. Team to consider using a feedback clips to obtain parent comments when sending out draft reports.

13. **Recommendations**

Members of the Trust Board are asked to consider the points noted.

North Staffordshire Combined Healthcare NHS Trust

REPORT TO: Trust Board – Open Section

Date of Meeting:	25 September 2014
Title of Report:	Finance and Activity Committee Report – Committee Meeting 18 September 2014
Presented by:	Tony Gadsby – Committee Chairman
Author of Report: Name: Date: Email:	 Steve Blaise 18 September 2014 Steve.blaise@northstaffs.nhs.uk
Purpose / Intent of Report:	• For Decision ✔ • Performance monitoring ✔ • For Information ✔
Executive Summary:	The attached report provides a summary of the Committee meeting held on the 18 September 2014 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. It also recommends the changes to Terms of Reference of the Committee and the acceptance of the change of name to the Finance & Performance Committee.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Customer Focus Strategy • IM and T Strategy ✔ • Governance Strategy ✔ • Workforce Strategy ✔ • Financial Strategy ✔ Helps ensure appropriate resources are directed to and protected for appropriate patient care services.
Relationship with Annual Objectives:	Supports achievement of financial targets, the monitoring of CQUIN requirements and the delivery of efficiency programmes
Risk / Legal Implications:	Principle risk register reviewed via committee and reported separately to the Board
Resource Implications:	
Equality and Diversity Implications:	None
Relationship with Assurance Framework [Risk, Control and Assurance]	Provides assurance over the Trust's arrangements for sound financial stewardship and risk management.
Recommendations:	The board are asked to: • note the contents of the report and take assurance from the review and challenge evidenced in the Committee. • the acceptance of the changes to the Terms of Reference, including the change of name to the Finance & Performance Committee.

North Staffordshire Combined Healthcare NHS Trust

Assurance Report to the Trust Board – Thursday, 25 September 2014

Finance and Activity (F & A) Committee Report to the Trust Board – 18 September 2014 – Open Section

This paper details the issues discussed at the Finance and Activity Committee meeting on 18 September 2014.

The meeting was quorate, approved the minutes from the meeting on the 24 July 2014 and reviewed the progress and actions taken from previous meetings.

The Committee received the financial update for month 5 (August 2014) 2014/15.

The income and expenditure position to Month 5 was slightly ahead of plan at a deficit of £0.74m against a plan deficit of £0.75m, a favourable variance of £0.01m. The paper also reported that the year-end forecast was in line with the planned position of £0.288m surplus, equating to a £0.754m surplus at adjusted financial performance level.

The Trust's cash balance at the end of August was £5.9m, which is £0.2m higher than the position at the end of July 2014 as a result of a £0.1m increase in debtors and a £0.3m increase in the level of creditors.

As previously reported in Month 3, the capital programme position remains behind plan and is likely to remain so throughout this financial year. The Trust will finalise a revised mid-year forecast during October.

The Trusts Continuity of Service Risk Rating at month 5 was an overall rating of 3. The Trusts liquidity metric remains high (level 4) but the Trusts planned deficit at 31 August, reduces the Capital Servicing Capacity to level 1. This rises by the end of year to level 2 as the Trust moves back into surplus. This maintains the year end forecast rating of level 3.

The Committee received the Month 5 Cost Improvement Programme (CIP) 2014/15 report which incorporated elements of the Workforce paper linked to CIP schemes. The paper highlighted the requirement to deliver £4.08m of CIP with plans in place to deliver £4.06m.

The paper also showed a "year to date" position of £1.5m delivery against the plan of £1.1m although it was noted that a significant element of that "year to date" delivery was on non-recurring schemes from Corporate and Trust wide areas.

The Committee noted that 40 new schemes with a total value of £1.67m had not, at this point, been subject to a Quality Impact Assessment (QIA). The Committee requested that this assessment be undertaken as a matter of urgency.

The Committee also received details of the CIP schemes being developed for the 2015/16 financial year. It was noted that considerable progress has been made with these schemes which totalled £3.7m but that more was still required given that the current forecast CIP target for 2015/16 was likely to be in the region of £5.1m (including a forecast £1.8m Non Recurrent CIP brought forward from 2014/15).

Other Reports and Updates

The Committee received additional reports and verbal updates as follows:

- A report detailing the progress being made to implement the Patient Level Costing (PLiCs) project plan. It was noted that the Quarter 1 model had been produced and published in line with the agreed timetable and that significant progress has begun to be made in gaining greater clinical engagement with PLiCs analysis.

- A report detailing the progress being made to ensure that the Trust is ready to meet the full introduction of Payment by Results (PbR) in 2015/16. The report highlighted that the current CHIPs information system is not able to produce PbR data. It was noted, however, that following a CHIPS redesign commissioned from the Health Informatics Service, PbR compliant data will be available from November 2014.

  It was also noted that a Trust wide PbR Group has been reconvened to take forward the PbR work programme in readiness for the 2015 implementation. This includes producing recommendations to resolve a number of data quality issues that currently exist. Additionally Clinical Audit will commence a cluster data quality review in October 2014.

- The Director of Finance gave a verbal update on the national NHS financial picture facing NHS Trusts, FT's and CCG's. He also provided an update regarding the expectation that NHS bodies drive efficiency savings from procurement and issues arising from safer staffer requirements.

  He also confirmed that the Trust has recently completed a survey (issued by the TDA) on the current level of engagement with regard to the development of local Better Care Fund.

- Minutes were received from the Capital Investment Group

North Staffordshire Combined Healthcare NHS Trust

Terms of Reference

The committee reviewed its Terms of Reference (TofR) and the proposed changes to:

- incorporate Trust performance metrics into the committee's work
- revise the name of the Committee to Finance and Performance

The Committee agreed to approve the revised TofR for a period of 12 months.

Recommendations

The Committee recommends to the Board

- **the acceptance of the proposed changes to the TofR of the Committee, including the change of name to the Finance & Performance Committee.**

The Board is asked to note the contents of this report and take assurance from the review and challenge evidenced in the Committee. Additionally the Board is asked to approve that the recommendation above.

Tony Gadsby – Chair of Finance and Activity Committee

18 September 2014

North Staffordshire Combined Healthcare NHS Trust

REPORT TO THE TRUST BOARD (OPEN)

Date of Meeting:	25 September 2014
Title of Report:	Financial Performance – Month 5
Presented by:	Chris Calkin, Interim Director of Finance
Author of Report: Name: Date: Email:	 Andy Turnock 15 September 2014 andrew.turnock@northstaffs.nhs.uk
Purpose / Intent of Report:	Financial Performance monitoring for information
Executive Summary:	The attached report summarises financial performance for the period to the end of August 2014. Headline performance is: • A retained deficit of £0.738m, giving a favourable variance against plan of £0.013m. • A year-end forecast that indicates an achievement of a retained surplus of £0.288m (£0.754m surplus at adjusted financial performance level), representing a favourable variance of £0.02m against Plan • A year to date Continuity of Service Risk Rating of 3, with a year-end forecast rating of 3 • CIP target of £4.08m, with a forecast delivery • Capital expenditure of £0.017m to date and a forecast gross expenditure of £2.64m • A cash balance of £5.9m at the end of August 2014.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Financial Strategy Not directly as a result of this report
Relationship with Annual Objectives:	Delivery of financial plan
Risk / Legal Implications:	Not directly as a result of this report
Resource Implications:	Not directly as a result of this report

Equality and Diversity Implications:	Not directly as a result of this report
Relationship with Assurance Framework [Risk, Control and Assurance]	Monitoring delivery of the financial plan
Recommendations:	The Board is asked to: • *note that financial performance to date is on plan, with a favourable variance reported of £0.013m* • *note the delivery of CIP is on plan, however this has been supported by the addition of a number of non-recurring schemes* • *note the cash position as at 31 August 2014 of £5.9m* • *note the year to date Continuity of Service Risk Rating of 3 and also the forecast rating of 3* • *note the capital expenditure position as at 31 August 2014 is currently behind plan*

FINANCIAL OVERVIEW as at 31 August 2014

Income & Expenditure - Retained Surplus / (Deficit)

£000	Plan	Actual	Var	%	RAG
YTD Surplus / (Deficit)	-751	-738	13	-1.7	G
FOT Surplus / (Deficit)	268	288	20	7.5	G

Gross Capital Expenditure

£000	Plan	Actual	Var	%	RAG
YTD Exp	330	17	-313	-94.8	A
FOT Exp	2,640	2,640	0	0.0	G

Cost Improvement

£m	Plan	Actual	Var	%	RAG
YTD	1.56	1.56	0.00	0.26	G
FOT	4.08	4.08	0.00	0.00	G

Cash Balances

£m	Plan	Actual	Var	%	RAG
YTD Balance	3.6	5.9	2.3	64.9	G
FOT Balance	4.5	4.5	0.00	0.0	G

Continuity of Service Risk Rating

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

Notes

Risks:

Achievement of income targets.

Delivery of the challenging CIP requirement.

Managing cost pressures.

Assumptions:

Clinical income targets are predominately achieved.

Charges against provisions provided for last year do not exceed the value provided.

1. Financial Position

1.1 Introduction

As detailed in the Operating Plan the Trust is planning to make a retained surplus of £0.288m in 2014/15.

This report details the Trust's performance against the Plan for the period ending 31 August 2014.

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

At the end of Month 5, the Trusts budgeted plan was a retained deficit of £0.751m. The reported retained position is a deficit of £0.738m, giving a favourable variance of £0.013m from 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. Further SOCI's for each division and also for the combined corporate functions are shown in Appendix A, pages 2 to 5.

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	74,572	5,994	6,023	29	29,236	29,595	360
Pay	-54,868	-4,557	-4,538	19	-22,914	-22,287	627
Non pay	-16,186	-1,279	-1,335	-56	-5,718	-6,694	-975
EBITDA	**3,519**	**158**	**150**	**-8**	**603**	**614**	**10**
Other Costs	-2,785	-242	-236	6	-1,161	-1,159	2
Adjusted Financial Performance	**734**	**-84**	**-86**	**-2**	**-558**	**-545**	**13**
IFRIC 12 Expenditure	-466	-39	-39	0	-193	-193	0
Retained Surplus / (Deficit) prior to Impairment	**268**	**-123**	**-125**	**-2**	**-751**	**-738**	**13**
Fixed Asset Impairment	0	0	0	0	0	0	0
Retained Surplus / (Deficit)	**268**	**-123**	**-125**	**-2**	**-751**	**-738**	**13**

Within non-pay, specific budgets have been set and held centrally. Table 2 shows these reserves and it is envisaged that they will be allocated to divisions and directorates appropriately during the financial year.

Table 2: Reserves Held Centrally

Description	£
Contingency (0.5% of Turnover per NTDA requirements)	331,000
Family & Friends	60,000
Cleanliness in Hospitals	61,808
Out of Area Treatments	100,000
Support from CCG's *	450,000
CCG developments **	574,127
Other Earmarked reserves	273,887
Total	**1,850,822**

* Support from local CCGs on a non-recurring basis

** Various developments (see below) included in the two main CCG contracts subject to full business cases plus the Community Triage investment (£0.08m)

1. Autism Assessment £0.2m
2. Dementia Service £0.15m
3. Healthy Minds £0.14m

It should be noted that the receipt of the mandate for month five from our host commissioners did not include payment for a number of developments. They are awaiting the business cases to enable the funding to be released.

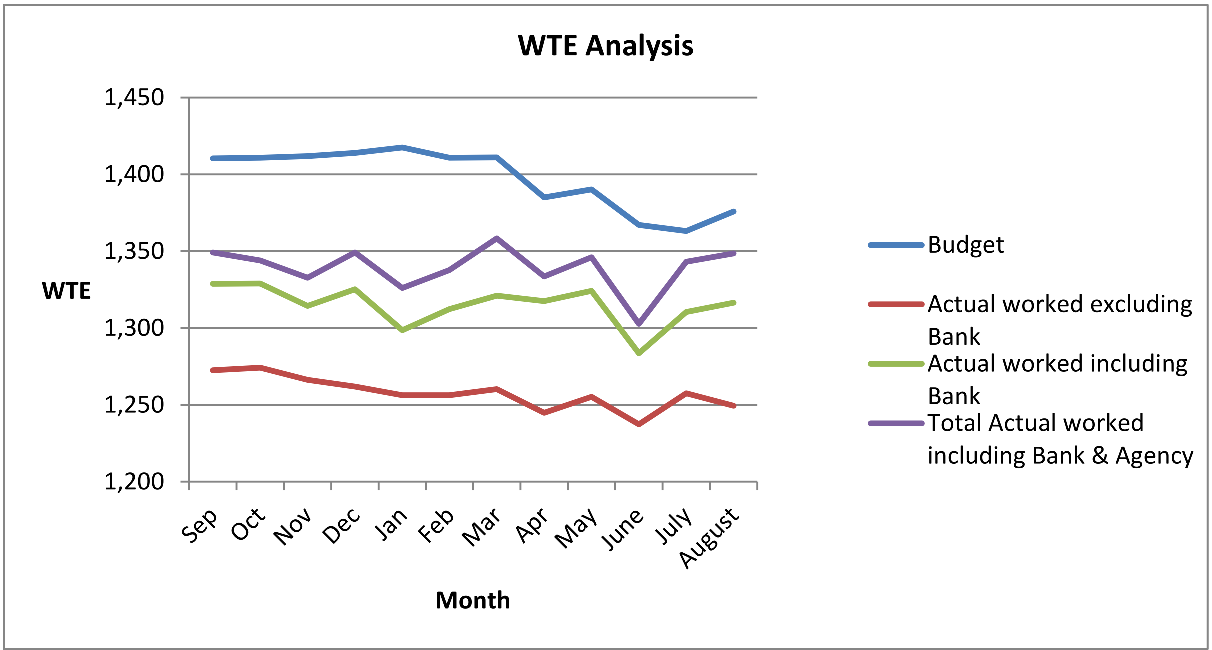
Contained within non-pay are the CIP targets for divisions and directorates. Work remains on-going to transact the majority of these negative budgets to reflect the CIP schemes within the respective divisions and corporately. As at month 5, only schemes with a high degree of complexity have yet to be transacted.

1.3 Workforce Analysis

Graph 1 below shows the whole time equivalent (wte) numbers for the last 12 months, incorporating Bank and Agency usage[1]. Graph 2 shows the usage of Bank and Agency staff in isolation. Table 3 shows the data being represented by the graphs.

[1] Agency wte is calculated using an average cost per month per staff category.

Graph 1: WTE Anaylsis



Graph 2: WTE Anaylsis

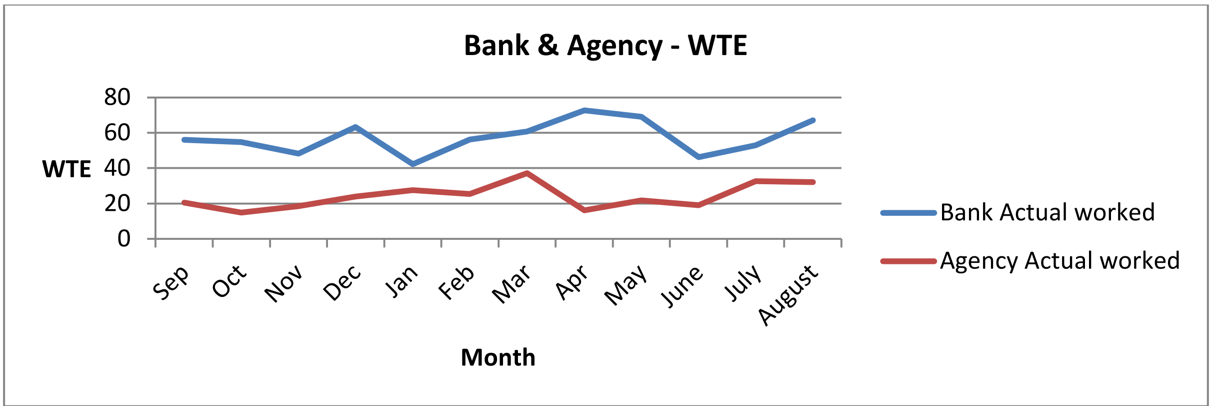


Table 3: WTE Analysis

	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	August
Bank Actual worked	56.09	54.76	48.13	63.33	42.18	56.12	60.74	72.68	69.09	46.28	52.86	66.99
Actual worked excluding Bank	1272.57	1274.19	1266.19	1261.92	1256.31	1256.21	1260.30	1244.73	1255.17	1237.35	1257.55	1249.38
Actual worked including Bank	**1328.66**	**1328.95**	**1314.32**	**1325.25**	**1298.49**	**1312.33**	**1321.04**	**1317.41**	**1324.26**	**1283.63**	**1310.41**	**1316.37**
Agency	20.43	14.89	18.45	23.97	27.62	25.42	37.21	16.21	21.71	19.05	32.68	32.10
Total Actual worked inc Bank & Agency	**1349.09**	**1343.84**	**1332.77**	**1349.22**	**1326.11**	**1337.75**	**1358.25**	**1333.62**	**1345.97**	**1302.68**	**1343.09**	**1348.47**
Budget	1410.40	1410.70	1411.78	1413.87	1417.48	1410.78	1410.90	1384.91	1390.09	1367.02	1363.04	1375.82

It is noticeable that there was an increase in bank WTE during the period January and May 2014. This was due to both a reduced demand and the delay in timesheet submission. August's bank usage is relatively high compared to previous months due to vacancies in LDNOAP being held due to the planned ward closure as well as the impact of the delay in the transfer of clients from Chebsey.

1.4 Forecast Year End Performance

Following the finalisation of the month 5 position, a worked up forecast outturn has been undertaken which supports the required retained surplus. The required retained surplus is now £0.288m (£0.754m at adjusted financial performance level) which is an increase of £0.02m compared to Plan. This revised surplus represents 1% of the Trusts anticipated turnover.

The Trust is forecast to over perform against its clinical and non-clinical income budgets. In terms of clinical income, this over performance of circa £0.16m is predominately the anticipated Out of Area Treatments (OATs) and Non Contract Activity (NCA). Non-clinical income is forecast to over achieve by circa £0.55m due to an increase in services provided and recharges to other NHS bodies, including property recharges, pay recharges, the staff counselling service, as well as an extension to the Yellowhouse service within the Children's directorate for a further six months.

The Trusts forecast outturn position is highly dependent on achieving the cost improvement programme, as well as managing cost pressures that may arise. This forecast position has been shared with the NTDA as part of their financial monitoring regime.

1.5 Cost Improvement Programme

The target for the year is £4.08m which is approximately 6% of clinical income. This takes into account the requirement to deliver the 1% surplus referred to above, plus hold a 0.5% contingency of £0.367m.

As at month 5, the Trust is reporting a position of £1.561m CIP delivery against a plan of £1.557m. It should be noted that the year to date performance has been supported by the addition of a number of non-recurring CIP schemes.

2. Summary of Financial Position

A Statement of Financial Position is shown in Appendix A, page 6.

2.1 Fixed Assets

Property, Plant & Equipment and Intangible assets balances of the Trust have remained relatively static. The movement is the net result of capital additions and the depreciation charge for the period April to August 2014.

2.2 Cash

As at 31 August 2014, the Trust's cash position was £5.9m which represents an increase during the month of £0.2m. This comprises an increase in debtors of £0.05m and an increase in creditors of £0.3m. A monthly cash flow forecast is shown in Appendix A, page 7.

2.3 Debtors

Trade & Other Receivables balances have increased during the month by £0.05m. This movement relates to a decrease in NHS debtors of £1.0m, an increase in local authority debtors of £0.6m and other debtors of £0.45m.

Within the overall value, £6.2m relates to invoiced debt. Invoiced debt is summarised by age in Appendix A, page 8.

2.4 Creditors

There has been an increase in the month of trade payables of £0.3m. This movement is due to an increase in accruals and deferred income of £0.2m, other creditors of £0.1m and local authority creditors of £0.2m, as well as a decrease in NHS creditors of £0.2m.

2.5 Non-Current Liabilities

The Trust's PFI scheme (Harplands Hospital) is accounted for on the "borrowings" line, reflecting the requirements of International Financial Reporting Standards.

3. Capital Expenditure and Programme

The Trust's permitted capital spend in 2014/15 is £2.64m; this is the combination of the Trust's £1.5m Capital Resource Limit (CRL) and its asset sales of £1.14m. The gross capital expenditure for the year as at 31 August 2014 is £0.02m which represents an under spend against the profiled gross capital expenditure (excluding envisage proceeds from sales) shown in the Plan submitted to the NTDA.

The Trust continues to monitor the delivery of the planned schemes against the CRL. Should it be deemed likely that the gross capital expenditure will be significantly under the initial plan of £2.64m, the limit will need to be amended when there is an opportunity to do so. At this point the forecast outturn is in line with Plan. Appendix A, page 9 shows the expenditure to date and the forecast outturn.

4. Risk Rating

From the 1 April 2014, the Trust is monitored using the Continuity of Service Risk Rating which replaces the previously used Financial Risk Rating.

As reported in the Operating Plan, the Trust is planning to achieve a Continuity of Service Risk Rating of 3 by the end of the financial year. As at month 5 this is calculated as 3 compared to the rating of 3 planned at this stage in the year. The forecast outturn rating is also 3, in line with the planned rating previously mentioned. Appendix A, page 10 shows the separate metrics and the outputs in detail.

5. Closure of Chebsey Close

The Board has been updated on an on-going basis upon the closure and associated risks and other issues. The year to date trading account is detailed in Table 4 below and confirms that the service is in operational surplus.

Table 4: Chebsey Close Trading Account

Detail	£'000
Income	
Clinical Income	
North Staffs & Stoke-on-Trent CCG	542.8
East Staffs CCG	155.2
Staffs & Surrounds CCG	143.4
Cannock CCG	143.4
Telford & Wrekin	100.3
Total income	1,085.2
Expenditure	
Pay	-858.4
Non-pay	-30.1
Total expenditure	-888.5
Net Position Surplus / (Deficit)	**196.7**

6. Recommendations

The Board is asked to:

- ***note that financial performance to date is largely on plan, with a small favourable variance of £0.013m reported***

- ***note the cash position of the Trust as at 31st August 2014 of £5.9m***
- ***note the capital expenditure position as at 31st August 2014 is an under spend against the year to date gross capital expenditure planned***
- ***note the year to date Continuity of Service Risk Rating of 3 and also the forecast rating of 3***

Statement of Comprehensive Income including Forecast Outturn – Trust Wide

	Full Year Budget £000	< < < Current Month > > > Actual £000	Budget £000	Variance £000	< < < Year to Date > > > Actual £000	Budget £000	Variance £000	< < < Forecast Outturn > > > Actual £000	Budget £000	Variance £000
Income:										
Revenue from Patient Care Activities	66,015	5,297	5,281	16	25,961	25,782	178	66,334	66,180	155
Other Operating Revenue	8,557	726	713	13	3,634	3,453	181	9,109	8,556	553
	74,572	6,023	5,994	29	29,595	29,236	360	75,444	74,736	708
Expenses:										
Pay										
Medical	-6,446	-492	-553	62	-2,399	-2,689	289	-6,249	-6,435	187
Nursing	-26,356	-2,174	-2,254	80	-10,835	-11,101	265	-25,654	-26,480	826
Other clinical	-12,741	-995	-992	-4	-4,973	-5,259	286	-12,056	-12,750	694
Non-clinical	-9,020	-703	-742	39	-3,492	-3,705	212	-8,621	-9,019	398
Non-NHS	-330	-173	-18	-155	-587	-171	-415	-1,381	-330	-1,052
Cost Improvement	25	0	2	-2	0	10	-10	0	25	-25
	-54,868	-4,538	-4,557	19	-22,287	-22,914	627	-53,961	-54,990	1,029
Non Pay										
Drugs & clinical supplies	-1,924	-195	-168	-27	-734	-741	7	-1,981	-1,925	-56
Establishment costs	-1,952	-111	-163	52	-561	-786	225	-1,503	-1,958	455
Premises costs	-2,222	-207	-183	-24	-1,018	-922	-96	-2,549	-2,220	-329
Private Finance Initiative	-3,823	-323	-319	-4	-1,627	-1,593	-34	-3,902	-3,823	-80
Other (including unallocated CIP)	-4,414	-499	-447	-52	-2,753	-1,676	-1,077	-7,190	-4,484	-2,705
Central Funds	-1,851	0	0	0	0	0	0	-820	-1,817	996
	-16,186	-1,335	-1,279	-56	-6,694	-5,718	-975	-17,945	-16,227	-1,718
EBITDA *	**3,519**	**150**	**158**	**-8**	**614**	**603**	**11**	**3,537**	**3,519**	**18**
Depreciation (excludes IFRIC 12 impact and donated income)	-884	-68	-74	6	-370	-370	0	-884	-884	0
Investment Revenue	11	1	1	0	6	5	2	13	11	2
Other Gains & (Losses)	119	0	0	0	50	50	0	119	119	0
Local Government Pension Scheme	0	0	0	0	0	0	0	0	0	0
Finance Costs	-1,400	-117	-117	0	-583	-583	0	-1,400	-1,400	0
Unwinding of Discounts	0	0	0	0	0	0	0	0	0	0
Dividends Payable on PDC	-631	-53	-53	0	-263	-263	0	-631	-631	0
Adjusted Financial Performance - Surplus / (Deficit) for the Financial Year **	**734**	**-86**	**-84**	**-2**	**-545**	**-558**	**13**	**754**	**734**	**20**
IFRIC 12 Expenditure ***	-466	-39	-39	0	-193	-193	0	-466	-466	0
Retained Surplus / (Deficit) for the Year excluding Impairment	**268**	**-125**	**-123**	**-2**	**-738**	**-751**	**13**	**288**	**268**	**20**
Fixed Asset Impairment ****	0	0	0	0	0	0	0	0	0	0
Retained Surplus / (Deficit) for the Year	**268**	**-125**	**-123**	**-2**	**-738**	**-751**	**13**	**288**	**268**	**20**

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

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

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

Statement of Comprehensive Income including Forecast Outturn – Adult Mental Health

Adult Mental Health	Annual	< < < 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	0	0	0	0	0	0	0	0	0	0
Other Operating Revenue	2,256	196	193	3	997	973	24	2,383	2,255	128
	2,256	196	193	3	997	973	24	2,383	2,255	128
Expenses:										
Pay										
Medical	-2,577	-218	-228	10	-1,090	-1,062	-28	-2,725	-2,577	-148
Nursing	-13,580	-1,123	-1,147	24	-5,590	-5,523	-67	-13,633	-13,581	-52
Other clinical	-6,719	-527	-554	26	-2,637	-2,724	87	-6,399	-6,719	320
Non-clinical	-1,438	-129	-117	-11	-635	-607	-27	-1,537	-1,438	-99
Non-NHS	-149	-48	-9	-40	-150	-90	-61	-284	-149	-135
Cost improvement	25	0	2	-2	0	10	-10	0	25	-25
	-24,439	-2,045	-2,052	7	-10,102	-9,995	-107	-24,578	-24,439	-139
Non Pay										
Drugs & clinical supplies	-1,451	-162	-129	-34	-561	-544	-17	-1,556	-1,452	-104
Establishment costs	-878	-49	-72	23	-260	-353	93	-652	-877	225
Premises costs	-559	-48	-54	6	-268	-236	-31	-614	-558	-56
Private Finance Initiative	0	0	0	0	0	0	0	0	0	0
Other	-964	-193	-81	-112	-1,078	-512	-566	-2,131	-965	-1,166
Central Funds	0	0	0	0	0	0	0	0	0	0
	-3,852	-453	-335	-117	-2,167	-1,645	-522	-4,953	-3,852	-1,101
EBITDA *	**-26,034**	**-2,302**	**-2,194**	**-108**	**-11,273**	**-10,668**	**-605**	**-27,148**	**-26,036**	**-1,112**

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

Statement of Comprehensive Income including Forecast Outturn – Children's Services

Children's Services	Annual Budget £000	Current Month Actual £000	Current Month Budget £000	Current Month Variance £000	Year to Date Actual £000	Year to Date Budget £000	Year to Date Variance £000	Forecast Outturn Actual £000	Forecast Outturn Budget £000	Forecast Outturn Variance £000
Income:										
Revenue from Patient Care Activities	0	0	0	0	0	0	0	0	0	0
Other Operating Revenue	1,240	115	119	-4	555	586	-31	1,352	1,240	112
	1,240	115	119	-4	555	586	-31	1,352	1,240	112
Expenses:										
Pay										
Medical	-707	-48	-59	11	-240	-295	54	-582	-707	125
Nursing	-2,272	-183	-181	-2	-905	-947	42	-2,193	-2,272	79
Other clinical	-2,363	-198	-127	-71	-987	-1,015	27	-2,328	-2,363	35
Non-clinical	-489	-33	-34	1	-169	-200	31	-399	-489	90
Non-NHS	-100	-61	-6	-56	-242	-49	-193	-658	-100	-558
Cost improvement	0	0	0	0	0	0	0	0	0	0
	-5,931	-524	-407	-117	-2,543	-2,505	-38	-6,160	-5,931	-229
Non Pay										
Drugs & clinical supplies	-43	-13	-4	-9	-56	-18	-38	-140	-43	-97
Establishment costs	-201	-15	-16	2	-62	-91	29	-150	-201	51
Premises costs	-298	-25	-26	1	-125	-130	4	-322	-298	-24
Private Finance Initiative	0	0	0	0	0	0	0	0	0	0
Other	261	-6	-81	75	-44	87	-130	-139	261	-400
Central Funds	0	0	0	0	0	0	0	0	0	0
	-281	-58	-127	68	-287	-152	-135	-751	-281	-470
EBITDA *	**-4,971**	**-467**	**-414**	**-53**	**-2,275**	**-2,071**	**-203**	**-5,559**	**-4,972**	**-587**

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

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Statement of Comprehensive Income including Forecast Outturn – Learning Disabilities, Neuropsychiatry and Older Peoples Psychiatry

Learning Disabilities, Neuropsychiatry and Older Peoples Psychiatry	Annual Budget £000	<<< Current Month >>> Actual £000	Budget £000	Variance £000	<<< Year to Date >>> Actual £000	Budget £000	Variance £000	<<< Forecast Outturn >>> Actual £000	Budget £000	Variance £000
Income:										
Revenue from Patient Care Activities	0	0	0	0	0	0	0	0	0	0
Other Operating Revenue	383	38	34	4	184	169	15	415	383	32
	383	38	34	4	184	169	15	415	383	32
Expenses:										
Pay										
Medical	-1,258	-96	-104	9	-497	-528	31	-1,277	-1,258	-18
Nursing	-10,040	-824	-889	65	-4,167	-4,437	270	-9,370	-10,180	811
Other clinical	-2,319	-158	-192	34	-781	-928	146	-2,022	-2,319	296
Non-clinical	-799	-60	-67	8	-323	-328	5	-770	-798	29
Non-NHS	-15	-4	-1	-2	-27	-6	-21	-71	-15	-57
Cost improvement	0	0	0	0	0	0	0	0	0	0
	-14,430	-1,141	-1,254	113	-5,796	-6,227	431	-13,510	-14,570	1,061
Non Pay										
Drugs & clinical supplies	-430	-20	-36	16	-117	-179	62	-285	-430	145
Establishment costs	-402	-22	-34	12	-123	-168	45	-317	-409	92
Premises costs	-200	-16	-17	1	-97	-83	-14	-258	-200	-59
Private Finance Initiative	0	0	0	0	0	0	0	0	0	0
Other	648	-11	53	-64	-67	221	-288	-156	648	-804
Central Funds	0	0	0	0	0	0	0	0	0	0
	-384	-68	-33	-35	-404	-210	-195	-1,016	-391	-626
EBITDA *	**-14,431**	**-1,171**	**-1,253**	**82**	**-6,016**	**-6,267**	**251**	**-14,111**	**-14,578**	**467**

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

Statement of Comprehensive Income including Forecast Outturn – Corporate Directorates

Corporate Directorates	Annual Budget £000	Current Month Actual £000	Current Month Budget £000	Current Month Variance £000	Year to Date Actual £000	Year to Date Budget £000	Year to Date Variance £000	Forecast Outturn Actual £000	Forecast Outturn Budget £000	Forecast Outturn Variance £000
Income:										
Revenue from Patient Care Activities	0	0	0	0	0	0	0	0	0	0
Other Operating Revenue	4,678	377	367	10	1,898	1,725	173	4,960	4,678	281
	4,678	377	367	10	1,898	1,725	173	4,960	4,678	281
Expenses:										
Pay										
Medical	-1,903	-130	-162	33	-571	-804	233	-1,665	-1,893	228
Nursing	-465	-44	-37	-7	-174	-194	20	-458	-447	-11
Other clinical	-1,339	-112	-119	7	-567	-593	25	-1,307	-1,350	43
Non-clinical	-6,294	-482	-523	42	-2,366	-2,570	203	-5,916	-6,294	378
Non-NHS	-66	-60	-3	-57	-167	-27	-141	-368	-66	-302
Cost improvement	0	0	0	0	0	0	0	0	0	0
	-10,068	-827	-845	18	-3,846	-4,187	341	-9,713	-10,050	336
Non Pay										
Drugs & clinical supplies	0	0	0	0	0	0	0	0	0	0
Establishment costs	-471	-25	-41	16	-115	-173	58	-384	-471	87
Premises costs	-1,164	-119	-86	-32	-528	-472	-55	-1,354	-1,164	-190
Private Finance Initiative	-3,823	-323	-319	-4	-1,627	-1,593	-34	-3,902	-3,823	-80
Other	-4,360	-289	-338	49	-1,565	-1,473	-93	-4,764	-4,428	-335
Central Funds	-1,851	0	0	0	0	0	0	-820	-1,817	996
	-11,669	-756	-784	28	-3,835	-3,711	-124	-11,225	-11,703	479
EBITDA *	**-17,059**	**-1,206**	**-1,262**	**56**	**-5,784**	**-6,173**	**390**	**-15,978**	**-17,075**	**1,096**

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

Statement of Financial Position – including forecast

Detail	Period End Date 31/03/2014 £000	30/06/2014 £000	31/07/2014 £000	31/08/2014 £000	FOT 31/03/2015 £000
NON-CURRENT ASSETS:					
Property, Plant and Equipment	33,834	33,534	33,409	33,302	32,118
Intangible Assets	109	94	94	94	150
Trade and Other Receivables	52	52	52	52	52
TOTAL NON-CURRENT ASSETS	33,995	33,680	33,555	33,448	32,320
CURRENT ASSETS:					
Inventories	98	92	81	88	84
Trade and Other Receivables	3,525	4,410	5,042	5,083	3,491
Cash and cash equivalents	5,445	5,228	5,729	5,940	4,528
SUB TOTAL CURRENT ASSETS	9,068	9,730	10,852	11,111	8,103
Non-current assets held for sale	1,148	1,148	888	888	2,875
TOTAL ASSETS	**44,211**	**44,558**	**45,295**	**45,447**	**43,298**
CURRENT LIABILITIES:					
NHS Trade Payables	-929	-772	-772	-621	-754
Non-NHS Trade Payables	-4,880	-6,016	-6,991	-7,438	-6,324
Borrowings	-360	-360	-360	-360	-351
Provisions for Liabilities and Charges	-2,502	-2,400	-2,365	-2,376	-697
TOTAL CURRENT LIABILITIES	-8,671	-9,548	-10,488	-10,795	-8,126
NET CURRENT ASSETS/(LIABILITIES)	1,545	1,330	1,252	1,204	2,852
TOTAL ASSETS LESS CURRENT LIABILITIES	**35,540**	**35,010**	**34,807**	**34,652**	**35,172**
NON-CURRENT LIABILITIES					
Borrowings	-13,343	-13,253	-13,223	-13,193	-12,993
Trade & Other Payables	0	0	0	0	0
Provisions for Liabilities and Charges	-401	-401	-401	-401	-115
TOTAL NON- CURRENT LIABILITIES	-13,744	-13,654	-13,624	-13,594	-13,108
TOTAL ASSETS EMPLOYED	**21,796**	**21,356**	**21,183**	**21,058**	**22,064**
FINANCED BY TAXPAYERS EQUITY:					
Public Dividend Capital	7,998	7,998	7,998	7,998	7,998
Retained Earnings	150	-290	-463	-588	418
Revaluation Reserve	13,596	13,596	13,596	13,596	13,596
Other reserves	52	52	52	52	52
TOTAL TAXPAYERS EQUITY	**21,796**	**21,356**	**21,183**	**21,058**	**22,064**

Cash-flow Forecast

Statement of Cash Flows (CF)	Actual Apr 14 £000	Actual May 14 £000	Actual Jun 14 £000	Actual Jul 14 £000	Actual Aug 14 £000	Forecast Sep 14 £000	Forecast Oct 14 £000	Forecast Nov 14 £000	Forecast Dec 14 £000	Forecast Jan 15 £000	Forecast Feb 15 £000	Forecast Mar 15 £000	2014/2015 Full Year £000
Cash Flows from Operating Activities													
Operating Surplus / (Deficit)	-62	-36	162	-56	44	*199*	*344*	*273*	*398*	*323*	*346*	*252*	**2,187**
Depreciation and Amortisation	123	123	85	125	107	*109*	*112*	*112*	*112*	*114*	*114*	*114*	**1,350**
Impairments and Reversals	0	0	0	0	0	*0*	*0*	*0*	*0*	*0*	*0*	*0*	**0**
Interest Paid	-117	-117	-117	-117	-116	*-117*	*-117*	*-117*	*-117*	*-117*	*-117*	*-114*	**-1,400**
Dividend Paid	0	0	0	0	0	*-314*	*0*	*0*	*0*	*0*	*0*	*-317*	**-631**
Inflow / (Outflow) prior to Working Capital	**-56**	**-30**	**130**	**-48**	**35**	***-123***	***339***	***268***	***393***	***320***	***343***	***-65***	**1,506**
(Increase) / Decrease in Inventories	13	-7	0	11	-7	*-4*	*-4*	*1*	*2*	*-5*	*1*	*13*	**14**
(Increase) / Decrease in Trade and Other Receivables	-754	239	-370	-632	-41	*9*	*154*	*197*	*-185*	*515*	*335*	*635*	**102**
Increase / (Decrease) in Trade and Other Payables	599	778	-555	924	243	*156*	*72*	*-50*	*186*	*-883*	*-216*	*-53*	**1,201**
Provisions (Utilised) / Arising	-23	-13	-66	-35	11	*-710*	*-762*	*-200*	*0*	*0*	*0*	*-293*	**-2,091**
Increase/(Decrease) in Movement in non Cash Provisions	0	0	0	0	0	*0*	*0*	*0*	*0*	*0*	*0*	*98*	**98**
Inflow / (Outflow) from Working Capital	**-165**	**997**	**-991**	**268**	**206**	***-549***	***-540***	***-52***	***3***	***-373***	***120***	***400***	**-676**
Net Cash Inflow / (Outflow) from Operating Activities	**-221**	**967**	**-861**	**220**	**241**	***-672***	***-201***	***216***	***396***	***-53***	***463***	***335***	**830**
Cash Flows from Investing Activities													
Interest Received	1	2	1	1	1	*1*	*1*	*1*	*1*	*1*	*1*	*1*	**13**
(Payments) for Property, Plant and Equipment	-11	0	-5	0	-1	*-160*	*-164*	*-155*	*-285*	*-384*	*-525*	*-810*	**-2,500**
Proceeds of disposal of assets held for sale (PPE)	0	0	0	310	0	*0*	*220*	*0*	*0*	*528*	*0*	*40*	**1,098**
Net Cash Inflow / (Outflow) from Investing Activities	**-10**	**2**	**-4**	**311**	**0**	***-159***	***57***	***-154***	***-284***	***145***	***-524***	***-769***	**-1,389**
NET CASH INFLOW / (OUTFLOW) BEFORE FINANCING	**-231**	**969**	**-865**	**531**	**241**	***-831***	***-144***	***62***	***112***	***92***	***-61***	***-434***	**-559**
Cash Flows from Financing Activities													
Capital Element of Payments in Respect of Finance Leases PFI	-30	-30	-30	-30	-30	*-30*	*-30*	*-30*	*-30*	*-30*	*-30*	*-28*	**-358**
Net Cash Inflow/(Outflow) from Financing Activities	**-30**	**-30**	**-30**	**-30**	**-30**	***-30***	***-30***	***-30***	***-30***	***-30***	***-30***	***-28***	**-358**
NET INCREASE / (DECREASE) IN CASH AND CASH EQUIVALENTS	**-261**	**939**	**-895**	**501**	**211**	***-861***	***-174***	***32***	***82***	***62***	***-91***	***-462***	**-917**
Cash and Cash Equivalents (and Bank Overdraft) at YTD	**5,184**	**6,123**	**5,228**	**5,729**	**5,940**	***5,079***	***4,905***	***4,937***	***5,019***	***5,081***	***4,990***	***4,528***	

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	4,599	328	277	57	152	**5,413**
Local Authorities	556	34	0	0	0	**590**
Other Debtors	91	27	14	1	46	**179**
Total	**5,246**	**389**	**291**	**58**	**198**	**6,182**

Capital Programme and Expenditure

Site	Detail	2014/15 Scheme Value £000	Year to Date £000	Forecast Outturn £000
Schemes Committed				
Developments				
Ward 4 Upgrade		750	0	750
Acquired Brain Injury		150	0	150
Ward Upgrade		400	9	400
AT & T and Telford Unit		250	0	250
Tackling Green Issues		100	0	100
Victoria Surgery & other minor schemes		190	0	190
Total for Service Redesign schemes		**1,840**	**9**	**1,840**
Bucknall Relocation				
New Corporate base		0	0	0
Total for Bucknall Relocation schemes		**0**	**0**	**0**
Maintenance of Infrastructure				
Other	Other	200	8	200
Total for Maintenance of Infrastructure schemes		**200**	**8**	**200**
Other Schemes				
Other equipment purchases - IT	Various	100	0	100
Various	Various	400	0	400
Other equipment purchases - other	Other	0	0	0
Total for Other Schemes		**500**	**0**	**500**
Not Yet Committed				
Harplands	Lifecycle	100	0	100
Total Expenditure		**2,640**	**17**	**2,640**
Disposals				
Sale of former Learning Disability properties		-1,140	-260	-1,140
Net Expenditure		**1,500**	**-243**	**1,500**

Capital Allocations	£000
Initial CRL (per NTDA Plan submission)	**1,500**
Revisions to Plan:	
None	-
Final CRL	**1,500**
Value of Schemes as at 31/08/14	**1,500**
Potential (Over) / Undershoot against CRL	**0**

Continuity of Service Risk Rating

	Current Month Metrics			Forecast Outturn Metrics		
Continuity of Services Risk Ratings	**Plan**	**Actual**	**Variance**	**Plan**	**Forecast**	**Variance**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Liquidity Ratio (days)						
Working Capital Balance	-266	228	494	-90	-107	-17
Annual Operating Expenses	29,125	28,980	-145	69,514	71,906	2,392
Liquidity Ratio Days	-1.37	1.18	2.55	-0.47	-0.54	-0.07
Liquidity Ratio Metric	3	4	1	3	3	0
Capital Servicing Capacity (times)						
Revenue Available for Debt Service	685	621	-64	3,715	3,550	-165
Annual Debt Service	996	996	0	2,389	2,389	0
Capital Servicing Capacity (times)	0.7	0.6	-0.1	1.6	1.5	-0.1
Capital Servicing Capacity metric	1	1	0	2	2	0
Continuity of Services Rating for Trust	2	3	1	3	3	0

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

North Staffordshire Combined Healthcare NHS Trust

REPORT TO TRUST BOARD

Date of Meeting:	25th September 2014
Title of Report:	Performance Report – Month 5 2014/15
Presented by:	Chris Calkin, Interim Director of Finance
Author of Report: Name: Date: Email:	 Kevin Daley, Performance Development Manager 16th September 2014 Kevin.Daley@northstaffs.nhs.uk
Purpose / Intent of Report:	Performance Monitoring
Executive Summary:	This report provides the Board with a summary of performance to the end of Month 5 (August 2014) Performance against the Monitor compliance framework and key National Targets is included within the report, all indicators are on target. A range of 122 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. There are three areas reported as under-performing (amber) and three reported as significantly under-performing as at end of August 2014. The attached summary by exception expands on the areas that are underperforming and Executive leads will provide a verbal update at the meeting, where appropriate.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Governance Strategy The Performance & Quality management Framework measures performance across National and local indicators, presented against the Trust's enabling strategies, commissioning contract and Monitor's 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 Assurance Framework	The Performance & Quality Management Framework is a key control within the Assurance Framework
Recommendations:	The Board are asked to • consider and discuss reported performance with particular emphasis on areas of underperformance

	• note the considerable number of metrics reported on target (green) • to confirm sufficient detail and assurance is provided

1 Introduction to Performance Management Report

The report includes proposed 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 Divisional Business Managers 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.

At month 5 there are 116 metrics rated as Green and 3 rated as Amber and 3 rated as Red

		YTD			Month 5		
Strategic Goal	Key Trust Objective	Red	Amber	Green	Red	Amber	Green
	TDA	0	0	0	0	0	0
SG1 Clinical Effectiveness	KTO 1	0	2	52	0	2	52
SG2 Partnership Working	KTO 2	2	0	31	2	0	31
SG3 Engagement	KTO 3	0	0	10	0	0	10
SG4 Innovation	KTO 4	0	0	0	0	0	0
SG5 Efficient Provider	KTO 5	0	0	13	0	0	13
	KTO 6	1	1	10	1	1	10
	Total	**3**	**3**	**116**	**3**	**3**	**116**

2.1 Proposed TDA Assurance Framework

The TDA assurance framework is included as these are the key performance indicators against which non foundation Trusts' performance is assessed. There are 41 **proposed** key quality indicators applicable to Mental Health Trusts. ***Please Note: Technical guidance has yet to be issued for these metrics.***

	Area	Metric Driver	Executive lead	Target	August	YTD	Trend	Forecast Year End	Data Quality
TDA 1	Inpatient scores from Friends and Family Test	TDA Assurance Framework	Director of Nursing		30	95	↗	G	G
TDA 2	Complaints – rate per bed days, MH contacts		Director of Nursing		Awaiting Guidance	Awaiting Guidance	↔	G	A
TDA 3	Inpatient Survey: Q68 Overall I had a very poor/ good experience?		Director of Nursing		Annual Data	Annual Data	↔	G	G

	Area	Metric Driver	Executive lead	Target	August	YTD	Trend	Forecast Year End	Data Quality
TDA 4	Community Mental Health: Q45 Overall, how would you rate the care you have received in the last 12 months?		Director of Nursing		Annual Data	Annual Data	↔	G	G
TDA 5	Mixed Sex Accommodation Breaches		Director of Nursing	0	0	0	↔	G	G
TDA 6	NHS England inpatients response rate from Friends and Family Test		Director of Nursing		38%	28.6%	↗	G	G
TDA 7	Data Quality of trust returns to the HSCIC		Director of Ops		Awaiting Guidance	Awaiting Guidance	↔	G	G
TDA 8	NHS Staff Survey: Percentage of staff who would recommend the trust as a place of work		Workforce Director		Annual Data	Annual Data	↔	G	G
TDA 9	NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment		Workforce Director		Annual Data	Annual Data	↔	G	G
TDA 10	Trust turnover rate		Workforce Director		1.11	11.47	↗	G	G
TDA 11	Trust level total sickness rate		Workforce Director		2.95%	4.39%	↘	G	G
TDA 12	Total trust vacancy rate		Workforce Director		4.3%	4.3%	↗	G	G
TDA 13	Temporary costs and overtime as % total paybill		Workforce Director		7.94%	7.94%	↗	G	G
TDA 14	Percentage of staff with annual appraisal		Workforce Director		25%	25%	↘	G	G
TDA 19	Deaths in low risk conditions		Medical Director		Awaiting Guidance	Awaiting Guidance	↔	G	A
TDA 21	IAPT – The proportion of people who complete treatment who are moving to recovery		Director of Operations		33%	36%	↘	G	G
TDA 22	C DIFF		Director of Nursing	0	0	0	↔	G	G

	Area	Metric Driver	Executive lead	Target	August	YTD	Trend	Forecast Year End	Data Quality
TDA 23	MRSA		Director of Nursing	0	0	0	↔	G	G
TDA 24	Never Event incidence			0	0	0	↔	G	G
TDA 25	Medication errors causing serious harm		Medical Director		0	0	↔	G	G
TDA 26	Percentage of Harm Free Care		Director of Nursing		n/a	97%	↗	G	A
TDA 27	Serious Incidents		Director of Nursing		5	27	↔	G	G
TDA 28	Proportion of reported patient safety incidents that are harmful		Director of Nursing		36	164	↗	G	G
TDA 29	CAS alerts		Medical Director		13	68	↘	G	G
TDA 30	Admissions to adult facilities of patients who are under 16 years of age (Number)		Director of Operations	0	0	0	↔	G	G
TDA 31	RTT waiting times for admitted pathways: percentage within 18 weeks		Director of Operations		0	0	↔	G	G
TDA 32	RTT waiting times for non-admitted pathways: percentage within 18 weeks		Director of Operations		95.5%	95.5%	↘	G	G
TDA 33	RTT waiting times incomplete pathways		Director of Operations		Awaiting Guidance	Awaiting Guidance	↔	G	G
TDA 34	RTT over 52 week waiters		Director of Operations				↘	G	G
TDA 35	The proportion of those on Care Programme Approach (CPA) for at least 12 months Who had a CPA review within the last 12 months		Director of Operations		94.6%	94.6%	↘	G	G
TDA 36	The proportion of those on Care Programme Approach(CPA) for at least 12 months having formal review within 12 months		Director of Operations		94.6%	94.6%	↘	G	G

	Area	Metric Driver	Executive lead	Target	August	YTD	Trend	Forecast Year End	Data Quality
TDA 37	The proportion of those on Care Programme Approach(CPA) for at least 12 months Receiving follow-up contact within 7 days of discharge		Director of Operations	95%	100%	100%	↔	G	G
TDA 38	Admissions to inpatient services who had access to Crisis Resolution/Home Treatment teams		Director of Operations	95%	100%	100%	↔	G	G
TDA 39	Meeting commitment to serve new psychosis cases by early intervention teams (Number)		Director of Operations		4	37	↔	G	G
TDA 40	Mental health delayed transfers of care		Director of Operations		2.64%	3.22%	↘	G	G
TDA 41	Data security breaches or lapses		Director of Operations		2	18	↘	G	G

3 Exception Reports

Below are exceptions where compliance of the KPIs which support the strategic goals and Key Trust Targets (KTO) are below expected levels of performance and require further action.

SG1: To deliver high quality, person-centred models of care Clinical Effectiveness

KTO 1. Delivery of high quality services evidenced by CQC compliance, compliance with NICE guidance, increase in service user engagement and improvement of patient (SG1)

Of the 54 metrics all except the 2 below are within accepted limits at month 5

KPI	Metric	Exec	Op	Target	M5 Perf	YTD	Forecast Outturn	Trend	Comment
O1 IP4	Readmission rate (28 days) For all inpatient settings reported by specialty (Monthly)	Dir of Ops		7.5%	AMBER **11.25%**	AMBER **9.76%**	AMBER	↗	**M5 figures are: 9 confirmed readmissions from 80 discharges = 11.25%** **YTD to August 42 confirmed readmissions from 430 discharges = 9.76%** Trust met with Commissioners 12/08/14 to discuss readmission issues. It has been agreed that a joint investigation by clinical leads will be undertaken to

									revalidate the readmissions year to date. This is expected to be completed within two months. Details of the 42 readmissions YTD have bent sent to the nominated investigation leads and a full review is currently being undertaken into the circumstances of the readmissions.
CQUIN GOAL 5	Listening and Responding to Feedback	Dir of Nursing			AMBER	AMBER	GREEN		All quarter 1 targets were met. CQUIN lead appointed (Steve Eley) - To meet with Audit lead to arrange working group meeting to agree parameters for quarter 2

SG2: To be at the centre of an integrated network of partnerships to provide a holistic approach to care

KTO 2. Integrated models of care evidenced by clinical strategy supported by commissioners, partners and service users. (Medical Director) (SG2)

Of the 33 metrics all except the below are within accepted limits at month 5

KPI	Metric	Exec	Op	Target	M5 Perf	YTD	Forecast Outturn	Trend	Comment
	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users, as defined in Contract Technical Guidance	Dir of Ops	SW	90%	**RED 79%**	**RED 79%**	**GREEN**	↗	**79% @ month 5 from 74% @ month 4** Please note that the latest data from HSCIC website is provisional for May 2014 which indicates 79% compliance. The Trust is above the national average (77%) compliance levels at 79% and in the middle cohort of Trusts in terms of data completeness. Met with Commissioners 21/08/14 to discuss

									IAPT reporting. Work ongoing within the teams to ensure that all relevant data fields are populated with valid coding which should show improvement in the reported activity for subsequent months. Would suggest this metric is added to DQIP to fully understand the data issues and ensure ongoing compliance
PHQ13_05	The proportion of people who have depression and/or anxiety disorders who receive psychological therapies (PHQ16_01 / PHQ16_02	Dir of Ops	SW	5.66% @ M5	**RED 0.88%**	**RED 4.11%**	**GREEN**	↗	This service is provided in partnership with Changes and Mind Q1 stepped target = 3.3% Q2 stepped target = 3.5% M5 target = 3.5%/3 = 1.17% M5 performance = 0.88% YTD target = 3.3% + 2.33% = 5.66% @ M5 YTD performance = 4.11% @ M5 Performance notice issued by Commissioners Met with Commissioners at Morston House 04/08/14 to review performance against the IAPT metrics and agree an action plan to bring the performance back on track.

SG3 To engage with our communities to ensure we deliver the services they require

KTO 3. Improve stakeholder relationships and working, evidenced by stakeholder survey at beginning and end of year. (Chief Executive) (SG3)
Of the 10 metrics all are within accepted limits at month 5

SG4 To be a dynamic organisation driven by innovation

KTO 4. Use technology as an enabler for high quality service delivery evidenced by implementation of a refreshed IT Strategy and real-time patient feedback systems.(Dir of Finance). (SG4)

SG5 To be one of the most efficient providers

KTO 5. Robust plans delivering quality and sustainable services evidenced by delivery of financial plan and TDA risk rating of maximum 2. (Dir of Operations) (SG5)
Of the 13 metrics all are within accepted limits at month 5

KTO 6. Improve culture of staff engagement evidenced by improvements in key staff survey indicators and improved team survey results. (Dir of Leadership & Workforce) (SG5)
Of the 13 metrics all except two are within accepted limits at month 5

KPI	Metric	Exec	Op	Target	M5 Perf	YTD	Forecast Outturn	Trend	Comment
O8.6	Percentage of staff compliant with mandatory training appropriate to their role	WF Dir	PD	95%	AMBER 89%	AMBER 89%	AMBER	⇔	**89% @ month 5 from 89% @ month 4** Month 5 AMH = 89% LDNAOP = 89% CYP = 89% Corporate = 89% Trust is proactively taking action with teams to ensure that all staff attend statutory & mandatory training and maintain their compliance.
O8.5	Annual appraisal and personal development plan All Staff	WF Dir	PD	90%	RED 25%	RED 25%	GREEN	↘	**24.85% @ month 5 from 42% @ month 4** Month 5 AMH = 25.16% LDNAOP = 17.44% CYP = 40% Corporate = 26.04% The issue is the cascade process undertaken to ensure that all PDRs reflect the Trust objectives throughout the organisation. Trust is proactively taking action to ensure that performance returns to required levels over the next couple of months.

4 Risk Ratings

The NHS Trust Development Authority measures Trust performance in five categories as follows:

1) No identified concerns
2) Emerging concerns
3) Concerns requiring investigation
4) Material issue
5) Formal action required

Until recently the TDA defined this Trust performance as category 3. This was favourably revised recently to category 2

The Trust Board is asked to:

- Note the performance reported including the forecast position
- Note that most national targets are being met
- Review areas of underperformance as summarised in this report and identify further action required

REPORT TO TRUST BOARD **Enclosure 14**

Date of Meeting:	25 September 2014
Title of Report:	NHS Trust Development Authority (NTDA) Monthly Self Certifications.
Presented by:	Chris Calkin, Interim Director of Finance
Author of Report: Name: Date: Email:	 Glen Sargeant, Head of Performance and Information 12 September 2014 glen.sargeant@northstaffs.nhs.uk
Purpose / Intent of Report:	Information and approval
Executive Summary:	This report presents the monthly NTDA self-certification documents for Board approval. These self-certification declarations form part of the NTDA Oversight and Escalation Process. Based on August 2014 data, the Trust is declaring compliance with all requirements.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Clinical, Finance and Governance. There is no direct impact on patients or the public.
Relationship with Annual Objectives:	To manage delivery of the milestones towards achieving FT status, in preparation for the Trust's proposed future form.
Risk / Legal Implications:	None
Resource Implications:	None identified
Equality and Diversity Implications:	None identified
Relationship with Assurance Framework [Risk, Control and Assurance]	None
Recommendations:	The Board is asked to : • Approve the self-certifications for submission to the NTDA on or before the last working day of September 2014.

NHS TRUST DEVELOPMENT AUTHORITY

tda Trust Development Authority
Quality. Delivery. Sustainability.

OVERSIGHT: Monthly self-certification requirements - Compliance Monitor
Monthly Data.

CONTACT INFORMATION:

Enter Your Name:	Chris Calkin		
Enter Your Email Address	chris.calkin2@northstaffs.nhs.uk		
Full Telephone Number:	03001231535	Tel Extension:	

SELF-CERTIFICATION DETAILS:

Select Your Trust:	North Staffordshire Combined Healthcare NHS Trust		
Submission Date:	30/09/2014	Reporting Year:	2014/15

Select the Month

○ April	○ May	○ June
○ July	○ August	○ September
○ October	○ November	○ December
○ January	○ February	○ March

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

1. **Condition G4** – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions).
2. **Condition G5** – Having regard to monitor Guidance.
3. **Condition G7** – Registration with the Care Quality Commission.
4. **Condition G8** – Patient eligibility and selection criteria.

5. **Condition P1** – Recording of information.
6. **Condition P2** – Provision of information.
7. **Condition P3** – Assurance report on submissions to Monitor.
8. **Condition P4** – Compliance with the National Tariff.
9. **Condition P5** – Constructive engagement concerning local tariff modifications.

10. **Condition C1** – The right of patients to make choices.
11. **Condition C2** – Competition oversight.

12. **Condition IC1** – Provision of integrated care.

Further guidance can be found in Monitor's response to the statutory consultation on the new NHS provider licence:
The new NHS Provider Licence

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

Comment where non-compliant or at risk of non-compliance

1. Condition G4
Fit and proper persons as Governors and Directors.

Yes

Timescale for compliance:

2. Condition G5
Having regard to monitor Guidance.

Yes

Timescale for compliance:

3. Condition G7
Registration with the Care Quality Commission.

Yes

Timescale for compliance:

Comment where non-compliant or at risk of non-compliance

4. Condition G8
Patient eligibility and selection criteria.

Yes

Timescale for compliance:

Comment where non-compliant or at risk of non-compliance

5. Condition P1
Recording of information.

Yes

Timescale for compliance:

6. Condition P2
Provision of information.

Yes

Timescale for compliance:

7. Condition P3
Assurance report on submissions to Monitor.

Yes

Timescale for compliance:

8. Condition P4
Compliance with the National Tariff.

Yes

Timescale for compliance:

Comment where non-compliant or at risk of non-compliance

9. Condition P5
Constructive engagement concerning local tariff modifications.

Yes

Timescale for compliance:

		Comment where non-compliant or at risk of non-compliance
10. Condition C1 The right of patients to make choices.	Yes	
		Timescale for compliance:
11. Condition C2 Competition oversight.	Yes	
		Timescale for compliance:
12. Condition IC1 Provision of integrated care.	Yes	
		Timescale for compliance:

Submit

NHS TRUST DEVELOPMENT AUTHORITY

tda Trust Development Authority
Quality. Delivery. Sustainability.

OVERSIGHT: Monthly self-certification requirements - Board Statements

Monthly Data.

CONTACT INFORMATION:

Enter Your Name:	Chris Calkin		
Enter Your Email Address	chris.calkin2@northstaffs.nhs.uk		
Full Telephone Number:	03001231535	Tel Extension:	

SELF-CERTIFICATION DETAILS:

Select Your Trust:	North Staffordshire Combined Healthcare NHS Trust		
Submission Date:	30/09/2014	Reporting Year:	2014/15

Select the Month

- ○ April ○ May ○ June
- ○ July ○ August ○ September
- ○ October ○ November ○ December
- ○ January ○ February ○ March

BOARD STATEMENTS:

CLINICAL QUALITY
FINANCE
GOVERNANCE

The NHS TDA's role is to ensure, on behalf of the Secretary of State, that aspirant FTs are ready to proceed for assessment by Monitor. As such, the processes outlined here replace those previously undertaken by both SHAs and the Department of Health.

In line with the recommendations of the Mid Staffordshire Public Inquiry, the achievement of FT status will only be possible for NHS Trusts that are delivering the key fundamentals of clinical quality, good patient experience, and national and local standards and targets, within the available financial envelope.

BOARD STATEMENTS:

For CLINICAL QUALITY, that

1. The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

1. CLINICAL QUALITY
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For CLINICAL QUALITY, that

2. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.

2. CLINICAL QUALITY
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For CLINICAL QUALITY, that

3. The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.

3. CLINICAL QUALITY
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For FINANCE, that

4. The board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time.

4. FINANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

5. The board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.

5. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

6. All current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.

6. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

7. The board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.

7. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

8. The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.

8. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

9. An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).

9. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

10. The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.

10. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

11. The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.

11. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

12. The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.

12. GOVERNANCE
Indicate compliance. Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

13. The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.

13. GOVERNANCE
Indicate compliance. Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

14. The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.

14. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

Submit

North Staffordshire Combined Healthcare NHS Trust

REPORT TO TRUST BOARD **Enclosure 14.1**

Date of Meeting:	25 September 2014
Title of Report:	NHS Trust Development Authority (NTDA) – Oversight Ratings and guidance.
Presented by:	Chris Calkin, Interim Director of Finance
Author of Report: Name: Date: Email:	 Glen Sargeant, Head of Performance and Information 12 September 2014 glen.sargeant@northstaffs.nhs.uk
Purpose / Intent of Report:	Information and assurance
Executive Summary:	This report presents the monthly NTDA Oversight Ratings that are prepared by the TDA and discussed during its Integrated Delivery Meetings with the Trust. These meetings form a key part of the TDA's Accountability Framework for NHS Trust Boards. The Oversight Ratings provide each NHS Trust with an overall risk rating, from 1 (high risk) to 5 (lower risk). Based on the latest data provided by the TDA (June 2014) this Trust is currently rated as 4, which is the second lowest risk category achievable. We continue to work towards achieving level 5 (there are still a few data quality issues in the quality score domains that are being addressed). The report contains a summary of the Trust's current rating and details of the breakdown, together with a copy of the TDA's guidance document. A copy of the latest summary will be presented to each Board meeting in future for assurance purposes, contained within the main Performance Report.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Clinical, Finance and Governance. There is no direct impact on patients or the public.

Relationship with Annual Objectives:	Delivery of high quality, evidence based services.
Risk / Legal Implications:	None
Resource Implications:	None identified
Equality and Diversity Implications:	None identified
Relationship with Assurance Framework [Risk, Control and Assurance]	None
Recommendations:	The Board is asked to : • Receive the report.

Oversight and Escalation slide

Trust Development Authority
Quality. Delivery. Sustainability.

North Staffordshire Combined Healthcare NHS Trust - June 2014

Quality Score	Finance Score	Sustainability
5 - Standard Oversight	GREEN	4 - Standard Oversight

Responsiveness Domain Score - 5

Effectiveness Domain Score - 3

Safe Domain Score - 5

Caring Domain Score - 5

Well Led Domain Score - 4

In Year Finance

Chief Inspector Outcome

No Visit Scheduled

Oversight and Escalation Score (Level 4) - Standard Oversight

Outcome of moderation meeting

The Oversight and Escalation score is 4 which is predominantly driven by a small number of quality, finance and sustainability concerns.

Quality: The Trust is below standard for one of the Care Programme Approach indicators.
Finance: The Trust is rated green due to the forecast surplus position in line with plan and a small shortfall on recurrent cost improvement plans.
Sustainability: Work to review core clinical pathways and develop the clinical strategy is underway with commissioners and key stakeholders. This will further inform the longer term sustainability of the Trust.

Month	April 2014	May 2014	June 2014	July 2014	August 2014	September 2014	October 2014	November 2014	December 2014	January 2015	February 2015	March 2015
Score	4	4	4									

Quality and Performance Summary

North Staffordshire Combined Healthcare NHS Trust

Responsiveness | Effectiveness | Safe Domain | Caring Domain | Well Led Domain

North Staffordshire Combined Healthcare NHS Trust - June 2014 Quality Score 5

Responsiveness Domain Score = 5

Metric	Standard	July 2013	August 2013	September 2013	October 2013	November 2013	December 2013	January 2014	February 2014	March 2014	April 2014	May 2014	June 2014	This Months Assessment
Referral to Treatment Admitted	90													
Referral to TreatmentNon Admitted	95													
Referral to Treatment Incomplete	92													
Referral to Treatment Incomplete 52+ Week Waiters	0													
Diagnostic waiting times	1													
A&E All Types Monthly Performance	95													
12 hour Trolley waits	0													
Two Week Wait Standard	93													
Breast Symptom Two Week Wait Standard	93													
31 Day Standard	96													
31 Day Subsequent Drug Standard	98													
31 Day Subsequent Radiotherapy Standard	94													
31 Day Subsequent Surgery Standard	94													
62 Day Standard	85													
62 Day Screening Standard	90													
Urgent Ops Cancelled for 2nd time (Number)	0													
		Q2 2013/2014	Q2 2013/2014	Q2 2013/2014	Q3 2013/2014	Q3 2013/2014	Q3 2013/2014	Q4 2013/2014	Q4 2013/2014	Q4 2013/2014	Q1 2014/2015	Q1 2014/2015	Q1 2014/2015	
Proportion of patients not treated within 28 days of last minute cancellation	0													
Delayed Transfers of Care	7.5	5.44	3.75	4.07	3.44	3.11	4.11	4.06	4.2	5.21	4.04	4.62	4.51	4.51
The proportion of those on Care Programme Approach for at least 12 months who have had a CPA review within the	95	83.86	82.09	82.36	82.35	83.57	86.48	87.59	88.74	90.31				
The proportion of those on Care Programme Approach (CPA) who have had a HoNOS assessment in the last 12 months	90	82.19	81.53	81.63	82.49	83.76	86.4	87.8	88.66	90.24				
		Q2 2013/2014	Q2 2013/2014	Q2 2013/2014	Q3 2013/2014	Q3 2013/2014	Q3 2013/2014	Q4 2013/2014	Q4 2013/2014	Q4 2013/2014	Q1 2014/2015	Q1 2014/2015	Q1 2014/2015	
Receiving follow-up contact within 7 days of discharge	95	100	100	100	100	100	100	100	100	100				100
Admmissions to inpatient services who had access to Crisis Resolution	95	100	100	100	100	100	100	100	100	100				100
Category A8 Red 1 calls	75													
Category A8 Red 2 calls	75													
Category A19 calls	95													

North Staffordshire Combined Healthcare NHS Trust - June 2014 Quality Score 5

Effectiveness Domain Score = 3

Metric	Standard	July 2013	August 2013	September	October	November	December	January	February	March 2014	April 2014	May 2014	June 2014	This Months
Hospital Standardised Mortality Ratio (DFI)														
Deaths in Low Risk Conditions														
Hospital Standardised Mortality Ratio - Weekday														
Hospital Standardised Mortality Ratio - Weekend														
				October 2012 - September 2013			January 2013 - December 2013			January 2013 - December 2013				
Summary Hospital Mortality Indicator (HSCIC)														
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	TBC	0	0	0	0	0	0	0	0	0				0
		Q2 2013/2014	Q2 2013/2014	Q2 2013/2014	Q3 2013/2014	Q3 2013/2014	Q3 2013/2014	Q4 2013/2014	Q4 2013/2014	Q4 2013/2014	Q1 2014/2015	Q1 2014/2015	Q1 2014/2015	
IAPT - Proportion of people who complete treatment who are moving to recovery	50													

Quality and Performance Summary

Trust Development Authority

Quality. Delivery. Sustainability.

North Staffordshire Combined Healthcare NHS Trust

Responsiveness | Effectiveness | Safe Domain | Caring Domain | Well Led Domain

North Staffordshire Combined Healthcare NHS Trust - June 2014 Quality Score 5

North Staffordshire Combined Healthcare NHS Trust - June 2014 Quality Score 5

Safe Domain Score = 5

Metric	Standard	July 2013	August 2013	September 2013	October 2013	November 2013	December 2013	January 2014	February 2014	March 2014	April 2014	May 2014	June 2014	This Months Assessment
Clostridium Difficile - Variance from plan														
MRSA bactaraemias	0													
Never events	0													0
Serious Incidents rate	0.064 - 0.739	0.434	0.790	0.615	0.616	0.351	0.265	0.525	0.349	0.428	0.213			0.213
Patient safety incidents that are harmful	0	2.9	3.7	3.2	4.1	0.0	0.8	1.8	4.6	0.0	1.8	1.2		1.220
Medication errors causing serious harm	0 - 0	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000			0.000
CAS alerts	0								0					0
Maternal deaths	1													0
VTE Risk Assessment	95													
Percentage of Harm Free Care	95	96.3	97.5	94.29	97.37	97.18	97.18	94.2	96.25	96.1	94.12	98.53	95.95	95.95
Admissions to adult facilities of patients who are under 16 years of age	0	0	0	0	0	0	0	0	0					

North Staffordshire Combined Healthcare NHS Trust - June 2014 Quality Score 5

Caring Domain Score = 5

Metric	Standard	July 2013	August 2013	September 2013	October 2013	November 2013	December 2013	January 2014	February 2014	March 2014	April 2014	May 2014	June 2014	This Months Assessment
Inpatient Scores from Friends and Family Test	60													
A&E Scores from Friends and Family Test	46													
Complaints	TBC													
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Inpatient Survey Q 68 - Overall, I had a very poor/good experience	>1	Annual Survey Data												
Community Mental health: Q45 - Overall, how would you rate the care you received in the last 12 months	>1	Annual Survey Data												2

North Staffordshire Combined Healthcare NHS Trust - June 2014 Quality Score 5

Well Led Domain Score = 4

Metric	Standard	July 2013	August 2013	September 2013	October 2013	November 2013	December 2013	January 2014	February 2014	March 2014	April 2014	May 2014	June 2014	This Months Assessment
Inpatients response rate from Friends and Family Test	30													
A&E response rate from Friends and Family Test	20													
NHS Staff Survey: Percentage of staff who would recommend the trust as a place of work	36.8	Annual Survey Data												41.7
NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment	40.9	Annual Survey Data												50.7
Data Quality of Returns to HSCIC	96							94.4	94.4	93.9	88.4	88.7		88.7
Trust turnover rate	TBC	10.5	14.5	14.7	14.5	13.8	13.3	13.1	12.9	14.3	14.2	14.4		14.43
Trust level total sickness rate	TBC	3.3	3.4	3.6	4.7	4.6	5.1	4.1	4.8	3.9	3.1	4.0		4
Total Trust vacancy rate	TBC													
Temporary costs and overtime as % of total paybill	TBC													
Percentage of staff with annual appraisal	TBC	54.7	38.7	26.5	90.1	91.1	91.6	92.1	92.7	93.5	93.0	91.2		91.2

NHS Trust Development Authority

Delivering High Quality Care for Patients: The Accountability Framework for NHS Trust Boards

GUIDANCE NOTES

tda Trust Development Authority

Quality. Delivery. Sustainability.

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NHS
Trust Development Authority

Delivering High Quality Care for Patients: The Accountability Framework for NHS Trust Boards

TECHNICAL GUIDANCE

1. Introduction

1.1 In April 2013 the NHS Trust Development Authority published '*Delivering High Quality Care for Patients: The Accountability Framework for NHS Trust Boards'*. The document describes how the NHS Trust Development Authority will work with NHS Trusts on a day-to-day basis, how we will assess the progress NHS Trusts are making and how we will provide the development and support each organisation needs to meet the challenges that lie ahead.

2. The Oversight Model

2.1 The oversight model describes how we are going to work with NHS Trusts on a day-to-day basis, creating a clear and unambiguous Framework which describes what success looks like and what expectations we have of NHS Trusts to deliver for the patients and communities they serve. The model describes how NHS Trusts can expect to be assessed by the NHS Trust Development Authority, how they can expect to be held to account for what they have promised to deliver, and what indicators will be used to determine whether we believe an organisation is delivering high quality care.

2.2 The oversight model sits at the head of *Delivering High Quality Care for Patients: The Accountability Framework for NHS Trust Boards*, and has a clear focus on quality, delivery and sustainability.

2.3 The metrics we will measure against will give us a clear understanding of how well an organisation is delivering, the strength of governance arrangements that sit beneath their approach and the rigour they apply to delivering a sustainable business plan.

2.4 Our oversight model is designed to align as closely as possible with the broader requirements NHS Trusts will need to meet from commissioners and regulators.

2.6 The framework also reflects the requirements of the Care Quality Commission and the conditions within the Monitor licence - those on pricing, competition and integration – which NHS Trusts are required to meet. Finally, the structure of the oversight model reflects Monitor's proposed new Risk Assessment Framework and as part of oversight we will calculate shadow Monitor risk ratings for NHS Trusts. In this way the NHS Trust Development Authority is seeking to align its approach whenever possible with that of other organisations and to prepare NHS Trusts for the Foundation Trust environment.

3. Structure of Oversight and Escalation Model

3.1 The Oversight and & Escalation Model for 2013/14 was structured using the Monitor Risk Assessment Framework (RAF) approach. For 2014/15 it is recommended that the NTDA reports Oversight and Escalation on two parts 'quality and delivery' and 'finance and sustainability'. 'Quality and delivery' is to be sub-divided into five sections, one for each of the Chief Inspectorate of Hospitals (CIH) domains (Caring, Effective, Responsive, Safe and Well Led). In doing this the NTDA is adopting the holistic view of quality that includes what we may have traditionally termed "performance" indicators as measures of access to timely responsive care in line with the CIH approach. The NTDA will continue to use all the indicators used in the Monitor Risk Assessment Framework to ensure we continue to align our escalation model with that of Monitor. Monitor will continue to use their Risk Assessment Framework approach for 2014/5.

3.2 Finance and Sustainability are not part of the CIH inspection or CQC Risk Rating but are still a very important part of Oversight and Escalation and therefore will be reported as the second section of the Oversight and Escalation Model.

3.3 The NTDA will adopt a similar scoring system of the CQC where 1 is high risk and 5 is lower risk, to reduce the potential of any confusion that might arise if the NTDA was to continue with 5 being the highest risk. The NTDA will continue to use the term 'escalation levels' as opposed to 'bands' to retain the distinction between our assessment of risk and that of the CQC. There is no intention that Oversight and Escalation will attempt to replicate or estimate future CQC risk ratings.

3.4 The scorecard to support Oversight and Escalation will be re-designed to move away from one for acute, community, mental health and ambulance services, to a single scorecard as the increasing multifaceted provision of services by Trusts mean these are increasingly artificial differentiations

4. Selection of Indicators

4.1 The CQC use over 140 indicators in the construction of their Risk Ratings. The goal of the NTDA was to produce a list of between 30-40 metrics that can be assessed on a monthly basis to take an operational view as to the relative strengths and weaknesses of the NHS Trusts.

4.2 The fact that the NTDA takes this considered view of Trusts monthly means that it cannot rely solely on the CQC risk ratings, as these are to be produced quarterly. This is too infrequent for monitoring improvement and/or deterioration and agreeing levels of escalation and intervention

4.3 In developing the list of indicators the following factors were considered:

- NHS Mandate or Constitution Targets;
- Measures used by Monitor in the Risk Assessment Framework;
- Measures required to be published in the Trusts Quality Account, reflecting the Outcomes Framework measurements ;
- Measures that underpin the Patient Experience Headlines tool;
- Measures which impose no additional burden of data collection on Trusts;
- Measures for which data is routinely available;
- Measures which are part of current Oversight and Escalation and are considered worth retaining;
- Removing measures that were included in the Oversight and Escalation scorecard in 2013/14, but proved of little value due to the lack of data or the lack of adequate benchmarks, or that have been superseded by other indicators.

4.4 The proposed indicators for 2014/15 are listed in Annex A. Table 1 lists the new indicators to be introduced with a comment as to why they are being proposed.

4.5 The NTDA has included a number indicators this year that are captured annually from the staff survey and patient surveys, as they feature strongly in the CQC Risk Rating and were absent from the 2013/14 Oversight and Escalation Model. The testing process will focus on how these indicators are weighted in the creation of the trust escalation levels

Table 1: New indicators proposed for inclusion in 2014/15

Domain	Indicator	Comment
Caring	F&F test for A&E	Included as part of the CQC Risk Rating and Patient experience headline tool
	Complaints	Was part of 2013/14 but no data was available. In 2014/15 NTDA will receive data under an Memorandum of Understanding with PSHO or via a direct report from Trusts
	Inpatient Survey: Q68 Overall I had a very poor/good experience?	Included as part of the CQC Risk Rating and Patient experience headline tool
	Community Mental Health: Q45 Overall, how would you rate the care you have received in the last 12 months?	Included as part of the CQC Risk Rating and Patient experience headline tool
Effective	IAPT The proportion of people entering treatment against the level of need in the general population	Included as part of the NHS Outcomes
	IAPT – The proportion of people who complete treatment who are moving to recovery	Included as part of the NHS Outcomes
Responsive	Certification against compliance with requirements regarding access to health care for people with a learning disability	Included as part of the Monitor RAF
	12 hour trolley waits in A&E	Included as part of the NHS Constitution
	Minimising mental health delayed transfers of care	Included as part of the Monitor RAF
Safe	Proportion of reported patient safety incidents that are harmful	Included as part of the CQC Risk Rating
Well Led	NHS England Inpatients response rate from Friends and Family Test	Included as part of the CQC Risk Rating and Patient experience headline tool
	NHS England A&E response rate from Friends and Family Test	Included as part of the CQC Risk Rating and Patient experience headline tool
	Data Quality of Trust returns to the HSCIC	Included as part of the CQC Risk Rating
	NHS Staff Survey: Percentage of staff who would recommend the trust as a place of work	Included as part of the CQC Risk Rating, but split into a place to work and to receive treatment as separate indicators and Patient experience headline tool
	NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment	Included as part of the CQC Risk Rating, but split into a place to work and to receive treatment as separate indicators and Patient experience headline tool

4.6 The indicators proposed not to continue in 2014/15 from the 2013/14 Oversight and Escalation process are listed in Table 2, along with the reason why they are being discontinued.

4.7 Annex B lists those indicators that are in the CQC Risk Rating but that are not to be included in the Oversight and Escalation Model. The primary reason for non-inclusion is that the CQC have used multiple indicators on a topic, and a suitable indicator has been already included in the scorecard. Indicators have also been set aside where the required data is not available to the NTDA; this is particularly true of whistleblowing and other CQC collected data.

Table 2: Indicators not continuing in Oversight and Escalation in 2014/15

Domain	Indicator	Comment
Safe	WHO Surgical Checklist	Removed because not routinely available
	MSSA	Removed because no agreed standard and out of alignment with national guidance
	E Coli	Removed because no agreed standard and out of alignment with national guidance
Responsive	Access to liaison teams in A&E	From Monitor BGAF, removed because not routinely available and not included in the RAF for 2014/15
Effective	Expected recovery following completion of psychological therapy treatment	Removed because not routinely available
	Transfers of full term babies to neo-natal units	From Monitor BGAF, removed because not routinely available and not included in the RAF for 2014/15
	Caesarean section rates	From Monitor BGAF, removed because not routinely available and not included in the RAF for 2014/15
Caring	Carer voice	Removed because not routinely available
	Patient voice	Removed because not routinely available
Well Led	Board turnover	Removed because not routinely available
	Nurse to Bed ratio	Removed because no agreed standard

4.8 In order to ascertain the suitability of indicators a number of testing processes were undertaken prior to the final selection of indicators. This testing included an assessment of the appropriate denominators to use for organisations, as well as an assessment of the ability of a selected standard to differentiate performance levels appropriately.

5. Scoring Methodology

5.1 The approach to scoring the domains is described below. This general methodology is applied to all domains.

Step 1

5.2 Ascertain which services are provided by which organisations. It is important to understand this so that an assessment of whether a data return has not been submitted can be made. A principle is applied that where a data return is not submitted the relevant indicator is assessed as not achieved.

5.3 Step 2

5.4 Each indicator is assigned a weighting (range 1 to 10) to reflect the relevant importance of the indicator in that domain.

Step 3

5.5 A total weighted score is calculated for each domain dependent upon whether the indicator should be populated. This score will potentially be different for each organisation.

Step 4

5.6 Each indicator is assessed against the standard and is given a score of 0 if achieving the standard and 1 if not achieving. Each indicator score is then multiplied by the indicator weighting to give a weighted score (range 1 to 10). These scores are then summed to give an overall score.

5.7 Step 5

5.8 The overall score is then divided by the total weighted score and multiplied to give an overall percentage.

Step 6

5.9 The domain score is then allocated as per the table below.

Table 3: Domain scoring

Percentage Score	Domain Score
0 -20	5
20 – 40	4
40 – 60	3
60 – 80	2
> 80	1

Worked Example

5.10 A worked example of the scoring methodology is shown in table 3, using the responsiveness domain for an acute NHS Trust.

5.11 In this the case the maximum score the organisation can achieve is 78, which would happen if the organisation were failing the standard for each indicator against which it is being assessed.

5.12 Due to good performance against a large number of standards the organisation has achieved a weighted score of 19.

5.13 To calculate the performance percentage the Weighted score, in this case 19, is divided by the Maximum possible achievable score, in this case 78 and multiplied by 100 to give the Percentage Performance, the result in this case being 24.4%.

5.14 This process is repeated for each of the domains to generate domain level scores.

Table 4: Worked Example of Scoring Methodology

Responsiveness Domain — Example Performance

Metric	Standard	Weighting	Performance	Score	Achievable Score	Weighted Score
Referral to Treatment Admitted	90	10	92.72	>= Standard 0, < Standard 10	10	0
Referral to TreatmentNon Admitted	95	5	96.24	>= Standard 0, < Standard 5	5	0
Referral to Treatment Incomplete	92	5	93.1	>= Standard 0, < Standard 5	5	0
Referral to Treatment Incomplete 52+ Week Waiter	0	5	0	= Standard 0, > Standard 5	5	0
Diagnostic waiting times	1	5	0.46	<= Standard 0, > Standard 5	5	0
A&E All Types Monthly Performance	95	10	89.27	>= Standard 0, < Standard 10	10	10
12 hour Trolley waits	0	10	0	= Standard 0, > Standard 10	10	0
Two Week Wait Standard	93	2	84.73	>= Standard 0, < Standard 2	2	2
Breast Symptom Two Week Wait Standard	93	2	98.6	>= Standard 0, < Standard 2	2	0
31 Day Standard	96	2	97.64	>= Standard 0, < Standard 2	2	0
31 Day Subsequent Drug Standard	98	2	100	>= Standard 0, < Standard 2	2	0
31 Day Subsequent Radiotherapy Standard	94	2	99.38	>= Standard 0, < Standard 2	2	0
31 Day Subsequent Surgery Standard	94	2	97.06	>= Standard 0, < Standard 2	2	0
62 Day Standard	85	5	83.53	>= Standard 0, < Standard 5	5	5
62 Day Screening Standard	90	2	90.57	>= Standard 0, < Standard 2	2	0
Urgent Ops Cancelled for 2nd time (Number)	0	2	0	= Standard 0, > Standard 2	2	0
Proportion of patients not treated within 28 days of last minute cancellation	0	2	4.9	= Standard 0, > Standard 2	2	2
Delayed Transfers of Care	3.5	5	2.95	<= Standard 0, > Standard 5	5	0
Certification against compliance with requirements regarding access to health care for people with a learning disability	TBC	5		>= Standard 0, < Standard 5		
The proportion of those on Care Programme Approach for at least 12 months who have had a CPA review within the last 12 months	95	5		>= Standard 0, < Standard 5		
The proportion of those on Care Programme Approach (CPA) who have had a HoNOS assessment in the last 12 months	90	5		>= Standard 0, < Standard 5		
Receiving follow-up contact within 7 days of discharge	95	5		>= Standard 0, < Standard 5		
Admmissions to inpatient services who had access to Crisis Resolution	95	5		>= Standard 0, < Standard 5		
Category A8 Red 1 calls	75	10		>= Standard 0, < Standard 10		
Category A8 Red 2 calls	75	5		>= Standard 0, < Standard 5		
Category A19 calls	95	5		>= Standard 0, < Standard 5		
Total					78	19

Sum of weighted score	19 (a)	
Possible Achievable Score	78 (b)	
Percentage Performance	24.4	= (a / b) * 100

Percentage Performance	Domain Score
0 - < =20	5
>20 - <= 40	4
> 40 - <= 60	3
>60 - <= 80	2
> 80	1

5.15 These domain level scores are then summed to generate a quality score as per Table 4

Table 5: Overall Quality Score Allocation

Sum of Domain Scores	Overall Quality Score
5 – 10	2
10 – 15	3
15 – 20	4
20 - 25	5

5.16 The next stage of the process is to bring together all elements of the oversight and escalation process, quality and delivery, and finance, to generate an overall score.

5.17 The overall score is the result of a moderation process bringing together the rules-based scores for quality and delivery and finance along with other intelligence held by the NTDA. The moderation process will include the application of override rules for Mortality, Finance and some key performance indicators.

6. Technical Construction of Indicators

Caring Domain

Indicator	**Inpatient Scores from Family and Friends Test**
Additional Information	https://www.gov.uk/government/publications/nhs-friends-and-family-test-guidance-on-scoring-and-presenting-results-published
Data Source	Unify2 Monthly Extract – Friends and Family Test A&E and Inpatients
Period	Monthly
Standard	National Average Score calculated form March 2014 UNIFY2 return
Assessment Criteria	RAG Rating Criteria – Red if more than 3 Standard deviations below national average. Green for all other scores.

Indicator	**A&E Scores from Family and Friends Test**
Additional Information	https://www.gov.uk/government/publications/nhs-friends-and-family-test-guidance-on-scoring-and-presenting-results-published
Data Source	Unify2 Monthly Extract – Friends and Family Test A&E and Inpatients
Period	Monthly
Standard	National Average Score calculated from March 2014 UNIFY2 return
Assessment Criteria	RAG Rating Criteria – Red if more than 3 Standard deviations below national average. Green for all other scores.

Indicator	**Complaints**
Additional Information	
Data Source	
Period	
Standard	
Assessment Criteria	

Indicator	**Inpatient Survey Q68**
Additional Information	
Data Source	
Period	
Standard	
Assessment Criteria	

Indicator	**Community Mental Health Q45**
Additional Information	
Data Source	
Period	
Standard	
Assessment Criteria	

Indicator	**Mixed Sex Accommodation**
Additional Information	http://www.england.nhs.uk/statistics/tag/mixed-sex-accommodation/
Data Source	UNIFY 2 Monthly Extract – MSA Provider Return
Period	Monthly
Standard	Zero breaches
Assessment Criteria	RAG Rating Criteria: Red for all values greater than zero. Green for zero breaches. Non submission of data will result in a Red RAG rating

Effectiveness Domain

Indicator	**Summary Hospital-level Mortality Indicator (SHMI)**
Additional Information	http://www.hscic.gov.uk/SHMI
Data Source	HSCIC Quarterly SHMI publication
Period	Quarterly
Standard	High outlier on over dispersion model as per national reporting
Assessment Criteria	RAG Rating Criteria: Red for high outliers. Green for those within expected range and low outliers.

Indicator	**Hospital Standardised Mortality Rate (HSMR)**
Additional Information	http://www.drfosterhealth.co.uk/docs/HSMR_Toolkit_Version_7.pdf
Data Source	Dr Foster Intelligence
Period	Quarterly
Standard	High outlier on Dr Foster methodology
Assessment Criteria	RAG Rating Criteria: Red for high outliers. Green for those within expected range and low outliers.

Indicator	**Hospital Standardised Mortality Rate (HSMR)**
Additional Information	http://www.drfosterhealth.co.uk/docs/HSMR_Toolkit_Version_7.pdf
Data Source	Dr Foster Intelligence
Period	Quarterly
Standard	High outlier on Dr Foster methodology
Assessment Criteria	RAG Rating Criteria: Red for high outliers. Green for those within expected range and low outliers.

Indicator	**30 day re-admissions**
Additional Information	http://www.indicators.ic.nhs.uk/webview/
Data Source	Hospital Episode Statistics
Period	Monthly
Standard	
Assessment Criteria	RAG Rating Criteria:

Indicator	**Delayed transfers of care**
Additional Information	**www.england.nhs.uk/statistics/taf/delayed-transefers-of-care/**
Data Source	UNIFY2 Monthly extract – Delayed Transfers of Care UNIFY 2 Quarterly extract – Bed availability and occupancy (KH03), Quarterly non consultant beds (QNC)
Period	Monthly
Standard	Acute Trusts 3.5% Non Acute Trusts 7.5%
Assessment Criteria	RAG Rating Criteria: Red if exceeding the applicable standard, Green for all other scores

Indicator	**IAPT Proportion of people who complete treatment who are moving to recovery**
Additional Information	**www.england.nhs.uk/statistics/taf/delayed-transefers-of-care/**
Data Source	
Period	
Standard	
Assessment Criteria	

NHS Trust Development Authority

Responsiveness Domain

Indicator	A&E 4 hour waiting time (All types)
Additional Information	http://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/
Data Source	UNIFY 2 Weekly Extract – Weekly A&E Sitrep Extracts
Period	Monthly (aggregated from weekly data)
Standard	95%
Assessment Criteria	RAG Rating Criteria: Red rating if below standard. (Rounding to 2 decimal places)

Indicator	A&E 12 hour trolley waits
Additional Information	http://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/
Data Source	UNIFY 2 Weekly Extract – Weekly A&E Sitrep Extracts
Period	Monthly (aggregated from weekly data)
Standard	Zero tolerance
Assessment Criteria	RAG Rating Criteria: Red for all values greater than zero. Green for zero breaches. Non submission of data will result in a Red RAG rating

Indicator	**18 weeks admitted pathways**
Additional Information	http://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/
Data Source	UNIFY 2 Monthly Extract – RTT Monthly Adjusted Performance
Period	Monthly
Standard	90%
Assessment Criteria	RAG Rating Criteria: Red for all values below standard. Green for all values above standard. Non submission of data will result in a Red RAG rating

Indicator	**18 weeks non admitted pathways**
Additional Information	http://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/
Data Source	UNIFY 2 Monthly Extract – RTT Monthly Non Admitted Performance
Period	Monthly
Standard	95%
Assessment Criteria	RAG Rating Criteria: Red for all values below standard. Green for all values above standard. Non submission of data will result in a Red RAG rating

Indicator	**18 weeks Incomplete pathways**
Additional Information	http://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/
Data Source	UNIFY 2 Monthly Extract – RTT Monthly Incomplete Performance
Period	Monthly
Standard	92%
Assessment Criteria	RAG Rating Criteria: Red for all values below standard. Green for all values above standard. Non submission of data will result in a Red RAG rating

Indicator	**18 weeks – Over 52 Week Waiters**
Additional Information	http://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/
Data Source	UNIFY 2 Monthly Extract – RTT Monthly Extract
Period	Monthly
Standard	Zero Tolerance
Assessment Criteria	RAG Rating Criteria: Red for all values greater than zero. Green for zero breaches

Indicator	**Number of diagnostic tests waiting longer than 6 weeks**
Additional Information	**http://transparency.dh.gov.uk/2012/07/05/diagnostics-information/**
Data Source	UNIFY 2 Monthly Extract – DM01 Monthly return
Period	Monthly
Standard	1%
Assessment Criteria	RAG Rating Criteria: Red for all values greater than standard. Green for all values below standard. Non submission of data will result in a Red RAG rating

Indicator	**Cancelled Operations not re-booked in 28 days**
Additional Information	**http://www.england.nhs.uk/statistics/cancelled-elective**
Data Source	UNIFY 2 Quarterly Extract – Cancelled Elective Operations (QMCO)
Period	Monthly
Standard	Zero Tolerance
Assessment Criteria	RAG Rating Criteria: Red for all values greater than zero. Green for zero breaches

Indicator	**Urgent Operations cancelled for the 2nd time**
Additional Information	http://transparency.dh.gov.uk/files/2012/07/MSitReps-Guidance-v1.051.doc
Data Source	UNIFY 2 Monthly Extract – Monthly Sitreps
Period	Monthly
Standard	Zero Tolerance
Assessment Criteria	RAG Rating Criteria: Red for all values greater than zero. Green for zero breaches

Indicator	**62-day urgent GP referral to treatment from screening**
Additional Information	http://transparency.dh.gov.uk/cancer-waiting-times/
Data Source	Open Exeter Database Monthly Extract
Period	Monthly
Standard	90%
Assessment Criteria	RAG Rating Criteria: Red for all values lower than standard. Green for all values above standard. Non-submission of data will result in a Red RAG rating. Organisations with less than 10 cases in a calendar month are excluded from assessment.

Indicator	**62-day urgent GP referral to treatment for all cancers**
Additional Information	http://transparency.dh.gov.uk/cancer-waiting-times/
Data Source	Open Exeter Database Monthly Extract
Period	Monthly
Standard	85%
Assessment Criteria	RAG Rating Criteria: Red for all values lower than standard. Green for all values above standard. Non-submission of data will result in a Red RAG rating. Organisations with less than 10 cases in a calendar month are excluded from assessment.

Indicator	**31-day second or subsequent treatment (surgery)**
Additional Information	http://transparency.dh.gov.uk/cancer-waiting-times/
Data Source	Open Exeter Database Monthly Extract
Period	Monthly
Standard	94%
Assessment Criteria	RAG Rating Criteria: Red for all values lower than standard. Green for all values above standard. Non submission of data will result in a Red RAG rating. Organisations with less than 10 cases in a calendar month are excluded from assessment.

Indicator	**31-day second or subsequent treatment (drug)**
Additional Information	http://transparency.dh.gov.uk/cancer-waiting-times/
Data Source	Open Exeter Database Monthly Extract
Period	Monthly
Standard	98%
Assessment Criteria	RAG Rating Criteria: Red for all values lower than standard. Green for all values above standard. Non-submission of data will result in a Red RAG rating. Organisations with less than 10 cases in a calendar month are excluded from assessment.

Indicator	**31-day second or subsequent treatment (drug)**
Additional Information	http://transparency.dh.gov.uk/cancer-waiting-times/
Data Source	Open Exeter Database Monthly Extract
Period	Monthly
Standard	98%
Assessment Criteria	RAG Rating Criteria: Red for all values lower than standard. Green for all values above standard. Non-submission of data will result in a Red RAG rating. Organisations with less than 10 cases in a calendar month are excluded from assessment.

Indicator	31-day second or subsequent treatment (radiotherapy)
Additional Information	http://transparency.dh.gov.uk/cancer-waiting-times/
Data Source	Open Exeter Database Monthly Extract
Period	Monthly
Standard	94%
Assessment Criteria	RAG Rating Criteria: Red for all values lower than standard. Green for all values above standard. Non-submission of data will result in a Red RAG rating. Organisations with less than 10 cases in a calendar month are excluded from assessment.

Indicator	31-day wait from diagnosis to treatment
Additional Information	http://transparency.dh.gov.uk/cancer-waiting-times/
Data Source	Open Exeter Database Monthly Extract
Period	Monthly
Standard	96%
Assessment Criteria	RAG Rating Criteria: Red for all values lower than standard. Green for all values above standard. Non-submission of data will result in a Red RAG rating. Organisations with less than 10 cases in a calendar month are excluded from assessment.

Indicator	**14-day GP referral to 1st outpatient, suspected cancer**
Additional Information	http://transparency.dh.gov.uk/cancer-waiting-times/
Data Source	Open Exeter Database Monthly Extract
Period	Monthly
Standard	93%
Assessment Criteria	RAG Rating Criteria: Red for all values lower than standard. Green for all values above standard. Non-submission of data will result in a Red RAG rating. Organisations with less than 10 cases in a calendar month are excluded from assessment.

Indicator	**14-day GP referral to 1st outpatient, breast symptoms**
Additional Information	http://transparency.dh.gov.uk/cancer-waiting-times/
Data Source	Open Exeter Database Monthly Extract
Period	Monthly
Standard	93%
Assessment Criteria	RAG Rating Criteria: Red for all values lower than standard. Green for all values above standard. Non-submission of data will result in a Red RAG rating. Organisations with less than 10 cases in a calendar month are excluded from assessment.

Indicator	**Receiving follow-up contact within 7 days of discharge**
Additional Information	http://transparency.dh.gov.uk/2012/06/21/mh-community-teams-activity-information/
Data Source	Unify2 Quarterly Extract – MH Provider Commissioner
Period	Quarterly
Standard	95%
Assessment Criteria	RAG Rating Criteria: Red for all values lower than standard. Green for all values above standard. Non-submission of data will result in a Red RAG rating.

Indicator	**Having formal review within 12 months**
Additional Information	http://www.hscic.gov.uk/mhmds/spec
Data Source	HSCIC Mental Health Minimum Dataset
Period	Quarterly
Standard	90%
Assessment Criteria	RAG Rating Criteria: Red for all values lower than standard. Green for all values above standard. Non-submission of data will result in a Red RAG rating.

Indicator	**The proportion of those on Care Programme Approach (CPA) for at least 12 months who had a HONOS assessment within the last 12 months**
Additional Information	http://www.hscic.gov.uk/mhmds/spec
Data Source	HSCIC Mental Health Minimum Dataset
Period	Quarterly
Standard	95%
Assessment Criteria	RAG Rating Criteria: Red for all values lower than standard. Green for all values above standard. Non-submission of data will result in a Red RAG rating.

Indicator	**Admissions to inpatient services that had access to Crisis Resolution/Home Treatment team**
Additional Information	http://transparency.dh.gov.uk/2012/06/21/mh-community-teams-activity-information/
Data Source	Unify2 Quarterly Extract – MH Provider Commissioner
Period	Quarterly
Standard	95%
Assessment Criteria	RAG Rating Criteria: Red for all values lower than standard. Green for all values above standard. Non-submission of data will result in a Red RAG rating.

Indicator	**Category A call – emergency response within 8 minutes, Red 1**
Additional Information	**http://transparency.dh.gov.uk/2012/06/19/ambqiguidance/**
Data Source	Unify2 Quarterly Extract – AmbSYS – Ambulance System Indicators v4
Period	Monthly
Standard	75%
Assessment Criteria	RAG Rating Criteria: Red for all values lower than standard. Green for all values above standard. Non-submission of data will result in a Red RAG rating.

Indicator	**Category A call – emergency response within 8 minutes, Red 2**
Additional Information	**http://transparency.dh.gov.uk/2012/06/19/ambqiguidance/**
Data Source	Unify2 Quarterly Extract – AmbSYS – Ambulance System Indicators v4
Period	Monthly
Standard	75%
Assessment Criteria	RAG Rating Criteria: Red for all values lower than standard. Green for all values above standard. Non-submission of data will result in a Red RAG rating.

Indicator	**Category A call – ambulance vehicle arrives within 19 minutes**
Additional Information	http://transparency.dh.gov.uk/2012/06/19/ambqiguidance/
Data Source	Unify2 Quarterly Extract – AmbSYS – Ambulance System Indicators v4
Period	Monthly
Standard	95%
Assessment Criteria	RAG Rating Criteria: Red for all values lower than standard. Green for all values above standard. Non-submission of data will result in a Red RAG rating.

Indicator	**Certification against compliance with requirements regarding access to health care for people with a learning disability**
Additional Information	
Data Source	
Period	
Standard	
Assessment Criteria	

Safe Domain

Indicator	**Incidence of Clostridium Difficile Infections – Year-to-date**
Additional Information	**http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HCAI/LatestPublicationsFromMandatorySurveillanceMRSACDIAndGRE/**
Data Source	Public Health England **(**Health Protection Agency HCAI Data Capture System)
Period	Monthly Year-to-date
Standard	Objectives set in planning round 2014/15
Assessment Criteria	RAG Rating Criteria: Red for all values above agreed objective. Green for all values equal to or less than objective.

Indicator	**Incidence of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia – Monthly**
Additional Information	**http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HCAI/LatestPublicationsFromMandatorySurveillanceMRSACDIAndGRE/**
Data Source	Public Health England **(**Health Protection Agency HCAI Data Capture System)
Period	Monthly
Standard	Zero tolerance
Assessment Criteria	RAG Rating Criteria: Red for all values above zero. Green for all values equal to zero.

Indicator	**Admissions to adult facilities of patients who are under 16 years of age**
Additional Information	http://www.hscic.gov.uk/mhmds/spec
Data Source	HSCIC Mental Health Minimum Dataset
Period	Quarterly
Standard	Zero tolerance
Assessment Criteria	RAG Rating Criteria: Red for all values above zero. Green for all values equal to zero.

Indicator	**Medication errors causing serious harm**
Additional Information	
Data Source	Strategic Executive Information System
Period	Monthly
Standard	Zero tolerance
Assessment Criteria	RAG Rating Criteria: Red for all values above zero. Green for all values equal to zero.

Indicator	**Harm free care (pressure sores, falls C-UTI and VTE)**
Additional Information	http://www.ic.nhs.uk/services/nhs-safety-thermometer
Data Source	HSCIC Safety Thermometer
Period	Monthly
Standard	95%
Assessment Criteria	RAG Rating Criteria: Red for all values below the standard. Green for all values above the standard. Non submission of data will result in a Red RAG rating

Indicator	**Serious Incidents**
Additional Information	
Data Source	Strategic Executive Information System
Period	Monthly
Standard	
Assessment Criteria	

Indicator	**Never Events**
Additional Information	
Data Source	Strategic Executive Information System
Period	Monthly
Standard	Zero Tolerance
Assessment Criteria	RAG Rating Criteria: Red for all values above zero. Green for all values equal to zero.

Indicator	**Patient Safety events that are harmful**
Additional Information	
Data Source	Strategic Executive Information System
Period	Monthly
Standard	Zero Tolerance
Assessment Criteria	RAG Rating Criteria: Red for all values above zero. Green for all values equal to zero.

Indicator	**Maternal deaths**
Additional Information	
Data Source	Strategic Executive Information System
Period	Monthly
Standard	Zero Tolerance
Assessment Criteria	RAG Rating Criteria: Red for all values above zero. Green for all values equal to zero.

Indicator	**VTE Risk Assessment**
Additional Information	**http://www.england.nhs.uk/statistics/tag/vte-2/**
Data Source	UNIFY2 Monthly Extract- VTE Risk Assessment
Period	Monthly
Standard	95%
Assessment Criteria	RAG Rating Criteria: Red for all values below the standard. Green for all values above the standard. Non submission of data will result in a Red RAG rating

Indicator	**Overdue CAS alerts**
Additional Information	**https://www.cas.dh.gov.uk/Home.aspx**
Data Source	Central Alerting System (CAS) website
Period	Monthly
Standard	Zero tolerance
Assessment Criteria	RAG Rating Criteria: Red for all values above zero. Green for all values equal to zero.

Well led Domain

Indicator	Inpatient Response rate from Family and Friends Test
Additional Information	https://www.gov.uk/government/publications/nhs-friends-and-family-test-guidance-on-scoring-and-presenting-results-published
Data Source	Unify2 Monthly Extract – Friends and Family Test A&E and Inpatients
Period	Monthly
Standard	30%
Assessment Criteria	RAG Rating Criteria: Red for all values below the standard. Green for all values above the standard. Non-submission of data will result in a Red RAG rating. Organisations not achieving the required response rate will be RAG rated Red on both response rate and score in the Effectiveness Domain.

Indicator	A&E Response rate from Family and Friends Test
Additional Information	https://www.gov.uk/government/publications/nhs-friends-and-family-test-guidance-on-scoring-and-presenting-results-published
Data Source	Unify2 Monthly Extract – Friends and Family Test A&E and Inpatients
Period	Monthly
Standard	20%
Assessment Criteria	RAG Rating Criteria: Red for all values below the standard. Green for all values above the standard. Non-submission of data will result in a Red RAG rating. Organisations not achieving the required response rate will be RAG rated Red on both response rate and score in the Effectiveness Domain.

Indicator	**Data Quality of returns to HSCIC**
Additional Information	
Data Source	
Period	
Standard	
Assessment Criteria	

Indicator	**NHS Staff Survey: Percentage of staff who would recommend the Trust as a place to work**
Additional Information	Annual inpatient survey
Data Source	
Period	Annual Survey
Standard	61%
Assessment Criteria	RAG Rating Criteria: Red for all values below standard. Green for all values above standard.

Indicator	**NHS Staff Survey: Percentage of staff who would recommend the Trust as a place to receive treatment**
Additional Information	Annual inpatient survey
Data Source	
Period	Annual Survey
Standard	67%
Assessment Criteria	RAG Rating Criteria: Red for all values below standard. Green for all values above standard.

Indicator	**Trust Turnover Rate**
Additional Information	The indicator is the percentage of leavers to the average of Staff in Post in the most recent month and from 12 months previous.
Data Source	ESR Data Warehouse
Period	Most recent available monthly data
Standard	N/A
Assessment Criteria	N/A

Indicator	**Trust level Total Sickness Rate**
Additional Information	The indicator is the number of sickness days recorded as a percentage of the total number of FTE days within the month
Data Source	ESR Data Warehouse
Period	Most recent available monthly data
Standard	N/A
Assessment Criteria	N/A

Indicator	**Total Trust vacancy Rate**
Additional Information	The Actual Total Workforce (WTE) as a percentage of the Planned Total Workforce (WTE)
Data Source	NTDA Workforce Data Collection
Period	Most recent available monthly data
Standard	N/A
Assessment Criteria	N/A

Indicator	**Temporary costs and overtime as a percentage of total paybill**
Additional Information	
Data Source	
Period	
Standard	
Assessment Criteria	

Indicator	**Percentage of staff with annual appraisal**
Additional Information	The Assignments with Completed Review in the last 12 months as a percentage of the Total Assignments
Data Source	NTDA Workforce Data Collection
Period	Most recent available monthly data
Standard	N/A
Assessment Criteria	N/A

7. Finance Indicators

8.1 The ten finance metrics used in 2013/14 have been revised to ensure that they focus on in year delivery against plan. This result of this review has been to remove three of the metrics relating to planned I&E and efficiency programmes and access to temporary borrowing with amendments made to the forecast I&E and access to permanent PDC for liquidity. The remaining seven metrics are individually RAG rated and then combined to give an overall finance RAG rating for the Trust.

Table 1: Individual Finance Risk Assessment Criteria

RAG rating and override rules for 2014/15

Ratings	Overall RAG Rating Criteria
REDs	Override - assessed as red on indicator 1a) OR has 3 or more other indicators assessed as red
AMBERs	Maximum of 2 indicators assessed as red from the remaining indicators OR 3 or more assessed as amber from the remaining indicators
GREENs	Maximum of 2 Amber, all other indicators are assessed as Green

Individual Indicators Risk Assessment Criteria

Indicator Number	Indicator description	Individual risk assessment criteria		
		Red	Amber	Green
1a)	Bottom line I&E position - Forecast compared to plan	FOT deficit or more than a 20% reduction in FOT surplus	Adverse variance that is a change in surplus between 5% and 20%	Positive variance or reduction giving a less than 5% change in surplus
1b)	Bottom line I&E position - Year to date actual compared to plan	More than a 20% reduction in surplus	Adverse variance that is a change in surplus between 10% and 20%	Positive variance or adverse variance giving a less than 10% change in surplus
2a)	Actual efficiency recurring/non-recurring compared to plan - Year to date actual compared to plan	Under delivery of efficiencies either in total or the recurring element of more than 20%	Under delivery of efficiencies either in total or the recurring element of up to 20%	Over delivery of efficiencies or breakeven
2b)	Actual efficiency recurring/non-recurring compared to plan - Forecast compared to plan	Under delivery of efficiencies either in total or the recurring element of more than 10%	Under delivery of efficiencies either in total or the recurring element of up to 10%	Over delivery of efficiencies or breakeven
3	Forecast underlying surplus/deficit compared to plan	Variance moves Trust to deficit or is more than a 20% reduction in planned surplus	Variance is 10% to 20% reduction in surplus	Positive variance or adverse variance is less than a 10% reduction in surplus
4	Forecast year end charge to capital resource limit	Forecast overspending capital programme or under spending by more than 20%	Forecast under spending capital programme by 10 - 20%	Forecast breakeven or under spend of less than 10%
5	Is the Trust forecasting permanent PDC for liquidity purposes?	Yes	-	No

8. Summary of Workforce, Paybill and Agency Spend

8.1 Below is a brief description of the information that is required to be submitted. Please note that in respect to all references to “plan” (both SIP and Paybill) within this guidance please submit the most recent Board agreed planned values.

SECTION A – CONTRACTED STAFF IN POST (FTE)

8.2 What section A should not include:

- Bank staff – these are captured in Section B
- Locums – these are captured in Section C
- Agency staff – these are captured in Section D

8.3 What section A should include:

- Should relate to contracted FTE only, and not to paid or worked hours.
- Should be based on the position on the last calendar day of the month. Highest/Lowest or averages should not be used; this will distort all the data and measure that are based on staff data, such as performance against plan, turnover and sickness absence.

Medical & Dental Guidance

8.4 Enter the number of all medical and dental staff including consultants and other career grades, all specialist registrars (registrars and senior registrars), SHOs and HOs, FY1 and FY2 doctors and other medical and dental Hospital Grades and locums, as defined within Matrix M of the NHS Occupation Code Manual v.12.

8.5 Include honorary consultants where they undertake some clinical activity.

8.6 Include all contracted medical and dental staff employed directly by the organisation even if they have locum in their job-title – the driver for inclusion in Section A is their contract. Medical and dental staff who do not have contracts should be included in Sections B, C, or D as appropriate for either Locum, Agency, or Bank staff.

of which - Medical and Dental Consultants

8.7 Enter the number of all HCHS medical and dental consultants in all specialties and employed directly by the organisation.

8.8 Include all contracted medical and dental consultants employed directly by the organisation even if they have locum in their job-title – the driver for inclusion in Section A is their contract.

8.9 Medical and dental staff consultants who do not have contracts with the organisation (i.e. those employed by NHS Professionals) should be included in Section C for Locum spend.

Ambulance Staff

8.10 Enter the number of ambulance staff as defined within Matrix A of the NHS Occupation Code Manual v.12.

Managers and Senior Managers

8.11 Enter the number of managers and senior managers as defined within Matrix G of the NHS Occupation Code Manual v.12.

Administration and Estates

8.12 Enter the number of administration and estates staff as defined within Matrix G of the NHS Occupation Code Manual v.12.

Support staff (including HCAs and other support staff)

8.13 Enter the number of all support staff including HCAs and those supporting maternity, and S, T & T as defined within Matrix H of the NHS Occupation Code Manual v.12.

All Qualified Nursing, Midwifery and Health Visiting Staff

8.14 Enter the number of all qualified HCHS nursing, midwifery and health visiting staff.

8.15 Enter the number of all qualified HCHS nursing, midwifery and health visiting staff as defined within Matrix N and P of the NHS Occupation Code Manual v.12.

All Qualified scientific, Therapeutic and Technical Staff

8.16 Enter the number of all qualified scientific, therapeutic and technical staff as defined within Matrix S and T of the NHS Occupation Code Manual v.12.

8.17 This should include Healthcare scientists, Allied Health Professions and other registered staff on the S and T Matrix.

Others

8.18 Enter the number of other staff not included above - all other staff (Z matrix) and nurse learners (P matrix).

SECTION B – BANK STAFF IN POST (FTE)

8.19 What section B should not include:

- Non-zero hours contracted staff – these are captured in Section A
- Locums including locums employed by NHS professionals – these are captured in Section C
- Agency staff – these are captured in Section D

8.20 What section B should include:

- Should relate to the hours worked by zero hours contracted bank staff only.
- Should reflect the total FTE equivalent of the bank staff hours worked during the month. Do not enter any other figure (i.e. number on the last day of the month, highest, lowest, average) as this will distort all the data and measures that are based on bank staff data such as performance against plan.

All medical and dental bank staff

8.21 Enter the FTE equivalent of the hours worked by all medical and dental bank staff including consultants and other career grades, all specialist registrars (registrars and senior registrars), SHOs and HOs, FY1 and FY2 doctors and other medical and dental Hospital Grades and locums.

8.22 Include honorary consultants where they undertake some clinical activity.

8.23 Include all medical and dental bank staff except for those locums employed via NHS Professionals – these should be captured under Section C.

of which - Medical and Dental Consultants

8.24 Enter the FTE equivalent of the hours worked by all HCHS medical and dental consultants in all specialties employed directly by the organisation.

8.25 Include all medical and dental consultant bank staff except for those locums employed via NHS Professionals – these should be captured under Section C.

Ambulance Staff

8.26 Enter the number of ambulance staff as defined within Matrix A of the NHS Occupation Code Manual v.12.

Managers and Senior Managers

8.27 Enter the number of managers and senior managers as defined within Matrix G of the NHS Occupation Code Manual v.12.

Administration and Estates

8.28 Enter the number of administration and estates staff as defined within Matrix G of the NHS Occupation Code Manual v.12.

Support staff (including HCAs and other support staff)

8.29 Enter the number of all support staff including HCAs and those supporting maternity, and S, T & T as defined within Matrix H of the NHS Occupation Code Manual v.12.

All Qualified Nursing, Midwifery and Health Visiting Staff

8.30 Enter the FTE equivalent of the hours worked by all qualified HCHS nursing, midwifery and health visiting bank staff. Enter the number of all qualified HCHS nursing, midwifery and health visiting staff as defined within Matrix N and P of the NHS Occupation Code Manual v.12.

All Qualified scientific, Therapeutic and Technical Staff

8.31 Enter the FTE equivalent of the hours worked by all qualified scientific, therapeutic and technical bank staff as per the census definition within S matrix and T matrix.

8.32 This should include Healthcare scientists, Allied Health Professions and other registered staff on the S and T Matrix.

Others

8.33 Enter the FTE equivalent of the hours worked by all staff not included above. All other staff (Z matrix) and nurse learners (P matrix)

SECTION C – LOCUM SPEND (FTE)

8.34 Enter the value of medical locum FTE.

SECTION D – AGENCY STAFF (FTE)

8.35 What section D should not include:

- Non-zero hours contracted staff – these are captured in Section A
- Bank staff – these are captured in Section B
- Locums – these are captured in Section C

8.36 What section D should include:

- Relate to the hours workforce by external agency staff only.
- Reflect the total FTE equivalent of agency staff hours worked during the month. Do not enter any other figure (i.e. number on the last day of the month, highest, lowest, average) as this will distort all the data and measures that are based on agency staff data such as performance against plan.

Medical & Dental

8.37 Enter the FTE equivalent of the hours worked by all medical and dental bank staff including consultants and other career grades, all specialist registrars (registrars and senior registrars), SHOs and HOs, FY1 and FY2 doctors and other medical and dental Hospital Grades and locums.

8.38 Include honorary consultants where they undertake some clinical activity.

8.39 Include all medical and dental agency staff except for those locums employed via NHS Professionals – these should be captured under Section C.

of which - Medical and Dental Consultants

8.40 Enter the FTE equivalent of the hours worked by all HCHS medical and dental consultants in all specialties employed directly by the organisation.

8.41 Include all medical and dental consultant bank staff except for those locums employed via NHS Professionals – these should be captured under Section C.

Ambulance Staff

8.42 Enter the number of ambulance staff as defined within Matrix A of the NHS Occupation Code Manual v.12.

Managers and Senior Managers

8.43 Enter the number of managers and senior managers as defined within Matrix G of the NHS Occupation Code Manual v.12.

Administration and Estates

8.44 Enter the number of administration and estates staff as defined within Matrix G of the NHS Occupation Code Manual v.12.

***Support staff (i*ncluding HCAs and other support staff)**

8.45 Enter the number of all support staff including HCAs and those supporting maternity, and S, T & T as defined within Matrix H of the NHS Occupation Code Manual v.12.

All Qualified Nursing, Midwifery and Health Visiting Staff

8.46 Enter the FTE equivalent of the hours worked by all qualified HCHS nursing, midwifery and health visiting bank staff. Enter the number of all qualified HCHS nursing, midwifery and health visiting staff as defined within Matrix N and P of the NHS Occupation Code Manual v.12.

All Qualified scientific, Therapeutic and Technical Staff

8.47 Enter the FTE equivalent of the hours worked by all qualified scientific, therapeutic and technical bank staff as per the census definition within S matrix and T matrix.

8.48 This should include Healthcare scientists, Allied Health Professions and other registered staff on the S and T Matrix.

Others

8.49 Enter the FTE equivalent of the hours worked by all staff not included above. All other staff (Z matrix) and nurse learners (P matrix).

SECTION E - PAYBILL (CUMULATIVE)

8.50 What section E should not include:

- Paybill data for Bank Staff (these are captured in Section F)
- Paybill data for Locums (these are captured in Section G)
- Paybill data for Agency staff (these are capture in Section H)

8.51 What section E should include:

- Paybill data for all staff in both Section A (FTE in post)
- All of the information in Section E should reflect the cumulative year to date position on the last calendar day of the month. Do not enter any other figure (i.e. in month only) as this will distort all the data and measures that are based on staff paybill and the assessment of performance against the plan.

8.52 As a general rule the cumulative paybill should rise for all groups in line with the actual SIP employed over the year. It should never normally decrease from one month to the next.

Medical & Dental

8.53 Enter the paybill for all medical and dental staff including consultants and other career grades, all specialist registrars (registrars and senior registrars), SHOs and HOs, FY1 and FY2 doctors and other medical and dental Hospital Grades and locums.

8.54 Include honorary consultants where they undertake some clinical activity.

of which - Medical and Dental Consultants

8.55 Enter the number of all HCHS medical and dental consultants in all specialties employed directly by the organisation.

Ambulance Staff

8.56 Enter the paybill for ambulance staff as defined within Matrix A of the NHS Occupation Code Manual v.12.

Managers and Senior Managers

8.57 Enter the paybill for managers and senior managers as defined within Matrix G of the NHS Occupation Code Manual v.12.

Administration and Estates

8.58 Enter the paybill for administration and estates staff as defined within Matrix G of the NHS Occupation Code Manual v.12.

Support staff (including HCAs and other support staff)

8.59 Enter the paybill for all support staff including HCAs and those supporting maternity, and S, T & T as defined within Matrix H of the NHS Occupation Code Manual v.12.

All Qualified Nursing, Midwifery and Health Visiting Staff

8.60 Enter the paybill for all qualified HCHS nursing, midwifery and health visiting staff as defined within Matrix N and P of the NHS Occupation Code Manual v.12.

All Qualified scientific, Therapeutic and Technical Staff

8.61 Enter the paybill for all qualified scientific, therapeutic and technical staff as defined within Matrix S and T of the NHS Occupation Code Manual v.12.

Others

8.62 Enter the paybill of other staff not included above - all other staff (Z matrix) and nurse learners (P matrix).

SECTION G – LOCUM SPEND

8.63 This section should detail the year to date actual locum spend and planned spend.

SECTION H - AGENCY SPEND (CUMULATIVE)

8.64 **What section E <u>should not</u> include:**

- Contracted staff – the paybill for these is captured in Section E
- Bank staff - these are captured in Section F
- Locums– these are captured in Section G

8.65 **What section E <u>should</u> include**:

- spend data for all agency staff
- Including all medical agency procurement made directly by a Trust or where NHS Professionals procured third party agency staff on a Trust's behalf. Please exclude expenditure made via NHS Professionals bank service.
- All of the information in Section H should reflect the cumulative year to date position on the last calendar day of the month. Do not enter any other figure (i.e. in month only) as this will distort all the data and measures that are based on agency spend and the assessment of performance against the plan.

8.66 As a general rule the cumulative agency spend rise for all groups in line with the actual numbers used over the year. It should never normally decrease from one month to the next.

<u>Medical and Dental</u>

8.67 For each month, enter the cumulative spend on external agency spend on HCHS medical and dental staff groups. This includes all medical agency procurement made directly by a trust or where NHS Professionals procured third party agency staff on a trust's behalf. It should exclude expenditure made via NHS Professionals bank service.

<u>Ambulance</u>

8.68 For each month, enter the cumulative spend on external Agency spend on ambulance staff . This includes all ambulance staff agency procurement made directly by a trust or where NHS professionals procured third party agency staff on a trust's behalf. It should exclude expenditure made via NHS Professionals bank service.

Administration and Estates

8.69 For each month, enter the cumulative spend on external agency spend on administration and estates staff. This includes all agency procurement made directly by a trust or where NHS professionals procured third party agency staff on a trust's behalf. It should exclude expenditure made via NHS Professionals bank service.

Healthcare Assistants and other support staff

8.70 For each month, enter the cumulative spend on external agency spend on healthcare assistants and support staff. This includes all support to clinical staff agency procurement made directly by a trust or where NHS Professionals procured third party agency staff on a trust's behalf. It should exclude expenditure made via NHS Professionals bank service.

Qualified Nursing, Midwifery and Health Visiting Staff

8.71 For each month, enter the cumulative spend on external agency spend on qualified nurses, midwives and health visitors. This includes all qualified nurse agency procurement made directly by a trust or where NHS Professionals procured third party agency staff on a trust's behalf. It should exclude expenditure made via NHS Professionals bank service.

Qualified scientific, Therapeutic and Technical Staff

8.72 This includes the cumulative spend on external agency spend on qualified S,T&Ts. This should include Healthcare scientists, Allied Health Professions and other registered staff on the S and T Matrix.

8.73 This includes all agency procurement made directly by a trust or where NHS Professionals procured third party agency staff on the trust's behalf. It should exclude expenditure made via NHS Professionals bank service.

Other Agency Spend

8.74 For each month, enter the cumulative spend on external agency spend on staff groups not covered in the above categories - managers and senior managers.

SECTION I VACANCY RATES:

!Definition - A vacancy is defined as a post which employers are actively trying to fill.
!Calculation - *Vacancy Rate* - Total vacancy rates are calculated using:

$$\frac{\text{Total Number of Full Time Equivalent Vacancies}}{\text{Total Funded or Budgeted Establishment (Staff in Post + Vacant posts)}}$$

8.75 Specific Staff Group Vacancy rates required displayed as a percentage for:

Medical (split by):

1. **Consultant**
2. **Career/Staff Grades** (to include)
   Medical staff who are neither consultant nor in training grades

Non-Medical (split by):

1. **Registered Nursing, Midwifery and Health visiting staff** (to include)
   - Acute, Elderly and General (adult nurses)
   - Community Services (including district nurses)
   - Registered Health Visitors
   - Education Staff
   - Health Visitors
   - Registered Midwives
   - Paediatric Nursing (Child nurses)
   - Psychiatry (MH nurses)
   - Learning Disabilities (LD nurses)
   - School Nurses
   - Other Nursing

2. **Allied Health Professionals** (to include)
   - Art/ Music/ Drama therapy
   - Chiropody / Podiatry
   - Dietetics
   - Occupational Therapy
   - Orthoptics / Optics
   - Physiotherapy
   - Radiography (Diagnostic)
   - Radiography (Therapeutic)
   - Speech and Language Therapy

3. **Scientific, Therapeutic and Technical Staff** (to include)
   - Clinical Psychology
   - Dental
   - IAPT
   - *Operating Theatre's / ODPs
   - Pharmacy
   - Pharmacy Technicians
   - Psychotherapy
   - Social Services (workers)
   - Other STT Staff
   - Clinical Engineering & Physical Sciences
   - Life Sciences / Pathology
   - Physiological Sciences

4. **Qualified Ambulance Service Staff** (to include)
   - Ambulance Paramedic
   - Ambulance Technician
   - Other Qualified Ambulance Staff

5. **Support to clinical staff** (to include)
   - Support to nursing staff
   - Support to STT & HCS staff
   - Support to ambulance staff
   - Other clinical support staff

SECTION J. APPRAISAL COMPLETION:

8.76 It is recommend for the calculation of this data that no exemptions are applied to the information including removal of those staff on maternity, new starters and long term sick. Consideration needs to be applied for seconded staff depending on the duration of secondment to another NHS organisation, i.e. where this exceeds a year.

Medical Appraisal – Current Validation Year:

8.77 This is the medical appraisal completion rate for the current validation year and should include all medical and dental staff who are employed substantively by the Trust.

Agenda for Change Appraisal completion (12 month rolling rate)

8.78 This is the number of appraisals completed for Agenda for Change contracted staff within the last 12 months and can be calculated by the following:

$$\frac{\text{Total Number of Appraisals Completed within last 12 months}}{\text{Total number of Agenda for Change Staff due Appraisal}}$$

SECTION K. ACCIDENT AND EMERGENCY STAFFING:

Medical Workforce Definitions	Non-Medical Workforce Definitions
Consultant – Include all consultant grade CTC doctors	**Assistant Practitioners –** Include all Assistant Practitioners working with ED
Training Grades:	**Qualified Nurses –** Include all RNs working with ED
SAS Grade – To include all associate specialist, staff grade/speciality doctor	**AHPs –** Include all AHPs working with ED, including Pharmacists, but excluding Paramedic
Registrar Group – Include all ST4-6	**Clinical Support –** Include all posts directly supporting those in clinical roles, but excluding Assistant Practitioners
Foundation – FY1 (if applicable), FY2 and CT Core Trainees	
GP (A&E) – Include all GPs working within ED	

Additional PA's

8.79 Please include all work directly relating to the prevention, diagnosis or treatment of illness that forms part of the services provided by the Trust. This includes emergency duties (including emergency work carried out during or arising from on-call); operating sessions including pre-operative and post-operative care; ward rounds; outpatient activities; clinical diagnostic work; other patient treatment; public health duties; multi-disciplinary meetings about direct patient care and administration directly related to the above (including but not limited to referrals and notes).

North Staffordshire Combined Healthcare NHS Trust

REPORT TO: **Trust Board** (open)

Date of Meeting:	25 September 2014
Title of Report:	Audit Committee Report
Presented by:	Mrs Bridget Johnson Acting Chair of Audit Committee
Author of Report: Name: Date: Email:	Sandra Storey, Trust Secretary / Head of Corporate & Legal Affairs/ Sandra Storey 15 September 2014 sandraj.storey@northstaffs.nhs.uk
Purpose / Intent of Report:	• For Assurance & Approval
Executive Summary:	This report provides a summary of the recent meeting of the Audit Committee held on 11 September 2014. Trust Board members are reminded that the full minutes and papers are available for inspection from the Trust Secretary / Head of Corporate and Legal Affairs.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Governance Strategy • Finance Strategy • Customer Focus
Relationship with Annual Objectives:	Relates to all annual objectives
Risk / Legal Implications:	N/A
Resource Implications:	N/A
Equality and Diversity Implications:	N/A
Relationship with Assurance Framework [Risk, Control and Assurance]	The Assurance Framework provides the Board with evidence to support the Statement of Internal Control.
Recommendations:	The Board is asked to • Receive and note the contents of this report • Ratify the policies highlighted in the report.

Audit Committee Summary Report to the September 2014 Trust Board of the meeting held on 11 September 2014

1. Audit Committee Terms of Reference

Mrs Storey asked committee members to consider a revision to its Terms of Reference. It was noted that the Audit Committee are required to review its Terms of Reference at least annually. The last review took place in September 2013. Following review by the committee it was agreed that no significant changes were required with the exception that the committee will review the process for signing off the Charitable Fund Accounts and the Charitable Funds Committee will hold responsibility for their approval prior to submission to the Trust Board.

In addition, given the change in portfolio for the Trust's Risk Management and CQC compliance arrangements, the Executive Director of Nursing & Quality or deputy will be invited to meetings to present these reports.

It was agreed that the Terms of Reference will be presented to the Trust Board to request formal ratification for a period of 12 months.

2. Audit Committee Annual Report 2013/14

Mrs Storey presented the committee's annual report for the period 2013/14, advising that the Audit Committee handbook recommends that each year the Audit Committee should produce an annual report to the Trust Board on action taken by the committee to satisfy its Terms of Reference. Committee members considered the draft report and agreed that it reflected the performance of the committee during 2013/14 particularly in terms of its responsibility to provide the Trust Board with assurances about the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the Trust. The report was approved for submission to the September 2014 Trust Board meeting.

3. Implementation of Audit Recommendations – Performance Management Report

On behalf of Mr Calkin, Mr Blaise provided the committee with a position statement, as at 04 September 2014 with regards to progress in the implementation of existing audit recommendations and progress being made against new audit recommendations.

It was noted that since the last report, 2 audit reports have been finalised relating to Local Counter Fraud services which resulted in 13 low to medium new recommendations with 7 of those already implemented at the time of the meeting.

In respect to existing recommendations, it was reported that 12 recommendations have been implemented since the last report and there were no high recommendations outstanding.

The committee also considered the outcome from 2 follow up audits. Of concern was the Audit review of the management arrangements for the Semperian/Carillion Contract. While it was confirmed that the majority of actions had evidence of completion, this showed that two actions reported to Committee as complete had not been completed. Mr Blaise explained this had happened due to staff changes and now formed part of a bigger contract review.

Committee members discussed the process for implementing audit recommendations and sought assurance that this was an exceptional set of circumstances because of the change of management and handover within the Estates function. As the director of internal audit, Mr Palethorpe advised that as part of any follow up audit, completed recommendations would be reviewed and that this had not been an issue previously.

Committee members remained concerned to learn that these particular actions were not complete having previously received confirmation that they had. They asked that the Senior Leadership Team take responsibility for ensuring the report sent to Audit Committee is accurate going forward. Mrs Storey stated that this is now a standing item at the newly formed Senior Leadership Team meeting and audit recommendations are closely monitored. It was also noted that these 2 recommendations had now been fully completed.

The discussion concluded that overall the position remains positive with good outcomes to audits and overall there remained a small number of recommendations outstanding.

4. Risk Management Strategy and Policy Assurance Report

On behalf of the Director of Nursing & Quality, Mrs Storey presented this report which provided the committee with assurance about the robustness of the Trust's risk management arrangements and review process.

It was noted that there had been no changes to the Risk Management Strategy since the last report to the committee in March 2014. The next review of the Strategy and Policy will take place in February 2015.

The committee were advised that the executive responsibility for risk now falls within the portfolio of the Executive Director of Nursing & Quality.

5. Healthcare Quality Standards Assurance Report

On behalf of the Director of Nursing & Quality, Mrs Storey provided the committee with information on the processes in place to monitor compliance with the healthcare quality standards defined by the Health and Social Care Act 2008.

The report described the 3 level CQC compliance framework which involves Team Visits, Team Self Assessment and Annual Declaration of compliance, and Corporate Self Assessment and annual declaration of compliance.

It was noted that Level 1 (Essential Standard Team Visits) had been completed for all teams for 2014/15. Level 2 (Team Self-Assessment and Annual Declaration of compliance) was noted to be progressing and will be repeated again in July 2015. Level 3 (Corporate Self-Assessment and Annual Declaration of Compliance) was noted to be scheduled for completion in September 2014, the outcome of which will be reported in the next report to the committee.

Committee members received the report for assurance purposes and were satisfied with the robustness of the process to monitor compliance with Healthcare Quality Standards.

6. Policy Review

Mrs Storey presented the **Trust's Scheme of Delegation** to the committee. Changes relating to revenue spending limits were supported by committee members for the posts of Director of Operations and Director of Strategy and Development so these could be aligned with the spending limits for Executive Directors.

The tendering, contracting and purchasing arrangements in respect to competitive quotations would remain unchanged at that time. Mr Blaise agreed to provide an analysis to the committee on the volume of spend for individual quotations.

Mr Blaise presented a **revised Anti-Bribery policy, Cash and Treasury Management policy, and Local Counter Fraud policy.** These were supported by the committee for ratification by the Trust Board.

7. Internal Audit progress report

Mr Palethorpe presented the committee with a progress summary against the Internal Audit Plan, noting the audits completed and those on plan to take place later in the financial year, all of which will help inform the Trust's Annual Governance Statement. This gave assurance to the committee that the plan is on schedule.

The committee also received informative briefings NHS News Briefing covering areas such as Culture and Leadership in the NHS, Care Act 2014, new approach to transactions, National Fraud Initiative.

8. Annual Audit Letter 2013/14

Mr Stanyer said that he was pleased to present the Annual Audit Letter which summarised their 2013/14 audit of the Trust. It was noted that they have issued:

- An unqualified opinion of the Trust's financial statements;
- There were no matters arising from the use of resources work;
- An unqualified Group Audit Assurance Certificate to the National Audit Office regarding the Whole

The Annual Audit Letter will be presented to the September 2014 Trust Board and published thereafter on the Trust's website.

9. Single Tender Waiver Report

Mr Blaise presented the approved single tender action requests that have been reported since the last committee meeting. It was noted that some of the waivers were of high value and Mr Blaise agreed to review the EU procurement limits and report back his findings to the committee.

10. Preparing for the National Fraud Initiative 2014/15

Mr Palethorpe informed the committee that the Trust was taking part in this initiative and that this work was being led by the Local Counter Fraud Team. The exercise matches electronic data within and between public and private sector bodies to prevent and detect fraud. This initiative has been run every two years since 1996, the outputs of which will be reported in January 2015.

11. Review of the Business of other Board Committees – Integrated Governance arrangements

The committee received the following summary business reports:

- *Quality Committee Meetings* – 20 May, 17 June and 15 July 2014;
- *Finance & Activity Committee Meetings* – 29 May, 26 June and 24 July 2014;
- *People and Culture Development Committee Meetings* – 23 May, 16 June and 21 July.

The committee noted that it would be helpful to receive the summaries from the Risk Management Committee meetings in future in order to provide further assurance to the committee on the Trust's risk management arrangements.

12. Cycle of Business

The Committee received the revised cycle of business and meeting dates for the coming year.

13. Next meeting

13 November 2014

On behalf of the Committee Chair
Sandra Storey
Trust Secretary / Head of Corporate and Legal Affairs
15 September 2014

North Staffordshire Combined Healthcare NHS Trust

Encl 16

REPORT TO: Trust Board

Date of Meeting:	25 September 2014
Title of Report:	Audit Committee Annual Report 2013/14
Presented by:	Bridget Johnson, Non Executive Director Acting Chair of the Audit Committee
Author of Report: Name: Date: Email:	Sandra Storey, Trust Secretary/Head of Corporate and Legal Affairs 02 September 2014 sandraj.storey@northstaffs.nhs.uk
Purpose / Intent of Report:	• For review and approval
Executive Summary:	The Audit Committee handbook recommends that each year the Audit Committee should produce an annual report to the Trust Board on action taken by the committee to satisfy its Terms of Reference. The report draws attention to the work that the committee has undertaken through the year, with input from internal and external audit, including reviewing its terms of reference, a review of its effectiveness, cycle of business and priority business areas. Committee members also undertook a self-assessment against the Audit Committee handbook to ensure that it was meeting its must do, should do, and could do requirements. The view of the committee is that assurances can be given to the Trust Board that the Audit Committee has discharged its duties in meeting its Terms of Reference during 2013-14.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Governance Strategy • Financial Strategy
Relationship with Annual Objectives:	Governance and Finance
Risk / Legal Implications:	The report has been produced to comply with statutory and legislative requirements
Resource Implications:	None
Equality and Diversity Implications:	None
Relationship with Assurance Framework [Risk, Control and Assurance]	The NHS Codes of Conduct and Accountability and the NHS Audit Committee Handbook require that an Audit Committee is established as a committee of the Trust Board to provide an independent and objective view on its financial systems, financial information and compliance with laws, guidance and regulations governing the NHS. The establishment and constitution of an Audit Committee is mandated by the Standing Orders of the Trust Board. This report provides the Trust Board with assurance that the Audit Committee has satisfied its terms of reference in this regard.
Recommendations:	For the Trust Board to receive this annual report and to satisfy itself that the Audit Committee has complied with its Terms of Reference

Audit Committee of North Staffordshire Combined Healthcare NHS Trust

Annual Report 2013/14

1. Purpose of the Report

The Audit Committee (the committee) has prepared this report to the Trust Board. It provides information about actions taken by the committee to satisfy its terms of reference in the financial year 1 April 2013 to 31 March 2014.

2. Background

The NHS Codes of Conduct and Accountability and the NHS Audit Committee Handbook require that an Audit Committee is established as a committee of the Trust Board to provide an independent and objective view on its financial systems, financial information and compliance with laws, guidance and regulations governing the NHS. The establishment and constitution of an Audit Committee is mandated by the Standing Orders of the Trust Board.

3. Governance, Establishment and Duties

Members of the committee are appointed by the Board from amongst the Non Executive directors of the Trust. There must be at least three members of the committee, one of whom is appointed by the Board to chair the committee. The Trust's audit chair has recent and relevant financial experience and is financially qualified. In complying with the Audit Committee Handbook, the Chairman of the Trust is not entitled to be a member of the committee and therefore does not attend any meetings. Information about membership and length of service on the committee is provided in table one.

The committee's terms of reference state that the Director of Finance and representatives of internal and external audit will normally attend meetings. It is the committee's current practice to invite the Trust Secretary, Assistant Director of Finance and the Head of Performance Management to be in attendance. Other Directors and Trust staff are invited to attend for the discussion of specific items of business. The committee receives support from the Trust Board Secretariat Team.

The committee's regular meetings usually begin with a private meeting between committee members and representatives from internal and external Audit. These meetings provide an opportunity for committee members and the auditors to discuss matters without any other persons being present and allow the committee to check that relationships between internal and external audit are effective.

The Audit Committee terms of reference were extensively revised in February 2006 to comply with the NHS Audit Committee Handbook issued in October 2005.

For the first time the committee was given specific responsibilities for providing assurance on the adequacy of the Trust's controls across the whole range of its activities. In accordance with good governance principles the terms of reference are reviewed annually. The most recent review was in October 2013 , minor revisions were made at this time and the terms of reference were subsequently ratified by the Trust Board for a further 12 months and will be reviewed again by 31 September 2014.

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

The minutes of the committee are formally recorded by a member of the Trust Board Secretariat Team and are available to all members of the Trust Board. A summary report to the Trust Board is prepared by the Trust Secretary on behalf of the committee chair after each meeting of the committee. The Chair of the committee, Director of Finance and Trust Secretary make sure that the report draws to the attention of the Board any issues that require disclosure to the full Board, or issues that require further discussion or executive action.

4. Audit Committee Effectiveness

There were seven committee meetings during the year. All committee meetings were quorate and attendance by internal and external audit was excellent. Information about attendance at the committee is provided in table two.

Members have discussed the effectiveness of the committee during the year. At the November 2013 meeting, Committee members reviewed the committee's performance against the terms of reference, which included discussing membership, frequency of meetings, duties, and in particular its relationship with other committees of the Board.

The NHS Audit Committee handbook sets out best practice in how Audit Committees should self-assess their own performance. The committee has previously completed the self-assessment checklist and concluded that it is meeting its must do, should do and could do requirements. This conclusion was supported by internal and external auditors who attend all Audit committee meetings. This work will be repeated during 2014/15.

The committee has a cycle of business which is ordered around its terms of reference. The cycle of business ensures that the committee receives the reports and assurance it needs to report to the Board in a timely manner. The committee reviews the cycle of business at each meeting to ensure that it is fit for purpose and adjustments are made as required.

5. Governance, Risk Management and Internal Control

The Audit Committee supports the Board by critically reviewing governance and assurance processes on which the Board places reliance. As such, the committee reviews the establishment and maintenance of the systems of governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical).

The committee received assurance reports on the processes for assessing **compliance in relation to Healthcare Quality Standards as defined by the Health and Social Care Act 2008**.

The Trust had a self-assessment methodology, which includes corporate self assessments and divisional self assessments to assess and monitor compliance with healthcare quality standards. A new compliance monitoring framework was approved by the Quality Governance Committee in January 2013 to replace the self-assessment process. This has been previously been subject to an audit by Baker Tilly. Auditors have been encouraged by the progress that the Trust has made in developing further the new control framework.

During the year much emphasis has been placed on overseeing **Internal Audit Recommendations** and considering reports in relation to audits completed to date, assurance levels and progress in the implementation of audit recommendations.

While there are a small number of audit recommendations currently outstanding, the committee noted that during the year the numbers outstanding are at their lowest level. Internal auditors have stated that this is a good outcome for the Trust and indicates that the Trust continues to take audit recommendations seriously. Work will continue during 2014/15 to maintain progress in this regard and ensure that target dates for completion of audits are achieved. The committee will focus its attention on high level actions and exception reporting and will advise the Board accordingly on areas that are underachieving and need close attention.

All NHS Trusts are required to maintain an **effective Assurance Framework.** The purpose of the Assurance Framework is to provide the Board with a tool for the effective and focussed management of the risks that threaten the delivery of their principal objectives. The current Assurance Framework was approved by the Board in April 2006 following an extensive review of the trust internal control systems.

The committee has again looked behind the framework in year to provide assurance to the Board that this process is still valid and suitable for the Board's requirements. The committee has received reports on the development and implementation of the Assurance Framework and has advised the Board on the adequacy of the framework and its operation. During 2013/14 the Assurance Framework reports to the committee (which are process focussed) were further strengthened to draw out more explicitly the gaps in control and assurance identified in the Assurance Framework and the agreed actions to address them. Presenting the report in this way has helped the committee to more easily identify issues and bridge to other more detailed performance reports.

During the year **an audit of the Assurance Framework** was undertaken as part of the internal audit periodic plan for 2013/14. The review sought to validate the design and application of the Assurance Framework in relation to ongoing development and maintenance. The audit gave a positive opinion and highlighted examples of strong practice to support the Trust's Annual Governance Statement. Of note is that the Assurance Framework is a network of interlinking documents that identifies key items of assurance that the Trust Board can place reliance on to support fulfilment of its principal objectives.

Auditors noted that the Trust Board has been appropriately engaged in developing and maintaining the Assurance Framework. This has been supported by the work of the Audit Committee who has overseen the maintenance of the Assurance Framework during the course of the year in accordance with its terms of reference.

As part of the **audit of the Assurance Framework an assurance stock take was also undertaken** to validate sources of assurance were actually in existence and that they were appropriate for the objectives against which they had been listed. Testing was performed and the audit gave a positive opinion and concluded that the assurances recorded within the Assurance Register of the Assurance Framework were in existence and up to date.

An **audit of the Trust's reporting structures and information** flows was undertaken by Trust auditors. The objective of the review was to ensure that the Trust has a robust governance structure in place supported by effective processes to demonstrate sound governance. The audit concluded that the Board can take substantial assurance that the controls upon which the organisation relies to manage this area are suitably designed, consistently applied and effective. Of note was that reports from the committee meetings are presented to the Board in a timely manner and was considered to be very good practice.

A component part of the Assurance Framework is the Trust's approach to **risk management.** Baker Tilly undertook an audit of the Trust's risk management arrangements during the course of the year and reported their findings to the Audit Committee. Their review concluded that the Trust has actively sought to develop its risk management framework over the last 12 months and changes outlined continue to be embedded into the framework and culture of the Trust. At a meeting of the Risk Management Committee in February 2014, the Risk Management Strategy and Policy were revised as part of their annual review. It was agreed that going forward the Risk Management Committee and the Trust Board would take a more forward look at risks rather than giving too much focus on considering them retrospectively.

The Audit Committee has received detailed reports on progress made during the year and has given assurance to the Trust Board about the arrangements in place and areas that will be developed over the next year (such as management of risk at divisional level overseen by the Trust's Risk Review Group.).

During 2013/14 Baker Tilly observed the Trust's Risk Review Group and based on their observations they reported in January 2014 that the Risk Review Group was well attended by the Executive Team and Divisions. It was noted that there was plenty of evidence around challenge, scrutiny and discussion of risk descriptions, risk scores and mitigating actions. Auditors concluded that they were encouraged by this and have been able to see the steps taken by management to ensure that Risk Management is embedded into the culture of the organisation.

Overall the Assurance Framework has given assurance to the committee that the organisation has a sound system of internal control with no significant control issues. All key components required by the Department of Health in respect to an Assurance Framework have been confirmed by auditors to be in place. Auditors have concluded that **"an Assurance Framework has been established which is designed and operating to meet the requirements of the 2013/14 Annual Governance Statement and provides reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation".**

In addition, based on the work undertaken in 2013/14 the draft Head of Internal Audit Opinion is that **"significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisations objectives and that controls are generally being applied consistently".** This has helped to inform the Trust's Annual Governance Statement 2013/14 which has been reviewed and approved by the committee as part of its cycle of business before review by the Board.

While there were no significant control issues, internal auditors did identify to the committee some control weaknesses and the committee has closely monitored the achievement of recommendations from audits and will continue to do so through its cycle of business during 2014/15.

During the year the reporting structures within the Trust have been further refreshed; key changes have included new membership for committees and the streamline of their terms of reference to ensure no gaps or unnecessary duplication in business across the committees.

During the year the committee has also received reports on **Information Governance (IG) Disclosures,** which have detailed the issues raised and the committee have sought assurance regarding learning points and action taken.

Reports on **Interests, Gifts and Hospitality** that have been declared have been scrutinised by the committee as part of its cycle of business.

The committee also received the proposed Project Plan to manage the **Quality Account 2013/14**, which included chronology of events and relevant guidance to give assurance to the Trust Board on the robustness of the processes behind the quality account.

During the year the committee has maintained its **relationship with the other board committees**. At each meeting the committee has considered the business of the other committees by reviewing their summary reports. This has helped to further identify any issues being raised, the assurances being derived from each committee and their value and reliability.

6. Financial Reporting

The committee reviews the **Annual Report and Financial Statements** before submission to the Board. The committee must also ensure that the systems for financial reporting to the Board, including those of budgetary control, provide complete and accurate information.

The committee received a report in March 2014 summarising the key milestones with the production of the 2013/14 **annual accounts.** The committee also received a report providing an update on the Trust's accounting policies seeking approval before the completion of the Accounts in April 2014.

The Committee noted that the DoH's Financial Reporting Manual (FREM) and International Reporting Standards (IFRS) require organisations to disclose information regarding their operating segments in accordance with reporting standards IFRS8. The committee approved the reporting of one **"provision of healthcare" segment with the 2013/14 Financial Statements.**

The Audit Committee subsequently reviewed the Accounts at its meeting on May 2014 and recommended their adoption by the Trust Board at its meeting in June 2014.

At each meeting of the Audit Committee the Director of Finance provides an update to the committee on the process to support achievement of the **cost improvement programme**. By doing so this gives assurance to the committee in respect to the robustness of the processes in place, e.g. the quality impact assessment process that is in place to ensure that that any plans do not adversely affect the quality of service provision.

During the year the committee received reports and discussed information in relation to:

- Trust's Two Year Operating Plan;
- Finance Shared Service internal audit reports – Executive summaries;
- Review of Standing Financial Instructions, Standing Orders and Scheme of Delegation;
- Trust's Transport Policy;
- Protocol for the management and review of audit reports;
- Review of other Trust Finance policies e.g. budgetary control and related issues, disposal of items surplus to requirements, official orders, patients property procedure, petty cash, security of assets, banking procedures, cash handling at ward level, losses and special payments
- Annual Accounts and Report 2012/13 – Charitable Funds
- Losses and special payment reports
- Single Tender/Competitive quotation waivers
- SFI Exception reports and retrospective requisitions

7. Internal Audit

The committee ensures that the Trust has an effective internal audit function that meets mandatory public sector Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. The scope of internal audit is the systematic review and evaluation of risk management, control and governance procedures that are put in place to achieve the principal objectives of the Trust.

The internal auditors for the Trust are Baker Tilly and the Head of Internal Audit for the year ended 31 March 2014 was Mr Glen Palethorpe. In March 2013 the committee received and approved the strategy for internal audit 2013/14. The plan also included flexible allocation to be used by the committee linked to key emerging risks of the Trust.

The draft plan was discussed with the Executive Team to confirm the linkages of their work with the Trust's objectives. The plan was also driven by the need to review key financial systems to ensure that continued external audit reliance is placed upon the work of internal audit.

In May 2013 the committee received Baker Tilly's annual report year ended March 2013, which acts as an overarching summary of their findings from their programme of work undertaken during the course of the year.

The committee has also overseen the conduct of the internal audit work undertaken by Baker Tilly in 2013/14. The committee requested improvements to controls arrangements where some weaknesses were identified following internal audit. Auditors have noted that overall the progress made by the Trust demonstrates the Trust's positive approach to the recommendations emanating from the work of internal audit.

In April 2013 the Trust received the draft annual internal audit opinion for the year ending March 2013. Based on the work undertaken in 2012/13 significant assurance was given that there was a sound system of internal control, designed to meet the organisation's objectives and that controls are generally being applied consistently. Some control weaknesses were identified though these issues did not require flagging as significant issues within the Trust's Annual Governance Statement 2012/13.

As part of the client service commitment, during 2013-14 auditors issued NHS sector client updates and general briefings. Auditors have also confirmed to the committee that their internal audit services comply with the NHS Internal Audit Standards.

7.1 Local Counter Fraud Specialists

In March 2013, a work plan for 2013/14 was approved by the committee which outlined core activities to be undertaken by the Local Counter Fraud Specialist (LCFS) during the financial year and related resources expected to enable such tasks as detailed in the plan to be delivered and completed successfully.

The committee has received regular progress reports throughout the year noting progress against the work plan, including counter fraud benchmarking data. The LCFS annual report 2012/13 was received by the committee at its meeting in May 2013. Highlights included much work being undertaken to enhance the anti-fraud culture through induction of new staff, team meetings, meeting staff during fraud awareness month and a review of a number of Trust policies and procedural documents.

The committee received the annual workplan for 2014/15 at its meeting in March 2014. The workplan is focussing on working alongside management and staff in targeting resources in areas which are considered at risk from fraud and bribery from occurring. The workplan is split into areas:

- Inform and involve
- Prevent and deter
- Hold to account
- Strategic governance.

Progress against these areas will be reported through to the committee during the course of 2014/15.

8. External Audit

The Trust's external auditors are appointed by the Audit Commission. The external auditor for 2013/14 was KPMG. Their Appointed Auditor was Mr Andrew Bostock.

The committee reviews the work and findings of the External Auditor and considers the implications and management's responses to their work. The committee considered and approved the external audit plan and fees for 2013/14.

The committee has received regular external audit progress reports which highlight work being carried out and planned activity.

In year the committee discussed KPMG's fee letter and external audit plan for the year, which has focussed on cost improvement delivery and financial performance.

The External Auditor is also required to produce an annual audit letter each year. The purpose of the audit letter is to advise the directors of the key issues arising from their work.

The final annual audit letter for 2012/13 was received by the committee in September 2013. An unqualified opinion was issued on the Trust's accounts in June 2013. In addition an unqualified opinion was issued on the use of resources. Following review by the committee, the Annual Audit Letter was presented to the September 2013 meeting of the Trust Board

In May 2013 the committee discussed and approved the ISA 260 audit memorandum relating to KPMG's audit of the Trust's 2012-13 financial statements. This concluded that the Trust had met its statutory financial duties in 2012/13 and delivered a CIP of £5.4m (7% of turnover), but also noting the challenge going forward.

As part of the audit of the financial statements KPMG also read the content of the annual report, including the Remuneration report, and reviewed the Trust's Annual Governance Statement. There key findings was that there are no unadjusted audit differences.

KPMG also undertakes a testing of the Trust's Quality Account and for the Quality Account 2012/13 this was completed in June 2013 and reported to the Audit Committee accordingly.

During the course of the year, KPMG also completed the Charitable Funds Audit 2012/13 with no significant issues.

The Trust is obliged to disclose the cost of work performed by the external auditor in the year to 31 March 2014.

The cost represents an overall 30% reduction compared to the previous audit year and is in line with the scale fee recommended by the Audit Commission. The fee was also in line with the fee agreed at the start of the year with the Trust's Audit Committee.

Audit Services	Statutory audit and services carried out in relation to the statutory audit (inc review of Quality Account).	£68,824 (ex vat)
	Charity Audit	£4,590 (ex vat)
Further Assurance Services	Services unrelated to the statutory audit where the Trust has discretion whether or not to appoint an auditor.	-
Other Services	Review of Quality Governance Assurance arrangements	£16,500) (ex vat)

Table 1: Membership 1 April 2013 – 31 March 2014

Name	Position	Appointed to the committee	Retired from the committee
Roger Carder	Committee Chairman	Member of committee from 09/10/2012, Chairman from 20/11/2012	July 2014
Tony Gadsby	Member	14/09/10	-
Judith Griffin	Member	13/03/12	September 2013
Bridget Johnson	Member Acting Chair from 10/10/2013	10/09/13	

Table 2: Attendance 1 April 2013 – 31 March 2014

Members:		09Apr 13	28May 13	10 Sept 13	10Oct 13	4 Nov 13	15 Jan 14	13Mar 14
Roger Carder	Member Chairman	√	√	√	×	×	×	×
Bridget Johnson	Member and Acting Chairman	-	-	√	√	√	√	√
Tony Gadsby	Member	√	√	√	√	√	√	√
Judith Griffin	Member	×	√	-	-	-	-	-
In attendance:								
Trish Donovan	Director of Finance	√	√	-	-	-	-	-
Kieran Lappin	Interim Director of Finance			√	√	√	√	√
Sandra Storey	Trust Secretary	√	×	√	√	√	√	√
Steve Blaise	Deputy Director of Finance	×	√	√	×	√	√	√
Baker Tilly / LCFS		√	√	√	√	√	√	√
KPMG		√	√	√	√	√	×	√

√ = Present / in attendance × = Apologies

<u>Document Change Control</u>

Version	Date	Author(s)	Description of Change
1.0	03/09/14	S Storey	First draft created.
1.1	14/09/14	S Storey	Final following Audit Committee meeting 11/09/14

REPORT TO: Trust Board (open)

Date of Meeting:	25 September 2014
Title of Report:	Audit Committee Terms of Reference
Presented by:	Mrs. B Johnson Acting Chair of the Audit Committee
Author of Report: Name: Date: Email:	Sandra Storey Trust Secretary / Head of Corporate and Legal Affairs 15 September 2014 Sandraj.storey@northstaffs.nhs.uk
Purpose / Intent of Report:	• For Approval
Executive Summary:	The Audit Committee are required to review its Terms of Reference at least annually. The last review took place at the Audit Committee meeting held on the 11 September 2014. There are no significant changes proposed to the Committee's Terms of Reference The purpose of this paper is to seek approval from the Trust Board of the Terms of Reference for the next 12 months.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Governance Strategy
Relationship with Annual Objectives:	Governance
Risk / Legal Implications:	To ensure that the Trust is complying with its Standing Orders
Resource Implications:	None identified as a result of this report
Equality and Diversity Implications:	None identified as a result of this report
Relationship with Assurance Framework [Risk, Control and Assurance]	Provides assurances that appropriate governance arrangements are in place
Recommendations:	For review and approval

AUDIT COMMITTEE

TERMS OF REFERENCE

Membership	▪ Not less that three Non-Executive Directors
Quorum	▪ Two Members
In Attendance	▪ Director of Finance ▪ External Audit ▪ Internal Audit ▪ Trust Secretary/Head of Corporate and Legal Affairs ▪ Director of Nursing & Quality or Deputy ▪ Deputy Director of Finance
Frequency of Meetings	▪ At least five meetings per year
Accountability and Reporting	▪ Accountable to the Trust Board ▪ Report to the Trust Board after each meeting ▪ Minutes of meetings available to all Trust Board members on request ▪ Annual report to Trust Board on actions taken to comply with terms of reference
Date of Approval by Trust Board	▪ 25 September 2014
Review Date	▪ By 25 September 2015

AUDIT COMMITTEE

TERMS OF REFERENCE

1. Constitution

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

2. Membership

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

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

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

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

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

In accordance with best practice as identified in the NHS Audit Committee Handbook, meetings shall be held not less than five times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

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

4. In Attendance

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

The Director of Finance, Trust Secretary/Head of Corporate and Legal Affairs, Director of Nursing & Quality or Deputy, Deputy Director of Finance, and appropriate Internal and External Audit representatives shall normally attend meetings. However, at least once a year the Committee will meet privately with the External and Internal Auditors.

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

5. Authority

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

6. Duties

<u>Governance, Risk Management and Internal Control</u>

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

In particular, the Committee will review the adequacy of:

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

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

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

Internal Audit

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

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

External Audit

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

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

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

Other Assurance Functions

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

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

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

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

Management

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

Financial Reporting

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

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

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

7. Accountability and Reporting Arrangements

The minutes of Committee meetings shall be formally recorded by the Trust Secretary or their deputy. Copies of the minutes of Committee meetings shall be available to all Trust Board members on request.

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

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

8. Sub-Committees and Reporting Arrangements

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

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

9. Compliance and Effectiveness

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

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

10. Administration

The Committee shall be supported administratively by the Trust Secretary, or their nominated deputy, whose duties in this respect will include:

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

11. Requirement for Review

The Terms of Reference will be reviewed at least annually by the committee for approval by the Trust Board and the next review must take place before 25 September 2015.

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: **OPEN TRUST BOARD**

Date of Meeting:	25 September 2014
Title of Report:	KPMG Annual Audit Letter 2013/14
Presented by:	Chris Calkin Interim Director of Finance
Author of Report: Name: Date: Email:	KPMG Report for North Staffordshire Combined Healthcare NHS Trust
Purpose / Intent of Report:	• For Information
Executive Summary:	This report was discussed at the Trust's Audit Committee on the 11 September 2014. The Annual Audit Letter 2013/14 summarises the findings arising from KPMG (external auditors) 2013/14 audit at the Trust. This report will be published on the Trust's website. The audit concluded that the Trust has generally sound processes in place for the production of the accounts and in relation to use of resources.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Governance Strategy • Workforce Strategy • Financial Strategy
Relationship with Annual Objectives:	To deliver the planned financial position and drive efficiencies
Risk / Legal Implications:	
Resource Implications:	
Equality and Diversity Implications:	
Relationship with Assurance Framework [Risk, Control and Assurance]	Provides assurance that the Trust has complied with its regularity requirements in that in all material respects the expenditure and income have been applied to the purposes intended by Parliament. Provides assurance that the Trust has complied with the DoH's requirements in the preparation of the Trust's Annual Governance Statement (AGS), and compliance with the Quality Account regulations.
Recommendations:	For the Trust Board to receive this Annual Audit Letter 2013/14 for information purposes.

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Our ref NSC Trust AAL/201314
Enclosure 18

18 July 2014

To the Directors of North Staffordshire Combined Healthcare NHS Trust

Annual Audit Letter 2013/14

We are pleased to submit our annual audit letter which summarises our 2013/14 audit for North Staffordshire Combined Healthcare NHS Trust ("the Trust"). It summarises the key issues arising from our 2013/14 audit at the Trust. Although this letter is addressed to the Directors of the Trust it is also intended to communicate the issues arising from the audit of the Trust to external stakeholders, such as members of the public. It is the responsibility of the Trust to publish this letter on the Trust's website at www.combined.nhs.uk.

Scope of our audit

The statutory responsibilities and powers of appointed auditors are set out in the Audit Commission Act 1998. Our main responsibility is to carry out an audit that meets the requirements of the Audit Commission's Code of Audit Practice ("the Code"). On the 3 June we presented our ISA 260 report to those charged with governance to the Audit Committee which summarised our conclusions from the 2013/14 audit and outlined our auditor responsibilities under statute and the Code. Following the presentation of our ISA 260 report to the Audit Committee we have:

- issued an unqualified opinion on the Trust's 2013/14 financial statements on 6 June meeting the Department of Health's deadline of 9 June;
- concluded that there were no matters arising from our use of resources work that we need to report for the year ended 31 March 2014;
- issued an unqualified Group Audit Assurance Certificate to the National Audit Office regarding the Whole of Government accounts submission with no exceptions.

Quality Accounts

At the Audit Committee on 3 June we highlighted the findings of our mandated work in regard to the Trust's Quality Accounts. The main conclusions can be summarised as:

- The Trust achieved a limited assurance opinion on compliance with the Quality Accounts Regulations.
- The Trust achieved a limited assurance opinion on consistency with other specified information.
- The Trust achieved a limited assurance opinion on the indicators in the quality account.

Public Interest Reporting

We have a responsibility to consider whether there is a need to issue a public interest report or whether there are any issues which require referral to the Secretary of State. There were no matters in the public interest that we needed to report or refer to the Secretary of State in 2013/14.

Key findings

The Trust has generally sound processes in place for the production of the accounts and in relation to use of resources. We raised one low priority recommendations relating to the application of fixed asset indexation. This is detailed within our ISA260 report to those charged with governance.

Fees

Our fee for the 2013/14 external audit was £68,824 excluding VAT. This included £10,000 for our review of the Trust's Quality Accounts. This was in line with the fee agreed at the start of the year with the Trust's Audit Committee.

Our fee for non audit services for 2013/14 was £16,500 excluding VAT. This related to a review of the Trust's quality governance systems and processes.

Closing remarks

I have discussed and agreed this letter with the Director of Finance of the Trust and confirmed that all Directors of the Trust have received a copy. I would like to thank the finance team, the Directors and the Audit Committee for their support and co-operation throughout the 2013/14 audit.

Yours sincerely

Andrew Bostock
Partner

North Staffordshire Combined Healthcare NHS Trust

REPORT TO: Trust Board

Date of Meeting:	25 September 2014
Title of Report:	Digital by Choice Programme
Presented by:	Andrew Hughes, Interim Director of Strategy
Author of Report: Name: Date: Email:	 Andrew Hughes 15 September 2014 Andrew.Hughes@northstaffs.nhs.uk
Purpose / Intent of Report:	To brief the Board of Directors on the predicted timescales for the Digital by Choice Programme and to advise on details for the Board Development Workshop on 8 October 2014.
Executive Summary:	The Board of Directors will be aware that the Trust is working to review its IT Strategy under the 'Digital by Choice' banner. Gwyn Thomas, an external consultant with very considerable expertise in the area, has been commissioned to support the work and timelines have been set for various phases of the programme. A Board Development Workshop will be held on 8 October 2014 and the Report provides the agenda for that session.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	IM&T Strategy Not directly as a result of this paper, however implementation of the strategy will lead to improved information.
Relationship with Annual Objectives:	To implement the clear priorities for the IT strategy and pro-actively take forward the outputs from the IT review to deliver high quality services and use technology as an enabler for high quality services.
Risk / Legal Implications:	Not directly as a result of this report
Resource Implications:	Resource implications, yet to be fully quantified, will arise as a result of ongoing implementation of the strategy.
Equality and Diversity Implications:	Not directly as a result of this report

Relationship with Assurance Framework [Risk, Control and Assurance]	Implementing the strategy will reduce risk associated with current IT systems
Recommendations:	The Board of Directors is asked to: • **RECEIVE** a briefing on the Digital by Choice Programme. • **UNDERSTAND** the timelines that have been set for the phases of the Programme. • **NOTE** the agenda for the Digital by Choice Workshop arranged for 8 October 2014.

Introduction and Purpose

01. The Board will be aware that the Trust is looking to review and refresh its existing IM&T Strategy under the *Digital by Choice* banner.

02. Gwyn Thomas, an external consultant with very significant expertise in the area (recently retired as Chief Information Officer for Wales) has been commissioned to support the Trust in this endeavour. In July he facilitated a workshop within the Trust, which was attended by a wide range of clinical and non-clinical staff and at which some key strategic, organisational and user requirements were agreed.

03. This Report has been prepared to brief the Board of Directors about the Programme, to describe the principal timelines that have been set, and to highlight the agenda that has been set for the Board Development Workshop on 8 October, which will be dedicated to *Digital by Choice*.

Digital by Choice

04. The agenda for the Board Development Workshop on 8 October 2014 is attached to this Report for information. The Board is invited to note that there is a clear and critical link to the strategic quality agenda, which was discussed at September's Board Development Workshop.

05. The Development Workshop will be taken as an opportunity to brief the Board more fully on the *Digital by Choice* agenda but, in summary, the aim is to drive a programme of change, informed by stakeholder engagement, that will deliver specific benefits to service users and efficient and safe care.

A Phased Approach

06. The Digital Strategy will be delivered through four parallel (i.e., concurrent not sequential) phases, as follows:

   i. **Credibility** (improving the present). This phase is expected to take three months, i.e., to be complete by the end of the calendar year, and will address day-to-day problems that are causing immediate frustration and inefficiency, such as slow or limited access and Wi-Fi connectivity. A 'Hit Squad' will be developed to respond to need and an initial audit.

   ii. **Confidence** (preparing for the future). This phase is expected to take six months, i.e., to be complete by the end of the financial year, and will tackle major operational issues that pose real or potential risks to care, such as incompatibility of software, poor or duplicate information.

   iii. **Commitment** (describing the future). This phase also is expected to take six months and will set the vision and strategic aims for the future in response to strategic, organisational and user requirements. The product will be a live *Digital Strategy* to replace the existing IM&T Strategy.

iv. **Change** (delivering the future). This final phase is likely to take at least two years to complete, i.e., until the end of the 2016 calendar year, and will comprise a portfolio of projects that respond to the strategic quality drivers and *Digital Strategy*.

Planning to Succeed

07. It is clear that the Trust will need both to organise for delivery, through a robust governance structure, and to invest in the skills and expertise to become an informed user. The potential resource implications will be discussed on 8 October.

08. There can be no doubting that this is a high priority for the organisation, however. The *Listening into Action* Big Conversations are reinforcing what has long been assumed – that colleagues are faced by inadequacies in existing information systems and processes that create a major encumbrance to efficient care. The scale of the organisation should enable us to be flexible and agile in our response to these frustrations and the aim of becoming a national exemplar for use of digital technology should be realised.

Recommendations

09. The Board is asked to:

- **RECEIVE** the briefing on the *Digital by Choice* Programme.
- **UNDERSTAND** the timelines that have been set for the phases of the Programme.
- **NOTE** the agenda for the *Digital by Choice* Workshop arranged for 8 October.

North Staffordshire Combined Healthcare NHS Trust

The Trust's *Digital by Choice* Strategy

Board of Directors' Development Workshop
8 October 2014

The Board Development Session will start at 1000. The first hour will be a catch up of key issues for the Board's information and attention.

***Digital by Choice* Workshop**

Time	Session	Lead
1100	To introduce the Board to the purpose and content of the day	Andrew Hughes
1105	**"Becoming a *Digital by Choice* Organisation"** To gain a shared understanding of the Trust's *Digital by Choice* Strategy. • Shortened version of the July workshop presentation.	Gwyn Thomas
1135	**"Progress Made so far"** To brief the Board on progress made with Phase One of the *Digital by Choice* Strategy	Chris Calkin
1150	**"Planning for the Future"** To explore the implications of the Strategic, Organisational and User requirements agreed at the July workshop (see below for details)	Gwyn Thomas
1210	Feedback and group discussion	Gwyn Thomas
1230	**"Our Offering to Service Users"** To ratify a set of specific "Propositions for Patients" for each of the four quality themes agreed at the September Board Development Workshop • access, • safety, • recovery • personalised care)	Andrew Hughes and Karen Wilson
1245	**Lunch**	

Time	Session	Lead
1315	Group Discussion, Feedback & Agreement	Andrew Hughes
1400	**"Organising for Delivery"** To present and seek Board agreement to the management processes covering • governance, and decision making • priorities & resources • engagement & communications to assure implementation within agreed timescales	Andrew Hughes
1430	**"What are we going to tell staff and patients?"** To agree communication messages, methods and responsibilities	Andrew Hughes
1440	Concluding remarks	Gwyn Thomas

NSCHT *Digital by Choice* Strategy

STRATEGIC REQUIREMENTS

We want to become a *Digital by Choice* organisation with a national reputation as a leader in the use of digital technology that enables

- the delivery of excellent care services
- service users and carers to recover;
- staff and partners to work together easily and effectively
- innovation in the delivery of healthcare services

ORGANISATIONAL REQUIREMENTS

As we move to become a *Digital by Choice* organisation, we will adopt the following core principles.

Our deployment of technology must be

- able to allow us to share information effectively with service users and partners
- fit-for-purpose for today and future-proofed for tomorrow
- delivered safely and on time.
- able to show value for money through standardisation

USER REQUIREMENTS

As we move to become a *Digital by Choice* organisation our technology will be

- Standardised so that it is easy for people to use
- Personalised to satisfy individual requirements
- Fast and accessible for everyone, providing the right information for staff and users
    - anytime,
    - anyplace,
    - anywhere,

    that care is delivered

North Staffordshire Combined Healthcare NHS Trust

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REPORT TO: Trust Board

Date of Meeting:	**25 September 2014**
Title of Report:	Compliance with Emergency Planning, Resilience and Response [EPRR] Self Assessment of Core Standards
Presented by:	Andy Rogers
Author of Report: Date: Email:	Kath Clark 29 August 2014 Kath.clark@northstaffs.nhs.uk
Purpose / Intent of Report:	**Approval by the Trust Board**
Summary of Report:	As part of the new health changes Trusts now have to follow the Emergency Preparedness. Resilience and Response [EPRR] Framework. A set of core standards for EPRR have been published and all organisations must demonstrate that they have plans in place and can deal with a wide range of incidents and emergencies. We have been requested to undertake a self assessment against these core competencies and provide an improvement plan. This has to be signed off by each organisation Trust Boards. The document was reviewed and agreed by the Quality Committee at its meeting on the 16 September 2014
Which Care Quality Commission domain does this relate to:	• Safe • Effective • Caring • Responsive to people's needs • Well led
Which Annual Objective does this relate to:	• Robust plans delivering quality and sustainable services

Risk / Legal Implications:	Civil Contingencies Act 2004
Resource Implications:	
Equality and Diversity Implications:	None known
Relationship with Assurance Framework [Risk, Control and Assurance]	NA
Recommendations:	The Trust Board is asked to approve the report and sign off before submission to the NHS England Area Team on the 26 September 2014

Introduction/Background

Following the reorganisation of the NHS under the Social Care Act 2013, NHS England published a set of Emergency Preparedness, Resilience and Response [EPRR] Core Standards.

The main aim was to clearly set out the minimum EPRR Standards expected of each organisation and provider of NHS funded care.

Of the core standards 31 are applicable to North Staffordshire Combine Healthcare NHS Trust.

The intention is that by requiring providers to comply with these standards the NHS will be in a position to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care.

Aim

In line with NHS England's requirements the purpose of this report is to present to the Board with

- A summary of compliance as at August 2014
- A statement of NSCHT compliance with the core standards
- An action plan outlining g how the gaps in compliance will be addressed
- The full self assessment

The Board is asked to

- Accept the self assessment results
- Approve the statement of compliance
- Approve and support the action plan to achieve full compliant with the EPRR Core Standards

Summary of Compliance as at August 2014

Out of the 31 Standards applicable to us:-

- 22 of the Standards are Green = fully compliant with core standard
- 8 are Amber =Not compliant but evidence of progress and in the EPRR work plan for the next 12 months

1 Core Standard has 8 subsections

- 5 are Amber
- 6 are Green

Statement of EPRR Compliance

The self assessment of EPRR Compliance indicates that's as August 2014 the Trust is fully compliant with 68% of Core Standards and 32% that are not compliant but evidence of progress and in the work plan for the next 12 months.

The Emergency Planning Team has been working with the CCU and has a 12 month plan in place to meet the outstanding core competencies.

The attached Action Plan details the areas that as a Trust we need to ensure compliance and we will be actively working with our CCU link manager to ensure not only our areas for improvement are achieved but that we maintain our status in relation to areas of current full compliance.

Conclusion

The Trust has made progress this year to embed its EPRR arrangements and has carefully assessed its compliance with the new EPRR core standards.

As a Trust we need to continue to build on the progress to date as we will be unable to achieve full compliance across all standards without the commitment and support of all staff at all levels of the organisation.

Recommendation

Quality Committee are asked to approve the report and improvement plan to enable them to be presented to the Trust Board for sign off before submission to the NHS England Area Team on the 26 September 2014

Kath Clark
Emergency Planning Lead

EPRR Core Standards Self-Assessment Improvement Plan

No	Detail of Standard	Requirement		Improvement Plan	Timelines
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Lessons identified from your organisation and other partner organisations. NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans to ensure that they reflect: - the undertaking of risk assessments and any changes in that risk assessment(s) - lessons identified from exercises, emergencies and business continuity incidents - restructuring and changes in the organisations - changes in key personnel - changes in guidance and policy		We need to be more robust in the management of EPRR across the organisation. Business continuity plans for each area need to be developed and we need to ensure review as services and key personnel change. We do review all incidences but this needs to include lessons learnt from emergencies and business continuity incidents. We will be providing a regular report to the Senior Leadership Team which will cover all the key headings of business continuity, emergency response , training exercises and risk	December 2014
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Arrangements are put in place for emergency preparedness, resilience and response which: • Have a change control process and version control • Take account of changing business objectives and processes • Take account of any changes in the organisations functions and/ or organisational and structural and staff changes • Take account of change in key suppliers and contractual arrangements • Take account of any updates to risk assessment(s) • Have a review schedule • Use consistent unambiguous terminology, • Identify who is responsible for making sure the policies and arrangements are updated, distributed and regularly tested; • Key staff must know where to find policies and plans on the intranet or shared drive. • Have an expectation that a lessons identified report should be produced following exercises, emergencies and /or business continuity incidents and share for each exercise or incident and a corrective action plan put in place. • Include references to other sources of information and supporting documentation		The working Group structure that we have had in place is not proving to be effective and requires review, therefore we are going to be altering the structure and the personnel involved. The Tactical Responders are our current on call managers and so therefore we are proposing that this Group of staff are brought together as the On Call Managers EPRR Operational Group. This will support us going forward and will be forum where the Emergency Planning Leads and CCU can ensure this work stream is achieved.	December 2014

No	Detail of Standard	Requirement		Improvement Plan	Timelines
4	The accountable emergency officer will ensure that the Board and/or Governing Body will receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) . Must include information about the organisation's position in relation to the NHS England EPRR core standards self assessment.		Introduction of regular report to the Senior Leadership Team which will cover all the key headings of business continuity, emergency response, training exercises and risk, this will be presented through Quality Committee to Trust Board.	December 2014
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	corporate and service level Business Continuity (aligned to current nationally recognised BC standards)		Meeting arranged with Emergency Planning Team and CCU to finalise Business Continuity Plans. Information has been collated from all areas and requires 'dropping in' to the new template	December 2014
		HAZMAT/ CBRN		We are awaiting further guidance, but we believe we need to further develop our plans to ensure that we have a process in place should we have someone self present at our reception or in one or our community settings	December 2014
		Pandemic Flu		SRF have issued a Draft Plan , once approved, local plans will be reviewed	Awaiting Staffordshire Resilience Plan to be reviewed.
		Lockdown		A plan will be through the new On Call Managers EPRR Operational Group	January 2015
		Utilities , IT and Telecommunications Failure		This will be addressed through the Business Continuity Planning	December 2014
11	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Decide: - Which activities and functions are critical - What is an acceptable level of service in the event of different types of emergency for all your services - Identifying in your risk assessments in what way emergencies and business continuity incidents threaten the performance of your organisation's functions, especially critical activities		Meeting arranged with Emergency Planning Team and CCU to finalise Business Continuity Plans. Information has been collated from all areas and requires 'dropping in' to the new template	December 2014

No	Detail of Standard	Requirement		Improvement Plan	Timelines
12	Arrangements explain how VIP and/or high profile patients will be managed.	This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management		This will be developed through the Review of the Major Incident Plan in conjunction with the Communication Team	December 2014
13	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content	Specify who has been consulted in the relevant document and plans		Please see 3 above	December 2014
23	Arrangements ensure the ability to communicate internally and externally during communication equipment failures	Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.		We have an internal IT disaster recovery plan. This will also be addressed though finalising the Business Continuity plans. We will be taking part in multi agency resilience planning and exercising	January 2015
27	Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.	Mutual aid agreements are wider than staff and should include equipment, services and supplies.		Multi agency mutual aid agreements are in place via the SRF. The Health Economy will be developing mutual aid agreements led by NHS England Area Team	To be agreed through the EPO Structure

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental healthcare providers	NHS England Area teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																		
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)		Y	Y	Y	Y	Y	Y	Y	Y			Y	• Ensuring accountaable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergeny Preparedness Resilience and Response, and Business Continuity Management agendas • Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible. • Appointing an emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles. • Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles. • Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes, strategies and action plans across the organisation. • That there is an approporiate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation.	**Andy Rogers - Director of Operations is the appointed Accountable Emergency Officer. (Job Description)**			
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Lessons identified from your organisation and other partner organisations. NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans to ensure that they reflect: - the undertaking of risk assessments and any changes in that risk assessment(s) - lessons identified from exercises, emergencies and business continuity incidents - restructuring and changes in the organisations - changes in key personnel - changes in guidance and policy	Y	Y	Y	Y	Y	Y	Y	Y			Y		**Report to Senior Leadership Team update of EPRR approval for Trust Board presentation in December 2014. (Report will cover the key headings of Business Continuity, Emergency Response, Training and Exercises and Risk).**	**To ensure quarterly report to Trust Board**	**Andy Rogers**	Dec-14
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Arrangements are put in place for emergency preparedness, resilience and response which: • Have a change control process and version control • Take account of changing business objectives and processes • Take account of any changes in the organisations functions and/ or organisational and structural and staff changes • Take account of change in key suppliers and contractual arrangements • Take account of any updates to risk assessment(s) • Have a review schedule • Use consistent unambiguous terminology, • Identify who is responsible for making sure the policies and arrangements are updated, distributed and regularly tested; • Key staff must know where to find policies and plans on the intranet or shared drive. • Have an expectation that a lessons identified report should be produced following exercises, emergencies and /or business continuity incidents and share for each exercise or incident and a corrective action plan put in place. • Include references to other sources of information and supporting documentation	Y	Y	Y	Y	Y	Y	Y	Y			Y		**The Working Group Structure previously used did not meet the requirements.**	**We will be formally closing the working group and moving to a EPRR Ops Group**	**Kath Clark**	Dec-14
4	The accountable emergency officer will ensure that the Board and/or Governing Body will receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) . Must include information about the organisation's position in relation to the NHS England EPRR core standards self assessment.	Y	Y	Y	Y	Y	Y	Y	Y			Y		**See Response to Item Number 2.**	**See Response to Item Number 2**	**Andy Rogers**	Dec-14
Duty to assess risk																		
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver it's functions.	Risk assessments should take into account community risk registers and at the very least include reasonable worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment (including denial of access); • fuel shortages; • surges and escalation of activity; • IT and communications; • utilities failure; • response a major incident / mass casualty event • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites) There is a process to consider if there are any internal risks that could threaten the performance of the organisation's functions in an emergency as well as external risks eg. Flooding, COMAH sites etc.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments • Version control • Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages • Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans. • Sharing appropriately once risk assessment(s) completed	The National Risk Register is interpreted locally into the Community Risk Register this in turn is reviewed within the LHRP and then reviewed internally within the Trust (part of the Trust Risk Monitoring Group).		Andy Rogers	
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		See Response to Item Number 5 above.		Andy Rogers	
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Other relevant parties could include COMAH site partners, PHE etc.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		See Response to Item Number 5 above.		Andy Rogers	
Duty to maintain plans – emergency plans and business continuity plans																		
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Relevant plans: • demonstrate appropriate and sufficient equipment (inc. vehicles if relevant) to deliver the required responses • identify locations which patients can be transferred to if there is an incident that requires an evacuation; • outline how, when required (for mental health services), Ministry of Justice approval will be gained for an evacuation; • take into account how vulnerable adults and children can be managed to avoid admissions, and include appropriate focus on providing healthcare to displaced populations in rest centres; • include arrangements to co-ordinate and provide mental health support to patients and relatives, in collaboration with Social Care if necessary, during and after an incident as required; • make sure the mental health needs of patients involved in a significant incident or emergency are met and that they are discharged home with suitable support • ensure that the needs of self-presenters from a hazardous materials or chemical, biological, nuclear or radiation incident are met. • for each of the types of emergency listed evidence can be either within existing response plans or as stand alone arrangements, as appropriate.	MIP in place			
			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Meeting to develop and finalise BC plans	**EPO**	01-Dec-14
		HAZMAT/ CBRN	Y	Y	Y	Y	Y					Y			We would seek further advice on mental health input via the Command and Control Structure in place at the time.	To ensure a plan is in place to deal with self presentation within a community setting.(i.e. lockdown - MIP response).	**EPO**	Awaiting Staffordshire Reslience Plans to be reviewed
		Severe Weather (heatwave, flooding, snow and cold weather)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Plan in place			
		Pandemic Influenza	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		SRF issued Draft Plan.	Approved Staffordshire Plan will then review local plan.	**EPO**	Awaiting Staffordshire Reslience Plans to be reviewed
		Mass Countermeasures (eg mass prophylaxis, or mass vaccination)	Y	Y	Y	Y		Y	Y				Y		n/a			
		Mass Casualties	Y	Y	Y	Y		Y	Y				Y		n/a			
		Fuel Disruption	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Plan in place expecting further guidance. (SRF fuel plan in place)			
		Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care)	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y		Part of the Reslience, Demand and Capacity Groups within the local health economy.			
		Infectious Disease Outbreak	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y		Infection plans in place under the SLA with UHNS		**EPO**	
		Evacuation	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Evacuation Plan in Place.			
		Lockdown	Y	Y	Y	Y	Y	Y	Y			Y	Y		to develop plan		**Andy Rogers**	Dec-14
		Utilities, IT and Telecommunications Failure	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Developing BC plans see response above 8b			
		Excess Deaths/ Mass Fatalities	Y	Y	Y			Y	Y				Y		n/a			
		having a Hazardous Area Response Team (HART) (in line with the current national service specification, including a vehicles and equipment replacement programme)			Y										n/a			
		firearms incidents in line with National Joint Operating Procedures;			Y										n/a			
9	Ensure that plans are prepared in line with current guidance and good practice which includes:	• Aim of the plan, including links with plans of other responders • Information about the specific hazard or contingency or site for which the plan has been prepared and realistic assumptions • Trigger for activation of the plan, including alert and standby procedures • Activation procedures • Identification, roles and actions (including action cards) of incident response team • Identification, roles and actions (including action cards) of support staff including communications • Location of incident control centre (ICC) from which emergency or business continuity incident will be managed • Generic roles of all parts of the organisation in relation to responding to emergencies or business continuity incidents • Complementary generic arrangements of other responders (including acknowledgement of multi-agency working) • Stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • Contact details of key personnel and relevant partner agencies • Plan maintenance procedures (Based on Cabinet Office publication Emergency Preparedness, Emergency Planning, Annexes 5B and 5C (2006))	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Being able to provide documentary evidence that plans are regularly monitored, reviewed and systematically updated, based on sound assumptions: • Being able to provide evidence of an approval process for EPRR plans and documents • Asking peers to review and comment on your plans via consultation • Using identified good practice examples to develop emergency plans • Adopting plans which are flexible, allowing for the unexpected and can be scaled up or down • Version control and change process controls • List of contributors • References and list of sources • Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).	MIP includes all the identified bullet points in line with EPRR framework.			
10	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	Enable an identified person to determine whether an emergency has occurred - Specify the procedure that person should adopt in making the decision - Specify who should be consulted before making the decision - Specify who should be informed once the decision has been made (including clinical staff)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Oncall Standards and expectations are set out • Include 24-hour arrangements for alerting managers and other key staff.	All procedures in place			
11	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Decide: - Which activities and functions are critical - What is an acceptable level of service in the event of different types of emergency for all your services - Identifying in your risk assessments in what way emergencies and business continuity incidents threaten the performance of your organisation's functions, especially critical activities	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		See BC response in 8b			
12	Arrangements explain how VIP and/or high profile patients will be managed.	This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management	Y	Y	Y	Y	Y								Will develop in the MIP review		**EPO**	Jan-15
13	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Specifiy who has been consulted on the relevant documents/ plans etc.	See response to item number 3			
14	Arrangements include a debrief process so as to identify learning and inform future arrangements	Explain the de-briefing process (hot, local and multi-agency, cold)at the end of an incident.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		See MIP plan and part of the LHRP (NHS England) response. Multi Agency under SRF responsibility			
Command and Control (C2)																		
15	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	Organisation to have a 24/7 on call rota in place with access to strategic and/or executive level personnel	Y	Y	Y	Y	Y	Y	Y	Y			Y	Explain how the emergency on-call rota will be set up and managed over the short and longer term.	In place - on call rotas can be provided for both Strategic and Tactical.			
16	Those on-call must meet identified competencies and key knowledge and skills for staff.	NHS England publised competencies are based upon National Occupation Standards .	Y	Y	Y	Y	Y	Y	Y	Y			Y	Training is delivered at the level for which the individual is expected to operate (ie operational/ bronze, tactical/ silver and strategic/gold). for example strategic/gold level leadership is delivered via the 'Strategic Leadership in a Crisis' course and other similar courses.	CCU Training and Exercising in place. NHS England are responsible for health strategic on call training.			
17	Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Control Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	This should be proportionate to the size and scope of the organisation.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements detail operating procedures to help manage the ICC (for example, set-up, contact lists etc.), contact details for all key stakeholders and flexible IT and staff arrangements so that they can operate more than one control centre and manage any events required.	MIP in place			
18	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Trained Loggists - information governance and procedures. Utilisation of METHANE reporting tool.			
19	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		NHS England EPRR Sitrep templates as annexes to MIP			
20	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.	Both acute and ambulance providers are expected to have in place arrangements for accessing specialist advice in the event of incidents chemical, biological, radiological, nuclear, explosive or hazardous materials	Y		Y										n/a			

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental healthcare providers	NHS England Area teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
21	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Both acute and ambulance providers are expected to have arrangements in place for accessing specialist advice in the event of a radiation incident	Y		Y										n/a			
Duty to communicate with the public																		
22	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Arrangements include a process to inform and advise the public by providing relevant timely information about the nature of the unfolding event and about: - Any immediate actions to be taken by responders - Actions the public can take - How further information can be obtained - The end of an emergency and the return to normal arrangements Communications arrangements/ protocols: - have regard to managing the media (including both on and off site implications) - include the process of communication with internal staff - consider what should be published on intranet/internet sites - have regard for the warning and informing arrangements of other Category 1 and 2 responders and other organisations.	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	• Have emergency communications response arrangements in place • Be able to demonstrate that you have considered which target audience you are aiming at or addressing in publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous information campaigns to inform the development of future campaigns • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'. • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes. • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work.	Internally defer to the Communication Team. Health only major incidents via the NHS England Area Team. Multi Agency response through the Staffordshire Reslience Forum, via the emergency, media and comms plan.			

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental healthcare providers	NHS England Area teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	**Self assessment RAG** **Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months.** **Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months.** **Green = fully compliant with core standard.**	Action to be taken	Lead	Timescale
23	Arrangements ensure the ability to communicate internally and externally during communication equipment failures		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.	internally a draft IT disaster recovery plan. Business Continuity plans. Multi Agency resilent communications plan and exercise mercury.			
Information Sharing – mandatory requirements																		
24	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	These must take into account and inclue DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supercedes this, the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public', or subsequent / additional legislation and/or guidance.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Where possible channelling formal information requests through as small as possible a number of known routes. • Sharing information via the Local Resilience Forum(s) / Borough Resilience Forum(s) and other groups. • Collectively developing an information sharing protocol with the Local Resilience Forum(s) / Borough Resilience Forum(s). • Social networking tools may be of use here.	Arrangements in place with CCU. Information sharing forum. Staffordshire prepared website (members area)			
Co-operation																		
25	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)		Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	• Attendance at or receipt of minutes from relevant Local Resilience Forum(s) / Borough Resilience Forum(s) meetings, that meetings take place and memebership is quorat. • Treating the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership as strategic level groups • Taking lessons learned from all resilience activities • Using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to consider policy initiatives • Establish mutual aid agreements • Identifying useful lessons from your own practice and those learned from collaboration with other responders and strategic thinking and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to share them with colleagues • Having a list of contacts among both Cat. 1 and Cat 2. responders with in the Local Resilience Forum(s) / Borough Resilience Forum(s) area	LHRP is attended and minutes received			
26	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA		Y	Y	Y	Y	Y	Y	Y	Y		Y	Y		Attendance to LHRP, EPO and SRF.			
27	Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.	NB: mutual aid agreements are wider than staff and should include equipment, services and supplies.	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y		multi agency mutual aid agreements in place via the SRF. Health Econmy will be developing mutual aid agreements led by NHS England Area Team.	EPO Group	**EPO**	To be defined.
28	Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.				Y			Y	Y				Y		n/a			
29	Arrangements outline the procedure for responding to incidents which affect two or more regions.				Y				Y				Y		n/a			
30	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	Examples include completing of SITREPs, cascading of information, supporting mutual aid discussions, prioritising activities and/or services etc.	Y	Y	Y	Y	Y			Y		Y			Attendance to LHRP,EPO. Sitrep templates and BC plans			
31	Plans define how links will be made between NHS England, the Department of Health and PHE. Including how information relating to national emergencies will be co-ordinated and shared								Y						n/a			
32	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months							Y	Y						n/a			
33	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level		Y	Y	Y	Y	Y	Y		Y		Y	Y		yes arrangements in place			
Training And Exercising																		
34	Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	• Staff are clear about their roles in a plan • Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type. • Training is linked to Joint Emergency Response Interoperability Programme (JESIP) where appropriate • Arrangements demonstrate the provision to train an appropriate number of staff and anyone else for whom training would be appropriate for the purpose of ensuring that the plan(s) is effective • Arrangements include providing training to an appropriate number of staff to ensure that warning and informing arrangements are effective	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Taking lessons from all resilience activities and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership and network meetings to share good practice • Being able to demonstrate that people responsible for carrying out function in the plan are aware of their roles • Through direct and bilateral collaboration, requesting that other Cat 1. and Cat 2 responders take part in your exercises • Refer to the NHS England guidance and National Occupational Standards For Civil Contingencies when identifying training needs. • Developing and documenting a training and briefing programme for staff and key stakeholders • Being able to demonstrate lessons identified in exercises and emergencies and business continuity incidentshave been taken forward • Programme and schedule for future updates of training and exercising (with links to multi-agency exercising where appropriate) • Communications exercise every 6 months, table top exercise annually and live exercise at least every three years	CCU training needs analysis cover both training and exercising for all relevant areas			
35	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	• Exercises consider the need to validate plans and capabilities • Arrangements must identify exercises which are relevant to local risks and meet the needs of the organisation type and of other interested parties. • Arrangements are in line with NHS England requirements which include a six-monthly communications test, annual table-top exercise and live exercise at least once every three years. • If possible, these exercises should involve relevant interested parties. • Lessons identified must be acted on as part of continuous improvement. • Arrangements include provision for carrying out exercises for the purpose of ensuring warning and informing arrangements are effective	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		CCU training needs analysis cover both training and exercising for all relevant areas			
36	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises		Y	Y	Y	Y	Y	Y	Y	Y			Y		particpate in mercury and ravens.			
37	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.		Y	Y	Y	Y	Y	Y	Y	Y			Y		See response to item 35 - also an agenda item on the EPRR Ops Group			

North Staffordshire Combined Healthcare NHS Trust

REPORT TO: **Trust Board (open)**

Date of Meeting:	25 September 2014
Title of Report:	People and Culture Development Committee Report
Presented by:	Mr Peter O'Hagan Chair of the People and Culture Development Committee
Author of Report: Name: Date: Email:	Sandra Storey, Trust Secretary / Head of Corporate & Legal Affairs 23 September 2014 Sandraj.storey@northstaffs.nhs.uk
Purpose / Intent of Report:	• For information / assurance
Executive Summary:	This report provides a summary of the meeting of the People and Culture Development Committee that took place on the 18 August 2014. The report highlights key points discussed and agreed outcomes.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Workforce Strategy • Governance Strategy • Customer Focus • Clinical
Relationship with Annual Objectives:	Cuts across all objectives
Risk / Legal Implications:	N/A
Resource Implications:	N/A
Equality and Diversity Implications:	None in this report
Relationship with Assurance Framework [Risk, Control and Assurance]	Provides assurance to the Board that the committee is working in according with its Terms of Reference
Recommendations:	• To receive for information and assurance purposes.

Summary to Trust Board of the People and Culture Development Committee meeting held on the 18 August 2014

1. Workforce Service Line Performance – June 2014

The committee received presentations from each of the service line leads on their performance against key workforce indicators.

Members discussed in detail areas such as sickness absence across the service lines which had decreased significantly in comparison to previous reports. Statutory and mandatory compliance was noted as improving at 91% but required ongoing commitment by teams to ensure this upward trend continues. Members agreed to report this back to their various teams and reinforce the need to improve performance in this area.

Committee members also discussed the performance of workforce metrics in respect to Corporate teams and how this should be given more visibility to ensure that teams feel it is given the same level of focus as clinical areas.

In respect to completion of individual Personal Development Reviews (PDR) it was noted that the cascade from the Board down to teams started slightly later this year. Consequently the numbers completed were lower than usual but were forecast to significantly rise by the time of the next report.

Committee members also discussed the benefits of PDR and how the Trust uses this information to both support individuals as well as the wider teams. The intention of PDR is that this is not a one off event. Personal development and review of performance was agreed to be an ongoing activity which culminates in the annual review between the staff member and their manager.

2. Incident reporting

The committee received information from Mrs Sylvester on the work that is being done in respect to incident reporting. This included training for staff and further developments to the incident reporting system to make it easier for staff to navigate the system. The committee also received information on why at times there may be high numbers of incidents, which may relate to the acuity of patients, and how this is being managed.

3. Horizon Scan – Leadership & Workforce Update

Mr Draycott provided the committee with an update on the latest news and information relating to the NHS workforce both from a local and national perspective:

- **Industrial action** – unions are balloting on industrial action regarding the pay award to staff and results will be known by the end of September 2014.
- **Leadership recognition awards** – staff were advised of the awards and encouraged to think about nominating teams or individuals.

- **Compassionate Leadership & Talent Exchange Projects** – this is an exchange project funded by Staffordshire and Shropshire LETC, the project will look across the patch on how individuals can be supported and developed in partnership with other stakeholders.
- **West Midlands HR Streamlining** – across the West Midlands the HR network has sponsored a network to streamline processes in recruitment, mandatory training and occupational health. This followed an initial project in London and is being rolled out with a view that processes will be more effective resulting in efficiencies.
- **Partnership work with Staffordshire University** – Mr Draycott advised that he had met with Staffordshire University with a view to working in partnership in using technology to deliver some services across the Trust. Of particular interest was the work that is being progressed in developing an Ap to support recovery for clients.

Mr O'Hagan welcomed this report and requested that a quarterly report is provided to the committee.

4. Committee Development

The main focus of the People and Development Committee meeting was for members to have time out to consider the Trust's future workforce requirements linked to the clinical pathway work.

Ms Rook provided the committee with a presentation and committee members were asked to work in groups to consider key point to help move the agenda forward.

Key themes:

- Flexible workforce and future proofing to ensure workforce can respond to local and national changes
- Change in patient need and therefore being clear about our strategy and overall purpose
- Enabling staff to fulfil their potential
- Working in partnership – locally and nationally
- Being an employer of choice
- We are recognised as a learning organisation
- Skilled and valued workforce that can lead itself
- Understanding the current skill set and training requirements to deliver integrated care
- Recognising and responding to interdependencies with other stake holders
- Improved technology and mobile working.

Mr Draycott summarised the session by saying that this important work will help to further inform the Trust's workforce strategy. The committee will be kept informed of developments with this work.

Mr O'Hagan welcomed the session and noted that we also need to continue to take time out to recognise those who are doing an excellent job as well as supporting those who have aspirations for future development, change in role and responsibility.

5. Next meeting: 22 September 2014

On behalf of the Committee Chair, Mr Peter O'Hagan

Sandra Storey
Trust Secretary / Head of Corporate and Legal Affairs
05 August 2014

North Staffordshire Combined Healthcare NHS Trust

REPORT TO: Trust Board

Date of Meeting:	Thursday 25th September 2014
Title of Report:	Retirement and Long Service
Presented by:	Paul Draycott
Author of Report: Name: Date: Email:	Kerry Smith Associate Director of HR 12/09/14 Kerry.smith@northstaffs.nhs.uk
Purpose / Intent of Report:	To request approval on two matters relating to the Trust's current practice with regards to Long Service Award on retirement.
Executive Summary:	Feedback has been received from retiring employees that the choice of gift supplier is unsatisfactory. Upon provision of a receipt the employee will be reimbursed up to a maximum of £100. To further recognise the achievement of long standing NHS service we are recommending that eligible employees be invited to attend the open section of the Trust Board for presentation of a Long Service Certificate. We further recommend that we broaden the choice of gift for retiring employees.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	
Relationship with Annual Objectives:	
Risk / Legal Implications:	None
Resource Implications:	No additional work required with regards to choice of gift. Limited administration required to support the attendance at Trust Board. Retiring individuals may require back-fill arrangements if front line area.

Equality and Diversity Implications:	No implications
Relationship with Assurance Framework [Risk, Control and Assurance]	
Recommendations:	The Trust Board are asked to approve the additional option of giving employees more choice for their gift and also to invite all eligible retiring employees to the open section of the Trust Board. As stated, currently staff receive a letter of acknowledgement on retirement signed by the Chairman and Chief Executive. Whilst this is a form of acknowledgement it is felt that this could be further enhanced by having this personally presented at an open Board meeting.

1. Introduction and background

The Trust is committed to recognising employees long service and providing an award for those who are retiring with a total of 20 years or more NHS service (separate periods of NHS service may be aggregated for this purpose). The award currently applies to any form of retirement including normal age retirement, premature retirement as a result of redundancy or early retirement under one of the schemes described in the Trust's Retirement policy.

The award is not available for long service whilst in employment with the Trust or on leaving to take up further employment.

The award currently takes the form of a personalised letter of appreciation signed by the Chairman and Chief Executive, together with a cash gift token of £100 which may be used at selected suppliers, or a £100 maximum contribution towards the cost of a buffet. The award is a choice between these options and not a combination. The gift tokens relate to two fixed suppliers; Edwards China and Wrench's Jewellers.

2. Current System Issues

It is recognised that the choice of gift supplier is very restricted.

It should be noted that there are tax implications and restrictions provided by HM Revenue & Customs regarding retirement gifts. However, they advise that Employers and Employees are exempt from tax if the gift/award:

- Is for 20 Years of continuous service with the same company or subsidiaries of that company
- The value of award does not exceed £50.00 for each year of service
- Must be tangible, normally in the form of a Gift, a non-cash Voucher but can be shares in the Company

3. Proposal

To further enhance the experience and sense of achievement, it is also proposed that all eligible employees be invited to attend the open section of the Trust's Board Meeting prior to their retirement. During which employees will be personally presented with a certificate of recognition by the Chairman and Chief Executive.

It is proposed to ensure all eligible employees are given as much choice as possible for their choice of award, whilst meeting the detailed exemptions, the following option be made available as an addition to the options detailed in section 1:

- An employee may purchase an item themselves up to the value of £100 from a VAT registered retailer of their choice. Following the submission of a VAT receipt for the item the Trust will reimburse the employee for the gift up to a maximum value of £100.

It is not possible to predict the exact number of individuals who are due to retire each year. However, on reviewing the number of retirements in previous years, on average approximately 11 employees retire each year.

If approved both abovementioned matters could be implemented with immediate effect.

4. Proposal

It is proposed that:

1. Employees are given more choice with regards to their long service retirement gift.
2. Employees are invited to attend the open section of the Trust's monthly Board Meeting to be personally presented with their certificate of recognition.

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North Staffordshire Combined Healthcare NHS Trust

REPORT TO: Trust Board

Date of Meeting:	25th September 2014
Title of Report:	Health care support workers interim report
Presented by:	Paul Draycott
Author of Report: Name: Date: Email:	Beverley Dawson 29/7/14 Beverley.dawson@northstaffs.nhs.uk
Purpose / Intent of Report:	For decision
Executive Summary:	In 2014 Combined Healthcare introduced a learning and development approach for all of its support workers which included a number of components, some universally available and others that are targeted. This report provides an update on progress to date. In addition there have been significant local and national developments since the introduction of our support worker learning programme which will have implications for the way in which the programme is delivered in future. A separate proposal has been commissioned to take these changes into account and make recommendations for the future – this report will be received by PCD in November.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Workforce Strategy The Francis report and subsequent Cavendish Review made clear recommendations about the need to provide effective training and development opportunities for support workers.
Relationship with Annual Objectives:	Supports the strategic goal to be a provider of high quality care.
Risk / Legal Implications:	The findings of the Francis enquiry and subsequent recommendations of this report and the Cavendish review demonstrate the risks that can result from lack of adequate training and development for support staff.
Resource Implications:	Funding to support the delivery of components of this training have been secured through a strategic training bid in 2014/5
Equality and Diversity Implications:	Non anticipated
Relationship with Assurance Framework [Risk, Control and Assurance]	Not applicable

Recommendations:	It is recommended that: • A full report taking into account the significant changes that affect the first two parts of the support worker programme is prepared and received by PCD in November. • Continue to deliver the CCMH running cohorts to meet needs with a maximum of 2 cohorts per year • Continue to explore other advanced training and development options to extend offers for the future. • That the CCMH course continues to be recognised as an appropriate level 3 mental health qualification for support workers to build upon the foundation level course. • That a standard of 1 day study time per assignment is allocated to candidates on this course in addition to the attendance days to allow sufficient time for research and to complete the written work. • That a focus group of managers, qualified staff and support workers give consideration to extending eligibility for the programme to include ‘qualified’ staff as the course has a recovery and values based focus • That a celebratory event is planned for the completion of the CCMH course at which candidates will describe how their practice has changed and the positive impact this has had on service delivery. • That the next cohorts of this programme commence in June 2015 and that recruitment for this programme commences in January 2015. • That the CCMH is included as a good news story at next year’s AGM.

Interim report on the Health Care Support Worker learning programme

17/09/2014
Combined Healthcare
Dawsob/Richardson/Ainsworth

Introduction

In 2014 Combined Healthcare introduced a learning and development approach for all of its support workers which included a number of components, some universally available and others that are targeted. This includes

- A supported period for new staff be implemented as and when national guidance has been issued in relation to the certificate in care.
- A locally developed 5 day foundation programme, focussed on the themes outlined in the minimum standards and code of practice for support workers 2013 and embedding the code of conduct for support workers.
- Locally determined skills development for support workers co-ordinated through the education team and delivered through clinical skills leaders.
- Certificated learning on the Certificate in Community Mental Health leading to a City and Guilds level 3 certificate.
- The approach was planned to integrate with recruitment and employment practices already in place within the Trust and that this development approach should be considered as part of the support worker review that was on-going at the time.

There have been significant local and national developments since the introduction of our support worker learning programme which will have implications for the way in which this is delivered in the future.   These changes have been fully specified in a development proposal which will be received by combined Healthcare PCD in October 2014 which suggests significant changes in the way in which the programme is organised and delivered. This report provides progress reports on the current support worker programme delivery.

Recommendations

It is recommended that:

- A full report taking into account the significant changes that affect the first two parts of the support worker programme is prepared and received by PCD in October.

- Continue to deliver the CCMH running cohorts to meet needs with a maximum of 2 cohorts per year

- Continue to explore other advanced training and development options to extend offers for the future

- That the CCMH course continues to be recognised as an appropriate level 3 mental health qualification for support workers to build upon the foundation level course.

- That a standard of 1 day study time per assignment is allocated to candidates on this course in addition to the attendance days to allow sufficient time for research and to complete the written work.

- That a focus group of managers, qualified staff and support workers give consideration to extending eligibility for the programme to include ‘qualified’ staff as the course has a recovery and values based focus

- That a celebratory event is planned for the completion of the CCMH course at which candidates will describe how their practice has changed and the positive impact this has had on service delivery.

- That the next cohorts of this programme commence in June 2015 and that recruitment for this programme commences in January 2015.

- That the CCMH is included as a good news story at next year’s AGM.

Foundation Programme

The five day foundation programme is locally developed and delivered, reflects the standards of the Care Certificate and is primarily classroom based. The first cohort of this programme will completed in December 2014 with a second cohort commencing in September 2014 to allow both cohorts to complete by the end of the financial year.

The decision about whether to continue with this programme is contained within a separate report which will be received by PCD in October 2014.

Programme Content

Programme Day	Content
Launch Day	**Delivered by in-house providers** Including programme orientation, introduction to supportive services, reflective practice, compassionate care and 6C's
Communication and Customer Care	**Delivered by the National Performance Advisory Group** Including; who are our customers, customer perceptions, effective communications, assertiveness, managing complaints and concerns, specialist communication skills for people living with mental health issues, organisational values and service standards.
Risk and Core Clinical Awareness	**Delivered by in-house practitioners** What is risk, improving awareness and identification of risk in the workplace, managing risk in your team, risk assessment and feedback Three awareness raising sessions focussing on elements of our service delivery: Dementia care, Substance misuse, Learning disabilities.
Physical Aspects of Care	**Delivered by in-house practitioners and Keele University** Dysphagia awareness and nutritional management, baseline observations, awareness of change in physical and mental health including practical sessions in the clinical skills laboratory
Focus on Values	**Delivered by Judy Thorley Associates** and including Emotional and spiritual wellbeing, privacy and dignity, advocacy and support, person centred care planning, rights and duty of care, role of PPIsand PALS, safeguarding vulnerable people

Promotion and Recruitment

The programme has been well promoted within the Trust using written, verbal and electronic media and messages have been targeted to reach potential delegates (including personal emails to all support workers who had not yet signed up), their managers and senior managers across the organisation.

The programme is designed to have a common launch day (to which all delegates were invited) followed by four repeats of each subsequent day to prevent pressure on clinical areas in terms of cover requirements

The original proposal to recruit 100 support workers to each Foundation Programme and to deliver the 4 cohorts required over a 2 year period has slipped due to an inability for this number of staff to be released at any one time. Cohort 1 recruited 50 staff and cohort 2 has recruited 43 staff. Lower recruitment rates appear to be associated with difficulties in providing clinical cover this has implications for costs and timescales for delivery.

Retention

Retention to the programme has been good until challenges for staff release led to a dip on module 3.

Launch	100% attendance (50 staff)
Communication and customer care	98% attendance (49 staff)
Risk and Core clinical awareness	76% attendance (38 staff) Due to emergency ward cover 11^{th} July 3 DNA – 2 ward 1, 1 ward 3 24^{th} July 7 DNA – 2 ward 4, 3 ward 2, 1 ward 1, 1 Hillcrest 30^{th} July 2 DNA – 1 ward 1

Please note: The risk and core clinical awareness days ran over July, during this time, according to communications from Andrew Rogers, COO and Service line managers there were staffing issues across the Trust. Staff who were unable to attend their planned session have been accommodated in November with Cohort 2.

Evaluation of the programme days 1 – 3

The full programme has not yet completed. Evaluation results are available for the first three days. The summary of main themes and overall average responses is given below. A more detailed evaluation is included in Appendix 2.

	Overall evaluation	Level of impact on practice	Would you recommend to others
Launch Day	28% excellent	Not applicable as this day	79% Yes

	48% good 16% average 8% poor	was introductory	7% Yes - some elements 7% only to new staff 7% no
Communication & customer care	96% excellent 4% good	39% significant 57% minor 4% none	100% Yes
Risk and core clinical awareness	63% excellent 37% good	25% significant 69% minor 6% none	93% yes 7% maybe

Main themes from the narrative comments.

- In general candidates have found the programme valuable and useful. A percentage of respondents comments suggest that it would be most useful for staff who are just starting out as support workers and some commented that it is too basic for experienced staff.
- Participants valued the opportunity to refresh their knowledge and to reflect on practice
- The quality and facilitation of the communications day was highly commended and participants commented that this would be useful training for other groups of staff.
- The awareness raising sessions served to whet the appetite of some delegates for more information. Some delegates commented that they already had this level of knowledge.
- There was a small number of comments to say that more focus on acute mental health issues was required.

It is therefore recommended that we amend content as determined by the feedback from Cohort 1. This would include a repeat of all the four days evaluated to date with some amendment of content to meet the needs of the more experienced support workers and that the range of awareness raising options are increased to include acute mental health.

It is also recommended that future recruitment to the Foundation programme (if this programme continues) focuses on support workers who have not previously undertaken more advanced training.

Development of Clinical Skills Leaders

A significant component of this development programme is the consolidation of clinical skills relevant to the area of practice for the support worker. The original aspiration was to link this component to the regional SERC project which aimed to provide local and mobile skills training facilities, and also the opportunity to train clinical staff to become local skills trainers.

Unfortunately, the Trust was not able to recruit a person to the post of SERC Clinical Tutor by the start date of June 14. The project lead has therefore needed to modify the way in which this project will be delivered and will use the associated funding to secure external providers, who are able to deliver on agreed training outcomes for physical healthcare.

The focus of the SERC project has also been modified over this time with the steering group identifying that the original proposal that the Trust delivered training to 40 staff was insufficient. A new Trust target has been identified as follows 210 staff to be trained, 70 of which will be the delivery of Mental Health awareness training, on subjects identified by Staffordshire and Stoke-on-Trent Partnership Trust. As the SERC project now has a different focus and will not be suitable as a way of preparing clinical skills leads to provide the required training for support workers alternative options to deliver this outcome are currently being investigated.

Certificate in Community Mental Health (CCMH) City and Guilds level 3

This programme has been approved by Stoke on Trent City Council-Learning and Development Centre and the internal verifier is Susan Ruscoe. The internal course tutors are Julie Richardson and Christine Malbon.

City and Guilds have approved the course delivery in terms of :-

- Standard of delivery and assessment of written work by the course tutors
- Attendance and assessment records provided
- Standard and content of the training presentations written and developed by the course tutor(sample provided unit 3)
- Level of support provided to candidates by the course tutors in terms of:-
- Proof reading of assignments prior to submission for marking
- Individual tutorials
- Study skills sessions (sample provided unit 3 study skills)

The course requires 12 months part time study and commenced in February 2014. 36 candidates were recruited and formed two cohorts. The candidate mix is provided in appendix two and includes Combined Healthcare employees, 3rd sector partner employees and service users.

6 candidates have withdrawn or been deferred including 3 services users, 2 staff from Chebsey and 1 staff from Brighter Futures.

At this point in the year 4 of the 8 units of the programme have been delivered as follows:

- Understand mental well-being and mental health promotion
- Understanding mental ill health
- Understanding mental health interventions
- Understanding the legal, policy and service framework in mental health

Attendance rates for these modules has been 90%. Candidates have fed back that they find the course challenging in terms of how much work is required but informative and comprehensive in the detail and subjects covered. Candidates have also said that they feel that nursing staff should be offered the training due to its focus on recovery and values rather than clinical interventions.

For two of these units assignments have been returned. 28 of the 30 candidates have passed these assignments – 2 of these are services users.

A further 4 units will be delivered prior to the end of the course in February 2015. Planning is in place for an end of programme celebratory event to which candidate managers and supporters will be invited. Plans for recruitment to future cohorts of the programme have commenced.

Conclusion

The Support Worker Development Programmes have made good progress and have received positive initial evaluation. The next steps are covered within the recommendations and will include responding to the national guidance and embedding the development in to practice in the appropriate settings.

Recommendations

It is recommended that:

- Continue to deliver the CCMH running cohorts to meet needs with a maximum of 2 cohorts per year
- Continue to explore other advanced training and development options to extend offers for the future.
- That the course continues to be recognised as an appropriate level 3 mental health qualification for support workers to build upon the foundation level course.
- That a standard of 1 day study time per assignment is allocated to candidates in addition to the attendance days to allow sufficient time for research and to complete the written work.
- That a focus group of managers, qualified staff and support workers give consideration to extending eligibility for the programme to include ‘qualified’ staff as the course has a recovery and values based focus
- That a celebratory event is planned for the completion of the course at which candidates will describe how their practice has changed and the positive impact this has had on service delivery.
- That the next cohorts of this programme commence in June 2015 and that recruitment for this programme commences in January 2015.
- That the CCMH is included as a good news story at next year’s AGM.

Appendix 1
Overview of the support worker education programme

Widening Access

Modern Apprenticeships / Work experience

Foundation Level Learning

Based on national standards, and focussing on compassionate care

Target group: All support workers in the Trust. Matches competencies required at band 2 and pre-requisite for advanced level learning.

Aim: To provide a standard baseline of knowledge for support workers

Modality: Blended learning approach - co-ordinated centrally through training team with support from local areas

Monitoring Coverage: Attendance Statistics on OLM

Monitoring Application: Supervision / caseload management meetings with line manager

Skills Development

Based on locally agreed skill requirements

Target Group: All new staff and all existing staff identified as having skills gaps as part of the SERC project. Pre-requisite for advanced level learning

Aim: Clinical standards assurance tailored to clinical areas

Modality: Practice based learning - Co-ordinated through the education team. Training delivered at departmental level by clinical skills leaders or support worker mentors

Monitoring Coverage: Attendance statistics on OLM

Monitoring Application: Clinical skills champions assessment in practice

Advanced Level Learning

Based on selected validated programmes.

Target Group: Clinical support staff working at bands 3 and 4. Candidates will be identified through;-

A. Workforce planning - required for specified roles

B. PDR - potential to move onto skills escalator

Aim: Development of more advanced skills to meet business need and/or offer individual progression

Modality: In-house or external provisions of validated ptrogrammes leading to recognised qualification

Monitoring Coverage: Attendance and qualification on course

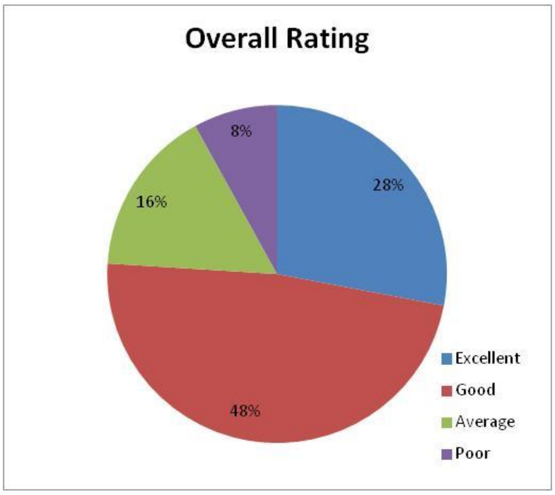
Monitoring Application: Annual PDR and regular review meetings with line manager

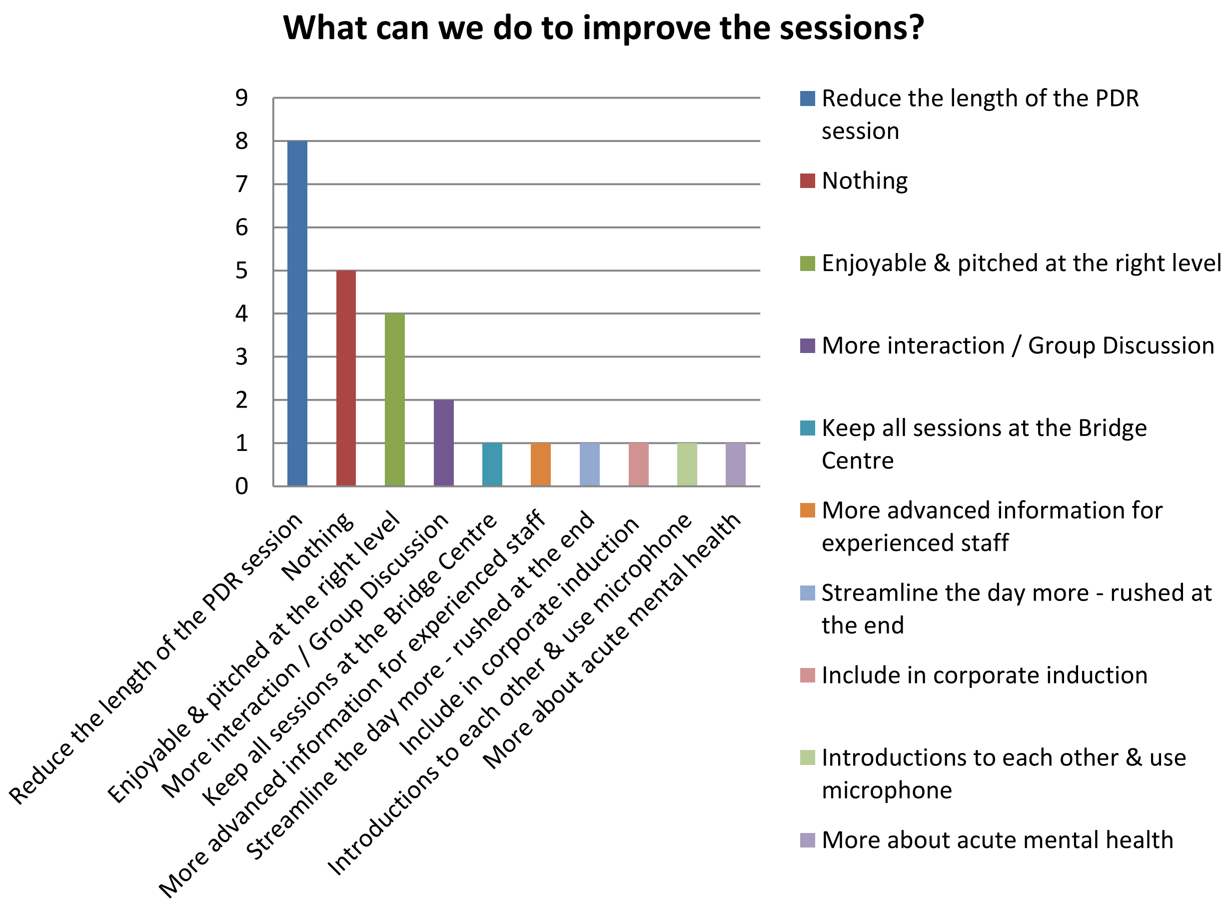
Skills Escalator

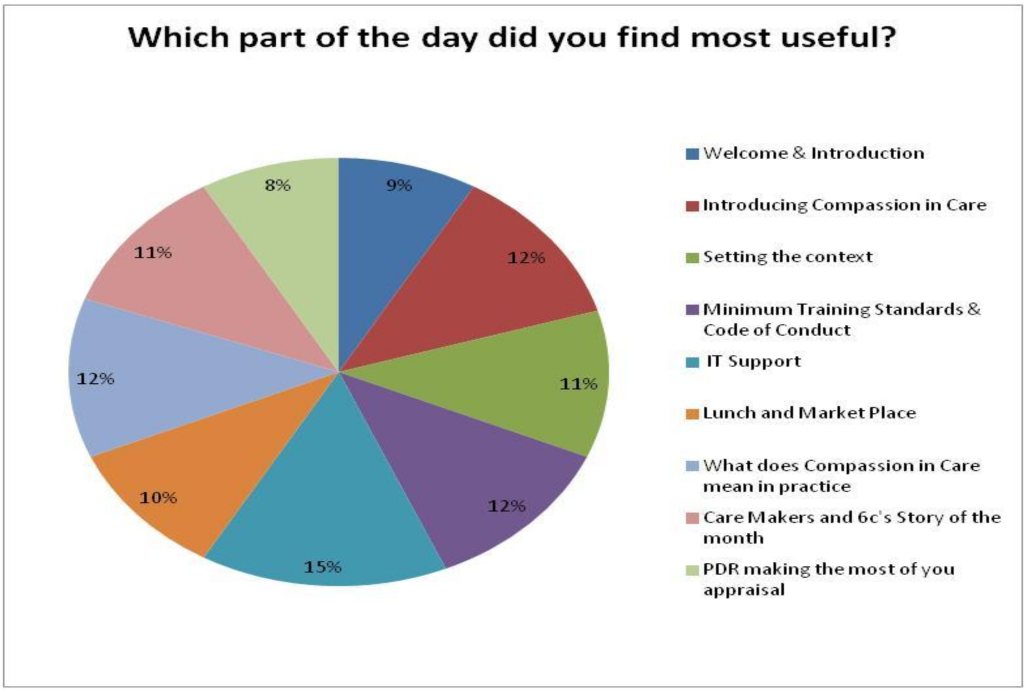
Entry to pre-reg clinical education - for staff who have potential and ambition to continue career pathway

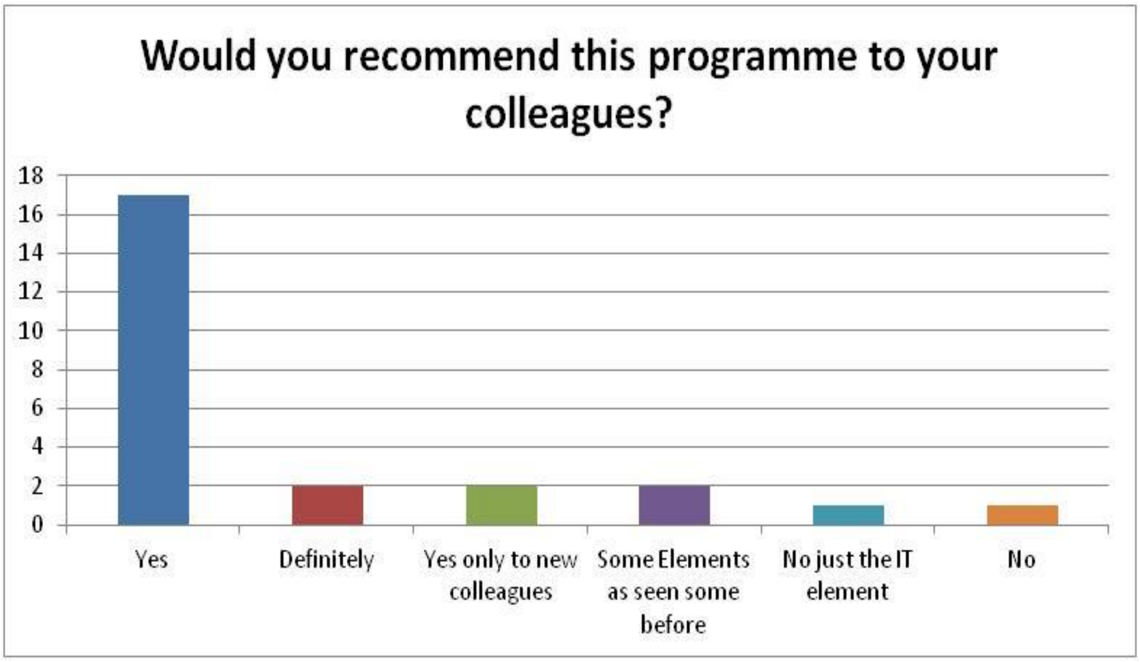
Appendix 2 Detailed Evaluation of the 5 day Foundation Programme Evaluation of Days 1 to 3

Launch Day: 50 staff attended 25 evaluation forms received.









Themes from written comments

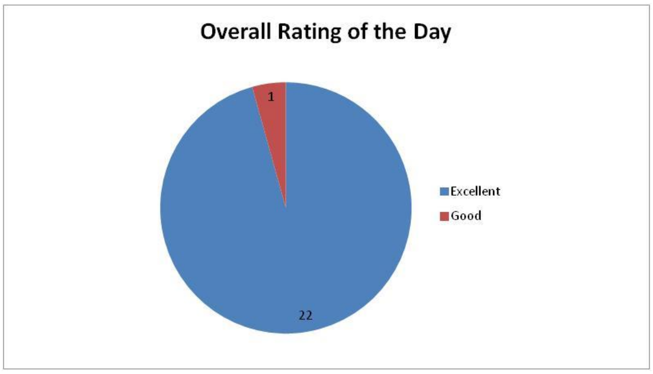
The day was perceived as enjoyable and well presented by most participants

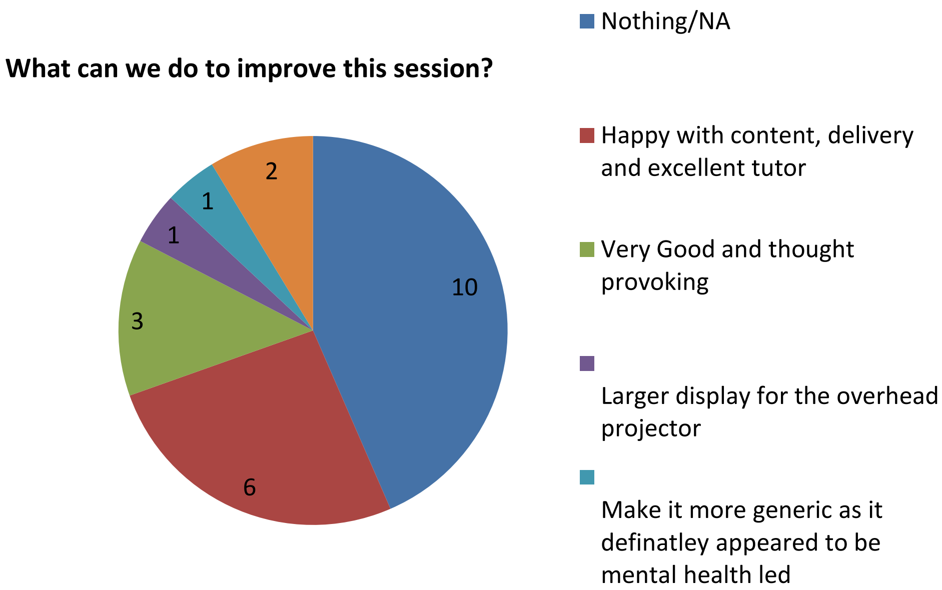
Some experienced staff felt that the 6C's and discussion on standards of care was patronising as they had been delivering care for many years.

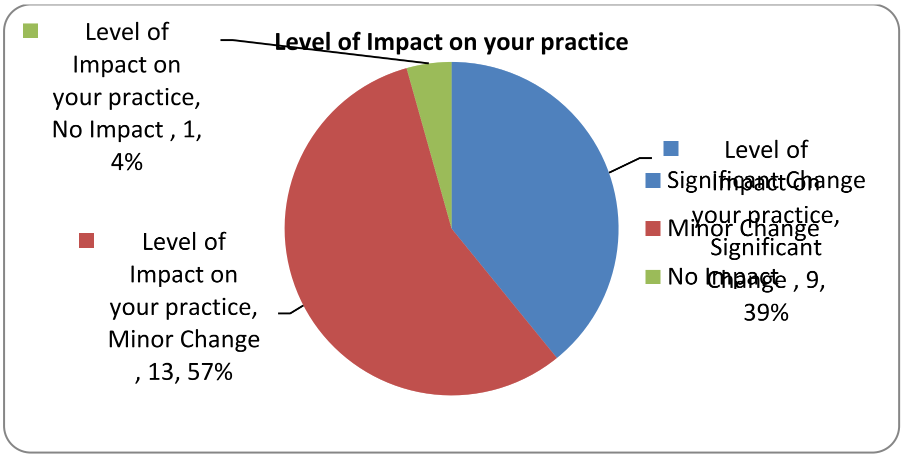
Some staff commented that they felt refreshed by taking time to consider familiar topics from a new angle and have the opportunity to reflect on practice.

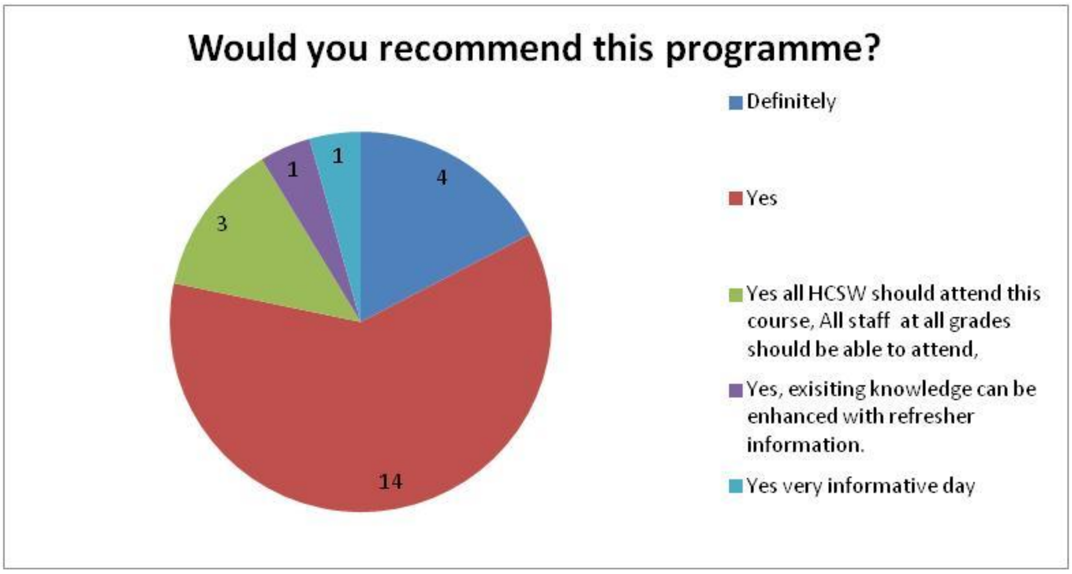
Day 2 Communications and Customer care

49 staff attended and 23 feedback forms received.









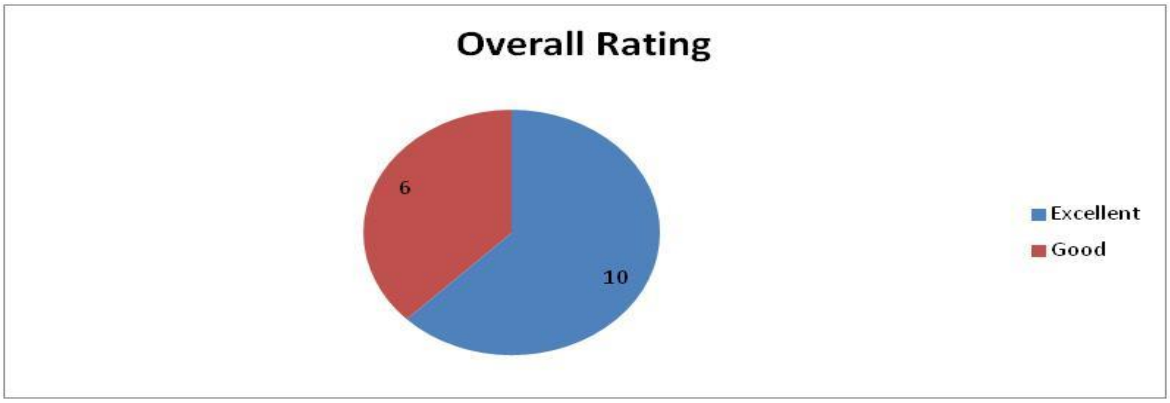
Themes from Written comments

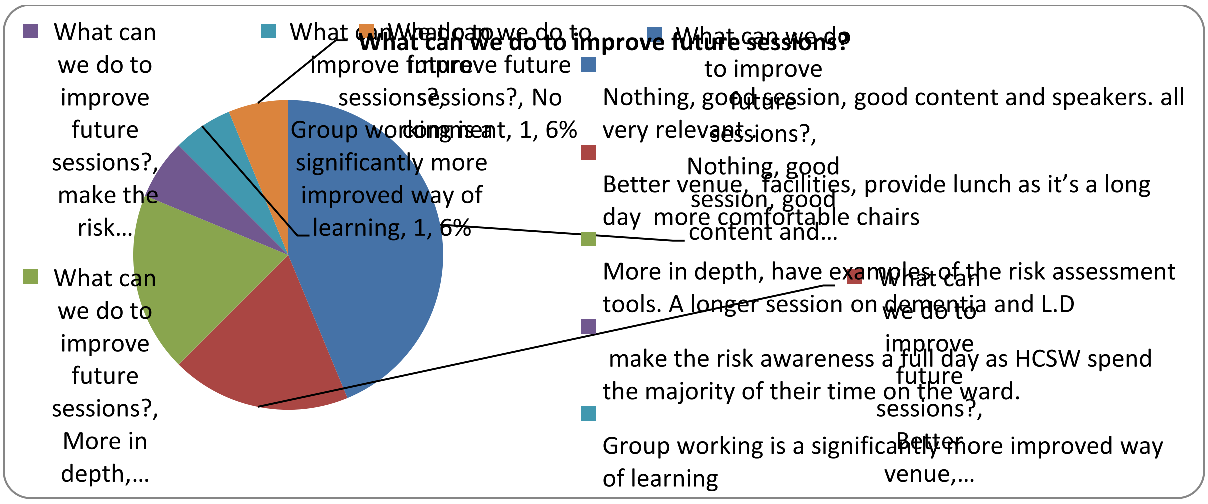
- Many commented on the quality of the training and trainer and some felt it was the best training day they had attended.
- People enjoyed the warm and friendly environment
- Some felt that this training should be available to other bands of staff
- Participants also commented that taking the perspective of the service user had given them a new way of looking at the challenges faced by the people they care for.

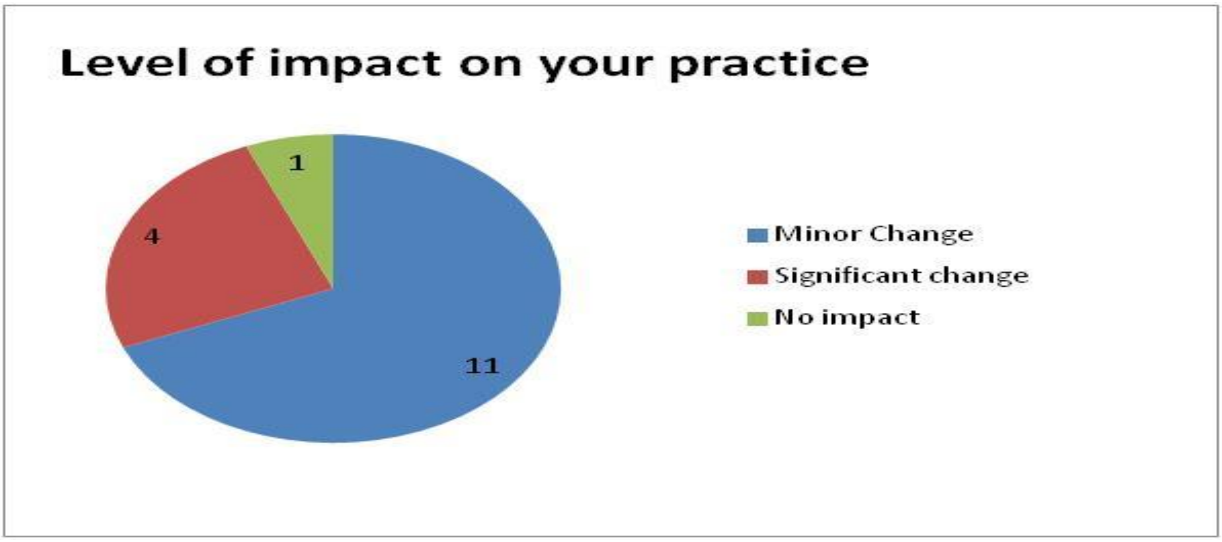
Evaluation of day 3 – Risk and core clinical awareness.

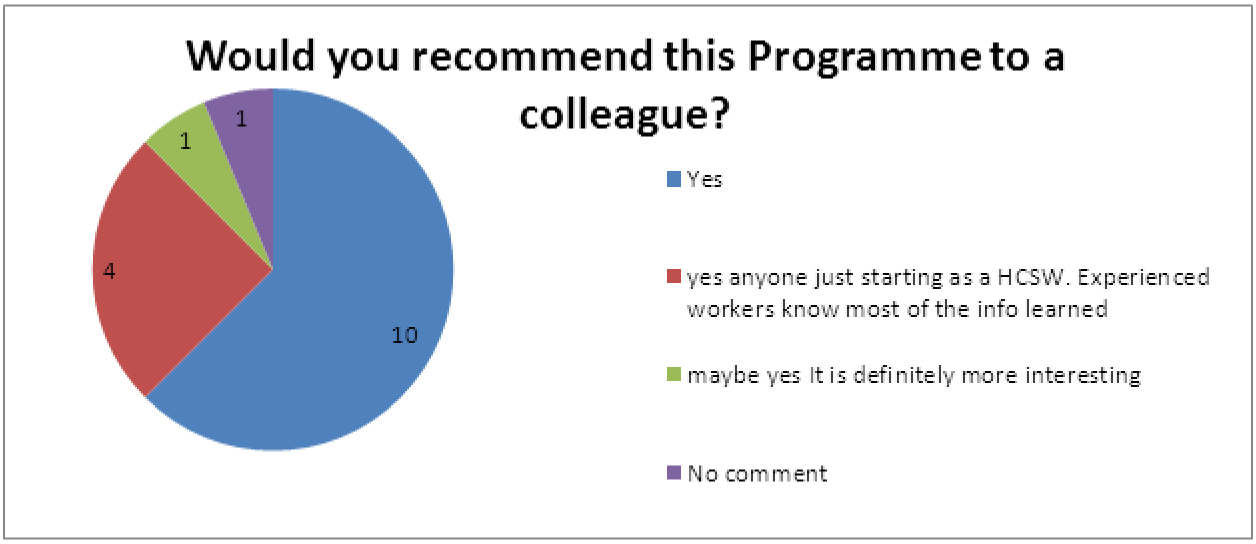
38 Delegates attended and 16 responses were received.

Attendance was a challenge due to emergency cover required on wards 1 – 7




What can we do to improve future sessions?
What can we do to improve future sessions?, make the risk…
What can we do to improve future sessions?, More in depth,…
Group working is a significantly more improved way of learning, 1, 6%
What can we do to improve future sessions?, Better venue,…
Nothing, good session, good content and speakers. all very relevant
Better venue, facilities, provide lunch as it's a long day more comfortable chairs
More in depth, have examples of the risk assessment tools. A longer session on dementia and L.D
make the risk awareness a full day as HCSW spend the majority of their time on the ward.
Group working is a significantly more improved way of learning


Level of impact on your practice
1
4
11
Minor Change
Significant change
No impact


Would you recommend this Programme to a colleague?
1
1
4
10
Yes
yes anyone just starting as a HCSW. Experienced workers know most of the info learned
maybe yes It is definitely more interesting
No comment

Themes collated from narrative comments.

- Some delegates would like to follow up on the awareness raising sessions and commented positively on the content of the sessions.
- Delegates asked for hospitality to be provided
- Some delegates felt that the level of information was more suitable to newly appointed support workers

Appendix 2 Breakdown of candidates on the CCMH

36 candidates were recruited as follows:-

- 6 Service users
- 4 Brighter futures Staff
- 3 Hillcrest team
- 2 Florence House
- 1 Community rehab CPN team
- 1 EI team
- 1 Nuero Psychiatry Bennett centre
- 1 community addiction team –Moorlands
- 5 Harplands staff(various wards)
- 2 Telford unit
- 1 parent & baby
- 1 Bradwell hospital
- 1 Raid team
- 1 Criminal Justice