North Staffordshire Combined Healthcare NHS Trust

MEETING OF THE TRUST BOARD

TO BE HELD IN PUBLIC
ON Thursday 25th October 2018, 10:00AM,
BOARDROOM, LAWTON HOUSE, TRUST HEADQUARTERS,
BELLRINGER ROAD, TRENTHAM LAKES SOUTH,
STOKE ON TRENT, ST4 8HH

	AGENDA	
1.	**APOLOGIES FOR ABSENCE** *To NOTE any apologies for absence*	Note
2.	**DECLARATIONS OF INTERESTS RELATING TO AGENDA ITEMS**	Note
3.	**MINUTES OF THE OPEN AGENDA – 26th September 2018** *To APPROVE the minutes of the meeting held on 26th September 2018*	Approve Enclosure 2
4.	**ACTION MONITORING SCHEDULE & MATTERS ARISING FROM THE MINUTES** *To CONSIDER any matters arising from the minutes*	Note Enclosure 3
5.	**CHIEF EXECUTIVE'S REPORT** *To RECEIVE a report from the Chief Executive*	Note Enclosure 4
6.	**CHAIR'S REPORT** *To RECEIVE a verbal report from the Chair*	Note
7.	**STAFF RETIREMENTS** *To EXPRESS our gratitude and recognize staff who are retiring* *To be introduced by the Chief Executive and presented by the Chair*	Verbal
8.	**REACH RECOGNITION TEAM AWARD ON EXCELLENCE** *To PRESENT the REACH Recognition Team Award to Ward 4 NOAP* To be introduced by the Chief Executive and presented by the Chair	Verbal

	QUESTIONS FROM MEMBERS OF THE PUBLIC	
9	*To RECEIVE questions from members of the public*	Verbal
	TO ENHANCE SERVICE USER AND CARER INVOLVEMENT	
10	**SERVICE USER AND CARER COUNCIL** *To RECEIVE an update from Wendy Dutton Chair of the Service User and Carer Council*	Assurance Enclosure 5
	ENCOURAGE, INSPIRE AND IMPLEMENT RESEARCH AND INNOVATION AT ALL LEVELS	
11	**TOWARDS OUTSTANDING INNOVATIVE PRACTICE** *To RECEIVE a briefing re: Towards Outstanding Innovative Practice from Dr Darren Carr, Associate Medical Director / Clinical Director North Staffordshire Directorate*	Assurance Enclosure 6
	TO PROVIDE THE HIGHEST QUALITY SERVICES	
12	**NURSE STAFFING MONTHLY REPORT (AUGUST 2018) AND RECRUITMENT AND RETENTION INITIATIVES** *To RECEIVE the Nurse Staffing Monthly Report and the Recruitment and Retention Initiatives Report from Maria Nelligan, Executive Director of Nursing & Quality*	Assurance Enclosure 7
13	**ANNUAL RESTRAINT AND SECLUSION REPORT** *To RECEIVE a report on Annual Restraint and Seclusion Report from Maria Nelligan, Executive Director of Nursing & Quality*	Assurance Enclosure 8
14	**QUARTER 1 SERIOUS INCIDENT REPORT** *To RECEIVE the Quarter 1 Serious Incident Report from Dr Darren Carr, Associate Medical Director / Clinical Director North Staffordshire Directorate*	Assurance Enclosure 9
15	**DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC) QUARTER 1 REPORT** *To RECEIVE the Director of Infection Prevention and Control (DIPC) Quarter 1 report from Maria Nelligan, Executive Director of Nursing and Quality*	Assurance Enclosure 10
16	**MORTALITY SURVEILLANCE QUARTER 1 REPORT** *To RECEIVE the Mortality Surveillance Quarter 1 Report from Dr Darren Carr, Associate Medical Director / Clinical Director North Staffordshire Directorate*	Assurance Enclosure 11
17	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 5** *To RECEIVE the Month 5 Performance Report from Suzanne Robinson, Director of Finance, Performance and Digital*	Approval Enclosure 12

	CREATE A LEARNING CULTURE TO CONTINUALLY IMPROVE	
18	**DIVERSITY AND INCLUSION ACTION PLAN** *To RECEIVE the Diversity and Inclusion Action Plan from Caroline Donovan, Chief Executive*	Assurance Enclosure 13
	MAXIMISE AND USE OUR RESOURCES INTELLIGENTLY AND EFFICIENTLY	
19	**FINANCE REPORT – MONTH 5 (2018/19)** *To RECEIVE for discussion the Month 5 Financial position from Suzanne Robinson, Director of Finance, Performance and Digital*	Approval Enclosure 14
20	**ASSURANCE REPORT FROM THE FINANCE, PERFORMANCE & DIGITAL COMMITTEE** *To RECEIVE the Finance, Performance & Digital Committee Assurance report from the meeting held on the 11th October 2018 from Tony Gadsby, Chair/Non-Executive Director*	Assurance Enclosure 15
21	**CYBERSECURITY REPORT** *To RECEIVE the Cybersecurity Report from Suzanne Robinson, Director of Finance, Performance and Digital*	Assurance Enclosure 16
22	**LORD CARTER NHS OPERATIONAL PRODUCTIVTY IN MENTAL HEALTH SERVICES** *To RECEIVE an update on the Lord Carter NHS Operational Productivity in Mental Health Services Report from Suzanne Robinson, Executive Director of Finance, Performance and Digital*	Assurance Enclosure 17
	ATTRACT AND INSPIRE THE BEST PEOPLE TO WORK HERE	
23	**ASSURANCE REPORT FROM THE QUALITY COMMITTEE** *To RECEIVE the Quality Committee Assurance report from the meeting held 27th September 2018 from Patrick Sullivan, Non-Executive Director*	Assurance Enclosure 18
	CONTINUALLY IMPROVE OUR PARTNERSHIP WORKING	
24	**LOCALITY WORKING / RESTRUCTURE** *To RECEIVE an update regarding Locality Working / Restructure from Jonathan O'Brien, Director of Operations*	Assurance Enclosure 19
	CONSENT AGENDA ITEMS	

25	**TRUST BOARD/ COMMITTEE DATES AND TRUST BOARD CYCLE OF BUSINESS 2018/19 and 2019/20** *To RECEIVE the Board Meeting / Committee Dates and Trust Board Cycle of Business 2018/19 and 2019/20 from Laurie Wrench, Associate Director of Governance*	Assurance Enclosure 20
	ANY OTHER BUSINESS	
	The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday 22nd November 2018 at 10:00am.	
	MOTION TO EXCLUDE THE PUBLIC *To APPROVE the resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admissions to Meetings) Act 1960)*	
	THE REMAINDER OF THE MEETING WILL BE IN PRIVATE	
	DECLARATIONS OF INTEREST	Note
	DECLARATIONS OF ANY OTHER BUSINESS	Note
	SERIOUS INCIDENTS	Assurance
	PERFORMANCE	Approve
	ESTATES	Assurance
	WORKFORCE AND AGENCY	
	ANY OTHER BUSINESS	

TRUST BOARD

Minutes of the open section of the North Staffordshire Combined Healthcare NHS Trust Board meeting held on Thursday 26th September 2018 At 10:00am in the Boardroom, Trust Headquarters, Lawton House Bellringer Road, Trentham, Stoke on Trent, ST4 8HH

Present:

Chairman:

David Rogers
Chairman

Directors:

Caroline Donovan
Chief Executive

Maria Nelligan
Executive Director of Nursing and Quality

Suzanne Robinson
Director of Finance, Performance and Digital

Patrick Sullivan
Non-Executive Director

Alex Brett
Executive Director of Workforce, Organisational Development and Communications

Gan Mahadea
Non-Executive Director

Tony Gadsby
Non-Executive Director

Jonathan O'Brien
Director of Operations

Dr Keith Tattum
GP Associate

In attendance:

Laurie Wrench
Associate Director of Governance

Joe McCrea
Associate Director of Communications

Dennis Okolo
Associate Medical Director / Clinical Director AMH Inpatient

Retirees
None

Lisa Wilkinson
Corporate Governance Manager (minutes)

Members of the public:
Grant Williams
Joanne Williams
C. Hodinda - Data Analysis

REACH Team Recognition Award
Anna Frary, Deputy Ward Manager, Ward 3

The meeting commenced at 10:04am.

175/2018	**Apologies for Absence** Dr Buki Adeyemo, Medical Director, Wendy Dutton, Chair of Service User Carer Council, Lorien Barber, Non-Executive Director, Jenny Harvey, Unison Representative	**Action**
176/2018	**Declaration of Interest relating to agenda items** There were no declarations.	
177/2018	**Minutes of the Open Agenda – 26th July 2018** The minutes of the open session of the meeting held on 26th July 2018 were approved.	
178/2018	**Matters arising** The Board reviewed the action monitoring schedule and agreed the following:- ***116/2018 – Learning from Deaths Quarterly Report -*** *Report going to Quality Committee 27th September 2018 and will come to Trust Board 25th October 2018.* ***140/2018 – Safer Staffing Monthly Report April 2018*** *- Update due at October Trust Board.* ***141/2018 (1) – Serious Incident Report (1)*** *- Update due at September Trust Board.* ***141/2018 (3) – Serious Incident Annual Report (3)*** *– Deep Dive will be included in the Falls Annual Report which will be going to Quality Committee 27th September 2018.*	
179/2018	**Chief Executive's 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. Alex Brett will be taking up a new role with Midlands Partnership Foundation Trust (MPFT) on the 1st October. We are delighted that Linda Holland will be starting as Interim Director of Workforce and Organisational Development from mid November 2018, starting to work in the Trust on ad hoc days from September onwards. Linda is a very experienced Director and the Trust is lucky to attract her from her current Director role at Mid Cheshire Hospitals NHS FT. In the meantime the HR function will be led by Jonathan O'Brian, Communications by Dr Buki Adeyemo and	

Organisational Development by Caroline Donovan.

CQC RETURNING TO TRUST – OUR JOURNEY CONTINUES

The results of our 2017 CQC inspection confirmed that the Trust's journey of improvement, previously described by the CQC itself as the fastest improving mental health trust in the country, had continued without let-up. The Trust said it would not be complacent and wanted the journey of improvement to continue.

Since then, the Trust has done just that, particularly with the move towards locality working and our continuing leadership of key workstreams in the Together We're Better STP.

The Trust is aware of the amount of effort that goes into supporting a CQC inspection, particularly in the middle of major change and transformation can seem a challenge. Therefore it will come as mixed news that the Trust has received a request from CQC for its Routine Provider Information Request – something that has to be completed annually as part of the new well-led inspection regime. This also served as an announcement that the Trust will receive an inspection within 6 months.

The Trust submitted its provider information request (PIR) with over 200 returns by the deadline of 21st September. The requests were split between qualitative (narrative information requests) and quantitative (numerical data requests). Key operational and corporate leads worked on the data requests to ensure the return is an accurate reflection of our services and Trust performance.

The Trust has also completed its own self-assessment of its 11 core services which demonstrate continued improvement. This was discussed collectively at the Senior Leadership Team meeting and will be presented to the Board.

Previous CQC inspections have helped the Trust to continually improve and the Trust needs to approach this next one with a mindset of showing the inspection team continued progress demonstrating the dedication and commitment shown by our staff.

LOCALITIES UPDATE

Progress towards locality working continues. At the start of September, staff response to the Stage 3 consultation was published. A really important principle of the process has been to make sure the Trust is co-producing the new structure in partnership with staff. That is one of the main reasons that the process has been designed in 4 phases so the Trust can co-produce, listen and respond.

There were five main themes that came out from the consultation:

- Directorate Makeup / Placement of Services
- Substance Misuse
- Psychology Structure
- Quality Improvement Lead Nurse / Matron

- Acute / Urgent Care

In the response document, a considered response was provided on each of these. As part of the Trusts commitment to openness, the Report was made available on the web after the staff have been given the opportunity to read it first. This is being presented by the Director of Operations later on the Agenda.

The Trust has also created a dedicated website to support the consultation process. This generated the majority of feedback. Every question and answer handled by the website is also published on the publicly available website.

The Trust wants to thank all staff affected by this consultation for their continued professionalism, engagement and for their valuable contributions to the finalised structure. The Trust reccognises that this process can be stressful and their input has been valued throughout the process into embedding a structure which further enhances the ability of teams to deliver the fantastic, patient led services of which they are rightly so proud.

Thanks to Jonathan O'Brien for his leadership on this agenda.

HEALTH AND WELL-BEING BOARD HEARS OF PROGRESS ON CQC LOCAL SYSTEM IMPROVEMENT PLAN

In August, Caroline Donovan attended the latest meeting of the Stoke-on-Trent Health and Wellbeing Board. One of the key roles of the Board is to oversee the system CQC Improvement plan, which to date Caroline has led. Caroline advised it was really positive to be able to present the plan in a very positive light and hand over the leadership to Paul Edmondson-Jones, the City Council's Director of Social care, Integration and Wellbeing. A call followed with the Department of Health Lead Director who passed on compliments from the Secretary of State for Health on the progress made as a system - it has been a great example of system working - a massive thank-you to all who have contributed. The CQC will be returning in November to do a review of progress on the Stoke system. In addition, a CQC system review starts on 17th October across Staffordshire County Council and its partners.

ACTION ON INCLUSION

Caroline Donovan opened the Trust's Second Staffordshire Symphony of Hidden Voices. Caroline advised that the inclusion conference which was chaired by Jenny Harvey, Staff Side Chair was absolutely fabulous and she spent the whole day listening to incredible real life stories and insights:

- life as a British-born nurse, health expert, tutor, lecturer and medical professor of Irish and Nigerian descent by Professor Dame Elizabeth Anionwu;
- growing up as a young black man in the West Midlands in the aftermath of Enoch Powell's Rivers of Blood speech, by Roger McKenzie, Assistant General Secretary Unison
- how it was to live as a gay man before decriminalisation of homosexuality in 1967 and to have recovered from AIDS, by Maurice Greenham, Older People's LGBT Group;

- fascinating stories of living with a learning disability from service users in the Combined Healthcare Talk and Change Group
- insight into the work of Trans Staffordshire from Kirsty Lewis;
- discussion of the complexity of how different identities intersect with LGBT inclusion from Emma Jennings, Stonewall
- stories of how deafness can introduce particular challenges in living with and providing support for people with mental health issues, from Julia Grint, Community Psychiatric Nurse

One particular highlight were two contributions from local poet Gabriella Gay. The second of her poems was an incredibly powerful piece about coping with racism in the workplace - which itself was based on the true life experience of a nurse working at Combined. It was truly humbling and painful to hear of her experiences. It is essential the Trust learns and improves from them. The Unison Award for Equality and Inclusion was also presented to Stevan Thompson.

Hearing about challenges and gaining insights means nothing if the Trust does not act on what it hears. A very detailed plan of action will be developed, building on the work already undertaken on diversity and inclusion. On 20th September, Caroline was pleased to chair the first meeting of the Inclusion Council where streams were identified for improvements. These are:

1. Developing HR Processes for inclusion - including recruitment and selection; disciplinary and grievance; workforce equality info processes; bank and agency staff (building in inclusion from start to finish of the process)
2. Supporting the development of BAME staff : Developing equal and inclusive access to career, leadership and education development opportunities
3. Reporting, learning and improving following incidents and incidences of racist abuse and aggression
4. Culture of Inclusion: Developing clear standards of expected and unacceptable behaviour (policies, training, leadership styles, service user involvement). Addressing how staff treat each other day-to-day; inclusive treatment of colleagues; addressing micro-assaults and inequalities). Also considering religion and culture, food, etc.
5. Communication for inclusion delivering clear communication inclusion, including: feedback from staff (including trainees); BAME network; engaging with our agency staff; events; posters; staff; BAME champions; app to gather staff experiences on exit – and starting with #WearRedDay #19Oct #ShowRacismTheRedCard

The Trust has identified BAME Leaders to sponsor each of the programmes to ensure co-production.

SYSTEM DIAGNOSTIC

Over the last few weeks the STP have been leading on a 'System Diagnostic'; this looks at all the data and statistics available from across Staffordshire & Stoke-on-Trent and builds a story outlining where key challenges and opportunities lie for improved quality and financial savings but from a system perspective rather than individual organisations. This

work has been supported by the NHS Delivery Unit which is headed up by Tessa Walton the Director of RightCare so the Trust is really privileged to have this level of support from her team but it's also important that we work together to get real value from what its telling us. The initial themes emerging highlight mental health where there is under investment across the system but high spend across acute, ambulance, primary care, mental health etc; which suggests that people aren't always able to access the support they need in the right setting and with clear pathways.

MENTAL HEALTH REGIONAL CONFERENCE

Caroline Donovan recently chaired a fantastic regional mental health conference at the start of September. The conference focused on sharing good practice with nearly all Trusts across the region showcasing different services and innovations. Combined shared the work undertaken on compassionate leadership. The event was opened by the Feel Good Choir - a community choir who were fantastic and talked to us about the importance of connection and wellbeing. We were also really pleased that Clare Murdoch, National Mental Health Director for NHS England, came to talk to us about progress of the mental health national strategy and thoughts for future priorities.

HEALTH KEELE UNIVERSITY PARTNERSHIP GOES FROM STRENGTH TO STRENGTH

In August Caroline Donovan, Dr Buki Adeyemo and Andrew Hughes went to visit Professor Trevor McMillan - Vice Chancellor and Helen Duffy - Partnership and Engagement Manager from Keele University.

It was a really positive and exciting meeting where discussion was had about the excellent progress the Trust has made from both an educational and research perspective.

Particular thanks to Dr Chris Link and Dr Darren Carr who have made such good progress. The Trust will hopefully soon have more clinicians taking up senior lecturer roles in both education and research with Keele University and more plans afoot all which will help improve patient care and attract and retain talented staff. Andrew Hughes is presenting an update later on the Agenda.

FIRST CONFERENCE FOR NON-REGISTERED CARE WORKERS

Maria Nelligan led a conference this month to celebrate and support the work of the Trust's care workers. This staff group is amongst the biggest in the Trust, with the most proportion of time in direct patient-facing roles.

The event also featured keynote presentations from a great friend of the Trust, Tommy Whitelaw – Leading Change Adding Value Champion at NHS England and from Shaun Maher, Principal Educator Quality Improvement Team at NHS Scotland.

The morning session of the event gave opportunities for care workers to share insights into the fantastic work they do at Combined, including presentations from:

- Ben Walmsley and Matt Wright – HCSWs, Darwin
- Lisa Boon – STR Worker, Access and Home Treatment
- Jackie Weightman – Assistant Practitioner, Ward 7
- Workers from our Learning Disabilities Team
- Amanda Dibble – HCSW, Intoxication Observation Unit
- David Hilton – Activity Worker, Ward 7

The afternoon session was devoted to a Listening Into Action event, facilitated by our OD Team, listening to feedback and ideas from our staff on how they feel about their work, the opportunities it offers as well as the challenges they face, what more the Trust can be doing to support them and how we can maximise the routes for personal and career development. Well done to everyone involved in putting on a great event.

CONTINUING TO SUPPORT POSITIVE PRACTICE

The Trust is a strong supporter of the Positive Practice in Mental Health Collaborative. This is a user-led multi-agency collaborative of 75 organisations, including NHS Trusts, CCGs, Police Forces, third sector providers, front line charities and service user groups. It exists to identify and disseminate positive practice in mental health services by working together across organisations and sectors to facilitate shared learning and to raise the profile of mental health with politicians and policy makers.

The Trust is proud to play a very active collaborative role and to have been featured regularly in their Positive Practice Awards. This year's entries from Combined were the highest ever and everyone is looking forward to the Awards ceremony in Liverpool next month. The Trust is delighted to have been shortlisted for two of these awards - within the Mental Health Safety Improvement Category and the Mental Health Workforce Wellbeing Category.

The Trust has also been asked to lead the national Children's Positive Practice Awards next year. Caroline Donovan, Carol Sylvester and Joe McCrea, had an enjoyable session this week with Angie and Tony Russell, Directors of Positive Practice, brainstorming ideas about how the Trust can make the Awards a fun and memorable event. The Board will be provided with an update on progress.

BBC RADIO STOKE FOCUS ON MENTAL HEALTH

The Trust has developed a strong and productive relationship with the local radio station, BBC Radio Stoke - and in particular with the breakfast programme "Liz Ellis and John Acres at Breakfast". This has included working with the programme's presenters and producers on developing and/or contributing to story ideas that raise the profile of mental health in an informed way, promote a recovery-based approach, and raise awareness of the services and support available either directly from the Trust, from its partners or more widely across our patch.

In August, the breakfast programme devoted a slot every day to stories on mental health. The stories were approached from the perspective of the service user or their families and provided a fascinating insight - not pulling

punches, but also being positive and fair in the way they explained and included the input and perspective of services as well.

The week's topics were:

- Monday - The personal journey of recovery of a service user
- Tuesday - Coping with OCD
- Wednesday - Brighter Futures
- Thursday - Step On
- Friday - Coping with Eating Disorders and out of area placements

The Trust continues to develop its relationship with the BBC as well as other local media outlets.

WORKING TOGETHER TO MEET THE CHALLENGE OF MONKEY DUST

Monkey Dust is a particular feature of substance misuse in Stoke-on-Trent and has been something on which the Trust has been actively involved, both in providing support services via the Community Drug and Alcohol Service and in developing partnerships across the local NHS, local government, voluntary sector and emergency services including the police.

As with any relatively new substance, there is always the danger for the press to over dramatise the situation or exaggerate its prevalence. In times like this, it's really important that all of the agencies involved work together to ensure they communicate calmly and responsibly the reality of the situation and what is being done to address it.

Caroline Donovan advised she was pleased to see that approach being adopted over recent weeks, in particular some really good work by Dr Derrett Watts, our Clinical Director for Substance Misuse and colleagues from the Community Drug and Alcohol Service. This welcome has been shared by Paul Edmondson-Jones, Director of Social Care, Health Integration and Well-being at Stoke City Council, who shared a message of thanks and appreciation for the collaborative approach being taken with the communications teams and services across our area.

DOUBLE CONTRACT SUCCESS FOR SUBSTANCE MISUSE

The Trust has been successful in securing the Stoke-on-Trent Drug and Alcohol Service (CDAS) contract in partnership with Addaction and BAC O'Connor through a procurement process.

The bid was submitted on the 10 July 2018 to Stoke-on-Trent City Council and was awarded on 23 August 2018 with commencement of service delivery on 1 January 2019. The contract period is 5 years plus option to extend the contract for a further two years and has a value of £3.9m per year.

CDAS offers support to adults, young people, carers, partners and families who live in Stoke-on-Trent to make a positive and sustainable change to their lives and the community they live in. It is a free service commissioned by Stoke-on-Trent City Council.

Also, working in a partnership of three organisations, the team have won a new contract for the delivery of health services at Stoke Heath Prison. The five-year contract, which was commissioned by NHS England, begins in

April 2019 and includes a potential two-year extension that would take it to 2026.

It sees North Staffordshire Combined Healthcare NHS Trust teaming up with Shropcom and The Forward Trust to form what is being called the Stoke Heath Integrated Care partnership (SHIC). The partnership brings together three exceptionally experienced, passionate and proven healthcare providers with extensive experiencing safely and seamlessly transitioning services.

Combined will deliver secondary mental health and clinical substance misuse services. All three organisations already deliver health services at the prison, near Market Drayton, but the new contract involves the introduction of a new model of care that will be shaped over the next six months in the run-up to the launch on 1 April.

As a Trust we have been proud of our successful delivery of Substance Misuse services and we are excited to extend our service offer to include Mental Health services within the prison. The Trust knows how important it is to respond positively to Mental Health conditions whatever the environment and setting.

COLLABORATION WITH MICHAEL WEST ON NATIONAL WEBINAR

Caroline Donovan recently travelled to London with Associate Director of Organisational Development, Jane Rook, to present a national webinar with Professor Michael West of The Kings Fund London.

This was part of a series of webinars to support the national Developing People, Improving Care Strategy. There are 5 conditions that underpin this, condition 2 is the need for compassionate, inclusive and effective leaders at all levels.

It was an opportunity for Combined to share insights on its Trust improvement journey and how staff have been front and centre of that. Jane also shared the work the Trust is undertaking to strengthen its approach to inclusions. There are now over 756 of staff who have been recognised for their acts of compassion.

COMBINED PLAYS ITS PART IN THE WORLD'S BIGGEST COFFEE MORNING

Lawton House are holding a 'World's Biggest Coffee Morning' on 28th September, fund raising in support of Macmillan Cancer Support. It is a great thing to be involved with, particularly as part of this event our own Sue Slater, Education and Development Manager, is 'Braving the Shave' at 1pm she will be having all of her hair removed!

The Trust will be having cake and coffee for donations for the charity. There will also be filming and photographing of Sue's shave so if you can't make it you will certainly be able to see it afterwards.

COMBINED SHORTLISTED FOR HSJ PATIENT DIGITAL PARTICIPATION AWARD

Combined has been shortlisted for the HSJ Patient Digital Participation award for our Autographer project. The new category has been introduced to recognise how the use of digital technology can radically improve patient interaction with their own care. The wearable camera 'Autographer' was used as a memory support intervention for patients with dementia, which helped to build self-care and management capabilities.

WINTER PLANNING

As normal, over the summer months operational teams have been working with partners across the health economy to plan for the forthcoming winter period. This has involved partners working together to ensure that additional capacity and resources are available over the winter months and specifically December 2018 to March 2019. The local acute trust, University Hospitals of North Midlands, have received a capital allocation of almost £9m to build two additional wards and these are currently on plan to open in December 2018.

Combined Healthcare has been supporting by planning to provide additional capacity within its older peoples' community teams, mental health liaison services and crisis services. Specifically, the Trust has been asked once again to contribute by increasing capacity on Ward 4 in Harplands Hospital from 15 to 19 beds over this period. We are currently awaiting confirmation that funding will be made available for this uplift in capacity and will communicate further on this, once we have confirmation.

NEW FLU VACCINATION TO REDUCE BURDEN ON NHS THIS WINTER

Delegates at the Public Health England (PHE) conference heard that a more effective flu vaccine for those aged 65 and over this winter has the potential to prevent deaths and significantly reduce the burden on the NHS.

The vaccine, available for the first time this year in the UK for those aged 65 and over, could reduce GP consultations by 30,000, hospitalisations by over 2,000 and prevent over 700 hospital deaths from flu in England, alleviating some of the health burden that seasonal flu places on the population, workplaces and the NHS.

The newly available 'adjuvanted' vaccine is expected to significantly boost effectiveness by improving the body's immune response to the vaccine. This is important because typically, older adults' bodies do not respond as well to the flu vaccine due to their naturally weaker immune systems. Older adults are also more likely to suffer complications from flu.

Rob Sillito from Combined Healthcare was interviewed this month by Stuart George on BBC Radio Stoke. The main focus on the interview was to promote health care and social care staff to get their free flu jab. But also to

promote the general public to seek out more information about the flu jab.

Rob discussed who is eligible for a free Jab, these being people over 65, children, people with some chronic medical conditions e.g. diabetes, chronic heart disease, COPD and also healthcare and social care staff. He also discussed how people can get their flu jab by speaking to infection control or Team Prevent. He then went on to discuss the importance of staff getting the flu jab - for protecting ourselves, other staff, family and most importantly protecting the patients we are caring for. Finally, he dispelled people's false beliefs that the flu jab can give you the flu or a cold and explained that the flu jab has a killed virus in and this makes the body produce antibodies and when we are exposed to the flu virus in the flu season, our body is ready to fight the virus.

Combined Healthcare will be kicking off our flu campaign on the 5th October with a 24 hour Jabathon, with a member of staff roaming and giving as many staff as possible the flu vaccine throughout the day and night.

MENTAL HEALTH THERAPISTS IN GP PRACTICES COULD BE THE NORM

New guidance has been drawn up to encourage doctors to place mental health therapists in practice surgeries – bringing more mental and physical health services under one roof. These new therapists will be integrated into primary care teams and focus on common mental health disorders such as anxiety and depression, particularly where this occurs in patients with a long term physical health condition such as diabetes, respiratory or heart problems.

Evidence suggests nine out of 10 adults with mental health problems are supported in primary care and broadening the range of services for patients, means local health services are better equipped to deal with patients' physical and mental health needs.

Claire Murdoch, NHS England's National Director for Mental Health said: **"**Joining up talking therapy services in primary care settings is another big step forward for our patients and a key plank in putting mental health at the centre of the long-term plan for the NHS. We are on track to deliver 3,000 therapists in primary care, with over 800 in surgeries at the end of last year and this handy guidance should convince those practices that are yet to take the plunge of the benefits."

In line with the National Directive the Healthy Minds service operates a Stoke Locality Hub and Spoke Model where IAPT Long Term Condition therapists are located in the therapy suite at the northern part of the city and a the second hub operates in a shared location with third sector in south stoke.

The spokes of the service where therapy is delivered are:

- GP Practice's

	More specifically some GP Practices have offered room space for IAPT Long Term Condition (LTC) therapists to be co-located with the nursing practice teams so that there is a holistic approach to client care for people where the therapist is part of the overall GP Primary Care Team. • Primary Care Centre's The Healthy Minds IAPT- LTC therapists have been co-located in Primary Care Centre's and Health Centre's with the Specialist COPD and Diabetes Physical Health Teams. • Community Venues The Interface within Primary Care has been implemented including: • Outreach visits by the IAPT Clinical Lead to GP Practice Teams and GP Locality Meetings. • Co-location with the Specialist Physical Health Teams (COPD, Diabetes, GP Teams) across the locality enables therapists to attend physical healthcare clinical team meetings, provide opportunities for clinical consultation. • Specialist Case Recognition Training has been delivered for the COPD and Diabetes teams and physical health training has been reciprocated for the IAPT-LTC/Core team. • Shadow working arrangements have been developed with the Community COPD and Diabetes Teams to understand the roles between practitioners. • IAPT-LTC therapists deliver 'wellbeing educational programs' as part of the COPD Pulmonary Rehab and Diabetes treatment programs within practices. • Cardiac Educational Programs have been developed and rolled out for the Cardiac Rehab Team by IAPT-LTC therapists. • To improve access to the service specialist physical health leaflets have been marketed and distributed across the locality. **Received**	
180/2018	**Chair's Report** David Rogers, Chairman provided an update. David thanked Joe McCrea for all of his hard work following a successful and positive Annual General Meeting (AGM) yesterday. David advised that the NHS England and NHS Improvement have revealed their intention to work much more closely together to maximise efficiencies and reduce duplication. While legislation prevents a formal merger between the two organisations, the plan is to combine forces for functions where integration is possible and beneficial. From September 2018 (subject to board approval), the groups intend to increase integration and alignment of national programmes and activities,	

	led by one team where possible, as well as integration of NHS England and NHS Improvement regional teams, to be led in each case by one regional director working for both organisations. David talked about the imminent CQC visit advising this will be a lighter touch than previous visits as they will be looking more at strategy rather than undertaking a well led review albeit the data requests are still excessive. ***Noted***	
181/2018	**Staff Retirements** There were no staff retirements	
182/2018	**REACH Individual Recognition Award July 2018** **Anna Frary, Deputy Ward Manager** Anna has worked for Combined Healthcare since she qualified 15 years ago. All of these years have been served on our acute wards. Anna has been working as a deputy ward manager for 3 years and has developed so much in this time. Completing the trusts people management program and supporting ward 3 through the biggest pathway change in its history. Anna's development and hard work have been recognised recently in her being appointed to the ward manager post on ward 3. Working as a registered nurse for 15 years in any acute environment deserves its own level of recognition and even after all this time Anna remains passionate about the service and what it delivers. Anna is a popular member of staff with both patients and staff. Her compassion is palpable and is recognised by all. She works closely with students and newly qualified nurses to share her knowledge and experience which is truly invaluable. Working for any service for 15 years means that naturally you have seen many changes, some good and bad. Anna truly embraced the acute care pathway and is its biggest fan, promoting its impact whenever she has the opportunity. Ward 3 has been through some very difficult circumstances in the last few years. The improvements and the changes have been acknowledged repeatedly however its often important to acknowledge what hasn't changed and the support, guidance and passion offered by Anna has been consistent throughout that time and she has been key in our team moving forward. She is an asset to this trust. Anna demonstrates all of the Trust values: - Anna is consistently described as compassionate by her peers and patients. Even during difficult times her approach never falters. She is able to have difficult conversations whilst maintaining a kind and calm approach.	

	- Anna is approachable to all which is how she has made and maintained the strong relationships she's has built over these years. - Responsible- Anna has taken on the responsibility of managing a ward and implementing change with passion and enthusiasm. - Excellent- Anna is a catalyst for change and speaks passionately about anything which is believes will impact on patient care and experience in a positive way. ***Noted***	
183/2018	**PATIENT STORY – SHAMUS HARVEY – HILLCREST** Shamus Harvey came to our services from a secure unit and first had contact with Hillcrest in April 2018. Initially Shamus was able to access the short stay facilities where he worked well with all staff, STR and OT workers. Shamus then took residency in the male side of Hillcrest and continued to engage with the support services available. Shamus has now moved into his own flat with support from Brighter Futures and continuing support from Hillcrest. Members of the Board watched a video of Shamus talking about his journey through Combined and other organisations services, his positive and negative experiences and the support he has received from Brighter Futures and Hillcrest. Maria Nelligan thanked Shamus for sharing his story and advised it touches on a number of areas the Trust wishes to improve on. Joan Walley asked in terms of where Shamus is now if there is enough support going forward. Shamus advised he is looking forward to the future although still hearing voices they are not as intense as before. Shamus added that Brighter Futures have supported him to get a nice house and to come and talk to Board members here today. There are staff in the flat between 9.00am and 5.00pm if any problems arise and he needs them. Caroline thanked Shamus for sharing his story and advised that the Trust is trying to improve supporting people on substance misuse and alcohol.	
184/2018	**QUESTIONS FROM MEMBERS OF THE PUBLIC** Mr Grant Williams advised that it has been brought to his attention that North Staffordshire Combined Healthcare are losing Section 75 funding for staff at Lymebrook and has subsequently contacted Staffordshire County Council who he felt were very secretive. Having asked what will happen when funding is removed he was told 'we do not know yet'. Mr Williams advised he was aware that Combined have been fighting to keep the service but felt this is a disaster waiting to happen. Mr Williams has discussed with Matthew Ellis, Staffordshire Police and Crime Commissioner who also shares Mr Williams's concern. Mr Williams highlighted that	

	yesterday staff were told they can contact patients to say we are not offering support but no one has received a call to say who is offering support. Caroline Donovan highlighted that this is something the Trust have actively been resisting for two years. Combined believe this is not the right decision, the original plan was that social care staff under the Section 75 agreement were going to be transferred to Midlands Partnership Foundation Trust (MPFT). The Council changed their mind and transferred staff to the County Council which Combined did not agree with. Caroline advised we have to accept his is happening but reiterated that the Trust have worked hard to ensure patients do not fall through the net and that the transfer of patients will be as smooth as possible. The Local Authority have indicated this is only for a period of 12 months then staff will TUPE into MPFT. Jonathan O'Brien confirmed that he had been involved in the transfer process since the final decision was made. Jonathan has met with staff fortnightly to ensure the arrangements are in place and will happen as smoothly as possible given the potential for disruption to patient care which the Trust wanted to ensure did not happen. There are 13 members of staff transferring to the County Council not just from Lymebrook The transfer predominantly affects North Staffordshire and not Stoke-on-Trent. The Trust has worked closely with transferring staff; the County Council has put some induction procedures in place. Combined have been working in parallel on a piece of work for staff and for patients and those that may come into our service in the future and need social input into their care packages. Patients who have predominately social care needs will transfer with staff for continuity of social care needs and we have identified approx. 220 patients. As teams will not be located together the Trust have ensured clear access pathways. We have also put together MDT's and ensured they are still available. During the process we did not want to cause unnecessary upset for service users. Combined has been open with service users, staff and media about the transfer and the fact that the Trust did not agree with it, we did not communicate immediately with service users as we have to look at who would transfer with the staff. This work was concluded one week ago, at that point we agreed communications with social care and the County Council to agree this is how we would move forward. Mrs Joanne Williams advised that she is one of the 200 service users affected by the transfer and advised she has no package in place. Mrs Williams confirmed she does not know if she is going to have a Social Worker, a CPN or a Care Coordinator. Mrs Williams acknowledged this was not the Trust's fault and felt the was down to cost and money it's highlighted it is always mental health services that suffer where money is concerned. Jonathan confirmed he was happy to look into Mrs Williams's personal circumstances and those of any other service users. Jonathan confirmed he would ensure all service users have had clear communications as this is critical.	**JOB**

	Mr Williams highlighted that the County Council were not aware of how many people were being transferred Mr Williams stated that they do not have a clue as they do not have the experience. Jonathan highlighted this is an outcome Combined did not want but was almost predictable. Jonathan will seek assurance from the teams today. Mrs Joanne Williams highlighted that she would have wanted to know at the beginning rather than find out later as this would have enabled some forward planning. Mrs Williams advised that she felt strongly enough to come to Board today, patients have not been informed correctly and she felt that service users will struggle over the next few months and the Trust will feel the ramifications of this. Mrs Williams highlighted that Stoke-on-Trent service users have received all of the support but Newcastle and Staffordshire once again get nothing. MPs need to be speaking up for Staffordshire Moorlands. David Rogers reiterated that the Trust has fought this battle for the last two years with everybody it could. The Trust was working towards integration and this is marching in the opposite direction. Staffordshire County Council have the right to do this in the sense that the contract has terms to enable it to come to an end. The Trust has taken legal action but cannot prevent the transfer what we can do is try to influence people to see the harm this could cause. The Trust has done all it can to ensure the transition is manageable, the plan for how future services will be provided has been slow to emerge therefore the trust has been unable to provide assurances not knowing the plan ourselves.	
185/2018	**SERVICE USER AND CARER COUNCIL** Maria Nelligan, Director of Nursing and Quality provided an update in Wendy Dutton's (Chair) absence. At the Workshop on 27th June 2018 the following was discussed: • Citizens Jury is to enter an 'Action Plan' phase. There is assurance this will involve service providers, 3rd sector workers as well as service users and carers. Maria is involved in this stage. A meeting took place yesterday. The Service User Carer Council have been invited to attend as part of taking forward the action plan for the Citizens Jury. **Service User & Carer Council Business meeting to be held 26th September 2018** • There will be an update on the Patient Aide application and changes to non- emergency transport by Ben Boyd, Associate Director of Specialised Services alongside a discussion on the BeAble application. Wendy Dutton trialled the application for 2 weeks, currently in simplistic prototype form, the potential breadth of application was discussed and encouraged; the trial had some interesting outcomes. • A robust review of all open actions with a view to refreshing targets	

	and agenda in line with the new Directorate structure. • Nominations for Vice Chair and October workshop (by which time hopefully the new Directorate structure will be in place) a review as to how the Council can best support service user's/carer's ***Received***	
186/2018	**RESEARCH AND DEVELOPMENT ANNUAL REPORT 2017/18** Dr Dennis Okolo, Clinical Director AMH Community presented the report. Research and Development (R&D) Annual Report is to present information on the R&D activity for the period 1st April 2017 to 31st March 2018. The report shares the Trusts research journey over the last 12 months, sharing successes, performance and stories. Dr Okolo highlighted the following: In 2017 – 18 - There was a reduction in funding received from NIHR. - The Trust achieved and exceeded the Trust target locally. - 4 out of 6 objectives were fully achieved - We had 13 active Principal Investigators and work is ongoing with the Clinical Research Network (CRN) to recruit/train more Principal Investigators. - In May the Neurodegenerative Active Partnership (NOGAP) took research on the road - In June The National Centre for Mental Health (NCMH) study was adopted in the Trust The study aims to better understand the triggers and modifiers of mental disorders - In September a video created by NOGAP to raise awareness about the dementia research being undertaken locally between the Trust and University Hospitals of North Midlands (UHNM) received recognition at Stoke City Football Club. - Research sponsored by the Trust was published in the Journal of the American National Association (JAMA) - The CYP research team topped the leader board for recruitment onto the Pre-School parenting interventions (COPPI) trial. Looking forward to 2018/19, a set of key objectives are set out in the Trust's Board Assurance Framework and progress has already been made. ***Received***	
187/2018	**SAFER STAFFING MONTHLY REPORT – JUNE / JULY 2018** Maria Nelligan, Director of Nursing & Quality presented the report. The papers outline the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during June and July 2018 in line with the National Quality Board requirements.	

	The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during June 2018 was 77% for registered staff and 106% or care staff on day shifts and 82% and 107% respectively on night shifts. Overall a 94% fill rate was achieved. The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during July 2018 was 77% for registered staff and 102% or care staff on day shifts and 80% and 111% respectively on night shifts. Overall a 94% fill rate was achieved. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward manager supporting clinical duties. The data reflects that Ward Managers are staffing their wards to meet increasing patient needs as necessary. Maria advised in terms of direction of travel we will not see our fill and vacancy rate improve until October 2018. Plans are in place to receive new registered nurses with a programme of preceptorship and action learning sets and masterclasses. We are ensuring new registered nurses have 'buddies' on the ward to ensure a supportive experience. Maria advised she previously presented a paper to Board that looked at ways to improve recruitment this has since been updated and is noted on the action schedule to come to October Board. A lot of work is ongoing on the wards in supporting frontline staff and ensuring the Trust provides safe staffing. In addition from 1st October 2018 the same care module that gives real time information re: acuity and staffing will be implemented across the community teams. David Rogers highlighted that staffing is an issue nationally. The rate of the decline has been arrested locally in the last few months but remains an issue. Maria confirmed this is a team and whole organisation approach the first cohort of Nursing Associates has commenced. Six places have been identified and 3 filled as individuals did not meet the criteria for entry. The Trust is therefore supporting HCSWs with Maths and English qualifications to enable eligibility. The Trust has also been working with Consultant Nurses to develop an in house CPD programme. Tony Gadsby queried if staffing plans have remained on target for the PICU opening. Maria confirmed they had and that Natalie Larvin, Head of Directorate had been leading on this. Jonathan highlighted the importance when carrying out visits and staff express concerns about workforce that they are clear it is not a financial issue. Patrick Sullivan noted that looking at the figures and the vacancies there are nearly 50 staff required, which will reduce when new nurses commence, but	

	they will be inexperienced. PICU's are complex clinical areas and Patrick requested assurance that PICU can be staffed without leaving other wards unsafe. Maria advised there is a skill mix of people to staff the unit; some experienced. We are mapping this out. If there is a huge gap we would review further but there is no indication at the moment this is the case. The Trust Board is asked to: • Receive the report • Note the challenges with recruitment and mitigations/action in place • Note the challenge in filling shifts • Be assured that safe staffing levels are maintained ***Noted / Received / Assured***	
188/2018	**SAFEGUARDING CHILDREN AND ADULTS ANNUAL REPORT 2017/18** Maria Nelligan, Director of Nursing & Quality presented the report. The Safeguarding Annual Report 2017-2018 provides assurance on safeguarding activity throughout the Trust. This includes referral rates, training, audit and case reviews. The scope of the report is the portfolio of the Safeguarding Team and includes Safeguarding Children, Safeguarding Adults, Prevent and Domestic Abuse. Maria highlighted the following: - This has been a year of significant change for the safeguarding team with the appointment of both a new Named Doctor and Head of Safeguarding (Named Nurse). The service has continued to deliver both internal and external training packages resulting in compliance for internal Safeguarding Children level 3 training reaching 85% at the end of the second year of a three year project to raise compliance to Trust target of 85%. - The Trust Safeguarding Group meets quarterly and provides an opportunity for representatives from key services to discuss issues, report progress and provide assurances against documented action plans and audit - The Trust's Assurance Framework includes reports from the Executive Safeguarding Lead to the Quality Committee ***Received***	
189/2018	**INFECTION PREVENTION AND CONTROL ANNUAL REPORT** Maria Nelligan, Director of Nursing & Quality presented the report. The purpose and content of this annual report is to provide an overview of the Infection Prevention and Control (IPC) activities from April 2017 to 31st March 2018, and to highlight achievements and the progress made against the priorities outlined in the Infection Prevention and Control Group (IPCG) work programme 2017/2018.	

	Maria highlighted the following: - During 2017/18 the Infection Prevention and Control Team achieved zero number of Healthcare Associated Infections (HCAIs) cross infection cases in patients or staff (excluding small round structured virus outbreaks) - The Trust has introduced a number of actions to monitor and prevent sepsis - Combined continued to use the Antimicrobial prescribing guidelines for general practice for use within in-patient and community services. The in-patient audit criteria are being reviewed to include the antimicrobial stewardship principles of TARGET. - The Trust has maintained exceptionally high PLACE scores - With regards to the Flu Campaign. Overall across healthcare 68.7% of frontline staff were vaccinated. CQUIN, Immform and NHSI submissions for the Trust were all 72.1% with the CQUIN target achieved, 70% by the end of February 2018. More emphasis will be placed on individuals to be more responsible in having the vaccine. Tony Gadsby asked if there is a plan to vaccinate Board members at a future Board meeting as we have before. Maria agreed to ensure vaccinations could take prior to or during the October Board meeting. ***Received***	**MN**
190/2018	**HEALTH AND SAFETY ANNUAL REPORT** Maria Nelligan, Director of Nursing & Quality presented the report. The purpose of this Annual Report is to provide details of the current management arrangements in place for health and safety and to give assurances that we are meeting our statutory requirements for health and safety. The report also summarises key areas associated with good practice and successful health and safety management for the period 1st April 2017 – 31st March 2018. Maria highlighted the following: - The Trust was issued with the improvement notice on 17th January 2017 in respect of the Control of Vibration at Work Regulations 2005 and given until 17th March 2017 to address the identified breaches. Following a significant programme of work to remedy the identified contraventions, the HSE re-inspected the Trust on 16th March 2017. The Trust was deemed to have completed and implemented excellent work by the HSE inspector, however the improvement notice was extended for 3 months until 16th June 2017 to allow time for the estates team to gather evidence of staff's exposure during work activities. - The number of assaults resulting in harm to staff fell in accordance with the overall figure from 155 in 2016-17 to 143 in 2017-18. The vast majority of harm incidents were rated as minor (141) with 2 rated as	

	moderate harm representing 44% of the total number of incidents. Strategies adopted by the Trust to attempt to reduce violence against staff will be discussed at the end of the report. ***Received***	
191/2018	**COMPLAINTS AND PALS ANNUAL REPORT** Maria Nelligan, Director of Nursing & Quality presented the report. During 2017-18 the Patient Experience Team have continued to provide a more holistic, patient experience approach to providing support to service users, their families and carers. There has been a very positive response to what has been implemented with strong support from directorates at all levels. Maria highlighted the following: - There has been fewer formal complaints and more issues being resolved to the satisfaction of the complainant through local resolution or the PALS process - There has been a significant increase in the number of compliments received and recorded which is another indicator that the Trust is improving the experience of service users and their families. - Most complaints relate to the Community Directorate which is expected as this is the largest directorate. - Each complaint has an action plan which is owned by the team. Going forward we are strengthening that process with an audit process to ensure actions have been completed - There has been a lot of work undertaken regarding resolving concerns - In comparison to other Mental Health Trusts the number of complaints we received during 2017/18 are very low as evidenced by the NHS National Mental Health Benchmarking Network. - Of the 33 complaints in the report 19 were from Females and 14 from Males, 32 were white British with 1 white Irish, 32 had no disability 1 had physical disability. However, during 2017/18 there have been no themes arising in relation to protected characteristics. The PET team will continue to monitor and analyse protected characteristics and highlight any emerging themes or trends. - The team are looking to develop proactive work with service users within the Learning Disabilities Directorate as very few complaints are received from this service. Patrick Sullivan noted the trend on complaints is significantly down and compliments have increased. Patrick queried if this could be related to the fact services are improving. With regards to benchmarking, the number of Trust complaints are low Patrick queried if this was due to proactive work to resolve issues early or that people were unable to complain. Maria highlighted that she too was initially cautious but advised that staff are proactively supporting staff and PALS contacts have increased which is the right direction of travel.	

	Received	
192/2018	**AHP DRAFT STRATEGY** Maria Nelligan, Director of Nursing & Quality presented the report. Maria welcomed Sarah Mountford, Team Manager and Sam Trofimowicz, Physiotherapist who presented the Allied Health Professional (AHP) Strategy for Board approval to enable it to be launched at the AHP Event next week. The development of an AHP Strategy is intended to describe how the Trust will harness the collective strengths and unique contributions of the AHP workforce to transform care, increase quality and embed a culture of improvement. The document describes how it will deliver the key themes of the national AHP framework as stated within the NHS England AHP Strategy (AHP's into Action 2017). It will require commitment and involvement at all levels including senior leaders, our AHP leads, our AHP's, stakeholders and from our communities. The strategy has been developed in consultation with the AHP workforce who has identified 6 key strategic themes, namely: • Person centeredness • Recruit, retain, develop and support AHP workforce • Realising ambition and driving innovation • Forging relationships • Delivering quality services • Valuing achievement These themes are aligned to support our commitment to work together and to each individual Allied Health Professions own professional standards. Jonathan asked Sarah if she thought the Trust had asked what AHPS can contribute. Sarah commented there are a small set of staff practising their core skills however there is lots of breadth and depth in Occupational Therapists (OT) and Physiotherapists portfolio. We need to promote what can do and work with this going forward and build into strategies. Maria commented that OTs have taken on the role of Care Coordinators; not been able to carry out their specialist role however work has been undertaken to look at this. The next phase of management of change (Phase 4) will be clear what multidisciplinary team working looks like. Patrick Sullivan commented that multidisciplinary working is not about generic working Patrick and that where he had seen people work using their specialist skills it makes a real difference. Patrick highlighted the need to look at protecting roles and training. Jonathan advised a piece of work will be undertaken looking at MDTs in Phase 4. Maria added that there will also be a professional leadership piece in Phase 4 to ensure people develop within the organisation. Maria has discussed training with local universities	

	as they do not provide OT training if they can deliver locally this may bring more people forward. Patrick asked how the action plan will be evaluated. Maria confirmed this will be annual action plan to take forward the strategy progress will be reported via the AHP Network. Suzanne highlighted this work values creative, quality driven, good practice and is a real opportunity to promote the network and connect to other strategies within the organisation and drive transformation. Joe McCrea highlighted the new intranet was launched at the AGM and there is currently no dedicated section on the current internet for AHPs. Joe agreed to work with AHPs to get an AHP section on the intranet and raise the profile. David Rogers thanked Sarah and Sam for the presentation. ***Approved***	**JMc**
193/2018	**MEDICAL REVALIDATION ANNUAL ORGANISATIONAL (AOA) COMPARATOR REPORT** Dr Dennis Okolo, Associate Medical Director / Clinical Director of AMH Community Services presented the report in the absence of Dr Buki Adeyemo, Executive Medical Director. The paper outlines the review of the Medical Appraisal and Revalidation action plan in 2018/19. Also attached is the review of the AOA for Medical Appraisal and Revalidation for 2017/18 for information. This is the first quarterly report presented to the Board following on from recommendations to monitor the medical appraisal process in May 2018. The Trust has, in 2017/18, achieved a 100% appraisal and revalidation rate. One Doctor's appraisal was completed after 31st March deadline, which resulted in a 97.5% appraisal rate for the Trust's Annual Organisational Audit. Tony Gadsby queried who appraises the Medical Director. Dr Okolo confirmed the Medical Director is appraised by a RO external to the Trust. ***Received***	
194/2018	**SMOKE FREE PROGRESS REPORT** Dr Dennis Okolo, Associate Medical Director / Clinical Director of AMH Community Services presented the report on behalf of Dr Buki Adeyemo, Executive Medical Director. The report updates and provides assurances for quarter one (Q1) and the	

	majority of quarter 2 (Q2). All inpatient areas are now smoke free, with Edward Myers Unit (EMU) becoming smoke free on 1st July 2018. This has been an accumulation of all the actions since February 2017 when Combined commenced its "Towards Smoke Free" Journey. This journey included the formation of a Task & Finish Group (T&FG) chaired by the Executive lead Dr Adeyemo. The final action plan and progress are attached to the report. Patrick Sullivan highlighted that Ward 3 is an outlier in terms of incidents. Out of 63 incidents there have been 47 on Ward 3. Patrick advised he has visited Ward 3 on a number of occasions and noted that staff are challenged as there are individuals admitted to Ward 3 who smoke which creates a concern for the safety of staff and patients. Dr Okolo added this is the nature of patients admitted and staff recognise this and work closely with individuals to implement a difficult and challenging process noting there have been positives from patients who have gradually reduced or given up smoking which is welcoming. It was not anticipated it would be smooth but an ongoing implementation. Caroline Donovan highlighted that Dr Adeyemo and Amanda Miskell, Consultant Nurse for Physical Health and Deputy Director of Infection Prevention & Control, have been proactive and visited Ward 3 due to the high level of incidents. Maria Nelligan advised that she and Dr Adeyemo have discussed with Ward Managers and Consultants and listened to staff to see what changes were required and subsequently implemented. This is a journey; the name of the policy has been changed to Towards Smoke Free which indicates there is a lot of work ongoing across the organisation to make this happen. The Trust does have staff that smoke and they are being offered the support they need. Maria highlighted that incidents relating to smoking are being recorded therefore there is a link with the Smoke Free Task and Finish Group and Health and Safety. ***Received***	
195/2018	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 2** Suzanne Robinson, Executive Director of Finance, Performance and Digital, presented the report highlighting key points. The following performance highlights should be noted: Access and waiting times: - 93.9% of patients have received treatment or intervention within 18 weeks of referral (target 92%). Jonathan O'Brien highlighted there has been a significant improvement in CAMHS the team have worked incredibly hard all of the children on the pathways have been seen in a timely manner and the back log is being cleared. - 75.0% of early intervention in psychosis patients have received treatment within 2 weeks (target 53%)	

	- 100% of service users referred to an IAPT programme were treated within 6 weeks of referral (target 100.0%) - All MH Liaison target response times have been met CPA compliance: - 97% of those on Care Programme Approach (CPA) for at least 12 months received a formal review within 12 months (target 95%) - 96.3% of those on Care Programme Approach (CPA) received a follow-up contact within 7 days of discharge (target 95%) Exceptions - Delayed transfers of care 7.8% against target of 7.5% - The Board action schedule asked for a breakdown in CCG's. This has been actioned within the report and demonstrates the split re: Staffordshire, Stoke and North Staffordshire. There is a meeting planned to discuss further. - The 7 day follow up for all service users is a metric not seen before at Board. Metric 80.2% against local target 90%. A deep dive as been commenced re: consistency. Caroline Donovan talked about the system CQC reviews happening at the moment. There are drastic differences in delays for Staffordshire and Stoke. Stoke have made excellent progress but things have worsened with social care for Staffordshire County Council. The Trust needs to do all it can. David Rogers highlighted the pressure points are with the County Council. ***Received / Approved***	
196/2018	**BEING OPEN QUARTERLY REPORT** Caroline Donovan, Chief Executive presented the report highlighting key points. The Being Open report provides a combined report of Dear Caroline, FSUG, Raising Concerns and Grievances submissions, reporting on their collective activity providing details regarding the themes, trends and patterns for assurance at Trust Board. It provides a full summary of activity covering a 12 month period for July 2017 – June 2018 and a detailed quarterly review for the period of April 2018 – June 2018. There have been 31 submissions, 2 FTSU and 2 raising concerns. Combined Being Open Key themes – July 2017 – June 2018 Top three themes: - Policies, Procedures and Processes - Other - Staffing levels and workload Combined Being key themes – Apr 18 – June 18	

	Top themes: - Policies, Procedure and Processes - Other - Manager Behaviour - Patients It is proposed that the Trust will: - Continue to utilise all four mechanisms to support staff to raise concerns and issues - Support the ongoing development of an open and transparent culture through development and embedding of the Trust Values and supporting Behaviours Framework - Continuation of the Freedom to Speak Up Guardian role including further strengthening of approach/ development of a range of Freedom to Speak Up Champions to further support the FSUG role. - Continue and strengthen communication to the wider Trust to help promote speaking to managers, professional leads, trade union representatives as well as the more formal routes that are available. Caroline highlighted that "Dear Caroline's" are discussed at Execs fortnightly. There is a session booked on the next Leadership Academy and the Trust is keen to get feedback and see how it fits into the Being Open policy. David Rogers asked what proportion of Dear Caroline's received are anonymous , Caroline confirmed this was approximately 80% ***Received***	
197/2018	**MONTH 4 FINANCE REPORT** Suzanne Robinson, Executive Director of Finance, Performance and Digital, presented the report highlighting key points. The report summarises the finance position at month 4 (July 2018). Trust Board are asked to note: - The reported YTD surplus of £229k against a planned surplus of £156k. This is a favourable variance to plan of £73k. - The M4 CIP achievement: o YTD achievement of £349k (51%); an adverse variance of £335k; o 2018/19 forecast CIP delivery of £1,458k (52%) based on schemes identified; an adverse variance of £1,337k to plan; o The recurrent value of schemes transacted at £1,043k, 37% of target. - The cash position of the Trust as at 31st July 2018 with a balance of £10,159k. The increase in the cash balance is due to receipt of the final 2017/18 STF funding payment relating to the bonus element of STF at £1.871m and the quarter 4 core STF payment at £0.175m. The cash plan is £852k higher than planned, mainly due to lower	

	payroll payments compared to plan as well as the timing of pay award arrears which will be paid in August. The Trust anticipates being slightly above plan by March 2019. - Month 4 capital expenditure at £122k compared to planned capital expenditure of £167k. - Use of resource rating of 2 against a plan of 2. Trust Board are asked to approve: - The month 4 position reported to NHSI. Patrick Sullivan noted the Month 4 variants are obviously out of sync with the overall year to date and asked if this was expected. Suzanne advised this is not material as the £35K is linked to our income which is variable. The issue stems from the Darwin Centre's under occupancy. ***Noted / Approved***	
198/2018	**ASSURANCE REPORT FROM THE FINANCE, PERFORMANCE & DIGITAL COMMITTEE** Tony Gadsby Non-Executive Director and Chair of the Finance, Performance and Digital Committee presented the report for assurance from the meeting that took place on 3rd August and 6th September 2018. **Highlight from the 3rd August 2018 meeting re: Cluster 99** Post ROSE implementation and particularly the Q4 2017/18, the committee noted concern that the percentage of unassigned clusters (cluster 99) rose to over 55% and performance was not improving, despite focus. The Associate Director of Performance presented a much improved position for 2018/19 Q1, following the implementation of the PBR action plan and work with Directorates. The committee noted that there was still some work to do but commended the performance team for the work to date, particularly noting the positive impact Miss Boswell has made since joining the trust. A further update will be presented in Q2. **Highlights from the 6th September 2018 meeting** - **Pay Award Update –** An update around the pay award, originally presented in August 2018. The overall annual cost pressure is estimated to be £99k, which includes £103k unrealised pressure for vacant posts not currently filled - **Restructure** – the Trust needs to ensure we do not lose the CIP focus. - **Digital Update -** The Committee received an update around Key Digital Developments. An updated business case has been submitted to NHS Digital, since the business case approved at board due to changes in the funding envelope. The programme costs have reduced from £3.65m to £3.1m, which includes a £10k reduction the North Staffordshire Combined contribution. The committee were given assurance that there would be no reduction in specification as a result of the funding reduction.	

	The Board is asked to receive the contents of this report and take assurance from the review and challenge evidenced in the Committee. ***Received***	
199/2018	**DECLARATION OF INTERESTS – AUGUST 2018** Laurie Wrench, Associate Director of Governance presented the report. The report provides an update as at the 31st August 2018 of current Board members interests. It is the Trust Board's responsibility to ensure the Trust operates its services in an open and transparent way. In line with the Code of Conduct and Accountability for NHS Board members and the Trust's Standards of Business Conduct Policy this information is published on the website and available for public view. Maria Nelligan declared that she is now a Company Secretary for the National MH Nurse Directors Forum. Laurie will make the appropriate amendments to the Declaration Register for Board Members. ***Received***	**LW**
200/2018	**ASSURANCE REPORT FROM THE PEOPLE AND CULTURE DEVELOPMENT COMMITTEE** Patrick Sullivan, Non-Executive Director presented the report for assurance in the absence of Lorien Barber (Chair) from the meeting that took place on 10th September 2018. The following was highlighted: - **Sickness absence** - rate is exceptionally low at 3.57%. The highest recorded reason for sickness is anxiety/stress/depression. - **Staff Survey** - The Committee received the action plan and noted the progress made. It was further noted that the Staff Survey for this year is due to 'Go live' on 24 September 2018 and close on 30 November 2019. A monetary initiative will also be implemented for teams who complete the most returns. - Policies: Approval was requested for the following policies: o 3.30 Learning & Development Policy (previously extended until the July PCD meeting) o 7.2 Subject Access Request Policy o 7.1 Draft Confidentiality of Patient & Employee Information - Extensions until the end of December 2018 were requested for the following policies: o 3.01 Disciplinary Policy – expires 30.09.2018 o 3.09 Freedom to Speak Up Policy (expired 30.09.2017) o 3.12 Equality of Opportunity – expired 30.07.2018 o 3.19 Retirement Procedure – expires 30.09.2018 o 3.36 Supporting Staff Policy – expires 30.09.2018 o 3.39 Medical Appraisal Policy – expires 30.09.2018	

	o 3.40 Local Government Pension Scheme – expires 30.09.2018 o 3.41 Management Supervision Guidance – expired 02.03.2018 o 3.42 Medical & Dental Starting Salary Procedure – expires 31.10.2018 Tony Gadsby noted the Committees are being asked to extend policies and highlighted that the Trust should not be waiting for policies to pass their review date although acknowledging content may still be relevant. It was noted this process needs to a be strengthened. ***Ratified / Received***	
201/2018	**ASSURANCE REPORT FROM THE AUDIT COMMITTEE** Gan Mahadea, Non-Executive Director presented the report for assurance from the meeting that took place on 6th September 2018. **Board Assurance Framework Q1 2018/19** The Chair requested further assurance in terms of concerns with CIP and opening of PICU. It was noted that key leadership appointments for PICU have now been made and it is anticipated that further appointments will be made with the new intake of students in October 2018. The Committee approved the Board Assurance Framework Q1 2018/19 subject to final Board approval. **Risk Assurance Mapping Exercise** The report was split by Committee and members noted the risks. Assurance was provided that this information is scrutinised by the Senior Leadership Team and mitigations are challenged. The Committee agreed that a risk mapping exercise report will be submitted on a quarterly basis going forward. **Healthcare Quality Standards Assurance Report** The Trust has now implemented the process for community teams as well as inpatient teams with each visit comprising an Executive Director, Non-Executive Director, Service User / Carer representative, Peer Reviewer and a member of Governance Team. The visits involve the teams being reviewed in line with the CQC's Key Lines of Enquiry (KLOES) and the Institute for Innovation and Improvement 15 Steps challenge methodology. The visits are reported to the Quality Committee and Performance Meetings. A quarterly report will be overseen by the Committee going forward. **KPMG** Internal Audit Progress Report –There have been some frustrations with progress regarding IT General Controls with the Trust's IT provider (third party). This was anticipated to be complete but will now be completed by the end of September 2018.	

	LCFS Progress Report - LCFS continue to support the Trust's Induction sessions to provide new starters with guidance on prevention of fraud and bribery. LCFS have also reviewed the Trust's Anti-Fraud and Bribery policies. HR Governance Report - Internal Audit have provided partial assurance with improvement required as a result of their review. **Ernst and Young – Annual Audit Letter** Ernst and Young presented the Annual Audit Letter following their completion of their audit procedures for the year end 31 March 2018. External Audit have concluded that the financial statements give a true and fair view of the financial position of the Trust as of 31 March 2018 and of its expenditure and income for the year and therefore issued an unqualified opinion. **Finance Policies** The Committee approved the following policies for 3 years and request formal ratification at September 2018 Trust Board. - Standing Financial Instructions Policy - Scheme of Delegation Policy - Standing Orders - Local Counter Fraud Policy - Bribery Policy ***Ratified / Received***	
202/2018	**ASSURANCE REPORT FROM THE QUALITY COMMITTEE** Patrick Sullivan, Non-Executive Director presented the report for assurance from the meeting that took place on 9th August 2018. Patrick advised that many of the reports provided to the Committee for assurance have been discussed during the course of today's meeting. Policy report – the recommendations supported by the Committee for ratification of policies by the Trust Board for 3 years, or otherwise stated as follows: - 1.62 Physical Health Policy - Medical Gases New Policy - 4.25 Consent Policy - MHA01 Supervised CTO – Extend to 31.12.18 - MHA03 Nurses Holding Power - MHA04 Doctors Holding Power - MHA09 S117 Aftercare – Extend to 31.12.18 - MHA12 Section 17 Leave - MHA16 Mental Capacity Act Policy - MHA18 Deprivation of Liberty Safeguards - 4.34 Intellectual Property – Extend to 31.12.18	

	Ratified / Received	
203/2018	**2018 WORKFORCE RACE EQUALITY STANDARD WRES REPORT AND ACTION PLAN** Caroline Donovan, Chief Executive Officer presented the report. This is the Trust's third WRES report. Since April 2015, all NHS organisations were required to demonstrate through the nine point WRES metric how they are addressing race equality issues in a range of staffing areas through the NHS Standard Contract. The Trust has made great strides in raising the profile of workforce (and service user) race inclusion, increasing visibility and beginning to identify and address the associated issues. This is at every level, from Board to service/team and individual staff levels. It is acknowledged, however, that some areas are more actively involved and engaged than others. Progress has been made in terms of developing the workforce profile to be more representative of our local population for BAME ethnicity across the organisation and at board level. However, there remain service areas, staff groups and pay bandings where BAME ethnicities are significantly absent or under-represented. We are still short of achieving our goal of being representative of the local community for BAME by 2020 (after medical staff excluded from the data). It remains that there is both an immediate and a long-term challenge around addressing a range of societal, historical, cultural and organisational factors which culminate in our BAME workforce experiencing poorer employment prospects and experiences than their white counterparts in the NHS on a range of measures. 2017-18 has been a game-changer for the Trust in relation to workforce race inclusion. This was significantly boosted by 2 visits by Yvonne Coghill and Habib Naqvi from the NHS England WRES team in late July and early August 2017. In late July, Yvonne attended a Board Development Session and presented to Trust Board members about the case for WRES and about the Trust's position in relation to the WRES indicators. Yvonne returned the following week with colleague Habib to facilitate 2 BAME Focus Groups in the morning, followed by leading a session on Race Equality to Trust leaders at the Trust's Leadership Academy in the afternoon. The impact of these sessions on those who participated was considerable and galvanising our ability to achieve additional momentum behind our plans to develop greater race inclusion. The Trust additionally had a major race inclusion element included in its Symphony for Hidden Voices Inclusion Conference in September 2018. Unfortunately, despite the significantly increased focus on race inclusion through 2017-18, the Trust has seen a worsening position in a number of the WRES indicators (6 of 9) since 2017. Three indicators improved. It is unexplained as to why there has been such a decline in our WRES data	

	despite the positive work that has been begun over the last 12 months. Caroline highlighted the need to ensure this is the at the top of the Trust's priority list and the need to take action collectively. Caroline advised that the People and Culture Committee received a story re: racism she was receiving within the Trust and this was converted into a local poet video which is embedded in this week's CEO blog. The Trust has attempted to commence a BAME network and more focus will be given to this. Caroline advised that Trust Board members will be invited to develop reverse mentoring relationships, including positive action to encourage staff in protected characteristic groups to seek high level mentoring support. Joan Walley asked how much trade unions are involved in taking this forward. Caroline advised they have been involved in meetings and have been incredibly supportive and will sponsor the wider BAME network we want to promote as well. Patrick Sullivan asked where we have cases of harassment and bullying internally are we able to focus and find out exactly what the situations are. Caroline responded it is the little things the managers do each day that helps, often they are the minority BAME staff in the team who do not want to speak up we need to look at a culture change. When someone has completed an incident form we are looking at a softer approach, and looking at what we have done about that and what we are doing about patients that are racist. Suzanne Robinson questioned how we can use our data to better understand this. Caroline highlighted this is something we have started to talk about as Execs we need to be looking at every report we receive and asking what this means for inclusion. Patrick noted that a lot of work has been undertaken but the Trust has decreased in score therefore we cannot be getting it absolutely right. Caroline responded we need to instill this in the DNA of the organsiation. Dr Okolo highlighted the issue is potentially more cultural. As a senior doctor he has received more queries regarding his decision making. Joan Walley added if this is happening within the organisation and the Trust is looking at integration across Staffordshire is this something the STP is focused on and are we looking share our experience? Caroline advised that she had raised this in the OD System Leadership meeting. The BAME system wide Leadership Programme has now been launched with national funding. There are 120 places for staff, the first cohort commenced last week across all organisations. *Received*	

204/2018	**LOCALITY WORKING /RESTRUCTURE** Jonathan O'Brien Director of Operations presented the report. The report provides the detail of the progress on the Locality Restructure of the Trust, the consultation response to Phase 3 and the final operational structure. Phase 3 of the restructure is scheduled for implementation on 1st October 2018, from which point the Trust will operate and report on the basis of four Clinical Directorates. Consultation formal response has been made public re: Phase 3 and concerns. The final structure chart is included in report. Jonathan provided an update on what has changed: - The 4 directorate structure has been revaluated. Board decision was taken to pause and give extra breathing time to consider feedback and ensure the right changes are made to the structure. Staff appreciated this. - The confirmed final structure was circulated on the 31st August 2018 for consultation responses received in September. In the final phase is an assessment process for 22 individuals operating at managerial and matron level within our structures. There have been group exercises facilitated by an external facilitator and all staff received technical competency based interviews. We will have another session as a senior team tomorrow to make final appointments to the structure and go live from next week. - The Trust has appointed a Head of Nursing in Professional Practice. - The Head of Directorate for Substance Misuse (SMS) was at risk but has been appointed as Senior Service Manager within SMS their skills, talents and knowledge will be retained which is positive. - From October the Trust needs to move on as an organisation focussing on transformation, business and new services. We need to move away from talk of restructure to more about transformation of services. ***Received***	
205/2018	**Any Other Business** There were no items for discussion	
206/2018	**Date and time of next meeting** The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday 25th October 2018 at 10:00am, in the Boardroom, Lawton House, Trust HQ.	
207/2018	*** Motion to Exclude the Public**	

	The Board approved a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted.	

The meeting closed at 1.25pm

Signed: _____ Date_____
Chairman

Board Action Monitoring Schedule (Open Section)

Trust Board - Action monitoring schedule (Open)

Action	Meeting Date	Minute No	Action Description	Responsible Officer	Target Date	Progress / Comment
1	24-May-18	116/2018	Learning From Deaths Quarterly Report - In all of the cases reviewed the care provided by our clinical teams was felt to be adequate to excellent. Caroline Donovan highlighted the need to identify where learning / improvements are being made and add to future reports. 25.09.18 - Report going to Quality Committee 27th September 2018 and will come to Trust Board 25th October 2018	Dr Buki Adeyemo	25-Oct-18	Agenda item
2	21-Jun-18	140/2018	Safer Staffing Monthly Report - April 2018 - Maria to bring an update on recruitment initiatives back to Trust Board	Maria Nelligan	25-Oct-18	Agenda item
3	21-Jun-18	141/2018 (1)	Serious Incident Annual Report (1)- Deep Dive Workshop outcomes on falls to go to Quality Commiitee and to Board. Detail around inclusion of family and carers and how this is undertaken to come back to Trust Board in next report. 25.09.18 - Deep Dive will be included in the Falls Annual Report which will be going to Quality Committee 27th September 2018.	Dr Buki Adeyemo	25-Oct-18	Falls Report agenda item for 2nd November 2018 Quality Committee
4	26-Sep-18	184/2018	Questions from Members of the Public Section 75 transfer - Jonathan to ensure all service users have had clear communications	Jonathan O'Brien	25-Oct-18	Every service user has received a personal letter to advise point of contact during their care.
5	26-Sep-18	189/2018	Infection Prevention and Control Flu jabs to made available for Board members at next Trust Board meeting	Maria Nelligan	25-Oct-18	Actioned. Flu vacination will be available during the lunchtime break for members of the Board in the Breakout Room at Lawton House
6	26-Sep-18	192/2018	AHP Strategy Joe McCrea highlighted the new intranet was launched at the AGM and there is currently no dedicated section on the current internet for AHPs. Joe agreed to work with AHPs to get an AHP section on the intranet and raise the profile.	Joe McCrea	25-Oct-18	Discussions underway and plans in place to implement.
7	26-Sep-18	199/2018	Declaration of Interests Maria Nelligan declared a new declaration of interest. New form to be submitted and update to register	Laurie Wrench	25-Oct-18	Actioned

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO TRUST BOARD

Enclosure No:

Date of Meeting:	25th October 2018		
Title of Report:	CEO Board Report		
Presented by:	Caroline Donovan, Chief Executive Officer		
Author:	Caroline Donovan, Chief Executive Officer		
Executive Lead Name:	Caroline Donovan, Chief Executive Officer	Approved by Exec	☒

Executive Summary:	Purpose of report	
This report updates the Board on activities undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Integration Programme Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☒ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☒ 4. Encourage, inspire and implement research & innovation at all levels.☒ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☒ 7. Continually improve our partnership working. ☒		
Risk / legal implications: Risk Register Reference	None		
Resource Implications: Funding Source:	None		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	Staff Survey and Freedom to Speak Up Champions integrated with our diversity and inclusion strategy		
STP Alignment / Implications:	Move to locality working integral to STP. Includes CQC system learning and STP Digital work stream		
Recommendations:	To receive for information		
Version	Name/group	Date issued	
1.0	Caroline Donovan	11th October	

Chief Executive's Report to the Trust Board
25th October 2018

PURPOSE OF THE REPORT

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

LOCAL UPDATE

1. LOCALITY STRUCTURE GOES LIVE

1st October was a really exciting day as we mobilised into our new structure, with Associate Directors and Clinical Directors formally responsible for their new Directorates. Service Managers and Quality Leads (Matrons) will be working with their new ADs and CDs to coordinate handover to new roles as swiftly and efficiently as possible.

Alastair Forrester has been appointed as Head of Nursing & Professional Practice and will transition to his role starting from 1 October 2018.

We have also completed our appointments to Service Manager and Quality Improvement roles. Congratulations to everyone on their appointment:

NORTH STAFFORDSHIRE

- Clinical Director – Darren Carr
- Associate Director – Sam Mortimer
  - Brigette Hamlett – Quality Improvement Lead Nurse (Matron)
  - Simon Wilson – Service Manager – Newcastle
  - Nicky Griffiths – Service Manager – Moorlands

STOKE-ON-TRENT

- Clinical Director – Dr Dennis Okolo
- Associate Director – Jane Munton-Davies
  - Sue Parkes - Quality Improvement Lead Nurse (Matron)
  - Rachael Birks – Service Manager – North
  - Darryl Gwinneth – Service Manager – South Stoke
  - David Smith – Service Manager - South Stoke and Social Care Lead

SPECIALIST CARE

- Clinical Director – Dr Darren Perry
- Associate Director – Ben Boyd
  - Stuart Fisher – Quality Improvement Lead Nurse (Matron)
  - Tina Mottram – Quality Improvement Lead Nurse (Matron)
  - Jessica Fitzgerald – Service Manager – LD & CAMHS IP
  - Fiona Platt - Service Manager – Neuro & Rehab
  - Darren Bowyer – Senior Service Manager – Substance Misuse
  - Craig Heffernan-Stone – Service Manager – Substance Misuse

ACUTE & URGENT CARE

- Clinical Director – Carol Sylvester (Interim)
- Associate Director – Natalie Larvin (Interim)
  - Dawn Burston – Quality Improvement Lead Nurse (Matron)
  - Val Stronach – Quality Improvement Lead Nurse (Matron)
  - Josey Povey – Service Manager – Urgent Care

We have started transitioning to our new structures and appreciate that this will mean change for lots of people – in who their manager may be and in starting to think about how we may need to work in a different way.

Phase 4 of the restructure will really be about how we can think of new ways of working and transformation. Our improvement partner, AQUA, will be working alongside us supporting this next phase. We really need to enable as many of our staff as possible to be equipped with improvement skills.

A very big thank-you to Jonathan O'Brien, our Executive Director of Operations, who has done a fantastic job in supporting the redesign to date. Jonathan of course hasn't done this alone – Maria Nelligan and Dr Buki Adeyemo have led the professional structure and Nicky Griffiths has given Jonathan great support, as have the Clinical and Associate Directors, Nursing and HR teams – so a massive thank-you to everyone.

2. NHS STAFF SURVEY

Our staff are our most valuable resource and ensuring the Trust is a great place to work is essential. That's why the annual NHS Staff Survey feedback is crucial for us to understand what we are doing well and where we can further improve.

Following feedback from last year, staff identified areas for us to improve, resulting in:

- Focused work on Diversity and Inclusion and specifically on how to improve the experiences of staff from a BAME background
- 16 teams supported to complete our Towards Outstanding Engagement programme
- A quality improvement approach to encourage greater empowerment of teams to make improvements
- Refreshed being open and raising concerns at work through the Freedom to Speak up Guardian
- Medical staff development programme
- The launch of our first care conference for frontline staff, which included an LiA big conversation

Last year, we achieved a response rate of 52% and, whilst this is higher than the national average, we want to increase this even further.

We have put in place incentives to encourage as many people as possible to take part:

- Teams reaching their target response rate will automatically be entered into a prize draw to receive £250 to spend on a team-focused priority
- Staff will have dedicated time off for completing the survey – managers have been encouraging them to take this 10 minutes to do so
- We are providing roaming polling stations, providing space and a laptop to complete surveys, with staff on hand to provide IT support

All survey responses will be strictly confidential. Personal details and individual responses will remain with Quality Health, which is external to the Trust.

3. COMBINED FLUFIGHTERS 2018

It's that time again, as the colder months drawer nearer, that we do our utmost to protect our patients and colleagues by getting a free flu vaccination from the Trust. Our #CombinedFluFighter 2018 campaign launched formally on Friday 5 October. We have been holding clinics at various locations throughout the Trust – a full list of upcoming clinics and information on how to get their vaccination has been shared with all staff. We have also been giving full comms support to the campaign with posters, leaflets, videos, pictures, dedicated e-newsletter and social media support.

This year, we have 27 peer vaccinators and a record number of people received their jabs in the first couple of weeks. The flufighter team have reported there is a "real buzz about the flu jabs this year, with loads of people/services asking for it".

If staff have had the flu jab elsewhere (GP, Pharmacy, supermarket, other trust) we are asking them to complete a declaration form and email the completed form to flufightersnscht@combined.nhs.uk

This year, we have 20 golden tickets randomly placed across the vaccines. Once a vaccine box is open, if it contains a golden ticket, staffu can exchange this for a £10 Love To Shop voucher.

We want to be the best-performing mental health Trust in the country for vaccination of our frontline staff and are urging all staff to be a #CombinedFluFighter to help us achieve this goal.

We have dial a jab, email request, a "jabber near you" and peer vaccinators, as well as our Team Prevent colleagues at Feel Good Fridays etc.

4. ANOTHER GREAT CONTRACT WIN FOR SUBSTANCE MISUSE

Hot on the heels of their success in securing the contract from Stoke City Council for Community Drug and Alcohol Services, our Substance Misuse Team have been successful again. Working in a partnership of three organisations, the team have won a new contract for the delivery of health services at Stoke Heath Prison. The five-year contract – which was commissioned by NHS England – begins in April 2019 and includes a potential two-year extension that would take it to 2026.

It sees North Staffordshire Combined Healthcare NHS Trust teaming up with Shropcom and The Forward Trust to form what is being called the Stoke Heath Integrated Care partnership (SHIC), with Shropcom taking the lead. The partnership brings together three exceptionally experienced, passionate and proven healthcare providers with extensive experience, safely and seamlessly transitioning services. Combined will deliver secondary mental health and clinical substance misuse services. All three organisations already deliver health services at the prison, near Market Drayton, but the new contract involves the introduction of a new model of care that will be shaped over the next six months in the run-up to the launch on 1 April.

5. LEARNING FROM CQC REVIEWS

I was privileged to be asked by the CQC to present at a national conference on our experiences and learning from the Stoke-on-Trent CQC system review. York and Birmingham were also asked to share their experiences.

Paul Edmondson-Jones, Director Social Care, Health Integration & Well-being Stoke-on-Trent Council, and Mark Seaton supported the event. It was really good to hear of others' experiences and quite cathartic to be able to talk about the progress that has been made. The CQC is returning to Stoke in November and has already started a system review of Staffordshire. Both reviews will report on their findings before the end of the year.

6. SECOND AHP CONFERENCE

The Trust held our second AHP Conference, chaired by our Director of Nursing and Quality, Maria Nelligan. The event was a chance for team leaders, senior leadership team members, executives, AHP colleagues, partners and service users to find out about our innovative practices, as well as formally launching the AHP strategy.

There was a packed programme, including a 'Who wants to be a millionaire" AHP quiz, presentations and videos from a whole range of teams and a keynote presentation from Glenn Westrop, AHP Clinical Fellow at NHS Improvement.

Congratulations to all involved for a fabulous and informative event.

7. DIGITAL BOARD

I am really pleased with the progress that has been made at our STP Digital Board. All our organisations across Staffordshire have worked really well together identifying collective digital priorities for us to submit to NHS England for significant funding to come into Staffordshire.

I need to say a big thank-you to Gwyn Thomas, Digital STP Lead Director, Paddy Hannigan, the STP Chief Clinical Information Officer, and Chris Bird, Integrated Care Record Senior Responsible Owner, for leading this within a very short timescale. Thanks also to all the Chief Information Officers for their work.

8. GREAT MENTAL HEALTH ACT REPORT FOR FLORENCE HOUSE

It was a real pleasure to read a great Mental Health Act Report following an unannounced MHA inspection. The report was in keeping with the teams CQC rating of outstanding and acknowledges some of their good practice. I was particularly pleased that the report acknowledged the service's least restrictive approaches to the care of their patients.

It went onto to highlight the following areas of good practice;

- Florence House producing its own newsletter for patients; the letter is succinct with information about local and Trust events and is used to tell staff stories, healthy food recipes and other interesting topics
- a copy of the MH code of conduct available in the lounge area for all patients (their patients had designed some of the booklet)
- employed an STR worker who is happy to share his own experience of receiving mental health care, creating a sense of hope amongst the patients
- patients describing a very positive response form Advocacy and IMCA service
- staff explaining that patients were provided with a swipe card to exit the unit when they wished to smoke; this included informal and detained patients (who had the required leave). There had been no concerns.
- work towards a least restrictive environment with a view to converting the unit into an open rehabilitation unit
- Florence House staff actively promoted independence and autonomy – patients' care & risk plans were clearly developed with them and person centred
- regular patient community meetings and a 'you said, we did' board that was up to date and evidenced a response to patient requests for a BBQ, Karaoke machine etc.

Invariably, as a result of an inspection, there are areas for improvement which I am pleased to say the team have promptly responded to, including a telephone ringing during the night and a few of the community meetings not always having a response / update from the ward manager. The report also highlighted the need for the medical team to ensure that they are recording, in Lorenzo, any discussions that they have with patients relating to consent.

9. LAUNCH OF FREEDOM TO SPEAK UP CHAMPIONS

October was Freedom to Speak Up month and we marked the event by launching our Freedom to Speak Up Champions initiative. Working with the Trust's Freedom to Speak Up Guardian, Zoe Grant, the Champions will help to promote a positive culture in which staff feel comfortable and supported to speak up about things that may concern them.

By having Freedom To Speak Up Champions across the Trust's localities and diverse staff and professional groups, the aim is to give staff a wide choice of who they may be most comfortable in speaking up to.

The Champions will be supported by Zoe, and their role will be supporting staff to speak up and helping her identify themes and trends emerging from the front line.

The opportunity to become a Champion is available to all Combined staff. Anyone interested in becoming a Champion can, in the first instance, e-mail Zoe Grant

10. ACTION ON DIVERSITY

Our latest Leadership Academy took the opportunity to watch and reflect on the insights and lessons we can learn from our recent Staff Nurse Story film, featuring the words of a BAME member of staff, and discussed the action plan we are putting in place. We have identified the five key areas for action for us as a trust below – which I am personally leading:

- Developing our HR Processes for inclusion – including recruitment and selection; disciplinary and grievance; workforce equality info processes; bank and agency staff (building in inclusion from start to finish of the process)
- Supporting the development of our BAME staff – developing equal and inclusive access to career, leadership and education development opportunities
- Reporting, learning and improving following incidents and incidences of racist abuse and aggression (both preventing incidents as far as possible and responding better, and supporting people better when incidents do happen)
- Culture of Inclusion – developing clear standards of expected and unacceptable behaviour (policies, training, leadership styles, service user involvement). Addressing how we treat each other day-to-day; inclusive treatment of colleagues; addressing micro-assaults and inequalities). Also considering religion and culture, food, etc.
- Communication for inclusion – delivering clear communication, including: feedback from staff (including trainees); BAME network; engaging with our agency staff; events; posters; BAME champions; app to gather staff experiences on exit – and starting with #WearRedDay #19Oct #ShowRacismTheRedCard

We have BAME Leaders sponsoring each of our programmes who will work alongside each of the project managers to ensure co-production. I have given a personal commitment that each BAME leader will be released from their workplace to enable us to truly develop our improvements in partnership.

We all have a responsibility to speak out if we observe any behaviours which are not congruent with our values and I personally ask you to discuss diversity and inclusion within your team meetings and seek the views and support of teams to stamp out racism.

11. CHANGES TO THE EXECUTIVE TEAM

I was delighted to announce that we have appointed Ursula Martin to be Assistant Chief Executive Officer. This is a new role for which the Board had recognised the need - particularly with my role increasingly demanding as I focus on the leadership of pan-Staffordshire STP priorities. The post will lead on corporate governance and quality improvement, working very closely with other Executive Directors. It will also lead on Freedom to Speak Up and Communications.

Ursula joins us from Warrington and Halton Hospitals, where she is currently the Director of Governance and Quality. She is hugely experienced, having worked at a senior level in the NHS for 10 years. Ursula has worked across primary care, the acute sector and has worked in Mental Health trusts, in primarily governance and quality improvement roles, for 18 years in the NHS.

On her Twitter account, Ursula describes herself as "Proud to be NHS through and through" and this pride in the NHS shone through during the interview and appointment process. What impressed us particularly was the importance that Ursula placed on supporting staff to deliver excellence and quality services, whilst demonstrating Trust and NHS values.

It is with truly mixed emotions that I informed colleagues that Suzanne Robinson, our Director of Finance, Digital and Performance, is leaving us. She has been appointed as Director of Finance at Pennine Care NHS Foundation Trust, which provides Mental Health & Community services across Greater Manchester. Whilst we are very sad to see Suzanne leave the Trust, we are extremely proud that she has been appointed to the role, which is a promotion for Suzanne and incredibly well deserved. This opportunity also allows Suzanne to continue working in the mental health sector of the NHS which she has come to love, but removes the significant commute from the North West each day that she has been doing since 2016.

Suzanne has been an extremely highly valued member of the Trust Board and Executive Team and has made a significant contribution to increasing the profile and understanding of finance across the Trust, leading her teams to achieve a number of awards and recognitions. She will also be stepping down from her position as STP Director of Finance over the coming weeks and I know Simon Whitehouse, STP Director, and Sir Neil Mckay, STP Independent Chair, will join me in thanking her for her contribution. Although we will greatly miss her, we wish her every success in the future.

He have also advertised for a substantive Director of Strategy and Development post. Andrew Hughes has worked with us since the summer last year on a fixed-term contract. Andrew has always been clear that he did not want to take up a substantive role, as he has worked as a consultant across the health sector as well as various other roles, including being a trustee on the Teenage Cancer Trust.

We have been incredibly lucky to have Andrew working with us over the last four years. His first stint was in 2015-2016 and again more recently from summer 2017. He has been very well regarded and his leadership of business development has resulted in successful tender bids. He has also taken a key role in supporting the development of the North Staffordshire Alliance Board. I know the Board will join me in thanking Andrew for the enormous amount of commitment and dedication he has shown in this role.

NATIONAL UPDATE

12. NAO REPORT ON IMPROVING CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH SERVICES

The National Audit Office published a report during October on improving children and young people's mental health services.

It says that steps taken by the government to improve parity of esteem between physical and mental health are welcome but there is a long way to go to ensure equal access to care.

It also warns that even if current initiatives are delivered as intended, there would remain significant unmet need for mental health services amongst young people.

It adds that slow progress on increasing the mental health workforce in England by 40% is emerging as a major risk to delivering the government's ambitions to implement its 2015 strategy, Future in Mind, in full.

The NAO says that most up-to-date estimates indicate that 10% of five-to 16 year olds have a mental health condition, although as little as 25% of children and young people with a diagnosable condition actually access services.

The NAO Report is available at https://www.nao.org.uk/report/improving-children-and-young-peoples-mental-health-services/

13. NEW MINISTER FOR SUICIDE PREVENTION

The Government has announced the appointment of a minister for suicide prevention.

Jackie Doyle-Price will be given the new brief and tasked with ensuring that every local area has effective plans in place to stop unnecessary deaths, and investigating how technology can help identify those most at risk.

The Minister will lead a new national effort on suicide prevention, bringing together a ministerial taskforce and working with national and local government, experts in suicide and self-harm prevention, charities, clinicians and those personally affected by suicide.

She will also ensure every local area has an effective suicide prevention plan in place, and look at how the latest technology can be used to identify those most at risk.

Starting in 2019, the government will publish a 'State of the Nation' report every year on World Mental Health Day, highlighting the trends and issues in young people's mental well-being – the first time children's mental health will be reported in this way, alongside their physical health and academic attainment.

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO: TRUST BOARD

Enclosure No:5

Date of Meeting:	25 October 2018		
Title of Report:	Service User & Carer Council Report		
Presented by:	Wendy Dutton, Chair, Service User & Carer Council		
Author:	Wendy Dutton, Chair, Service User & Carer Council		
Executive Lead Name:	Maria Nelligan, Executive Director of Nursing & Quality	Approved by Exec	☒

Executive Summary:		Purpose of report	
This report has been prepared to provide an update to Trust Board of the Service User & Carer Council since the last meeting		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☒ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☐ 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Reference	None identified		
Resource Implications: Funding Source:	None identified		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	The Service User & Carer Council supported the principle of increasing representation across the Protected characteristics when reviewing the Diversity and Inclusion Strategy. They also committed to supporting inclusive services and workforce in their review of the Strategy		
STP Alignment / Implications:	As part of ongoing service user/carer engagement, service user and carer views are encouraged within the STP workstreams		
Recommendations:	The Trust Board receives the update for information and assurance		
Version	Name/Group	Date issued	

NHS
North Staffordshire
Combined Healthcare
NHS Trust

SERVICE USER AND CARER COUNCIL UPDATE
FOR TRUST BOARD ON 25th October 2018.

1 Service User & Carer Council Business Meeting 26th September 2018

- Person Centredness, updated, similar themes working within the Service User & Carer Council workshop and also workshops undertaken with staff at the first Non-registered Conference.
- Update from Ben Boyd on Care and Risk Assessments linked to the first pilot of the Patient Aide app, hopefully in January 2019, which will allow Service Users/Carers to interface with the app directly.
- BAME was discussed as an on-going issue as to how we can actively engage and encourage participation of a more diverse membership of the Service User & Carer Council and volunteering. It was suggested it would be really useful for staff within Directorates to be pro-active with this.
- Peer Support Mentors potential was discussed with a definite date being given for a meeting to focus on this being given. This meeting has since taken place and was well attended with a lively, productive discussion and concrete actions suggested.
- A one page Service User & Carer Council Strategy was reviewed, positive feedback with time allowed for members to feedback directly to Veronica Emlyn.
- Discussion with Clinical Audit, highlighting their role and the possibility of working with the Service User & Carer Council to identify 'gaps' which could lead to a meaningful piece of work.
- Discussion has taken place with Ben Boyd on the use of patient transport, looking at the eligibility criteria with suggestions for greater clarity were taken on board.
- Phil Leese, Healthwatch Stoke, brought some leaflets and badges from the work on raising the issue of Loneliness which is going from strength to strength
- **AGM,** members who attended were very complementary, saying there was an upbeat feel and people seemed generally happier!

.

2 Workshop /Educational meetings

Having now undertaken 3 workshops at the Harplands between 5pm and 7pm, the poor uptake was discussed and it was agreed to revert back to the 2.30pm time and ideally a Lawton House venue. It was suggested that this maybe the time to refresh aspects of the Service User & Carer Council:-

- Election of a new Vice Chair
- Refreshing practicalities of the Service User & Carer Council for example; Terms of Reference, Confidentiality Agreement, DBS, Roles and Responsibilities to be reviewed. This would enable is greater clarity and consistency for all.
- A review of who is attending what for the Service User & Carer Council to enable members to discuss/change/highlight areas of interest with a clear focus of representing the wider service user and carer population.
- A robust review of all open actions with a view to refreshing targets and agenda in line with the new Directorate structure.

This work will be supported by the Executive Director of Nursing & Quality.

Wendy Dutton
Chair, Service User & Carer Council
12th October 2018

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO Trust Board

Enclosure No:6

Date of Meeting:	25 October 2018		
Title of Report:	Summary: Autographer + Flo: A Memory Support Intervention Improving the Quality of Lives for People with Mild Cognitive Impairment (MCI) or Mild to Moderate Dementia		
Presented by:	Dr Darren Carr, Associate Medical Director / Clinical Director North Staffordshire Directorate		
Author:	Kerri Mason, Research and Development Lead		
Executive Lead Name:	Dr Olubukola Adeyemo, Medical Director	Approved by Exec	☐

Executive Summary:	Purpose of report	
Following the success of using Florence simple telehealth text messaging with people who had mild cognitive impairment (MCI) and other vascular risk factors, the idea for a related project in which two everyday technologies would be 'bolted' together was developed. Outcomes of the project included; three out of the four participants showing a reduced number, and reduced total duration, of community team appointments (pre and post project entry compared). The Autographer + Flo project was presented at the West Midlands Health Informatics network, Technology enabled care regional conference and local GP conference as part of the wider WMAHSN exemplar project	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☐

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Integration Programme Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.√ 2. To provide the highest quality services √ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels. √ 5. Maximise and use our resources intelligently and efficiently. √ 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Reference	No current risk or legal implications		
Resource Implications: Funding Source:	No current risk or legal implications		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I	No diversity or inclusion implications		

Guidance		
STP Alignment / Implications:	Not applicable	
Recommendations:	Project team continue to scope out Technology enabled care	
Version	Name/group	Date issued
2	Maria Nelligan	18.10.18

Autographer + Flo: A Memory Support Intervention Improving the Quality of Lives for People with Mild Cognitive Impairment (MCI) or Mild to Moderate Dementia

1 Introduction

Following the success of using Florence simple telehealth text messaging with people who had mild cognitive impairment (MCI) and other vascular risk factors, the idea for a related project in which two everyday technologies would be 'bolted' together was developed.

Autographer plus Flo is a protocoled intervention consisting of a thirteen week text messaging protocol which is repeated, alongside a wearable camera. Autographer was used to support autobiographical memory, with Florence text messaging the conduit for delivering short informational texts with content designed to support individual wellbeing and management of memory difficulties.

2 Outcomes

A number of outcome measures were used to evaluate the Autographer + Flo project, these included:

- **Service Usage Data**: A sample of four of the participant's data was obtained from the Information Analyst team at NSCHT. The time period which the data reflected varied across the four participants, with three out of the four participants showing a reduced number, and reduced total duration, of community team appointments(pre and post project entry compared);

- **Participant narrative**: Ten interviews were conducted at the mid-point of each individual's participation. This was with the exception of two interviews; one with a participant who had dropped out of the project so was interviewed at the point when he dropped out; and the other with a participant with whom Autographer was used as a one-off therapeutic intervention for a social phobia who was interviewed a week after the intervention.

3 Next Steps

The Autographer + Flo project was disseminated in a number of ways including presentations and poster presentations at the West Midlands Health Informatics network, Technology enabled care regional conference and local GP conference as part of the wider WMAHSN exemplar project. The project team were also nominated for the Digital Participation Award Health Service Journal in September 2018 and were invited to London to present the project to an award judging panel and await the outcome of the ceremony in November.

4 Recommendations

The Board is asked to note this development

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO TRUST BOARD

Enclosure No:7

Date of Meeting:	25 October 2018		
Title of Report:	August 2018 Monthly Safer Staffing Report (inc Recruitment and Retention Action Plan)		
Presented by:	Maria Nelligan, Executive Director of Nursing & Quality		
Author:	Julie Anne Murray, Deputy Director of Nursing, AHP & Quality		
Executive Lead Name:	Maria Nelligan, Executive Director of Nursing & Quality	Approved by Exec	☐

Executive Summary:	Purpose of report	
This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during August 2018 in line with the National Quality Board requirements. The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during August 2018 was 73% for registered staff and 104% or care staff on day shifts and 81% and 111% respectively on night shifts. Overall a 94% fill rate was achieved. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward manager supporting clinical duties. The data reflects that Ward Managers are staffing their wards to meet increasing patient needs as necessary.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☒ Execs ☐ Date: 16 Oct 2018	Document Version No.	
Committee Approval / Review	• Quality Committee ☒ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☒ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Reference	Delivery of safe nurse staffing levels is a key requirement to ensuring that the Trust complies with National Quality Board standards.		
Resource Implications: Funding Source:	Temporary staffing costs. Budgeted establishment and temporary staffing spend.		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	None		
STP Alignment / Implications:	None		
Recommendations:	To receive the report for assurance and information		

Version	Name/Group	Date
1	SLT	16 Oct 2018
2	Trust Board	25 Oct 2018

1 Introduction

This report details the ward daily staffing levels during the month of August 2018 following the reporting of the planned and actual hours of both Registered Nurses (RN) and Health Care Support Workers (Care Staff) to NHS Digital. Additionally from April 2018 Care Hours per Patient Day (CHPPD) have also been required to be reported to NHS Digital. The CHPPD calculation is based on the cumulative total number of patients daily over the month divided by the total number of care hours (appendix 1).

2 Background

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

In addition to the monthly reporting requirements the Executive Director of Nursing & Quality is required to review ward staffing on a 6 monthly basis and report the outcome of the review to the Trust Board of Directors. A comprehensive annual report for 2017 was presented to April 2018 Board and the recommendations agreed. These are being progressed through the Safer Staffing Group.

3 Trust Performance

During August 2018 the Trust achieved a staffing fill rate of 73% for registered staff and 104% for care staff on day shifts and 81% and 111% respectively on night shifts. Taking skill mix adjustments into account an overall fill-rate of 94% fill was achieved. Where 100% fill rate was not achieved, staffing safety was maintained on in-patient wards by nurses working additional unplanned hours, cross cover, Ward Managers (WMs) and the multi-disciplinary team (MDT) supporting clinical duties and the prioritising of direct and non-direct care activities. Established, planned (clinically required) and actual hours alongside details of vacancies, bed occupancy and actions taken to maintain safer staffing are provided in Appendix 1. A summary from WMs of issues, patient safety, patient experience, staff experience and mitigating actions is set out below.

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

4 Care Hours per Patient Day (CHPPD)

The Trust is required to report CHPPD on a monthly basis. The CHPPD calculation is based on the cumulative total number of patients daily over the month divided by the total number of care hours. The CHPPD metric has been developed by NHSI to provide a consistent way of recording and reporting deployment of staff providing care in inpatient units. The aim being to eliminate unwarranted variation in nursing and care staff distribution across and within the NHS provider sector by providing a single means of consistently recording, reporting and monitoring staff deployment. The CHPPD:

- gives a single figure that represents both staffing levels and patient numbers, unlike actual hours alone
- allows for comparisons between wards/units as CHPPD has been divided by the number of patients, the value doesn't increase due to the size of the unit – allowing comparisons between different units of different sizes
- splits registered nurses from care staff (healthcare support workers /assistants) to ensure skill mix and care need is reflected
- is a descriptor of workforce deployment that can be used at ward, service or aggregated to trust level
- is most useful at a clinical ward level where service leaders can consider workforce deployment over time compared with similar wards within a trust or at other trusts as part of a review of staff productivity alongside clinical quality and safety outcomes measures

The Trust will use CHPPD to benchmark between specialities within the organisation and once the information is available through the model hospital national benchmarking will help inform safer staffing reviews.

5 Impact

WMs report the impact of unfilled shifts on a shift by shift basis. Staffing issues contributing to fill rates are summarised in Appendix 2. The report will be reviewed and summarised going forward on a quarterly basis.

5.1 Impact on Patient Safety

There were 4 incidents reported during August 2018 relating to nurse staffing issues that had a potential impact on patient safety as detailed in the table below. **There was no harm to patients reported for the month of August.**

Ward	Incident
Site management	On one night shift, numerous wards required short notice increased staffing due to acuity and incidents. Site manager deployed staff from other wards where appropriate.
Ward 1	One incident where the site manager had to take charge of Ward 1 as the agency member of staff did not report for duty. This was a regular agency staff and on follow up the agency had not advised the Trust of the cancellation. One incident where staffing was reduced due to supporting service user who was transferred to UHNM. The nursing team were supported by the MDT to maintain safe staffing.
Ward 7	One occasion where it was challenging to maintain observation levels due to staffing levels.

5.2 Impact on Patient Experience

Staff prioritise patient experience and direct patient care. During August 2018 it was reported that 3 activities were cancelled (1 of which was rearranged) due to nurse staffing levels, these occurred on Darwin. A further 5 activities were shortened due to nurse staffing levels, these occurred on Ward 5.

5.3 Impact on Staff Experience

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

- 130 staff breaks were cancelled (equivalent to approximately 2.7% of breaks)
- 9 supervisions, PDRs and mandatory training sessions were cancelled

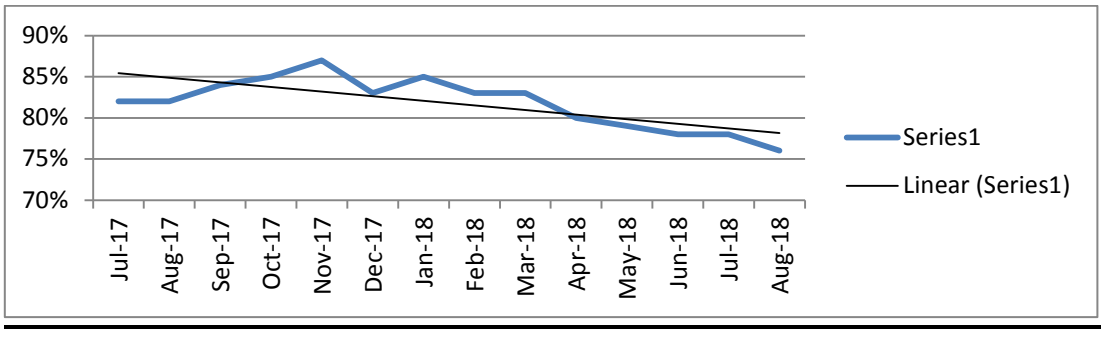
Any time accrued due to missed breaks is taken back with agreement of the Ward Manager.

5.4 Mitigating Actions

Ward Managers and members of the multi-disciplinary team have clinically supported day shifts to ensure safe patient care. Skill mix has been altered to backfill shortfalls. For example a total of 491 RN shifts were covered by HCSW where RN temporary staffing was unavailable. A total of 103 HCSW shifts were covered by RN staff where HCSW temporary staffing was unavailable. Additionally, as outlined in section 4.3, staff breaks have been shortened or not taken (time is given in lieu) and wards have cross covered to support safe staffing levels.

5.5 RN Staffing Recruitment

In line with the national picture RN recruitment is challenging. The RN 12 month fill-rate trend line is showing a decreasing trend although this is expected to rise once the newly qualified nurses commence in October 2018.



The Trust is participating in the NHSI Retention Support Programme and this has informed the Trust Recruitment and Retention Action Plan (appendix 3) which details the actions that are being taken by the Trust to attract and retain registered nurses. This Action plan was previously reviewed by Board in April 2018. These include recruitment incentives such as

refer a friend, continued professional development offer, housing and flexible hours. These incentives are included in all RN job adverts.

Positively, 29 newly qualified nurses have commenced with the Trust in October 2018. They are being supported by a robust preceptorship programme; this programme has been refined and strengthened annually since 2016 and, with the exception of one nurse, all newly qualified RNs have been retained in the Trust in the past 2 years.

The nursing career pathway has been strengthened and 4 Trainee Nursing Associates and 2 Trainee Advanced Nurse Practitioners commenced their training in September 2019. These are academic programmes which run alongside significant work based and placement learning. The education programme to support CPD and career progression for all RNs is being strengthened. Additionally, a potential increase in Band 6 RNs is being considered as part of the Safer Staffing Mid-Year Review, currently being undertaken.

6. Summary

Safe staffing reporting indicated challenges in staffing wards during August 2018. Over the past 2 years a significant number of RN vacancies have been filled by newly qualified RNs; a further 25 newly qualified nurses will be joining the Trust in October 2018. The Trust continues to employ alternate strategies with the support of the HR and communication teams to attract RNs during this national shortage.

The Trust is participating in the NHSI Retention Support Programme. A project team visit has been completed and learning shared, this has been incorporated into the Trust Recruitment and Retention Action Plan.

7. Recommendations

The Trust Board is asked to:

- Receive the report
- Note the challenges with recruitment and mitigations and action plan in place
- Note the challenge in filling shifts in August
- Be assured that safe staffing levels have been maintained

Appendix 1 August2018 Safer Staffing

Aug-18

	Day				Night				DAY		NIGHT								
	Registered Nurses		Care Staff		Registered Nurses		Care Staff		Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	RN fill-rate	Overall fill-rate	Safe staffing was maintained by:	RN Vacancies	HCSW Vacancies	Bed occupancy	Movement
Ward name	Clinically required Hours	Total monthly actual hours	Clinically required	Total monthly actual hours	Clinically required	Total monthly actual hours	Clinically required	Total monthly actual staff hours											
Ward 1	1428	1045.9	1255.5	1641.07	688.2	375.8	699.3	1009.37	73%	131%	55%	144%	67%	100%	Nurses working additional unplanned hours and altering skill-mix.	5.40	-2.59	90%	↓
Ward 2	1428	946.17	1674	1653.48	688.2	413.9	1032.3	1277.65	66%	99%	60%	124%	64%	89%	Nurses working additional unplanned hours and altering skill-mix.	5.00	0.21	86%	↓
Ward 3	1428	1260.16	1350	1408.96	688.2	552.9	788.1	971.97	88%	104%	80%	123%	86%	99%	Nurses working additional unplanned hours, cancelling non-direct care activities and altering skill-mix.	0.60	2.14	93%	↑
Ward 4	1428	869.88	1255.5	1559.66	344.1	355.2	1032.3	1131.5	61%	124%	103%	110%	69%	96%	Nurses working additional unplanned hours and altering skill-mix.	6.20	0.00	72%	↓
Ward 5	1567.5	949	1695	1816.5	344.1	344.35	1243.2	1331.5	61%	107%	100%	107%	68%	92%	Nurses working additional unplanned hours, shortening patient activities, altering skill mix.	1.50	-1.20	97%	↑
Ward 6	1428	833.2	1674	2058.23	344.1	378.4	1376.4	1469.46	58%	123%	110%	107%	68%	98%	Nurses working additional unplanned hours, support of MDT and altering skill-mix.	1.30	2.35	93%	↑
Ward 7	1009.5	841.71	1377	1556.28	344.1	344.1	1032.3	995.4	83%	113%	100%	96%	88%	99%	Nurses working additional unplanned hours, support of MDT and altering skill-mix.	2.80	0.00	100%	↑
A&T	1009.5	961.9	2115.75	1789.84	688.2	344.1	1076.7	1360.8	95%	85%	50%	126%	77%	91%	Nurses working additional unplanned hours and altering skill-mix.	4.23	3.08	83%	↓
Edward Myers	1009.5	850.85	837	799.19	344.1	344.1	688.2	654.9	84%	95%	100%	95%	88%	92%	Nurses working additional unplanned hours and altering skill-mix.	3.10	0.20	94%	↔
Darwin Centre	1164.75	907	1437.75	1444.58	344.1	344.1	710.4	691.8	78%	100%	100%	97%	83%	93%	Nurses working additional unplanned hours, cancelling patient activity and altering skill-mix.	3.30	0.82	85%	↔
Summers View	930	591	930	949	332.32	332.32	664.64	600.32	64%	102%	100%	90%	73%	87%	Nurses working additional unplanned hours and altering skill-mix.	2.40	0.00	99%	↑
Florence House	637.5	571.73	930	584.75	332.32	332.32	332.32	332.32	90%	63%	100%	100%	93%	82%	Nurses working additional unplanned hours and altering skill-mix.	0.00	1.06	99%	↓
Trust total	**14468**	**10629**	**16532**	**17262**	**5482**	**4462**	**10676**	**11827**	**73%**	**104%**	**81%**	**111%**	**76%**	**94%**		**35.83**	**6.07**		

August2018 Safer Staffing (cont'd)

Aug-18			
	CHPPD		
Ward name	Total Actual Hours PD	Cumulative Count over the month of Patients @ 23:59	Care Hours Per Patient Day
Ward 1	4072.14	391	10.41
Ward 2	4291.2	589	7.29
Ward 3	4193.99	626	6.70
Ward 4	3916.24	424	9.24
Ward 5	4441.35	390	11.39
Ward 6	4739.29	434	10.92
Ward 7	3737.49	611	6.12
A&T	4456.64	155	28.75
Edward Myers	2649.04	316	8.38
Darwin Centre	3387.48	387	8.75
Summers View	2472.64	309	8.00
Florence House	1821.12	158	11.53
Trust total	**44179**	**4790**	**9.22**

Appendix 2 Staffing Issues

- At the end of August 2018, including PICU, there were 41 WTE RN vacancies in in-patients (4.8 WTE were PICU). This has reduced significantly as the majority of the twenty nine newly qualified nurses who joined the Trust in October 2018 are placed within in-patient units. We continue to advertise for the remainder of the vacancies in a variety of part and whole time roles.

- At the end of August 2018, there were 6 WTE HCSW vacancies reported within in-patient wards. The majority of these are in the recruitment process.

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

- RN night shift cover remained challenging during August 2018. This is a result of increasing night cover to 2 RNs on the acute wards (1, 2 and 3) however the number of vacancies on these wards has made this challenging to achieve consistently.

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

Appendix 3 Trust Recruitment and Retention Action Plan

Recruitment & Retention Action Plan						
	IDEAS	ACTION BY	WHEN	Progress End June	Progress Update w/c 18th October 18	Completed date
1	Reach out to retired RN and offer to pay for registration (£120) and support validation to work fixed term bank etc. (need to fast track application)	Maria Nelligan	30th June 2018	Letter completed circulated in June.	First letter sent out , this needs repeating for retirees from 6-12mths and 12mths-24mths	Complete
2	Return to practice contact HEE for support with a scheme locally	Julie-Anne Murray	End of Oct	Regional return to practice meeting scheduled for beginning of July, to date attempts to attract RTP students have been unsuccessful aim is to gain ideas from regional forum..	Only MH RTP is available locally; joint advertising/recruitment being pursued with Staffs Uni for this; next intake March 2019. LD RTP being explored with Chester and Wolverhapmton Universities.	Completed initial steps
3	Review skill mix on wards to identify increase in Band 6 practitioners (other roles) attracted externally	Julie-Anne Murray	End May 2018	Review of skills mix will be via safer staffing. MN & JAM to discuss potential for change to configuration.	Proposal to add Band 6 in each ward; JAM to include this in SS Mid-Year Report due to Board Nov 2018	ongoing
4	Introduce a friend scheme for RNs and Consultants £150	Kerry Smith	30th June 2018	Introduce a friend scheme – Action completed - Narrative has been updated and sent to communications. Access to the scheme form on intranet to be checked as it has been reported as not working.	Action completed no interest to date- on going rolling marketing	Completed
5	Transport provision to the Harplands for "out of area" RN include in advert	Kerry Smith	30th June 2018	KS to scope out possibility	Idea explored -found no concentration of supply identified - locations wide spread	Review in 6 months
6	Accommodation and relocation to be offered to oversees and "out of area" RN included in advert	Kerry Smith	30th June 2018	It was noted we do not have tier 2 visa status and this is required for overseas recruitment	Action completed - Solution provided by Staffordshire Housing . Promotion to be included in adverts/recruitment website	Completed
7	CPD offer to all RNs with individual career advice, included in advert	Kerry Smith Julie Anne Murray	30th June 2018	Signposting to all staff and CPD plan developed	Action Completed Statement included in advert Nursing CPD programme developed with Consultant Nurses to deliver a in-service programme	Completed
8	Weekly payroll for Bank staff explore option for substantive inpatient RN and e payslips (some costings done already £20k for 250 bank)	Julie-Anne Murray Mike Newton	Paper for Execs 18th June 2018	Paper has been drafted for submission to executives	Survey Monkey to be sent to all bank staff to explore interest in options by end of Oct 2018 Impact of aggregation of pay resulting from weekly pay being explored with payroll.	Ongoing
9	Temp staffing and e rostering ensure we utilise all available Apps and apply to substantive staff where appropriate	Julie-Anne Murray	30th June 2018	JAM following up with e rostering	All App's avalible to staff	Complete
10	Overseas recruitment scope current activity	Maria Nelligan Kerry Smith	30th June 2018	Scoping on going	Tier 2 was accepted from 6th October. SOP required and review of process	ongoing
11	Student nurse on the bank offer on commencement of course with clear buddies identified to mentor through programme	Julie-Anne Murray	30th June 2018	Scoping on going	Offers made to studuent nurses - following placement	Completed Ongoing
12	Preceptorship programme, highlight on recruitment and offer to all RN posts	Julie-Anne Murray	30th June 2018	Preceptorship programme established and offered to all new RN's, AHPs and Social Workers		Completed Ongoing
13	Clear career structure from HCA to DON promoting Consultant Nurses and Advanced Practitioner roles	Julie Anne Murray Maria Nelligan	30th June 2018	Career structure from HCA to DoN – work ongoing	Career on a page completed Link with Comms to publish and link with WFP cycle	Completed
14	Rotation to learn other specialties or specialising on one available as part of CPD and recruitment offer	Julie-Anne Murray	Current	Offered to preceptors and part of recruitment for all RN's		Completed Ongoing
15	Scope the HCA interest and who will meet criteria for RN course now, some funding may become available from NHSE for LD	Julie-Anne Murray Maria Nelligan	Completed nursing assurance 30th June 2018	Scoping of HCA interest in nursing associate role ongoing	4 positions offered for Sep 2018 intake and now on the programme. Next intake takes place March 2019 - further preparation required to help internal applicants meet requirements	1st Round Complete OnGoing
16	Revisit roles particularly the Ward manager role for PICU. Hybrid of WM and Clinical Nurse Specialist to attract experienced PICU Ward Manager	Maria Nelligan Natalie Larvin	30th June 2018	Ward manager role exteneded to attract experienced PICU ward manager.	New JD in Development	Revised due date end of Oct

	IDEAS	ACTION BY	WHEN	Progress End June	Progress Update w/c 17th Sept 18	Completed date
17	Aspiring Team Managers development programme to develop clinical leadership and resilience	Julie-Anne Murray Jane Rook	Sep-18	Aspiring ward manager development programme work in progress.	Programe in development	Due date Jan 19
18	Routine Recruitment pace, see how this can be streamlined and sped up	Kerry Smith	30th June 2018	Aiming for a target of 11-12.8 weeks	Ongoing process reviews to reduce Time to Hire - Current Ave 90 Days	Ongoing
19	Media Campaign- included incentives above "why best to work" @ Combined and local highlights	Joe McCrea	31st July 2018	Media campaign continues to be developed and refreshed by the Communication Team	CC working with JM (Comms) to develop Employer Brand	Ongoing
20	"One Stop Shop" to be streamlined	Joe McCrea Kerry Smith	Current	One stop shop benefits realisation underway	Consolidation of recruitment activity to continue - rolling programmes - In-patients/Community/GP Focus	Ongoing
21	Consider a practice educator bank for B-7 staff to attract experienced senior staff to support newly qualified nurses	Julie Anne Murray	Sep-18		No response to advert . Revisited whether Retire & Return could support - still no interest.	Oct-18
22	Extend nurse bank to other bands	Julie Anne Murray	Nov-18		Band 6 JD developed and currently in job-matching process - Next Band 7	In progress
23	Review campaigns from other area's i.e. Leighton hospital recent recruitment drive	Kerry Smith Cherie Cuthbertson	mid October		Further work required to benchmark attraction activity against competition	In Progress

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO: TRUST BOARD

Enclosure No:8

Date of Meeting:	25 October 2018		
Title of Report:	Annual Report on the use of Restrictive Practices (restraint, seclusion and rapid tranquillisation) in Inpatient Services 2017-2018		
Presented by:	Maria Nelligan, Executive Director of Nursing and Quality		
Author:	Dean Burgess, Workforce Safety Lead		
Executive Lead Name:	Maria Nelligan, Executive Director of Nursing and Quality	Approved by Exec	☐

Executive Summary:	Purpose of report	
The purpose of this report is to provide information regarding the use of physical restraint and seclusion within the inpatient services of North Staffordshire Combined Healthcare NHS Trust. The report will focus on the use of physical restraint and seclusion, comparing activity for the 2017-18 financial years.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☒	Date: 11/09/2018
	Execs ☐	Date:

Committee Approval / Review	• Quality Committee ☒ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. ☒ 2. To provide the highest quality services. ☒ 3. Create a learning culture to continually improve. ☒ 4. Encourage, inspire and implement research & innovation at all levels. ☐ 5. Maximise and use our resources intelligently and efficiently. ☐ 6. Attract and inspire the best people to work here. ☐ 7. Continually improve our partnership working. ☒
Risk / legal implications: Risk Register Ref	
Resource Implications: Funding Source:	No implications attached to this report. However, there is a cost each year regarding the provision of MAPA training to all inpatient staff.
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	Nationally protected characteristics have been highlighted as potentially being linked to restrictive practice. From 2017 protected characteristic data has been gathered in relation to restrictive practice and is analysed within this report.
STP Alignment/Implications	None
Recommendations:	To receive for information & assurance

Version	Name/group	Date issued
1	SLT	11.09.18
2	DON	19.09.18
3	Quality Committee	27.09.18

1. Introduction

The purpose of this report is to provide the Trust Board with information regarding the arrangements and systems in place to monitor the use of physical restraint and seclusion within the inpatient services of North Staffordshire Combined Healthcare NHS Trust. The report will focus on the use of physical restraint or restrictive physical interventions (RPI) and seclusion comparing activity for the 2017-18 financial year.

2. Background

The Department of Health (2014) define physical restraint as *"any direct contact where the intervener's intention is to prevent, restrict or subdue movement of the body, or part of the body of another person".*

In 2014 the Department of Health published Guidance "Positive and Proactive Care: reducing the need for restrictive interventions". Since then it has been a requirement for NHS Trusts to routinely monitor the use of physical restraint within its clinical services and to introduce plans to reduce the use of all restrictive interventions.

It is acknowledged that the use of restrictive practices are at times a necessary component of mental health and learning disability care, the use of the Mental Health Act 2007 to detain a patient against their will being an example of this. It is important therefore that NHS Trusts closely monitor the use of all restrictive practices within its services. The aim being to ensure they are the least restrictive, are only used when absolutely necessary and when all other options have been explored.

The use of restrictive physical interventions and seclusion is routinely monitored by the workforce safety team on a weekly basis. This report details the number of incidents and trends from this monitoring during 2017-18. Within the report the incidence of restrictive physical interventions is broken down by clinical area, restraint position, level of restriction, duration of restriction and reasons for the intervention.

Training in the management of violence and aggression is mandatory for all staff working in identified, high risk areas. The training focuses on the identification and proactive management of potential violent situations, aiming to prevent escalation to physical restraint. Although the training focuses on the prevention and reduction of restraint, it is necessary due to the nature of our services, to also teach restrictive physical intervention skills (MAPA® skills). This is supported by the Care Quality Commission who assert in their 2012 Guidance that where staff may have to use physical interventions, they should be trained to do so.

3. Restraint Reduction Strategy

The Trust has a Restraint Reduction Strategy and an annual work plan is monitored by a multidisciplinary restraint reduction group which includes service user representation. The focus for 2018-19 will be on continuing the delivery of MAPA training programmes which have a strong values and person centred ethos to our staff, assuring and monitoring the quality of patient debrief following incidents and the development and delivery of a "Trauma informed Care" training package to frontline staff.

The Trust has also worked collaboratively with the "Advancing Quality Alliance (AQuA)" to facilitate individual quality improvement projects around restraint reduction in three clinical areas. This programme is due to end in July but the intention is to roll out this work across the Trust. In L/D services, a consultant nurse has been appointed to lead the provision of PBS training for staff and NOAP inpatient services are utilising the "Newcastle Model" (James and Stephenson, 2007) in their work with people with dementia who present behaviours that challenge. The Newcastle model provides a framework and process in which to understand behaviour that challenges in terms of needs which are unmet, and suggests a structure in which to develop effective interventions that keep people with dementia central to their care and reduce the need for restrictive interventions.

4. Arrangements for monitoring

Monitoring and assurance regarding the use of restraint and other restrictive practices forms a key part of the Trust Governance arrangements. All incidents of restraint are reviewed by the workforce/patient safety team via the incident reporting system on a weekly basis and any practice issues are immediately fed back to the team. The emphasis being on minimising the use of restraint via the use of de-escalation skills and person centred care planning which focuses on primary and secondary interventions before the situation escalates to a crisis that might necessitate the use of physical restraint. The identification of triggers in relation to service users becoming violent and/or aggressive is a key factor in the reduction of all restrictive practices.

The Trust Restraint Reduction Group meets bi-monthly to review data around the use of restraint in clinical areas, share best practice, and monitor and review progress against the annual restraint reduction work plan.

5. Figures for the use of Physical Restraint during 2017-18

5.1 Trust wide Figures

The graph (Fig 1) shows the total number physical of restraint incidents across the Trust for each quarter period in 2017-18. During the reporting period the Trust Incident Reporting System indicates that there were 185 incidents in Q1, 180 incidents in Q2, 211 incidents in Q3 and 121 incidents in Q4. Although the trend line for 2017-18 is downwards the total incidents of physical restraint for 2017-18 was 697 which represents a slight increase of 3% from the previous year (675 incidents).

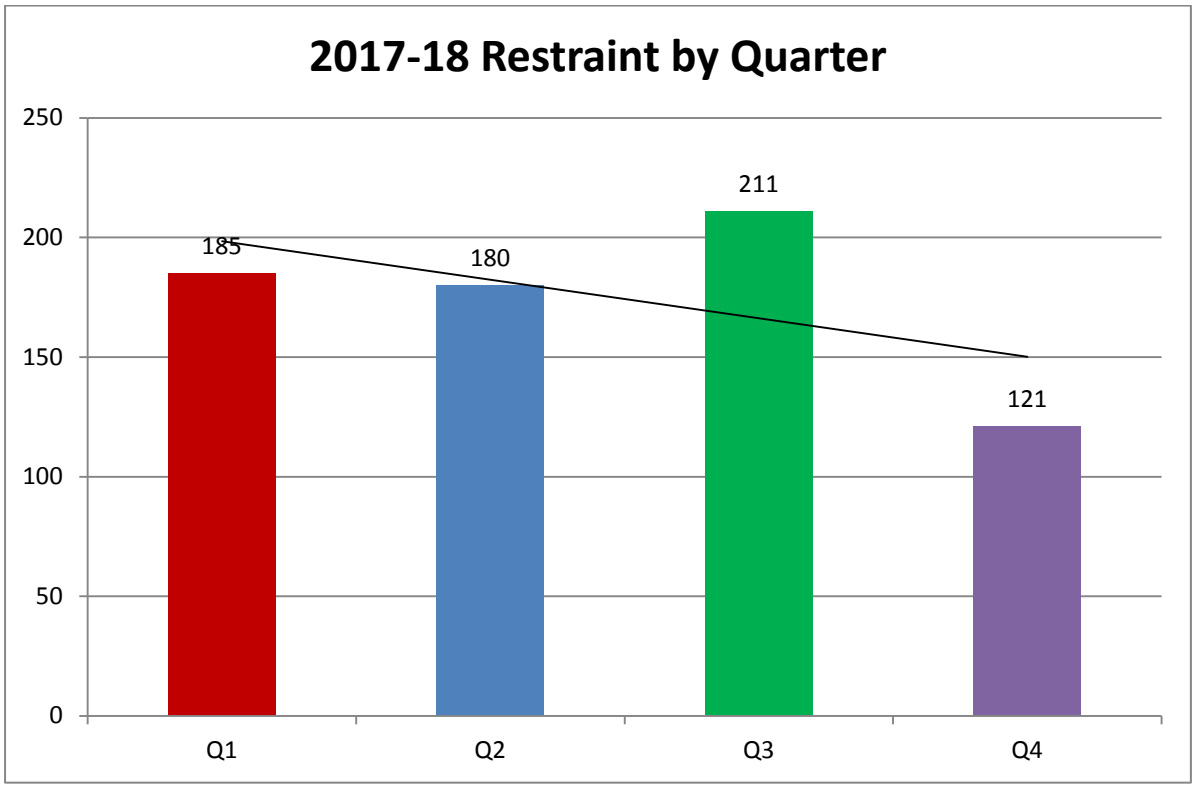


Fig 1 – Quarterly figures for restraint incidents across the Trust 2017-18 showing downward trend.

5.2 Use of Restrictive Physical Intervention (RPI) by Clinical Area

Fig 2 shows a comparison on the use physical restraint by clinical area for 2016-17 and 2017-18. It shows a considerable reduction on Ward 1 of around 64% but also shows significant increases for A&T (57%), Ward 3 (39%) and Darwin (58%). Ward 3 and A&T had the highest use of physical restraint during 2017-18 with 180 and 162 incidents respectively. In the higher reporting areas it is often a small number of very complex service users who are responsible for a high proportion of incidents. This is particularly true of A&T who only have 6 beds but reported the second highest number of incidents thus demonstrating the extreme complexities of this client group. There is a strong emphasis in this area on person centred care planning and PBS (Positive Behaviour Support) approaches.

Ward 3 has also had a number of highly complex service users, many of whom exhibit self-harming behaviours using ligatures, hence staff intervening during self-harm attempts is a major trigger for the use of physical restraint in this area.

Darwin by contrast had an increase in the use of physical restraint due to a small number of service users with an eating disorder requiring the use of physical interventions to support the passing of NG tubes and NG feeding. In this scenario physical restraint can last for 45 mins to an hour and would be supported by an individualised care plan and Standard Operating Procedure (SoP). There is a strong focus on MDT decision making, least restrictive interventions and patient debrief before, during and following such interventions.

The graph below (Fig 2) also demonstrates that occasionally there are episodes of restraint in areas such as MH Liaison, IST, Dragon Square, Florence House and place of safety. Although these are rare incidents, these areas continue to receive MAPA training.

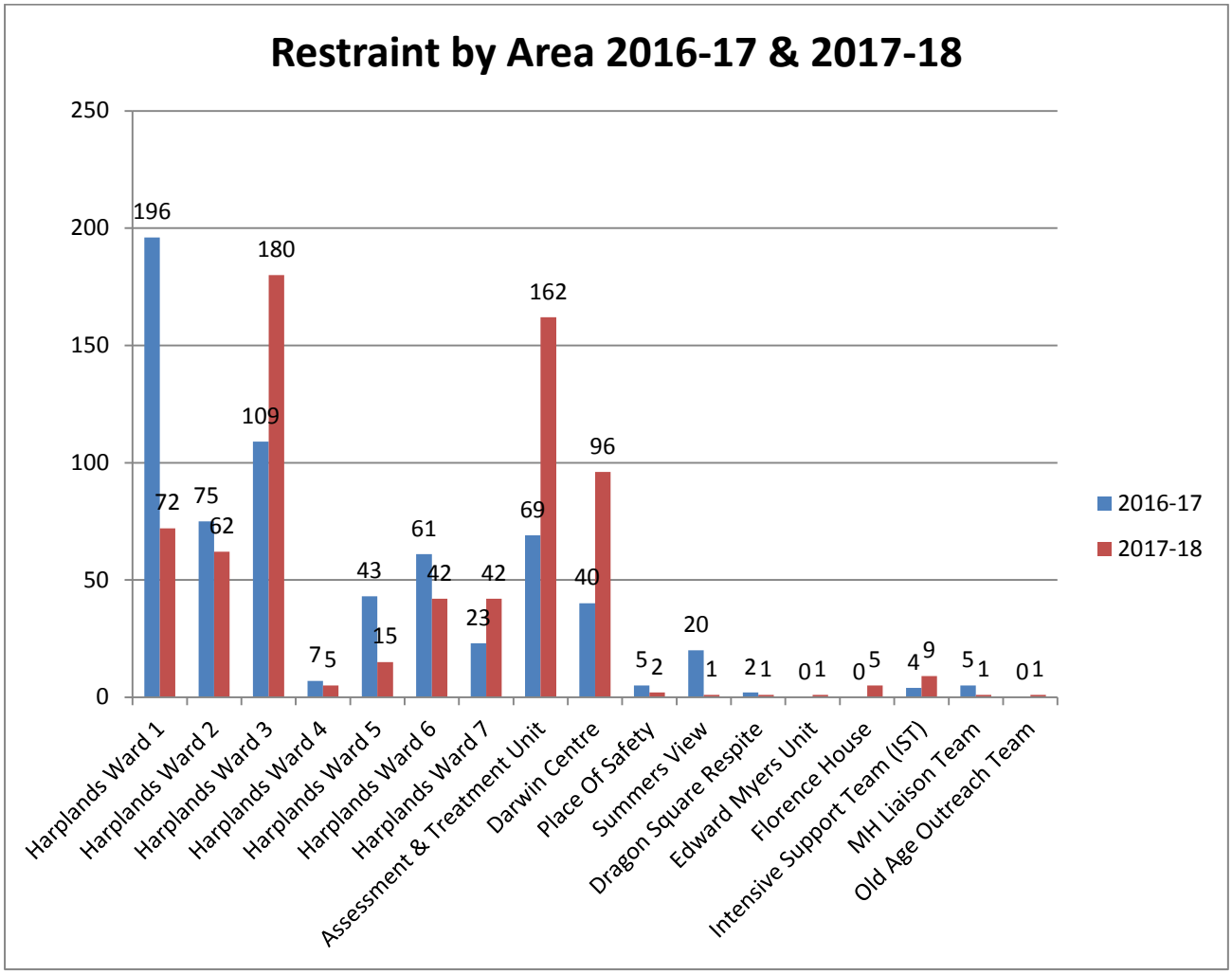


Fig 2 – Use of Physical Restraint by Clinical Area

5.3 Position that patients are held in during Physical Restraint

The most recent literature around the use of physical restraint emphasises the risks involved from physically holding a patient in a prone (face down) position. For some years now, training in the management of violence and aggression has highlighted these risks and therefore staff are taught not to initiate prone restraint. Rather, staff are encouraged to let go or to support the individual into a safer position such as supine (face up), seated or standing. In addition, physical intervention training this past year has included a new position of “side holding” as an alternative to “prone” when administering rapid tranquillisation.

The use of physical restraint in any position is not “risk free” hence the emphasis in training around proactive management strategies.

The graph below (Fig 3) shows that there were 20 instances of prone (face down) restraint during year. This represents a reduction of 40% on the previous year (33 instances). This means that approximately 3% of all restraint involves service users being held in a prone position. The most common positions for physical restraint are standing 49% and seated 32%, whilst supine restraint (face up) accounts for approximately 10% and the new position of side holding accounts for 4%. This evidences staff attempts to implement the least restrictive interventions when having to physically restrain service users to maintain safety.

Analysis of incidents of prone restraint shows that 80% (16/20) occurred in adult acute services (wards 1, 2 and 3). There were three episodes (15%) in A&T, and one episode on Ward 7. These figures reflect the age, physical ability and acuity of patients in acute services. Gender wise, 30% (6) of the incidents involved female patients and 70% (14) involved male patients.

A review of incident forms and feedback from participants on MAPA training courses demonstrates that staff endeavour to avoid using physical restraint in a prone position and never initiate prone restraint. If a patient is restrained in a prone or supine position staff attempt to alter this to utilise standing or seated restraint as quickly as possible. Staff also ensure that restraint is for the shortest possible time.

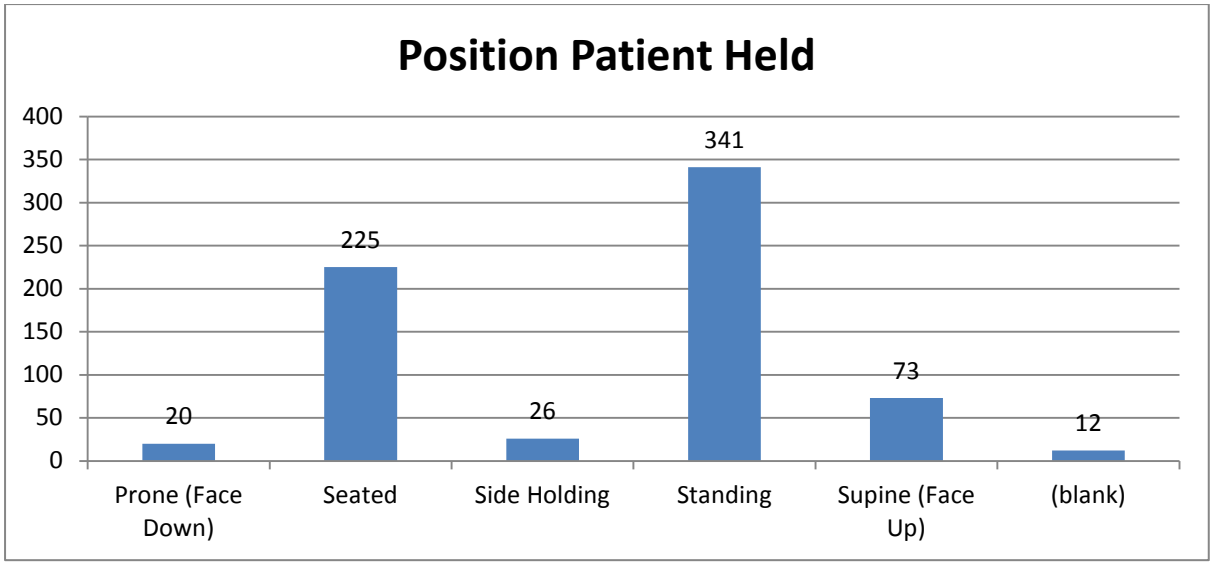


Fig 3 – Position during the use of Physical Restraint

5.4 Levels of restriction during the use of Physical Restraint

During restrictive physical intervention training staff are taught three levels of restriction with regard to the management of arms and these are graded as low level, medium level and high level. Any situation whereby a patient is held on the floor is viewed as an emergency. Staff are therefore taught high level restrictions for floor holding because if a high level of restriction is not required the patient should be prompted/supported into a less risky position e.g. seated or standing. This philosophy is supported within the MAPA model of training which is nationally accredited.

The graph below (Fig 4) demonstrates that the most frequently used levels of restriction are medium and high. This would suggest that situations have already escalated to a level requiring more than low levels of restriction. This is in keeping with statements in the Positive and Proactive Care (DOH, 2014) document which call for an end to the "routine use of restraint" and that restraint should be a "last resort".

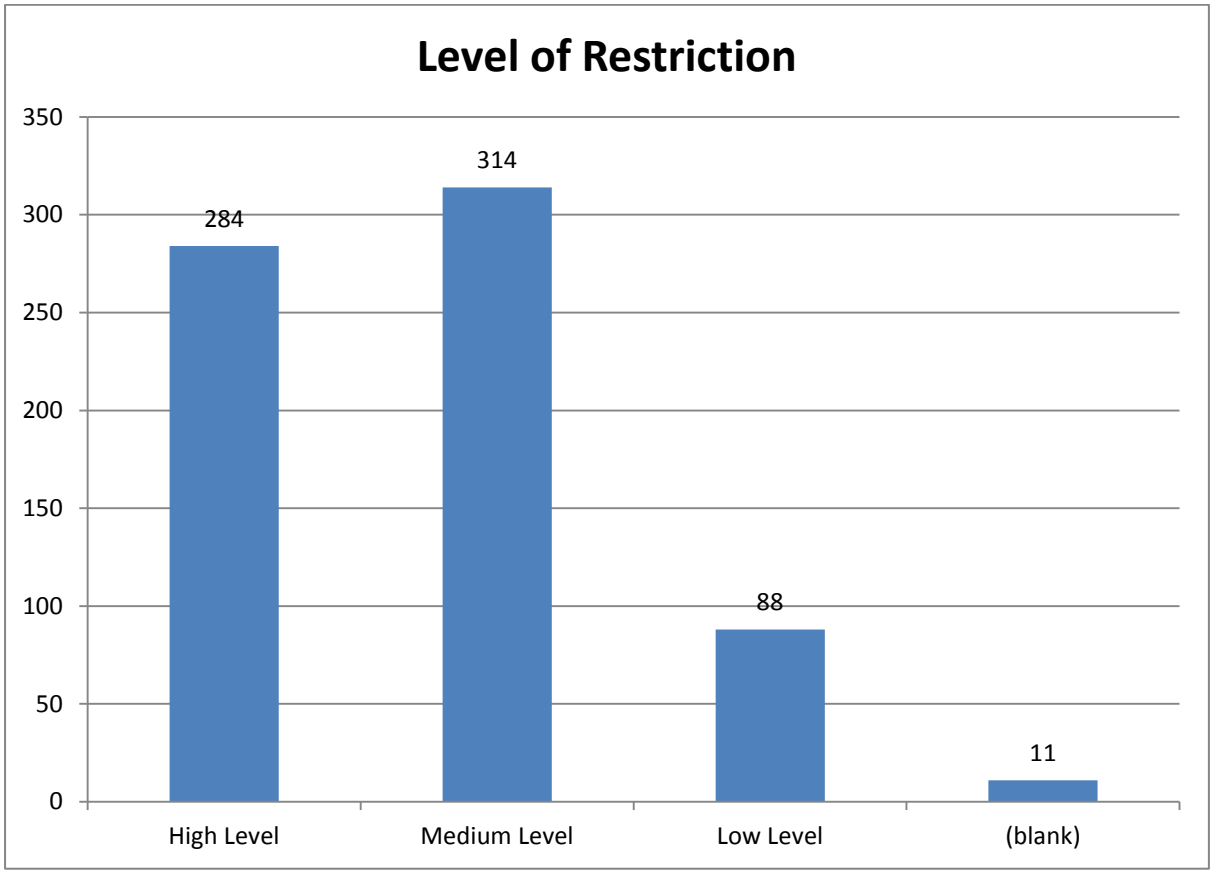


Fig 4 – Levels of restriction during physical restraint.

5.5 Length of time of Physical Restraint

The graph below (Fig 5) demonstrates that the majority of incidences of physical restraint last no longer than 5 minutes with 59% being in this category. Additionally 81% of all incidents lasted less than 15 minutes. All incidents lasting for longer than 60 minutes are subject to a review of the data on the incident form. None involve a patient being held in a prone position for that length of time and all demonstrate either attempts to disengage from the restraint, "intermittent" restraint during the identified time frame and/or low/medium level restraint in a seated position. Only a very small number of complex individuals are responsible for these incidents, for example two female patients on A&T accounted for 14 incidents (64%).

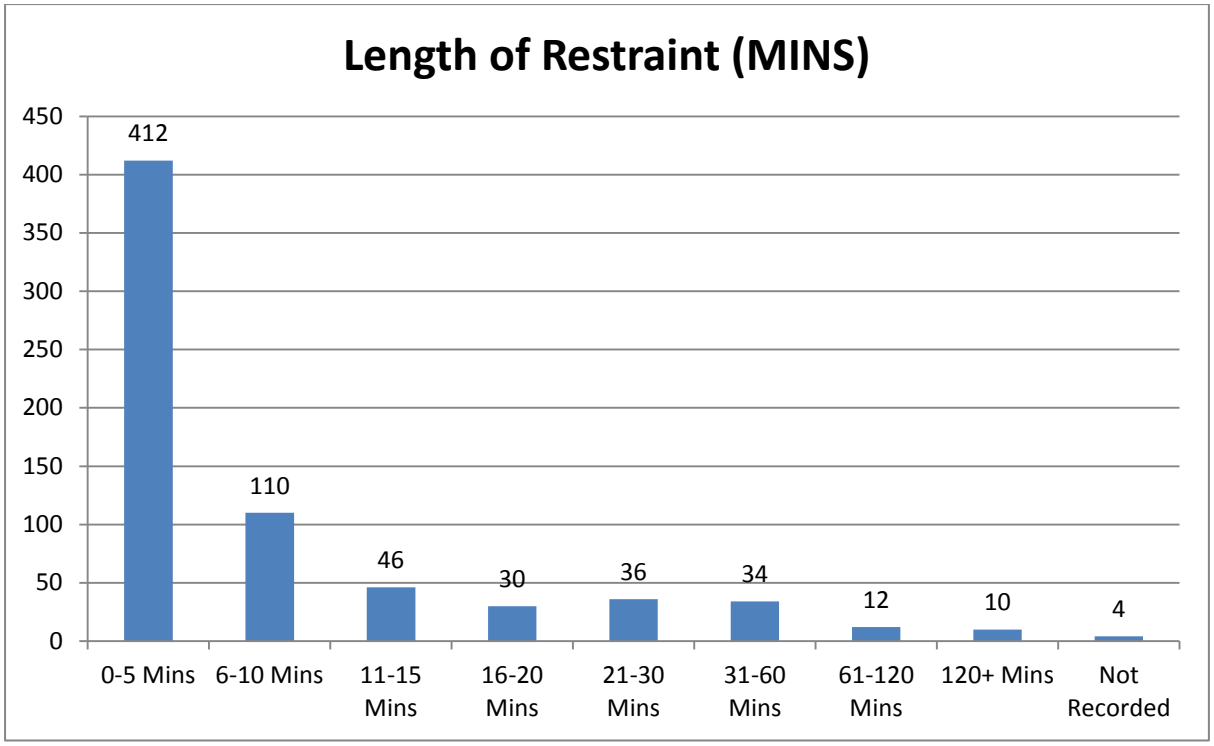


Fig 5 – Length of time for Physical Restraint

5.6 Triggers for the use of Physical Restraint

The graph below (Fig 6) shows that the most frequent trigger for the use of physical restraint is “harm to others”. Understanding what triggers incidents can help in reducing the need for restrictive interventions.

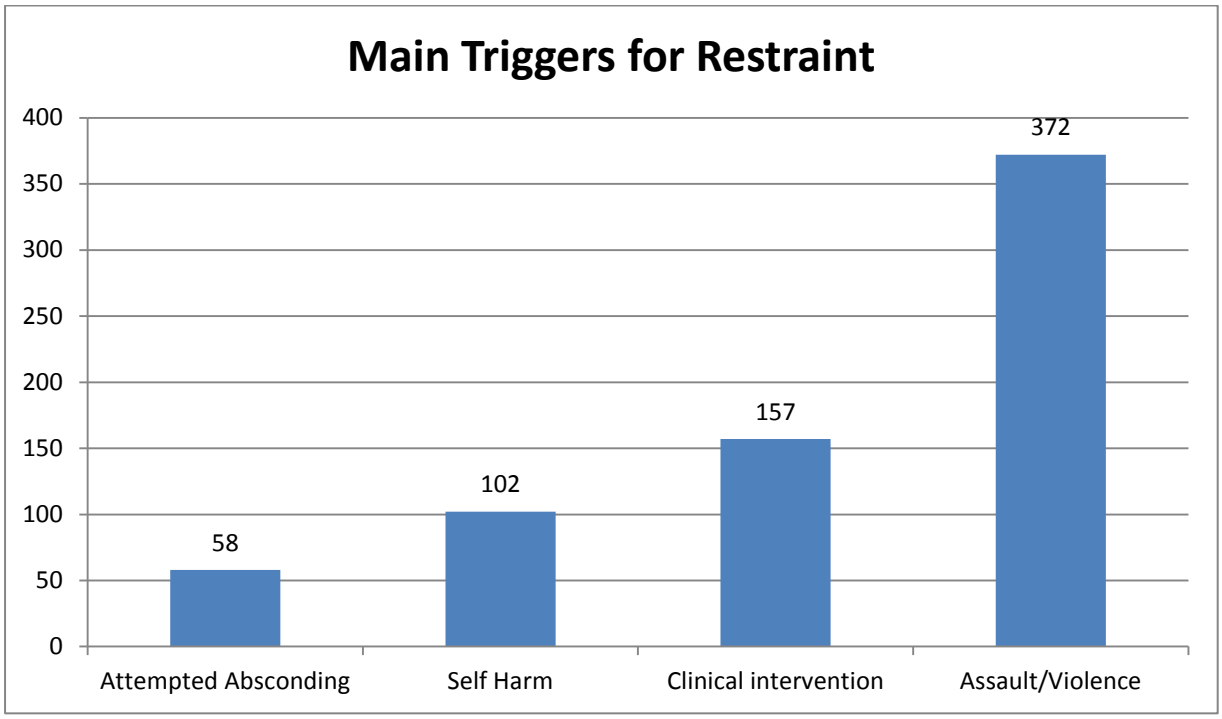


Fig 6 – Triggers for the use of physical restraint

6. Seclusion

Introduction: The Mental Health Act Code of Practice, chapter 26.103 defines seclusion as

"the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others"

Seclusion is an emergency response and should therefore be used as a "last resort" after other less restrictive interventions such as de-escalation, physical intervention and rapid tranquillisation have been tried and failed or, the risk is so immediate that seclusion represents the least restrictive option to manage the risk presented.

The purpose of this report is to show the recorded use of seclusion for the period April 2017 to March 2018.

6.1 Seclusion Facilities

Due to ongoing works to develop a Psychiatric Intensive Care Unit (PICU) the Trust has been without a dedicated seclusion facility since July 2017. Prior to this date a dedicated seclusion facility was available on Ward 1 at Harplands. Proactive plans to mitigate for the temporary loss of this facility included screening of potential admissions with a view to arranging direct access to out of area PICU placements and a lowering of the threshold at which a PICU referral would be considered for existing patients within the adult acute inpatient wards. This change in practice is reflected in the figures for the use of seclusion in Fig 8 below and this will be discussed in the report.

6.2 Total Number of Seclusion Episodes

The number of seclusion episodes during 2017-18 was 10. For the reasons stated above this is a much lower figure than that for 2016-17 (129 episodes). Each episode of seclusion triggers a Safeguard incident form completed at ward level and a "seclusion tracker" completed by the DSN (now Site Manager) which documents the seclusion reviews. The episode of seclusion reported in January occurred on ward 3 where a female patient had become very distressed which manifested into serious aggression towards staff. The patient had spent long periods of time being physically restrained and the staff team, in conjunction with the site manager and duty doctor felt that the very restrictive manner in which the patient was being nursed in her bedroom met the MHA Code of Practice definition for seclusion. It was therefore logged as such and the policy was followed regarding medical reviews. The use of seclusion is monitored via the night site manager and Workforce Safety Lead by reviewing all seclusion documentation ensuring that it is completed appropriately. Any issues identified are able to be monitored in a timely manner and fed back to the individual ward managers.

The graph below (Fig 7) indicates that the use of seclusion virtually ended after June 2017 as a consequence of the reasons stated earlier in this report.

The figure for Q1 of this reporting period when the seclusion room was still fully operational (9) was still significantly lower than the figure for Q4 of the previous reporting period (25) and this was also significantly lower than the monthly average of seclusion episodes for 2016-17 (10.75 per month).

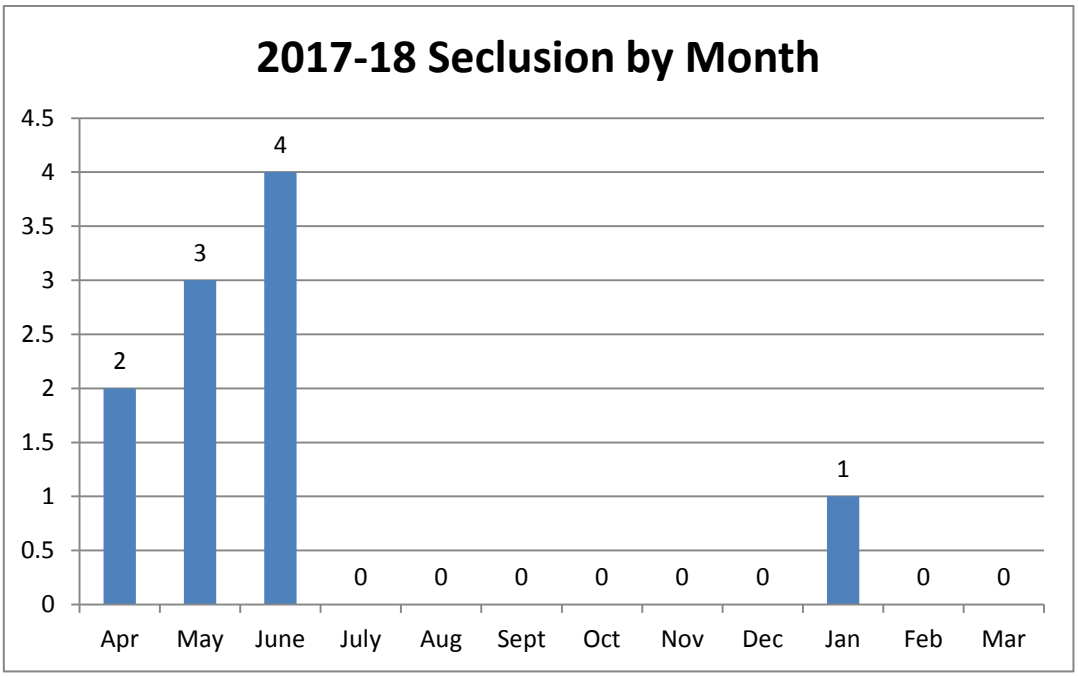


Fig 7 Seclusion Episodes by month

6.3 Review of Seclusion Episodes

Review of the figures indicate that 9 different patients accounted for the 10 episodes with only one patient being subject to seclusion more than once. Fig 8 below shows that 5 of the 10 seclusion episodes during the reporting period lasted for less than 2 hrs, the shortest being 1 hr and 20 minutes. There was one episode lasting 16 hrs 50 mins and three lasting over 24 hours, the longest being a patient who was in seclusion for 70 hours. All four of these longer episodes involved patients who were extremely disturbed and were awaiting the provision of a bed on a psychiatric intensive care unit (PICU). It is envisaged therefore that the length of time patients spend in seclusion should reduce once the recently commissioned PICU becomes operational.

In relation to seclusion, considerable time and effort has been devoted to ensuring that the Trust is compliant with the guidance in the new MHA Code of Practice around its use. This has included a number of visits to clinical areas to reinforce the policy and ensure staff awareness regarding the use, recognition and monitoring arrangements required for this restrictive practice, and also bespoke training for acute staff regarding the process of entering and exiting the seclusion room in the safest possible manner.

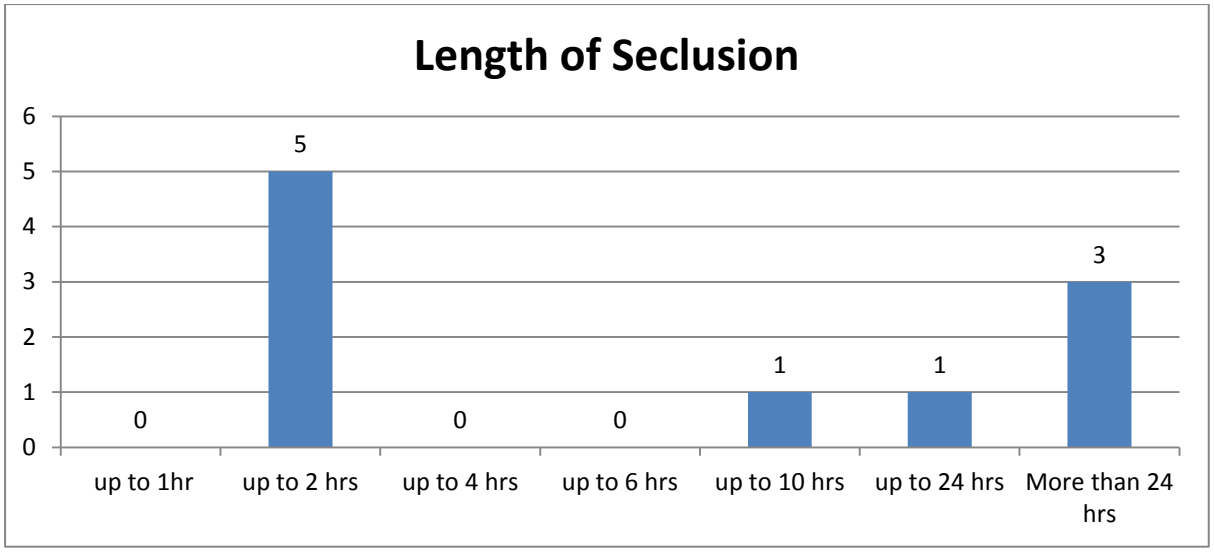


Fig 8 Length of Seclusion Episodes

6.4 Diversity and Inclusion

The Safeguard incident reporting system allows reporters to enter data around "protected characteristics" but the gathering of this data is still proving to be problematic. However, following analysis of seclusion incidents we are able to conclude that there were 6 "white British" male, 1 white British female, 1 British Asian male and 1 British Asian female service users subjected to the use of seclusion during the reporting period.

6.5 Learning from not having a Seclusion Room

As stated earlier in 6.1, the Trust has been without a dedicated seclusion facility since July 2017 due to building work to complete a new psychiatric intensive care unit (PICU). This has required the acute adult services to lower the threshold at which referral to an out of area PICU bed may be sought but it has also created the opportunity for clinical staff to explore and improve de-escalation strategies and early recognition/assessment of those patients most likely to become violent. Ward 1 in particular have focused on a "trauma informed" approach as part of their quality improvement work and have utilised the Dynamic Assessment to Situation Aggression (DASA) assessment tool as a means of identifying potentially aggressive individuals so that proactive/preventative strategies can be implemented. The absence of a seclusion room has also afforded clinical staff an opportunity to reflect on its use prior to closure and recognise the purpose of its use and potential for reactivating trauma.

7. Rapid Tranquillisation

Rapid Tranquillisation (RT) is a means of managing violent and/or aggressive behaviour when other interventions such as de-escalation and physical restraint have not calmed the situation and the patient is still exhibiting extreme risk behaviours that could cause serious harm to themselves or others. The Trust policy defines rapid tranquillisation as:-

"*the use of medication via parenteral (usually intramuscular or exceptionally intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed to reduce the risk to self and/or others."*

7.1 Arrangements for monitoring

As with other potentially restrictive practices, it is important that there is a robust monitoring system in place to offer assurance and governance around this area of practice. The NICE Quality Standards 2017 state that people with mental health problems who receive rapid tranquillisation should have their vital signs monitored after the intervention. Incidents of rapid tranquillisation are monitored by both a senior medical practitioner and the workforce/patient safety team. The latter monitor the use of RT on a weekly basis via the incident monitoring system to ensure that requirements of the NICE quality standard and Trust policy are maintained e.g. completion of NEWS and other physical health monitoring post incident. Medical monitoring involves the presentation of a report to the clinical effectiveness group on a quarterly basis by senior consultant psychiatrist regarding incidence of RT and pharmacology.

7.2 Figures for use of Rapid Tranquillisation 2017/18

The graph in Fig 9 below details the incidence of rapid tranquillisation by month and similarly to physical restraint, shows a downward trend over the reporting period. In total there were 223 incidences of rapid tranquillisation during the reporting period across the Trust.

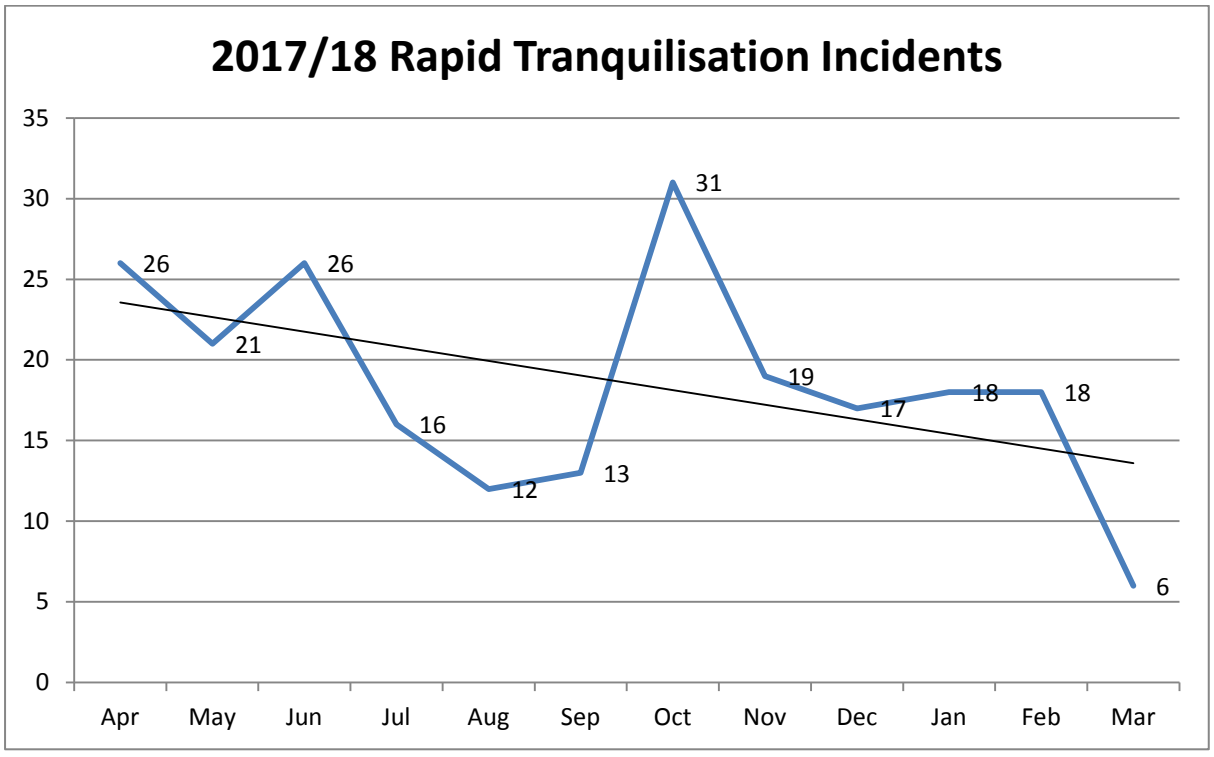


Fig 9 Rapid Tranquillisation Incidents for 2017/18

7.3 Use of Rapid Tranquillisation 2017/18 by Clinical Area

The graph in Fig 10 below shows that, similarly to restraint, ward 3 (62 incidents) and Assessment & Treatment Unit (44 incidents) were the highest users of RT during the reporting period. Ward 7 (36 incidents) also features quite highly, closely followed by the other two adult acute wards (ward 1, 29 incidents and ward 2, 24 incidents).

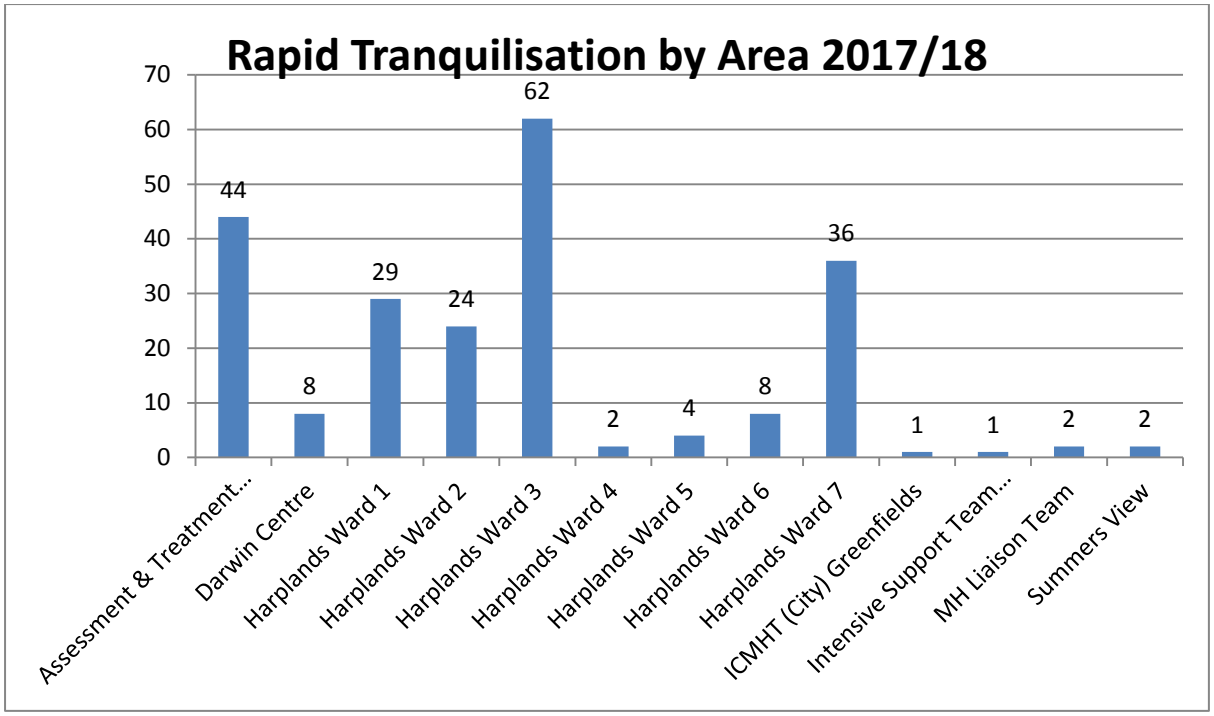


Fig 10 Use of Rapid Tranquillisation 2017/18 by Clinical Area

8. Self Harm

A higher prevalence of self-harm by female patients in mental health settings is often cited as a reason why nationally, women are more likely than men to be subject to the use of physical restraint. Looking at the graph below in Fig 11 this would initially appear to be the case as the all-female ward 3 (172 incidents) again features highest amongst other clinical areas. However, closer scrutiny of the data reveals that physical restraint was only used in 22 (13%) of these incidents. Of the 114 self-harm incidents at Darwin, all but 4 involved female patients but again only 28 (25%) required the use of physical restraint. The picture is slightly different at Assessment & Treatment where 40 (67%) of the self-harm attempts involved male patients and 20 (33%) involved females. Physical restraint was used in 36 (60%) of all self-harm incidents in this area.

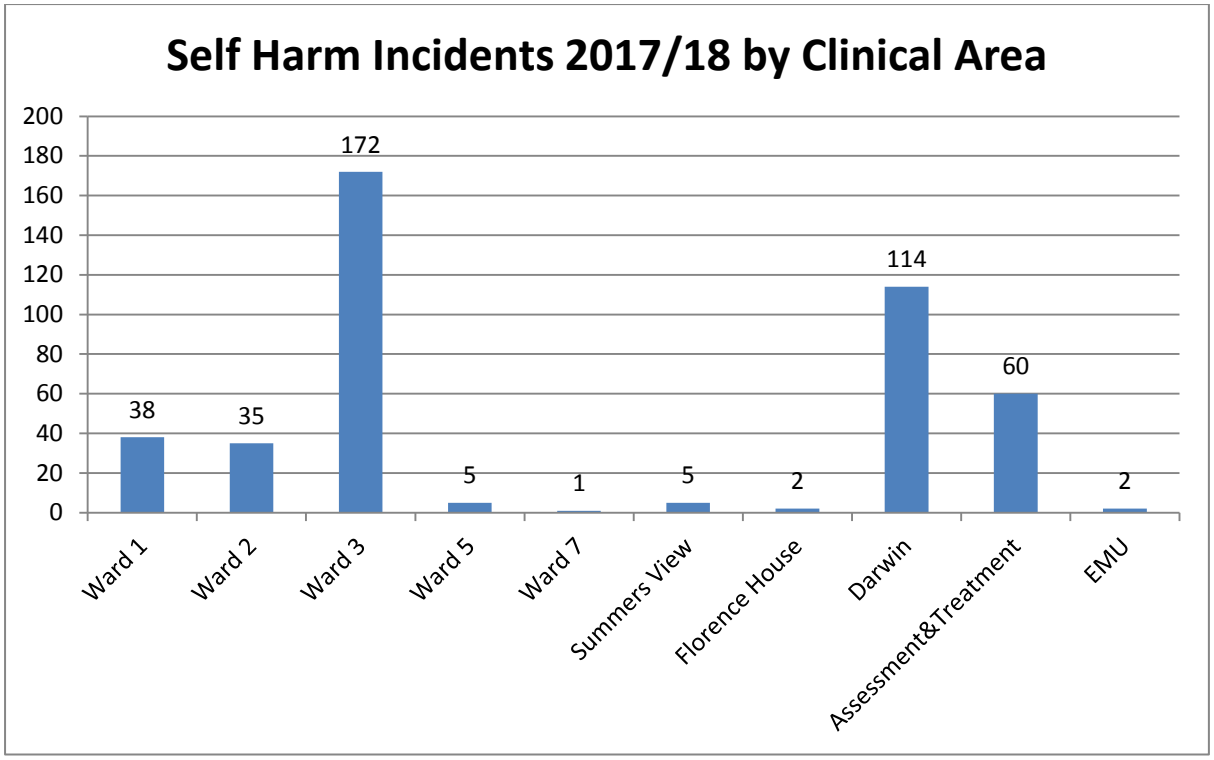


Fig 11 Incidents of Self Harm 2017/18 by Clinical Area

9. Positive Behaviour Support (PBS)

Positive behaviour support (PBS) is a person-centred approach to people with a learning disability and/ or autistic people, who display or at risk of displaying behaviours which challenge. This is the model of support which is implemented within the Trust Learning Disability (LD) services. The training is based on the BILD model of PBS and arose out of the PBS competence framework. It is offered on three levels with Level 2 and 3 consisting of a theory based approach supplemented by a live case study where work is assessed in practice by PBS coaches.

Level 1 is basic awareness of PBS as a model and this is offered to all support services staff and administrators working in the LD directorate. (2 hour session)

Level 2 is for non-registered staff and covers the basic principles of Positive Behaviour Support (PBS), observations and the PBS pathway, Active Support, restrictive practices and capable environments, and recording and collation of data. (2 half days over a two month period).

Level 3 is for all registered professionals and psychological assistants. This training focuses on the context and theory of Positive Behaviour Support, understanding behaviour, behaviour support plans and Quality of life and Wellbeing. Key Components of Positive Behaviour Support and Preventative, proactive and reactive strategies including teaching alternatives, Restrictive practices and capable environments and PBS Interventions. (4 half days over a three month period). The current take up of training is detailed in the graphs below in Fig 12 and 13.

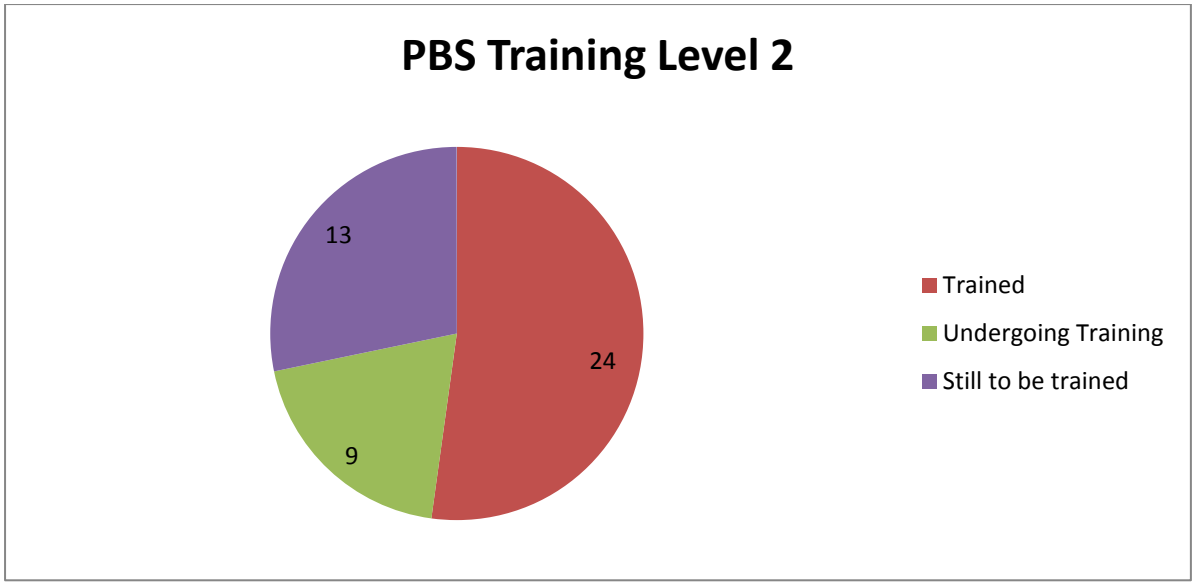


Fig 12 Current Figures for Level 2 PBS Training

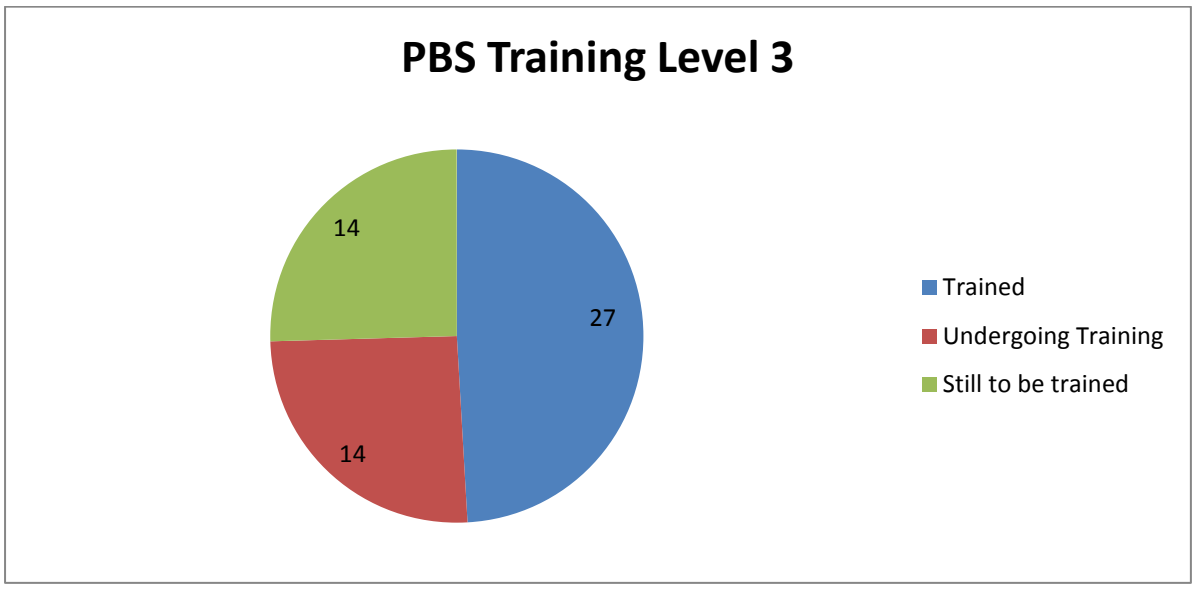


Fig 13 Current Figures for Level 3 PBS Training

10. National Benchmarking

The principle objective of Mental Health Benchmarking is to improve Mental Health Services by using benchmarking to understand and compare services and their outcomes and to promote best practice. Current benchmarking exercises show that the Trust is well below the national average for the use of prone restraint in its services but slightly above the national average for use of all physical restraint. Openness and transparency has always been encouraged within the Trust in relation to the reporting of all restrictive practices. This, in addition to differences in relation to how some Trusts define restraint e.g. difference between restraint and clinical holding, may account for our position in relation to all restraint.

The model of training taught to our staff in relation to value base, risks of physical restraint (particularly prone) and staff taught not to initiate prone restraint, have undoubtedly contributed to the Trust being well below the national average in relation to the use of prone restraint.

11. Conclusion

It is important from a governance and quality perspective that the Trust can evidence monitoring of the use of restrictive practices (restraint, seclusion and rapid tranquillisation) within its clinical services. The trust has robust processes in place to monitor and review restrictive practices in order to ensure compliance with national directives around best practice (NICE Quality Standards, 2017), and initiatives such as the role out of Positive Behaviour Support training, the AQuA Restraint Reduction project, focus on patient debrief and trauma informed care, and other local quality improvement initiatives, have all contributed to a more person-centred approach to patient care. National guidance and research suggest that this has a positive impact on the reduction of restrictive practices.

This report provides assurance of the scrutiny underpinning this area of practice within the Trust. It demonstrates progress towards a reduction in the number of incidences of the use of restrictive practices within services and/or mitigation for when increases have occurred in specific services. The information contained within this report also evidences of the impact a small number of patients can have on restrictive practice data.

The Trust has a restrictive practice reduction strategy which is monitored by the Restraint Reduction Group via an annual work plan, with the ultimate aim of reducing restrictive practices across the organisation, and where they are necessary, to ensure that they are a last resort, least restrictive and for the shortest possible time. Progress regarding the annual work plan will be reported across services and also to the Senior Leadership Team (SLT) and the Trust Quality Committee (QC) annually**.**

12. Recommendations

The Board is asked to approve this Annual Report.

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO: OPEN TRUST BOARD

Enclosure No:9

Date of Meeting:	25 October 2018		
Title of Report:	Q1 Serious Incident and Duty of Candour Report		
Presented by:	Dr Darren Carr, Associate Medical Director / Clinical Director North Staffordshire Directorate		
Author:	Jackie Wilshaw, Head of Patient & Organisational Safety		
Executive Lead Name:	Dr Buki Adeyemo, Executive Medical Director	Approved by Exec	☒

Executive Summary:	Purpose of report	
This report provides analysis of Serious Incidents which occurred during April to June 2018. It is noted that the number of serious incidents, especially the number of suspected suicides, has increased. The report also includes a statement regarding the Trust Duty of Candour reporting position.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☐

Seen at:	SLT ☒ Execs ☐ Date: 14 August 2018	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☒ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Integration Programme Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☐ 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Reference	None identified		
Resource Implications: Funding Source:	None identified None identified		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	No issues with regards to protected characteristics have been identified during the analysis of the Q1 SI data.		
STP Alignment / Implications:	None		
Recommendations:	For information and assurance		

Version	Name/group	Date issued
1	Dr Buki Adeyemo	11.07.18
2	Quality Committee	27.09.18

1. Purpose of the report

This report provides assurance to the Quality committee of the Trust processes relating to Serious Incidents (SIs) and Duty of Candour. The report covers the period from 1st April 2018 to 30th June 2018 (Quarter 1, 2018/19) and details the following:

- The status of SIs currently open and trend data for Q4 2017/18 and Q1 2018/19.
- Serious Incidents by category reported by quarter.
- Themes, learning and change arising from Serious Incident investigations.
- The quarterly Duty of Candour report.

2. Serious Incidents Q1

SI investigations are undertaken following incidents involving people in receipt of services or who have been in receipt of services in the previous 12 months. Investigations are completed for incidents where death, serious injury or occurrence has occurred. For the purposes of this report, investigations are not completed for those service users whose deaths are determined by HM Coroner to be the result of natural causes. The table below illustrates the total number of SIs reported by quarter for the period April 2017 to June 2018.

Table 1

StEIS Incident category	Q1	Q2	Q3	Q4	Total 2017/18	Q1	Q2	Q3	Q4	Total 2018/19
Apparent/actual abuse	0	1	2	2	5	2				
Unexpected potentially avoidable injury causing serious harm: this is subdivided as shown below										
Apparent/actual/suspected self-harm criteria meeting SI criteria	1	0	2	2	5	2				
Slip, trip, fall	2	6	3	3	14	1				
Unexpected potentially avoidable injury causing serious harm	0	0	0	0	0	3**				
Disruptive, aggressive behaviour meeting SI criteria	0	0	0	0	0	1				
Unexpected potentially avoidable death: This is subdivided as shown below										
Pending review	4	10	8	11	33	7				
Apparent/actual/suspected self-harm criteria meeting SI criteria (suspected suicide)	3	6	2	5	16	10				
Total	10	23	17	23	73	26				

** this included one incident where the harm occurred to a member of the public but the nature of StEIS does not allow for this in the reporting framework.

The tables below shows the incidents reported in Q1 by team and by directorate.

Table 2

Team	Apr-18	May-18	Jun-18	total
Acute Home Treatment		1		1
Ashcombe Centre	1			1
Assessment & Treatment	1			1
CDAS		1		1
Darwin Centre		1		1
Early Intervention		1		1
ECT Suite		1		1
Greenfield Centre	1	1	1	3
Lymebrook Centre	2		1	3
One Recovery (Newcastle)		1		1
One Recovery (Stafford)		2	1	3
One Recovery/Adult Community (EI County)			1	1
Sutherland Centre	2	1		3
Sutherland Centre/CDAS			1	1
Ward 2		1		1
Ward 4	1	1		2
Ward 3			1	1
Grand Total	8	12	6	26

Directorate	**Apr-18**	**May-18**	**Jun-18**	**Grand Total**
Adult Com	6	4	2	12
Adult Com*/Sub Misuse			1	1
Adult IP		2	1	3
CYP		1		1
LD	1			1
NOAP	1	1		2
Sub Misuse		4	1	5
Sub Misuse/Adult Com*			1	1
Grand Total	**8**	**12**	**6**	**26**

*indicates the lead directorate for purposes of the SI investigation.

During Q1 26 incidents were reported into StEIS and have undergone or are in the process of undergoing SI investigation.

The main points to note are:

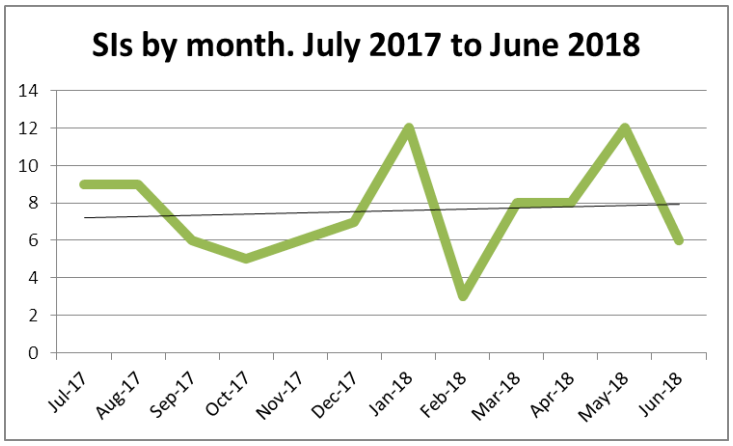
- There were 13 serious incidents reported for the Adult Community Directorate. There were 10 unexpected, potentially avoidable deaths, 1 incident of serious self-harm and 1 incident of potentially avoidable harm. Of the deaths reported 2 people were known to mental health

and substance misuse services, therefore joint investigations will be completed. In 1 case, the AMH Community Directorate will be the lead investigator.

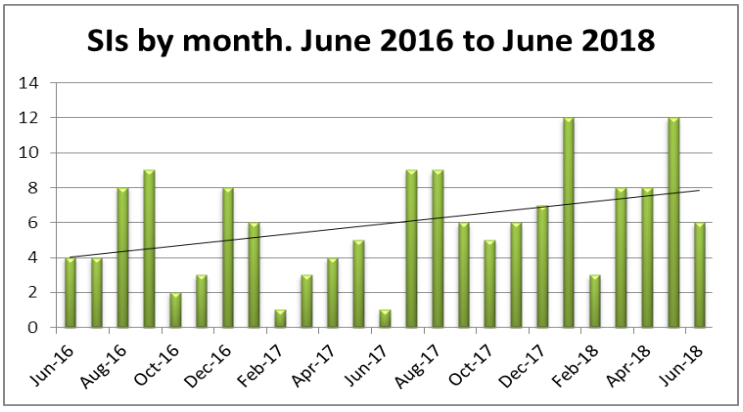
- There were 6 unexpected, potentially avoidable deaths in the Substance Misuse Directorate. This includes the death of 1 person who was open to substance misuse services and adult mental health services and in this case the Substance Misuse Directorate will be the lead investigator.
- In the NOAP Directorate, there were 2 incidents of a physical health nature. 1 slip, trip fall that resulted in a fracture and 1 avoidable pressure ulcer.
- There were 3 incidents in the Adult Inpatient Directorate. 1 incident involved the assault on a member of the general public by a person who had absconded from the ward. 1 person suffered a fracture to the foot as a result of kicking a piece of furniture and 1 person suffered fractures whilst receiving ECT.
- There were 2 incidents of admissions to adult mental health services as a result of CYP and LD services being unable to locate beds in the appropriate services.

3. Themes and Trends

The graph below shows the number of Serious Incidents reported monthly over the previous 12 months.



The trend line for SIs over the last 12 months is marginally increasing however if viewed over a longer timeframe (24 months), the trust is reporting an increasing number of SIs. See graph below



This increase in incidents reported is attributed to the opening of ward 4, as there has been a number of SI's in relation to slips, trips and falls. There has also been an increase in the number of

deaths reported by Substance Misuse Services after service expanded when the contract for Stoke Community Drug and Alcohol Services was awarded to the Trust. The broader impact of budget cuts to substance misuse services in general is yet to be determined however the Trust will continue to monitor drug and alcohol related deaths through the SI and Mortality Surveillance processes.

The numbers of slip, trips, falls has reduced in Q1 with 1 fracture reported in Q1, with 6 fractures in Q4.

The number of suspected suicides has increased in Q1.There were 10 unexpected deaths where death by suicide was suspected in Q1 and this is in comparison to 16 suspected suicides in 2017/18. The Trust continues to work alongside partner agencies in the Stoke-on-Trent and Staffordshire Suicide Prevention Strategy group. We have also obtained funding for external training in suicide prevention interventions and are in the planning stages of a suicide prevention conference to be held at the end of 2018.

It is noted that the incidents listed as 'pending review' are generally incidents which relate to the deaths of people who have received input from the Trust substance misuse services. These deaths tend to be in relation of people who have longer term problems of drug or alcohol addiction. The use of drugs or alcohol may also feature in the unexpected deaths of people in mental health services. However in these cases, the use of drugs or alcohol may not be in relation to issues of addiction and may be single or unpredictable, chaotic use therefore the consideration for dual diagnosis services would not be appropriate.

Q1 also showed an increase in the categories: unexpected potentially avoidable injury causing harm and disruptive, aggressive behaviour meeting SI criteria.

- These were the 3 incidents in the adult inpatient directorate and one potential harm incident in the adult community where a service user threatened staff and members of the public with a weapon.

During Q1 the Trust received the latest data table and report from the National Learning and Reporting System (NRLS). This data shows an improvement in the Trust position in relation to the number of deaths reported as a percentage of the total number of incidents. See table below.

	Number of deaths reported	% of total number of incidents (Trust)	% of total number of incidents (national)
April to September 2016	26	2.1	0.8
April to September 2017	13	1.2	0.7

4. Learning from Serious Incidents

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

- Increased monitoring of the Access team use of the Threshold Assessment Grid (TAG) tool. Staff are to be supported in their understanding of this tool and its use in clinical care decision making.
- There is a need to ensure that people discharged from home treatment services before they have an appointment date with the CMHTs are provided with relevant information/contact

details of how to access support if required in the interim. Therefore changes made to documentation provided on discharge. People discharged from the Acute Home treatment team are provided with information/contact details etc. regarding accessing support whilst waiting for appointments with the CMHTs.

- Where the Access Team are required to complete the seven day follow-up contacts post discharge, there is a need to ensure that they have all relevant information. A template for seven day contacts has been devised and implemented in order to ensure that the reviewer from the Access Team has a comprehensive overview of care needs previously provided.
- A practice note has been issued by the Medical Director, to provide staff with a quick reference guide of actions to be taken in ward round with regards to the processes for the management of MHA documentation. This followed an incident where a person was unlawfully detained in hospital as staff did not follow the correct processes in a timely manner.
- A fall which resulted in a fracture on one of the NOAP wards was found after a delay in the patient being transferred to A+E. Actions from this incident include post falls training, including completion of all documentation for bank staff, a reminder via the college tutor for doctors to record all contacts with patients and for bank staff on ward 4 to receive training in the care of people with dementia.
- As in previous investigations, communication and documentation issues continue to be a feature of investigations. In particular this relates to inputting into the electronic patient record in a timely manner and thereby ensuring that the information is available to other members of the team. Actions plans for improvements are in place for individuals and teams in relation to specific incidents. However there is a need to ensure that the messages are cascaded across the organisation and therefore the learning from several incidents has been incorporated into the Learning Lessons bulletin and workshops.

As in previous reports there were a number of investigation were no recommendation for change were made.

As part of the determination to strengthen Trust processes, the Patient + Organisational Safety Team (P+OST) have developed and implemented an overarching action plan from SI investigations. This action plan will be reviewed by P+OST at 6 and 12 monthly intervals post incident in order to ensure that the learning from investigations has been embedded into practice. Assurance from this process will be through the Clinical Improvement and Safety Group (CSIG).

5. Duty of Candour (Quarter 1 report)

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

In the case of SIs, it is not always possible to immediately determine which, if any of the deaths under investigation meet the Duty of Candour requirements. However should any investigation identify causal links between patient harm and service delivered, the Duty of Candour process would be initiated and a letter outlining the issues sent to the patient or next of kin. As a secondary measure, during Q1 SI investigations have been added to the mortality surveillance group agenda for discussion as part of the mortality surveillance process.

The table below shows the incidents that were initially reported as potentially meeting the DoC requirements.

	Moderate + incidents reported	Moderate+ incidents downgraded after review	Moderate+ incident. Managed via SI process	Moderate incident but does not meet DoC criteria	Incident meeting DoC requirement	Moderate+ incident. Managed through the MS process	**total**
Apr-18	18	11	4	2	0	1	36
May-18	42	30	8	4	0	0	84
Jun-18	24	15	4	1	0	1	45
total	84	56	16	7	0	2	165

During Q1 no incidents met the criteria for reporting under the Duty of Candour requirements. The ongoing SI investigations may determine that incidents meet the DoC criteria as part of the investigative process however the initial investigations do not indicate this.

6. Conclusion

- The Trust continues to monitor all incidents on a weekly basis and this report demonstrates compliance with Trust policies and processes.
- During this timeframe there has been an increase in the number of unexpected potentially avoidable deaths. This includes an increase in the number of deaths where suicide is suspected.
- The number of falls related SIs has reduced in this quarter. The NOAP teams have implemented a number of falls reduction initiatives as part of a quality improvement programme. The review of these initiatives will continue to be monitored through the weekly incident review group and the physical health group.
- The learning from investigations, as outlined above, is cascaded across the Trust through a variety of governance processes. From the internal team and directorate processes across to full Trust cascade and through the Learning Lessons framework. This is to ensure that the learning from investigations is not completed in isolation and that a positive learning culture is maintained, through supporting staff with the opportunity to reflect and share learning.

REPORT TO: TRUST BOARD

Enclosure No:10

Date of Meeting:	25 October 2018		
Title of Report:	Director of Infection Prevention & Control (DIPC) Q1, (April – June 2018) report		
Presented by:	Maria Nelligan, Executive Director of Nursing and Quality/DIPC		
Author:	Amanda Miskell, Consultant Nurse, Physical Health/Deputy DIPC		
Executive Lead Name:	Maria Nelligan, Executive Director of Nursing & Quality/DIPC	Approved by Exec	☒

Executive Summary:		Purpose of report	
To provide the Board with assurance in relation to the IPC arrangements within the Trust. The report will also give an overview of the Water Safety arrangements within the organisation.		Approval	☒
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☒	Date: 11th September 2018	
	Execs ☐	Date:	
Committee Approval / Review	• Quality Committee ☒ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. ☐ 2. To provide the highest quality services. ☒ 3. Create a learning culture to continually improve. ☒ 4. Encourage, inspire and implement research & innovation at all levels. ☐ 5. Maximise and use our resources intelligently and efficiently. ☒ 6. Attract and inspire the best people to work here. ☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	Although there is a risk to any deviation from the IPC Assurance Framework, this is monitored at IPC Group.		
Resource Implications: Funding Source:	Heatwave Plan, Planned Water Safety/ IPC works		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	There is no direct impact on protected characteristics in relation to the completion of this report.		
Recommendations:			

Version	Name/group	Date issued
V1	IPC Group	10/09/2018
V2	Director of Nursing & Quality (DIPC)/SLT/Quality Committee	10/09//2018

1. Purpose of the report

This report will update and provide assurances for quarter one (Q1) on IPC including water safety, and prevalence of IPC issues, including local and within the organisation. The Board will also be apprised of our position in relation to Health Care Acquired Infections (HCAIs) and other relevant issues.

2. Health Care Acquired Infections (HCAI)

During the Q1 period there were no HCAIs to report, in relation to Blood Stream Infections, MRSA Bacteraemia or C-difficile.

MRSA screening continues to result in a zero return in terms of positive results and no exceptions have been reported externally.

3. Water Safety programme & activity

The IPC assurance framework supports compliance with the Health and Social Care Act 2008 - Code of Practice on the prevention and control of infections and related guidance (DH 2015). Incorporated within this are several references to water safety for healthcare premises including systems to manage and monitor the prevention and control of infection by the use of risk assessments, considering the susceptibility of service users and any risks that their environment may pose to them, and have appropriate management and monitoring arrangements. This should include as a minimum:

- A Water Safety Group and water safety plan which are in place
- Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections. This includes the fabric of the building, related fixtures and fittings, and services such as air and water supplies
- Management of drinkable and non-drinkable water supplies
- Minimising the risk of Legionella and other water supply and building related infections e.g. Pseudomonas aeruginosa and aspergillus by adhering to national guidance
- There should be a policy for preventing contamination of any water lines, including appropriate water supply and maintenance schedules

At Combined we have a robust water quality assessment process with external organisations. One via Combined and another via Serco. Regular testing and flushing takes place which is reported into IPCG.

IPC and Estates staff meet regularly. Future considerations for action going forward include:

- Maintenance of any additional air conditioning for the heatwave plan.
- Alignment of risk assessments and testing processes which is currently under review with Estates and IPC.
- Consider increasing the safe levels of bacteria for safe water samples. Currently we have same guidance and levels as an augmented care unit.

- Review of the Water Safety/Legionella Policy.

4. Outbreaks

Ward 7 experienced an increased prevalence of diarrhoea and vomiting suggestive of a viral gastrointestinal outbreak. On 30th April it was reported there were 8 patients experiencing symptoms. The standard operating procedure (SOP) was followed and on day 3 it was confirmed as a small round structured virus (Norovirus). Three members of staff also became symptomatic. The ward reopened on 4th May (day 5) without incident and no bed loss days were incurred. One patient was admitted to UHNM unrelated to the outbreak and supportive communications took place between both IPC teams. A post outbreak meeting took place which found no gaps in the policy or SOP that was followed. Norovirus was circulated in the community at the time of the outbreak. The review and identification of an index case is highly suggestive of an outside source to the outbreak.

5. Infection Prevention & Control Group

The Infection Prevention and Control Group (IPCG) meets bi-monthly, and the last meeting took place in June 2018. The Chair`s summary comprises:

- Q4 DIPC, Cleanliness, Water and Antimicrobial Stewardship reports all approved by members and Chair.
- IPCG Terms of Reference (ToR) and those of the Housekeeper Group reviewed.
- The IPC Annual Report was reviewed for Quality Committee and Board.
- Additional training events have been added following the identification of some staff cohorts on a 3 year rather than an annual programme. Compliance should be above 85% by Q3.
- Surveillance data from April 2018 is now focused on invasive devices, infections and any other relevant IPC issues or concerns.

6. Recommendations

The Board is asked to note the DIPC Quarter 1 Report for 2018/19.

7. References

Health and Safety Executive (2014) HSG220 (2nd edition): Health and safety in care homes. Available from: http://www.hse.gov.uk/pubns/books/hsg220.htm

Health and Safety Executive (2013) (L8 4th edition) Legionnaires' disease. The control of legionella bacteria in water systems. Approved Code of Practice and guidance. Available from: http://www.hse.gov.uk/pubns/books/l8.htm

Health and Safety Executive (2013) HSG274 Part 1: Legionnaires' disease: Technical guidance The control of legionella bacteria in evaporative cooling systems. Available from: http://www.hse.gov.uk/pubns/books/hsg274.htm

Health and Safety Executive (2013) HSG274 Part 2: Legionnaires' disease: The control of legionella bacteria in hot and cold water systems. Available from: http://www.hse.gov.uk/pubns/books/hsg274.htm

Health and Safety Executive (2013) HSG274 Part 3: Legionnaires' disease: Technical guidance: The control of legionella bacteria in other risk systems. Available from: http://www.hse.gov.uk/pubns/books/hsg274.htm

Department of Health (2013) Health Technical Memorandum 04-01: Addendum Pseudomonas aeruginosa – advice for augmented care units. Available from: https://www.gov.uk/government/publications/addendum-to-guidance-for-healthcare-providers-on-managing-pseudomonas-published

Health and Safety Executive (2012) Control of Legionella in hot and cold water systems in care services/ setting using temperature Available from: http://www.hse.gov.uk/foi/internalops/sims/pub_serv/07-12-07/index.htm

Department of Health (2006) HTM 04-01: Water systems: the control of Legionella, hygiene, "safe" hot water, cold water and drinking water systems. Part A: Design, installation and testing and Part B: Operational management. Available from: https://www.gov.uk/government/publications/hot-and-cold-water-supply-storage-and-distribution-systems-for-healthcare-premises

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO: TRUST BOARD

Enclosure No: 11

Date of Meeting:	25 October 2018		
Title of Report:	Q1 Mortality Surveillance Report		
Presented by:	Dr Darren Carr, Associate Medical Director / Clinical Director North Staffordshire Directorate		
Author:	Jackie Wilshaw Head of Patient and Organisational Safety		
Executive Lead Name:	Dr Buki Adeyemo, Executive Medical Director	Approved by Exec	☒

Executive Summary:		Purpose of report	
This report provides analysis of the mortality surveillance activity during Q1 2018/19. The report identifies any learning from the MS review process and provides assurance regarding the trust compliance with the national learning from deaths agenda.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☐
Seen at:	SLT ☐	Date: July 2018	
	Execs ☐	Date:	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. ☐ 2. To provide the highest quality services. ☐ 3. Create a learning culture to continually improve. ☐ 4. Encourage, inspire and implement research & innovation at all levels. ☐ 5. Maximise and use our resources intelligently and efficiently. ☐ 6. Attract and inspire the best people to work here. ☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	Nil identified		
Resource Implications: Funding Source:	Nil identified		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	No issues with regards to protected characteristics have been identified during the analysis of the Q1 SI data		
Recommendations:	For information/assurance		
STP Alignment / Implications:	N/A		

Version	Name/group	Date issued
1	Dr O Adeyemo	31/07/2018
2	Quality Committee	27.09.18

1. Introduction.

In 2017 the National Quality Board published new guidance on learning from deaths. As a result there is a need to ensure that the Trust can be confident that all unexpected deaths are reported and investigated appropriately. Additionally, information contained within its databases must be accurate and comply with the Trust standard of transparency and accountability. This report is for the Q1 reporting period 2018/19 and provides information for the time frame April 2018 to June 2018.

2. Background

Physical and mental health are closely linked. People with severe and prolonged mental illness, including Learning Disabilities are at risk of dying on average 15 to 20 years earlier than other people. In addition, people with long term physical illnesses suffer more complications if they also develop mental health problems. The report aims to support trusts to review and consider these factors i.e. premature death of those with a mental disorder and the increased risk of complications for those with physical and mental health difficulties.

People die for a variety of reasons – both expectedly and unexpectedly. Not all deaths require an investigation and just because someone dies it does not mean that the quality of services is poor. What is important though is that when someone does die unexpectedly, this is identified so that the correct processes and appropriate levels of enquiry are made with a view to learning and taking preventative action in future. Some people die earlier than expected and it is important that these deaths are identified correctly. It is important that the right level of review or investigation is undertaken to improve services, identify any service failure, learn from any mistakes and to provide families and stakeholders with relevant information.

The purpose of reviewing the circumstances of or investigating a death is:

- to establish if there is any learning for the Trust around the circumstances of the death and the care provided leading up to a death;
- to learn from any care and delivery problems that need to be addressed to prevent future deaths and improve services;
- to identify if there is any untoward concern in the circumstances leading up to death;
- to be in a position to provide information to HM Coroner if requested;
- to be able to work with families to understand the full circumstances and answer questions;
- to have the full detail of the events available for any subsequent complaint or legal investigation.

3. Governance

This quarterly mortality surveillance report is discussed at the Clinical Safety Improvement Group and Quality Committee in order to ensure that the Trust is sighted on all natural cause deaths, in addition to those deaths subject to Serious Incident investigation. This provides the opportunity to identify any gaps in service delivery and/or lessons learnt are discussed and cascaded for action as appropriate.

All unexpected deaths, where the person is in receipt of services, are investigated through the Serious Incident process. There is robust governance around this process and areas for action are monitored by the directorate responsible. In addition, the learning from these deaths is disseminated throughout the Trust as part of Learning Lessons, with support from other trust departments, such as HR, as necessary.

Natural cause deaths (where the person is open to services at the time of death), as identified by HM Coroner, are not subject to SI investigation, however local investigations are undertaken in order to ensure that there are no gaps/omissions in service delivery.

The Coroner's Office informs the Trust in cases where the deaths have a drug or alcohol component; they also report deaths where there are suspicious circumstances in order to check if the person is known to mental health services. Deaths attributed to physical health issues in relation to excessive alcohol consumption are not subject to Coroner investigation however if sudden unexpected death in alcohol

misuse (binge drinking) is suspected, the Coroner may ask for an inquest and the Trust will undertake a SI investigation.

The vast majority of deaths reported to the Trust are for the Neuro and Old Age Psychiatry Directorate and relate to elderly people who have had some contact with the memory service. In the main these deaths relate to people who are over 75 years of age and/or have been out of service for over 12 months and therefore they would not meet the criteria for mortality surveillance. The process for reviewing the deaths of people with Learning Disabilities (LeDeR) is a separate process which is hosted externally to the Trust.

The LeDeR programme is delivered by the University of Bristol, and commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. Work on the LeDeR programme commenced in June 2015 for an initial three-year period. The overall aims of the LeDeR programme are to support improvements in the quality of health and social care service delivery for people with learning disabilities and to help reduce premature mortality and health inequalities.

A key part of the LeDeR programme is to support local areas in England to review the deaths of people with learning disabilities aged four years and over. The programme has developed and rolled out a review process for the deaths of people with learning disabilities. By the end of 2017, the LeDeR programme was fully rolled out across England, with local steering groups in place, and the deaths of people with learning disabilities being reviewed in all regions.
The LeDeR programme also collates and shares anonymised information about the deaths of people with learning disabilities nationally, so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements.

The current Staffordshire Learning Disability Mortality Review Steering Group has been operating since 1st October 2017 following the publication of national guidance in March 2017 by the National Quality Board. Since this date all deaths of a person with a learning disability who were receiving care from NSCHT had to be formally reported and reviewed as part of the Learning Disability Mortality review programme. The Trust currently has 3 people from the organisation trained as reviewers for the LeDeR programme.

The deaths of people known to LD services are reported to the national database at Bristol, by the Patient and Organisational Safety Team. These cases are then referred on to the regional steering groups i.e. the Staffordshire steering group for allocation of reviewers. The Trust has received periodic information regarding the progress of these reviews.

4. Trust reporting and data collection

The table below shows the number of deaths reported monthly during Q1. These deaths will be reviewed by the mortality surveillance group following completion of the investigation process.

Table 1. Deaths reported during Q1.

Month	Total number of deaths Recorded on Lorenzo	Total number of deaths – out of service	Reported as SI	Open to services at time of death- natural causes	Substance Misuse deaths			LD Deaths
					North Staffs	Stoke	Staffs	
Apr 18	63	30	7	26	0	0	0	1
May	48	33	7	8	1	1	2	1
Jun	21	7	5	9	1	0	1	0

NB. Substance Misuse deaths may be included in the Lorenzo column is the person is also open to mental health services.

During Q1 the mortality surveillance group reviewed the care of 15 people. There were 12 people who were reviewed under the mortality surveillance criteria and 3 people whose deaths were investigated under the SI Framework. These deaths did not occur in Q1.The analysis of these deaths is shown in the tables below:

Table 1: Natural cause deaths

Identifier	Level of care provided	Death Category	Death resulted as a consequence of problems in healthcare?	Duty of Candour applies?	Domain
56	Good	UN2	No	No	Physical health
9	Good	UN2	No	No	Physical health
14	Adequate	UN1	No	No	Physical health
30	Good	UN2	No	No	Drug and Alcohol
33	Good	UN2	No	No	Drug and Alcohol
34	Good	UN2	No	No	Drug and Alcohol
36	Good	UN1	No	No	Drug and Alcohol
45	Good	UN2	No	No	Physical health
48	Good	UN1	No	No	Physical health
49	Good	UN2	No	No	Drug and Alcohol
50	Good	UN2	No	No	Drug and Alcohol
51	Good	UN1	No	No	Physical health

Table 2: Deaths investigated under the SI process

Identifier	Phase of care score -Level of care provided	Death Category	Death resulted as a consequence of problems in healthcare?	Duty of Candour applies?	Domain
37	Excellent	UN2	No	No	Drug and Alcohol
41	Adequate	UN2	No	No	Drug and Alcohol
42	Good	UU	No	No	Drug and Alcohol

- EN1 - Expected Natural. *Deaths that were expected to occur in an expected timeframe e.g. terminal illness.*
- EU - Expected Unnatural. *Deaths that are expected but not from the cause expected or timescale e.g. misuse of drugs, alcohol dependant, eating disorders. Likely to be preventable should consider further investigation.*
- UN1 – Unexpected Natural*. Death from a natural cause e.g. sudden cardiac condition, stroke. May have been preventable, consider further investigation*
- UN2 – Unexpected Natural. *Death from natural cause but didn't need to be e.g. alcohol and drug dependency, care concerns. Likely to be preventable, consider further investigation.*
- UU – Unexpected Unnatural. *Suicide, homicide, abuse/neglect – needs investigation to be completed under SI policy.*

There is no national guidance on the criteria for the phase of care determination. However the mortality surveillance group considered that good care had been provided where there was evidence of the staff providing a good level of support, had responded quickly and appropriately to situations where deterioration in physical health was noted. There was one case where the group the care provided to be excellent. This was largely due to the quality of the entries in the clinical records as well as the action taken by the staff member. However the group noted that improvements could be made in 2 of the cases reviewed. Where despite appropriate interventions by the care coordinator to support the person's physical health needs, the care plan and risk assessment with regards to the person's mental health needs could have been improved. The care coordinators and line managers are contacted to discuss the learning/outcomes of the mortality surveillance process.

With regards to the mortality surveillance of people with Learning Disabilities, there have been a total of eight deaths reported to LeDeR since 1st October 2017. Of these eight cases, there have been two

completed reviews to date. One of these reviews concluded that there was a good standard of care overall. There was no specific learning highlighted and therefore no further action required. The second completed report indicated that there would be no value in completing a multi-agency review however the lessons learned were still under consideration as to whether or not they directly related to NSCHT.

The external Staffordshire LeDeR steering group are responsible for the allocation of investigators. In relation to the remaining six reported deaths, three have not had a reviewer assigned to them, one has just recently been assigned a reviewer and two are currently being reviewed. The Trust has requested that further information as to the progress of investigations is forwarded as soon as the investigations and reports are completed.

5. Conclusion

The Trust continues to monitor the deaths of people whose deaths are outside of the Serious Incident process. The monthly Mortality Surveillance Group receives and reviews investigations in order to provide assurance as to the quality of the care provided. The group identifies any learning from the reviews and offers recommendations for practice when required. In the deaths reviewed during Q1, there were no examples of problems in the healthcare provided by the trust which may be considered to have contributed to the death of any individuals.

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO Trust Board

Enclosure No:12

Date of Meeting:	25th October 2018		
Title of Report:	Performance & Quality Management Framework Month 5		
Presented by:	Suzanne Robinson, Director of Finance, Performance & Digital		
Author:	Vicky Boswell, Associate Director of Performance		
Executive Lead Name:	Suzanne Robinson, Director of Finance, Performance & Digital	Approved by Exec	☒

Executive Summary:	Purpose of report	
The report provides an overview of performance for August 2018 covering Contracted Key Performance Indicators (KPIs) and Reporting Requirements. In Month 5 there are no target related metrics rated as Red and 3 target related metrics as Amber; all other indicators are within expected tolerances. In addition to the performance dashboards a full database (Divisional Drill-Down) has been made available to Directorate Heads of Service and Clinical Directors to enable them to interrogate the supporting data and drive directorate improvement. This is summarised in the supporting PQMF dashboard.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☐

Seen at:	SLT ☒ Execs ☐ Date: Performance Review 2.10.18	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☒ • Audit Committee ☐ • People & Culture Development Committee ☒ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☒ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	All areas of underperformance are separately risk assessed and a rectification plan is developed, overseen by the relevant sub-committee of the Trust Board.		
Resource Implications: Funding Source:	There are potential contractual penalties if the Trust is not able to meet reporting requirements or performance standards. There have been significant improvements in data completeness and data quality following Lorenzo implementation. There are plans to address remaining issues and to support further developments in the Data Quality Improvement Plan agreed with commissioners.		

Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	The PQMF includes monitoring of ethnicity as a key national requirement. The Trust is seeking to ensure that all Directorates are recording in a timely way the protected characteristics of all service users to enable monitoring of service access and utilisation by all groups in relation to the local population. A new diversity and inclusion report is being developed to monitor trust performance on closing service user and workforce equality data gaps.
STP Alignment / Implications:	Reporting from Month 7 will reflect the Locality restructuring in support of STP alignment. This will include a breakdown of activity and performance standards according to North Staffs and Stoke localities. Some of the Board KPIs (Early Intervention and CYP Eating Disorders waiting times) support the delivery of the 5 Year Forward View for Mental Health [5YFV] and are monitored through the STP Mental Health work stream. The Trust's performance against 5YFV targets will be reported to Trust Board on a quarterly basis from Q2.
Recommendations:	The Trust Board is asked to • Receive the Trust reported performance, management action and committee oversight on the Month 5 position.

PERFORMANCE & QUALITY MANAGEMENT FRAMEWORK
REPORT TO TRUST BOARD

Date of meeting:	25th October 2018
Report title:	**Performance & Quality Management Framework** **Performance Report – Month 5 2018/19**
Executive Lead:	Suzanne Robinson, Director of Finance, Performance & Digital
Prepared by:	Vicky Boswell, Associate Director of Performance
Presented by:	Suzanne Robinson, Director of Finance, Performance & Digital

1 Introduction to Performance Management Report

The report provides an overview of performance for August 2018 covering Contracted Key Performance Indicators (KPIs) and Reporting Requirements.
In addition to the performance dashboards a full database (Divisional Drill-Down) has been made available to Directorate Heads of Service and Clinical Directors to enable them to interrogate the supporting data and drive directorate improvement. This is summarised in Appendix 1.

2 Executive Summary – Exception Reporting

The following performance highlights should be noted:

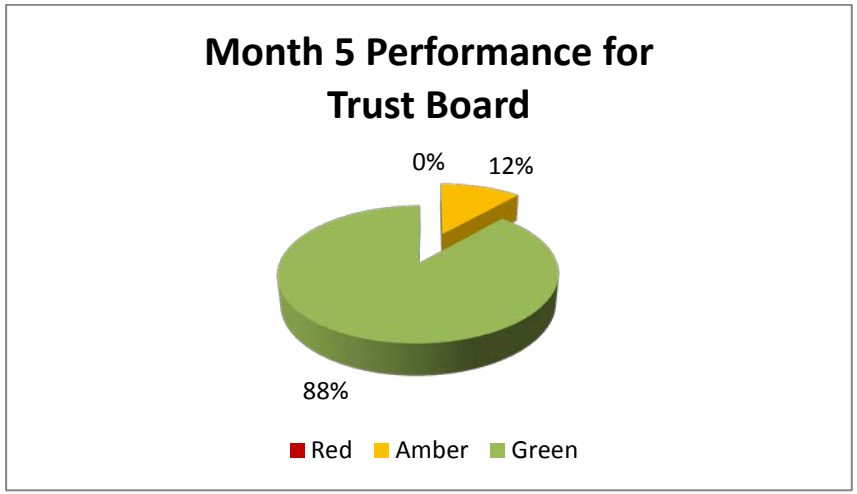
Access and Waiting Times:

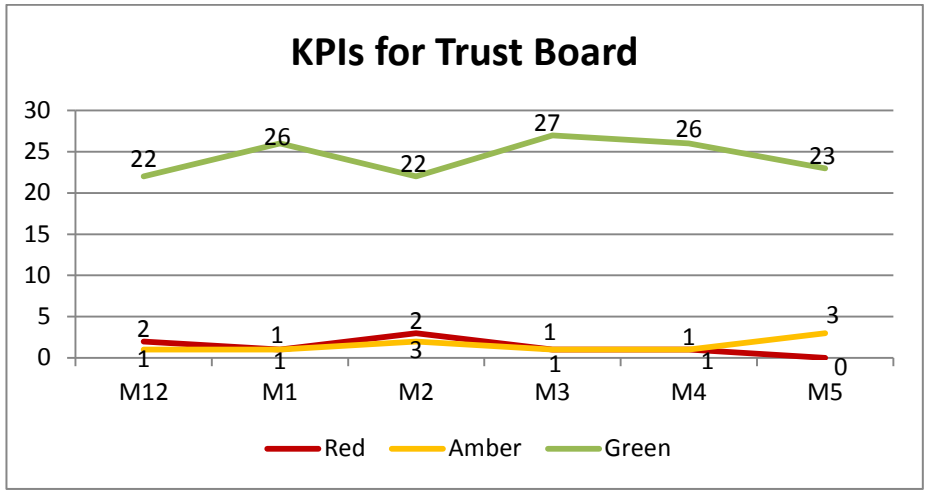
- 90% of clients referred for treatment through the Early Intervention team have been treated within 2 weeks (Target 50%)
- 93.9% of patients have received treatment or intervention within 18 weeks of referral (Target 92%)
- 66% of IAPT patients are moving to recovery (Target 50%)

CPA compliance:

- 96.4% of those on a Care Programme Approach (CPA) have received a follow up contact within 7 days of discharge (Target 95%)

In Month 5 there are no target related metrics rated as **Red** and 3 as **Amber**, all other indicators are within expected tolerances.





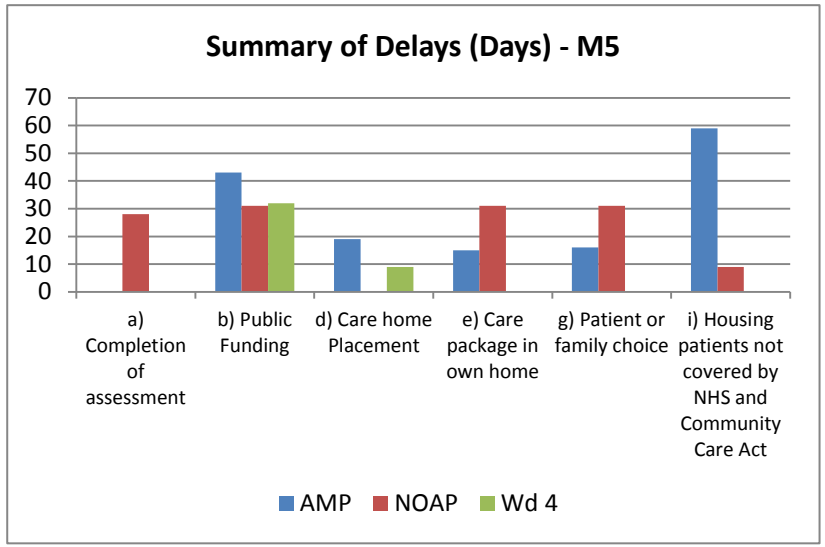
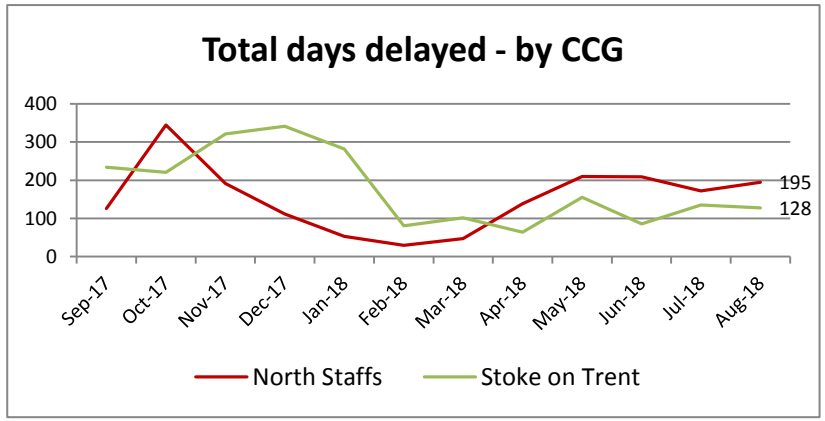
3 Updated metrics and targets

The following measures and targets have been updated for Month 5:

- Sickness absence percentage figures for May confirmed, provisional data received for June, July and August 2018

4 Exceptions - Month 5

KPI Classification	Metric	Exec/Op Lead	Target	M4	M5	Trend	Commentary
NHSI	Delayed Transfers of Care: Mental health delayed transfers of care (DTOC)	Exec Dir of Ops	7.5%	AMBER 7.8%	AMBER 7.8%	⇔	7.8% at M5 the same as at M4 AMHIP – 7.2% at M5 from 6.5% at M4 NOAP (Wards 5,6,7) – 9.0% at M5 from 6.7% at M4 Ward 4 - 9.7% at M5 from 19.6% at M4 • 60.4% attributable to North Staffordshire CCG • 39.6% were located with Stoke-on-Trent CCG Stoke CCG (88.2% NHS, 11.7% Social Care) Total days delayed 128 • 128 days attributed to NHS delays (119 days AMHIP, 9 days NOAP) • 15 days attributed to Social Care delays (AMHIP) The health delays in AMHIP are a consequence of delays in securing CCG funding through panel and a lack of availability of residential and nursing home places. This has been escalated to commissioners. North Staffordshire CCG (53.3% NHS, 46.6% Social Care) Total days delayed 195 • 104 days attributed to NHS delays (33 days Adult MH, 71 days NOAP) • 91 days attributed to Social Care delays (NOAP) There is a particular issue at the moment with the approval process in Staffordshire County Council, which is adding to delays. The Trust continues to liaise Staffordshire County Council to expedite the assessment and placement of individuals in need of social care packages or care home placements.

KPI Classification	Metric	Exec/Op Lead	Target	M4	M5	Trend	Commentary
							 

KPI Classification	Metric	Exec/Op Lead	Target	M4	M5	Trend	Commentary
NHSI	CPA Review: The proportion of those on Care Programme Approach (CPA) for at least 12 months having formal review within 12 months	Exec Dir of Ops	95.0%	GREEN 97.0%	AMBER 93.8%	↘	93.8% at M5 from 97.0% at M4 AMH Community - 94.6% at M5 from 97.4% at M4 LD – 100.0% at M5 the same as at M4 NOAP – 81.8% at M5 from 91.4% at M4 C&YP – 64.3% at M5 from 66.7% at M4 This measure has been consistently achieved year to date and has dipped to 93.8% in M5. All Directorates have action plans in place to ensure that the standard is achieved in M6 and sustained going forward. • AMH C - 94.6% (1264/1336) patients with a 12 month review recorded). • NOAP - 81.8% (6 out of 33 patients not reviewed) • CYP - 64.3% (9 out of 14 patients)
CCG	7 day Follow Up: The proportion of those receiving follow up within 7 days of discharge (all patients)	Exec Dir of Ops	90.0%	RED 80.2%	AMBER 87.3%	↗	87.3% at M5 from 80.2% at M4 This is a new contractual requirement introduced in M4 to ensure that all patients discharged from an inpatient admission receive a 7 day follow up, both CPA and non CPA. 117 of the 134 patients discharged in M5 were followed up within 7 days, 17 patients were not followed up within the timescale. • AMHIP - 96 of the 111 patients had recorded follow ups, 15 patients were not followed up within the timescale • NOAP – 21 of the 23 patients had recorded follow ups, 2 patients were not followed up within the timescale

KPI Classification	Metric	Exec/Op Lead	Target	M4	M5	Trend	Commentary
							Weekly monitoring has been strengthened and inpatient and community staff have been reminded of the requirements of the SOP in respect of discharge planning and follow up. The inpatient wards have strengthened the process of notifying community teams of impending discharges.

5 Recommendations

The Trust Board is asked to:

- Receive the Trust reported performance, management action and committee oversight on the Month 5 position

Month: **August**
5
Key:-

PQMF Report

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

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

	Metric	Frequency	Standard	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
NHSI	Early Intervention in Psychosis - A maximum of 2 week waits for referral to treatment (Target 17/18-50%, 18/19-53%)	Monthly	53%	75.0%	75.0%	100.0%	75.0%	90.0%							
NHSI	Early Intervention in Psychosis - A maximum of 2 week waits for referral to treatment (North Staffordshire CCG) (Target 17/18-50%, 18/19-53%)	Monthly	53%	100.0%	100.0%	100.0%	100.0%	100.0%							
	Early Intervention in Psychosis - A maximum of 2 week waits for referral to treatment (Stoke-on-Trent CCG) (Target 17/18-50%, 18/19-53%)	Monthly	53%	50.0%	66.6%	100.0%	66.6%	88.8%							
NHSI	CAMHS - % of CYP with ED (Routine Cases) referred with a suspected ED that start treatment within 4 weeks of referral (North Staffs and Stoke CCG)	Monthly/Quarterly	95%			100.0%									
	CAMHS - % of CYP with ED (Routine Cases) referred with a suspected ED that start treatment within 4 weeks of referral (North Staffs CCG)	Monthly/Quarterly	95%			100.0%									
	CAMHS - % of CYP with ED (Routine Cases) referred with a suspected ED that start treatment within 4 weeks of referral (Stoke CCG)	Monthly/Quarterly	95%			100.0%									
NHSI	CAMHS - Number of CYP with ED (Urgent Cases) referred with a suspected ED that start treatment within 1 week of referral (North Staffs and Stoke CCG)	Monthly/Quarterly	95%			100.0%									
	CAMHS - Number of CYP with ED (Urgent Cases) referred with a suspected ED that start treatment within 1 week of referral (North Staffs CCG)	Monthly/Quarterly	95%			100.0%									
	CAMHS - Number of CYP with ED (Urgent Cases) referred with a suspected ED that start treatment within 1 week of referral (Stoke CCG)	Monthly/Quarterly	95%			100.0%									
CCG	Compliance with 18 week waits (Referral to Treatment or Intervention)	Monthly	92%	90.5%	86.8%	93.5%	93.9%	93.9%							
CCG	AMH Community	Monthly	92%	90.1%	87.3%	92.7%	92.6%	89.3%							
CCG	LD	Monthly	92%	92.3%	87.5%	90.9%	100.0%	93.8%							
CCG	NOAP	Monthly	92%	92.5%	93.2%	95.0%	95.3%	95.7%							
CCG	C&YP	Monthly	92%	82.4%	65.2%	90.6%	91.9%	97.9%							
CCG	Zero tolerance RTT waits over 52 weeks for incomplete pathways	Monthly	0	0	0	0	0	0							
CCG	MH Liaison Team response to A&E referrals within 1 hour	Monthly	95%	94.8%	93.0%	98.0%	95.0%	97.9%							
CCG	Patients will be assessed within 12 weeks of referral to the Memory Assessment service	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%							
CCG	Number of people seen for crisis assessment within 4 hours of referral	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%							
National	Percentage of inpatient admissions that have been gatekept by crisis resolution/ home treatment team	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%							
National/CCG	Overall safe staffing fill rate	Monthly	No Target	93.7%	93.4%	94.1%	93.7%	93.6%							
National	Mental health delayed transfers of care (target NHSI)	Monthly	7.5%	5.5%	9.1%	7.6%	7.8%	7.8%							
CCG	Emergency Readmission rate (30 days). Percentage of patients readmitted within 30 days of discharge.	Monthly	7.5%	6.0%	4.8%	4.8%	6.5%	7.5%							
NHSI	Total **bed days** patients have been Out of Area	Monthly	No target	4.0	0.0	22.0	2.0	67.0							
Trust Measure	Adult	Monthly	No target	4.0	0.0	22.0	2.0	67.0							
Trust Measure	Older Adult	Monthly	No target	0.0	0.0	0.0	0.0	0.0							
NHSI	Ratio of days Out of Area to baseline (Baseline set at M9 2017/18 figure of 150 bed days, as per SOF guidance, shown as 100%. The ratio of days each month to this baseline figure is then expressed as a percentage.)	Monthly	<100%	2.7%	0.0%	14.7%	1.3%	44.7%							
Trust Measure	Total patients Out of Area	Monthly	No target	2.0	0.0	6.0	2.0	4.0							
Trust Measure	Adult	Monthly	No target	2.0	0.0	6.0	2.0	4.0							
Trust Measure	Older Adult	Monthly	No target	0.0	0.0	0.0	0.0	0.0							

	Metric	Frequency	Standard	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Trust Measure	Total bed days - PICU	Monthly	No target	252.0	441.0	715.0	547.0	252.0							
Trust Measure	Total patients - PICU	Monthly	No target	5.0	4.0	4.0	12.0	6.0							
SAFE															
CCG	Number of patients 16/17 years old admitted to Adult Psychiatric wards	Monthly	0.0	1.0	1.0	1.0	0.0	0.0							
NHSI	Admission to adult facilities of U16s	Monthly	0.0	0.0	0.0	0.0	0.0	0.0							
CCG	Bed Occupancy (incl home leave) - Trust	Monthly	85%	90.7%	89.0%	87.8%	85.4%	89.7%							
CCG	Bed Occupancy (incl home leave) - AMHIP	Monthly	90%	89.7%	77.8%	89.5%	91.1%	89.7%							
CCG	Bed Occupancy (Including Home Leave)-Trust excluding AMHIP	Monthly	85%	90.6%	94.9%	85.9%	79.6%	88.0%							
CCG	LD	Monthly	85%	79.7%	83.6%	90.6%	81.7%	80.3%							
CCG	Neuro	Monthly	85%	88.2%	102.0%	91.8%	93.1%	96.5%							
CCG	Old Age Psychiatry	Monthly	85%	91.5%	95.9%	83.4%	78.4%	88.2%							
CCG	C&YP	Monthly	85%	98.7%	95.1%	85.1%	68.3%	84.7%							
CCG	IAPT: The proportion of people who have depression and/or anxiety disorders who receive psychological therapies	Quarterly	19% per annum (4.75% per quarter)			4.84%									
NHSI / CCG	IAPT : The number of people who are moving to recovery. Divided by the number of people who have completed treatment minus the number of people who have completed treatment that were not at caseness at initial assessment	Monthly	50%	69.3%	71.7%	67.8%	70.3%	66.0%							
NHSI / CCG	Improving Access to Psychological Therapies (IAPT) Programme: the percentage of service users referred to an IAPT programme who are treated within 6 weeks of referral	Monthly	75%	100.0%	100.0%	100.0%	100.0%	100.0%							
NHSI / CCG	Improving Access to Psychological Therapies (IAPT) Programme: the percentage of service users referred to an IAPT programme who are treated within 18 weeks of referral	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%							
CCG	IAPT: Patients wait no longer than 90 days between 1st and 2nd treatment	Monthly	<10%	26.1%	17.9%	17.8%	15.1%	6.8%							
CCG	Place of Safety Assessments	Monthly	No Target	22	24	22	25	27							
National	The proportion of those on Care Programme Approach (CPA) for at least 12mnths having formal review within 12mnths *NHSI*	Monthly	95%	95.3%	96.5%	97.1%	97.0%	93.8%							
NHSI	The proportion of those on Care Programme Approach (CPA) receiving follow-up contact within 7 days of discharge	Monthly	95%	100.0%	97.9%	98.7%	96.3%	96.4%							
Trust Measure/CCG	(ALL PATIENTS) The proportion of those receiving follow up within 7 days of discharge	Monthly	Internal-No Target CCG -90%	91.2%	85.2%	91.0%	80.2%	87.3%							
NHSI/CCG	Never Events	Monthly	0	0.0	0.0	0.0	0.0	0.0							
National	Patient Safety Alerts not completed by deadline	Monthly	0	0.0	0.0	0.0	0.0	0.0							
CCG	Mixed Sex Accommodation Breach	Monthly	0	0	0	0	0	0							
CARING															
National	Inpatient Scores from Friends and Family Test – % positive	Monthly	No Target	90.8%	84.9%	89.2%	89.8%	87.0%							
National	Staff Friends and Family Test - % recommended - care	Quarterly	No Target			No data									
National	Percentage of complaints responded to in line with timescale agreed with complainant	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%							
National	Written complaints rate	Quarterly	No Target			9.4%									
CCG	Duty of Candour Each failure to notify the Relevant Person of a suspected or actual Reportable Patient Safety Incident	Monthly	0	0.0	0.0	0.0	0.0	0.0							
ORGANISATIONAL HEALTH															
National	% Year to Date Agency Spend compared to Year to Date Agency Ceiling	Monthly	0%	-45.0%	-39.0%	-23.0%	-12.9%	-2.0%							
National	Sickness Absence Percentage: Days lost	Monthly	4.95%	2.8%	2.64%	2.63%	2.34%	2.51%							
National	Staff Turnover (% FTE)	Monthly	>10%	0.6%	0.8%	0.5%	0.9%	1.2%							

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO OPEN TRUST BOARD

Enclosure No:13

Date of Meeting:	25th October 2018		
Title of Report:	Diversity and Inclusion Action Plan		
Presented by:	Caroline Donovan, Chief Executive Officer		
Author:	Lesley Faux, Inclusion and Diversity Lead		
Executive Lead Name:	Caroline Donovan, Chief Executive Officer	Approved by Exec	☒

Executive Summary:		Purpose of report	
This paper is the latest update on our D&I action plan. It contains an update on actions progressed through 2017/18 and outlines the further actions we are progressing through 2018/19.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☒ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☒ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. ☒ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve. ☒ 4. Encourage, inspire and implement research & innovation at all levels. ☐ 5. Maximise and use our resources intelligently and efficiently. ☐ 6. Attract and inspire the best people to work here. ☒ 7. Continually improve our partnership working. ☒		
Risk / legal implications: Risk Register Reference	Risk Register Reference 900/901		
Resource Implications: Funding Source:	To continue to highlight and champion the Inclusion and Diversity agenda within the Trust, we need to promote and enable staff to contribute to the newly established Inclusion Council. We have appointed BAME facilitators to support us in this work		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	The purpose of this action plan is to advance Equality, Diversity and Inclusion throughout the Trust and to improve people's experiences		
STP Alignment / Implications:	The STP is being supported in this approach to ensure we secure a diverse and inclusive workforce representative of our communities		
Recommendations:			

Version	Name/Group	Date
1	Lorien Barber Non-Executive	20.09.18

Towards Outstanding

Diversity and Inclusion

Diversity and Inclusion Action Plan 2017-19

Theme	Action to be taken	Due Date	Lead
National Standards and Templates	**1 Equality Delivery System (EDS2)** **a. EDS2 -** assessment report completed annually and reviewed at Trust Board. Work on emerging themes following publication of annual EDS2. **b. 2016/17** **c. 2017/18** **d. EDS2 2018-19** Throughout 2018-19, build in opportunities to consult on EDS2 at Trust service user and staff events including directorate and service engagement events, to include all protected characteristics groups **e. Trustwide trial:** 2018-2019 - Each Locality to review SU 2 -3 EDS elements (suggested access and experience from) and feedback to Trust (possible Leadership Academy TBC). f. HoDs tasked with completing this by end May 2019	• **JUNE 2017** • **PUBLISHED SEPT 2017** • **JUNE 2018** • **JUNE 2019** • **JUNE 2019** • **MAY 2019**	Lesley Faux & Alex Brett Head of Service
	2. Workforce Race Equality Standard (WRES) – see actions 28-43 for WRES progress update **a. WRES 2016-17** **b. WRES 2017-18 –** Preparations for 2018 report to commence from Q4 2017-18 and according to timescales as published **c. WRES 2018-19 –** Preparations for 2019 report to commence from Q4 2018-19	• **2016-17 WRES Report completed 19.06.17 and published Sept 2017** • **July 2018 data** • **September 2018 published** • **July 2019 data** • **September 2019 published**	Lesley Faux Alex Brett Dr Adeyemo to provide robust challenge
	3. NEW Gender Pay Reporting 2017-18 a) First GPG report produced and reviewed at SLT and Execs. b) Review medical bonus payments	• 30 March 2018 • 30 March 2019	Kerry Smith Lesley Faux Kullie Dey Georgie Evans

Diversity and Inclusion Action Plan 2017-19

Theme	Action to be taken	Due Date	Lead
National Standards and Templates	**4. NEW Sexual Orientation Monitoring (SOM) Information Standard** a) Implement the new standard for patient/service user monitoring. Awareness raising with staff and service users will be required. b) The system change to Lorenzo is now in place (Summer 2018) c) The SOM Standard provides the categories for recording sexual orientation information. This needs to be in place ready to report under the SOM Information Standard.	• June 2018 • April 2019	Lesley Faux Vicky Boswell
	5. NEW Workforce Disability Equality Standard a) Commence preparations for introduction of new requirements. Awareness raising with staff and sessions to encourage support staff in updating their personal data in relation to disability , where applicable. b) WDES implementation c) The Trust is signed up to the Disability Confident standard (see action 11) and will be developing a plan to progress this in 2018-19.	• April 2018 • August 2019 • April 2019	Lesley Faux Kerry Smith Kullie Dey

Diversity and Inclusion Action Plan 2017-19

Theme	Action to be taken	Due Date	Lead
Improvements to Combined D&I Strategy Development	6. Establish new **Trust Inclusion Forum** to provide suitably robust review and challenge to Trust strategy and delivery of action plans *Action suspended in discussion with Alex Brett. To be reviewed with interim HRD on commencement.*	Quarter 2 2017-18 ACTION SUSPENDED	Alex Brett Lesley Faux
	7. Ensure that **PCD** as a cycle of business regularly reviews action progress against D&I Strategy	March 2018 June 2018 Sept 2018 Dec 2018 Mar 2019	Alex Brett (Lesley Faux) through PCD
Process & Policy	8. Review Directorate Business Continuity plans and complete Equality Impact Assessment process for these. Specific reference to disability assessment. Review these and follow up re other directorates	March 2018 Sept 2018	Karen Day / Brian Macmillan Lesley Faux
	9. Flexible Working Policy to be reviewed in respect of carers and staff with disabilities being able to specify the reason for their flexible working application.	Jan 2018	Kerry Smith
	10. Audit of application of recent introduction of new Trust Committees cover sheet to ensure robust assessment of equality, diversity and inclusion impacts of papers to these committees together with more robust challenge around Diversity and Inclusion implications in Board Committees.	**COMPLETE**	Director of Workforce Lesley Faux Laurie Wrench
	11. Develop and deliver action plan to progress delivery of Disability Confident Employer Commitment. Links with development of WDES plans (see action 5). Action plan to be produced by end March 2018.	Action Plan was due by end January 2018 – delayed pending HR capacity Delivery postponed to end March 2018 in 1st instance / for review by Alex Brett	Kerry Smith Kullie Dey

Theme	Action to be taken	Due Date	Lead
Care Delivery and Evidencing Care	11. Accessible (easy read) care plans to be rolled out across the CAMHS-LD service.	COMPLETE	S. Mountford/ Andrew Adams
	12. a. Ensure the Service User and Carer Council monitor and provide feedback on the Trust's delivery against their quality standard of **personalised care**. b. Trust event held 3 November 2017 on developing the Trust's approach to Person Centred Care. c. Further action to follow to share and consult on our emerging Person Centred Framework.	 December 2017 December 2018	Maria Nelligan & Julie Anne Murray
	13. Review systems for **recording and reviewing use of restrictive practice interventions** by protected characteristics groups. Monitor and review based on first 6 months of data. First report on to Trust Health, Safety and Wellbeing Committee.	November 2017 November 2018	Jackie Wilshaw Jackie Wilshaw
	14. Supporting and facilitating **Advocacy Services** a. Share user-friendly information for staff and service users on legislated Advocacy Services across Trust Teams b. Raise awareness of Advocacy Services via a stall at the Trust Inclusion Conference c. Share advocacy information with Service User and Carer Council / Advocacy report into July Service User and Carer Forum	 June 2017 July 2017 July 2017	 Lesley Faux Advocacy leads/ reps Veronica Emlyn
	15. Trust to consider options for trying to enhance **patient transport** to key service delivery sites	**COMPLETE. Andrew Hughes to discuss with Alliance partners (action agreed Jan 2018)**	Andy Hughes Lesley Faux

Theme	Action to be taken	Due Date	Lead
Care Delivery and Evidencing Care	**16. Transitions between services** – with the shift to Multi-specialty Care Partnerships (MCP) model across North Staffs & SOT, there is a desire to integrate care better and where appropriate create ageless services where connectivity in local communities is improved.	October 2018	Andy Hughes
	17. To hold a **service user and carer listening event** in October to focus on patient access and experience	October 2017	Veronica Emlyn Julie Ann Murray
	18. To hold **Focus Groups** from a service provision as well as staff perspective considering service and experience for people who are LGBT (07.06.17) and BME (02.08.17). Develop and implement action from feedback gained.	**LGBT Focus Group - July 2017** **BME Focus Group – August 2017**	Lesley Faux

Theme	Action to be taken	Due Date	Lead
Training and culture	19. Enhancement of **e-learning offers for Diversity & Inclusion**: a. Trust D&I training to be translated into e-learning for standard training and refresher training, incorporating key focus on person-centred care and involvement of service users in decisions about the service they receive and on statutory obligations, particularly PSED. An enhanced level e-learning package to be developed for Trust managers and Senior Management Team to be completed on a 'once only' basis (repeat or update with major changes in legislative requirements). b. Team specific tailored D&I workshops available on request c. Inclusion Workshop incorporated into People Management Programme	**COMPLETE** December 2017 July 2017 April 2018	Lesley Faux/ Sue Slater Lesley Faux Lesley Faux
	20. a. One-off session of **Board Development on D&I** using external expert (Yvonne Coghill, Director of Implementation for WRES, NHS England). b. Repeated for our internal **Leadership Academy** of senior managers, plus extended invite to recruiting managers c. Subsequent repeats for new starters will be managed internally.	July 2017 Aug 2017 Ad hoc as required	Robert Cragg As above Lesley Faux
	21. a. Continue opportunities for **listening to staff** in 'Big Conversations through the LiA-style process and by more focussed team-level work through our Towards Outstanding Engagement Team Development programme b. Towards Outstanding Engagement launched May 2017 with 16 teams currently participating in Phase. c. Open Space Event in planning for January 2018. d. Also see 'Afternoon Tea with Director of Nursing' listening sessions e. BAME Staff Network listening approach and BAME LiA	March 2017 May 2017 January 2018 May 2018	Alex Brett Jane Rook Maria Nelligan Lesley Faux

Theme	Action to be taken	Due Date	Lead
Training and culture	22. a. Identify more clinical champions for diversity and extend work to clinical services in a more consistent and robust way b. Additional membership for Inclusion Forum element of Diversity and Inclusion Group identified - first meeting 20 December 2017.	September 2017 December 2017	Lesley Faux
Promotion and Communication	**23. Information and Communication Support** a. Continue to promote and develop delivery against 'Accessible Information Standard' for people with disabilities and sensory impairment and also for people with foreign language needs. P b. Printed AIS Communication Cards distributed to Directorates Dec/Jan 2017-18. c. Additionally, the Trust is in discussion with a servicer provider of automated communications that help us to meet the AIS requirements better (as well as saving money and helping us to go digital). d. Survey meetings planned with Greenfield and Sutherland Centres, March 2018. b. Trust Language Identification poster (including BSL) – A3 hard copy - to be released June 2017. Translate Me software available from February 2017. c. Implementation of Trust foreign language communication support, BSL communication support and digital foreign language translation. d. Further awareness raising underway March-April 2018 regarding digital translation, interpretation and translation services and Trust communications register.	On-going. Aug 2017. January 2018 October 2018 - pilot March 2018 June 2017 June 2017. April 2018	Trust services supported by LF and VE Lesley Faux Lesley Faux

Theme	Action to be taken	Due Date	Lead
Promotion and Communication	**24. Responding to and Preventing Personal Abuse of Staff** a. Create and display **local RESPECT poster** tailored to services as appropriate to encourage mutual respect and discourage personal abuse of NHS staff. Use of zero tolerance on racial harassment message as appropriate to Trust services and circumstances. b. Always challenging and always reporting inappropriate behaviour re personal abuse (eg racist, homophobic, biphobic, transphobic etc abuse) – to link in with Inclusion Council project work c. Create and share flow chart of responses and support following personal abuse of staff - being developed further through BAME LiA	March 2018 December 2018 September 2018	Comms Team Inclusion Council Lesley Faux
	25. To re-advertise the opportunity to establish staff **BAME and LGBT networks** across the organisation and offer support with meeting facilities, subject to demand.	COMPLETE Sept 2018 – further work ongoing	Lesley Faux & Cherelle Laryea
	26. a. Regular cycle of Diversity & Inclusion issues in the Trust to promote equality. This will include promotion of local case studies and diverse role models, both service users and Trust workers. Role models showcased at the first Symphony of Hidden Voices Inclusion Conference b. 2nd Conference c. 3rd Conference – to link in with 'Show Racism the Red Card Day'	June 2017 September 2018 October 2019	Veronica Emlyn Lesley Faux

Theme	Action to be taken	Due Date	Lead
Recruitment & Selection	**27. Creating a more representative workforce and addressing workforce imbalances re BME, LGBT and disability:**	March 2019	Paul Draycott
	a. Careers Recruitment – work with community groups linked to under-represented areas to highlight mental health career options A range of different opportunities have been taken to engage with young people and influence a diverse future workforce, including a variety of school career events working with a number of the inner city schools, and a highly successful NHS Careers Event on 22/11/17	November 2017	Kerry Smith & J-A Murray Kerry Smith & S Copestake
	b. Recent links forged with the Stoke Central Mosque	Feb 2018	
	b. Interviews – Pilot a new interview process in the Trust to ensure enhance diversity of panels for diverse shortlist candidates. Pilot at PICU on all interview panels and to do a monitoring process to capture frequency of deliver y on this.	March 2018	Kerry Smith Kullie Dey Laura Haddrell
	b. Have a diverse range of role models from different diversity groups in all advertising materials in hard press and social media.	Ongoing	
	c. Include a positive action statement in all recruitment advertising	August 2017	Lesley Faux Kirstie Cope

Theme	Action to be taken	Due Date	Lead
Workforce Race Equality Scheme (WRES) detailed actions	28. Establish systems for routine detailed analysis of staff and patient data by ethnicity and discussion at Trust and Directorate leadership meetings. Need to ensure ESR, Lorenzo, Ulysses are all able to capture the data and enable the Trust to analyse it to inform future decision making a. Data by band, by staff group, by Directorate, by service b. Understand service provision to BME service users. Seek to better understand:- • What is the experience of our BME patients? & • What is the experience of our BME staff? BME Staff experience - PCD session on BAME Staff Experience 12.03.18 and other BAME staff listening events.	Dec 2017 March 2018 March 2019	Lesley Faux Vicky Boswell
	29. Report on ESR, Lorenzo, Ulysses to inform future decision making. This will include Serious Incidents, detention under the MHA, service access and utilisation	April 2018 Action to develop further in 2018-19	Lesley Faux Vicky Boswell
	30. Work to eliminate barriers to BME staff entering employment at every level through the organisation. Specifically, introduce a new interview approach ensuring diverse panels for diverse shortlists (ie that all BME interview candidates will experience having a BME person on the interview panel in Trust interviews. Pilot process trialled with mixed success in NOAP and new PICU for March 2018. Revised principle is to strive to have BAME representation on all interview panels where there is identified under-representation to be considered for 2018-19 and revised process agreed and implemented as part of response to BAME LiA. New plans to be developed for 2018-19 at BAME LiA Taking Action session 20.09.18	**Mar 2018** **PARTIAL COMPLETION - carry forward to 2018-19**	Kerry Smith with D&I Lead

Theme	Action to be taken	Due Date	Lead
Workforce Race Equality Scheme (WRES) detailed actions	31. HR to work with staff side and new BME Staff Network to develop new support measures and mechanisms for BME staff who are subject to disciplinary processes and to ensure fairness of approach. (See Birmingham Trusts 'Cultural Ambassadors' model as one possible approach). PUT ACTION ON HOLD. Reconsider further to 2018 WRES data Further info: Cultural Ambassadors approach intro summary; Evaluation report Cultural Ambassadors approach	**Mar 2018** Further action in 2018-19	Kerry Smith
	32. Trust Inclusion Forum now to be established in 2017-18. Group to perform critical challenge around delivery of diversity and inclusion through the Trust Membership to include :- NED; Exec Director; D&I Lead; Directorate Head; Analyst / Performance Rep. ACTION SUSPENDED BY ALEX BRETT. REVIEW AGAIN IN 2018-19 with new substantive HRD when in post.	**Nov 2017** **ACTION SUSPENDED** Review further to substantive appt of new HRD in 2018-19	Lesley Faux
	33. Positive Action BME leadership development programme – ambition to be the first STP to establish and implement 3 cohorts to be delivered for Staffs STP: Sept-Oct 2018; Nov-Dec 2018; Feb-March 2019. Launch event 7 Sept to raise profile and confirm commitment to stress the need for culture change to ensure climate of readiness for change for participants completing the programme and returning to their organisations post-completion. NSCHT currently has 10 staff with places on this programme.	**Mar 2018** **Extended into 2018-19** **Programme delivery underway**	Caroline Donovan (STP SRO role) Lesley Faux Neil Clarke
	34. a. Spotlight services that are doing good work in BME inclusion (eg Healthy Minds positive action programme for reaching BME communities around access to IAPT services) 35. b. Plan Leadership Academy around developing SU accessibility and reach and tackling of health inequalities – EDS 2	Ongoing January 2019	Joe McCrea & Comms Team; D&I lead

Theme	Action to be taken	Due Date	Lead
Workforce Race Equality Scheme (WRES) detailed actions	35. a) Mentoring, support and encouragement for BME nursing/clinical staff who wish to progress their careers. b) BAME Afternoon Tea & Talk with Maria Nelligan held in October and December 2017. Issues discussed included:- c) Provision of coaching or mentoring specifically to BAME employees	**Dec 2017** Dec 2017 October 2018	Maria Nelligan, Director of Nursing & AHP Lesley Faux
	36. Positive BME Role Models – seek BME staff at every level to be diversity role models for the Trust. Share story on website, etc. Role Model pin / award? • Dr Buki Adeyemo role modelling championing race equality by leading communications about Stand Up to Racism Day, by seeking to have #20BAMEconversations, and sharing progress with these on Twitter (also see action 44) • Tendai Chirawu attended the NHS Employers Women Leaders' Conference 2017 in October. • Cherelle Laryea and Claudia Oakley attended WRES 2017 Conference, also in October. • Cherelle Laryea profile shared in Newsround staff newsletter • Further role models anticipated to emerge from developing BAME Network and from those Trust staff attending the Staffordshire Stepping Up Programme.	**Dec 2017** **Oct 2017** **Oct 2018** **October 2017** **October 2017**	Dr Buki Adeyemo Claudia Oakley Tendai Chirawu Cherelle Laryea

Theme	Action to be taken	Due Date	Lead
Workforce Race Equality Scheme (WRES) detailed actions	37. Keeping all staff involved and having positive conversations about ethnicity and racial equality. 'It's OK to ask' about ethnicity (with well-intentioned curiosity) etc. Raising awareness about BME experience and micro assaults in society, workplace etc • Race Equality stand at Harplands in August 2017 and again in October-November 2017 for Black History Month. • The August 2017 stand particularly shared information from Yvonne Coghill presentation and raised awareness about findings on the challenges of being black, Asian or from another ethnicity in the UK. Staff Networks stand (including BAME network) in Harplands December 2017. • It's OK to ask leaflets are shared at events such as Vaisakhi Festival, Stoke Pride etc. • World Religions Day information shared January 2018. Plans for further awareness raising around religions and cultures through 2018-19. • Sharing of BAME nurse experience at PCD in March and report on racist abuse of staff.	Dec 2017 August 2017 October 2017 November 2017 December 2017 January 2018 June 2018	Lesley Faux
	38. Bespoke Task and Finish Group to deliver Preventing Racial Abuse / 'zero tolerance' education campaign: • Trust RESPECT posters produced and displayed widely featuring Trust statement on 'no place for discrimination, harassment or abuse'. • Trust statement included in Trust letterhead and in letter template on Lorenzo from January 2018. • Report on staff racist abuse taken to PCD in March along with an account of a BAME staff nurse experience. • Further action is planned in 2018-19 to further raise visibility of this campaign and to develop our approach to preventing and supporting staff following racist incidents. These are 2 of the action areas from our BAME LiA session and action planning taking place on 20 September. Process map of response to racist incidents to be taken for further to LiA Action Planning session 20 September	**Dec 2017** January 2018 March 2018 September 2018	Lesley Faux

Theme	Action to be taken	Due Date	Lead
Workforce Race Equality Scheme (WRES) detailed actions	39. Developing our links with local BME communities through public engagement events, religious community visits etc (twin focus of raising awareness about mental health and promoting the Trust as an employer of choice) The Trust attended the Stoke Gurdwara on 5th Nov (Guru Nanak birthday celebrations) and received a very positive reception. Access Team represented along with Patient Experience and D&I. Female attendees expressed the desire for staff representing support for anxiety & depression, domestic abuse and suicide to attend to talk about services and self help. A number of individuals expressed interest in employment opportunities and working at the Trust. Further Trust attendances at the Temple to be planned for 2018-19. The Trust was welcomed to Hanley Central Mosque in February and visits are to be arranged for members of the mosque to visit the Harplands and for clinicians to visit the mosque to share information about mental health and Trust services. To arrange gender specific visits to and from the mosque	Mar 2018 November 2017 May 2018 November 2017 November 2018	Lesley Faux
	40. Staff empowered to have positive discussions about ethnicity including: • Establish offer of a BME staff network • Develop further opportunities for staff at all levels to be involved • Further BME focus group meeting(s) and activities • First BAME Staff Network meetings held 22 Nov 2017 and 31 Jan 2018 in addition to the BAME Tea with Maria and BAME LiA sessions. • A range of comms sharing positive messages of encouragement to attend through Dec 2017-March 2019 (Newsround, direct emails to BAME staff, CEO Blog, posters, etc)	Mar 2018 February 2018 March 2019	Cherelle Laryea supported by CD and LF Comms

Theme	Action to be taken	Due Date	Lead
Workforce Race Equality Scheme (WRES) detailed actions	41. Positive outreach to seek information about issues and experience from BME service user and staff perspective:- • Direct positive action communications / surveys including CEO Blog, Newsround, staff stories etc • BAME leadership programme planned for Sept 2018 launch • BAME Staff Network meeting launched October 2017 and email network linked to this as well as face to face meeting opportunities • BAME Staff Tea with Director of Nursing sessions (Oct and Dec 2017) • BAME Staff Listening into Action (May 2018) • Senior team to make positive outreach when undertaking team visits etc to ask BME service users and staff what their experience has been like and what could have been improved (also Buki's #20BAMEconversations – see action 44) • Reverse Mentoring by Board with BME staff	**Mar 2018** **ONGOING** **Sept 2018** **October 2017** **December 2017** **May 2018** **January 2019**	Lesley Faux Alex Brett Sue Slater
	42. Continue to work to support BAME bank staff and volunteers into substantive employment where the individual desires this. Support and encourage BAME bank workers to aspire to more regular substantive employment. Set up system to notify bank workers and volunteers of training opportunities. **IN PLACE.** • Development opportunities shared with Bank Coordinator and Bank Lead via the Training Distribution email group. These opportunities are forwarded on to volunteers and bank workers. Bank staff and volunteers have access to the LMS via their learning account and this offers a wide range of e-learning opportunities also. From November 2017, the D&I Lead shares education opportunities directly with BAME staff and encourages take-up. Bank staff are all offered 6-weekly supervision sessions with the bank lead, but participation is not mandatory and take-up is quite low. About half of active bank workers have participated in PDR. • The bank lead also recently reminded bank staff via e-mail that they can access all Trust training (face to face and e-learning) free. If they wished to attend any Trust training for development that was above and beyond their mandatory training this was free and their only contribution is the time taken to complete it.	Dec 2017 April 2018 April 2018	Lesley Faux LMS/S Slater LMS S Slater

Theme	Action to be taken	Due Date	Lead
Workforce Race Equality Scheme (WRES) detailed actions	43. Recruitment for diversity and inclusion (also see action 27 – delivered through pilot exercise in March 2018): • Trust recruitment campaigns in 2017-18 to include photos and case studies of Asian/Asian British ethnicity. HR Team BAME profiles to be developed and shared on Trust website and Trust jobs website • New Recruitment lead commenced to lead on this action • Encourage **block recruitment** whenever possible as this is proven to increase the likelihood of appointing BME staff and staff from other minority groups (evidenced to improve diversity of recruited talent). Encourage recruitment for difference. - To be incorporated into Inclusive Recruitment approach from LiA Taking Action session. Inclusive Recruitment is one of the 4 key areas for action emerging from the BAME LiA session in May and action planning on this is taking place on 20 September.	March 2018 March 2018 January 2019	Kerry Smith Lesley Faux Recruitment Lead Cherrie Cuthbertson
	44. **NEW ACTIONS AGREED BY MEDICAL DIRECTOR AS BELOW, OCTOBER 2017** • To engage in 20 conversations about race and ethnicity with a range of people and contexts (staff, service users, carers) and keep a brief record of each discussion by end December • To lead a campaign to encourage BAME staff to record their ethnicity by personally emailing staff who do not have ethnicity details recorded by end November • To personally take an interest in one or two BAME members of staff and encourage them to develop their leadership skills and experience and take opportunities to develop their careers (by end December) • To role model support for 'Give Racism the Red Card' day on 20th October 2017 by wearing an item of red and by Tweeting about personal commitment to this	**December 2017** **November 2017** **December 2017** **October 2017**	Buki Adeyemo

END

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO TRUST BOARD

Enclosure No:14

Date of Meeting:	25/10/2018		
Title of Report:	Finance Position Month 5		
Presented by:	M Newton – Deputy Director of Finance		
Author:	L Dodds - Assistant Director of Finance		
Executive Lead Name:	Suzanne Robinson – Executive Director of Finance, Performance and Digital	Approved by Exec	☐

Executive Summary:	Purpose of report	
The report summarises the finance position at month 5 (August 2018)	Approval	☒
	Information	☒
	Discussion	☐
	Assurance	☒
Seen at: SLT ☐ Execs ☒ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☒ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐	
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐	
Risk / legal implications: Risk Register Reference	Ref 1035: Trust top 3 risks around delivery of cost improvement target.	
Resource Implications: Funding Source:	None applicable	
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	There is no direct impact on the protected characteristics as part of the completion of this report;	
STP Alignment / Implications:	Part of the aggregate STP reported financial position	
Recommendations:	The Trust Board are asked to: Note: • The reported YTD surplus of £290k against a planned surplus of £210k. This is a favourable variance to plan of £80k.	

- The M5 CIP achievement:
  - YTD achievement of £445k (52%); an adverse variance of £416k;
  - 2018/19 forecast CIP delivery of £1,533k (55%) based on schemes identified; an adverse variance of £1,262k to plan;
  - The recurrent value of schemes transacted at £1,050k, 38% of target.

- The cash position of the Trust as at 31st August 2018 with a balance of £10,310k; £1,485k better than plan

- Month 5 capital expenditure at £179k compared to planned capital expenditure of £342k;

- Use of resource rating of 2 against a plan of 2.

Approve:

- The month 5 position reported to NHSI.

NHS
North Staffordshire Combined Healthcare NHS Trust

Financial Overview as at 31st August 2018

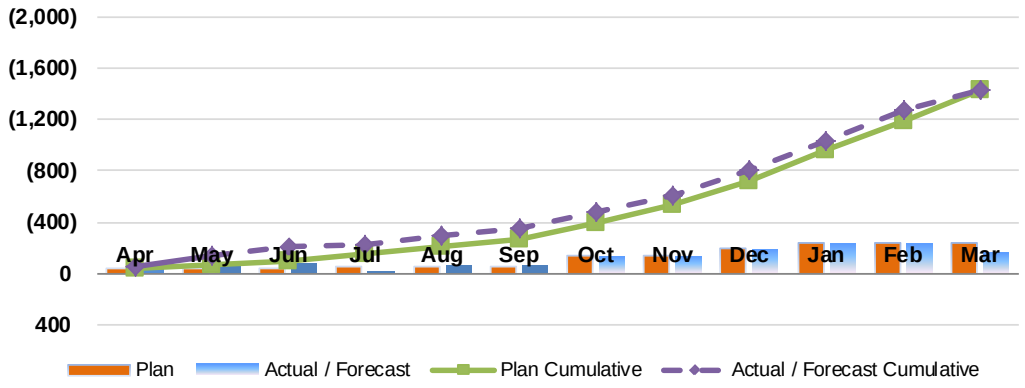
Income & Expenditure - Control Total (Surplus) / Deficit

£000	Plan	Actual	Var	%	RAG
YTD	(210)	(290)	(80)	(38)	G
FOT	(1,423)	(1,423)	0	0	G

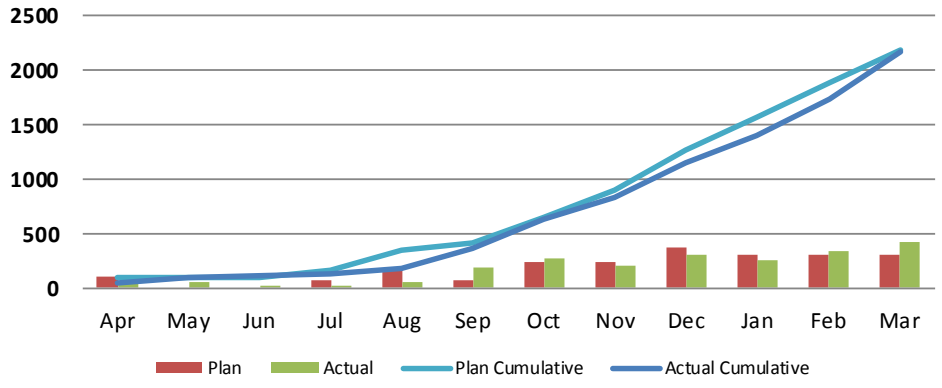
Charge to CRL

£000	Plan	Actual	Var	%	RAG
YTD	342	179	(163)	(48)	G
FOT	2,185	2,185	0	0	G

Retained (Surplus) / Deficit Run Rate 2018/19



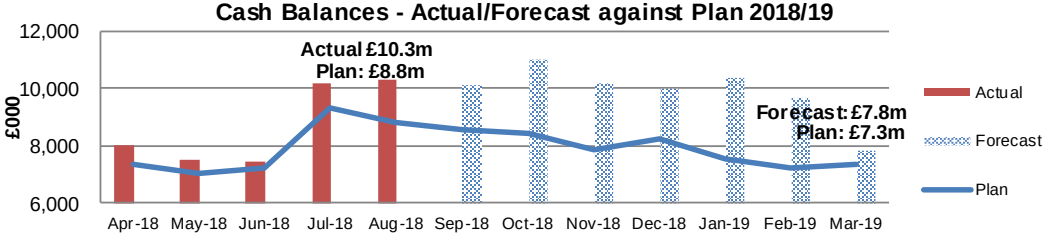
Net Capital Expenditure - Plan / Forecast 2018/19



Cash Balances

£000	Plan	Actual	Var	%	RAG
YTD	8,825	10,310	1,485	17	G
FOT	7,339	7,835	496	7	G

Cash Balances - Actual/Forecast against Plan 2018/19



Cost Improvement

£000	Plan	Actual	Var	%	Rec Var	RAG
Clinical	604	300	(304)	(50)	(550)	R
Corporate	257	145	(112)	(44)	(211)	R
Total	861	445	(416)	(48)	(761)	R

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

Introduction:

The Trust's 2018/19 financial plan is to deliver a trading position of £0.720m surplus. The Trust has accepted the Control Total from NHS Improvement (NHSI) of £1.423m surplus which includes £0.703m from the Sustainability & Transformation Fund.

1. Income & Expenditure (I&E) Performance

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

- During month 5, the trust had an in month trading position of £14k surplus against a plan of £7k surplus; **giving a favourable variance of £7k**. Provider Sustainability Funding (PSF) has been assumed at £47k for month 5, bringing the overall trust control to a £61k surplus against plan of £54k; **giving a favourable variance of £7k**.

- Year to date, the trust has a trading position of £91k surplus against a plan of £11k surplus, **giving a favourable variance of £80k**. Provider Sustainability Funding (PSF) is assumed at £199k, bringing the overall year to date trust control total to £290k surplus, **giving a favourable variance of £80k.**

- The Trust's forecast outturn for the year is expected to deliver in line with plan to give a trading surplus of £0.720m. Provider Sustainability Funding (PSF) is expected to be £0.703m in line with plan giving an overall Control Surplus of £1.423m.

		Month 5			Year to Date			Forecast		
Table 1: Summary Performance	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
Income	(83,908)	(7,043)	(7,194)	(152)	(34,858)	(34,993)	(136)	(84,132)	(84,321)	(188)
Pay	62,463	5,354	5,158	(195)	26,293	25,051	(1,242)	62,172	60,891	(1,281)
Non Pay	17,992	1,454	1,796	341	7,415	8,708	1,293	18,507	19,989	1,482
EBITDA	**(3,453)**	**(235)**	**(241)**	**(6)**	**(1,150)**	**(1,234)**	**(84)**	**(3,453)**	**(3,441)**	**12**
Other Non-Op Costs	2,733	228	226	(2)	1,139	1,143	4	2,733	2,720	(13)
Trading Surplus	**(720)**	**(7)**	**(14)**	**(7)**	**(11)**	**(91)**	**(80)**	**(720)**	**(720)**	**(0)**
Provider Sustainability Funding	(703)	(47)	(47)	0	(199)	(199)	0	(703)	(703)	0
(Surplus)/Deficit for the year	**(1,423)**	**(54)**	**(61)**	**(7)**	**(210)**	**(290)**	**(80)**	**(1,423)**	**(1,423)**	**(0)**

2. Income

Table 2 below shows the Trust income position by contract:

- The NHS Stoke-on-Trent CCG and NHS North Staffordshire CCG contracts are set on a block basis. Under performance relates to 2017/18 quarter 4 under performance of CQUIN, which was not confirmed until June 2018 and further CQUIN under performance in quarter 1 of 2018/19.
- Specialised Services are under performing year to date by £50k due to a reduction in activity at the Darwin Centre.
- Stoke on Trent Public Health is underperforming against the contract due to the Council reducing activity purchased on Inpatient Services.
- OATs income is over performing year to date by £143k due to additional patients in A&T recharged to Stafford & Surrounds CCG.

		Month 5			Year to Date			Forecast		
Table 2: Income	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
NHS Stoke-on-Trent CCG	(37,360)	(3,055)	(3,058)	(3)	(15,299)	(15,288)	11	(37,273)	(37,254)	20
NHS North Staffordshire CCG	(25,496)	(2,178)	(2,180)	(2)	(10,452)	(10,445)	7	(25,438)	(25,425)	13
Specialised Services	(3,189)	(266)	(255)	11	(1,329)	(1,279)	50	(3,189)	(3,070)	120
Stoke-on-Trent CC s75	(3,999)	(333)	(333)	(0)	(1,666)	(1,666)	(0)	(3,999)	(4,025)	(26)
Staffordshire CC s75	(1,054)	(88)	(88)	(0)	(439)	(440)	(1)	(527)	(528)	(1)
Stoke-on-Trent Public Health	(1,190)	(123)	(109)	14	(616)	(552)	64	(1,655)	(1,507)	148
Staffordshire Public Health	(613)	(51)	(51)	0	(256)	(255)	0	(613)	(613)	0
ADS/One Recovery	(1,467)	(122)	(122)	0	(611)	(611)	0	(1,467)	(1,467)	(0)
Associates	(1,476)	(105)	(106)	(1)	(617)	(619)	(1)	(1,476)	(1,482)	(6)
OATS	(771)	(64)	(105)	(41)	(321)	(464)	(143)	(771)	(1,080)	(310)
Private Patients	0	0	(2)	(2)	0	(5)	(5)	0	(5)	(5)
Total Clinical Income	**(76,616)**	**(6,385)**	**(6,409)**	**(24)**	**(31,607)**	**(31,624)**	**(16)**	**(76,408)**	**(76,455)**	**(47)**
Other Income	(7,293)	(657)	(786)	(128)	(3,250)	(3,369)	(119)	(7,724)	(7,866)	(141)
Total Income	**(83,908)**	**(7,043)**	**(7,194)**	**(152)**	**(34,858)**	**(34,993)**	**(136)**	**(84,132)**	**(84,321)**	**(188)**
Provider Sustainability Funding	(703)	(47)	(47)	0	(199)	(199)	0	(703)	(703)	0
Total Income Incl. PSF	**(84,611)**	**(7,090)**	**(7,241)**	**(152)**	**(35,057)**	**(35,192)**	**(136)**	**(84,835)**	**(85,024)**	**(188)**

3. Expenditure

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

- Underspend of £1,242k at month 5 on pay is due to vacancies across the trust, partially covered by agency.
- Agency costs at month 5 are £827k, **£13k below the M5 agency ceiling of £840k.**
- Non-Pay over spend at month 5 of £1,293k mainly due to residential payments and unachieved CIP.

Table 3: Expenditure	Annual Budget £'000	Month 5 Budget £'000	Month 5 Actual £'000	Month 5 Variance £'000	Year to Date Budget £'000	Year to Date Actual £'000	Year to Date Variance £'000	Forecast Budget £'000	Forecast Actual £'000	Forecast Variance £'000
Medical	7,412	624	532	(91)	3,118	2,522	(596)	7,519	6,559	(960)
Nursing	29,494	2,559	2,407	(152)	12,492	11,920	(572)	29,561	28,899	(662)
Other Clinical	15,106	1,316	1,093	(224)	6,345	5,461	(884)	14,584	13,115	(1,469)
Non-Clinical	10,229	837	872	36	4,245	4,229	(16)	10,286	10,311	25
Apprenticeship Levy	214	18	20	2	89	91	2	214	229	15
Agency	8	0	234	234	3	827	824	8	1,778	1,771
Total Pay	**62,463**	**5,354**	**5,158**	**(195)**	**26,293**	**25,051**	**(1,242)**	**62,172**	**60,891**	**(1,281)**
Drugs & Clinical Supplies	2,169	182	186	5	908	1,011	103	2,349	2,541	193
Establishment Costs	1,641	136	120	(16)	690	575	(115)	1,896	1,386	(510)
Information Technology	676	77	66	(11)	284	302	18	680	724	44
Premises Costs	2,143	180	167	(13)	909	963	54	2,180	2,394	215
Private Finance Initiative	4,372	364	358	(7)	1,822	1,814	(8)	4,372	4,381	9
Services Received	3,396	303	294	(9)	1,418	1,485	68	3,407	3,601	194
Residential Payments	1,760	147	261	115	733	1,118	385	1,760	2,439	679
Consultancy & Prof Fees	133	6	26	20	72	122	50	133	293	160
External Audit Fees	65	5	5	(0)	27	26	(1)	65	62	(3)
Legal Fees	65	5	16	11	27	30	3	65	58	(6)
Unacheived CIP	(1,746)	(82)	0	82	(414)	0	414	(1,262)	0	1,262
Other	3,318	131	296	165	940	1,262	322	2,863	2,109	(754)
Total Non-Pay	**17,992**	**1,454**	**1,796**	**341**	**7,415**	**8,708**	**1,293**	**18,507**	**19,989**	**1,482**
Finance Costs	1,293	108	103	(5)	539	525	(14)	1,293	1,239	(54)
Local Government Pension Scheme	0	0	0	0	0	0	0	0	0	0
Unwinding of Discounts	0	0	0	0	0	0	0	0	0	0
Dividends Payable on PDC	561	47	47	0	234	234	0	561	561	0
Investment Revenue	(14)	(1)	(4)	(2)	(6)	(14)	(9)	(14)	(36)	(22)
Fixed Asset Impairment	0	0	0	0	0	0	0	0	0	0
Depreciation (excludes IFRIC 12)	893	74	80	5	372	398	26	893	957	64
Total Non-op. Costs	**2,733**	**228**	**226**	**(2)**	**1,139**	**1,143**	**4**	**2,733**	**2,720**	**(13)**
Total Expenditure	**83,188**	**7,036**	**7,180**	**144**	**34,847**	**34,902**	**55**	**83,412**	**83,600**	**188**

Agency Breakdown		
Agency Type	YTD (£'000)	%
Medical	525	63%
Nursing	224	27%
Other Clinical	1	0%
Non Clinical	78	9%
Total	**827**	**100%**

Directorate Summary

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

Table 4: YTD Expenditure	Pay			Non Pay			Income			Total		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
AMH Community	7,588	7,084	(504)	1,827	2,248	421	(937)	(990)	(53)	8,478	8,342	(136)
AMH Inpatients	2,624	2,618	(6)	134	144	9	(1)	(1)	(0)	2,758	2,761	3
Children's Services	2,583	2,493	(90)	258	330	72	(251)	(271)	(20)	2,590	2,552	(38)
Substance Misuse	1,299	1,227	(73)	376	398	22	(206)	(142)	64	1,470	1,483	13
Learning Disabilities	2,260	2,062	(198)	90	138	47	(197)	(194)	3	2,153	2,006	(148)
Neuro & Old Age Psychiatry	5,252	4,988	(264)	219	322	103	(504)	(517)	(14)	4,967	4,792	(175)
Corporate	4,686	4,579	(107)	5,649	6,272	623	(32,961)	(33,077)	(116)	(22,626)	(22,226)	400
Total	**26,293**	**25,051**	**(1,242)**	**8,553**	**9,851**	**1,297**	**(35,057)**	**(35,192)**	**(136)**	**(210)**	**(290)**	**(80)**

- AMH Community is underspent on pay due to vacancies partially offset with bank and agency. The adverse variance on non-pay is due to an under delivery of CIP against the target and overspends on residential payments.

- Other Directorates are underspent on pay mainly due to vacancies, partially offset with under delivery of CIP.

4. Cost Improvement Programme

The Trust target for the year is £2,795k, as reported to NHSI. This takes into account the requirement to deliver a £1,423k control surplus for 2018/19. The table below shows the achievement by Directorate towards individual targets at M5. The Trust wide CIP achievement is 52% at M4 compared to plan.

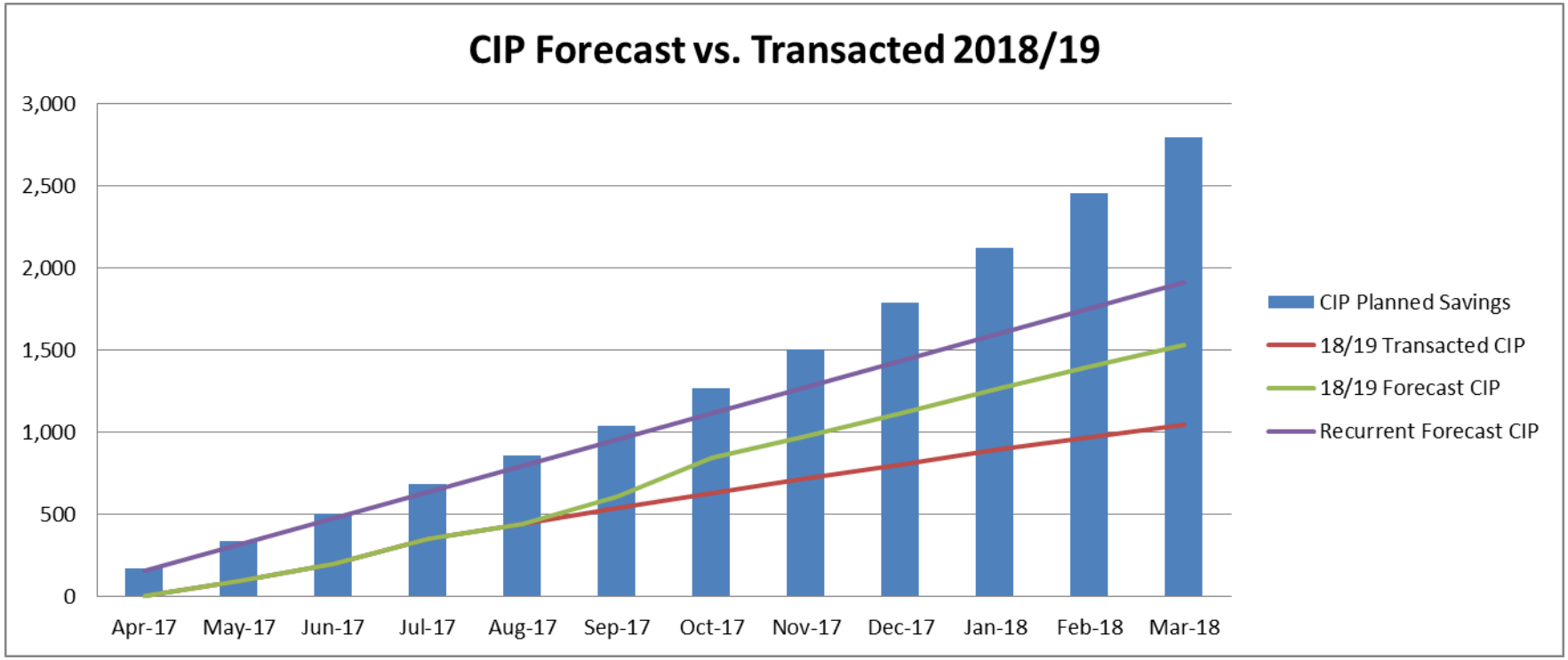
		YTD M5			Forecast					
CIP Delivery	Annual CIP Target 2018/19	Plan	Transacted	(Under)/Over Achievement	Plan	Total Schemes	(Under)/Over Achievement	RAG	Recurrent Transacted	Recurrent Position
	£'000	£'000	£'000	£'000	£'000	£'000	£'000		£'000	£'000
Clinical										
AMH Community	973	206	42	(163)	973	369	(604)	38%	140	636
AMH Inpatients	160	44	31	(13)	160	106	(53)	66%	129	129
Children's Services	296	97	84	(14)	296	257	(39)	87%	236	297
Learning Disabilities	234	114	79	(35)	234	178	(56)	76%	64	197
NOAP	551	144	65	(79)	551	283	(268)	51%	161	286
Total Clinical	**2,214**	**604**	**300**	**(304)**	**2,214**	**1,193**	**(1,021)**	**54%**	**730**	**1,545**
Corporate										
CEO	15	6	6	0	15	15	0	100%	15	15
Finance, Performance & Digital	43	18	25	7	43	60	17	140%	60	60
MACE	9	4	6	2	9	14	4	144%	14	14
Operations	6	2	2	(0)	6	6	0	100%	6	6
Quality & Nursing	41	17	9	(8)	41	34	(6)	84%	22	42
Strategy	11	5	5	(0)	11	11	0	100%	11	11
Trustwide	384	175	67	(108)	384	141	(243)	37%	133	163
Workforce & OD	72	30	25	(5)	72	60	(13)	82%	60	60
Total Corporate	**581**	**257**	**145**	**(112)**	**581**	**340**	**(241)**	**58%**	**320**	**370**
Total	**2,795**	**861**	**445**	**(416)**	**2,795**	**1,533**	**(1,262)**	**55%**	**1,050**	**1,916**

Below 75%	
Below 90%	

Target	**2,795**
Variance	**(879)**

- The forecast position as at M5 for 2018/19 is £1,533 (55%), which represents an in year shortfall against the annual target of £1,262k.

4.1 Cost Improvement Programme Forecast & Transacted 2018/19



5. Statement of Financial Position

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

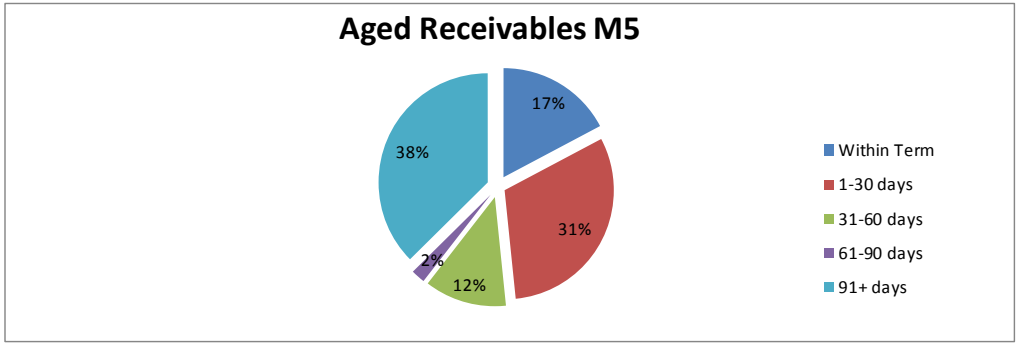
Table 6: SOFP	31/03/2018 £'000	30/06/2018 £'000	31/07/2018 £'000	31/08/2018 £'000
Non-Current Assets				
Property, Plant and Equipment - PFI	16,185	16,190	16,175	16,177
Property, Plant and Equipment	14,841	14,731	14,681	14,663
Intangible Assets	277	258	252	246
NCA Trade and Other Receivables	608	0	0	0
Other Financial Assets	1,089	1,089	1,089	1,089
Total Non-Current Assets	**33,000**	**32,269**	**32,197**	**32,174**
Current Assets				
Inventories	79	78	80	70
Trade and Other Receivables	7,347	7,568	5,722	5,647
Cash and Cash Equivalents	6,633	7,457	10,159	10,309
Non-Current Assets Held For Sale	0	0	0	0
Total Current Assets	**14,058**	**15,103**	**15,961**	**16,025**
Current Liabilities				
Trade and Other Payables	(7,166)	(7,476)	(8,298)	(8,342)
Provisions	(621)	(543)	(540)	(531)
Borrowings	(633)	(635)	(635)	(635)
Total Current Liabilities	**(8,420)**	**(8,653)**	**(9,473)**	**(9,508)**
Net Current Assets / (Liabilities)	**5,639**	**6,450**	**6,487**	**6,518**
Total Assets less Current Liabilities	**38,639**	**38,718**	**38,684**	**38,692**
Non Current Liabilities				
Provisions	(458)	(458)	(458)	(458)
Borrowings	(11,557)	(11,426)	(11,373)	(11,320)
Total Non-Current Liabilities	**(12,015)**	**(11,884)**	**(11,831)**	**(11,778)**
Total Assets Employed	**26,624**	**26,834**	**26,853**	**26,914**
Financed by Taxpayers' Equity				
Public Dividend Capital	7,648	7,648	7,648	7,648
Retained Earnings reserve	7,943	8,154	8,172	8,234
Other Reserves (LGPS)	1,089	1,089	1,089	1,089
Revaluation Reserve	9,944	9,944	9,944	9,944
Total Taxpayers' Equity	**26,624**	**26,834**	**26,853**	**26,914**

Current receivables are £5,647k, of which:

- £3,193k is based on accruals (not yet invoiced) and relates to income accruals for services invoiced retrospectively at the end of every quarter.
- £2,454k is awaiting payment of invoice. (£423k within terms)

£1,267k is overdue by 31 days or more and therefore subject to routine credit control processes.

		Days Overdue				
Table 6.1 Aged Receivables/Payables	Within Term £'000	1-30 Days £'000	31-60 Days £'000	61-90 Days £'000	91+ Days £'000	Total £'000
Receivables Non NHS	100	385	52	42	749	1,328
Receivables NHS	323	379	246	9	169	1,126
Payables Non NHS	474	193	10	(34)	15	658
Payables NHS	422	309	17	110	39	897

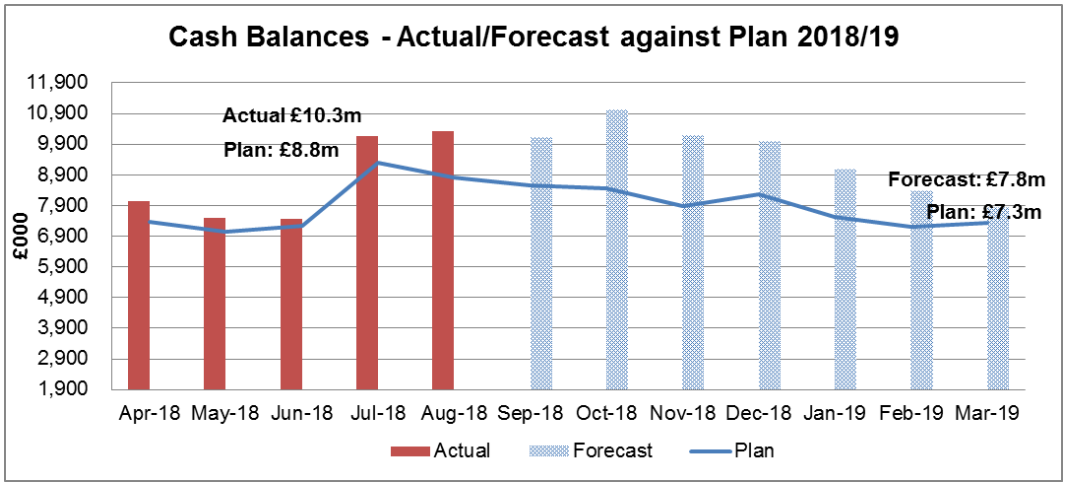


6. Cash Flow Statement

The Trust cash position at 31st August 2018 is £10.310m, **£1.485m higher than planned.** The variance to plan is mainly due to the high level of vacancies leading to lower monthly payroll payments, additional CCG income (CV's and patients in A & T and OATs), County Section 75 income (not planned to continue into 2018/19) and City Section 75 receipts higher than plan. The cash forecast is being closely monitored and the Trust anticipates being slightly above plan by March 2019.

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

Table 7: Statement of Cash Flows	Apr-18 £'000	May-18 £'000	Jun-18 £'000	Jul-18 £'000	Aug-18 £'000	Sep-18 £'000	Oct-18 £'000	Nov-18 £'000	Dec-18 £'000	Jan-19 £'000	Feb-19 £'000	Mar-19 £'000	Annual £'000
Net Inflows/(Outflow) from Operating Activities	927	(281)	159	2,908	408	83	1,355	(414)	126	(375)	(189)	274	**4,981**
Net Inflows/(Outflow) from Investing Activities	676	(60)	(8)	(6)	(54)	(65)	(238)	(238)	(238)	(304)	(305)	(597)	**(1,438)**
Net Inflows/(Outflow) from Financing Activities	(193)	(193)	(202)	(202)	(203)	(227)	(208)	(208)	(81)	(208)	(209)	(208)	**(2,341)**
Net Increase/(Decrease)	**1,410**	**(534)**	**(51)**	**2,701**	**151**	**(209)**	**909**	**(860)**	**(193)**	**(887)**	**(703)**	**(531)**	**1,202**
Opening Cash & Cash Equivalents	**6,633**	**8,043**	**7,509**	**7,458**	**10,159**	**10,310**	**10,101**	**11,010**	**10,150**	**9,957**	**9,069**	**8,366**	
Closing Cash & Cash Equivalents	**8,043**	**7,509**	**7,458**	**10,159**	**10,310**	**10,101**	**11,010**	**10,150**	**9,957**	**9,069**	**8,366**	**7,835**	
Plan	7,366	7,055	7,255	9,307	8,825	8,568	8,445	7,873	8,263	7,523	7,204	7,339	7,339
Variance	**(677)**	**(454)**	**(203)**	**(852)**	**(1,485)**	**(1,533)**	**(2,565)**	**(2,277)**	**(1,694)**	**(1,546)**	**(1,162)**	**(496)**	

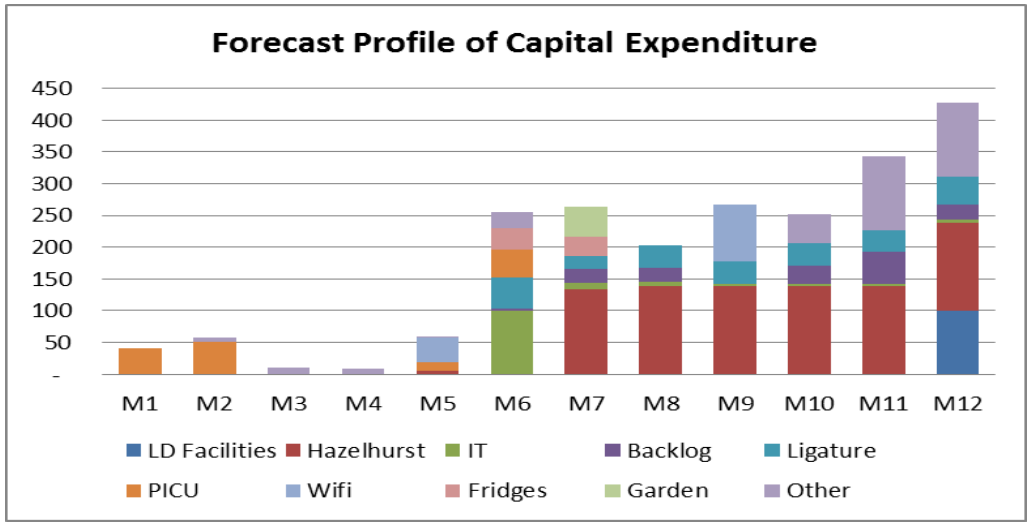


7. Capital Expenditure

The Trust's permitted capital expenditure agreed within the 2017/18 plan is £2,058k. Table 7 below shows the planned capital expenditure for 2018/19 as submitted to NHSI.

		Year to Date			Forecast		
Table 8: Capital Expenditure	Annual Plan £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Learning Disability Facilities	400	0	0	0	100	100	0
Hazelhurst incl Second Place of Safety	1,000	0	5	5	827	827	0
Information Technology Replacement Programme	108	108	0	(108)	108	137	29
Backlog Maintenance	150	50	0	(50)	150	150	0
Reduced Ligature Risks	250	84	0	(84)	250	250	0
Equipment Replacement Programme	50	0	0	0	50	50	0
Psychiatric Intensive Care Unit	0	100	109	9	100	150	50
Darwin	0	0	(1)	(1)	0	0	0
Generator	0	0	33	33	0	34	34
Garden Redesign CYP Short Breaks	0	0	0	0	0	48	48
IP Telephony Replacement	0	0	1	1	0	0	0
Pharmacy Temperature Monitoring System	0	0	0	0	0	65	65
Contingency	100	0	(5)	(5)	473	247	(226)
Sub Total Gross Capital Expenditure	**2,058**	**342**	**141**	**(201)**	**2,058**	**2,058**	**0**
Wifi	127	0	38	38	127	127	0
Total Gross Capital Expenditure	**127**	**342**	**179**	**(163)**	**2,185**	**2,185**	**0**

- **Actual Capital Expenditure** as at month 5 is £179k mainly relating to PICU, Wifi and the Estates generator.
- There is **£247k** available in contingency which is assumed to be spent in 2018/19.



8. Use of Resource Metrics

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

Table 9: Use of Resource	Year to Date Plan	Year to Date Actual	RAG Rating
Liquidity Ratio (days)			
Working Capital Balance (£000)		6,448	
Annual Operating Expenses (£000)		33,759	
Liquidity Ratio days		29	
Liquidity Ratio Metric	**1**	**1**	
Capital Servicing Capacity (times)			
Revenue Available for Debt Service (£000)		1,448	
Annual Debt Service (£000)		993	
Capital Servicing Capacity (times)		1.5	
Capital Servicing Capacity Metric	**3**	**3**	
I&E Margin			
Normalised Surplus/(Deficit) (£000)		290	
Total Income (£000)		35,192	
I&E Margin		0.8%	
I&E Margin Rating	**2**	**2**	
I&E Margin Variance from Plan			
I&E Margin Variance		0.2%	
I&E Margin Variance From Plan	**1**	**1**	
Agency Spend			
Providers Cap (£000)		840	
Agency Spend (£000)		827	
Agency %		(2%)	
Agency Spend Metric	**1**	**1**	
Use of Resource	**2**	**2**	

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

9. Better Payment Practice Code

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

At month 5, the Trust has achieved above the 95% target in terms of the value of invoices paid, but has under-performed against this target for the number of invoices, having paid 89% of the total number within target. Table 10 below shows the Trust's BPPC performance split between NHS and non-NHS suppliers.

	2017/18			2018/19 Month 5			2018/19 YTD		
Table 10: Better Payment Practice Code	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**
Number of Invoices									
Total Paid	659	10,933	11,592	47	912	959	281	4,554	4,835
Total Paid within Target	575	9,527	10,102	42	814	856	264	4,037	4,301
% Number of Invoices Paid	87%	87%	87%	89%	89%	89%	94%	89%	89%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-8%**	**-8%**	**-8%**	**-6%**	**-6%**	**-6%**	**-1%**	**-6%**	**-6%**
Value of Invoices									
Total Value Paid (£000s)	7,164	33,211	40,375	505	2,679	3,184	2,537	13,766	16,303
Total Value Paid within Target (£000s)	6,258	31,653	37,911	495	2,618	3,113	2,375	13,214	15,589
% Value of Invoices Paid	87%	95%	94%	98%	98%	98%	94%	96%	96%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-8%**	**0%**	**-1%**	**3%**	**3%**	**3%**	**-1%**	**1%**	**1%**

The majority of breaches in number of invoices relates to the retrospective raising of purchase orders, or late authorisation. The finance team will continue to monitor the retrospective raising of Purchase Orders and also to review the reasons for late authorisation.

10. Recommendations

The Trust Board are asked to:

Note:

- The reported YTD surplus of £290k against a planned surplus of £210k. **This is a favourable variance to plan of £80k.**
- The M5 CIP achievement:
  - YTD achievement of £445k (52%); **an adverse variance of £416k**;
  - 2018/19 forecast CIP delivery of £1,533k (55%) based on schemes identified; **an adverse variance of £1,262k to plan**;
  - The recurrent value of schemes transacted at £1,050k, **38% of target**.
- The cash position of the Trust as at 31st August 2018 with a **balance of £10,310k**; £1,485k better than plan
- Month 5 capital expenditure at £179k compared to planned capital expenditure of £342k;
- Use of resource rating of **2** against a plan of 2.

Approve:

- The month 5 position reported to NHSI.

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO OPEN TRUST BOARD

Enclosure No:15

Date of Meeting:	25 October 2018		
Title of Report:	Finance, Performance and Digital Committee Assurance Report		
Presented by:	Tony Gadsby Chair/Non-Executive Director		
Author:	Mike Newton - Deputy Director of Finance		
Executive Lead Name:	Suzanne Robinson – Executive Director of Finance, Performance and Digital	Approved by Exec	☒

Executive Summary:	Purpose of report	
This paper details the issues discussed at the Finance, Performance and Digital Committee meeting on the 11th October 2018. The meeting was quorate with minutes approved from the previous meeting on the 6th September 2018. Progress was reviewed and actions confirmed from previous meetings.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

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

Assurance Report to the Trust Board
25th October 2018

Finance, Performance and Digital Committee Report to the Trust Board – 25th October 2018.

This paper details the issues discussed at the Finance, Performance and Digital Committee meeting on the 11th October 2018. The meeting was quorate with minutes approved from the previous meeting on the 6th September 2018. Progress was reviewed and actions confirmed from previous meetings.

Executive Director of Finance, Performance and Digital Update

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

- **Use of Resources Self-Assessment –** Ahead of the launch of NHSI's Use of Resources assessment for Mental Health, the trust have designed a local framework based on the Acute Use of Resources Assessment. The Trust has self-assessed against the 5 Key Lines of Enquiry and suggested data collection and estimates that it is currently operating at an overall use of resources score of Good.

  A draft action plan has been proposed, based on areas where the trust could improve.

- **Restated 2018/19 Capital Plan –** An update of the 5 year Capital plan which restates 2018/19 for the up to date capital commitments agreed through CIG. The Capital plan will be refreshed in detail for the 5 years as part of the 2019/20 planning process.

Finance

- **Monthly Finance Report – M5**

The Finance position was presented, showing £80k favourable variance to plan. Agency utilisation in M4 was £827k against a ceiling of £840k, giving a £13k favourable variance.

The committee noted the improvement in performance around the Better Payment Practice Code compared to previous years.

Use of resource rating is 2 against a plan of 2.

- **Cost Improvement Programme (CIP)**

The Committee received an update for Cost Improvement for M5 and were concerned that the total identified was significantly short of the target. CIP achievement in M5 was £445k, giving an adverse variance of £416k. A high level forecast at M5 shows CIP delivery of £1,533k, giving an adverse variance to plan of £1,262k. The recurrent shortfall is forecast to be £879k.

The committee received an updated Cost Improvement Report, updated to reflect the performance by "theme" as outlined in the original 2018/19 plan. This highlighted where sufficient progress had not been made, particularly around Estates Rationalisation, Corporate Functions, procurement and medicines optimisation. The committee were informed that a work plan had been set out for Medicines Optimisation and challenged other workstreams to outline similar programmes to support delivery.

The Committee were assured that there was sufficient focus being placed on Cost Improvement but are unable to give assurance around the ability to deliver the target for 2018/19, particularly given the level of unidentified schemes.

Digital:

- **October Digital Update**

The committee received an update around Key Digital Developments, which included final approval from NHS Digital for the Digital Exemplar funding. Work has already commenced with DXC Consultants around the implementation.

The results of the User Survey and Directorate Assessments were presented outlining, 60% of respondents were experiencing issues with speed, 58% of respondents needed further training around local processes and the top 3 areas of the system users had trouble with were Care Plans, Care Plan Pathways and Clinical Notes.

The committee were concerned that the 15.5% response rate was not reflective of the overall staff experience and noted the intention to address this as part of the action plan.

Other:

- **Finance, Performance and Digital Risk Register**

The committee received an update on current risks which have an impact on Finance, Performance or Digital.

An update was provided around the progress on S.75 Stoke Residential Payments Contract which was highlighted as a key risk due to the forecast pressure of £700k. The Committee were assured with progress, noting the Trust had met the council and agreed a set of principals to mitigate part of the pressure in 2018/19 and to set up a transformation group to design a sustainable contract for both parties over the longer term.

Whilst the committee were assured with the progress the level of unmitigated overspend is still a concern and a significant financial risk to control.

- **Lord Carter Action Plan**

An update around the Lord Carter review of Operational Productivity; Unwarrented Variation in Mental Health and Community Services, outlining the 16 recommendations to deliver £1bn efficiencies. The committee received the Trust progress around the recommendations and action plan to address any areas of improvement.

The Committee received additional assurance reports as follows:

- Agency Utilisation M5
- Performance Report (PQMF) M5
- Cyber Security Action Plan refresh (mid year review)
- Committee Effectiveness Framework
- Contract Awards
- Cycle of Business 2018/19 *(for information)*
- Capital Report and Capital Affordability Q1 *(for information)*

Recommendation

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

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

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO Trust Board

Enclosure No:16

Date of Meeting:	25/10/2018		
Title of Report:	Cyber Security Action Plan - Update		
Presented by:	David Hewitt – Chief Information Officer		
Author:	David Hewitt – Chief Information Officer		
Executive Lead Name:	Suzanne Robinson – Executive Director of Finance, Performance and Digital	Approved by Exec	☐

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

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☒ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Reference	Supports the trust to mitigate against cyber vulnerabilities by implementing best practice.		
Resource Implications: Funding Source:	None applicable to deliver the standards None applicable.		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I	Cyber security cover all systems including systems which hold protected characteristics of service users and staff, it is essential that these controls are robust to protect this information.		

Guidance	
STP Alignment / Implications:	None applicable
Recommendations:	The Trust Board are asked to receive this paper for information.

Cyber Security Action Plan – Update October 2018

	Question	Response	Details / Measurement	Status	Owner
1	By 31 March 2018 organisations are required to achieve at least level 2 on the Information Governance (IG) toolkit. More information about the IG toolkit v14.1 can be found here: www.igt.hscic.gov.uk/help.aspx	The organisation has completed the IG toolkit, submitted its results to NHS Digital and obtained either level 2 or 3.	Results submitted at level 2	Annual review	David Hewitt - Chief Information Officer
2	All staff must complete appropriate annual data security and protection training. As per the IG toolkit, staff are defined as: all staff, including new starters, locums, temporary, students and staff contracted to work in the organisation.	At least 95% of staff have completed either the previous IG training or the new training in the last twelve months.	95% figure was submitted in the IG toolkit.	Annual review	David Hewitt - Chief Information Officer
3	Organisations must: • Identify a primary point of contact for your organisation to receive and co-ordinate your organisation's response to CareCERT advisories, and provide this information through CareCERT Collect • act on CareCERT advisories where relevant to your organisation • confirm within 48 hours that plans are in place to act on High Severity CareCERT advisories, and evidence this through CareCERT Collect	The organisation has registered for CareCERT Collect The organisation does not have plans in place for all CareCERT advisories up to 31/3/2018 that are applicable to the organisation The organisation has clear processes in place that allow it to confirm within 48 hours of a High Severity CareCERT advisory being issued that a plan is in place. The organisation has in post a primary point of contact who is responsible for receiving and co-ordinating CareCERT advisories.	These are picked up and recorded on the HIS call logging system and actioned by the HIS, when they relate to Training or Communications we send them via the Communications team. The high alerts are delivered to the CIO and response provided. Primary point of contact is the CIO	Initial response complete **Ongoing actions** Development of an escalation process map [November 2018]	David Hewitt - Chief Information Officer
4	Comprehensive business continuity plans must be in place to support the	The organisation is developing a business continuity plan(s) for	We have BCP's for the directorates/services not directly	Initial response complete	David Hewitt - Chief Information Officer

	organisation's response to data and cyber security incidents.	data and cyber security incidents. The plan(s) will take into account the potential impact of any loss of services on external organisations in the health and care system. The business continuity plan for cyber security incidents in has been tested in 2017/18.	Cyber but for loss of IT and disaster recovery plans in-relation to IT services provided. The S&SHIS disaster recovery plan is attested annually.	**Ongoing actions** Confirm local tests of directorate business continuity plans. Agreement of an ongoing test schedule for the S&SHIS DR plan and the directorate business continuity plans. [December 2018] Cyber issue event on the BCP test [March 2019] Commission a phishing exercise (Bi Annual) including Trust Board & NEDS [December 2018] Establish a S&SHIS partner Cyber security workshop. [December 2018]	
5	Staff across the organisation must report data security incidents and near misses, and incidents should be reported to CareCERT in line with reporting guidelines.	The organisation has a process or working procedure in place for staff to report data security incidents and near misses	The incident reporting process is in place via safeguard.	Initial response complete Ongoing monitoring by the Information Governance Steering Group.	David Hewitt - Chief Information Officer
6	Your organisation must: • identify unsupported systems (including software, hardware and applications) • have a plan in place by April 2018 to remove, replace or actively mitigate or manage the risks associated with unsupported systems.	The organisation has reviewed all its systems and any unsupported systems have been identified but not logged on the organisation's relevant risk register. By May 2018 the organisation will have developed a plan to remove, replace or actively mitigate or manage the risks associated with unsupported	We have replaced most of the systems but there is still an issue with the telephony which you are aware of. but these are managed on the S&SHIS risk register not ours. We have the plan to replace the telephony system as indicated above.	Current telephony system replacement is scheduled [March 2019]	David Hewitt - Chief Information Officer

		systems.			
7	Your organisation must: • have undertaken or have signed up to an on-site cyber and data security assessment by NHS Digital • act on the outcome of that assessment, including any recommendations, and share the outcome of the assessment with your commissioner.	Prior to 31 March 2018 the organisation signed up to undergo an NHS Digital on-site cyber and data security assessment but has not yet The organisation does not yet have an improvement plan in place on the basis of the findings of the assessment, and has not yet shared the outcome with the relevant commissioner(s) The organisation has not used an external vendor to audit the organisation's data and cyber security risks	The Trust have signed up for this but haven't received any response, this is being chased. No response received regarding a visit so there are no findings to share. The Trust have not had a separate cyber audit.	Current survey date being scheduled with NHS Digital Ongoing actions Commissioning a KPMG cyber security audit (scope to be agreed) [November 2018] Finalisation of a cyber security framework for the January Finance Performance and Digital Committee and Trust Board. [December 2018] Based on the IT audit and Cyber audit there are pressures attached to the ability of S&SHIS to deliver within our current allowance of days. Based on the IG support requirements this cost is estimated between 7-10k. [November 2018]	David Hewitt - Chief Information Officer
8	Organisation should ensure that any supplier of critical IT systems that could impact on the delivery of care, or process personal identifiable data, has the appropriate certification (suppliers may include other health and care organisations).	The organisation has not checked whether its suppliers of IT systems have appropriate certification.	DXC have this for Lorenzo but there hasn't been an active process for checking this with suppliers.	Initial response complete **Ongoing actions** Trust contract cyber security and information governance review.	David Hewitt - Chief Information Officer

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO Trust Board

Enclosure No:

Date of Meeting:	25/10/2018		
Title of Report:	Lord Carter Action Plan		
Presented by:	Suzanne Robinson – Executive Director of Finance, Performance and Digital		
Author:	M Newton – Deputy Director of Finance		
Executive Lead Name:	Suzanne Robinson – Executive Director of Finance, Performance and Digital	Approved by Exec	☒

Executive Summary:	Purpose of report	
In May 2018, Lord Carter issued a review around the Operational Productivity; Unwarranted Variation in Mental Health and Community Services. This paper outlines the findings of the review and actions, where appropriate, for the Trust in order to deliver the recommendations.	Approval	☒
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☒ Execs ☒ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☒ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Reference	Ref 1035: Trust top 3 risks around delivery of cost improvement target.		
Resource Implications: Funding Source:	As part of implementing some of the recommendations, there may be some improvements in efficiency of delivered services. Not applicable		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	There is no direct impact on the protected characteristics as part of the completion of this report; however in responding to the findings particularly optimising workforce wellbeing and engagement the importance of the Diversity and Inclusion work the Trust is leading is paramount.		
STP Alignment / Implications:	The Trust Financial Position is part of the aggregate STP reported financial position and the importance to be the most efficient provider we can be.		
Recommendations:	The Trust Board are asked to:-		

	▪ To support the development of an action plans to deliver suggested actions by the deadline date ▪ Receive a progress report on relevant actions in 6 months' time (March 2019)

North Staffordshire Combined Healthcare NHS Trust

Trust Board
NHS Operational Productivity: Unwarranted Variations in Mental Health and Community Services (Action Plan)
25th October 2018

1. Introduction

In May 2018, Lord Carter issued a review around the Operational Productivity; Unwarranted Variation in Mental Health and Community Services. This paper outlines the findings of the review and actions, where appropriate, for the Trust in order to deliver the recommendations.

2. Headline Findings

Lord Carter's review worked with a cohort of 23 mental health and community trusts, which account for 20% of the overall expenditure in the sectors, issuing a final report with 16 recommendations carrying an associated **£1bn** worth of savings opportunity to be delivered by 2020/21. It is expected that 80% would be delivered through clinical and workforce efficiencies including through the Getting it Right First Time (GIRFT) principals.

The review identified four important areas where operational improvement must be made;

1. **Staffing** - Effective rostering, job planning, managing sickness absence, maximising the clinical time of community staff, appropriate skills mixing, and effective training all lend themselves to detailed management attention.
2. **Contract specification** - the approach to contract specification and management is inconsistent and overly bureaucratic.
3. **Technology** - the use of technology is not optimal and lags behind even other public sector services, let alone the best in class
4. **Delivery** - NHS Improvement needs to have a clear idea of 'what good looks like' in these areas by broadening the focus of the clinically led Getting It Right First Time (GIRFT) programme and providing effective benchmarking information to providers through an adapted Model Hospital

The review team found a disparity in leadership capacity and focus from the Department of Health and Social Care, NHSE, NHSI between Mental Health and Community Services.

Whilst the 5YFV for Mental Health has engendered clear ambition, delivery programme and strong leadership, there is a lack of national work and evidence base around community services. The report suggests that NHSI and NHSE should do more to recognise and strengthen the role of community health services. This should bring together existing national workstreams with a single delivery plan and support local areas to achieve.

3. Action Plan

The action plan is included in appendix 1 and will be overseen via the Trust Committee structure. The following colour code system has been used to indicate the progress around the actions:

Action not applicable to the trust	
Trust required action	
Action already complete	

4. Recommendations

The Trust Board are asked to:-

- Support the development of action plans to deliver suggested actions by the deadline dates overseen by the relevant Board Committees.
- Receive a progress report on relevant actions in 6 months' time (March 2019)

Recommendation	Description	Action / Progress	Board / Committee	Due Date
Learning from new models of care	NHSE should codify and share the learnings from new models of care and the successful 'vanguards' to support **community health services** to play their full role in supporting the wider system. This will involve identifying how to work across STPs and ICSs.			N/A
Quality of care and GIRFT	The GIRFT programme should ensure that the role of community health services is considered in all relevant clinical specialities and make rapid progress in undertaking work in mental health. For mental health, this should include supporting the elimination of inappropriate out of area placements for adult mental healthcare by 2021.	Trust to receive the GIRFT pathways, review and implement findings.	Quality Committee	6 x months following receipt
Driving standardisation in the community health services 'offer'	NHSE should help strengthen commissioning and contracting mechanisms. This should include supporting STPS to work together to develop model frameworks for specifications of community services.	Development of model specifications for Mental Health Community services. Clear outcomes to be set for MH Services and alternative contracting mechanisms to be explored with gain share for Providers / Commissioners.	Finance, Performance & Digital	April 30th 2019
Restricted patients	The DHSC, Ministry of Justice and their arm's length bodies should work more closely to improve the administrative management of restricted patients.	N/A – the trust has 3 patients who are sectioned under the MOJ but have discharge plans. These patients would typically be treated in forensic MH.		N/A

Recommendation	Description	Action / Progress	Board / Committee	Due Date
Optimising workforce wellbeing and engagement	Improving cultures are critical to better staff engagement, driving positive change across organisations and improving both productivity and care quality. NHS Improvement should work with all Mental Health and Community Trust Boards to help improve the engagement, retention and wellbeing of their staff.	Trusts should review their training offer to explore whether they can adopt more efficient processes to improve staff productivity by spring 2019. The Trust has existing programs in place around engagement, retention and wellbeing these should be **reviewed** alongside Carter Report findings.	People & Culture Development Committee	Review complete by 31st December 2018 Findings to be implemented by 31st May 2019
Strengthening the oversight of workforce productivity for services delivered in the community	With support from NHSI and NHS Digital, and using the Model Hospital, providers should improve their understanding and management of productivity at organisational, service and individual level.	Benchmarking information is available on The Model Hospital; highlighting opportunities against NSCHT's peer group or selected Trusts. Model Hospital data to be included as part of performance reviews and Trust Committee reporting.	People & Culture Development Committee Quality Committee Finance, Performance & Digital	Quarterly from Q3
Improving the productivity of the clinical workforce for services delivered in the community	Community service providers should increase the productivity of their clinical workforce by improving and modernising their delivery models, though better use of digital solutions and mobile working.	Video consultation technology to be introduced across the Trust. DocMan electronic discharge in place for transfer between the Trust and Primary Care	Finance, Performance & Digital	March 31st 2019 March 31st 2019
Cost of inpatient care and care hours per patient day	NHSI should develop and implement measures for analysing workforce deployment, and Trusts should use these to report on the cost and efficiency of their inpatient services to their Board during 2018/19.	The Trust uses the Care Hours Per Patient Day (CHPPD) to inform the safer staffing reviews, reported through Board. This will be drawn explicitly into future reports.	Quality Committee	Q3 2018/19

Recommendation	Description	Action	Board / Committee	Due Date
Inpatient rostering and e-rostering	All community and mental health trusts should use an effective e-rostering system and set up formal processes to tackle areas of rostering practice that require improvement. NHSI should undertake a review of the rostering good practice guidance to ensure it is inclusive of all sectors.	Trust implemented an e-rostering system for all 24/7 services over the past 18 months. Inconsistencies in rostering practices (including annual leave, unused Hours etc.) to be highlighted through E-roster review.	Finance, Performance & Digital	31st December 2018
Medical job planning	NHSI should work with Trusts to ensure that the right doctor is available for patient at all times using effective and comprehensive job planning and rostering, and identify improvements in clinical efficiency and productivity.	Medical job planning has not been fully implemented in an automated rostering system. Job planning process currently being reviewed by the Medical Director, which includes updating the policy, with a view to using the electric system purchased (allocate) Implementation plan to be developed and agreed	Quality Committee	31st December 2018
Medicines and pharmacy optimisation	Trusts should develop plans to ensure their pharmacists and other pharmacy staff spend more time with patients and on medicines optimisation.	Job plans for Pharmacists to be reviewed, allocating more ringfenced time for patients and for Medicines optimisation, if required.	Quality Committee	31st December 2018
Corporate Services	Trusts should reduce variation in the cost of their corporate service functions, and should examine the opportunities to collaborate and share corporate service functions. Trusts need to complete the corporate services opportunity list self-assessment by October 2018.	Trust to complete corporate services self-assessment list in line with STP Efficiency Group. Plan to be developed to realise identified opportunity	Finance, Performance & Digital	31st December 2018

Recommendation	Description	Action	Board / Committee	Due Date
Estates and facilities management	NHSI should develop a comprehensive and tailored set of benchmarks for the sector by 2019/20, and all Mental Health and Community Trusts should review their existing estates and facilities and provide a report to their boards by April 2019. Trusts need to review and identify opportunities for estate consolidation and improved data capture by autumn 2018. In addition to this Trusts need to have a sustainable development management plan signed off by their Boards by winter 2018.	Trusts to review opportunities to consolidate / outsource Estates function, as well as exploring and implementing opportunities for efficiencies. Estates Rationalisation Plan Development of Sustainable Development Management Plan	Finance, Performance & Digital Committee Business Development Committee Business Development Committee	31st October 2018 31st January 2019 31st December 2018
Procurement	Trusts should reduce unwarranted price variation in procurement of goods and services by improving procurement practices, local and national collaboration and price benchmarking. All trusts should be using the Purchase Price Index and Benchmarking tool during 2018/19 should achieve accreditation of level 1 of the NHS Procurement & Commercial Strategy by March 2019, with level 2 achieved by March 2020.	The Trust has the Purchasing Price Index license with UHNM. The outsourced Procurement Service is already achieving level 2 accreditation.		Complete

Recommendation	Description	Action / Progress	Board / Committee	Due Date
Model Hospital	NHSI should develop the current Model Hospital and underlying metrics to ensure there is one repository of data benchmarks and good practice so all trusts can identify what good looks like. Trust boards need to ensure that mandatory data fields are submitted to the minimum datasets.	Model Hospital is available for use but the Clinical Mental Health Metrics are still under development as the Acute. The Trust has requested a WAU for Mental Health. MHMDS reported via SoF and PQMF		N/A
Implementation	Trusts, NHSI and NHSE and others should work together to take the action required to implement these recommendations.	N/A – not a trust action		N/A

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO: OPEN TRUST BOARD

Enclosure No:18

Date of Meeting:	25 October 2018		
Title of Report:	Assurance Report from the Quality Committee		
Presented by:	Patrick Sullivan, Non-Executive Director and Chair of Quality Committee		
Author:	Sandra Storey, Associate Director of MaCE		
Executive Lead Name:	Dr Buki Adeyemo, Executive Medical Director	Approved by Exec	☒

Executive Summary:		Purpose of report	
This report provides a high level summary of the work of the Committee from the meeting held on 27 September 2018 and request for the Trust Board to ratify polices and endorse recommendations in the report.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☒ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Primary Care Integration Programme Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☐ 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Reference	None identified		
Resource Implications: Funding Source:	N/A N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	None identified		
STP Alignment / Implications:	None		
Recommendations:	To note policy approval		

Version	Name/group	Date issued
1	Dr Buki Adeyemo	12.10.18
2	Maria Nelligan	18.10.18

No

ENC 13A M5 Trust Board Finance Report

Key points from the Quality Committee meeting held on 27 September 2018
For the Trust Board meeting on 25 October 2018

1. Introduction

This is the regular report to the Trust Board that has been produced following the last meeting of the Quality Committee with items aligned to the Trust's SPAR objectives.

2. Patient Story – presentation and discussion

The committee watched a video story presented as a poem from a former staff member's BAME perspective of working within the Trust. Committee members welcomed the presentation with its powerful message around culture. It was noted that this poem had been heard at other meetings and events such as the Trust Board and AGM.

The Executive Director of Nursing & Quality advised the Committee that following a Listening into Action (LIA) group with BAME staff, an agreed outcome was the establishment of an Inclusion Council led by the CEO.

The Committee will receive reports at its next meeting on progress against the Workforce Race Equality Standard (WRES) and Equality Delivery System2 (EDSs)

3. Reports received for review, information and/or approval

3a Reports:

- ✓ **Performance & Quality Management Framework Month 4 2018/*19*** *(*Report on performance by exception and the rectification plans in place. Month 4 was noted to have 7 target related metrics rated as red and 3 target related metrics as amber, with all other indicators within expected tolerances).
- ✓ **Nutrition Annual Report 2017/*18*** (overview of the provision of high quality nutritional care with highlights of achievements including the continuing excellent PLACE scores).
- ✓ **Mental Health Act Provider Action Statement – Ward 1** (the committee discussed the report and action plan following visit to Ward 1 in July 18).
- ✓ **Infection Prevention & Control (IPC) Quarter 1 Report 2018/19** (overview of the IPC activities, highlighting achievements and progress against annual work programme priorities).
- ✓ **Data Quality Forum update** (minutes of the meeting held on 23 July 2018).

- ✓ **Quality Impact Assessment (QIA) of Cost Improvement (CIPS)** (assurance report that all CIP transacted has had a QIA. Further report to committee on process for audit of schemes on-going or complete to identify any negative impact on quality of service provision. The report will include the detail of any pipeline schemes so that the committee can have oversight of upcoming projects.

- ✓ **Safer Staffing monthly report – June and July 2018** (assurance on the fill rate for R/N staff and care staff on day and night shifts and actions being taken to ensure the Trust complies with the National Quality Board requirements.

- ✓ **Eliminating Mixed Sex Accommodation (EMSA) Assurance Statement** (the committee received assurance that EMSA requirements have been met within the Trust during 2017-18).

- ✓ **NICE Report Q1 2018/19** (detailing the arrangements for the dissemination, implementation and monitoring of NICE guidance during this period).

- ✓ **Mortality Surveillance Report Q1 2019/19** (summary of the mortality surveillance activity and the learning identified from this review process. Report provides assurance that the Trust complies with the national learning from deaths agenda.

- ✓ **Serious Incident Report Q1 2018/19** (received for information and assurance in respect to incidents reported, identification of themes / trends, and learning and action being taken.

- ✓ **Performance in initiating and Delivering Clinical Research 2017/18** (summary of performance in respect to clinical research for the year. This was the first report to the committee which provided a detailed overview of work. High level reports will now be provided to the committee going forward with any issues by exception).

- ✓ **Health & Safety Annual Report 2017/18** (provides information and assurance on management arrangements in place and that the Trust is meeting its statutory obligations for health and safety. The report also summarised key areas associated with good practice).

- ✓ **Restraint Annual Report 2017/18** (provides information regarding the use of physical restraint and inclusion, comparing activity with previous years. Assurance around the scrutiny underpinning this area of work including annual work plan and oversight arrangements.

- ✓ **Complaints/PALS Annual Report 2017/18** (detailed reported on activity for the year. Highlighting reduction in the number of formal complaints, significant increase in the number of compliments received and the number of issues resolved through PALS. This is as a result of the continuous work throughout the year to provide a more holistic patient experience approach with strong support from Directorates at all levels).

- ✓ **Smoke Free Report April – September 2018** (assurance on the smoke free arrangements in place and the prevalence of issues, including regional, national and those within the organisation).

- ✓ **Self-Harm Annual Report 2017/18** (analysis of self-harm incidents, establishing trends in numbers, incident type and learning outcomes for reduction in any emerging themes.

- ✓ **Quality Committee Cycle of Business** *(*reviewed and approved). The committee will review its Terms of Reference at its November 18 meeting and align the cycle of business with the new Directorate structure. The Committee will undertake a review of its effectiveness in line with the other committees of the Board. The committee will also discuss the Trust's quality statement.

3b **Policy report** – the recommendations supported by the Committee for ratification of policies by the Trust Board for 3 years, or otherwise stated as follows:

Policy No.	Name	Recommendation
4.27	Protected Mealtime Policy	Remove as now incorporated into the Nutrition & Hydration Policy
1.25	Food Waste	Remove – as above
IC9	Food Safety	Remove – as above
7.1	Confidentiality of Patient & Employee Information	Approve 3 years
7.2	Subject Access Request	Renamed to Access to Health & Employee Records – approve 3 years
7.3	Information Security & Data Protection Policy	Approve 3 years
5.20	Health & Safety Audit Procedures	Remove – incorporated into new Health & Safety policy
1.68b	Guidelines for physical healthcare	Remove – the guidelines have been incorporated into the new physical health policy 1.62 approved by Trust Board, which also approved 1.62a SOP to support the physical health policy and 1.62b SOP to support neurological observations.
1.34	Pulse Oximetry Guidelines	Remove – as above
1.70	Managing Allegations of Abuse	Approve 3 years
4.22	Children Visiting Mental Health and Learning Disability premises	Approve 3 years
4.44	Policy on managing visits to Trust premises by Celebrities VIPs and other Famous People	Approve 3 years
5.22	Management of Mercury Guidance	Remove – policy no longer required
5.26	Sharps Find Procedure	Remove – incorporated into the IC1 policy
R10	Policy for the Provision of Physical Interventions and Advice to Parents and Carers	Approve 3 years
R07	Guidelines for when the Police use Incapacitant Spray or Taser on Trust Premises	Approve 3 years
1.19	Chaperone Policy	Approve 3 years

4.32	Privacy Dignity and Respect Policy	Approve 3 years
5.38	Lockdown Policy	Approve 3 years
5.42	Display Screen Equipment	Approve 3 years
1.75	Domestic Abuse	Approve 3 years
4.33	Clinical Photography	Approve 3 years
4.33a	Digital Photography Standing Operating Procedure	Approve 3 years
1.78	Palliative Care	Extension to 30.11.18
1.55	Advanced Statements	Extension to 30.11.18
1.04	Complimentary Therapies	Extension to 30.11.18
4.20	Volunteer Policy	Extension to 30.11.18
4.40	Being Open incorporating Duty of Candour	Extension to 30.11.18
5.01	Incident Reporting	Extension to 30.11.18
5.32	Serious Incident Policy	Extension to 30.11.18
MHA16	Mental Capacity Act Policy	Approve 3 years

4. Trust Risks to Quality Committee

There are currently 9 Trust risks for Quality Committee. Committee members considered these risks and how they interrelate to Directorate risks. Risk treatment plans and actions being taken were noted**.**

5. Next meeting:
Friday 2 November 2018 9.30 am.

On behalf of the Committee Chair, Mr Patrick Sullivan, Non-Executive Director
Sandra Storey Associate Director Medical and Clinical Effectiveness
11 October 2018

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO TRUST BOARD

Enclosure No:19

Date of Meeting:	25th October 2018		
Title of Report:	Locality Working / Restructure		
Presented by:	Jonathan O'Brien, Director of Operations		
Author:	Jonathan O'Brien, Director of Operations		
Executive Lead Name:	Caroline Donovan, Chief Executive	Approved by Exec	☒

Executive Summary:		Purpose of report	
The paper provides an overview of progress to date and a briefing on the launch of Phase 3 of the Trust's localities working restructure on Monday 16th July 2018. The paper seeks to brief the Trust Board on progress to date and the current position.		Approval	☐
		Information	☒
		Discussion	☒
		Assurance	☐
Seen at:	SLT X Execs ☐ Date: 16th October 2018	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve.☒ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☒ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Reference	Locality risks as noted on committee risk registers.		
Resource Implications: Funding Source:	N/A N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups). See wider D&I Guidance	As described in original Equality Impact Assessment – April 2018.		
STP Alignment / Implications:	Supports the STP-wide move to locality working and specifically aligns our community based services with 10 localities across North Staffordshire and Stoke-on-Trent.		
Recommendations:	To note and discuss the operation of the Trust's new Directorate form, effective 1st October 2018 and completion of management of change.		

Version	Name/Group	Date

1. Introduction

This paper provides an update on the transformation journey that has been undertaken following Board approval of the locality working project on the 18th April 2018 and the associated restructure of clinical directorates, which was completed on 30th September 2018.

2. Planned Implementation

Key to the success of the project is the phased approach to implementation.

2.1 Phase 1 – Clinical Directors, Associate Directors (HOD's), Deputy Director of Operations

Phase 1 commenced on Monday 30th April 2018 and was formally completed on Friday 6th July 2018. This was on schedule. Following the formal consultation, the appointments of new Clinical Directors and Associate Directors has taken place.

Two of the previous Heads of Directorate were displaced but have now been appointed as Head of Nursing and Professional Practice and Senior Service Manager – Substance Misuse. One former Head of Directorate is also taking up post as Consultant Nurse – Acute Care.

Interviews for the vacancies of Associate Director of Acute & Urgent Care and Deputy Director of Operations post are scheduled to take place on 24th October 2018.

2.2 Phase 2 – Configuration of Trust-wide Professional Heads

Phase 2 of the locality restructure commenced on the 4th June 2018 through formal consultation and closed on the 4th July 2018. This phase relates primarily to the senior Professional Leadership Structure within the Trust concerning Heads of Nursing, Allied Health Professionals, Psychology, Social Work and Medical Associate Directors. This phase was led by the Trust's Director of Nursing and Quality and the Trust's Medical Director.

The following appointments have been made:

Head of Nursing & Professional Practice	- Alastair Forrester
Head of Psychology	- Dr Darren Perry
Deputy Director – MACE	- Helen Sweeney

The posts of Head of AHP and Head of Social Work are to be recruited to.

2.3 Phase 3 - Appointment of Service Managers, Quality Improvement Lead Nurses and Clinical, Psychology and AHP Leads

Phase 3 of the locality restructure focused on the management structures within each of the newly established Directorates. These include the roles of Service Managers, Quality Improvement Lead Nurses, Clinical, Psychology and AHP Leads. The newly appointed CD's and AD's have led this phase, including ownership of the launch and the resulting consultation under a management of change process.

Phase 3 launched into formal consultation with staff on Monday 16th July 2018 and was implemented from 1st October 2018, following the formal consultation, detailed consultation response and a subsequent competency based assessment and appointments process. Staff side representatives were involved throughout the process and supported staff as required.

There are two members of staff displaced with whom discussions are ongoing in line with HR processes and one appeal relating to the post allocated. Appointments to posts and the structure are included on the following page.

The appointment processes for Clinical Leads, Psychology Leads and AHP Leads are currently taking place.

NHS
North Staffordshire
Combined Healthcare
NHS Trust

Directorate Service Manager & QUIN (Matron) Appointments

NORTH STAFFORDSHIRE

Clinical Director: Dr Darren Carr
Associate Director: Sam Mortimer

Name	Post	WTE
Brigette Hamlett	Quality Improvement Lead Nurse (Matron)	1.0
Simon Wilson	Service Manager – Newcastle	1.0
Nicky Griffiths	Service Manager – Moorlands	0.8

STOKE-ON-TRENT

Clinical Director: Dr Dennis Okolo
Associate Director: Jane Munton-Davies

Name	Post	WTE
Sue Parkes	Quality Improvement Lead Nurse (Matron)	1.0
Rachael Birks	Service Manager – North	1.0
Darryl Gwinneth	Service Manager – South Stoke	0.6
David Smith	Service Manager - South Stoke Social Care Lead	1.0

SPECIALIST CARE

Clinical Director: Dr Darren Perry
Associate Director: Ben Boyd

Name	Post	WTE
Stuart Fisher	Quality Improvement Lead Nurse (Matron)	1.0
Tina Mottram	Quality Improvement Lead Nurse (Matron)	0.4
Jessica Fitzgerald	Service Manager – LD & CAMHS IP	1.0
Fiona Platt	Service Manager – Neuro & Rehab	0.8
Darren Bowyer	Senior Service Manager – Substance Misuse	1.0
Craig Heffernan-Stone	Service Manager – Substance Misuse	1.0

ACUTE & URGENT CARE

Clinical Director: Carol Sylvester (Interim)
Associate Director: Natalie Larvin (Interim)

Name	Post	WTE
Dawn Burston	Quality Improvement Lead Nurse (Matron)	1.0
Val Stronach	Quality Improvement Lead Nurse (Matron)	0.6
Josey Povey	Service Manager – Urgent Care	1.0

3. Governance Arrangements

Reporting to the Senior Leadership Team, two task and finish groups were established, both of which were chaired by the Trust's Executive Director of Operations. The groups were established to oversee the governance arrangements for the management of change. They provided a forum for discussion and 'confirm and challenge', allowing a place for the development of the process in a meaningful and engaging way.

- Corporate Services Task & Finish Group (CSG) - representation at a fortnightly meeting from Workforce, Communications, Finance, Performance & Digital, Estates and Nursing, Quality and Governance.

- Clinical Directorates Task & Finish Group (CDG) - representation from existing and new Associate Directors and Clinical Directors.

These forums have now been stood down, with the final Corporate Services Task & Finish group taking place on 18th October 2018. Corporate services representatives confirmed at this meeting that reporting arrangements and the necessary changes have been implemented across finance, performance, HR, ESR, governance and quality functions. All corporate services have reported that work is complete in relation to supporting the new structure and that data from 1st October 2018 will be reported on the basis of four Directorates.

Terms of Reference and membership of the Senior Operational Team meetings, chaired by the Director of Operations, have been fully updated and signed off through the Senior Leadership Team meeting.

The Clinical Lead for the Project, Nicky Griffiths, will be returning to her substantive post in the new structure from 1st November 2018.

4. Completed Engagement & Feedback

The Trust has specifically developed a website - Integrated Locality Working Project: http://localities.wpengine.com/. This is a stand-alone website whereby staff can learn about the project aims and provide comments and feedback. It includes information on the new structure, governance arrangements and a calendar of events. It also includes a Frequently Asked Questions (FAQ) page so that staff can see if their queries are addressed in this section without having to submit individual questions.

5. Trust-wide Engagement Plans / Organisational Development

The professional network groups have been provided with opportunities for update, engagement, comment and feedback - all of which are chaired / led by one of the Executive Team. These have included:

- Senior Operational Team (SOT) – Chaired by Director of Operations
- Senior Leadership Team (SLT) – Chaired by Chief Executive.
- Senior Medical Team (SMT) – Chaired by Medical Director
- Professional Leadership Advisory Group (PLAG) - Chaired by Medical Director
- Professional Network Groups including-
  - Nurse Network – Chaired by Director of Nursing and Quality
  - AHP Leads Meeting – Chaired by Director of Nursing and Quality
  - Social Care Forum – Chaired by Director of Nursing and Quality
  - Leadership Academy – Chaired on rotation by an Executive Director

6. Risks and Mitigations

All committees of the board have the restructure programme identified on their risk registers to provide assurance and ensure risks are appropriately managed and mitigated. These continue to be reviewed at each committee and will be modified as the described risks associated with the restructure subside.

7. Summary

In the time period since the Trust Board approved the restructure of operational directorates in April 2018, a significant amount of work has been completed to ensure that the restructure is delivered within the planned timescale, with the Trust being ready to operate on the basis of four Clinical Directorates from 1st October 2018. The programme of work has now been completed.

It should be noted that there is now a requirement for a significant amount of work to be completed by the new Directorate teams and within localities, to ensure our resources are structured in the most optimal manner to support the 10 localities across our geographical footprint and to ensure we are using our available resources in the most efficient manner possible.

8. Recommendations

The Trust Board is asked to:

- Receive the report.
- Note completion of Phases 1-3 of the Trust restructure.
- Receive a further update on progress and activities within the new structure in November 2018.

North Staffordshire Combined Healthcare NHS Trust

REPORT TO Open Trust Board

Enclosure No:20

Date of Meeting:	25 October 2018		
Title of Report:	Trust Board / Committee Dates and Cycle of Business 2018/19 and 2019/20		
Presented by:	Laurie Wrench, Associate Director of Governance		
Author:	Lisa Wilkinson, Corporate Governance Manager		
Executive Lead Name:	Caroline Donovan, Chief Executive Officer	Approved by Exec	☒

Executive Summary:		Purpose of report	
The paper provides an update of Trust Board / Committee Meetings and the Trust Board Cycle of Business for the remainder of 2018/19 and provides new dates and the Cycle of Business for the next financial year 2019/20.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐	Date:	
	Execs ☒	Date:8th October 2018	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☒ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. ☐ 2. To provide the highest quality services. ☒ 3. Create a learning culture to continually improve. ☐ 4. Encourage, inspire and implement research & innovation at all levels. ☐ 5. Maximise and use our resources intelligently and efficiently. ☒ 6. Attract and inspire the best people to work here. ☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	None identified		
Resource Implications: Funding Source:	None identified		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	No issues with regards to protected characteristics have been identified		
Recommendations:	For information and assurance		
STP Alignment / Implications:	None		

Version	Name/group	Date issued
1	Execs	17/07/18
2	Execs	25/09/18
3	Execs	08/10/18

Committee and Board Overview Chart 2018

	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T
Jan 18	1 Bank hol	2 Perf	3	4 FPP BDCP	5	6	7	8 PDCP	9 Exec	10	11 F&P BDC	12	13	14	15 PCD	16 SLT	17 BOD TBP	18 TBPM	19	20	21	22 Day 15	23 Exec	24	25 TB Remco	26	27	28	29	30 Perf	31							
Feb				1 FPP QCP	2	3	4	5	6 Exec	7	8 F&P QC	9	10	11	12	13 SLT	14 TBP	15 TBPM	16	17	18	19	20 Exec	21 Day 15	22 TB ACP	23	24	25	26	27 Perf	28							
March				1 AC FPP BDCP	2	3	4	5 PCDP	6 Exec	7	8 F&P BDC	9	10	11	12 PCD	13 SLT	14 BOD TBP	15 TBPM	16 TBP	17	18	19	20 Exec	21 Day 15	22 TB	23	24	25	26	27 Perf	28	29 FPP QCP	30	31				
April							1	2 Bank Hol	3 Exec	4	5 F&P QC	6	7	8	9	10 SLT	11 TBP	12 TBPM	13	14	15	16 ACP	17 Exec	18 TB Remco	19	20	21	22	23 Day 15 AC	24 Exec time out	25	26	27	28	29	30	
May		1 Perf	2	3 FPP BDCP	4 PCDP	5	6	7 Bank Hol	8 Exec PCDP	9	10 F&P BDC	11	12	13	14 PCD	15 SLT	16 TBP	17 TBPM	18 ACP	19	20	21	22 Day 15 Exec	23	24 TB	25 AC	26	27	28 Bank Hol	29 Perf	30	31 BOD FPP QCP						
June					1	2	3	4	5 Exec	6	7 F&P QC	8	9	10	11	12 SLT	13 TBP	14 TBPM	15	16	17	18	19 Exec	20	21 Day 15 TB	22	23	24	25	26 Perf	27	28 FPP BDCP	29	30				
July							1	2 PCDP	3 Exec	4	5 F&P BDC	6	7	8	9 PCD	10 SLT	11 TBP	12 TBPM	13	14	15	16	17 Exec	18	19	20 Day 15 BOD	21	22	23	24 Execs	25	26 TB	27 FP P	28	29	30	31 Perf
Aug			1	2 QCP	3 F&P	4	5	6	7 Exec	8	9 QC	1	11	12	13	14 SLT	15	16	17	18	19	20	21 Day 15 Exec	22	23	24	25	26	27 Bank Hol	28 Perf	29	30 FPP BDCP ACP	31					
Sept						1	2	3 PCDP	4 Exec	5	6 AC F&P BDC	7	8	9	10 PCD	11 SLT	12 TBP	13 TBP M	14	15	16	17	18 Exec Time out	19	20 QCP	21 Day 15	22	23	24	25 Exec	26 TB	27 QC	28	29	30		
Oct	1	2 Perf	3	4 FPP	5	6	7	8	9 Exec	10	11 F&P	12	13	14	15	16 SLT	17 TBP	18 TBP M	19 Day 15	20	21	22	23 BOD	24	25 TB QCP	26	27	28	29	30 Perf	31							
Nov				1 FPP BDCP	2 QC	3	4	5 PCDP	6 Exec BOD	7	8 F&P BDC	9	10	11	12 PCD	13 SLT	14 TBP	15 TBP M	16	17	18	19	20 Exec	21 Day 15	22 TB	23	24	25	26	27 Perf	28 BOD	29 FPP ACP	30					
Dec						1	2	3	4 Exec	5	6 AC F&P	7	8	9	10	11 SLT	12	13	14	15	16	17	18 Exec	19	20	21 Day 15	22	23	24	25 Bank hol	26 Bank hol	27	28	29	30	31	
Jan 19		1 Bank Hol	2 Perf	3 FPP QCP	4	5	6	7 PCDP	8 Exec	9	10 F&P QC	11	12	13	14 PCD	15 SLT	16 TBP HCTB	17	18 TBPM	19	20	21	22 Day 15 Exec Time out	23	24 TB Remco	25	26	27	28	29 Perf	30	31 BOD FPP						
Feb					1	2	3	4	5 Exec	6	7 F&P BDC	8	9	10	11	12 SLT	13	14	15	16	17	18	19 Exec	20	21 Day 15 TBP HCTB	22 TBPM	23	24	25	26 Perf	27	28 TB FPP QCP ACP						
March					1	2	3	4 PCDP	5 Exec	6	7 AC F&P QC	8	9	10	11 PCD	12 SLT	13	14 BOD	15	16	17	18	19 Exec	20 TBP	21 Day 15 TBPM HCTB	22	23	24	25	26 Perf	27	28 TB QCP FPDP BDCP ACP	29	30	31			

Version 8

Committee and Board Overview Chart 2018

Key: dates in **red** are key holiday periods

15th Working Day
TB – Trust Board
PCD – People and Culture
PCDP – PCD papers deadline
Performance meeting
TBP – Trust Board Papers due
QC – Quality Committee
QCP – QC paper deadline
Execs
TBPM – Trust Board Pre meet
F&P – Finance and Performance
F&PP – F&P paper deadline
SLT
BOD – Board Development
BDC – Business and Development
BDCP – BDC papers deadline
REMCO – Remuneration Committee
AC – Audit Committee

Audit Committee 9am to 11am
Finance & Performance Committee 11am to 1pm
Business Development Committee 2pm to 4pm
Quality Committee 2pm to 5pm
People & Culture Development Committee 9.30am to 12.30pm
Trust Board 10am to 4pm
Board Development 10am to 4pm

Open and Closed Trust Board Meetings	Lead	18 April Board	24 May Board	21 June Board	20 July Board	26 September Board	25 October Board	22 November Board	24 January Board	21 February Board	21 March Board
Standing Items											
Chairs Report	Chairman	x	x	x	x	x	x	x	x	x	x
Chief Executive's Report	Chief Executive	x	x	x	x	x	x	x	x	x	x
NHSI PRM Meeting (Bi monthly)	Chief Executive	x		x		x	x		x	x	
Patient Story/ Clinical presentation	Director of Nursing and Quality	x		x		x		x		x	
REACH Recognition Individual Award	Corporate Governance Manager			x		x		x		x	
REACH Recognition Team Award	Corporate Governance Manager	x	x		x		x		x		x
Service User and Carer Council Update	Director of Nursing and Quality	x	x	x	x	x	x	x	x	x	x
Staff Retirements	Corporate Governance Manager	x	x	x	x	x	x	x	x	x	x
Cyber Security	Director of Finance Performance and Digital						x				
Quality & Governance Committee											
Annual Declaration of Emergency Preparedness (EPRR)	Director of Operations					x					
Annual Restraint and Seclusion Report							x				
CQC - Compliance Review reports (when received)	Director of Nursing and Quality						x				
CQC Mental Health Community Survey Report / Action Plan	Director of Operations	x									
Complaints / PALS Annual Report	Director of Nursing and Quality					x					
DIPC Quarterly Report	Director of Nursing and Quality	x (Q4)				x (Q1)	x (Q2)			x (Q3)	
Eliminating Mixed Sex Accomodation Annual Declaration of Compliance	Director of Nursing and Quality	x									
Fire Annual Safety Report	Director of Operations						x				
H & S Annual Report	Director of Nursing and Quality				x						
Infection Prevention and Control Annual report	Director of Nursing and Quality				x						
Learning From Deaths Quarterly Report (Mortality Surveillance)	Executive Medical Director		x (Q4)			x (Q1)		x (Q2)		x (Q3)	
MHA Compliance Action Plan Quarterly Report	Executive Medical Director		x (Q4)			x (Q1)		x (Q2)		x (Q3)	
Nurse Staffing 6 month Progress Report	Director of Nursing and Quality		x			x		x			
Nurse Staffing Monthly Report	Director of Nursing and Quality	x	x	x	x	x	x	x	x	x	x
Quality & Governance Committee Assurance Report	Associate Director of MACE	x	x	x	x	x	x	x	x	x	x
Quality & Governance Committee Review of TOR	Assocaite Director of MACE										x
Quality Account (Progress update and final submission June)	Executive Medical Director			x						x (project plan)	
Quality Strategy (as required)	Director of Nursing and Quality and Executive Medical Director					x					
Report on Board clinical / unanounced visits Q1, Q2, Q3, Q4 (Closed)	Director of Nursing and Quality	x (Q4)				x (Q1)		x (Q2)		x (Q3)	
Research and Development Committee Effectiveness Annually	Executive Medical Director				x						
Research and Development Quartley Report	Executive Medical Director	x (Q4)				x (Q1)		x (Q2)			
Safeguarding Annual Report	Director of Nursing and Quality					x					
Serious Incident Monthly Update (Closed)	Executive Medical Director	x	x	x	x	x	x	x	x	x	x
Serious Incident Quarterly Report	Executive Medical Director	x (Q4)			x (Q1)		x (Q2)		x (Q3)		
Serious Incidents Annual Report	Executive Medical Director			x							
Smoke Free Quarterly Report	Executive Medical Director		x (Q4)			x (Q1)		x (Q2)		x (Q3)	
Workforce											
Assurance Report from People and Culture Committee	Associate Director of HR		x								
Being Open Report Closed)	Director of Workforce & OD		x			x			x		
Diversity and Inclusion Action Plan	Director of Workforce & OD						x				
Equality and Diversity Annnual Plan	Director of Workforce & OD				x						
EDS2	Director of Workforce & OD					x					
Freedom To Speak Up Annual Report	Chief Executive Officer		x								
Medical Recruitment and Retention	Executive Medical Director										x
Medical Revalidation Annual Organisational (AOA) Report	Executive Medical Director					x					
Go Engage Quarterly Report	Director of Workforce & OD		x			x			x		
OD and Development and People Strategy	Director of Workforce & OD				x						
People and Culture Committee Annual Review of ToR	Director of Workforce & OD		x								
Staff Survey Results	Director of Workforce & OD					x					
Staff Survery Update	Director of Workforce & OD							x			
Towards Outstanding Engagement Annual Report	Director of Workforce & OD		x								
Workforce Plan (Closed)	Director of Workforce & OD				x			x			x
World Mental Health Day	Associate Director of Communications				x						
WRES Annual Report and Action Plan	Director of Workforce & OD					x					
Finance Performance & Digital Committee											
Charitable Funds Summary	Deputy Director of Finance								x		
Charitable Funds TOR	Deputy Director of Finance						x		x		
Commissioning Intentions	Director of Finance, Performance & Digital							x	x		

Finance and Budget Plan	Director of Finance, Performance & Digital										x
Finance Report	Director of Finance, Performance & Digital	x	x	x	x	x	x	x	x	x	x
Finance, Performance & Digital Assurance Report	Director of Finance, Performance & Digital	x	x	x	x	x	x	x	x	x	x
FPD Annual Review of ToR	Deputy Director of Finance					x					
FPD Assurance Report	Director of Finance, Performance & Digital	x	x	x	x	x	x	x	x	x	x
IG Toolkit Annual Declaration	Director of Finance, Performance & Digital	x									
PQMF Report - (Open) PQMF Trust Measures (Closed)	Director of Finance, Performance & Digital	x	x	x	x	x	x	x	x	x	x
Remuneration Committee Annual Report / TOR	Director of Finance, Performance & Digital	x									
Audit Committee	Director of Finance, Performance & Digital										
YTD Utilisation Report (Agency)	Director of Finance, Performance & Digital	x	x	x	x	x	x	x	x	x	x
Audit Committee											
Annual Accounts	Director of Finance, Performance & Digital		x								
Annual Governance Statement	Associate Director of Governance		x								
Annual Report & Summary Financial Statements	Director of Finance, Performance & Digital		x								
Annual Statement of Purpose	Associate Director of Governance										
Audit Committee Assurance Report	Associate Director of Governance	x	x	x					x		
Audit Committee TOR	Associate Director of Governance					x					
Charitable Funds Annual Accounts & Report	Director of Finance, Performance & Digital								x		
Declaration of Interests- Board Members	Associate Director of Governance					x					x
External Audit Annual Plan	Director of Finance, Performance & Digital										x
External Audit Report	Director of Finance, Performance & Digital										x
Gifts and Hospitality / Sponsorship Annual	Associate Director of Governance								x		
Internal Audit Annual Plan	Director of Finance, Performance & Digital										x
LCFS Annual Report	Director of Finance, Performance & Digital					x			x		
Risk Management Strategy & Policy	Associate Director of Governance					x					
Self Assessment	Associate Director of Governance					x					
Self Certification G6 & FT4	Associate Director of Governance	x									
Standing Financial Instructions (as required)	Director of Finance, Performance & Digital										
Standing Orders Annual (as requiired)	Director of Finance, Performance & Digital										
Governance											
Annual Governance Statement	Associate Director of Governance		x								
Board & Committee meeting dates	Associate Director of Governance						x				
Board Assurance Annual Report	Associate Director of Governance	x									
Board Assurance Framework Q1, Q2, Q3, Q4	Associate Director of Governance		x (Q4)			x (Q1)		x (Q2)		x (Q3)	
Board review of its cycle of business and TOR	Associate Director of Governance						x				
Board review of its effectiveness	Associate Director of Governance		x								
Register of Sealed Documents	Associate Director of Governance								x		
Scheme of Delegation (as required)	Associate Director of Governance										
Business and Strategy											
Assurance Report from BDC (Closed)	Joint Director of Strategy and Development	x	x	x	x	x	x	x	x	x	x
BDC Annual Review of TOR	Joint Director of Strategy and Development								x		
One Year Operational Plan to be submiited to NHSI mid April (Closed)	Joint Director of Strategy and Development		x								
Northern Alliance / Trust Strategy Alignment Quarterly Report	Joint Director of Strategy and Development		x (Q4)			x (Q1)		x (Q2)		x (Q3)	
Primary Care Integration Programme Board											
Assurance Report	Joint Director of Strategy and Development	x	x	x	x	x	x	x	x	x	x
Review of TOR	Joint Director of Strategy and Development										x

Committee and Board Overview Chart 2019-2020

	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T
Jan 19		1 Bank Hol	2 Perf	3 FPP QCP	4	5	6	7 PCDP	8 Exec	9	10 F&P QC	11	12	13	14 PCD	15 SLT	16	17 TBP HCTB	18 TBPM	19	20	21	22 Day 15 Exec time out	23	24 TB Remco	25	26	27	28	29 Perf	30	31 BOD FFP BDCP					
Feb					1	2	3	4	5 Exec	6	7 F&P BDC	8	9	10	11	12 SLT	13	14	15	16	17	18	19 Exec	20 TBP	21 Day 15 TBPM HCTB	2	23	24	25	26 Perf	27	28 TB ACP/FPP QCP					
March					1	2	3	4 PCDP	5 Exec	6	7 AC F&P QC	8	9	10	11 PCD	12 SLT	13	14 BOD	15	16	17	18	19 Exec	20 TBP	21 Day 15 TBPM HCTB	22	23	24	25	26 Perf	27	28 TB	29	30	31		
April	1	2 Exec time out	3	4 FPP BDCP	5	6	7	8	9 Exec	10	11 F&P BDC	12	13	14	15	16 SLT	17 TBP	18 HCTB ACP TBPM	19 Bank Hol	20	21	22 Bank Hol	23 Day 15 Execs	24	25 TB	26 AC	27	28	29	30 Perf							
May			1	2 FPP QCP	3	4	5	6 Bank Hol	9 Exec PCDP	8	9 F&P QC	10	11	12	13 PCD	14 SLT	15 TBP	16 HCTB BOD	17 ACP TBPM	18	19	20	21 Exec	22 Day 15	23 TB	24 AC	25	26	27 Bank Hol	28 Perf	29	30 FPP BDCP CFP	31				
June						1	2	3	4 Exec	5	6 CF F&P BDC	7	8	9	10	11 SLT	12	13	14	15	16	17	18 Exec	19 TBP	20 HCTB TBPM	21 Day 15	22	23	24	25 Exec time out	26	27 TB	28	29	30		
July	1	2 Perf	3	4 FPP QCP	5	6	7	8 PCDP	9 Exec	10	11 F&P QC	12	13	14	15 PCD	16 SLT	17 TBP	18 HCTB TBPM	19 Day 15	20	21	22	23 Exec	24	25 TB	26	27	28	29	30 Perf	31							
Aug				1 BOD FPP BDCP	2	3	4	5	6 Exec	7	8 F&P BDC	9	10	11	12	13 SLT	14	15 HCTB	16	17	18	19	20 Exec	21 Day 15	22	23	24	25	26 Bank Hol	27 Perf	28	29 ACP FPP QCP	30	31			
Sept							1	2 PCDP	3 Exec	4	5 AC F&P QC	6	7	8	9 PCD	10 SLT	11	12 BOD	13	14	15	16	17 Exec	18 TBP	19 HCTB	20 Day 15 TBPM	21	22	23	24 Exec time out	25	26 TB	27	28	29	30	
Oct		1 Perf	2	3 FPP BDCP	4	5	6	7	8 Exec	9	10 F&P BDC	11	12	13	14	15 SLT	16 TBP	17 HCTB TBPM	18	19	20	21 Day 15	22 Exec	23	24 TB	25	26	27	28	29 Perf	30	31 FPP QCP CFP					
Nov					1	2	3	4 PCDP	5 Exec	6	7 CF F&P QC	8	9	10	11 PCD	12 SLT	13	14 BOD	15	16	17	18	19 Exec	20 TBP	21 Day 15 HCTB	22 TBPM	23	24	25	26 Perf	27	28 TB ACP/FPP BDCP	29	30			
Dec							1	2	3 Exec	4	5 AC F&P BDC	6	7	8	9	10 SLT	11	12	13	14	15	16	17 Exec	18	19 HCTB	20 Day 15	21	22	23	24	25 Bank Hol	26 Bank Hol	27	28	29	30	31
Jan 20			1 Bank hol	2 Perf FPP QCP	3	4	5	6 PCDP	7 Exec	8	9 F&P QC	10	11	12	13 PCD	14 SLT	15 TBP	16 HCTB	17 TBPM	18	19	20	21 Exec	22 Day 15	23 TB	24	25	26	27	28 Perf	29	30 BOD FPP BDCP	31				
Feb						1	2	3	4 Exec	5	6 F&P BDC	7	8	9	10	11 SLT	12	13	14	15	16	17	18 Exec	19 TBP	20 HCTB TBPM	21 Day 15	22	23	24	25 Perf	26	27 TB ACP/FPP QCP	28	29			
March							1	2 PCDP	3 Exec	4	5 AC F&P QC	6	7	8	9 PCD	10 SLT	11	12 BOD	13	14	15	16	17 Exec	18 TBP	19 HCTB	20 Day 15 TBPM	21	22	23	24 Exec time out	25	26 TB	27	28	29	30	31 Perf

Committee and Board Overview Chart 2019-2020

Key: dates in **red** are key holiday periods

15th Working Day
TB – Trust Board
PCD – People and Culture
PCDP – PCD papers deadline
Performance meeting
TBP – Trust Board Papers due
QC – Quality Committee
QCP – QC paper deadline
Execs
TBPM – Trust Board Pre meet
F&P – Finance and Performance
F&PP – F&P paper deadline
SLT
BOD – Board Development
BDC – Business and Development
BDCP – BDC papers deadline
Charitable funds committee
REMCO – Remuneration Committee
AC – Audit Committee

Audit Committee 9am to 11am
Charitable Funds committee 9am to 11am
Finance & Performance Committee 11am to 1pm
Business Development Committee 2pm to 4pm
Quality Committee 2pm to 5pm
People & Culture Development Committee 9.30am to 12.30pm
Trust Board 10am to 4pm
Board Development 10am to 4pm

Open and Closed Trust Board Meetings	Lead	25 April Board	23 May Board	27 June Board	25 July Board	26 September Board	24 October Board	28 November Board	23 January Board	27 February Board	26 March Board
Standing Items											
Chairs Report	Chairman	x	x	x	x	x	x	x	x	x	x
Chief Executive's Report	Chief Executive	x	x	x	x	x	x	x	x	x	x
NHSI PRM Meeting (Bi monthly)	Chief Executive	x		x		x	x		x	x	
Patient Story/ Clinical presentation	Director of Nursing and Quality	x		x		x		x		x	
REACH Recognition Individual Award	Corporate Governance Manager			x		x		x		x	
REACH Recognition Team Award	Corporate Governance Manager	x	x		x		x		x		x
Service User and Carer Council Update	Director of Nursing and Quality	x	x	x	x	x	x	x	x	x	x
Staff Retirements	Corporate Governance Manager	x	x	x	x	x	x	x	x	x	x
Cyber Security	Director of Finance Performance and Digital						x				
Quality & Governance Committee											
Annual Declaration of Emergency Preparedness (EPRR)	Director of Operations					x					
Annual Restraint and Seclusion Report	Director of Nursing and Quality						x				
CQC - Compliance Review reports (when received)	Director of Nursing and Quality						x				
CQC Mental Health Community Survey Report / Action Plan	Director of Operations	x									
Complaints / PALS Annual Report	Director of Nursing and Quality					x					
DIPC Quarterly Report	Director of Nursing and Quality	x (Q4)				x (Q1)	x (Q2)			x (Q3)	
Eliminating Mixed Sex Accomodation Annual Declaration of Compliance	Director of Nursing and Quality	x									
Fire Annual Safety Report	Director of Operations						x				
H & S Annual Report	Director of Nursing and Quality				x						
Infection Prevention and Control Annual report	Director of Nursing and Quality				x						
Learning From Deaths Quarterly Report (Mortality Surveillance)	Executive Medical Director		x (Q4)			x (Q1)		x (Q2)		x (Q3)	
MHA Compliance Action Plan Quarterly Report	Executive Medical Director		x (Q4)			x (Q1)		x (Q2)		x (Q3)	
Nurse Staffing 6 Month Progress Report	Director of Nursing and Quality		x			x		x			
Nurse Staffing Monthly Report	Director of Nursing and Quality	x	x	x	x	x	x	x	x	x	x
Quality & Governance Committee Assurance Report	Associate Director of MACE	x	x	x	x	x	x	x	x	x	x
Quality & Governance Committee Review of TOR	Assocaite Director of MACE										x
Quality Account (Progress update and final submission June)	Executive Medical Director			x						x (project plan)	
Quality Strategy (as required)	Director of Nursing and Quality and Executive Medical Director					x					
Report on Board clinical / unanounced visits Q1, Q2, Q3, Q4	Director of Nursing and Quality	x (Q4)				x (Q1)		x (Q2)		x (Q3)	
Research and Development Committee Effectiveness Annually	Executive Medical Director				x						
Research and Development Quartley Report	Executive Medical Director	x (Q4)				x (Q1)		x (Q2)			
Safeguarding Annual Report	Director of Nursing and Quality					x					
Serious Incident Monthly Update (Closed)	Executive Medical Director	x	x	x	x	x	x	x	x	x	x
Serious Incident Quarterly Report	Executive Medical Director	x (Q4)			x (Q1)		x (Q2)		x (Q3)		
Serious Incidents Annual Report	Executive Medical Director			x							
Smoke Free Quarterly Report	Executive Medical Director		x (Q4)			x (Q1)		x (Q2)		x (Q3)	
Workforce											
Assurance Report from People and Culture Committee	Associate Director of HR		x								
Being Open Report Closed)	Director of Workforce & OD		x			x			x		
Diversity and Inclusion Action Plan	Director of Workforce & OD						x				
Equality and Diversity Annnual Plan	Director of Workforce & OD				x						
EDS2	Director of Workforce & OD					x					
Freedom To Speak Up Annual Report	Chief Executive Officer		x								
Medical Recruitment and Retention	Executive Medical Director										x
Medical Revalidation Annual Organisational (AOA) Report	Executive Medical Director					x					
Go Engage Quarterly Report	Director of Workforce & OD		x			x			x		
OD and Development and People Strategy	Director of Workforce & OD				x						
People and Culture Committee Annual Review of ToR	Director of Workforce & OD		x								
Staff Survey Results	Director of Workforce & OD					x					
Staff Survery Update	Director of Workforce & OD							x			
Towards Outstanding Engagement Annual Report	Director of Workforce & OD		x								
Workforce Plan (Closed)	Director of Workforce & OD				x			x			x
World Mental Health Day	Associate Director of Commuications				x						
WRES Annual Report and Action Plan	Director of Workforce & OD					x					
Finance Performance & Digital Committee											
Charitable Funds Summary	Deputy Director of Finance			x				x			
Charitable Funds TOR	Deputy Director of Finance						x		x		
Commissioning Intentions	Director of Finance, Performance & Digital							x	x		
Finance and Budget Plan	Director of Finance, Performance & Digital										x
Finance Report	Director of Finance, Performance & Digital	x	x	x	x	x	x	x	x	x	x

Finance, Performance & Digital Assurance Report	Director of Finance, Performance & Digital	x	x	x	x	x	x	x	x	x	x
FPD Annual Review of ToR	Deputy Director of Finance					x					
FPD Assurance Report	Director of Finance, Performance & Digital	x	x	x	x	x	x	x	x	x	x
IG Toolkit Annual Declaration	Director of Finance, Performance & Digital	x									
PQMF Report - (Open) PQMF Trust Measures (Closed)	Director of Finance, Performance & Digital	x	x	x	x	x	x	x	x	x	x
Remuneration Committee Annual Report / TOR	Director of Finance, Performance & Digital	x									
Audit Committee	Director of Finance, Performance & Digital										
YTD Utilisation Report (Agency)	Director of Finance, Performance & Digital	x	x	x	x	x	x	x	x	x	x
Audit Committee											
Annual Accounts	Director of Finance, Performance & Digital		x								
Annual Governance Statement	Associate Director of Governance		x								
Annual Report & Summary Financial Statements	Director of Finance, Performance & Digital		x								
Annual Statement of Purpose	Associate Director of Governance										
Audit Committee Assurance Report	Associate Director of Governance	x	x	x					x		
Audit Committee TOR	Associate Director of Governance					x					
Charitable Funds Annual Accounts & Report	Director of Finance, Performance & Digital								x		
Declaration of Interests- Board Members	Associate Director of Governance					x					x
External Audit Annual Plan	Director of Finance, Performance & Digital										x
External Audit Report	Director of Finance, Performance & Digital										x
Gifts and Hospitality / Sponsorship Annual	Associate Director of Governance								x		
Internal Audit Annual Plan	Director of Finance, Performance & Digital										x
LCFS Annual Report	Director of Finance, Performance & Digital					x			x		
Risk Management Strategy & Policy	Associate Director of Governance					x					
Self Assessment	Associate Director of Governance					x					
Self Certification G6 & FT4	Associate Director of Governance	x									
Standing Financial Instructions (as required)	Director of Finance, Performance & Digital										
Standing Orders Annual (as requiired)	Director of Finance, Performance & Digital										
Governance											
Annual Governance Statement	Associate Director of Governance		x								
Board & Committee meeting dates	Associate Director of Governance						x				
Board Assurance Annual Report	Associate Director of Governance	x									
Board Assurance Framework Q1, Q2, Q3, Q4	Associate Director of Governance		x (Q4)			x (Q1)		x (Q2)		x (Q3)	
Board review of its cycle of business and TOR	Associate Director of Governance						x				
Board review of its effectiveness	Associate Director of Governance		x								
Register of Sealed Documents	Associate Director of Governance								x		
Scheme of Delegation (as required)	Associate Director of Governance										
Business and Strategy											
Assurance Report from BDC (Closed)	Joint Director of Strategy and Development	x	x	x	x	x	x	x	x	x	x
BDC Annual Review of TOR	Joint Director of Strategy and Development								x		
One Year Operational Plan to be submiited to NHSI mid April (Closed)	Joint Director of Strategy and Development		x								
Northern Alliance / Trust Strategy Alignment Quarterly Report	Joint Director of Strategy and Development		x (Q4)			x (Q1)		x (Q2)		x (Q3)	
Primary Care Integration Programme Board											
Assurance Report	Joint Director of Strategy and Development	x	x	x	x	x	x	x	x	x	x
Review of TOR	Joint Director of Strategy and Development										x