North Staffordshire Combined Healthcare NHS
NHS Trust

MEETING OF THE TRUST BOARD

TO BE HELD IN PUBLIC ON THURSDAY 29 OCTOBER 2015, 10:00AM, BOARDROOM, LAWTON HOUSE, TRUST HEADQUARTERS, BELLRINGER ROAD, TRENTHAM LAKES SOUTH, STOKE ON TRENT, ST4 8HH

	AGENDA	
1.	**APOLOGIES FOR ABSENCE** *To NOTE any apologies for absence*	Note
2.	**DECLARATION OF INTEREST RELATING TO AGENDA ITEMS**	Note
3.	**DECLARATIONS OF INTERESTS RELATING TO ANY OTHER BUSINESS**	Note
4.	**MINUTES OF THE OPEN AGENDA – 24 SEPTEMBER2015** *To APPROVE the minutes of the meeting held on 24 September 2015*	Approve Enclosure 1
5.	**ACTION MONITORING SCHEDULE & MATTERS ARISING FROM THE MINUTES** *To CONSIDER any matters arising from the minutes*	Note Enclosure 2
6.	**CHAIR'S REPORT** *To RECEIVE a verbal report from the Chair*	Note
7.	**CHIEF EXECUTIVE'S REPORT** *To RECEIVE a report from Mrs. C Donovan, Chief Executive*	Note Enclosure 3
	FOCUSING ON QUALITY AND SAFETY AND BEING AN EMPLOYER OF CHOICE	
8.	**SPOTLIGHT ON EXCELLENCE** *To PRESENT the Spotlight on Excellence Team and Individual Awards to staff* *To be introduced by the Chief Executive and presented by the Chair*	Verbal
9.	**PRESENTATION FROM ADMH INPATIENT DIRECTORATE** *Presentation from Dr Xenofon Sgouros, Clinical Director, ADMH Inpatient*	Verbal
10.	**STAFF RETIREMENTS** *To EXPRESS our gratitude and recognise staff who are retiring.* *To be introduced and presented by the Chair*	Verbal

11.	**QUALITY COMMITTEE REPORT** *To RECEIVE the Quality Committee assurance report from the meeting held on 20 October 2015 from Mr. P Sullivan, Chair of the Quality Committee*	Assurance Enclosure 4
12.	**NURSE STAFFING MONTHLY REPORT – September2015** *To RECEIVE for information and assurance report on the planned versus actual staff variances from Ms. C Sylvester, Acting Director of Nursing & Quality*	Assurance Enclosure 5
13.	**BOARD ASSURANCE FRAMEWORK - QUARTER 2** *To RECEIVE the Board Assurance Framework Q2 Updates from Ms L Wrench, Associate Director of Governance*	Assurance Enclosure 6
14.	**FEEDBACK FROM THE TRUST DEVELOPMENT AGENCY SURVEILLANCE GROUP** *To RECEIVE for assurance the summary of the outcome from the Quality Surveillance Group from Mrs. C Donovan, Chief Executive*	Assurance Enclosure 7
	DELIVERING OUR FINANCIAL PLAN AND ENSURING GOOD GOVERNANCE	
15.	**FINANCE REPORT – Month 6 (2015/16)** *To RECEIVE for discussion the month 6 financial position from Ms. A Harrison, Interim Director of Finance*	Assurance Enclosure 8
16.	**ASSURANCE REPORT FROM THE FINANCE & PERFORMANCE COMMITTEE CHAIR** *To RECEIVE the Finance & Performance Committee Assurance report from the Committee Chair, Mr. T Gadsby from the meeting held on 22 October 2015*	Assurance Enclosure 9
	CONSISTENTLY MEETING STANDARDS	
17.	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 6** *To RECEIVE the month 6 Performance Report from Ms. A Harrison, Interim Director of Finance*	Assurance Enclosure 10
18.	**SELF CERTIFICATIONS FOR THE NHS TRUST DEVELOPMENT AGENCY** *To APPROVE the Self Certifications for the TDA from Ms. A Harrison, Interim Director of Finance*	Assurance Enclosure 11
19.	**ESTATES COMPLIANCE ASSURANCE REPORT** *To RECEIVE the Estates Compliance Assurance Report for assurance purposes from Mr A Rogers, Operations Director*	Assurance Enclosure 12
20.	**WHOLE SYSTEMS LEADERSHIP (HEATLH & WELLBEING STOKE)** *To RECEIVE the Whole Systems Leadership (Health & Wellbeing Stoke) paper for information purposes from Mr T Thornber, Director of Strategy & Development*	Information Enclosure 13

	BEING AN EMPLOYER OF CHOICE, DEVELOPING ACADEMIC PARTNERSHIPS AND EDUCATION AND TRAINING INITIATIVES	
21.	**PEOPLE AND CULTURE DEVELOPMENT COMMITTEE REPORT** *To RECEIVE the People and Culture Development Committee assurance report from the meeting held on the 19 October 2015 meeting from Mr. P. O'Hagan, Committee Chair*	Assurance Enclosure 14
22.	**To *DISCUSS* Any Other Business**	
	QUESTIONS FROM MEMBERS OF THE PUBLIC	
23.	*To ANSWER questions from the public on items listed on the agenda*	
	DATE AND TIME OF THE NEXT MEETING	
	The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday 25 November 2015 at 10:00am.	
24.	**MOTION TO EXCLUDE THE PUBLIC** *To APPROVE the resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admissions to Meetings) Act 1960)*	
	THE REMAINDER OF THE MEETING WILL BE IN PRIVATE	

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

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

TRUST BOARD

Minutes of the open section of the North Staffordshire Combined Healthcare NHS Trust Board meeting held on Thursday, 24 September 2015 At 10:00am in the Boardroom, Trust Headquarters, Lawton House Bellringer Road, Trentham, Stoke on Trent, ST4 8HH

Present:

Chairman:

Mr K Jarrold
Chairman

Directors:

Mrs C Donovan
Chief Executive

Dr B Adeyemo
Medical Director

Ms A Harrison
Interim Director of Finance

Mr T Gadsby
Non-Executive Director

Mr P O'Hagan
Vice Chairman

Mr P Sullivan
Non-Executive Director

Mr P Draycott
Director of Leadership &Workforce

Ms C Sylvester
Acting Director of Nursing

Mr D Rogers
Non-Executive Director

Mr A Rogers
Director of Operations

Dr K Tattum
GP Associate Member

In attendance:

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

Mrs L Wrench
Head of Clinical Audit/Research

Members of the public:
Hilda Johnson - North Staffs User Group

Mrs J Scotcher
Executive PA

Team Spotlight:
Jane Munton-Davies,
Head of Directorate NOAP
Darryl Gwinnett
Wendy Thorley
City Community MH Team NOAP

Ms J Harvey
UNISON

Individual spotlight
David Manley – Senior OT CAMHS Disability Team
Kath Clark, Head of Directorate CAMHS

The meeting commenced at 10:00am.

128/2015	**Apologies for Absence** Apologies were received from Dr Laws, GP Associate member. The Chair gave a warm welcome to Mr Thornber, Director of Strategy and Development and Ms Sylvester, Acting Director of Nursing and Quality.	**Action**

	The Chair further noted that sadly this is the final meeting for Mrs Storey in her role as Trust Board Secretary/Head of Corporate and Legal Affairs; however he was delighted to note that she will be taking up a new post as Associate Director of Medical and Clinical Effectiveness (MACE). He thanked Mrs Storey on behalf of the Trust Board for all her hard work and support. The Chair gave a further warm welcome to Mrs Wrench, in her new role as the new Associate Director of Governance.	
129/2015	**Declaration of Interest relating to agenda items** There were no declarations of interest relating to agenda items.	
130/2015	**Declarations of interest relating to any other business** There were no declarations of interest.	
131/2015	**Minutes of the Open Agenda – 30 July 2015** The minutes of the open session of the meeting held on 30 July 2015 were approved as a correct record	
132/2015	**Matters arising** The Board reviewed the action monitoring schedule and agreed the following:- **08/2015 - Priority Referral Team - CYP Directorate -** Mrs Donovan queried what was the impact from changes at Stafford on the Trust. Dr Barton stated that statistics were available from when Stafford closed A&E services. It was noted that we need to transparency for commissioners; Mr A Rogers to take forward to provide more information to the Board. ***Mr Rogers commented that this issue is slightly wider than the Priority Referral Team, it is in relation to Mid staffs activity transferring to Stoke. Ms Harrison has started to underpin this piece of work, this can be closed off for now – remove from schedule.*** ***86/2015 – Spotlight – Moorlands Community MH Team based at Ashcombe/Brandon –*** Mr A Rogers stated that other locations have been identified and the aim is to move somewhere in Leek, but not pursued due to other issues and this was being progressed under the Estates rationalisation of the Trust.	

	Part of rationalisation plan – update on progress in October 2015. The Chair noted that although this is a pleasant location it is not best placed for service users. Mrs B Johnson also queried whether Dragon Square provision in Staffordshire Moorlands would be reviewed. Mr Rogers gave assurance that this will fundamentally be a review of the whole Estates Strategy and all areas will be considered in relation to team's accessibility.	**Mr A Rogers**
	86/2015 – Spotlight – Moorlands Community MH Team based at Ashcombe/Brandon – Dr Carr commented on the rapid transformation that the team has been through with very little collateral damage. He further noted the strong relationships the team have with other organisations and suggested the Board use the team to evaluate and innovate new services. The Chair encouraged this and suggested further discussion to be held at PCD. ***On People and Culture Development Committee agenda – remove from schedule***	
	89/2015 - Safe staffing monthly report – Ms Harrison has also supported Mr Dinwiddy in this area. Each ward has been mathematically calculated taking into account a number of factors and a number of decisions about acuity. The third and final reiteration of the calculations will be shared with Mr Dinwiddy and Ward Managers. There may be some challenge and if necessary we can remodel, other factors which have been considered i.e. what does each bed cost, what ratio of staff, qualified to unqualified. The reallocation of budgets will be made accordingly ***On PCD – remove from schedule***	
	90/2015 – Safe Staffing six monthly report – Mr Sullivan also commented that in respect of incorporating ward managers into staffing levels; we must also be mindful of the time required for their management duties. Mr Dinwiddy to take forward with Mr Sullivan. ***Final agreement incorporating ward managers suggestions will be agreed by the Executive and the budget allocation will take place M6. It was further noted by Ms Sylvester that ward managers would have more clinical visibility (20%) as discussed with Mr Sullivan. A paper due to be submitted to SLT – remove from schedule***	
	104/2015 – HCSW Development programme – Ms Harvey also remarked on the importance of this and the good focus for Bands 1 – 4. She recalled a brilliant	

	scheme which was available to Trust employees some time ago 'Lifelong learning scheme' which gave funding to staff for a specific subject not necessarily relating to their role. – ***remove part of PCD***	
133/2015	**Chair's Report** The Chair noted that as he had previously mentioned at the AGM on Tuesday, this is a time of great challenge for the NHS. The Secretary of State, appearing before the Health Select Committee last week said that the financial pressure in the NHS is "the worst it's ever been in its history". Chris Ham, Chief Executive of the Kings Fund, one of the most respected commentators on the NHS, has argued that the NHS will need an emergency injection of funding this year to deal with forecast deficits perhaps amounting to £1billion. He goes on to say that "Honesty and realism, rather than panic and denial, are a better basis for deciding how much funding is needed and when it should be made available. Calm heads and clear thinking are needed now more than ever" The Chair also said at the AGM this week, that he has brought the news that the Cambridge Foundation Trust, one of the elite group of teaching hospitals, is being placed in special measures. This comes the week after the Secretary of State made it clear that CQC ratings have replaced Foundation Trust status as the "single definition of success for NHS providers". The analysis published by the Health Service Journal shows that 30 Foundation Trusts have been rated as requiring improvement while 11 non FTs have been rated as good. As the Board are aware we had our own CQC Inspection two weeks ago. He also remarked that he had said to the CQC at the beginning of the week, the report, when it comes, will be an opportunity for us to continue our journey of healing, recovery and renewal. We will celebrate the good practice identified and learn from whatever requires improvement. We need to learn and serve. Ms Harvey commented that a great number of Trusts have staffing level concerns. However, it is staff who should be praised and it is important to make sure the feedback is communicated to staff and not a criticism of staff on front line. ***Received***	
134/2015	**Chief Executive's Report** Mrs Donovan, Chief Executive, presented this report which provides an update on the activities undertaken since the last meeting in July 2015 and draws the Board's attention to any	

	other issues of significance or interest. **Quality Assurance** The CQC inspection took place on 7 – 11 September 2015. The inspection has continued during the last 2 weeks and is due to finish tomorrow. It is anticipated that we may still have an unannounced visit. It was further noted that there has been a large amount of information requests approximately over 500. All credit goes to the CQC team and all teams across the Trust who have been very responsive. The Trust is awaiting initial feedback; formal feedback will be presented at a Quality Summit in December 2015. **Appointments** The Board were made aware of the following appointments; Dr Hardeep Uppal, Consultant Psychiatrist in the LD Directorate, he also has an interest in digital technology and will be joining the Digital by Choice Group. Veronica Emlyn, Service User and Carer Engagement Lead Dr Swathi Theegala, Consultant Psychiatrist on Ward 3 Rob Cragg, Health Economy Director of Leadership and Transformation Tom Thornber, Director of Strategy and Development. Andy Oakes, currently Head of Directorate in Adult Community Services, is taking up a new role as Head of Partnerships and Social Care; Claire Holmes will act as Interim Head of Directorate from 28 September on temporary basis **Crisis Care Programme** This helps to reduce use of police cells as a 'place of safety' by more than 50% for people experiencing mental health crisis. The Crisis Care concordat is a national programme to improve standards. It has been a particular priority for us and since it was launched in February 2014, locally we have seen a significant reduction in the number of people who have been taken into police cells. Last year we had 29 occasions, for the same period this year only 2. **Balanced Scorecard** The Trust has introduced a Balanced Scorecard in relation to performance and information and is split into 4 domains; Workforce	

	Finance Quality Performance The scorecard has strengthened performance and information in an easily accessible format. The scorecard was presented to the Quality Committee on 15 September 2015 and will continue to be developed. It is also interactive at team and directorate levels. We will have benchmarked information available for both internal and external. Mrs Donovan thanked Ms Harrison and the clinical teams involved. Mr O'Hagan queried when the Board would have sight of the scorecard. Ms Harrison gave assurance that this would be in December; there are some formatting issues at present. He also noted the requirement for being '*paperless*'. **Listening into Action** The second 'Pass it on' event is planned for 23 October 2015 at the Britannia Stadium. Initially, we had 15 clinical teams at the beginning of the year, we now have a further 14 teams who will help identify themes for our next LiA teams. **Annual General Meeting** The Annual General Meeting took place on 22 September 2015 and the trust has received very positive feedback. The AGM was more informal and more interactive than previous years. Mrs Donovan thanked the Communications Team and Clinical teams for all their hard work. Mrs H Johnson praised the Trust for the excellent AGM and what a great opportunity it had been for her to meet staff and other stakeholders. She particularly thanked Ms Harrison for the finance presentation, which was easy to understand. **Mental Health Champion for Schools** The Department of Health are working with NHS England and is investing new funding for Children and Young People in mental health services and there is a Mental Health Champion for Schools to help raise awareness and reduce the stigma around young people's mental health. The Chair thanked Mrs Donovan for her update and noted that the AGM had summarised some of the work carried out by the Trust and that is what an AGM should be. ***Received***	Ms Harrison
135/2015	**Individual Spotlight Award - David Manley, Senior Occupational Therapist, CAMHs Disability Team**	

Children & Young People's Directorate

Dave's role involves working with children who have learning and/or physical disabilities across Stoke and Staffordshire. He works closely with all the Children's Directorate Teams and with our partners, including social care and special schools across North Staffordshire.

Dave has developed the occupational therapy service within the CAMHs Disability Team from nothing; he has worked hard and has gained the respect of other agencies.

Dave is inspirational in his approach and well-liked by colleagues. He is not afraid to challenge and always has the best interests of Children, Families, colleagues and services at the fore front of everything he does. He is very much a team player, showing great respect for colleagues and for the other agencies he works with.

Children with profound difficulties and their families have an improved quality of life as a result of the work that Dave and the team do.

Dave lives the values that guide our behaviours. He demonstrates this daily by valuing people as individuals - he is professional in his approach with the ability to put everyone he comes into contact with at ease, the standard of care he provides is of a very high quality. Dave and the Team are instrumental in enabling families to gain support from other service areas to ensure that Children's needs are fully met, demonstrating our value of working together for better lives.

He is always open and honest, challenging appropriately and is universally respected for his professional and honest approach.

Team Spotlight Award and Presentation
City Community Mental Health Team
Neuro and Old Age Psychiatry Directorate

The City Community Mental Health Team [CMHT] is a well-established team offering interventions to older adults with a range of mental health needs. They work with many different professional groups and organisations across both the statutory and voluntary sectors to ensure person-centred and holistic service provision.

The team is co-located with social care colleagues and will soon be moving to form part of a Specialist Dementia Service which is currently being developed at Marrow House.

	The City CMHT provides a consistently high standard of service to their patients. Over the last 3 years there have been no complaints relating to the service. This is to the credit of the team who manage 180 referrals into the service on average per month. The team work in a patient centred manner and conduct themselves with a high level of professionalism. They consistently demonstrate the Trust values, but what the patient story will demonstrate is the way in which they strive to exceed expectations and the positive impact this has on both the patient, their carers and their families. Following receipt of their Team Spotlight Award, the City Community Mental Health Team delivered a presentation led by Ms Munton-Davies, Head of Directorate (NOAP), Mr Gwinnett, Modern Matron and Mrs Thorley, CMHT Manager. Ms Munton-Davies also read out the Patient Story in relation to this team, written by Jane Blagg in respect of her mother who was diagnosed with Alzheimer's in 2006. The patient story gave a background to her mother's illness and the journey she and her family had been on. It was extremely moving and acknowledged the team's care and compassion throughout. Dr Adeyemo stated that it made her proud to be part of the team She commended Mr Gwinnett's approach in that *'he drops everything and responds'* this makes people feel at ease and supported. Mr Draycott acknowledged the good work and made reference to a recent report in respect of Memory clinics and diagnosis of dementia. Local diagnosis rate in all areas is be 67%, which is the best in the West Midlands. Mr Gwynett stated that the team has been fortunate to work closely with GPs and primary care and this joint partnership working enables this support. Dr Adeyemo praised Mr Gwinnett and his team again and highlighted to the Board that whilst we acknowledge support from GP colleagues, with the team's amount of resources Mr Gwinnett underplays the responsiveness and that he goes beyond the call of duty. This is definitely something we should shout about it and be proud of, especially with the meagre resources we have and what we have achieved. This is down to leadership within the team. Ms Munton-Davies commended the team for the way in which they engage and their pro-activeness. It is a very effective way of working. Mr Gwinnett noted that all team members have great skills and that it is a testament to all teams working and it is about all community services.	

	Mr Draycott reiterated Dr Adeyemo's comments that they should be proud to be the best in the West Midlands. Mr O'Hagan felt humbled by the presentation and the work of the team and that sometimes it is not a system that makes the difference, but the people. Dr Tattum stated that he was aware of several cases and involvement with the team and he felt overwhelmed with their attitude. We should *'bottle it and sell it'* and that for him personally, as a consumer, it is a great service and in awe of the team and thanked them personally and on behalf of the families . Dr Tattum also queried whether grades within the team would be enhanced? Ms Munton-Davies stated that there would be opportunities in terms of RAID; working far more around front of house and at the triage point. Enabling the team to acknowledge frequent attenders and to take more appropriate course of action, with links in terms of elderly care and strengthening relationships with wards. There is also a development for embedding longer working hours with more accessibility for the team (24 hours) this would be recurrent funding for community hospitals. Mrs Donovan thanked the team and their fantastic approach within our workforce. In respect of two pilots in Staffordshire currently being developed, she stated that the team should be showcase their skills and be more proactive in leading in primary care rather than just acting as support. Mr Sullivan commented on the compassionate work of the team and the presentation. He asked whether there was any support that the Board could provide or how to make their work easier? Mr Gwinnett commented that the team embraced change on a daily basis and that moral support is vital to the team. Mr H Johnson also commented on she had had the pleasure of meeting Mr Gwinnett, through one of her residents. She further added that the Trust is very lucky to have the team's commitment and compassion and to keep up the good work! Mrs Donovan noted utilisation of the better care fund may be of benefit. ***Received***	

136/2015	**REACH Awards** The next item was also to present the City Community Mental Health Team with their REACH Award for Service User and Carer Category. Darryl Gwynett and Wendy Thorley who were unable to attend on the evening accepted the award with thanks and the Board noted they were worthy winners.	
137/2015	**Staff Retirements** **Hilary Whalley** Hilary commenced employment with the NHS on the 28 June 1965 at Central Out-Patients and worked in numerous departments across the North Staffs Royal Infirmary, City General Hospital, Accident Unit and the Orthopaedic Hospital, prior to joining the Community Unit as the Locality Administrative Manager for the Longton/Werrington locality in 1989. Initially, Hilary was based at Longton Health Centre, managing 23 clerical officers across 8 health centres and went on to become Personal Assistant to Alison Norman, the Locality General Manager. In November 2000, Hilary reduced her hours and took a secondment in the Complaints Department, after which she went to work in Performance Management, where she has remained until recently as the Registration & Quality Improvement Support Manager giving her the opportunity to meet staff and service users. Throughout her service Hilary kept patient care at the very front of everything that she did, with areas such as Growthpoint being particularly close to her heart. Hilary would always take time to help clinical teams when they needed support and her experience will be missed. The Board wished Hilary a long and happy retirement.	
138/2015	**Quality Committee Summary held on 15 September 2015** Mr Sullivan, Non-Executive Director, presented the Quality Committee Summary from the meeting held on 15 September for assurance purposes.	

	Mr Sullivan noted that the meeting had a combination of information and range of assurances. The following policies were approved for a further 3 years ; ➢ Serious Incident Policy ➢ Incident Reporting policy ***Ratified*** The Quality Committee discussed the following ; ***Quality Impact Assessment of Cost Improvement Schemes (CIPs)*** - there are no issues and no changes to the current position. ***Annual report on PALs and Complaints*** – which is also on today's agenda ***Report received following the TDA Infection Prevention and Control Visit to the Harplands Hospital*** – reasonably positive, it was noted there are some actions to be taken forward. ***Leadership and Workforce update*** – this gave the Quality Committee the opportunity to raise any concerns around quality. ***Letter to Trust CEO from the Quality Surveillance Group – July 2015*** – no specific concerns, rated green. ***Seclusion report Q1 2015/16*** ***Domain reports ;*** ***Patient Safety,*** ***Clinical effectiveness,*** ***Organisational safety and efficiency,*** ***Customer focus.*** The Quality Committee scrutinised; ***Nurse Staffing monthly report*** – due to circumstances, this was a virtual report but was circulated later on the day. ***Quality metrics from the Performance Quality Management Framework (PQMF) Month 5 2015/16 – on today's agenda***	

	Quality Committee Terms of Reference – on today's agenda **Risk to Quality of services M5 2015/16** ***CQC visit – Ward 2 unannounced visit*** – generally positive, however there is some learning identified in respect of record keeping and environment changes. For information purposes ; ***Director of Quality Report*** ***Overview of Safeguarding Activity*** ***Update on CQC Quality Assurance Programme*** ***National Confidential Inquiry into Suicide and Homicide by people with mental illness (NCISH) Annual Report July 2015***. Finally reports from each Clinical Director or their nominated deputies for each directorate regarding risks – there were no major issues to be raised with the Board ***Received***	
139/2015	**Quality Committee Terms of Reference** Ms Sylvester, Acting Director of Nursing and Quality, presented Terms of Reference for the Quality Committee for approval by the Trust Board. Mr Sullivan noted that the Terms of Reference had been presented to the Quality Committee on 15 September 2015 and although approved some governance issues were raised and will need aligning to the Integrated Business Plan (IBP) and Safe, Personalised, Accessible, Recovery (SPAR), which will then inform any changes to the Terms of Reference to the Quality Committee. It was also noted that the Cycle of Business will be reviewed by Mrs Wrench as part of an overall review of the committee structure. Mrs Storey noted that a third NED has been added to the membership of the Quality Committee; Mrs B Johnson, who is also the link for the Service User and Carer Council. ***Approved***	**Mrs Wrench**

140/2015	**Safe Staffing Monthly report** Ms Sylvester, Acting Director of Nursing and Quality, presented the assurance report. This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during the data collection period August 2015 Ms Sylvester updated the Board as follows; The performance relating to the fill rate (actual numbers of staff deployed vs numbers planned) on the wards for March was 97.87%: being a total fill rate of 96.02% for registered nurses and 99.0%for HCSWs. The position reflects that ward managers are effectively deploying additional staff to meet increasing patient needs as necessary. Ms Sylvester noted that there are some amber and red ratings whereby some challenges have been made in context of other metrics, for instance, looking at incident sickness levels. In respect of Ward 4, there is progress for a stable workforce. Ward 4 have had reduced occupancy rates and lower acuity in terms of observation levels. The Ward Manager has given assurance that there has been no impact to the quality of care we deliver. There have also been issues with the reliance of bank staff. On a positive note, there have been 13 vacancies appointed to and this should have an impact with fill rates. In respect of A&T and Telford units, there has been some sickness and some vacancies. However, the sickness overall is reducing and we are reviewing the whole unit to ensure safe staffing levels are maintained across those two areas. With the safe staffing review there has been an uplift in staff on Wards 2, 3 and 6. A rolling programme of recruitment to vacancies is being implemented. Dr Tattum queried whether the Trust has been able to capture newly qualified nurses? Mr Draycott stated that we are working through the details. We are finalising the process to make conditional offers of employment to final year student nurses to secure recruitment on a rolling programme. Ms Harvey raised concerns regarding staff working 12 – 13 hour shifts and that the Trust needs to be mindful that some staff may struggle to perform and the impact this may have.	

	Ms Sylvester stated that this has been recognised and the Trust are working towards a 3 shift system to replace the long day shift system. This was also about strengthening the handover period. Ms Harrison clarified that we have encompassed 24% headroom into figures and appropriate levels of handover. Ms Sylvester to speak to Mr Sullivan in respect of the remodelling and the proposed consultation to staff Ms Harvey raised further concerns regarding staff members having difficulties with child care and this would need further discussions. The 3 shift system remodelling proposal would be discussed at the next Quality Committee. Mr D Rogers noted the progress with inpatient care but raised community services. Mrs Donovan clarified this was the next priority. Ms Harrison stated that there has been rising demand within adult community services. A review has been ongoing in respect of utilisation of clinics and community services; what levels of DNAs and cancellations, with a view to a more efficient way of working and review of funding. The first draft will be discussed at Executive Team. Mrs H Johnson commented that she was pleased to see that community services are being reviewed and that she has concerns in this area. She also noted that inpatient staffing problems sometimes have an impact on the community staff, when staff are drafted in from the community to cover the Harplands. Mr A Rogers stated that this is a very last resort, although this has happened on a few occasions and once fully staffed at Harplands this should be less frequent. . The Chair noted the good progress made with the inpatient wards and empathised that this is very challenging and has been for many years. ***Received***	**Ms Sylvester** **Ms Sylvester** **Ms Harrison**
141/2015	**Listening and Responding – PALS and Complaints Annual Report 2014/15** Ms Sylvester, Acting Director of Nursing, presented the PALs and Complaints Annual Report. The report details the number of complaints over 2014/15 (65 in total) showing a decrease of	

	29 complaints from the previous year 2013/14. The report describes initiatives during 2014/15 including the commencement of Listening and Responding training, development of new Improving the Patient Experience literature and investigating officers' complaints handling training. It was also noted that the Trust has received 155 compliments this year. The report will be strengthened going forward with the forthcoming appointment of Veronica Emlyn and also the development of Service User and Carer Council. Mrs H Johnson noted that she always ensured compliments are passed on from ward visits. NSUG members are impressed with the new PALs leaflet. Mrs H Johnson also commented on the support and good skills provided by Mr Coleman in the PALs team. Ms Sylvester stated that she would pass this on. The Chair remarked on good progress made in this area and that there had been previous issues, but we are moving in the right direction. ***Received***	
142/2015	**Financial Performance – Month 5 (2015/16)** Ms A Harrison, Interim Director of Finance, presented this report and highlighted the headline performance for the period. The Trust's financial performance is a retained deficit of £0.526m against a planned deficit of £0.544m, a favourable variance of £0.018m. The in-year cost improvement target is £2.66m with a year to date performance of £0.011m behind plan. The cash balance at 31 August 2015 was £7.36m. The net capital expenditure is a negative (£0.129m) which is behind the plan of £0.125m an underspend of £0.254m. The continuity of service risk rating is reported as 3 in line with the plan. Members of the Board noted that the Trust is on target with the plan. There has been an agreed stretched target of £900k from £750k, which we will achieve. This has been submitted to the TDA; however we are awaiting a response.	

	It was noted that the Capital Programme is slightly behind; however there is a robust plan and this will move forward with support from Mr Thornber and Mr A Rogers. Both Mr D Rogers and Mr Sullivan queried delivery and completion of the relevant business cases and Ms Harrison gave assurance that we are monitoring these and tracking within the Estates Plan. The Chair agreed that it is necessary to keep up the momentum with regard to the business cases to ensure we deliver the Capital Programme. ***Received***	
143/2015	**Assurance Report - Finance and Performance Committee Report – 17 September 2015** Mr Gadsby, Non-Executive Director, tabled the assurance report to the Trust Board from the Finance and Performance Committee held on 17 September 2015 and apologised for the lateness of the report. Board members were assured that the Trust is in a reasonable position, in respect of our current status and for the forecast year-end. However, Mr Gadsby drew the Board's attention to the forecast which is having substantial support from reserves. Taking this into account, the operating position is not as healthy as we would like. Furthermore, there are some challenges with CIP in respect of non-recurring. Mr Gadsby also noted and as previously discussed the Capital plan needs to be moving forward as soon as possible; however in comparison to previous years we are in a better position. In terms of reports received; • ***Digital by Choice IT Strategy***; the committee did not receive the financial information in relation to this and this will be submitted in due course. • ***Revised Lease Car Policy;*** approved and for ratification today at Board. ***Ratified***	

	• ***Term of Reference – Finance and Performance***; similar comments made to the Quality Committee - approved on an interim basis. • ***Finance and Performance Key risks; reviewed***. In respect of the Lease Car Policy, Ms Harvey queried what the revision was in relation to. Mr Draycott clarified that there were no significant changes; these were in respect of tax implications. ***Received***	
144/2015	**Finance and Performance Terms of Reference** Ms Harrison, Interim Director of Finance, presented the Terms of Reference for the Finance and Performance Committee. The Terms of Reference had been reviewed at the committee meeting on 17 September 2015. There have been some minor amendments. The Terms of Reference were approved but will also be refreshed and aligned in due course. ***Approved***	
145/2015	**Assurance Report from the Audit Committee** Mr Rogers, Non-Executive Director and Chairman of the Audit Committee presented this report for assurance purposes following the meeting held on 14 September 2015. Board members noted that the role of the Audit Committee is not only financial but encompasses quality aspects as well. The new External Auditors Ernst and Young were present at the Audit Committee meeting and presented their Audit Fee which is overseen by the Public Sector Audit Appointments Ltd (PSA) an independent company set up by the Local Government Association. It was also noted that our Internal Auditors Baker Tilly would be changing their name to 'RSM' in the near future. Mr Rogers reflected on the recent CQC inspection and in general terms this will have an impact on areas in which we will devote internal audit attention. Once the report has been published, we will therefore be reviewing the Internal Audit programme accordingly.	

	Mr O'Hagan agreed that the Audit Committee's role is to review audit and risk. Discussion took place in respect of the links with the Board Assurance Framework and it was clarified that this had a relationship with all the committees, with a 3 pronged approach. He further noted that data security should be reviewed at the Audit Committee. Mr D Rogers stated that the Audit Committee had received a report on Information Governance breaches at the last meeting. Mrs Storey confirmed that there had been no breaches in accordance with the legislation and that no significant control issues have been highlighted following a review of the incidents. There is further drill down with this report at the Quality Committee. Ms Harvey noted fraud in the NHS which has been recently publicised on the news and that it would be interesting to see the report for our Trust. In addition, she also highlighted that should there be any policies which may have an impact on such matters she would need to have sight of these. She also queried who delivers the fraud training and to whom? Mr D Rogers noted that RSM Internal Auditors have LCFS specialists who concentrate on fraud and this is monitored regularly. Ms Harrison also clarified that the LCFS team have a Work plan for 2015/16. Mr Draycott noted that fraud training is dealt with as an element within mandatory training and induction together with articles in Newsround and Team Brief. ***Received***	
146/2015	**Audit Committee Terms of Reference** Mr Rogers, Non-Executive Director and Chairman of the Audit Committee presented the Terms of Reference for the Audit Committee which were approved at the meeting on 14 September 2015. As discussed previously with the other committees of the Board, the Terms of Reference would be refreshed in due course. ***Approved***	
147/2015	**Performance and Quality Management Framework Report (PQMF) Month 5** Ms Harrison, Interim Director of Finance, presented this report. The report provides the Board with a summary of performance to the end of Month 5 (August 2015)	

	Performance against the TDA metrics and key National Targets is included within the report. A range of metrics is in place to monitor performance, quality and outcomes. The indicators are those set by our commissioners and local trust targets and aligned to the relevant Trust objectives. Performance against these KPIs has been reviewed by the Finance & Performance Committee prior to this report being presented to Trust Board At month 5 there is 1 metric rated as Red and 2 rated as Amber; the attached exception report expands on these areas. Members reviewed the exceptions and noted that IAPT was not present on the report this is due to the good progress made in this area. Dr Fazal-Short has overseen this. This area is also due to go out to tender. Other exceptions noted; ***Training –*** amber at 90% - the Trust is proactively taking action with teams to ensure that all staff attending statutory and mandatory training ***Appraisal –*** red 77% the Trust is proactively taking action with teams to ensure that all staff have an appraisal. ***CPA*** – amber 92.8% - The Trust is aiming to reach target by the end of the month ***Early Intervention -*** This validates the Trust's decision to invest funds in IAPT to deliver service to national target for going live next year 2016/17. ***Received***	
148/2015	**Self-Certifications for the NHS Trust Development Agency** Mrs Harrison, Interim Director of Finance, presented the executive summary. The summary indicates that the Executive Team have reviewed the declarations and are ready to be submitted. There is only one change in respect of Information Governance. Several Information Governance toolkits were changed when version 13 was launched in June 2015 and the Trust was unable to evidence full compliance. An action plan has been implemented to address this and full compliance is anticipated	

	by October 2015. ***Received***	
149/2015	**People and Culture Development Committee Report** Mr O'Hagan, Non-Executive Director/Chair of the PCD Committee, tabled this report which is a summary from the People and Culture Development Committee meeting which took place on 21 September 2015 The PCD Committee considered the following; ***Workforce Directorate Performance presentations***; concerns about sickness/absence were raised, although assurance was given that the Trust is taking steps to help reduce this. ***Staff survey*** is due to be circulated The PCD committee approved the following policies for 3 years, with the exception of Management of Change Policy which is extended for 6 months. ➢ Local Government Pension Scheme Discretions Policy (describes retirement procedures for staff who transferred to the Trust under the S75 arrangement and who remain in the local government pension scheme ➢ Retirement Procedure (final updates to include addition of the 2015 pension scheme) ➢ Job Planning (Associate Specialists and Specialty doctors) Policy & Procedure (revised and brought up to date) ➢ Job Planning Policy and Procedure (revised and brought up to date) ➢ Disciplinary Policy (revised and incorporates new quick resolution process) ➢ Recruitment and Selection Procedure (incorporates changes to legislation) ➢ Support for Staff (revised and brought up to date) ➢ Management of Change Policy (extend by 6 months while LIA work is ongoing	

	There were 2 risks in respect of Workforce and Organisational Development discussed as follows ; ➢ Insufficient staff to deliver appropriate care because of staffing vacancies and increased referrals ➢ The Trust fails to reduce sickness levels to anxiety / stress. A rich discussion took place regarding the PCD Committee's effectiveness. The relationship the Committee has with the Staff side was noted and this was always positive and appreciated. Mr O'Hagan also remarked on the purpose and function of some committees within the wider assurance framework. He highlighted that the Board should be mindful of the costs with people in attendance and printing costs. Dragon's Den is due to take place in November 2015, ideas to be submitted as soon as possible. Library service report received; a partnership with Keele and a number of other trusts – further promotion of this service through Team Brief and Newsround. It was also noted that they offer a good research service National Student Survey 2014/15 – positive results received. ***Received***	
150/2015	**Better Leadership for tomorrow – NHS Leadership Review – Rose Report : Local Implications** Mr Draycott, Executive Director of Leadership and Workforce presented this report. The Rose Report makes far-reaching recommendations which are set largely within the national context. The local relevance of these recommendations is outlined in this paper. It is recommended that the Trust; Specific local recommendations are outlined and in general it is recommended that the Trust use the local applications as part of the Trust approach to leadership development and build these recommendations into the wider OD strategy for the Trust. The Rose Report has also been discussed at PCD. A local plan will be adapted and feedback through the PCD. The Chair commented that this is important for the Trust and	

	that he was pleased to see the emphasis on graduate training scheme. Mrs H Johnson commented that the Trust has been developing good leadership at all levels and noted on the rising star award for Dan Platt at REACH, she also commented on one of the Activity workers who was moving on. ***Approved***	
151/2015	**Any other business** **Wi-Fi Access** Mrs H Johnson acknowledged the Wi-Fi___33 access which was now available and much better for patients and staff.	
152/2015	**Date and time of next meeting** The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday, 29 October 2015 at 10:00am, in the Boardroom, Lawton House, Trust HQ.	
153/2015	*** Motion to Exclude the Public** The Board approved a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted.	

The meeting closed at 12.30 pm

Signed: _____ Date_____

Chairman

Board Action Monitoring Schedule (Open Section)

Trust Board - Action monitoring schedule (Open)

Meeting Date	Minute No	Action Description	Responsible Officer	Target Date	Progress / Comment
30-Jul-15	86/2015	**Spotlight - Moorlands Community MH Team based at Ashcombe/Brandon** - Mr A Rogers stated that other locations have been identified and the aim is to move somewhere in Leek, but not pursued due to other issues and this was being progressed under the Estates rationalisation of the Trust.	Mr A Rogers	29-Jan-15	Part of rationalisation plan – update on progress in October 2015. The Chair noted that although this is a pleasant location it is not best placed for service users. Mrs B Johnson also queried whether Dragon Square provision in Staffordshire Moorlands would be reviewed. Mr Rogers gave assurance that this will fundamentally be a review of the whole Estates Strategy and all areas will be considered in relation to team's accessibility.
24-Sep-15	134/2015	**Balanced Scorecard** - Mr O'Hagan queried when the Board would have sight of the scorecard. Ms Harrison gave assurance that this would be in December; there are some formatting issues at present. He also noted the requirement for being 'paperless'.	Ms Harrison	29-Jan-15	
24-Sep-15	139/2015	**Quality Committee - Terms of Reference** - It was also noted that the Cycle of Business will be reviewed by Mrs Wrench.	Mrs Wrench	29-Jan-15	
24-Sep-15	140/2015	**Safe Staffing Monthly Report** - Ms Sylvester to speak to Mr Sullivan in respect of the remodelling and the proposed consultation to staff . The 3 shift system remodelling proposal would be submitted to the next Quality Committee.	Ms Sylvester	29-Oct-15	This has been presented to Quality Cte
24-Sep-15	140/2015	**Safe Staffing Monthly Report** - Ms Harrison stated that there has been rising demand within adult community services. A review has been ongoing in respect of utilisation of clinics and community services; what levels of DNAs and cancellations, with a view to a more efficient way of working and review of funding. The first draft will be discussed at Executive Team.	Ms Harrison	29-Oct-15	Verbal update

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: Trust Board

Date of Meeting:	Thursday 29 October 2015
Title of Report:	Chief Executive's Report to the Trust Board
Presented by:	Mrs Caroline Donovan
Author of Report: Name: Date: Email:	Caroline Donovan, Chief Executive Caroline Donovan 19 October 2015 Caroline.donovan@northstaffs.nhs.uk
Committee Approval/Received prior to Trust Board:	• Quality Committee • Finance and Performance Committee • Audit Committee • People and Culture Development Committee • Charitable Funds Committee • Business Development and Investment Committee
Purpose / Intent of Report:	**For information**
Executive Summary:	This report updates the Board on activities undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Customer Focus Strategy • Clinical Strategy • IM & T Strategy • Governance Strategy • Innovation Strategy • Workforce Strategy • Financial Strategy • Estates Strategy
Relationship with Annual Objectives:	**n/a**
Risk / Legal Implications:	**n/a**
Resource Implications:	**n/a**
Equality and Diversity Implications:	**n/a**
Relationship with the Board Assurance Framework	1. Focusing on quality and safety 2. Consistently meeting standards 3. Protecting our core services 4. Growing our specialised services 5. Innovating in the delivery of care 6. Developing academic partnerships and education and training initiatives 7. Being an employer of choice 8. Hosting a successful CQC inspection 9. Becoming digital by choice 10. Reviewing and rationalising our estate 11. Devolving accountability through local decision making that is clinically led assuring governance arrangements. 12. Delivering our financial plan
Recommendations:	**To receive this report for information**

North Staffordshire Combined Healthcare Trust

Chief Executive's Report to the Board of Directors
29 October 2015

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. ACCOUNTABILITY SESSION
The Trust was invited to present to the Staffordshire County Council Health Staffordshire Overview and Scrutiny Committee (OSC) on 14 October 2015, as part of the OSC's programme of Accountability Sessions. Members of the Trust Board gave a formal overview of the work undertaken by the Trust in the last 12 months.

The session was challenging, as expected from a scrutiny session, but the feedback from councillors was in the main positive and gave us an opportunity to share some of the excellent work undertaken across our services in the past year, as well as share our plans for the future.

2. COMMISSIONING INTENTIONS
The Trust received the Commissioning Intentions for 2016/17 at the start of October which outlines the key themes that Commissioners will apply to all their providers.

'We're Better Together' there are some initiatives which we are currently working through and will respond to Commissioners following consideration across our Directorates.

The specific details in the Commissioning Intentions which relate to each Directorate will be shared over the next month.

3. PAN STAFFORDSHIRE TRANSFORMATION PROGRAMME
On 20th October, the Chairman and I attended a leadership conference for members of the Transformation Programme, to further influence the overall Staffordshire Wide Programme.

It is important that clinicians are leading the transformation and, as such, the programme is now asking for Clinical Leads to put themselves forward to lead on workstreams, as well as advertising for a new Medical Director post. There are also opportunities for people to get involved in the workstreams. The four workstreams are: Fit and Well; High Risk and Independent; In the System – this workstream is split into three areas, of which one has a specialist interest in mental health and Provider, this is the new 4th

I lead on the cross cutting workforce and Organisational Development workstream for the programme and am chairing a summit we are holding on 9 November 2015, to progress this workstream further.

4. SERVICE USER AND CARER COUNCIL

The Service User and Carer Council met in October. This important group, providing a real voice for those who use our services, is progressing well and is already influencing the way in which decisions are made and services are developed in Combined.

5. DIGITAL BY CHOICE

I chaired our October Digital by Choice Programme Board and was pleased with the progress we have made in recent weeks. We have developed the first draft of the business plan to go to the Department of Health for our new Electronic Patient Record that we are hopeful will be funded. Clinical leads have been identified for each directorate, to support this important workstream.

We are also working on developing an app targeted initially at GPs to help them understand how to refer into our different services, providing simple accessible up-to-date information.

6. QUALITY ASSURANCE

With the CQC Comprehensive Inspection now complete, we are working to integrate the CQC programme into Trust systems and processes, led by the new Associate Director of Governance (ADG). Our draft reports will be published by the CQC in early December; significant work will then be required to populate action plans and provide evidence against improvements made since the inspection. In line with its programme of ongoing assessment and reassurance, further announced or unannounced visits may continue to be conducted by the CQC. We continue to progress actions identified from the peer reviews, along with recommendations already made by the CQC through the inspection.

7. TRUST CHAIRMAN

I wanted to take an opportunity via my CEO Report to extend my sincere thanks to our Chairman, Ken Jarrold CBE, who has made the decision not extend his term of office.

Ken's four-year term of office ends on 30 November 2015 and after much consideration, he has decided not to consider a second term of office. However, the NHS Trust Development Authority (TDA) has, in discussion with Ken, agreed to extend his term of office until March 2016 while his successor is recruited and appointed by the TDA.

Ken has personally been a massive inspiration to me, consistently supporting me taking up my first Chief Executive role. His key principles of putting service users, carers and our staff as central to all we do complements my vision and values for the future. I have learnt so much from his key values, openness, transparency and human compassion and will miss working with him enormously.
Ken has been key to the healing, renewal and recovery of Combined. I wish him well in in retirement and look forward to reading the books he plans to write over the next few years.

8. STAFF FLU VACCINATION PROGRAMME

Our drop-in flu clinics got underway at the beginning of October and staff have been receiving their free vaccination. It's really important that all staff members get the flu jab in order to keep themselves and patients flu safe, as well as colleagues, family and friends.

Clinics are being held across the Trust throughout October and November, supported by a roving team of Flu Champions who will be offering the vaccination to staff at Harplands. A full list of flu clinics is available on posters across all Trust sites and via the staff intranet

Follow **@NHSFlufighter** on Twitter for all the latest flu updates and developments across the NHS and join the conversation adding the hashtag **#flufighter**.

9. CRISIS CARE PROGRAMME

At the end of September, I spent time dealing with the media issues that had developed as a result of Mathew Ellis, the Staffordshire Police and Crime Commissioner, releasing a story of an incident that happened in March this year. Our teams worked tirelessly to support a service user who lived outside of the county but needed a psychiatric intensive care unit (PICU) bed. There was a lack of appropriate bed availability across the NHS, which resulted in a service user being held in a police cell. Although our teams and the police worked really well together, the NHS as a system let this service user down for which I apologise. The issue of the lack of a PICU for our Trust had already been identified as a gap with our Commissioners and I am pleased that we have now developed a business case and we have set aside capital funding to build this. We are currently working with Commissioners to progress this.

10. LISTENING INTO ACTION UPDATE

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

I am delighted that the LiA Wave 2 Pass it On Event took place on 23 October 2015. The event celebrated the excellent progress made by the 14 teams. It also provided an opportunity for staff to have their say in how we progress into Wave 3.

The 14 Teams are:

- Supervision
- Record Keeping & Mental Health Act
- Transitions Between Services
- Caseload Management
- Zokens
- Deaf Awareness
- Improving Safety In-Patient Environments
- Improving Bed Management
- Values & Behaviours
- Team Environments
- Junior Doctors
- Support Worker
- Recruitment
- No Change About Me Without Me

Representatives from across a range of teams and clinical backgrounds and partners attended the exciting and creative event to get involved in shaping the way our services are run for the benefit of patients and service users

11. STOKE-ON-TRENT CO-OPERATIVE WORKING MODEL

Also this month, Tom Thornber, our Director of Strategy & Development, and I met with YMCA North Staffordshire Chief Executive Danny Flynn and Becky Bryant, Deputy Chief Executive for Staffordshire Fire and Rescue Service, to discuss how we can integrate the principles of the Stoke-on-Trent Co-operative Working model (which Becky chairs) across the NHS and across our Trust.

The Co-operative Working approach aims to help vulnerable people to live their lives well by offering a more co-ordinated approach across Stoke-on-Trent City Council and partner services to help solve problems. Residents will get the support they need at the right time – only having to tell their story once. It is based on a successful pilot scheme and is a completely new approach to helping residents to live independently.

Through increasing efficiencies in the way partners work together, and by working with residents at an early, preventative stage, it is estimated it will save the council and partners in the region of £36m over the next three years. We already partner with the programme and over 50% of issues relate to mental health. We need to integrate this model of working more widely and the £4.9m transformation grant awarded recently to Stoke-on-Trent by the government will help.

12. WORLD MENTAL HEALTH DAY

The Mental Health Foundation chose 'dignity' as the theme of this year's World Mental Health Day, which took place on Saturday 10 October and was championed by Combined Healthcare.

Trust staff held a series of events to celebrate World Mental Health Day. The Physiotherapy team at Harplands Hospital held a sports activity day, wherein patients, service users and visitors took part in a range of fun activities, including table tennis, badminton, volleyball and a penalty shootout.

Meanwhile, the Harplands Activity Workers organised a drop-in art session for patients to let their creative juices flow by colouring in and painting a mural that will be put on display in the hospital.

Patients on Wards 4-7 were treated to a performance by local singing group Elms Friends, while bingo sessions were also held. In addition, patients and visitors were encouraged to write down how they felt on pieces of paper and card cut into the shape of a human head.

A mental health issue can have a serious impact on someone's ability to sustain a connection with a friend or to simply get through the day. Many people with mental ill health sadly still experience stigmatisation and can feel stripped of any dignity. By celebrating days such as World Mental Health Day, the Trust is aiming to reduce stigma and shine a light on this issue.

13. CAMHS

The Paediatric Oncology team has been given royal approval after meeting Prince Harry at the prestigious WellChild Awards in London. The team won a WellChild Award for their work treating seriously ill children and were nominated by two families whose children had been treated at Royal Stoke. They were picked out for the award from hundreds of nominations in the category of Best Medical Team. The Paediatric Oncology Team includes CYP's Dr Carole Martin, who provides clinical psychology support.

NATIONAL UPDATES

DEPARTMENT OF HEALTH GUIDANCE DOCUMENTS

The Department of Health has produced a range of guidance documents to support staff on social care and specialist mental health care

The guidance documents are designed to be used by social workers at all levels, from front line practitioners to senior social workers, social work supervisors and managers, to support them to deliver the best outcomes for the people with whom they work.

The documents, which have been shared with the relevant staff across our organisation, are as follows:

- Mental Capacity Act 2005 in practice: learning materials for adult social workers
- A manual for good social work practice: supporting adults who have dementia
- A manual for good social work practice: supporting adults who have autism

Caroline Donovan
Chief Executive
Thursday 29 October 2015

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: **Open Trust Board**

Date of Meeting:	29 October 2015
Title of Report:	Summary of the Quality Committee meeting held on the 20 October 2015
Presented by:	Mr Tony Gadsby, Vice Chair of Quality Committee
Author of Report: Name: Date: Email:	Sandra Storey, Trust Secretary, Associate Director of Medical and Clinical Effectiveness 21 October sandraj.storey@northstaffs.nhs.uk
Purpose / Intent of Report:	• For decision / assurance
Executive Summary:	This report provides a high level summary of the key headlines from the Quality Committee meeting held on the 20 October 2015. The full papers are available as required to Trust Board members
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Customer Focus Strategy • Clinical Strategy - • Governance Strategy
Relationship with Annual Objectives:	Ensure provision of safe clinical services
Risk / Legal Implications:	N/A
Resource Implications:	N/A
Equality and Diversity Implications:	N/A
Relationship with Assurance Framework [Risk, Control and Assurance]	The Quality Committee has an integral relationship with Improving Quality/ Registration.
Recommendations:	• To note the contents of the report • Ratify the policies as highlighted in the report

Key points from the Quality Committee meeting held on 20 October 2015 for the Trust Board meeting on the 29 October 2015

1. **Introduction**

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

   Mrs Bridget Johnson, Non Executive Director, was welcomed as a new member to the committee.

2. **Director of Quality Report**

   The committee received the refreshed Director of Quality Report which the Associate Director of MACE has aligned to the Trust's four quality priorities, namely SPAR. The aim of the report remains the same. The report updates the committee on activities undertaken since the last meeting and draws the committee's attention to any other issues, local or national, or of significance or interest.

   Notable items as follows:

Safe:

- **Department of Health consultation on the roles and functions of the National Data Guardian (NDG) for Health and Care –** the consultation seeks views on the roles and functions of the new statutory NDG for Health and Care is the starting point for identifying the key principles that define that role. The role will not simply be to lobby for change but to hold individuals and organisations to account for how they use and share people's data. Organisations will have to act upon the views and advice of the NDG. The Government proposes that the NDG should have the power to refer actions by an individual to the appropriate regulator for the profession concerned and how the NDG and regulators can maximise the appropriate use of existing sanctions and fines. Dr Adeyemo (who is the Caldicott Guardian for the Trust) welcomed comments or suggestions and the Associate Director of MACE will co-ordinate the Trust's response.

Personalised:

- **CQC: Accessing use of resources in NHS Hospital**
  – the CQC's inspection remit is being enhanced and from April 2016, it is likely they will also look at how resources are being used as part of their inspection of hospitals.
- **Lasting Power of Attorney forms**
  New forms came into effect in July and the Office of the Public Guardian has explained that the changes reflect the feedback from users. The redesign makes the forms easier to follow and faster to complete and it is certainly features in the work undertaken by our Trust clinicians.
- **End of Life**
  The Health Service Commissioner (Ombudsman) has published a complaints report into end of life care. The Ombudsman calls upon the whole NHS to use learning from the report to underpin new ambitions for end of life care. It was noted that members of the Quality Committee received revised palliative care guidelines at its meeting in July 2015 which promotes high quality care for all adults at the end of their life.

Accessible:

- **Urgent and Emergency Care for Older People** – the NHS Confederation has formed an independent commission to drive improvements in urgent and emergency care for older people which has begun a series of visits to discover more about innovative approaches to unscheduled care and initiatives keeping people out of hospital. The learning, best practice examples and review of literature will help develop a set of practical recommendations to be rolled out to organisations next year.

Recovery Focused

- **Personal Health Budgets** – Forward View into Action planning for 2015/16 outlined the expectation that commissioners will lead a major expansion over the next twelve months in the offer and delivery of personal health budgets, not least into the area of learning disabilities, as recommended in the Bubb report.

3. Policy Review

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

- Clinical Audit 4.39
- Resuscitation 4.12
- Slips, trips and falls 5.33
- Display screen equipment (new)
- Observation 1.34 *
- Missing persons 1.08 *
- Physical Assessment – 1.62 *
- Clinical Risk Assessment 1.41
- CPA Policy 1.64

*Extend for 1 month while out for consultation

The committee also reviewed the Forward Look Policy report and noted that this is an ongoing piece of work with flags in place to ensure appropriate period for review, consultation and sign off by the Policy Working Group.

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

Dr Adeyemo noted that there were no new schemes to report since the last meeting. All individual CIP schemes have been quality impact assessed. It was also noted that monitoring of the quality metrics have not identified any issues resulting from CIP schemes that have been put in place. The Chair noted the low number of new schemes being reported to the committee with a view that there would be new schemes for reporting at the next meeting.

5. Nurse Staffing Performance monthly report – September 2015

The committee received the nursing staff performance on a shift by shift basis for the month of September 2015. While there are still some ongoing challenges a proposed model has been presented to the Executive which included ward managers commencing 20% clinical shifts to provide enhanced leadership. It was noted that almost all vacancies based on the current establishment have been filled. Two areas were highlighted (Ward 4 and Assessment & Treatment) where there had been under occupancy which required less staff, though no impact

from under fill on safety and quality due to reduced acuity and occupancy. It was noted that the situation will show an improvement and further reports will include the timescales for those improvements.

6. **Quality Metrics from the Performance Quality Management Framework Report (PQMF) month 6 2015/16**

The committee reviewed the quality metrics extracted from the wider PQMF. As noted previously, the role of the committee is to consider the impact of metrics potentially going off track. Of the total 73 metrics at month 6, 2 quality metrics were noted to be rated as red and 2 rated as amber. As reported at month 5, these relate to compliance with Personal Development Review (PDR) targets, the percentage of staff compliant with mandatory training, compliance with 18 week referral to treatment (ASD) and RAID response times. The committee discussed the mitigation plans to improve performance.

Committee members also discussed the Balance Scorecard that will be adopted by the committee going forward. This document, using the quality objectives, was well received previously by the committee. It is intended that this will reduce the number of reports that are presented to the committee in the future and the scorecard captures a significant amount of this information such as performance by Trust and Directorate level in respect to key metrics, benchmarking, nurse staffing, patient experience and so on. It is anticipated that this will be in place by December 2015.

7. **Review of Safeguarding arrangements**

The committee received an independent report that reviewed the Trust's safeguarding arrangements following an anonymous concerns being raised. The report concluded that there is evidence that Safeguarding practice and principles are embedded into the governance and leadership within the organisation. While the allegations were not substantiated, the review provided the opportunity to identify areas to strengthen to continually drive standards of safeguarding practice including developing a training strategy and exploring models of delivery and resources for safeguarding.

8. **Terms of Reference for Infection Prevention & Control including update against annual programme of work**

The committee considered and approved the revised terms of reference. The committee also received progress against the annual programme of work which provided assurances that work is on track and meeting the required milestones. It was noted that going forward reports on progress will be in the form of a suite of documents, to include the annual report, as this will enable the committee to read the documents in conjunction with one another, better understand the information being presented and receive the required assurance sooner.

9. **Supporting people with a learning disability and/or autism who have a mental health condition or display behaviour that challenges**

The committee received a paper for information on the key principles underpinning a new (draft) national framework designed to improve the care of people with learning disabilities, shifting services away from hospital care and towards community based settings. Current local actions in response to these principles were set out in the paper and the committee discussed

implementation of the service model which will require operational and cultural changes across all Directorates.

10. Eliminating Mixed Sex Accommodation – Q2 update

The committee received a report summarising the work undertaken and declaration that there has been no breaches during this reporting period.

11. Business Cases

The committee received information on the status of the Psychiatric Intensive Care Unit (PICU) and Ward reconfiguration. It was noted that in future the committee would receive high level summaries relating the quality aspects of the business cases. The full business case will be discussed at the newly established Business Development and Investment Committee.

12. Directorate Performance Reports

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

13. Risk to Quality of Services M6 2015/16

Committee members considered the report for quality risks, noting the risk treatment plans in place. Members discussed the lack of PICU availability which means there is a risk that patients are not supported in an appropriate environment and the progress being made with this case. Committee members also discussed the newly introduced target scores and how this will help develop the risk management process. Further discussions will take place at the Risk Review Group.

14. Good Governance Institute Recommendation Follow up Report

The committee received for information a report outlining progress made against the recommendations in the report.

15. CQC Quality Assurance Programme Update

The committee received an update summarising the progress made by the Quality Assurance Programme Board including achievements over the last 7 months. As the programme was completed as of September 2015, further actions and recommendations were noted, including the proposal to integrate work of the meetings into existing structures. It also noted that self-assessments should be updated on a six monthly basis with peer reviews taking place after the updates.

The committee noted that two reports had been received from the Care Quality Commission. The first related to Ward 3 following a Mental Health Act review that took place during the CQC inspection week. The second report related to a review of CAMHS during the inspection week. Both reports are being considered including learning and action with further information being reported to the committee as this work progresses.

16. **Quality Surveillance Group**

Following the Quality Surveillance Group meeting on 29 September 2015, the TDA have reported that the Trust is rated as green, no specific concerns but watchful eye for any dips in performance.

17. **Domain Updates**

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

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

  It was noted that work was underway to refresh the domains and align these to the Trust's Quality Objectives and this will inform future reports and the cycle of business for the committee.

18. **Next meeting: 17 November 2015**

On behalf of the Committee Vice Chair, Mr Tony Gadsby, Non Executive Director
Sandra Storey
Associate Director of Medical and Clinical Effectiveness
21 October 2015

Enc. 5

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO TRUST BOARD

Date of Meeting:	**29 OCTOBER 2015**
Title of Report:	Nurse Staffing Performance on a shift-by-shift basis
Presented by:	Maria Nelligan, Executive Director of Nursing & Quality
Author of Report: Name: Date: Email:	 Carol Sylvester, Deputy Director of Nursing & Quality 20 October 2015 Carol.Sylvester@northstaffs.nhs.uk
Committee Approval/Received prior to Trust Board:	• Quality Committee • Finance and Performance Committee • Audit Committee • People and Culture Development Committee • Charitable Funds Committee • Business Development and Investment Committee •
Purpose / Intent of Report:	For Assurance
Executive Summary:	This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during the data collection period (1 – 30 September 2015) in line with the National Quality Board expectation that: *"The Board:* *• Receives an update containing details and summary of planned and actual staffing on a shift-by-shift basis* *• Is advised about those wards where staffing falls short of what is required to provide quality care, the reasons for the gap, the impact and the actions being taken to address the gap* *• Evaluates risks associated with staffing issues* *• Seeks assurances regarding contingency planning, mitigating actions and incident reporting* *• Ensures that the Executive Team is supported to take decisive action to protect patient safety and experience* *• Publishes the report in a form accessible to patients and the public on their Trust website (which could be supplemented by a dedicated patient friendly 'safe staffing' area on a Trust website)".*

	The performance relating to the fill rate (actual numbers of staff deployed vs numbers planned) on the wards for September was 97.6%: being a total fill rate of 95.4% for registered nurses and 99.9% for HCSWs. The position reflects that ward managers are effectively deploying additional staff to meet increasing patient needs as necessary. A full review will take place in November and will include the original review methodology. The review will take into account acuity and bed occupancy, workforce leadership and practice issues.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Customer Focus Strategy • Clinical Strategy • Governance Strategy • Workforce Strategy • Financial Strategy
Relationship with Annual Objectives:	Supports the delivery of the Trust's Annual Objectives and the delivery of high quality care.
Risk / Legal Implications:	Delivery of safe nurse staffing levels is a key requirement to ensuring that the Trust complies with National Quality Board standards.
Resource Implications:	Recruitment to vacant posts in progress.
Equality and Diversity Implications:	None
Relationship with the Board Assurance Framework	1. Focusing on quality and safety 2. Consistently meeting standards 3. Protecting our core services 4. Growing our specialised services 5. Innovating in the delivery of care 6. Developing academic partnerships and education and training initiatives 7. Being an employer of choice 8. Hosting a successful CQC inspection 9. Becoming digital by choice 10. Reviewing and rationalising our estate 11. Devolving accountability through local decision making that is clinically led assuring governance arrangements. 12. Delivering our financial plan
Recommendations:	To receive the report for assurance and information.

North Staffordshire Combined Healthcare NHS
NHS Trust

In patient safer staffing metrics-September 2015

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

Ward	Performance (% planned vs actual)				Overall fill rate%	Bed Occupancy % (including home leave)	Sickness %	Mand Training %	PDR %	Incident Rate	SI`s	Complaints
	Day %		Night %									
	Reg`d	Care	Reg`d	Care								
Ward One	123%	92.8%	100.1%	117.7%	108.4%	101 ↓	11.03↑	81↓	75↓	42 ↑	0 ↔	1↑

Ward Manager narrative:
Ward Manager reports a challenging month for bed pressures including availability to step down to ward 3 due to their over occupancy. Increase in incidents related to use of “legal high” substances and an increase in self harm attributable to one female service user. Sickness has increased with increase in staff reporting stress related conditions. Ward Manager actively engaging staff in utilising stress measurement tool to address underlying causes. Eleven DSN shifts covered. Overfill of shifts relates to ongoing high acuity including high levels of level 3 observation

Ward Two	108.9%	91.6%	103.4%	136.7%	110.1%	115%↑	3.93↓	78↓	85.1 ↓	23↑	0 ↔	0↔
Ward Manager narrative: Increased occupancy in September in addition to increased levels of observation based on risk assessment and management reflecting requirement for additional shift cover. Increase in incidents but no particular themes/trends. Awaiting commencement of two band 5 posts and band 6 post. Fifteen DSN shifts covered.												
Ward Three	112.2%	93.5%	122.6%	126.7%	113.7%	104↑	8.16 ↓	79↓	72↓	10↓	0 ↔	0↔
Ward Manager narrative: Increased occupancy with higher than usual readmission rate. Actively working with community teams to address this. Reducing sickness with long term sickness ending shortly. Mixture of care and registered sickness. No particular trends. High acuity particularly due to high observation levels requiring additional temporary staffing, where possible from own resource. Incident rate reduced. Thirteen DSN shifts covered and five shifts used to cover ECT from ward establishment.												
Ward Four	114.8%	60.5%	66.7%	110.3%	88.05%	86↓	0.00 ↓	95↑	85.7 ↑	14 ↑	0↔	1↑
Ward Manager narrative: **Reduced occupancy** during this month but active in-reach and liaison with UHNM to ensure clinically appropriate transfer at the first opportunity. Substantive recruitment to the ward agreed and will reduce reliance on agency and bank where a high number of cancelled shifts have been reported. Issues being dealt with through ward manager and HR relating to this. Under fill of registered nurses on night relates to the ward basing planned figures on two registered nurses with care staff booked to supplement the under-fill of registered staff. Generally there has been one registered nurse thus showing as an under fill however, reported by W/M that, occupancy and acuity has reduced with no impact on quality of care. Ten Duty Senior Nurse shifts covered. Increase of one incident in comparison to August. Review of incident data to look at themes/trends underway to provide assurance that reduced staffing fill rates have not impacted on safety.												

Ward Five	100%	102.4%	95.1%	101.7%	99.8%	82% ↓	2.98↓	85↓	93.1 ↓	17↑	0↔	1↑
Ward Manager narrative: No pressures on occupancy. Reducing sickness. Two band 5 vacancies currently being recruited to. Six DSN shifts covered. Small increase in incidents. No specific themes												
Ward Six	92.8%	96.0%	100%	100%	95.9%	95% ↓	16.99 ↑	91↑	100 ↔	9↓	0↔	0↔
Ward Manager narrative: Increase in sickness, post-surgery, stress and non-stress related short term sickness. Ward Manager post appointed and will lead to band 6 and band 5 posts now being advertised. Further, substantive recruitment to ward 4 will support release of staff to return to ward 6. Six Duty Senior Nurse shifts covered. Decrease in incidents in particular relating to the stabilisation of one patient.												
Ward Seven	92.8%	90.9%	109.6%	121.0%	103.5%	96%↑	0.39↓*	93↓	92↑	19↑	0↓	0↔
Ward Manager narrative: Increased occupancy during September due to fully occupied beds within NOAP areas at specific times. One fixed term vacancy to cover maternity leave currently being appointed to. Sickness remains low. Small increase in incidents with no specific trends. Five Duty Senior Nurse shifts covered. High fill rate of HCSW due to high night time activity including close observation and personal care.												
EMC	99.7%	87.3%	100%	98.4%	96.3%	83%↓	3.98↓	95↓	80.9 ↑	8↓	0↔	0↔
Ward Manager narrative: Reduced bed occupancy during September. Under-fill of HCSW covered by registered staff when and if required. Two band 5 vacant posts now recruited to and awaiting start date confirmation. Band 7 ward manager post appointed from external candidate. And 6 appointed to DSN band 7 role. Three Duty Senior Nurse shifts covered												
A&T	62.3%	116.0%	100%	100%	94.5%	80↔	1.27 ↓	85↓	100 ↑	14↓	0↔	1↑
Ward Manager narrative (combined A&T and Telford): Both units co-located with staffing supporting each unit flexibly based on acuity of each unit. Under-fill of registered staff enhanced by care staff with supernumerary deputy unit manager providing registered cover across both units and not included in the safer staffing data.												

Under occupancy between the two units occupied bed days 59% on beds in both units requiring less usage for temporary staffing whilst recruiting to vacant posts x 2 band 5 and 1 band 3. High input in to Duty Senior Nurse rota which will be addressed by appointment to 2 band 6 Duty Senior Nurse posts to be advertised Unit Leader reports no impact from under fill on safety and quality due to reduced acuity and occupancy. Incident rate reduced in September and reducing sickness rate across both units.												
Telford	76.3%	70.9%	100%	100%	86.8%	74↓	1.43↓	87↓	94.1 ↓	12↓	0↔	0↔
As above												
Summers View	95.8%	99.7%	100%	141.8%	109.3%	97↑	3.43 ↓	94↑	95↓	7↓	0↔	0↔
Ward Manager narrative: Small increase in occupancy, reduced sickness level in September although current sickness. Overfill on night duty care staff due to increase in observation levels absorbed by higher staffing availability on day shifts but requiring additional shifts on night. One band 5 post recruited to following retirement and band currently awaiting recruitment. Five Duty Senior Nurse shifts covered.												
F` House	106.7%	84.3%	100%	100%	97.7%	102% ↑	4.31	93↔	90.91 ↑	1↓	0↔	0↔
Ward Manager narrative: Small increase in bed occupancy. Only absence due to maternity leave. No safety or quality issues to report. Under fill on day care shifts covered by excess hours from registered staff.												
Darwin	90.5%	83.6%	88.8%	101.5%	91.1%	59% ↓	2.54↑	93↑	88.9 ↑	7↓	0↔	0↔
Ward Manager narrative: Reduced bed occupancy reflective of national picture at the current time. Shifts lost due to maternity leave, secondment and sickness (awaiting sickness data) but no impact on safety and quality given reduced occupancy and reduced acuity for this month. Registered staff shortfall on night duty covered by movement from other clinical area.												

D`Square	124.7%	98.6%	86.7%	86.7%	99.1%	68% ↓	3.22	95↑	100 ↓	2↑	0↔	0↔
Ward Manager narrative: Under-fill explained by closure of respite beds as planned each year. Additional resource booked during CQC inspection week to support visits by inspection team. No issues reported by modern matron												

Key points to note

- Safer Staffing review recommendations with proposed model presented to Executive meeting September 22nd and accepted. Review includes the following key points:-

- Wards 2, 3, 6 will receive an uplift in establishment.
- Appointment of Duty Senior Nurse completed and post holder commenced.
- Further two Band 6 Duty Senior Nurse posts to be advertised to support reduction in time out from inpatient settings for Band 6 Deputy Ward Managers.
- Newly recruited Ward Managers will commence 20% clinical shifts to provide enhanced leadership.
- Skill Mix reviewed-all adult acute inpatient wards will be staffed to 50:50 ratio.

Unify return September 2015

		Day				Night				Day		Night	
Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
710 - ADULT MENTAL ILLNESS		900.00	1106.55	1800.00	1670.10	322.00	322.39	965.30	1136.04	123.0%	92.8%	100.1%	117.7%
710 - ADULT MENTAL ILLNESS		900.00	980.50	1350.00	1236.75	321.60	332.43	642.90	878.75	108.9%	91.6%	103.4%	136.7%
710 - ADULT MENTAL ILLNESS		900.00	1009.50	1350.00	1262.50	321.60	394.44	642.90	814.44	112.2%	93.5%	122.6%	126.7%
715 - OLD AGE PSYCHIATRY		1350.00	1549.50	1800.00	1089.50	553.50	369.31	840.40	926.90	114.8%	60.5%	66.7%	110.3%
715 - OLD AGE PSYCHIATRY		900.00	900.00	1319.00	1350.00	295.51	281.10	552.83	562.20	100.0%	102.4%	95.1%	101.7%
715 - OLD AGE PSYCHIATRY		900.00	835.00	1800.00	1728.00	281.00	281.00	1040.00	1040.00	92.8%	96.0%	100.0%	100.0%
715 - OLD AGE PSYCHIATRY		900.00	835.00	1350.00	1227.00	281.10	308.14	562.50	680.82	92.8%	90.9%	109.6%	121.0%
700- LEARNING DISABILITY		900.00	560.25	1182.00	1370.75	225.75	225.75	1064.25	1064.25	62.3%	116.0%	100.0%	100.0%
700- LEARNING DISABILITY		768.00	585.75	1200.00	850.75	96.75	96.75	548.25	548.25	76.3%	70.9%	100.0%	100.0%
710 - ADULT MENTAL ILLNESS		900.00	897.00	900.00	785.50	281.10	281.10	562.20	553.27	99.7%	87.3%	100.0%	98.4%
711- CHILD and ADOLESCENT PSYCHIATRY		1170.00	1058.50	1110.00	928.50	383.00	340.00	602.00	611.00	90.5%	83.6%	88.8%	101.5%
710 - ADULT MENTAL ILLNESS		840.00	804.50	840.00	837.50	292.04	292.04	592.28	840.00	95.8%	99.7%	100.0%	141.8%
710 - ADULT MENTAL ILLNESS		450.00	480.00	900.00	759.00	312.90	312.90	312.90	312.90	106.7%	84.3%	100.0%	100.0%
700- LEARNING DISABILITY		450.00	561.00	962.00	949.00	277.50	240.50	277.50	240.50	124.7%	98.6%	86.7%	86.7%

Enclosure 6

REPORT TO TRUST BOARD

Date of Meeting:	29th October 2015
Title of Report:	Board Assurance Framework – Q2 Update
Presented by:	Laurie Wrench, Associate Director of Governance
Author of Report: Name: Date: Email:	 Laurie Wrench 21st October 2015 Laurie.wrench@northstaffs.nhs.uk
Committee Approval/Received prior to Trust Board:	• **Quality Committee** • **Finance and Performance Committee** • Audit Committee • **People and Culture Development Committee** • Charitable Funds Committee • Business Development and Investment Committee
Purpose / Intent of Report:	• Assurance and Information
Executive Summary:	The Board Assurance Framework (BAF) aligns the Trust strategic objectives to our quality priorities and key risks including the Board's level of risk appetite. The BAF provides an update and RAG rating for those actions due during quarter 2 and provides an update against future actions including gaps and challenges to be addressed. In Q2, the Trust introduced a target RAG rating providing a year-end forecast to delivery.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• **Customer Focus Strategy** • **Clinical Strategy** • **IM & T Strategy** • **Governance Strategy** • **Innovation Strategy** • **Workforce Strategy** • **Financial Strategy** • **Estates Strategy**
Relationship with Annual Objectives:	The Board Assurance Framework describes the risks, progress, mitigation and actions to be taken to deliver the Trust's strategic objectives.
Risk / Legal Implications:	None
Resource Implications:	None
Equality and Diversity Implications:	None
Relationship with the Board Assurance Framework	1. Focusing on quality and safety 2. Consistently meeting standards 3. Protecting our core services 4. Growing our specialised services 5. Innovating in the delivery of care 6. Developing academic partnerships and education and training initiatives

	7. Being an employer of choice 8. Hosting a successful CQC inspection 9. Becoming digital by choice 10. Reviewing and rationalising our estate 11. Devolving accountability through local decision making that is clinically led assuring governance arrangements. 12. Delivering our financial plan
Recommendations:	The Board receive the Q2 Update against the Board Assurance Framework for assurance and information purposes

North Staffordshire Combined Healthcare NHS Trust

Board Assurance Framework (BAF)

Welcome to the Board Assurance Framework for North Staffordshire Combined Healthcare NHS Trust.

The Trust Board is responsible for ensuring that North Staffordshire Combined Healthcare NHS Trust consistently follows the principles of good governance applicable to NHS organisations. The Board does this through the development of systems and processes for financial and organisational control, clinical and information governance and risk management.

Our Board Assurance Framework identifies the procedures for risk management against our key strategic objectives, encompassing the management of all types of risk to which the Trust may be exposed, our controls and the assurances we have in place. This includes the effective integration and management of clinical and non-clinical risk.

Those key risks, mapped against our two strategic goals and 12 objectives are set out in the following pages. We have also categorised each objective against our quality priorities – SPAR. RAG ratings have been provided for those actions due during Quarter 2 with the addition of a forecast RAG rating for year end.

safe • personalised • accessible • recovery focused

spar

our vision
To be a **high quality** health and social care provider that continuously improves **patient experience** and deploys its **resources** intelligently and efficiently

our values
valuing people as **individuals**
providing high quality **innovative care**
working together for better lives
openness and **honesty**
exceeding expectations

Goal:	**To improve patient experience and pathways**
Objective 1:	**Focusing on quality and safety**
SPAR PRIORITY	
Exec owner:	Medical Director (MD) and Director of Nursing (DoN)
Assurance Committee:	Quality

Risk appetite									
	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2
	Safety		4		1		0		1

RISK: The Trust fails to improve patient safety, eliminate avoidable harm and deliver high quality services, resulting in reputational harm, increased scrutiny and regulatory restrictions	**Gross Risk**			**Residual Risk**			**Target Risk**		
	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE
	3	4	12	2	4	8	1	4	4

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q2 RAG status**	**End Year RAG Forecast**
1.1	Reduce medication errors.	10% reductions based on 31 March 2015 position. 2.5% reduction to be achieved per quarter	5% by end of Q2	30% reduction achieved	MD	GREEN	GREEN

1.2	Deliver CQUIN targets: • Implementation of appropriate processes relating to cardiometabolic risk factors • Evidence communication to GPs of specified clinical information • Edinburgh Mental Wellbeing Scale. • Reducing medication errors through the implementation of the Medication Safety Thermometer in community services • Embedding a safety culture • Measuring service outcomes for people with learning disabilities.	Fully deliver targets.	All targets achieved by end Q2	Potential risks to achievement at Quarter 2 as follows: • **GOAL 4 MAPSAF** Additional evidence requested by commissioners. All other Q2 targets achieved	ADG	YELLOW	GREEN
1.3	Perform QIA of all CIPs ensuring no impact on delivery of quality service	All CIP schemes have QIA scrutiny resulting in Directorate, MD and ND approval and ongoing monitoring of quality metrics.	July 2015.	Action complete. Has been agreed at monthly Care Quality Review Meeting with Commissioners Quality KPIs agreed for CIP is regular agenda item on the monthly performance monitoring meeting for Directorates	MD/DoN	GREEN	GREEN

1.4	Improve the multi-disciplinary team approach.	Psychology embedded in all directorates	March 2016	• Adult inpatient complete • Adult community complete • Learning disabilities complete • Children and young people complete • NOAP ongoing NOAP continue to move forward with embedding a multi-disciplinary approach within teams. Social work support has been factored into the business case for Ward 4 and discussions are in progress with Psychology in terms of increasing their input to the Directorate.	MD		GREEN
1.5	Raise the service user voice across the Trust.	Establish the Patient Council Service User to sit on Board Committees and on the Board.	March 2016	Council established Patient Experience Lead in post	DoN	GREEN	GREEN
		Family & Friends Test response rate increased by 30% 7.5% per quarter	15% by end Q2	15% increase not achieved. **Inpatient:** To achieve 30% increase n=37 additional responses. 0% increase as of Q2. **Community:** To achieve 30% increase n=12 additional responses. 15% decrease as of Q2. This will now be taken forward by the appointed Patient Experience	DoN	AMBER	**RED**

				Facilitator working with Service Users, Council membership and Directorate Team Managers to agree a plan to address and encourage improvement in low return rates			
		PALs contacts increased by 10%. 2.5% per quarter	5% by end Q2	Achieved Q4 2014/15 = 46 PALS (increase of 4 PALS required). Q1 2015/16 = 72 PALS increase of 26 cases.	DoN	GREEN	GREEN
		Complaints reduced by 10%. 2.5% per quarter	5% by end Q2	Achieved 2013/14= 94. 2014/15= 65 reduction of 29. 105 would be a reduction of 9.	DoN	GREEN	GREEN
1.6	Ensure Nurse Revalidation.	Embed process with HR to ensure 100% assurance.	April 2016	Corporate Quality Lead nurse working alongside HR to embed this process NMC have confirmed state of readiness and revalidation commencement from April 2016.	DoN	YELLOW	GREEN
1.7	Reduce moderate harm incidents per 1,000 bed days.	Trust position, as measured by NRLS, reduced from average to better than average.	Ongoing	Improved position for dataset for April 2014 - September 2014. Median reporting for Trust is 41.27 per 1000 bed days compared to national average of 32.82.	DoN	YELLOW	GREEN
1.8	Ensure infection free environments.	10% increase in number of patients vaccinated against Flu. Nil MRSA cases.	March 2016	Vaccination programme launched and being led by IPC Nurse. Current position maintained.	DoN	GREEN	GREEN

Goal:	**To improve patient experience and pathways**									
Objective 2:	**Consistently meeting standards**									
SPAR PRIORITY										
Exec owner:	Director of Operations (DO)									
Assurance Committee:	Finance and Performance									
Risk appetite	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2	
	Safety		4		1		0		1	

RISK: The Trust fails to hit required performance targets and is placed under a greater scrutiny regime by the TDA.	**Gross Risk**			**Residual Risk**			**Target Risk**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	3	3	9	3	3	9	2	3	6

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q2 RAG status**	**End Year RAG Forecast**
2.1	Delivery of new national mental health access targets.	Plan approved by Board EI September target is 20% - performance 23% IAPT 6 week target is 75% - performance 94.5% IAPT 18 week target is 95% - performance	June 2015	Maintain performance	DO	GREEN	GREEN

		100%					
2.2	Deliver operational KPIs.	Deliver (measures monthly and report to F&P committee) with rectification plans as needed.	March 2016	CPA and IAPT targets delivered	DO	GREEN	GREEN

Goal:	**To improve patient experience and pathways**									
Objective 3:	**Protecting our core services**									
SPAR PRIORITY										
Exec owner:	Director of Strategy and Development (DSD)									
Assurance Committee:	Business Development									
Risk appetite	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2	
	Safety		4		1		0		1	

RISK: The Trust fails to consolidate its position as the local provider of local mental health and learning disability services, loses business to other providers and is not clinically, financially or operationally sustainable.	**Gross Risk**			**Residual Risk**			**Target Risk**		
	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE
	4	4	16	3	4	12	2	4	8

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q2 RAG status**	**End Year RAG Forecast**
3.1	Respond to commissioners' service development opportunities.	Produce approved business cases for PICU, high dependency rehabilitation, ward reconfiguration, learning disabilities and dual care.	June 2015 to Commissioners July 2015 approved by Trust Board	Submitted to Commissioners 30 June. Received by QC and F&PC June and July. Commissioner support being sought escalated to October commissioning board.	DSD	GREEN	GREEN

3.2	Respond to tender opportunities and lead the bidding process as prime contractor.	Deliver service and capital changes linked to approved business cases.	From August 2015 to agreed phasing	Shropshire Community Substance Misuse tender submitted 1 July 2015. Leicester Substance Misuse tender submitted 10 July 2015. Clarification questions for Staffordshire substance misuse submitted 8/10/15	DSD	GREEN	AMBER
		RAID	December 2015	Commissioners yet to publish commissioning intentions Improved performance of RAID targets with !00% response in emergency portals	DSD		GREEN
		IAPT	March 2016	Commissioners extended IAPT contract Significant improvement in IAPT performance	DSD		GREEN
3.3	Embed mental health services with Physical health and social care	Support delivery of long term condition funding with UHNM Continued commissioning of Ward 4	December 2015	Executive engagement in developing collaborative approach. Agreement with UHNM that mental health integral to LTC Agreement of funding extended until March 2016	DSD		YELLOW

Goal:	**To improve patient experience and pathways**									
Objective 4:	**Growing our specialised services**									
SPAR PRIORITY										
Exec owner:	Director of Strategy and Development (DSD)									
Assurance Committee:	Business Development									
Risk appetite	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2	
	Safety		4		1		0		1	

RISK: The Trust fails to consolidate its position as the local provider of local mental health and learning disability services, loses business to other providers and is not clinically, financially or operationally sustainable.	**Gross Risk**			**Residual Risk**			**Target Risk**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	4	4	16	3	4	12	2	4	8

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q2 RAG status**	**End Year RAG Forecast**
4.1	Develop the Trust's capacity and capability for commercial change.	Appoint a substantive Director of Strategy & Development.	May 2015	Achieved. Starts 14 September 2015.	CEO	GREEN	GREEN

		Establish a Business Development and Investment Committee.	November 2015	Business development interface discussion Board Away day October First Committee scheduled for November.	DSD		GREEN
		Produce a comprehensive business planning framework for annual business planning.	January 2016	in line with IBP refresh	DSD		GREEN
		Enhance horizon scanning and business opportunity identification.	December 2015	Directorate operational plan meetings in place to develop directorate	DSD		GREEN
		Train SLT in core competencies: business case production and project management.	December 2015	NHS Elect training session Qtr 1 2015 done in conjunction with PMO	DSD		GREEN
		Establish rules and principles for bidding.	November 2015	Directorate operational plan meetings to support prioritisation of new business opportunities.	DSD		GREEN
4.2	Respond to tender opportunities and lead the bidding process as prime contractor.	Stoke on Trent Substance Misuse services.	June 2015	Inpatients retained. Community and Recovery not successful.	DSD	GREEN	GREEN

		Staffordshire in-patient Substance Misuse services.	September 2015	Tender submitted and Clarification questions submitted 8/10/15	DSD	YELLOW	GREEN
		Shropshire Community Substance Misuse services.	July 2015	Unsuccessful – Lessons learned process underway	DSD	RED	RED
		Adult PICU repatriation + spot purchasing	March 2016	Commissioner support clarity on volumes of activity and	DSD	AMBER	GREEN
4.3	Work with independent and third sector partners to implement new and innovative models of care.	Priory and Staffordshire Housing for CAMHS Tier IV	December 2015	Contact made, commissioning intentions indicate reduced bed demand for CAMHS tier 4 exploration of Children's PICU	DSD	AMBER	AMBER
		RAPT for prison in-reach services	December 2015	Stoke Heath Prison contract extended 2 years. Consideration around Wrexham 800 bed discussed with directorates	DSD	GREEN	GREEN
		Develop proposal for ICO with Stoke-on-Trent Council	May 2015	Proposal complete, Presented to Council Executives , September 2015	CEO	GREEN	GREEN
		Develop partnership with Northern Staffordshire GP Federation.	June 2015	Joint bid for dementia in primary care submitted to the Health Foundation GP locality meetings established	CEO	GREEN	GREEN

Goal:	**To improve patient experience and pathways**									
Objective 5:	**Innovating in the delivery of care**									
SPAR PRIORITY										
Exec owner:	Medical Director (MD)									
Assurance Committee:	Quality									
Risk appetite	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2	
	Safety		4		1		0		1	

RISK: The Trust fails to exploit its potential in innovation and loses credibility and reputation in the healthcare community.	**Gross Risk**			**Residual Risk**			**Target Risk**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	4	3	12	3	3	9	2	3	6

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q2 RAG status**	**End Year RAG Forecast**
5.1	Raise the profile and influence of the Trust across region for innovation.	Chief Executive - Chair of Regional MHLETC.	June 2015	CEO chaired 1st Mental Health LETC and gave presentation to c200 stakeholders	CEO	**GREEN**	GREEN
		Chief Executive is Workforce and OD lead for pan-Staffordshire programme	September 2015	Director of Leadership and Transformation appointed	CEO	**GREEN**	GREEN

		Trust selected to be featured in Healthcare Parliamentary Review	March 2016	DoH contacted Trust	CEO	**GREEN**	GREEN
		Director of Leadership and Workforce – Regional W/F planning lead.	June 2015	Trust DL&W is regional lead	DL&W	GREEN	GREEN
		Medical Director – Regional Dementia Lead	June 2015	A Skills and Competency Framework has been agreed, as has a catalogue of the resources and courses which are available to train and educate staff. A tool has been piloted which can be applied to any health or care organisation to identify training needs. Next steps include identifying what new courses and resources need commissioning, and setting up a web site and marketing campaign to inform every member of staff in organisations across the region how to access the resources.	MD	GREEN	GREEN
		Chief Executive – Leadership Lead for Shropshire & Staffordshire	June 2015	CEO leading on talent management and compassionate leadership across Shropshire and Staffordshire. CEO requested to lead workforce and leadership across Staffordshire. Director of Leadership and Workforce appointed	CEO	GREEN	GREEN
5.2	Improve our approach to service improvement.	Establish service improvement capacity and capability within the Trust.	September 2015	Posts now banded and out to advert in October	DLW	RED	GREEN
		Demonstrate improvements in at least 10 services.	March 2016	Awaiting posts to commence as above	DL&W		AMBER

		Train at least 30 staff in service improvement	March 2016	Awaiting posts to commence as above	DL&W		AMBER
5.3	Participate in the Staffordshire wide research strategy and West Midlands academic health sciences network.	Enhance relationships with local partners on the development and delivery of research.	March 2016	R&D Workshop held with Keele University to refresh vision. The Trust is part of the ongoing Staffordshire Wide Research group and is currently leading on a research engagement project on behalf of the WM CRN.	MD		GREEN
5.4	Encourage increased participation in research across all professional groups across the Trust.	Develop Trust wide information of all published research.	September 2015	Complete. To be updated quarterly.	MD	GREEN	GREEN
		Recognize research as part of REACH awards.	September 2015	Complete. Assessed under innovation category for 2015 and will be a standalone recognition award in 2016	MD	GREEN	GREEN
		Establish Trust wide research group with multi-professional membership.	December 2015	Currently research discussed at the Clinical Effectiveness group with plans to re-establish the standalone Research Interest Group	MD		GREEN

Goal:	**To improve patient experience and pathways**									
Objective 6:	**Developing academic partnerships and education and training initiatives**									
SPAR PRIORITY										
Exec owner:	Director of Leadership and Workforce (DLW)									
Assurance Committee:	People and Culture Development									
Risk appetite	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2	
	Safety		4		1		0		1	
RISK: The Trust fails to educate and develop its workforce resulting in the failure to deliver safe quality services impacting on the ability to attract talent.		**Gross Risk**			**Residual Risk**			**Target Risk**		
		LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
		3	4	12	2	4	8	2	4	8

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q2 RAG status**	**End Year RAG Forecast**
	6.1 Improve our approach to education and development	Refresh the PDR process and ensure that 90% have a PDR and that we are above average in comparison with other MH Trust's for quality of experience as evidenced in the staff survey.	Quarterly	Quality of PDR Audits will be undertaken which will inform a refresh of the process	DL&W	RED	GREEN

		Business case for professorial unit	March 2016	Workshop held. Medical Director to maintain links with Keele. Business Case to be developed with the Director of Strategy and Development, led by the Medical Director.	MD		GREEN
		Ensure that 95% of teams have undertaken the ARTP review process. Show improvement in 75% of the teams.	March 2016	80% teams as of Q2 have completed their first ARTP	DL&W		YELLOW
		Launch You Tube learning channel.	November 2015	NSCHT You Tube channel in place. Additional learning channels with a specific focus on key trust services being developed by OD and Communications New channel now in place with launch in November planned	DL&W		GREEN
		Improve education experience for learners within the Trust as demonstrated by improvement in all experience surveys. Improve JEST scores from good to excellent.	March 2016	JEST scores received in June achieved this. Two reported as 'needing attention' with all other scores at 'good' or 'excellent'	DL&W		GREEN
		All newly appointed Consultants allocated a mentor.	October 2015	System set up for a mentor to be allocated as part of the induction process. Objectives to be achieved set up for mentor and consultant with a quarterly review.	MD		GREEN

		Develop an OD plan including talent management	July 2015	OD plan to be developed by end December 2015	DL&W	RED	GREEN

Goal:	**To improve patient experience and pathways**									
Objective 7:	**Being an employer of choice**									
SPAR PRIORITY										
Exec owner:	Director of Leadership and Workforce (DLW)									
Assurance Committee:	People and Culture Development									
Risk appetite	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2	
	Safety		4		1		0		1	

RISK: The Trust fails to manage relationships with it is staff, to improve engagement and enhance inclusion resulting in higher turnover and reduced effectiveness of service delivery, threatening clinical and operational sustainability	**Gross Risk**			**Residual Risk**			**Target Risk**		
	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE
	4	4	16	3	4	12	2	4	8

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q2 RAG status**	**End Year RAG Forecast**
7.1	Become an employer of choice	Produce workforce plan that supports the Integrated Business Plan.	May 2015	Completed as part of the TDA and Health Education West Midlands submissions	DL&W	**GREEN**	GREEN

		Refresh the workforce planning process to strengthen competency based workforce planning produces Directorate detailed workforce plans.	June 2015	Template for Directorate one year workforce plans produced and populated by directorates	DL&W	GREEN	GREEN
		Reduce stress at work and sickness to below 4%.	March 2016	Stress Less Action Plan in place and being implemented. Monitored through PCD and linked to Staff Survey actions. As a % of the absence reasons there has been a decrease from July to August 2015 from 34.24% to 31.6%. The Adult Inpatient Directorate which had the highest % now shows a downward trend. Overall sickness absence in August was 3.98% under the target however the rolling figure remains at 4.5%.	DL&W		YELLOW
		Reduce the average time taken to recruit new employees by half.	October 2015	• Part of LIA Team • 'One stop shops' in place for large campaigns • EDBS live in July • OH process streamlined Time taken to recruit has reduced by on average around 4 weeks with a target of 6 week reduction. Further work is ongoing to reduce it with expectation that it will reach 6 weeks by year end.	DL&W		GREEN
7.2	Improve Communication and Engagement.	Improve the staff survey results in 25% of areas.	March 2016.	LiA Pulse check second round shows improvement in staff experience	DL&W		YELLOW
		Improve satisfaction of staff with experience of change measured by	March 2016.	Staff survey currently out for completion.	DL&W		YELLOW

		improving the staff survey scores to above average for MH Trusts.		Quarterly Friends and Family figures show slight deterioration			
		Develop a communication strategy for Communication and Engagement that is co-produced across the Trust and approved by the Board	February 2016	NHS Elect commissioned to diagnose and Board Development session planned for December 2015	DL&W		GREEN
		Develop Corporate Accountability Framework (CAF).	October 2015	Accountability framework to be developed	DL&W		RED
		Implement CAF in line with agreed plan	March 2016		DL&W		GREEN
7.3	Support and enhance inclusion.	Develop a strategy and plan to improve inclusion, diversity and equality within the Trust.	November 2015.	Using Autonomy Framework as a start point this will be developed across the whole Trust with particular focus on delivery of accountability of corporate services to Clinical Directorates Appointment of dedicated lead in post. E&D Plan developed in full	DL&W		GREEN
		Implement approach to widening participation to ensure that we deliver: • 10 apprenticeships • Enable 10 people to use the process • Increase active volunteers by 25%	March 2016.	Widening Participation lead now in post. Apprentice numbers already over half way to target.	DL&W		GREEN

		• Introduce Peer Support Workers Every selection process across the Trust invites service user representation					

Goal:	**To improve patient experience and pathways**									
Objective 8:	**Hosting a successful CQC inspection**									
SPAR PRIORITY										
Exec owner:	Chief Executive (CEO)									
Assurance Committee:	Quality									
Risk appetite	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2	
	Safety		4		1		0		1	

RISK: The Trust fails to secure an overall "good" rating in its CQC inspection, resulting in loss of reputation, reduced opportunity for development and greater scrutiny from regulators..	**Gross Risk**			**Residual Risk**			**Target Risk**		
	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE
	4	4	16	3	4	12	1	4	4

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q2 RAG status**	**End Year RAG Forecast**
8.1	Update the current supervision policy and develop a management supervision policy, ensuring structures are in place at all levels of the Trust identifying supervisors for all staff. We will develop a	a. Update clinical supervision policy. b. Develop a management supervision policy. c. Ensure structures are in place at all levels of the trust including identifying supervisors for all staff	August 2015	The LIA group has delivered the planned objectives set for 20 weeks it now needs a period of consolidation and quality assurance to ensure embedded. The recording process, whilst being used and over 250 recorded sessions, is not yet being utilised throughout.	DL&W	AMBER	GREEN

	data system whereby supervision can be recorded and set supervision targets which are monitored through the directorate performance dashboards.	including Band 3. d. Develop a data system whereby supervision can be recorded for example through ESR. e. Set supervision targets that are monitored through the directorate performance dashboards.					
8.2	Review the Ligature Risk Review policy and environmental risk assessment tool, together with all risk assessment plans from wards and clinical areas to identify gaps/ problems.	a. Review the current policy and environmental Risk Assessment tool. b. Review all Risk Assessment plans from ward & clinical areas. c. Identify gaps and problems. d. Identify work that should be progressed to improve the clinical environments.	August 2015.	Trust has established LiA Environmental Risk Group comprising membership from operating corporate and estates teams. The group has - • Reviewed existing policy and compliance with policy. • Identified gaps in the policy and associated processes. • Reviewed Environmental Risk Registers and identified themes. • Enhanced the policy and recommended approval by the Quality Committee (21st July 2015) Plans to be developed going forward to address objective D	DoN	AMBER	GREEN
8.3	Develop a caseload management system use and embed this across all teams.	Develop a caseload management system for all community teams to use.	August 2015.	Caseload management tool completed during August. Roll out an embedding of process in Q3	DO	AMBER	GREEN
8.4	Develop a transition policy for Children & Young People to Adult & Adult to Older People's services, and	a. Develop a transition policy for children & YP to adult and adult to older people's services.	August 2015	It was decided that Guidance would be issued as opposed to a policy. This was completed and issued in August.	DO	AMBER	AMBER

	review transitions between learning disabilities and mental health services. Review systems and inter team working to identify issues and improve the pathway for patients.	b. Review transitions between LD and MH services. c. Identify any pathway issues/concerns and provide solutions in relation to above. d. Review systems and inter team working for example community to inpatient and identify issues & solutions to improve the pathway.		Plans to be developed going forward to address objectives B, C and D which were outside the original scope of the LiA Work			
8.5	Improve MHA compliance in relation to record keeping.	a. Case file responsibility & general housekeeping. b. S17 leave. c. S132 Patient Rights. d. S58 Consent to treatment.	August 2015	The Listening into Action working group and Health Records Group are working collaboratively to improve compliance with record keeping including refresh of policy, guidance notes and training. While aspects of the work will always be ongoing, key actions are on track for completion. The year-end RAG relates to completion of those actions.	MD	GREEN	GREEN
8.6	Review the Bed Management processes to identify blockages in the system and also undertake a capacity and demand exercise. Establish and embed the bed management and establish metrics for success in relation to out for area bed usage, length of stay and readmission rates.	a. Review bed management processes. b. Identify blockages in the system. c. Capacity & demand exercise. Review bed usage by care cluster for example a high use by cluster 8s. d. Review gatekeeping. e. Review admission & discharge pathways. f. Review role of the community teams &	August 2015.	A full review of the bed management process is underway with significant progress made to realise assurances.	DF	AMBER	AMBER

		interface. g. Establish bed management					

Goal:	**To deploy our resources more efficiently and intelligently**								
Objective 9:	**Becoming digital by choice**								
SPAR PRIORITY									
Exec owner:	Director of Strategy and Development (DSD)								
Assurance Committee:	Business Development								
Risk appetite	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2
	Safety		4		1		0		1

RISK: The Trust fails to invest appropriately in its infrastructure meaning that it is unfit for the future and the Trust is unable to deliver its business goals and objectives.	**Gross Risk**			**Residual Risk**			**Target Risk**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	3	4	12	2	4	8	1	4	4

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q2 RAG status**	**End Year RAG Forecast**
9.1	Establish a robust governance structure	Programme Governance Board in place. Information Sharing and Service	June 2015 June 2015	Achieved. Achieved.	DSD	GREEN	GREEN

		Management Groups in place.					
9.2	Enhance Trust internal capacity and capability.	Appointment of Chief Information Officer Appointment of Head of Portfolio Management.	June 2015 October 2015.	Achieved. Starts in post 27 July 2015. Interviews completed appointments made	DSD	GREEN	GREEN
9.3	Develop key partnerships to initiate and build on lessons learned elsewhere and to implement change within the Trust.	Formalised agreements with Airedale NHS Foundation Trust; SAS; Service user app (Staffordshire University). Telemedicine Predictive text analysis Suicide Prevention	October 2015. December 2015 October 2015. Live November 2015.	Prioritisation of digital initiatives. Digital engagement strategy to be developed on to provide framework for external partnerships linked to key deliverables.	DSD	GREEN	GREEN
9.4	Progress on delivery of an electronic patient record for the Trust.	Business case development with CSC and approved by Trust Board.	October 2015	Lorenzo investment case stage 1 submitted to October Digital by choice board and submitted to HSCIC. Lorenzo investment case stage 2 in work up	DSD	GREEN	GREEN

Goal:	**To deploy our resources more efficiently and intelligently**									
Objective 10:	**Reviewing and rationalising our estate**									
SPAR PRIORITY										
Exec owner:	Director of Operations (DO)									
Assurance Committee:	Finance and Performance									
Risk appetite	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2	
	Safety		4		1		0		1	

RISK: The Trust fails to manage its infrastructure, meaning that it's unfit for the future and the Trust is unable to deliver its business goals and objectives.	**Gross Risk**			**Residual Risk**			**Target Risk**		
	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE
	4	4	16	3	4	12	2	4	8

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q2 RAG status**	**End Year RAG Forecast**
10.1	Sale of Bucknall Hospital.	Contract of sale exchanged.	June 2015	Exchange completed August 2015 (£200k non-refundable deposit paid by Keep Moat)	DF	GREEN	GREEN
		Contract of sale completed.	December 2015	Completed	DF	GREEN	GREEN

10.2	Produce an estates rationalization plan.	Plan approved by Board, with clear trajectories and milestones to reduce accommodation footprint linked to a mixed economy of freehold and leasehold properties.	November 2015	• Business case submitted to Board	DO		GREEN
10.3	Master plan for Harplands Hospital.	Approved development control plan demonstrating medium to long term potential.	September 2015	Business cases for PICU, Darwin, Dragon Square have been achieved. Due to ongoing dialogue with commissioners in respect of A&T/Telford and ward reconfiguration, this is still in abeyance. Development away day with Directorates planned for November to develop next stage**.**	DO	GREEN	GREEN

Goal:	**To deploy our resources more efficiently and intelligently**									
Objective 11:	**Devolving accountability through local decision making that is clinically led assuring governance arrangements.**									
SPAR PRIORITY										
Exec owner:	Director of Operations (DO)									
Assurance Committee:	Finance and Performance									
Risk appetite	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2	
	Safety		4		1		0		1	

RISK: The Trust fails to meet key regulatory and compliance requirements and is placed under a greater scrutiny regime by the TDA.	**Gross Risk**			**Residual Risk**			**Target Risk**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	3	4	12	2	4	8	1	4	4

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q2 RAG status**	**End Year RAG Forecast**
11.1	Develop a Board Assurance Framework.	BAF embedded and used to drive committee business.	June 2015 (achieved).	Achieved	CEO	GREEN	GREEN
11.2	Maintain a strong Head of Internal Audit opinion.	No negative assurances in the annual governance statement Positive opinion, demonstrating	ongoing	Positive opinions received for 2014/15	CEO	GREEN	GREEN

		robust system of internal control.					
11.3	Maintain quality governance standards.	Maintain performance against Quality Surveillance Score green, CQC banding 1, TDA rating 4.	ongoing	Achieved	CEO	GREEN	GREEN
11.4	Strengthen contract management.	Review approach to contract management, led by the Head of Legal Services.	March 2016	As part of contract pre meeting in July and September the Commissioning Team will identify the level of support required by the Trust to ensure any legal issues relating to contracts are considered. The role of the Legal Advisor will be drafted. Plan will go to Finance and Performance Committee November	DF		GREEN
11.5	Improve effectiveness of the audit committee.	Timely delivery of the internal audit plan and completion of audit recommendations.	Sept 2015	Ongoing review to follow up action on outstanding recommendations	DF	AMBER	GREEN

Goal:		**To deploy our resources more efficiently and intelligently**							
Objective 12:		**Delivering our financial plan**							
SPAR PRIORITY									
Exec owner:		Director of Finance (DF)							
Assurance Committee:		Finance and Performance							
Risk appetite	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2
	Safety		4		1		0		1

RISK: The Trust fails to meet its financial responsibilities and/or fails to deliver year one of its LTFM, resulting in greater scrutiny form regulators and commissioners and the threat of financial non-sustainability.	**Gross Risk**			**Residual Risk**			**Target Risk**		
	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE
	3	4	12	2	4	8	1	4	4

	CONTROLS	ASSURANCES	TIMESCALE	GAPS AND ACTIONS	Lead Director	End Q2 RAG status	End Year RAG Forecast
12.1a	Spend within cash resource limit.	CIP plans are robust and delivered to time and financial targets for 2015/16.	Q2 end September 2015	Q2 Year to date is on track Element of non-recurring CIP still remains	DF	GREEN	AMBER
		Budgets approved with a robust system of recording activity for payment by results (ongoing).	May 2015	Complete	DF	GREEN	GREEN

12.1b		Development of robust CIP plans for 2016/17	October 2015	Commencement of discussions with Clinical Directors and Heads of Directorate	DO		GREEN
12.2	Embed service line reporting within Directorates.	SLR information produced (quarterly) with financial reporting based on commercial, profit and loss basis (ongoing).	August 2015	2014/15 First draft will be finalised July 2015. Q1 data will be finalised in September 2015. Paper to November Finance and Performance Committee	DF	AMBER	GREEN
12.3	Improve the Trust's performance management and reporting processes.	Board report developed to support better understanding of the Trust's financial position.	July 2015	Board report to be linked to Balanced Scorecard	DF	AMBER	GREEN
		Balanced scorecard developed showing workforce, quality, finance and performance quadrants.	July 2015	Plan for completion as follows: • Quality – September • Performance - October • Workforce – November • Finance – November The Board will be able to fully drill down by Directorates in January 2016	DF	AMBER	GREEN
		Responsibility for performance management transferred to the Director of Strategy and Development under the management of the Chief Information Officer and Digital by Choice.	November 2015	Discussion will take place in September with the Director of Strategy and Development and Director of Finance to make corporate arrangements for transfer	DF		GREEN

12.4	Focus on Efficiency and Productivity.	Review the pharmacy service delivery model by undertaking a cost benefit analysis.	March 2016	Review with Director of Strategy and Development	MD		AMBER
		Implement revised PFI contract management arrangements, focusing on accountability through process.	June 2015	New structures operational. Work this year is focussed on improving value for money and improved transparency on contract particularly in relation to environment life cycle	DO	GREEN	GREEN
		Seek best value for money in the PFI contract, identifying savings that could be realised.	September 2015.	Complete. Savings of circa £65K identified	DO	AMBER	GREEN
		Reducing Drugs overspend by 50%.	25% reduction by end Q2	The current projection for year end 15/16 indicates an 10% increase in overspend compared to year end 14/15 The Chief Pharmacist will actively work with directorates to help them understand drug expenditure and develop recovery actions plans to reduce drug overspend	MD	RED	RED
		Lead Psychiatrist identified for each GP locality	September 2015	Lead identified	MD	GREEN	GREEN
		Further embed improvement in GP relationships by increasing the use of GP support email by a further 20% from March 2015 baseline (March 2016).	10% increase by end Q2	10% increase achieved	MD	GREEN	GREEN

12.5	Completion of capital investment in line with plan	Progress reported to Finance and Performance Committee and Board to confirm progress	Quarterly	Small variance to capital programme remains on track. End of year forecast aligns to plan	DF	AMBER	AMBER

Enclosure 7

REPORT TO TRUST BOARD

Date of Meeting:	29 October 2015
Title of Report:	Quality Surveillance Letter
Presented by:	Caroline Donovan
Author of Report: Name: Date: Email:	Caroline Donovan 14 October 2015 Caroline.donovan@northstaffs.nhs.uk
Committee Approval/Received prior to Trust Board:	Not applicable
Purpose / Intent of Report:	Information /Assurance
Executive Summary:	NHS England uses a Surveillance Rating System. The letter indicates that the Trust is rated as Green – Regular Surveillance – no specific concerns but watching eye on any dips in performance .
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Clinical Strategy • Governance Strategy • Financial Strategy •
Relationship with Annual Objectives:	-
Risk / Legal Implications:	-
Resource Implications:	-
Equality and Diversity Implications:	-
Relationship with the Board Assurance Framework	Not applicable
Recommendations:	Receive for assurance purposes

Dear Caroline

Caroline Donovan
Chief Executive
North Staffordshire Combined
Healthcare NHS Trust
Trust Headquarters
Bellringer Road
Trentham
ST4 8HH

North Midlands Area Team
Anglesey House
Towers Business Park
Wheelhouse Road
Rugeley
Staffordshire
WS15 1UZ

Telephone Number : 011382 50526

2 October 2015

Re: Letters to CEO post Quality Surveillance Group

Following the Quality Surveillance Group held on the 29 September 2015. I am writing to inform you of the discussion which took place regarding your organisation.

- Ward 4 Shared Care – decrease in staff fill rates
- That a CQC inspection was undertaken on 7 September 2015

NHS England now uses a Surveillance Rating and your organisation is rated

Green: Regular Surveillance:- No specific concerns but watching eye on any dips in performance.

With Kind Regards

Yours sincerely

Wendy Saviour
Director of Commissioning Operations

Cc
Lee George, NSCCG
Lorraine Cook, SOTCCG
Julie Oxtoby,NSCCG

Definitions

Green: Regular Surveillance:- No specific concerns but watching eye on any dips in performance
Amber: Enhanced Surveillance:- Concerns need to be reviewed at every meeting due to existence of recover action plans/increased visits/contractual measures.
Red: Risk Summit Required:- Significant concerns beyond the need for enhance surveillance, which reinstate further action in form of a risk summit.

REPORT TO TRUST BOARD (OPEN)

Date of Meeting:	29 October 2015
Title of Report:	Monthly Finance Reporting Suite – September 2015
Presented by:	Ann Harrison, Interim Director of Finance
Author of Report: Name: Date: Email:	 Andy Turnock 22 October 2015 andrew.turnock@northstaffs.nhs.uk
Committee Approval/Received prior to Trust Board:	Finance and Performance Committee
Purpose / Intent of Report:	Performance monitoring
Executive Summary:	The attached report contains the financial position to 30 September 2015. The Trusts financial performance is a retained deficit of £0.526m against a planned deficit of £0.596m, a favourable variance of £0.042m. The in-year cost improvement target is £2.66m with a year to date performance of £0.074m ahead of plan. The cash balance as at 30 September 2015 was £6.9m. The net capital expenditure is a negative (£0.076m) which is behind the Plan of £0.150m, an under spend of £0.226m. The Continuity of Service risk rating is reported as 3 in line with the plan.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Financial Strategy
Relationship with Annual Objectives:	Financial Reporting
Risk / Legal Implications:	n/a
Resource Implications:	As above

Equality and Diversity Implications:	n/a
Relationship with the Board Assurance Framework	Delivering our financial plan
Recommendations:	***The Board is asked to:*** • ***note that the financial performance to date is on plan, with a favourable variance reported of £0.042m*** • ***note the in-year cost improvement target is £2.66m and a year to date performance slightly ahead of Plan*** • ***note the cash position of the Trust as at 30 September 2015 of £6.9m*** • ***note the net capital expenditure position as at 30 September 2015 is an under spend against Plan of £0.226m*** • ***note the year to date Continuity of Service risk rating of 3***

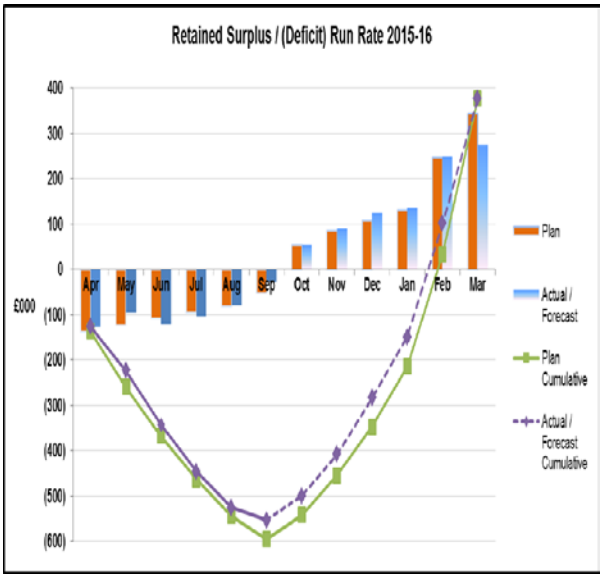
DRAFT FINANCIAL OVERVIEW as at 30 September 2015

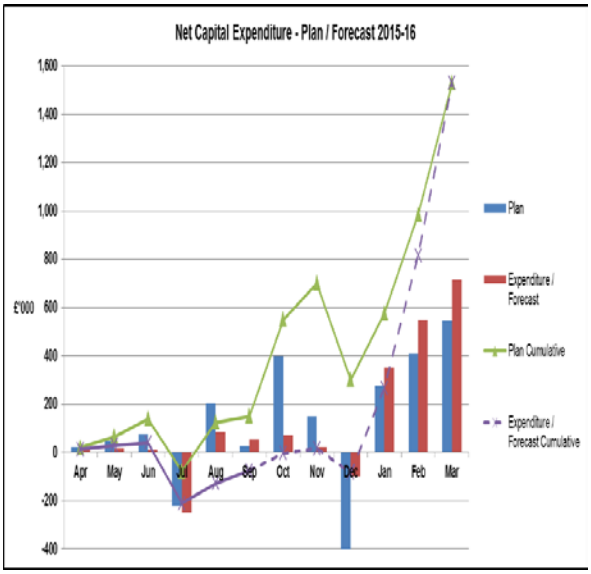
Income & Expenditure - Retained Surplus / (Deficit)

£000	Plan	Actual	Var	%	RAG
YTD	(596)	(554)	42	7	G
Forecast	377	377	0	0	G

Net Capital Expenditure

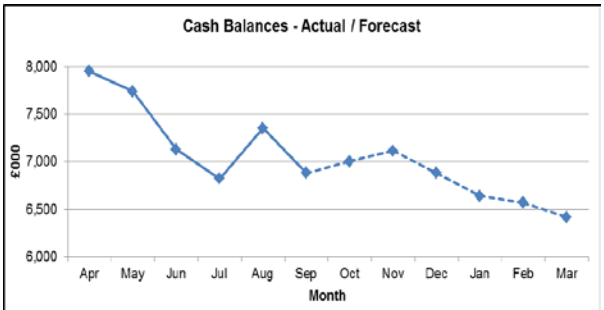
£000	Plan	Actual	Var	%	RAG
YTD	150	(76)	(226)	(151)	A
Forecast	1,530	1,530	0	0	G

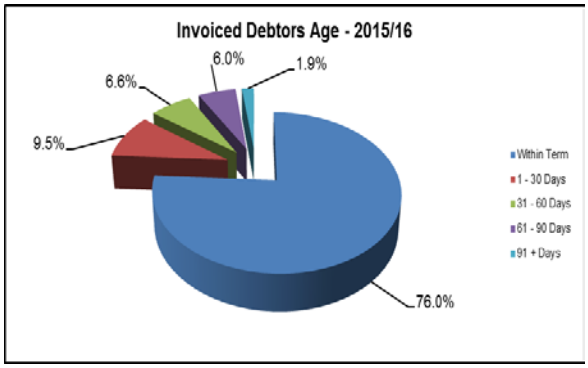




Cash Balances

£m	Plan	Actual	Var	%	RAG
YTD	5.5	6.9	1.4	26	G





Continuity of Service Risk Rating

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

Notes

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

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

1. Financial Position

1.1 Introduction

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

In September 2015 the Trust submitted a revised financial Plan which showed an increase of £0.150m to the surplus, resulting in an 'adjusted financial position' of £0.900m. This amendment follows the directive issued from the NTDA for provider Trusts to improve their forecast position.

This report details the Trust's performance against this revised Plan for the period ending 30 September 2015.

1.2 Income & Expenditure (I&E) Performance at Month 6

At the end of Month 6, the Trusts budgeted plan was a retained deficit of £0.596m (£0.332m deficit at adjusted financial performance level). The reported retained position is a deficit of £0.554m, giving a favourable variance of £0.042m against plan.

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

Table 1: Statement of Comprehensive Income

Detail	Full Year Annual Budget £000	Current Month £000			Year to Date £000		
		Budget	Actual	Variance	Budget	Actual	Variance
Income	75,959	6,513	6,571	58	37,105	37,413	309
Pay	(56,845)	(4,965)	(4,705)	259	(28,789)	(27,543)	1,246
Non pay	(15,613)	(1,327)	(1,599)	(272)	(7,276)	(8,811)	(1,536)
EBITDA	**3,500**	**221**	**267**	**46**	**1,041**	**1,059**	**19**
Other Costs	(2,750)	(229)	(252)	(23)	(1,373)	(1,350)	23
Adjusted Financial Performance	**750**	**(8)**	**15**	**23**	**(332)**	**(290)**	**42**
IFRIC 12 Expenditure	(523)	(44)	(44)	0	(264)	(264)	0
Retained Surplus / (Deficit) prior to Impairment	**227**	**(52)**	**(29)**	**23**	**(596)**	**(554)**	**42**
Fixed Asset Impairment	0	0	0	0	0	0	0
Retained Surplus / (Deficit)	**227**	**(52)**	**(29)**	**23**	**(596)**	**(554)**	**42**

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

Also contained within non-pay, specific budgets have been set and held centrally. Table 2 shows these central reserves forecast budgets which equate to £1.112m, against which the Trust is forecasting expenditure of £0.588m. This highlights that the Trusts achievement of the forecast retained surplus of £0.377m is predicated on the support to the operational position from reserves of £0.524m.

It should be noted that Safer Staffing funding has been allocated to Directorates in month 6.

Table 2: Reserves Held Centrally

Description	Forecast Annual Budget (£000)	Committed within FOT (£000)
Contingency	5	0
Cleanliness in Hospitals	15	15
Quality & Reform	153	150
QNIC	24	0
Other Earmarked reserves	915	423
Total	**1,112**	**588**

1.3 Forecast Year End Performance

Following the finalisation of the month 6 position, a worked up forecast outturn has been undertaken which supports the revised retained surplus of £0.377m (£0.900m at adjusted financial performance level) which is in line with the revised Plan. This outturn position is dependent on achieving the cost improvement programme as well as managing cost pressures, existing or arising, during the financial year. The Trust's forecast position will be shared with the NTDA as part of their financial monitoring regime.

1.4 Cost Improvement Programme

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

As at month 6, the performance against the planned schemes on a year to date basis is slightly behind plan, with £0.875m being achieved against the target of £1.030m. However, additional schemes have been identified which have delivered £0.229m on a year to date basis resulting in an overall performance of £1.104m, and therefore a £0.074m over achievement. This is shown in table 3 below.

Table 3: CIP Delivery – Year to Date

	Plan £000	Delivered £000	Variance £000
Original schemes	1,030	875	(155)
New schemes	0	229	229
Total schemes	**1,030**	**1,104**	**74**

2. Summary of Financial Position

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

2.1 Fixed Assets

Property, Plant & Equipment and Intangible assets balances of the Trust have remained relatively static which reflects the slow start to the 2015/16 capital programme.

2.2 Cash

As at 30 September 2015, the Trust's cash position was £6.9m which represents a decrease during the month of £0.472m. In September the Trust paid the first instalment of its 2015/16 dividend payment (£0.256m) to the Department of Health which is the main reason for the in-month cash reduction. A monthly cash flow forecast is shown in Appendix A, page 3 which demonstrates the cash movements.

2.3 Other Working Balances

There has been little change in the working balances during the month, with an overall net increase of circa £0.3m. This is a result of an increase in creditors of £0.2m and an increase of debtors of £0.5m (predominantly NHS debtors).

It is worth noting that there is minimal or no risk associated with the above increases in debtor values.

Within the overall debtors value, £3.66m relates to invoiced debt. Invoiced debt is summarised by age in Appendix A, page 4, along with the analysis of the stage of recovery.

3. Capital Expenditure and Programme

The Trust's permitted capital expenditure in 2015/16 is £2.3m; this is the combination of the Trust's £1.53m Capital Resource Limit (CRL) and its predicted asset sales of

£0.77m. The capital expenditure for the year as at 30 September 2015 is a negative £0.076m, made up of £0.194m of expenditure and (£0.270m) from the disposal of the former Learning Disability property Meadow View. This represents a variance against the profiled net capital expenditure of £0.226m shown in the Plan submitted to the NTDA.

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

4. Continuity of Services Risk Rating Risk Rating

As reported in the Plan, the Trust is planning to achieve a Continuity of Service Risk Rating of 3 by the end of the financial year. As at month 6, this is calculated as 3. The forecast outturn rating is also 3, in line with the planned rating previously mentioned.

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

5. Recommendations

The Board is asked to:

- ***note that the financial performance to date is predominately on plan, with a favourable variance reported of £0.042m***
- ***note the in-year cost improvement target is £2.66m and a year to date performance ahead of Plan***
- ***note the cash position of the Trust as at 30 September 2015 of £6.9m***
- ***note the net capital expenditure position as at 30 September 2015 is an underspend against plan of £0.226m***
- ***note the year to date Continuity of Service Risk Rating of 3 and also a forecast rating of 3.***

Statement of Comprehensive Income including Forecast Outturn – Trust Wide

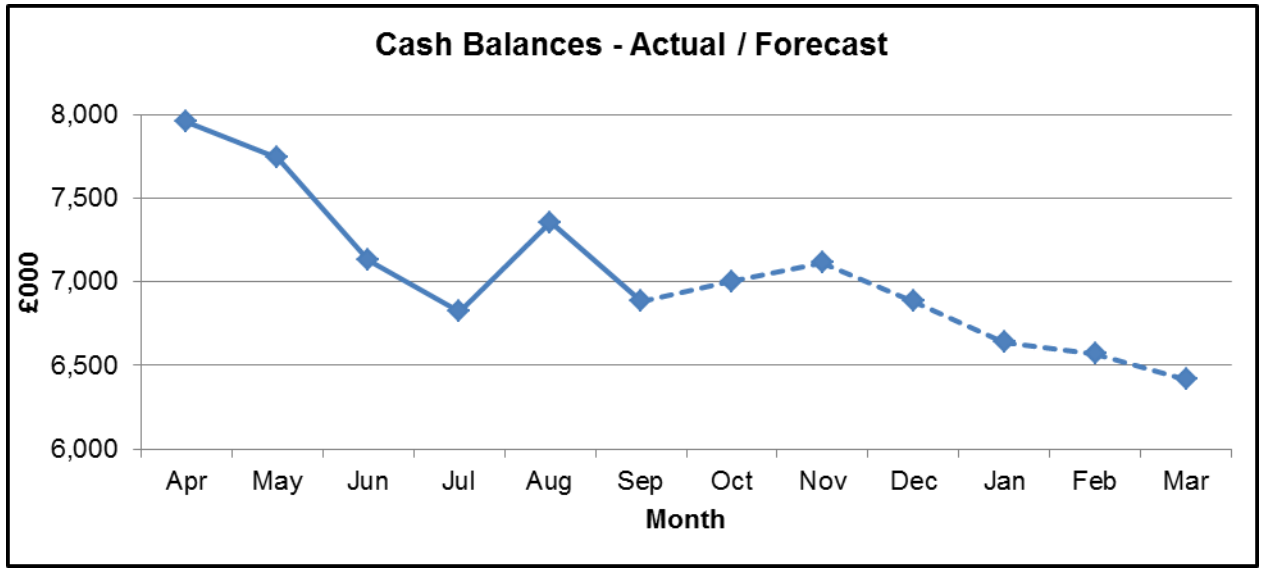
	Full Year	< < < Current Month > > >			< < < Year to Date > > >			< < < Forecast Outturn > > >		
	Budget	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Income:										
Revenue from Patient Care Activities	67,572	5,947	5,911	36	33,130	32,940	190	68,669	68,623	46
Other Operating Revenue	8,387	624	601	23	4,283	4,165	118	8,112	8,386	-274
	75,959	6,571	6,513	58	37,413	37,105	309	76,781	77,010	-229
Expenses:										
Pay										
Medical	-6,750	-468	-547	79	-2,880	-3,361	481	-6,089	-6,774	685
Nursing	-26,490	-2,096	-2,412	315	-12,879	-13,510	631	-26,166	-27,124	958
Other clinical	-13,424	-1,079	-1,104	25	-6,128	-6,733	605	-12,411	-13,452	1,041
Non-clinical	-9,479	-731	-774	44	-4,228	-4,716	488	-8,912	-9,490	578
Non-NHS	-702	-331	-128	-203	-1,427	-468	-960	-2,507	-984	-1,523
Cost Improvement	0	0	0	0	0	0	0	0	0	0
	-56,845	-4,705	-4,965	259	-27,543	-28,789	1,246	-56,085	-57,825	1,739
Non Pay										
Drugs & clinical supplies	-1,978	-199	-211	12	-1,154	-1,011	-144	-2,281	-2,012	-269
Establishment costs	-1,709	-144	-134	-9	-742	-850	109	-1,501	-1,703	202
Premises costs	-1,989	-388	-174	-214	-1,437	-1,066	-372	-2,887	-1,989	-898
Private Finance Initiative	-3,865	-333	-322	-11	-1,993	-1,932	-61	-3,990	-3,865	-125
Other (including unallocated CIP)	-5,970	-535	-841	306	-3,485	-2,771	-713	-5,838	-4,895	-943
Central Funds	-103	0	355	-355	0	355	-355	-587	-1,111	524
	-15,613	-1,599	-1,327	-272	-8,811	-7,276	-1,536	-17,085	-15,575	-1,510
EBITDA *	**3,500**	**267**	**221**	**46**	**1,059**	**1,041**	**19**	**3,611**	**3,610**	**1**
Depreciation (excludes IFRIC 12 impact and donated income)	-797	-90	-66	-24	-420	-396	-24	-844	-797	-47
Investment Revenue	12	2	1	1	10	6	4	16	12	4
Other Gains & (Losses)	0	0	0	0	42	0	42	42	0	42
Local Government Pension Scheme	0	0	0	0	0	0	0	0	0	0
Finance Costs	-1,364	-114	-114	0	-682	-682	0	-1,364	-1,364	0
Unwinding of Discounts	0	0	0	0	0	0	0	0	0	0
Dividends Payable on PDC	-601	-50	-50	0	-301	-301	0	-561	-561	0
Adjusted Financial Performance - Surplus / (Deficit) for the Financial Year **	**750**	**15**	**-8**	**23**	**-290**	**-332**	**42**	**900**	**900**	**0**
IFRIC 12 Expenditure ***	-523	-44	-44	0	-264	-264	0	-523	-523	0
Retained Surplus / (Deficit) for the Year	**227**	**-29**	**-52**	**23**	**-554**	**-596**	**42**	**377**	**377**	**0**

Statement of Financial Position – including forecast

Detail	Period End Date 31/03/2015 £000	30/06/2015 £000	31/07/2015 £000	31/08/2015 £000	30/09/2015 £000	Forecast 31/03/2016 £000
NON-CURRENT ASSETS:						
Property, Plant and Equipment	30,863	30,573	30,493	30,466	30,397	31,799
Intangible Assets	52	40	40	40	28	66
Trade and Other Receivables	0	0	0	0	0	0
TOTAL NON-CURRENT ASSETS	30,915	30,613	30,533	30,506	30,425	31,865
CURRENT ASSETS:						
Inventories	86	82	90	82	75	86
Trade and Other Receivables	3,017	5,570	5,801	5,728	6,213	3,298
Cash and cash equivalents	6,805	7,130	6,822	7,355	6,883	6,416
SUB TOTAL CURRENT ASSETS	9,908	12,782	12,713	13,165	13,171	9,800
Non-current assets held for sale	2,520	2,520	2,250	2,250	2,250	1,750
TOTAL ASSETS	**43,343**	**45,915**	**45,496**	**45,921**	**45,846**	**43,415**
CURRENT LIABILITIES:						
NHS Trade Payables	-864	-1,065	-769	-772	-1,056	-676
Non-NHS Trade Payables	-4,374	-7,222	-7,319	-7,871	-7,581	-5,607
Borrowings	-351	-351	-351	-351	-351	-346
Provisions for Liabilities and Charges	-1,682	-1,636	-1,546	-1,526	-1,515	-882
TOTAL CURRENT LIABILITIES	-7,271	-10,274	-9,985	-10,520	-10,503	-7,511
NET CURRENT ASSETS/(LIABILITIES)	5,157	5,028	4,978	4,895	4,918	4,039
TOTAL ASSETS LESS CURRENT LIABILITIES	**36,072**	**35,641**	**35,511**	**35,401**	**35,343**	**35,904**
NON-CURRENT LIABILITIES						
Borrowings	-12,992	-12,904	-12,876	-12,846	-12,817	-12,647
Trade & Other Payables	-558	-558	-558	-558	-558	-558
Provisions for Liabilities and Charges	-604	-604	-604	-604	-604	-404
TOTAL NON- CURRENT LIABILITIES	-14,154	-14,066	-14,038	-14,008	-13,979	-13,609
TOTAL ASSETS EMPLOYED	**21,918**	**21,575**	**21,473**	**21,393**	**21,364**	**22,295**
FINANCED BY TAXPAYERS EQUITY:						
Public Dividend Capital	7,998	7,998	7,998	7,998	7,998	7,998
Retained Earnings	814	471	369	289	260	1,191
Revaluation Reserve	13,664	13,664	13,664	13,664	13,664	13,664
Other reserves	-558	-558	-558	-558	-558	-558
TOTAL TAXPAYERS EQUITY	**21,918**	**21,575**	**21,473**	**21,393**	**21,364**	**22,295**

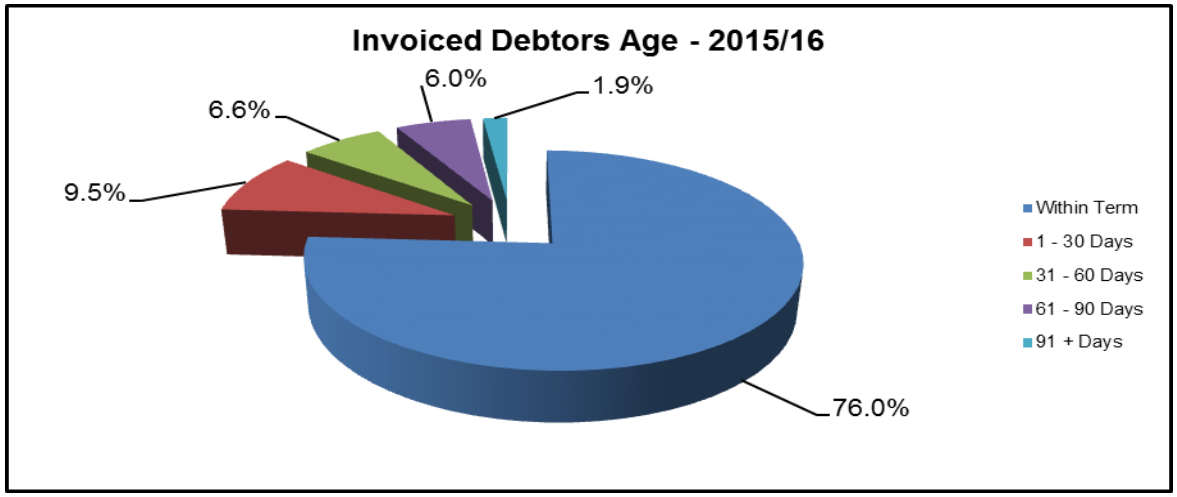
Cash-flow Forecast

Statement of Cash Flows (CF)	Actual Apr 15 £000	Actual May 15 £000	Actual Jun 15 £000	Actual Jul 15 £000	Actual Aug 15 £000	Actual Sep 15 £000	*Forecast Oct 15 £000*	*Forecast Nov 15 £000*	*Forecast Dec 15 £000*	*Forecast Jan 16 £000*	*Forecast Feb 16 £000*	*Forecast Mar 16 £000*	2015/2016 Full Year £000
Cash Flows from Operating Activities													
Operating Surplus / (Deficit)	35	66	42	17	82	134	*216*	*242*	*263*	*285*	*344*	*518*	**2,244**
Depreciation and Amortisation	113	112	117	98	110	134	*114*	*114*	*114*	*114*	*114*	*113*	**1,367**
Impairments and Reversals	0	0	0	0	0	0	*0*	*0*	*0*	*0*	*0*	*0*	**0**
Interest Paid	-114	-114	-114	-114	-114	-114	*-114*	*-114*	*-113*	*-113*	*-113*	*-113*	**-1,364**
Dividend Paid	0	0	0	0	0	-256	*0*	*0*	*0*	*0*	*0*	*-261*	**-517**
Inflow / (Outflow) prior to Working Capital	**34**	**64**	**45**	**1**	**78**	**-102**	***216***	***242***	***264***	***286***	***345***	***257***	**1,730**
(Increase) / Decrease in Inventories	0	-7	2	8	8	7	*0*	*0*	*-3*	*0*	*0*	*-1*	**14**
(Increase) / Decrease in Trade and Other Receivables	-658	-794	-1,101	-231	73	-485	*297*	*486*	*727*	*382*	*290*	*902*	**-112**
Increase / (Decrease) in Trade and Other Payables	1,817	581	509	-265	504	199	*-211*	*-795*	*-1,167*	*-206*	*230*	*-354*	**842**
Provisions (Utilised) / Arising	-3	-12	-31	-90	-20	-11	*-80*	*-125*	*-125*	*-325*	*-313*	*-493*	**-1,628**
Increase/(Decrease) in Movement in non Cash Provisions	0	0	0	0	0	0	*0*	*350*	*0*	*0*	*0*	*280*	**630**
Inflow / (Outflow) from Working Capital	**1,156**	**-232**	**-621**	**-578**	**565**	**-290**	***6***	***-84***	***-568***	***-149***	***207***	***334***	**-254**
Net Cash Inflow / (Outflow) from Operating Activities	**1,190**	**-168**	**-576**	**-577**	**643**	**-392**	***222***	***158***	***-304***	***137***	***552***	***591***	**1,476**
Cash Flows from Investing Activities													
Interest Received	2	2	2	1	2	2	*1*	*1*	*1*	*1*	*1*	*0*	**16**
(Payments) for Property, Plant and Equipment	-12	-18	-10	-18	-83	-53	*-72*	*-20*	*-100*	*-350*	*-595*	*-714*	**-2,045**
Proceeds of disposal of assets held for sale (PPE)	0	0	0	315	0	0	*0*	*0*	*200*	*0*	*0*	*0*	**515**
Net Cash Inflow / (Outflow) from Investing Activities	**-10**	**-16**	**-8**	**298**	**-81**	**-51**	***-71***	***-19***	***101***	***-349***	***-594***	***-714***	**-1,514**
NET CASH INFLOW / (OUTFLOW) BEFORE FINANCING	**1,180**	**-184**	**-584**	**-279**	**562**	**-443**	***151***	***139***	***-203***	***-212***	***-42***	***-123***	**-38**
Cash Flows from Financing Activities													
Capital Element of Payments in Respect of Finance Leases PFI	-29	-29	-29	-29	-29	-29	*-29*	*-29*	*-29*	*-30*	*-30*	*-30*	**-351**
Net Cash Inflow/(Outflow) from Financing Activities	**-29**	**-29**	**-29**	**-29**	**-29**	**-29**	***-29***	***-29***	***-29***	***-30***	***-30***	***-30***	**-351**
NET INCREASE / (DECREASE) IN CASH AND CASH EQUIVALENTS	**1,151**	**-213**	**-613**	**-308**	**533**	**-472**	***122***	***110***	***-232***	***-242***	***-72***	***-153***	**-389**
Cash and Cash Equivalents (and Bank Overdraft)	**7,956**	**7,743**	**7,130**	**6,822**	**7,355**	**6,883**	***7,005***	***7,115***	***6,883***	***6,641***	***6,569***	***6,416***	



Aged Debtor Analysis

Analysed as	Within Term £000	1 - 30 Days £000	31 - 60 Days £000	61 - 90 Days £000	91 + £000	Overall Balance £000
NHS	1,842	339	8	218	41	**2,449**
Local Authorities	54	0	230	0	0	**284**
Other Debtors	881	6	4	1	30	**922**
Total	**2,777**	**345**	**243**	**220**	**70**	**3,655**

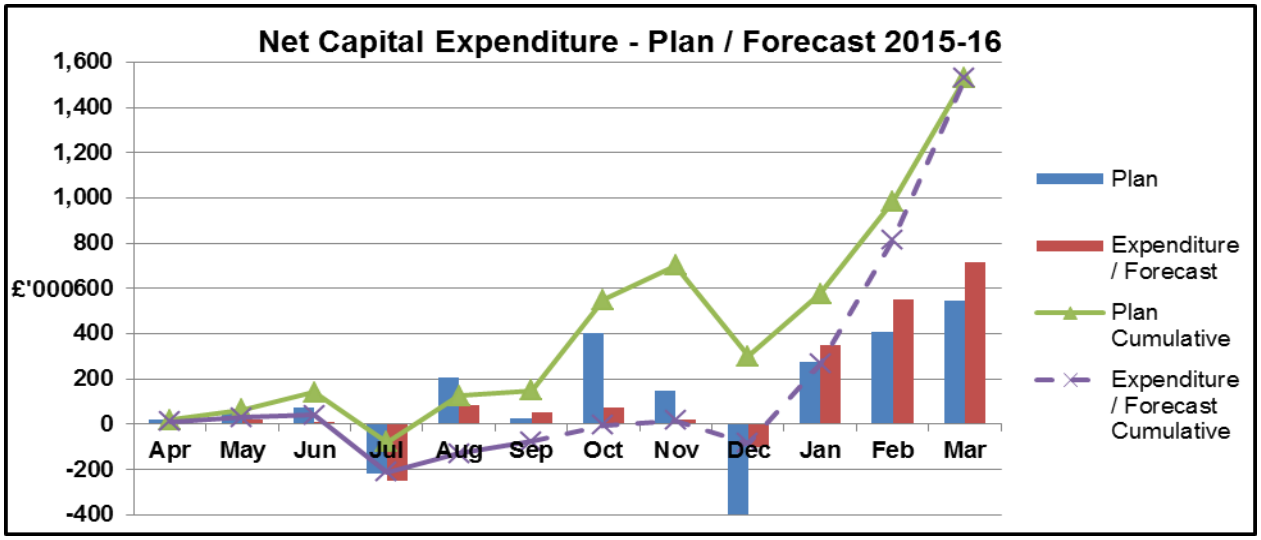


Analysed by Credit Control Stage	Within Term £000	1 - 30 Days £000	31 - 60 Days £000	61 - 90 Days £000	91 + £000	Overall Balance £000
No formal dispute received - full payment anticipated	2,777	345	243	220	41	**3,626**
Routine credit control processes activated	0	0	0	0	19	**19**
Resolved - Awaiting Credit Note to be issued	0	0	0	0	0	**0**
Escalated to Management / Solicitors	0	0	0	0	10	**10**
Total	**2,777**	**345**	**243**	**220**	**70**	**3,655**

Capital Programme and Expenditure

Scheme	Detail	2015/16 Original Scheme Value £000	2015/16 Revision £000	Year to Date £000	Forecast Outturn £000
Psychiatric Intensive Care Unit	awaiting business case approval	400	0	0	10
Low Secure unit with rehabilitation	awaiting business case approval	500	0	0	10
Assessment & Treatment and Telfold Unit	business case approved	600	500	0	500
Dragon Square Upgrade	business case approved	250	500	25	500
Darwin Upgrade	business case approved	0	680	20	530
Information Technology	various	100	100	71	150
Equipment	various	80	80	0	30
Other		270	270	78	170
Environmental Improvements	numerous sites	100	100	0	100
Total Expenditure		**2,300**	**2,230**	**194**	**2,000**
Disposals					
Former Learning Disability property	Meadow View	-270	-270	-270	-270
Bucknall Hospital (part)	staged receipts	-500	-500	0	-200
Net Expenditure		**1,530**	**1,460**	**-76**	**1,530**

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



Continuity of Service Risk Rating

Continuity of Services Risk Rating		YTD Actual £000	Forecast Plan £000	Forecast Actual £000
Liquidity Ratio	**Working Capital:**			
	Total Current Assets	15,421	11,550	11,550
	Total Current Liabilities	-10,503	-7,661	-7,511
	Inventories	75	86	86
	Non Current Assets Held for Sale	2,520	1,750	1,750
	Working Capital Balance	**2,323**	**2,053**	**2,203**
	Annual Operating Expenses:			
	Operating Expenses	37,039	72,680	74,537
	Add back:			
	Depreciation & Amortisation	-684	-1,350	-1,367
	Impairments	0	0	0
	Annual Operating Expenses:	**36,355**	**71,330**	**73,170**
	Liquidity Ratio (Working capital balance / Annual operating expenses)	11.7	10.4	11.0
	Liquidity Ratio Metric	**4.0**	**4.0**	**4.0**
Capital Servicing Capacity	**Revenue Available for Debt Service:**			
	EBITDA	1,059	3,486	3,611
	Interest Receivable	-10	-16	-16
	Revenue Available for Debt Service	**1,069**	**3,502**	**3,627**
	Annual Debt Service:			
	Finance Costs (including interest on PFIs and Finance Leases)	682	1,364	1,364
	Dividends	300	561	561
	Capital element of payments relating to PFI, LIFT Schemes and finance leases	175	351	351
	Annual Debt Service	**1,157**	**2,276**	**2,276**
	Capital Servicing Capacity (times) (Revenue available for Debt Service / Annual Debt Service)	0.9	1.5	1.6
	Capital Servicing Capacity metric	**1.0**	**2.0**	**2.0**
Continuity of Services Risk Rating for the Trust		**3.0**	**3.0**	**3.0**

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

Enclosure 9

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO TRUST BOARD

Date of Meeting:	29 October 2015
Title of Report:	Finance and Performance Committee Report – Committee Meeting 22 October 2015
Presented by:	Tony Gadsby – Committee Chairman
Author of Report: Name: Date: Email:	 Steve Blaise 22 October 2015 steve.blaise@northstaffs.nhs.uk
Committee Approval/Received prior to Trust Board:	n/a
Purpose / Intent of Report:	Performance monitoring For information
Executive Summary:	The attached reports provides a summary of the Committee meeting held on the 22 October 2015 and provides assurance to the Board over the level of review and challenge provided by the Committee of financial and other reporting as well as forecasting.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Financial Strategy Workforce Strategy Governance Strategy IM&T Strategy
Relationship with Annual Objectives:	Financial Reporting
Risk / Legal Implications:	n/a
Resource Implications:	As above
Equality and Diversity Implications:	n/a

Relationship with the Board Assurance Framework	Provides assurance over the Trust's arrangements for sound financial stewardship and risk management.
Recommendations:	The Trust Board are asked to: • Note the contents of the report and take assurance from the review and challenge evidenced in the Committee • Signs and seals the contract with Stoke on Trent City Council for Integrated Community Drug and Alcohol Recovery services.

Assurance Report to the Trust Board – Thursday, 29 October 2015

Finance and Performance (F & P) Committee Report to the Trust Board – 22 October 2015

This paper details the issues discussed at the Finance and Activity Committee meeting on 22 October 2015.

The meeting was quorate, approved the minutes from the meeting on the 17 September 2015 and reviewed the progress and actions taken from previous meetings.

The Committee received the financial update for month 6 (September 2015) 2015/16.

The income and expenditure position to Month 6 was ahead of plan at a deficit of £0.554m (£0.332m deficit at "adjusted financial performance" level) against a plan deficit of £0.596m, a favourable variance of £0.042m against plan. The paper also reported that the year-end forecast was in line with the revised planned position of £0.377m surplus, equating to a £0.900m surplus at adjusted financial performance level although it was noted that this forecast figure was support by Trust reserves. This position would represent a breakeven performance against a revised plan.

The Trust's cash balance at the end of September was £6.9m against the plan balance of £5.5m.

The Capital Resource Limit (CRL) for 2015/16 is £1.5m. The planned capital expenditure for the year is £2.3m funded by £1.3m depreciation, £0.8m of asset sales and cash in hand. At the end of September 2015 the Trust was £0.23m behind plan having incurred net capital spend of (£0.076m) against a plan of £0.150m.

It was noted that the Trust continued to report a Continuity of Service overall risk rating of level 3 at September 2015. Additionally, the Trust is also reporting a forecast year end overall rating of level 3. This level 3 rating is achieved primarily as a result of the Trusts healthy liquidity ratio.

Other Reports and Updates

The Committee received additional reports and verbal updates as follows:

- The verbal report from the Director of Finance included reference to the commissioning intentions letter from the local CCG's, the progress around the safer staffing work undertaken and associated funding, as well as an update regarding the implementation of PbR within mental health.

- A clinical contract information report that identified the income risks associated with the Trust's contract portfolio. Of particular concern was the current under performance of the NHS Specialised Services contract for the Children's Inpatient service. It was noted that this underperformance was linked to the national downturn on the demand for Tier 4 beds.

  In addition the Committee agreed to recommend that the Trust Board signs and seals the contract with Stoke on Trent City Council for Integrated Community Drug and Alcohol Recovery services.

- A Performance Management report including TDA metrics, agreed targets, trends and a revised RAG rating. The reported noted that, at month 6, there were 3 metric's rated as Red and 1 rated as Amber. The Committee were briefed on the issues within these areas.

- A report updating the Committee on the Trust's current tender activity. Particular reference was made to the Substance Misuse tender for Staffs inpatients, as well as the Staffordshire prison tender.

- The Committee received, for information, the minutes and report from the Trusts Capital Investment Groups (CIGs) that had taken place on 30 September 2015.

- A report regarding the backlog maintenance for the Trust and the calculated risk adjustment.

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

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

Recommendation

- The Board is asked to note the contents of this report and take assurance from the review and challenge evidenced in the Committee.
- The Board signs and seals the contract with Stoke on Trent City Council for Integrated Community Drug and Alcohol Recovery services.

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

Steve Blaise – Deputy Director of Finance

22 October 2015

Enclosure 10

REPORT TO TRUST BOARD

Date of Meeting:	29 October 2015
Title of Report:	Performance Report – Month 6 2015/16
Presented by:	Ann Harrison, Interim Director of Finance
Author of Report: Name: Date: Email:	Kevin Daley, Performance Development Manager 22 October 2015 Kevin.Daley@northstaffs.nhs.uk
Committee Approval/Received prior to Trust Board:	• Finance and Performance Committee
Purpose / Intent of Report:	Performance Monitoring
Executive Summary:	This report provides the Board with a summary of performance to the end of Month 6 (September 2015) Performance against the TDA metrics and key National Targets is included within the report. A range of metrics is in place to monitor performance, quality and outcomes. The indicators are those set by our commissioners and local trust targets and aligned to the relevant Trust objectives. At month 6 there are 2 metrics rated as Red and 1 rated as Amber; the attached exception report expands on these areas. Executive leads will provide a verbal update at the meeting, where appropriate.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Governance Strategy The Performance & Quality Management Framework measures performance across National and local indicators, presented against the Trust's enabling strategies, commissioning contracts and the TDA's assurance framework compliance framework.
Relationship with Annual Objectives:	The Performance & Quality Management Framework measures performance across all annual objectives
Risk / Legal Implications:	All areas of underperformance are separately risk assessed and added to the risk register dependent on the outcome of the risk assessments.
Resource Implications:	Not directly as a result of this report
Equality and Diversity Implications:	Not directly as a result of this report
Relationship with the Board Assurance Framework	1. Focusing on quality and safety 2. Consistently meeting standards 3. Delivering our financial plan

Recommendations:	The Board is asked to • Consider and discuss reported performance with particular emphasis on areas of underperformance. • Confirm sufficient detail and assurance is provided.

PERFORMANCE MANAGEMENT REPORT TO TRUST BOARD

Date of meeting:	29 October 2015
Report title:	Performance & Quality Management Framework Performance Report – Month 6 2015/16
Executive Lead:	Interim Director of Finance
Prepared by:	Kevin Daley, Performance Development Manager
Presented by:	Glen Sargeant, Head of Performance & Information

1 Introduction to Performance Management Report

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

- An Executive Summary (this report)

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

2 Executive Summary – Exception Reporting

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

In month 6 there are 2 metrics rated as Red and 1 as Amber; targets for the unrated metrics will be updated once 2015/16 technical guidance is received from the TDA. Figures for exceptions against internal targets are also provided in the table below.

	Month 6			
Metric Driver	Red	Amber	Green	Unrated
Exceptions – Month 6	2	1	58	23
Trust (Monitoring and Internal Stretch Metrics)	0	1	10	11

3 Exceptions - Month 6

Metric	Exec/Op Lead	Target	M6 Perf	YTD Perf	Forecast Outturn	Trend	Commentary
TRAINING: % staff compliant with mandatory training	Workforce Dir Op Lead D Thompson	95%	AMBER 90%	AMBER 90%	AMBER	↔	90% @ month 6 same as month 5 Month 6 breakdown Corporate Services = 88% AMH Community = 91% AMH In Patient = 85% Substance Misuse = 92% CYP = 87% Learning Disabilities = 94% NOAP = 92% Trust is proactively taking action with teams to ensure that all staff attend statutory & mandatory training and maintain their compliance. Target is rolling 12 months.
APPRAISAL: Annual appraisal and personal development plan % - All staff	Workforce Dir Op Lead D Thompson	90%	RED 78%	RED 78%	GREEN	↗	78% @ month 6 from 77% @ month 5 The rolling 12 month performance shows a small increase to 78%. Directorates are providing plans to ensure that all PDRs are completed in the next 2 months. These will be monitored against planned trajectories on a 2 weekly basis to ensure delivery of the final 12%.
RAID: All other referrals seen on same day or within 24 hours	Dir of Ops Op Lead D Carr	100%	RED 90%	RED 90%	GREEN	↘	90% @ month 6 from 92% @ month 5 - all other referrals seen on same day or within 24 hours Given the strategic importance of RAID and links to the urgent care system we have introduced monitoring at Board level. Given the growth of Urgent Care activity at UHNM, the service has increasingly been picking up out of area activity. NSCHT is

							currently in discussion with commissioners via the RAID steering group to agree response targets, which will be added as agreed.

4 Recommendations

- Note the contents of the report.

The following metrics is an internal stretch target (i.e. not contracted)

Metric	Exec/Op Lead	Target	M6 Perf	YTD Perf	Forecast Outturn	Trend	Commentary
18 WEEKS: Compliance with 18 week RTT - Trust Including ASD	Dir of Ops Op Lead tbc	95%	AMBER 93.9%	AMBER 93.9%	GREEN	↘	New method of calculation which now includes ASD waits (previously excluded with the agreement of Commissioners) 93.9% @ M6 from 94.8% @ M5 Month 6 breakdown AMH Community = 96% AMH In Patient = 100% Substance Misuse = 100% CYP = 86.5% inc ASD Learning Disabilities = 99% NOAP = 96% 18 week RTT figure overall for the Trust currently stands at 95% @ M6. We have however identified a tranche of ASD waits that need to be addressed and are not currently included in this measure. (If included, the overall measure internally would stand at 93.9% @ M6.) Investment is in place and an action plan has been created to treat the waits, which affect the Children and Young People directorate.

Enclosure 11

REPORT TO TRUST BOARD

Date of Meeting:	29 October 2015
Title of Report:	NHS Trust Development Authority (NTDA) Monthly Self Certifications.
Presented by:	Ann Harrison, Interim Director of Finance
Author of Report: Name: Date: Email:	Glen Sargeant, Head of Performance and Information 9 October 2015 glen.sargeant@northstaffs.nhs.uk
Purpose / Intent of Report:	Information and approval
Executive Summary:	This paper confirms that the monthly NTDA self-certification documents have been reviewed by the executive team and are ready to be submitted. Declarations include: • Fit & proper directors • Registration with CQC • Compliance with TDA Accountability Framework In all there are 26 self-certification declarations and these form part of the NTDA Oversight and Escalation Process. There is no change from last month's position to report, which confirms non-compliance with Board Statement 11 (Governance) - *The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.* Based on September 2015 data, the Trust is therefore declaring non-compliance with one TDA requirement. An action plan has been developed to address this gap, implemented by the IG Steering Group, and progress has been reported to Quality Committee. These actions have now been delivered and the Trust will be declaring full compliance at the 30 October 2015 IG Toolkit update submission. This will be reflected in next month's TDA self-certification report.

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

Enclosure 12

REPORT TO TRUST BOARD

Date of Meeting:	30th October 2015
Title of Report:	Estates Compliance Assurance Paper
Presented by:	Andy Rogers, Director of Operations
Author of Report:	Ian Ball, Head of Estates
Committee Approval/Received prior to Trust Board:	• Business Development and Investment Committee NB. It was agreed that this paper be brought to Trust Board in October prior to the first BDIC meeting. It has been presented to Execs instead.
Purpose / Intent of Report:	Assurance
Executive Summary:	This paper outlines the requirements in respect of Statutory Compliance in respect of NHS Estate. It outlines how NSCHT Estates function manages this risk on the Trusts behalf. The paper identifies that there are no specific areas of non-compliance in respect of NSCHT estate. The paper identifies potential risks to compliance.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Governance Strategy • Innovation Strategy • Financial Strategy • Estates Strategy NHS Estate and facilities form an important part of the way NHS services are delivered. The processes outlined support safety of buildings and premises and support fitness for purpose.
Risk / Legal Implications:	Statutory Compliance issues contained within paper
Resource Implications:	No additional resource implication
Equality and Diversity Implications:	None specifically
Relationship with the Board Assurance Framework	Focusing on quality and safety ✓ Consistently meeting standards ✓ Protecting our core services Growing our specialised services

	Innovating in the delivery of care ✓ Developing academic partnerships and education and training initiatives Being an employer of choice ✓ Hosting a successful CQC inspection Becoming digital by choice Reviewing and rationalising our estate ✓ Devolving accountability through local decision making that is clinically led assuring governance arrangements. Delivering our financial plan ✓
Recommendations:	Trust Board is asked to note the contents of this paper.

Background

NHS Trusts have a duty to ensure that buildings under their control comply with appropriate statutory, regulatory and NHS standards. In recent years this task has become increasingly complex, in the context of various potentially competing drivers including:-

- An increasing burden of legislative and regulatory duties falling on building occupiers.
- Increased focus on cost improvement - When services look to develop Cost Improvement Plans (CIP) their first priority is to protect clinical services and consequently look to other areas such as their estates budgets to make savings.
- Ability to appropriately control and manage activity within buildings which they manage on behalf of the Trust, and which are used by staff or clients for which they have legal responsibility.

Introduction

NSCHT Estates Team provides a comprehensive Estates Service to NSCHT, SSOTP in North Staffordshire and Stoke on Trent (SSSFT provide this service in the South) and some NHS Property Company Buildings in the area, primarily LIFT premises and other buildings used by Clinical Commissioning Groups.

This paper outlines the statutory compliance element which is managed by the Estates function on behalf of Trusts.

Harplands Hospital Site

As a PFI site, the majority of functions described within this paper as being carried out by the Estates Team are carried out on the Harplands site by Carillion, who provide these services on the Harplands site.

The Estates function oversees the work of Carillion by way of scrutiny and oversight at contract monitoring meetings including of contract monitoring reports etc.

Contract management of the Harplands PFI was the subject of an internal audit in 2014, board development session on 14th January 2015. This is not the core focus of this paper but since January, suggested improvements in contract management have been put in place and the Trust has adopted a more robust approach to its dealings with Town Hospitals.

Supported by advisors, the Trust met with Town on 23rd September and is due to meet again on 22nd October. We continue to pursue

1. Oversight of the programme to ensure safe, effective replacement of Pipework on the Harplands site
2. Additional energy cost associated with the latent defect in the fitting of a below spec heating system
3. Catering costs
4. Lifecycle

Legislation and guidance

The basis of British health and safety law is the Health and Safety at Work etc. Act 1974 (HSWA). This HSWA sets out the broad principles for managing health and safety legislation in most workplaces. The HSWA which came into force on 1st April 1975, still remains the main health and safety legislation in existence today.

The HSWA places a general duty on employers to "ensure so far as is reasonably practicable the health, safety and welfare at work of all their employees". Section 3 of the Act, General Duty to Others requires employers to conduct their undertaking in a way that does not pose risk to the health and safety of non-employees. This section is designed to give protection to the general public and other non-employees such as patients in clinics and contractors. A NHS Trust's activities are ones to which Section 3 of the HSWA is likely to be particularly relevant as the majority of premises occupied by NHS Trusts are open to the general public. Section 3 of the HSWA imposes a clear duty on NHS Trusts to conduct their undertakings in such a way as to ensure, so far as is reasonably practicable the safety of the public using the premises.

In addition to the Health and Safety at Work Act there are Approved Codes of Practice (ACOPs) and Health and Safety Executive (HSE) guidance documents and standards to be considered.

The NHS also provides further guidance in the form of Health Technical Memoranda (HTMs) and Health Building Notes (HBNs).

HTMs give comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare.

The focus of Health Technical Memorandum guidance remains on healthcare-specific elements of standards, policies and up-to-date established best practice. They are applicable to new and existing sites, and are for use at various stages during the whole building lifecycle.

Healthcare providers have a duty of care to ensure that appropriate governance arrangements are in place and are managed effectively. The Health Technical Memorandum series provides best practice engineering standards and policy to enable management of this duty of care.

Health building notes give best practice guidance on the design and planning of new healthcare buildings and on the adaptation/extension of existing facilities.

They provide information to support the briefing and design processes for individual projects in the NHS building programme.

Estates Management

The Estates Team provides North Staffordshire Combined Healthcare NHS Trust with a comprehensive Building / Engineering Maintenance Service in accordance with "Estate Code" guidance and best service principles, within available resources, for the following categories of works:

- Day to day maintenance of Buildings
- Day to day maintenance of Mechanical Installation.
- Day to day maintenance of Electrical Installation.
- Planned preventative maintenance and that required to comply with Statutory Regulations within resources available.

- Emergency breakdown repairs.
- Routine breakdown repairs.
- The department also:
- Provides advice on optimum levels of maintenance and minimum maintenance needed to meet statutory requirements.
- Implements a maintenance regime and manage the maintenance function.
- Monitors maintenance and advises on necessary changes by reviewing annually.

Estates provide maintenance of the building, its utilities and interior decoration, in order to provide a safe working environment which complies with all relevant statutory requirements. This will include the maintenance and repair of:-

Lighting	-	faults, replacement bulbs, switches
Heating	-	faults, repairs, sensors, temperature
Glazing	-	replacement
Windows	-	adjustment and repair
Doors	-	adjustment and repair
Locks	-	adjustment, repair, replacement
Sanitary ware	-	repairs
Floors	-	repairs
Ceilings/floors	-	plaster repair, paint/paper repair
Plumbing	-	repairs
All underground services	-	repairs
Roof tiles & guttering	-	clean, replace where necessary

Planned maintenance frequencies will be in accordance with manufacturer's recommendations or other accepted guidance. A planned maintenance schedule is established and delivered within the available resources.

Estates Helpdesk

There is an estates maintenance telephone help desk for all requests on:

Tel No. 01782 441600 Monday – Thursday 08.00 – 16.30 and Friday 08.00 – 14.30

Access to an emergency on-call service outside normal working hours to respond to emergency property and main utilities breakdowns is provided 7 days a week, 52 weeks a year including Bank Holidays. It can be contacted via 01782 441600 which is the main switchboard for the Trust based at Harplands Hospital.

Calls are categorised as follows:

Emergency Calls

Response same day, usually within 2 hours; By definition, emergency calls are where there is significant risk to patients and/or staff/visitors safety requiring an immediate response (i.e. Gas leak), in the most appropriate way and over-riding all other responsibilities. Emergency calls will take ultimate priority over all other requests and as such may, depending on resources, affect the department's liability to attain other targets.

Urgent Calls

Response time being same day. By definition, this is where a serious impact on patient, staff/visitors safety and/or comfort applies (i.e. heating failure)

Routine Calls

The Department will respond to requests for day-to-day maintenance in accordance with the client requirements and labour availability.

Types of Maintenance Activities

Statutory (legal compliance) Maintenance

This includes all insurance inspections, at predetermined intervals, of plant, systems and equipment, to ensure compliance with all relevant legislation/documentation which includes Health Technical Memoranda, Healthcare Building Notes and the Approved Code of Practice for Legionella Testing (L8).

Minor works

Minor works is a term which covers small items of Estates works involving adaptation, alteration and new installations which are often required to support changes in procedures and work practices (e.g. additional sockets, shelving etc.), which have been authorised and funded by the Trust.

Planned Preventative Maintenance

Preventative maintenance is a programme of scheduled maintenance activities that extend the serviceable life of equipment and systems and reduce breakdowns and repairs. It includes inspection, lubrication, adjustment, replacement of components, performance testing and analysis.

The programme is planned to satisfy statutory requirements and/or reduce the risk of potential failure. The categories of assets to be maintained, with tasks being carried out at different frequencies during the year, are listed below:

	Item	Frequency	Scope of Works
1.	Legionella Precautions	Weekly	Flushing of all outlets twice weekly in line with Policy and AcoP L8
2.	Water Storage Tank Cleaning	Annually	Clean and disinfection services are carried out in accordance with ACoP L8 following the procedures outlined in BS6700. •Isolation of the cold water storage tank and any pump sets •Fully drain the tank and undertake a physical clean •Chemical cleaning using silver based hydrogen peroxide - the use of this chemical halves the volume of water needed to be 'dumped' than using conventional methods •Use of alternative chemicals such as chlorine and bio/oil dispersants where applicable •Where required, full system disinfection including all assets and pipe work, measuring chemical levels at every outlet to ensure successful disinfection •Tests carried out for TVC, e-coli, coliform and Legionella by a UKAS accredited Microbiological laboratory
3.	Water Potability Samples	6 Monthly	Tests carried out by NHS Microbiological laboratory
4.	Water Temperature Checks	various	A competent person will identify 'sentinel' outlets (furthest and closest to each tank or cylinder) and check the distribution temperatures. They will also check the hot water storage cylinder temperatures.
5.	Mixer Valve Maintenance	6 monthly temperature check- yearly service and fail safe test.	• Inlet check valves (if fitted): Measure inlet pipework surface temperature for indication of cross-flow. A more effective test can be considered if appropriate, utilising drain points positioned between isolating and check-valves • Temperature measurements: a) locked; b) adjustable/pre-set maximum, Operate flow controls and measure blended temperature. Measure maximum and minimum blended temperature. For thermostat and pressure-balanced mixers, blend temperature shall stabilise quickly and remain within +2oC of set value. For manual mixers, refer to commissioning data. • Thermal shut-down (Thermostatic valves only): Operate mixer at blended temperature, then isolate cold supply. Valve must shut down in accordance with the manufacturer's data.

			• Temperature control: Operate mixer at blended temperature, then open other local cold outlets off common supply. Measure shift in blend temperature with reference data compiled at the commissioning stage. • Strainers: Isolate and visually inspect and clean as necessary. • Flow control(s): Operate fully and check for effective closure. If time delay is incorporated, measure length of flow cycle. • Automatic drain valve (if fitted): Check effective operation. • Mixing valve: a) temperature control; b) flow control(s); c) inlet check valves. Where specified by manufactures guidance and/or site conditions and inspection confirms the requirement, carry out visual inspection of internal serviceable mechanisms. Clean or renew components as necessary. Lubricate as indicated in manufacturer's data. Refer to manufacturer's data for recommended procedures and cleaning agents/lubricants. For products of (serviceable) cartridge construction, fit and commission exchange units if required. • Service displaced units in workshop as part of rolling planned maintenance procedure. • Supply pipe-work: Visually inspect for damage leaks, etc. and rectify. • For all new installations, record the supply pressures to allow the appointed person to compare these pressures and temperatures to confirm agreement with commissioning data. • Controls: Operate inlet valves and check individual flow rates of hot and cold water supplies. If valve is stripped down and reassembled all parts shall be greased as recommended in the manufacturer's maintenance instructions. • Thermostat: Check mixed water outlet setting. Ensure thermometer bulb is immersed in flowing water if measurement taken at shower head. • Temperature limiter: Measure mixed water outlet temperature at limit safety stop. Limiter setting 41oC. • Inlet check valves (where fitted): Check operation. Non-return valves may have been removed if operating with balanced pressure supplies). •

6.	Fire Alarm Testing	Weekly	In accordance with the regulatory reform (fire safety) order 2005 a weekly test of a manual call point to check that the control panel and alarm sounders operate satisfactorily
7.	Emergency Lighting Testing	Monthly – Function Test Annually – 3 Hr full discharge Test	Monthly: short functional test in accordance with BS EN 50172:2004 / BS 5266-8:2004. The period of simulated failure should be sufficient for the purpose of this test while minimising damage to the system components, e.g. lamps. During this period, all luminaires and signs shall be checked to ensure that they are present, clean and functioning correctly. Annually: A test for the full rated duration of the emergency lights (e.g. 3 hours) must be carried out. The emergency lights must still be working at the end of this test. The results are recorded and, if failures are detected, these are remedied as soon as possible.
8.	Gas Boiler Maintenance	Annually	Check performance reports since last service visit Carry out full Gas Boiler Service in line with Gas Safe regulations Issue required certification and highlight any remedial works required
9.	Patient Hoists	As per the manufacturers instructions & maintenance manuals for the equipment.	List of hoists maintained by Estates held in department.
10.	Fire Door Maintenance	Yearly	• Fire Doors are to be check adjusted if necessary and left in full working order after each visit. Only parts of equal or a better standard are to be fitted as running replacements. The following actions are to be completed on each visit (unless stated otherwise): • Check that Fire Door has a Fire Door sign on it both sides. • Check that if the Fire Door has glass in it that it does not rattle and it is not cracked or broken. Any Vision Panels in the door should clear (i.e. no

			labels on them). • Check to ensure there are 3 hinges per door and no screws are missing and that the door has not dropped on them and the pivot pin in each hinge is securely in position. • Lightly lubricate hinges if required (i.e. stop squeaking noise/stiff operation). • Ensure each Fire Door closes in a fluid and steady motion and does not slam shut. • Ensure the door self-closer is affixed to door and frame securely and does not catch the door. • Check to ensure no oil is leaking from door closure device. • Ensure that all Fire Doors close fully forming seal with door frame. • Ensure door handles function correctly and are not loose or missing. • Check the intumescent strip to insure it is intact and correctly fitted. • Ensure are any cold smoke seals fitted (i.e. brushes) in good condition and not missing or damaged. • Ensure that if Electromagnetic hold open devices or Electro Actuation devices are in use that they working correctly. • m. Remove any obstruction holding open a Fire Door unless it conforms to BS 5839 (as amended). • Sockets used for housing Fire Door Panic Bar bolts should be checked and cleaned out. • All Panic Bars are to be checked to ensure that they operate smoothly and correctly. FIRE DOOR RELEASE MECHANISMS Automatic door release mechanisms are checked as per: The Regulatory Reform (Fire Safety) Order 2005 (as amended). BS 5588 - 12 Managing fire safety (as amended).
11.	Portable Appliance Testing	Annually	A combined inspection and test, by a competent person in accordance with the Electricity at Work Regulations 1989

12.	Physiotherapy Equipment Checks (Couches)	As per the manufacturers the maintenance manuals for the equipment.	List of equipment held by estates
13.	Medical Furniture	As per the manufacturers the maintenance manuals for the equipment.	List of equipment held by estates
14.	Drain Maintenance	Annually	Lift manhole covers and inspect that drains are free flowing. Arrange for drains to be flushed as required. Arrange for more detailed inspection via CCTV as required.
15.	Rain Water Gutter Maintenance	Annually	The following are to be checked: **a. Gutters**: 1) They are free from debris (i.e. moss, stones etc). 2) Their joints are water tight. 3) There are sufficient supporting brackets to support them. 4) Supporting brackets are firmly secured. 5) They are positioned correctly for their intended purpose. 6) There are no cracks in them allowing water to escape. 7) Down Pipes have been fitted correctly 8) Any hopper feeding them water is free of debris (i.e. moss, stones etc). **b. Valleys are to be checked to ensure that:** 1) They are free from debris (i.e. moss, stones etc). 2) That their exposed material covering is in good condition and not in need of repair. **c. Down Pipes are to be checked to ensure that:** 1) They are securely fitted to the wall. 2) There are sufficient supporting brackets to support them. 3) That their joints are positioned correctly. 4) That there discharge point is not blocked.

			5) That the aperture for the water to enter the down pipe is not blocked on of the originally installed size.
16.	Ventilation Systems Maintenance	Annually	Carry out full visual inspection of all unit casing Carry out full test ensuring that any airflow or pressure switch interlocks are functioning properly Full test and service to be carried out in accordance with the maintenance schedule supplied
17.	Access Equipment Maintenance (Mansafe etc.)	Annually	Tested in accordance with: • BS 7883 : 2005 Application and use of anchor devices conforming to BS EN 795 (as amended). • BS EN 365 : 2004 Personal Protective Equipment against falls from height– General requirements for instructions for use and for marking (as amended). • BS EN 795 : 1997 Protection against falls from a height anchor devices - Requirements and testing need to be provided for the operative to attach via a lanyard and harness (as amended).
18.	Wheelchair Maintenance	yearly	List of wheelchairs held by estates
19.	Catering Equipment Maintenance	As per the manufacturers the maintenance manuals for the equipment.	List of relevant detail held by estates
20.	Emergency Generator Maintenance	As per the manufacturers the maintenance manuals for the equipment.	All fixed LV standby emergency generators shall be maintained, tested and fuelled to ensure their correct operation in the event of mains failure. The fuel storage of each generator connected fuel tank shall provide for a minimum of 10 hours running at the full rating of the generator. Additional on-site fuel storage to allow a minimum of 24 hours full load running of each generator shall be arranged. Each generator shall be tested on load each month. Fuel levels shall be checked at the end of each test. Any fault must be recorded and rectified.
21.	NICEIC Fixed Wiring Inspection & Testing	5 yearly According to IEE	*Low Voltage Periodic Testing of LV Electrical System* All fixed LV electrical systems owned by the Trust shall be periodically inspected

		Wiring Regulations 17th Edition (BS7671:2008)	and tested in accordance with BS 7671.lEE Wiring Regulations. The frequency of fixed wiring inspection and testing should not exceed 5 years. Details of the requirements and records for inspection and testing are held within the Estates Directorate. All testing must comply with Hospital Technical Memorandum HTM06-02. *Circuit Identification* All LV switchgear and distribution boards shall be uniquely identified by securely attached and prominent labels. Each distribution board shall have an on-site circuit chart that allows accurate and easy identification of all circuits connected to the switchboard. Each room containing an LV switchboard or panel shall have the required schematics and posters displayed as required by HTM 06-01 and 06-02 Final circuit outlets or switches shall also be labelled to reference them to their controlling switch/fuse and distribution board, both internally and externally. LV schematic diagrams showing the Trusts LV electrical system layout and circuit/switchgear identification references shall be provided and updated as necessary. *LV Fixed Equipment Maintenance* All low voltage equipment (e.g. ventilation systems, industrial boiler plant, lifts, industrial compressors etc) shall be regularly inspected, serviced and tested to ensure that they are maintained in a safe and serviceable condition. Test periods shall not exceed 12 months. A record of maintenance of electrical equipment shall be kept by the Estates Directorate and will contain brief details of all inspections, routine servicing, repair and modifications. *LV Switchgear* All LV Switchgear shall be maintained to ensure its safety and operational capability is maintained. Maintenance intervals shall not exceed the following periods: • Visual inspection and test every 5 years
22.	Inspection of Lightning Protection System	Annually	Lightning protection systems are to be: a. Tested in accordance with BS EN 62305 : 2006-2011 Protection of Structures Against Lightning (4 parts). b. Checked for their resistance to earth, measured in accordance with Code of

			Practice COP1013 'Earthing' (as amended).
21.	Fire Fighting Equipment	Annually	Extinguishers must be serviced by a competent contractor in accordance with the current British Standard
22.	Lifts	6 monthly – Insurance Inspection 6 monthly - Maintenance	A thorough examination by a competent person in accordance with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER), and to include the following: • landing and car doors and their interlocks; • worm and other gearing; • main drive system components; • governors; • safety gear; • suspension ropes; • suspension chains; • overload detection devices; • electrical devices (including earthing, earth bonding, safety devices, selection of • fuses, etc); • braking systems (including buffers and overspeed devices); and • hydraulics.
23.	Air Conditioning Units	6 monthly-maintenance 5 yearly condition assessment	Carry out a full visual inspection of all unit casing Full test and service to be carried out in accordance with the maintenance schedule supplied

Each element has a schedule which shows the site and frequency of the required maintenance/inspection along with an indicator showing if it has been completed or when it is due.

An example of this is shown in the Legionalla /Water Quality Risk assessment schedule and 5 year Fixed Electrical Testing Schedule

Legionella Water Quality Risk Assessments – CHC Sites

TESTED ✓ PROPOSED **X**

SITE	2011	2012	2013	2014	2015	2016
Ashlands				**Sep** ✓		**x**
Ashcombe Centre	**May** ✓		**Sep** ✓		**x**	
Bennett Centre	**May** ✓		**Aug** ✓		**x**	
Boat House				**Sep** ✓		**x**
Brandon Centre (Cheadle Hospital)						
Broom Street Clinic			**Aug** ✓		**x**	
Bucknall Hospital	**Jun** ✓					
Corporate HQ			**Oct** ✓			**x**
Corporate HQ Ashtenne Units 1 to 6			**Oct** ✓			**x**
Darwin Centre	**May** ✓			**Jun** ✓		**x**
Dragon Square			**Sep** ✓		**Delayed due To refurb**	**x**
Eaton House			**Sep** ✓			
Elvedon House		**Feb** ✓				
Epworth St. Child Resource						
Eversley House		**Feb** ✓				
Fox Hollow		**Feb** ✓				
Greenfields (SUMMERSVIEW)	**May** ✓		**Aug** ✓		**x**	
Holly Lodge				**Jun** ✓		**x**
Hope Centre			**Oct** ✓		**x**	
Kniveden				**X**	**X**	
Lymebrook	**May** ✓		**Sep** ✓		**x**	
Meadow View		**Feb** ✓				
Parent & Baby (Victoria Surgery)			**Aug** ✓		**x**	
Regent House		**Feb** ✓				
Richmond Terrace No.7				**Jun** ✓		**x**
Roundwell First Steps					**Feb** ✓	
Sutherland Centre (Florence house)	**May** ✓		**Aug** ✓		**x**	

NB – The requirement in this instance is to review the assessment regularly and specifically when there is reason to believe that the original risk assessment may no longer be valid. There is no specified timeframe. The Estates Team have continued to have Water Risk Assessments undertaken every 2 years as best practice.

Approved persons: The Trust has responsible persons in place, as required:

Area of responsibility	Named Person
Responsible persons for medical gases	Paul Roughton, Senior Estates Manager Chris Hodgkinson, Senior Project Manager
Responsible persons for LV	Ray Porter, Lee Wilton,
Responsible persons for lifts	Paul Roughton, Senior Estates Manager Alan Hough, Engineering Officer
Responsible person for water quality	Paul Roughton, Senior Estates Manager
Nominated fire manager	Mick Daniels, Compliance Officer: Fire & Security

The Estates Agency keeps a detailed log of all inspections and any actions that have been taken following an inspection. The Estates team has sufficient evidence to provide assurance that the Trust complies with all of the statutory regulations for its property.

Areas of non-Compliance

There are currently no specific areas of non-compliance. There are a number of properties due for various items of compliance to be inspected/completed in the current year. These are, however, identified and planned for completion by the Estates Team.

It should be noted that compliance relates to legislation and NOT guidance. Where building guidance is issued the expectation is that this is incorporated into new buildings and any refurbishment and this is practice within the Trust.

Key Compliance Risks

1. **Vacant Properties**
   There are a number of vacant properties or areas within properties i.e. Bucknall, Ashcombe and The Bennett Centre where the risks are increased due to non-occupation. The Estates Team have implemented various additional works and services to ensure that the areas remain as safe as possible and reduce the risks to the Trust. Additional security is on site at Bucknall to reduce the risk of trespass and access to the buildings which are now derelict, stringent flushing regimes are in place for the unoccupied areas of Ashcombe and The Bennett Centre, along with appropriate maintenance programmes for the fire safety equipment, boilers, smoke alarms....etc. Regular maintenance inspections are continued to keep the vacant areas of the properties in reasonable condition.
2. **Maintenance Budgets**
   The Estates Department do not hold any budgets for the maintenance of properties. Budgets are managed by the clinical directorates with an element included for estates maintenance. This means that the Estates Team need to seek approval from budget holders to undertake statutory compliance works. As many budget holders do not have any estates knowledge they are unaware of the relevant legislation and therefore do not always approve the works in a timely manner.

Enclosure 13

Update TO TRUST BOARD

Date of Meeting:	29/10/15
Title of Report:	Whole Systems Leadership - Health and Well Being Board (Stoke)
Presented by:	Thomas Thornber
Author of Report: Name: Date: Email:	Stoke on Trent Health and Well Being Board Diane Lea, Chair of Stoke on Trent Health and Wellbeing Board Engagement event 1/10/15
Committee Approval/Received prior to Trust Board:	N/A
Purpose / Intent of Report:	For information
Executive Summary:	Development of Health and Wellbeing board strategic aims. Contribution from NSCHT future engagement planned on Editorial Group.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Integrated Business Plan Alignment of Public sector and 3rd sector partners in improving the health and Wellbeing of Stoke.
Relationship with Annual Objectives:	Alignment of Health and Social care initiatives
Risk / Legal Implications:	Consultation stage
Resource Implications:	Consultation stage
Equality and Diversity Implications:	n/a
Relationship with Assurance Framework [Risk, Control and Assurance]	Link to Strategic goals of alignment of health and social care
Recommendations:	Note contents and receive for information

Stoke-on-Trent Health and Wellbeing

Whole System Leaders event
1st October 2015

1. Purpose of the event

1.1 For the Health and Wellbeing Board (HWBB) to seek the views of the key groups that underpin the Health and Wellbeing Board on the proposed 'Winnable Battles' and high level outcomes that the HWBB will focus on in its next Joint Health and Wellbeing Strategy (JHWBS).

1.2 Underpinning groups were also asked to discuss and share the wider set of priorities that they feel their respective partnerships need to focus on over the coming years.

2. Important to note

2.1 In advance of the session all partners were provided with the Joint Strategic Needs Assessment (JSNA) Outcomes Overview Report 2015, this document provides further detail to that considered by the HWBB at their recent development session held in July 2015.

2.2 Findings from the JSNA report, alongside current performance, knowledge of policy requirements and wider context have shaped the emerging priorities so far and will continue to be important as the JHWBS and underpinning plans are developed.

2.3 Those present were asked to consider the following 'Challenge Criteria' when supporting/proposing 'Winnable Battles'/priorities:

- Statutory requirement?
- National priority?
- Problem that we are going to be able to tackle?
- Evidence of effective interventions available?
- Addresses health and wellbeing inequality?
- Resource available?

3. The event was attended by:

Board	Name	Organisation/Sector
CYPSP	Amanda Owen	S-O-T City Council
CYPSP	Andrea Muirhead	S-O-T City Council
RAG	Barry Pitts	Staffs Housing
ASP	Brian Moss	Staffs Fire & Rescue
HWBB	Caroline Donovan	NSCHT
Board	**Name**	**Organisation/Sector**
ASP	Christine Whitehead	S-O-T City Council

CYPSP	Claire Gaygan	6th Form College
HWBB, **ASP**	Councillor Ann James	Councillor (Vice Chair of HWBB)
CYPSP	Daniel Flynn	YMCA
ASP	Dave Sanzeri	S-O-T CCG
CYPSP	Debbie Parkes	S-O-T City Council
HWBB, RAG	Diane Lea	Staffordshire Housing (Chair of HWBB)
ASP	Donna Broadhead	Staffs Fire & Rescue
ASP	Fran Jones	S-O-T City Council
RAG	Hazel Williamson	S-O-T City Council
RAG	John Mason	Probation Service
CYPSP, ASP	John Wood	SCB
RAG	Jonathan Tew	S-O-T City Council
RAG	Judy Kurth	S-O-T City Council
ASP	Julie Obada	S-O-T City Council
CYPSP	Karen Wilson	MIND
HWBB, **ASP**	Leanne Eardley	SSOTP
HWBB	Lesley Mountford	S-O-T City Council
HWBB, **CYPSP**, RAG	Louise Rees	S-O-T City Council
RAG	Mark Self	Probation Service
ASP	Melanie Dunn	S-O-T City Council
RAG	Paula Hammond	S-O-T City Council
RAG	Shahzad Tahir	S-O-T City Council
CYPSP	Sharon King	S-O-T CCG
RAG	Sharon Taaffe	S-O-T City Council
ASP	Simon Robson	S-O-T City Council
HWBB	Steven Allen	UHNM
CYPSP	Tom Thornber	NSCHT
RAG, **CYPSP**	Tracy Jackson	S-O-T City Council
HWBB, **ASP**	Val Lewis	Healthwatch
RAG	Vicki Yates	S-O-T City Council
CYPSP, **RAG**	Wayne Jones	Staffordshire Police

***bold denotes the group joined at the event.**

4. Key points in relation to 'Winnable Battles'

4.1 The following 'Winnable Battles were proposed by the HWBB for discussion/debate. Delegates were asked to discuss in groups 1. Are these the right 'winnable battles'? – issues for particular vulnerable groups? And 2. How could your respective Board contribute?

Proposed 'Winnable Battles':

- Increase breastfeeding
- Tackle childhood obesity
- Reduce conceptions amongst young women under 18
- Control tobacco
- Increase successful completions of treatment for people with substance misuse problems
- Mental health - could be timely access/early intervention up-stream
- Keeping people safe and well at home (older people)

4.2 General feeling was that the JHWBS and underpinning plans should have a longer period of focus.

4.3 Feeling that we should have a clear set of strategic priorities. The outcomes (such as some of the suggested as 'Winnable Battles' above) should be the **measures** of those priorities.

4.4 Feeling that the strategy needs to focus on the 'causes of the causes'.

4.5 Recognition that the HWBB will lead/raise profile of some priorities but others may be led by other partnerships.

4.6 Support for the principle that 'form should follow function' and the importance of integrated approaches to achieve biggest impact.

4.7 Support for the challenge criteria and the notion that activity should be evidence based.

4.8 Strong support that **prevention should run through our HWBS and underpinning plans.**

4.9 Feeling that the focus of the JHWBS should include determinants of health.

4.10 Support for the principle that the partnership should focus on what it can have an impact on by working together with additional challenge to all organisations in the partnership to look at how they can contribute to that priority.

4.11 Some debate whether the proposed 'Winnable Battles' were the right ones to focus on, following discussion the following were raised as emerging proposed priorities for the Joint Health and Wellbeing Strategy:

- Tackling childhood obesity
- Emotional and mental health – with a particular focus on children and young people
- Control tobacco/smoking
- Parenting
- Employment/employability (working with the Stoke-on-Trent and Staffordshire LEP)
- Keeping older/vulnerable people safe and well in their own homes

5. Key points in relation to underpinning priorities

5.1 **Children and young people**

- Need to ensure that there are a smaller number of focused priorities in the next Children, Young People and Families Plan.
- As above the discussion focused on the 'causes of the causes' - the group felt that the strategic overarching priority of parenting would impact on a number of outcomes.

- Following discussion at the event and with Children and Young People's Strategic Partnership Board members unable to be present on the 1st October, the emerging themes are:
  - Child Poverty inc. employability (parents and young people)
  - Parenting (inc. focus on early years) – include focus on smoking and childhood obesity outcomes
  - Early Help and prevention
  - Emotional and mental health – with a particular focus on children and young people (parents)

- Important to ensure that listening to children, young people, parents and carers is built into all future priorities.
- It is recognised that these emerging priorities overlap.

5.2 **Adults (vulnerable younger adults and older people)**

- Colleagues felt that the partnership could add value by focusing on the following themes where traction is needed to increase impact and improve outcomes:
  - Keeping older/vulnerable people safe and well in their own homes (early help and prevention)
  - Employment/employability
  - Tobacco control/smoking
  - Housing/environment

- There are common themes emerging across the life course.

5.3 **Responsible Authorities Group (Safer City)**

- RAG Board members present considered that there is a need to re-align Safer City Partnership Strategy with other Safer City Partnership's and HWBB – this will be complex to achieve.
- Annual refresh due – conversations from 1st October will be relayed to wider partners of the RAG.
- Agreed that Violence is the top priority for the RAG – but needs to be clearer and focus more on vulnerabilities.
- Much stronger emphasis on prevention required and clearer focus on engagement.
- Safer City Strategy to be refreshed as soon as possible on these lines.

6. Next steps

6.1 Board members will be asked to comment on this report and a final suite of emerging priorities ('Winnable Battles') will be shared for further discussion at stakeholder events on the 9th and 15th October 2015.

6.2 Following these events Board members will be asked to consider further feedback with a view to sharing priorities for wider/public consultation towards the end of October.

6.3 Detailed work to develop the JHWBS and underpinning plans will commence in November. Colleagues will be invited to participate in 'Think Tanks' to progress priority development.

North Staffordshire Combined Healthcare NHS Trust

Enclosure 14

REPORT TO TRUST BOARD

Date of Meeting:	29 October 2015
Title of Report:	People & Culture Development Committee Report
Presented by:	Amy Garside
Author of Report: Name: Date: Email:	Amy Garside, Associate Director of HR 21st October 2015 Amy.Garside@northstaffs.nhs.uk
Committee Approval/Received prior to Trust Board:	~~Quality Committee~~ ~~Finance and Performance Committee~~ ~~Audit Committee~~ People and Culture Development Committee ✓ ~~Charitable Funds Committee~~ ~~Business Development and Investment Committee~~
Purpose / Intent of Report:	For information/assurance
Executive Summary:	This report provides a summary of the meeting of the People & Culture Development Committee that took place on the 21st September 2015.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Customer Focus Strategy ✓ Clinical Strategy ✓ ~~IM & T Strategy~~ Governance Strategy ✓ ~~Innovation Strategy~~ Workforce Strategy ✓ ~~Financial Strategy~~ ~~Estates Strategy~~
Relationship with Annual Objectives:	Cuts across all objectives
Risk / Legal Implications:	N/A
Resource Implications:	N/A
Equality and Diversity Implications:	None in this report
Relationship with the Board Assurance Framework	1. Focusing on quality and safety 2. Consistently meeting standards 3. Protecting our core services 4. Growing our specialised services 5. Innovating in the delivery of care 6. Developing academic partnerships and education and training initiatives 7. Being an employer of choice

	8. Hosting a successful CQC inspection ~~9. Becoming digital by choice~~ ~~10. Reviewing and rationalising our estate~~ ~~11. Devolving accountability through local decision making that is clinically led assuring governance arrangements.~~ 12. ~~Delivering our financial plan~~
Recommendations:	• To receive for information and assurance purposes • Ratify policies identified in the report

North Staffordshire Combined Healthcare NHS
NHS Trust

Summary to Trust Board of the People and Culture Development Committee:

19th October 2015

1. Workforce Directorate Performance – August 2015

The Committee received presentations by exception from each of the directorate leads on their performance against key workforce indicators.

Members discussed areas such as sickness absence across each of the services and it was noted that this had decreased slightly in comparison to the previous month. The main reason for the absence across the Trust continues to relate to anxiety and stress and accounted for 31.6% of the absence.

It was noted however, that the use of overtime had decreased and the spend on agency and bank had decreased and recruitment to a number of vacancies had taken place. Further recruitment is ongoing and although turnover has decreased, it was noted that internal moves, for example Adult Inpatient to Adult Community, also have an impact on vacancy numbers.

Statutory and Mandatory training compliance has increased, however the 12 month rolling figures regarding Personal Development reviews have dropped slightly. Reviews continue to be undertaken and a significant number were scheduled to take place in September.

2. Policy Review

The committee considered the following policies:

- *Medical and Dental Starting Salary Procedure and Guidance* (outlines the process for determining Medical and Dental starting salaries; including protection for training grade appointments).

The procedure has been reviewed and supported by the JNLC.

It was recommended to the Trust Board that the Medical and Dental Starting Salary Procedure and Guidance should be ratified for a period of 3 years.

3. Workforce & Organisational Development Risks

The committee received the workforce and OD risks at August 2015. The source of each risk, its risk rating and progress on action plans to mitigate those risks was discussed. No further issues were highlighted and committee members accepted that the risks presented were the current risks that the committee needed to focus on:

- *Insufficient staff to deliver appropriate care because of staffing vacancies and increased referrals*
- *The Trust fails to reduce sickness levels to anxiety / stress.*

Members of the committee also considered other risks that may require adding to the adding to the risk register.

4. **Board Assurance Framework (BAF) – Quarter 2**

Work is ongoing with regard to the Quarter 2 BAF in preparation for Trust Board, therefore the Committee agreed to defer consideration of Quarter 2 BAF until the November meeting.

5. **Rose Report Action Plan**

Following the delivery of the Rose Report last month, an action plan has now been created in order to enact the recommendations. This was agreed.

6. **NICE Guidance**

The Committee received the NICE Clinical Guidelines regarding workplace policy and management practices to improve the health and wellbeing of employees. The paper has been reviewed at Senior Leadership Team (SLT) with the recommendation that monitoring of the actions will be conducted through CEG. HR/OD working together to review the action plan and consider whether the development of a Health and Wellbeing Policy or the re-design of the sickness policy to promote a Wellbeing focus would be the way forward..

7. **Future Agenda Presentation**

The Committee discussed the current and future agenda presentation, with a view to ensure agenda items fall within our SPAR priorities and have an identifiable link. Significant discussion ensued regarding the appropriate time to review and revise the agenda, all agreed that agenda items must relate to Trust priorities. Committee effectiveness and interconnectivity of all Committees to avoid duplication and ensure maximum value is being added.

8. **PCD Reporting Groups - minutes**

- Professional Leaders Advisory Group (August)
- Joint Negotiating and Consultative Committee (September)

9. **Next meeting: 9th November 2015**

On behalf of the Committee Chair, Mr Peter O'Hagan and Mr Paul Draycott, Director of Leadership & Workforce

Amy Garside, Associate Director of HR
21.10.15