North Staffordshire Combined Healthcare NHS Trust

MEETING OF THE TRUST BOARD

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

	AGENDA	
1.	**APOLOGIES FOR ABSENCE** *To NOTE any apologies for absence*	Note
2.	**DECLARATIONS OF INTERESTS RELATING TO AGENDA ITEMS**	Note
3.	**DECLARATIONS OF INTERESTS RELATING TO ANY OTHER BUSINESS**	Note
4.	**MINUTES OF THE OPEN AGENDA – 9th November 2017** *To APPROVE the minutes of the meeting held on 9th November 2017*	Approve Enclosure 2
5.	**ACTION MONITORING SCHEDULE & MATTERS ARISING FROM THE MINUTES** *To CONSIDER any matters arising from the minutes*	Note Enclosure 3
6.	**CHIEF EXECUTIVE'S REPORT** *To RECEIVE a report from the Chief Executive*	Note Enclosure 4
7.	**CHAIR'S REPORT** *To RECEIVE a verbal report from the Chair*	Note
8	**STAFF RETIREMENTS** *To EXPRESS our gratitude and recognize staff who are retiring* *To be introduced by the Chief Executive and presented by the Chair*	Verbal
9.	**REACH RECOGNITION AWARD ON EXCELLENCE** *To PRESENT the REACH Recognition Team Award to* Outreach Team, NOAP Directorate To be introduced by the Chief Executive and presented by the Chair	Presentation

	QUESTIONS FROM MEMBERS OF THE PUBLIC	
10.	*To RECEIVE questions from members of the public*	Verbal
	TO ENHANCE SERVICE USER AND CARER INVOLVEMENT	
11.	**SERVICE USER AND CARER COUNCIL** *To RECEIVE an update from, Wendy Dutton, Chair of the Service User and Carer Council*	Assurance Enclosure 5
	ENCOURAGE, INSPIRE AND IMPLEMENT RESEARCH AND INNOVATION AT ALL LEVELS	
12.	**KEELE SCHOOL OF MEDICINE QA VISIT REPORT** *To RECEIVE the report from the Keele School of Medicine QA Visit from Dr Buki Adeyemo, Medical Director*	Assurance Enclosure 6
	TO PROVIDE THE HIGHEST QUALITY SERVICES	
13.	**NURSE STAFFING MONTHLY REPORT - November 2017** *To RECEIVE the assurance report on the planned versus actual staff variances from Maria Nelligan, Executive Director of Nursing & Quality*	Assurance Enclosure 7
14.	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 8** *To RECEIVE the Month 8 Performance Report from Suzanne Robinson, Director of Finance, Performance and Digital*	Approval Enclosure 8
15.	**QUARTER 3 SERIOUS INCIDENT REPORT** *To RECEIVE the Quarter 3 Serious Incident Report from Dr Buki Adeyemo, Medical Director*	Assurance Enclosure 9
16	**LEARNING FROM DEATHS QUARTERLY REPORT** *To RECEIVE the Learning from Deaths Quarterly Report from Dr Buki Adeyemo, Medical Director*	Assurance Enclosure 10
17	**CQC LOCAL SYSTEM REVIEW ACTION PLAN** *To RECEIVE the CQC Local System Review Action Plan from Caroline Donovan, Chief Executive*	Assurance Enclosure 11
	CREATE A LEARNING CULTURE TO CONTINUALLY IMPROVE	
18.	**Received as Items 10 & 11 in Closed Board**	
	MAXIMISE AND USE OUR RESOURCES INTELLIGENTLY AND EFFICIENTLY	

19.	**FINANCE REPORT – MONTH 8 (2017/18)** *To RECEIVE for discussion the Month 8 financial position from Suzanne Robinson, Director of Finance, Performance and Digital*	Approval Enclosure 12
20.	**ASSURANCE REPORT FROM THE FINANCE & PERFORMANCE COMMITTEE** *To RECEIVE the Finance & Performance Committee Assurance report from the meetings held 11th January 2018 from Tony Gadsby, Chair/Non-Executive Director*	Assurance Enclosure 13
21.	**DECLARATION OF INTERESTS – December 2017** *To RECEIVE for information and assurance the Trust Board Register of Interests to December 2017 from Laurie Wrench, Associate Director of Governance / Trust Board Secretary*	Assurance Enclosure 14
22	**REGISTER OF SIGNED AND SEALED DOCUMENTS – 1 JANUARY – 31 DECEMBER 2017** *To RECEIVE for information and assurance purposes the Register of sealed documents from 1 January 2017 – 31 December 2017 from Laurie Wrench, Associate Director of Governance / Trust Board Secretary*	Assurance Enclosure 15
	ATTRACT AND INSPIRE THE BEST PEOPLE TO WORK HERE	
23	**ASSURANCE REPORT FROM THE PEOPLE AND CULTURE COMMITTEE** *To RECEIVE the People, Culture and Development Committee Assurance report from the meeting held 15th January 2018 from Lorien Barber, Chair/Non-Executive Director*	Assurance Enclosure 16
24	**ASSURANCE REPORT FROM THE QUALITY COMMITTEE** *To RECEIVE the Quality Committee Assurance report from the meeting held 21st December 2017 from Patrick Sullivan, Chair/Non-Executive Director*	Assurance Enclosure 17
25	**ASSURANCE REPORT FROM THE AUDIT COMMITTEE** *To RECEIVE the Audit Committee Assurance report from the meeting held 30th November 2017 from Tony Gadsby, Chair/Non-Executive Director*	Assurance Enclosure 18
	CONTINUALLY IMPROVE OUR PARTNERSHIP WORKING	
26	*To RECEIVE a verbal update on progress from Mr A Hughes, Joint Director of Strategy, Development and Estates (NSCHT/GP Federation)*	Verbal
	DATE AND TIME OF THE NEXT MEETING	
	The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday, 22nd February 2018 at 10:00am.	
	MOTION TO EXCLUDE THE PUBLIC *To APPROVE the resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be*	

	prejudicial to the public interest" (Section 1(2) Public Bodies (Admissions to Meetings) Act 1960)	

THE REMAINDER OF THE MEETING WILL BE IN PRIVATE

	DECLARATIONS OF INTEREST	Note
	DECLARATIONS OF ANY OTHER BUSINESS	Note
	SERIOUS INCIDENTS	Assurance
	BUSINESS PLAN UPDATE	Approve
	LEADERSHIP & WORKFORCE REPORT AND SERVICE REVIEW	Assurance
	ANY OTHER BUSINESS	

TRUST BOARD

Minutes of the open section of the North Staffordshire Combined Healthcare NHS Trust Board meeting held on Thursday, 9th November 2017 At 10:00am in the Boardroom, Trust Headquarters, Lawton House Bellringer Road, Trentham, Stoke on Trent, ST4 8HH

Present:

Chairman:

David Rogers
Chairman

Directors:

Caroline Donovan
Chief Executive

Dr Buki Adeyemo
Medical Director

Patrick Sullivan
Non-Executive Director

Dr Nasreen Fazal-Short
Acting Director of Operations

Joan Walley
Non-Executive Director

Paul Draycott
Executive Director of Leadership &Workforce

Dr Keith Tattum
GP Associate Director

Suzanne Robinson [part]
Director of Finance, Performance and Digital

Maria Nelligan
Executive Director of Nursing and Quality

Andrew Hughes
Joint Director of Strategy and Development

Tony Gadsby
Non-Executive Director

Lorien Barber
Non-Executive Director

Ganeshan Mahadea
Non-Executive Director

In attendance:

Laurie Wrench
Associate Director of Governance

Lisa Wilkinson
Acting Corporate Governance Manager (minutes)

Jenny Harvey
Staff Side Representative

Wendy Dutton
Chair of Service User Carer Council

Joe McCrea
Associate Director of Communications

Kerry Smith
Associate Director of Human Resources

Ms C Wilkes [part]
Team Leader Summersview (Patient Story)

Staff Retirements
Dr Pernia Arshad
Ms Carol Sylvester

REACH Individual Recognition Award
Dave Hewitt – Chief Operating Officer
Emma Mellor – Medical Staffing Officer

Members of the public:
Hilda Johnson
Phil Copestake
Paul Maddox – O2

The meeting commenced at 10:04am.

846/2017	**Apologies for Absence** David Rogers acknowledged this would be Paul Draycott, Director of Leadership and Workforce last Trust Board meeting. Paul Draycott will be leaving the Trust in December 2017. David Rogers expressed his sadness that Paul will be leaving but wished him well in his new appointment.	**Action**
847/2017	**Declaration of Interest relating to agenda items** There were no declarations of interest relating to agenda items.	
848/2017	**Declarations of interest relating to any other business** There were no declarations of interest relating to any other business.	
849/2017	**Minutes of the Open Agenda – 5th October 2017** The minutes of the open session of the meeting held on 5th October 2017 were approved.	
850/2017	**Matters arising** The Board reviewed the action monitoring schedule and agreed the following:- ***829/17 – Research and Innovation Strategy –*** *Complete* ***826/17 – Access and Home Treatment Spotlight*** *– Report will be available at the January 2018 Trust Board meeting.* ***830/17 – Safer Staffing Nursing Report August*** *– 6 month safer staffing report to go to January 2018 Board including fill rate trend due to changes in shift patterns* ***841/17 – Partnership Strategic Plan*** *– Report available for January 2018 Trust Board meeting.*	
851/2017	**Chief Executive's Report** Caroline Donovan, Chief Executive, presented this report which provides an update on the activities undertaken since the last meeting in October 2017 and draws the Board's attention to any other issues of significance or interest. **CQC UPDATE** Much of October was taken up with the CQC Inspection of clinical core services and the well-led review. The CQC visits started in the week commencing, Monday 2nd October 2017 with the Community CAMHS Team at Dragon Square and Adult Community team at Greenfields. As we had self-assessed learning disability wards, Florence House and Summers	

Views as Outstanding, the CQC also came to have a look at these services. The well-led review took place in the week commencing 30th October 2017. The feedback received at this stage has been overwhelmingly positive.

The Trust has been identified as an exemplar by the CQC as one of the fastest improving trusts in the country. The CQC exemplar team were on site in October 2017 to interview staff and running focus groups to learn about the Trusts journey of improvement. The CQC will now develop a case study narrative to be published nationally for all to learn. This is great news and a true testament to the excellent work staff are leading on.

NEW CHAIR FOR STP

Sir Neil McKay is the newly-appointed Chair for Staffordshire STP. Neil has previously been Chief Operating Officer at the Department of Health and was Chief Executive of the East of England Strategic Health Authority. It has been very helpful to hear his views, particularly his support of the Alliance Boards and integrated locality working.

BOMB SCARE AT HARPLANDS

Sometimes the best successes are when something is dealt with calmly and professionally whilst remaining relatively unseen to the rest of an organisation. This is exactly what happened with an incident at the Harplands Hospital, which showed the sheer professionalism and abilities of staff.

On Friday 6th October 2017, the Trust received a bomb threat which claimed that a device had been planted in Harplands Hospital. All staff worked together to support an evacuation of the hospital while the police supported with checking the main hospital and giving the all clear on the bomb threat. The staff then calmly supported all patients back to the wards. In the early and preliminary debrief some key lessons have been identified and a number of measures put into place to rectify anything that needed immediate attention. A full debrief is planned. The Trust emergency planning accountable Officer (Nasreen Fazal-Short) and operational lead (Natalie Larvin) have been in touch with all staff to remind them about the important processes to follow in such event.

STP DIGITAL WORKSTREAM AGREES BUSINESS CASE FOR INTEGRATED CARE RECORD

The STP Digital Workstream took a significant step by approving the draft Business Case for the Integrated Care Record. The draft is now being taken to each organisation in the STP for their agreement.

It's not simply introducing technology for technology's sake, but really concentrating on the benefits it can deliver for local care.

NEWCASTLE ACCELERATED DESIGN EVENT

The Trust has been working in recent months with the NHS Chief Transformation Officer, Helen Bevan, to develop a series of Accelerated Design Events. This is an innovative approach to transformation, getting people together to be creative and problem-solving in addressing major

challenges across our local health and care economy,

A recent Accelerated Design Event took place supported by the team at Combined and Helen and Dr Emma Dutton looking at how the Trust can build on the work we have been developing with the Staffordshire and Stoke-on-Trent Alliance to develop a new model of care in Newcastle.

Presentations were heard from a range of speakers, including the excellent Dr Mark Williams and Newcastle GP Dr Emma Sutton and Dr Dawn Moody who reminded us of the benefits of a more patient centred model for patients. Time was spent during the day planning how to establish the new model. Ideas from the event will be fed into work supporting the Alliance, but more widely across the STP in terms of its own developing thinking on how to be innovative about how to deliver care.

MEIR PARTNERSHIP CARE HUB WINS NATIONAL AWARD

An innovative partnership service that brings together health and social care services to deliver more effective services to those living within Meir in Stoke-on-Trent has won a national award. The Meir Partnership Care Hub beat tough competition to win the Mental Health and Social Care category at the Positive Practice in Mental Health Awards. The award recognises the work that is taking place within the hub to deliver fully integrated services to the patients of five GP practices in Meir. The hub has been running since October 2016 and is a partnership of North Staffordshire Combined Healthcare NHS Trust and Stoke-on-Trent City Council, with involvement from Staffordshire and Stoke-on-Trent Partnership NHS Trust, Staffordshire Fire and Rescue Service, Staffordshire Police and the voluntary sector. It has been supported by the Cooperative Working Partnership within Stoke.

FINANCE TEAM SHORTLISTED FOR NATIONAL TRAINING AWARD

Well done to the Finance team, who have been shortlisted in the Havelock Training Award at the 2018 Healthcare Financial Management Association (HFMA) Awards. The team have achieved some great things in 2017, including the innovative Valuemakers initiative, getting consultants engaged in key financial projects and the excellent animated film of the Trusts 2016/17 Annual Accounts that was produced for the most recent AGM which can be viewed on the Trusts YouTube channel.

LOCAL MPs DEBATE FINANCIAL SITUATION FACING NORTH STAFFORDSHIRE'S NHS IN HOUSE OF COMMONS

MPs representing Stoke-on-Trent took part in a debate in the House of Commons on Monday 23 October 2017 into the serious financial challenges facing the NHS in North Staffordshire. Thank you to Gareth Snell, MP for Stoke-on-Trent Central, for securing the debate and also to Jack Brereton, MP for Stoke-on-Trent South, who made the following comment highlighting Combined Healthcare's financial performance: "I recognise that there are significant financial challenges, particularly around the hospital, but North Staffordshire Combined Healthcare NHS Trust, for example, has made significant improvements in the wider health economy."

It is very welcome that the worrying financial situation facing the local health

and social care economy is being debated at this level. Philip Dunne, Health Minister and MP for Ludlow has agreed to visit the area to see first-hand the situation on the ground. Thank you also to Stoke-on-Trent North MP Ruth Smeeth and Stafford MP Jeremy Lefroy or taking part in the debate.

REACH AWARDS A HUGE SUCCESS

The Trusts biggest REACH Awards yet were held on 5 October 2017, with more nominations and awards than ever before. Almost 300 nominations were received.

A very special part of the evening was the launch of the Justin Griffiths Scholarship Award - an annual award which will support Social Workers, Best Interest Assessors and Approved Mental Health Professionals (AMHPs) to develop their knowledge and skills, improve the lives of others, encourage research, development and education within our mental health and learning disability services reflecting the work practice of the above professionals; and provide a scholarship(s) to those who are undertaking professional development through study, research or experiential learning. We will be publishing details on how to apply for the scholarship shortly. We were delighted to showcase our first ever Combined Healthcare Nursing Badge and thanked Deb Scragg and Sue Wood for their great design skills, while we also gave a special presentation to Paul Draycott, Director of Leadership and Workforce, for his service to the Trust over many years. You can still view the online stream of the REACH Awards via the Trust's Facebook page.

OLDER PEOPLES' COMMUNITY SERVICES AWARDED PRESIGIOUS KITE MARK FROM THE ROYAL COLLEGE OF PSYCHIATRISTS

The Trust has been granted accreditation for the next two years from the Royal College of Psychiatrists' (RCP) Memory Services National Accreditation Programme – the premier and highly prestigious kite mark for quality of care in memory clinics. Congratulations in particular to Rachael Birks, Memory Team Manager, and Claire Barnett, Advanced Nurse Practitioner, who led the application to the programme. This required substantial work and co-ordination with the MNSAP Inspection Team and involved a rigorous peer review process which has not only led to our Trust getting accreditation, but also the recognition of both leads as MSNAP Peer Reviewers in their own right.

DR RAVI BELGAMWAR APPOINTED NEW REGIONAL TRAINING DEPUTY DIRECTOR

Congratulations to Dr Ravi Belgamwar, Consultant Psychiatrist at the Lymebrook Centre, who has been appointed as Deputy Training Program Director for General Adult Psychiatry at the West Midlands Post Graduate School of Psychiatry. Dr Belgamwar will start this this role from 1 December 2017 and will work closely with Dr Derrett Watts, Substance Misuse Clinical Director, to ensure the delivery of good quality training, particularly in relation to the assessment process and curriculum requirements to help improve the quality of the training across the region.

As College Tutor for last eight years, Dr Belgamwar has played a vital role

in maintaining and developing the academic and educational activities within the Trust. The recruitment process will commence shortly for a replacement College Tutor.

PARTNERSHIP WITH KEELE UNIVERSITY DELIVERS RESULTS

One of our most valued partnerships is that with Keele University. The Trust is proud to be able to be called a Keele University Teaching Trust and, as part of the assurance overseeing this partnership, Caroline Donovan welcomed the Dean of the University and the School of Medicine QA monitoring panel to the Harplands Hospital. The panel were able to meet with students, doctors, tutors and other health professionals.

The feedback received was overwhelmingly positive. It is so important that students and trainees have a great learning experience when they come to Combined. A very big thank-you to Dr Buki Adeyemo, Dr Dennis Okolo, Dr Ravi Belgamwar and Dr Darren Carr who demonstrated their excellent leadership in leading medical education across our Trust.

We are also delighted that Keele University has been ranked joint first with the University of Oxford for producing the most psychiatrists of any medical school in England. Keele has had the most graduates progress to a career in psychiatry in the past three years, placing joint first with Oxford University in a new table published by the Royal College of Psychiatrists (RCPsych).

PERSON CENTREDNESS FRAMEWORK PLANNING DAY HELD

The Person Centredness Framework Planning Day took place on 3 November 2017 at Port Vale for staff to learn more about what person centredness really means – the results of which will inform the Trusts new person-centred framework. This will be co-produced with people who access services, as well as their carers, families and staff.

NATIONAL UPDATE

CHILDREN'S COMMISSIONER PUBLISHES REVIEW OF MENTAL HEALTH SERVICES FOR CHILDREN

On 10th October 2017, the Children's Commissioner published a review of mental health services for children. The Commissioner said that children's mental health was the issue most often raised with her over the past year, and it was the top of the list in her consultation with children about her priorities for the year ahead.

The Commissioner recommends:

- The forthcoming Green Paper presents an opportunity to transform children's mental health services. Its ambition should be to bring about a system designed around three principles:
    - A mental health service that is designed for children and built to meet their needs.
    - A service that supports children in the right place at the right time.
    - High quality, evidence based services, from the classroom to

hospital care.

- In order to achieve this, the Green Paper needs to set clear expectations as to what a child can expect in terms of mental health support and achieve consistency in every area of the country, and whose responsibility it is to provide this. To underpin this, we need a more transparent and accountable system.

CQC PUBLISHES REVIEW OF CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH SERVICES

On 27th October 2017, the Care Quality Commission (CQC) published its '*Review of children and young people's mental health services*' on the challenges facing providers of services for children and young people's mental health. The report is the first phase of a CQC review into the quality and accessibility of mental health services for children and young people and summarises the current state of knowledge from across a range of sources.

To coincide with the publication of the CQC Report, the Trust published updated waiting time figures, demonstrating the significant improvement and quality of services being delivered by our CAMHS service. Over the last two years, the Trust has made significant progress in ensuring children and young people are seen in a timely manner for an initial assessment, they receive a good quality risk assessment and care plan and that everyone is allocated a care coordinator, with the result that:

- Two thirds of children and young people are seen for a first assessment within four weeks - no child waits more than 18 weeks.
- 97% of children and young people receive treatment within 18 weeks.

The Trust's children and young people's services has also:

- Developed a multiagency single point of access service at the Bennett Centre in Stoke-on-Trent enabling children and young people receive the right service at the right time in the right place.
- Rolled out a new programme of high intensity evidence based treatment groups supporting children with a range of mental health disorders, including self-harm, anxiety and depression.
- Introduced attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) skills workshops in children and adolescent mental health service (CAMHS) sites across the whole of Stoke-on-Trent and North Staffordshire;
- Developed a new specialist community eating disorder team, with 100% of children and young people receiving treatment within four weeks of referral for routine cases; and one week for urgent cases.
- Unveiled a new garden at the Trust's Tier 4 CAMHS service at the Darwin Centre as part of a programme of investment to improve therapeutic environments.

The Trust has recently joined forces with local schools to launch a nationally leading new mental health and wellbeing strategy. The strategy has been launched as part of an exciting partnership between Combined Healthcare

	and a number of partner schools across Stoke-on-Trent. The Trust's updated figures were covered approvingly by BBC Radio Stoke, together with comments from Dr Matt Johnson. **Received**	
852/2017	**Chair's Report** David Rogers attended the NHS Providers conference yesterday. Simon Stevens CEO NHS England talked about not having additional funding and what the implications would be for government. We will have to see what the budget delivers. Cases are being made very strongly nationally. Following the Trusts recent CQC visit James Mullins quoted 'that the momentum of the Trusts improvement has been maintained' which was very positive. We are at a focal point in deciding how health care services particularly in North Staffordshire develop and pressure is being applied in a number of ways. Stoke-on-Trent is anticipating a visit from Simon Stevens during December which the Trust welcomes. The next few months are going to be very busy and as a Trust we are central to that process. Joan Walley highlighted the importance of looking to making sure any decision / discussions are an informed public debate and not as previously carried out behind closed doors. ***Noted***	
853/2017	**Staff Retirements** Caroline Donovan recognised a member of staff who is retiring this month as follows: **Carol Sylvester – Clinical Director, AMH Inpatient Services** Carol has had a long and successful career in Mental Health Services at Combined, starting initially as a Domestic Assistant at St Edward`s Hospital in 1979 and commencing Cadet training in 1980 and culminating in the role she is in now as Clinical Director for Adult Inpatient services. Following registration as a Registered Mental Health Nurse in 1984, Carol has worked in a number of operational and leadership roles, including Ward Manager and Duty Senior Nurse. In 2011 Carol was successfully appointed to the role of the Head of Patient and Organisational Safety and remained in post until January 2015. In the role of Head of Patient, Patient & Organisational Safety, Carol put in place significant systems and processes to support the Trust in developing a positive culture in incident reporting and safety.	

	In January 2015 Carol was appointed to the Deputy Director of Nursing post where she developed further expertise in the specialist field of safeguarding, patient experience and infection prevention within all areas. Carol also stepped up to Acting Director of Nursing from July to October 2015 to support the Executive Team and CQC Inspection in 2015. When the opportunity arose for an operational role in April 2017, Carol was appointed as Interim Clinical Director for Adult Mental Health In-patient Directorate. Carol has always been incredibly patient focused and champion's integrity and compassion in everything she does. This is often demonstrated in her interactions with patients, particularly those exhibiting levels of distress, whereby her compassionate, caring and calm approach comes to the fore. Carol will be greatly missed by everyone who has had the pleasure and privilege to work with her and I know you will join me in wishing her a very happy, healthy and well deserved retirement. Maria Nelligan presented Carol with a Combined Healthcare Nursing Badge. Dr Adeyemo also wished to personally acknowledge Carols retirement and dedication. **Dr Pernia Arshad – Consultant Psychiatrist, Learning Disabilities Service** Pernia first joined the NHS in June 1988 working in General Adult Psychiatry at Burnley General Hospital. In 1992 she took up a Learning Disabilities Registrar post Salford and moved into her first Consultant Learning Disability Post at Calderstones NHS Trust in 1999. Pernia joined the Trust in 2003 and has worked across both inpatient and community services since then including successfully fulfilling the position of Clinical Lead for Learning Disabilities. For the past few years she has been the Consultant Psychiatrist at the Assessment and Treatment Service. During her time at A&T Pernia has been involved in many of the changes that have seen our LD services evolve into a modern, high quality service. She has also been instrumental in leading a number of clinical projects to improve the quality of life for people with learning disabilities and autism; most recently she led the LD STOMP project which aims to stop the unnecessary over medication of people with a learning disability both by reducing the potential harm of inappropriate psychotropic drugs and by replacing the use of medication with more appropriate treatment options. Pernia has been a wonderful mentor and role model to the LD multi-disciplinary teams and is held in the highest regard by all of the staff at A&T and will be missed by all of her colleagues. Her retirement will provide the opportunity to spend more time with her family. However she will not be leaving her profession altogether as after a short break she aims to take up a part-time position with the Ministry of	

	Justice. Thank you Pernia and all the best for your retirement. ***Received***	
854/2017	**REACH Individual Recognition Award November 2017** **Dave Hewitt – Chief Operating Officer** Dave is the Trust's Chief Information Officer (CIO) and has been in post since summer 2015. He has made a huge impact since he joined us, leading the Trust on its Digital Journey. As a digitally 'immature' organisation in 2015, the Trust is almost unrecognisable now having achieved a number of notable successes including; a 61.5% increase in our digital maturity assessment, the successful implementation of our first EPR as part of the ROSE programme and submission of an application to be a national Lorenzo digital exemplar to name but a few. All of these achievements were unimaginable before Dave's time. Alongside these huge projects Dave maintains excellent relationships with people at all levels across the trust with a real "nothing is too much trouble" attitude. His colleagues note him to be a pleasure to work with and say he often helps out, advises, and provides solutions to problems outside of his portfolio. Going the extra mile is in Dave's DNA. Arguably Dave is driven by all of the Trust Values but the Value that most describes Dave is Responsible and this award goes some way to recognising the relentless work you do and goes some way to showing how much the Board and the Trust as a whole values you. Thank you Dave. **Emma Mellor – Medical Staffing Officer** Emma joined the Medical Staffing department as Medical Staffing Officer in February 2017. Emma's role as medical staffing officer involves managing the on-call rota, coordinating junior doctor rotations and liaising closely with Clinical Directors and recruitment agencies to support medical recruitment. Despite not working in the NHS or Medical Staffing previously, Emma has quickly learned how to build and maintain medical rotas, and has used her knowledge of agencies to the Trust's advantage. But she has not stopped there! Emma has re-negotiated numerous locum contracts which have delivered significant cost savings to the Trust and is working on supporting improved procurement – all of which go well beyond what would ordinarily be expected of someone in this role. Emma's motivation and attitude towards her work and colleagues has always been exceptional. She has brought an energy in her day to day work which has made her extremely popular with staff and a sense of responsibility for her role which is outstanding.	

	Emma has also made many suggestions to potential service improvements, including several through the Trust Valuemakers initiative. She has a real can-do attitude which is uplifting. She is also bursting with ideas to improve the way we do our business and has the ability to take people with her. Emma has created excellent working relationship with colleagues, including medical staff and medical agencies; across directorates and has also impressed the Executive Team with her approach. She has undoubtedly saved the Trust thousands of pounds through negotiating low commission rates on every locum booking, and ensured that the medical rota has been sufficiently covered when needed. She has done this, at times, in extremely challenging situations and is crucial to ensuring there is appropriate medical cover within the Trust at all times. In such a short period of time Emma has become an invaluable member of the workforce team and a real asset to the organisation. Emma represents all of the values of the Trust Values. However if we had to identify one in particular it would be Excellence as she continually strives to improve and be the best that she and the team can. Thank you Emma. Dr Adeyemo highlighted the transformation Emma has made to the team and wanted to thank Emma for her hard work. **Received**	
855/2017	**PATIENT STORY – SUMMERSVIEW – CAROLYN WILKES** Ms Nelligan introduced the patient story. A short video was displayed depicting the patient story of a young lady who talked openly about her journey of recovery through three of our directorates. The video can be found on the Trust's YouTube Channel. Carolyn Wilkes highlighted that the patient story shows how well the directorates work in partnership. It was also noted by all we should be proud of our multi-disciplinary working and team approach. Dr Fazal-Short emphasised the combined care plans we use in our services are what helps our patients. Joan Walley noted there was brief mention in the video regarding housing and asked how well placed we are with housing partnerships. Carolyn Wilkes advised the team work closely with housing i.e. Brighter Futures who offer a short break facility which eases people into a supported accommodation environment. Caroline Donovan noted the story highlighted how hard the transition is from the Darwin Centre to the Harplands and this is something the Trust needs to	

	look at in a different way. Dr Adeyemo highlighted transition from children to adult services is part of our CQUINS this year. Hilda Johnson wished to thank staff at Summersview and Florence House and highlighted the importance of having dedicated activity workers on the wards and seeing psychologists on the wards has been great its nice to see everyone supporting each other.	
856/2017	**Questions from the public** Jenny Harvey, Staff Side Representative acknowledged Paul Draycott's leaving as being a sad occasion and wished him all the best in his new position. Jenny referenced the debate in the House of Commons on Monday 23 October 2017 and discussion had regarding the serious financial challenges facing the NHS in North Staffordshire. Jenny acknowledged the underfunding in North Staffordshire is a big problem but highlighted another issue is reopening wards when previously support staff have been made redundant. Jenny felt this should not, must not and cannot be happening, staff need to have confidence in the people who are planning the health economy. Hilda Johnson highlighted this is her last Board meeting as a North Staffs Voice member and thanked Caroline Donovan and Maria Nelligan for all their support. Hilda will remain a Healthwatch member and will be taking part in future People and Culture Meetings.	
857/2017	**SERVICE USER AND CARER COUNCIL** Ms Wendy Dutton, Chair of the Service User Carer Council provided an update and highlighted the following. The Council was updated on Section 75 and the Trust's current position. Concerns were raised re lack of engagement with the Trust, robust consultation process with the public and service user's, the agreed preferred provider and clarity of what this means in real terms going forward. A long and frank discussion took place which highlighted the need for an individual and Group response to Staffordshire County Council in relation to Section 75 consultation. Dr Fazal-Short provided an update regarding Public consultation advising it has been put back as it was originally planned to commence in October 2017. The nature of the consultation was discussed. Consultation documents will be shared with key stakeholders and public meetings will be held if the Council feel they are required. Joan Walley suggested the Board write to the Council and request public meetings. It was confirmed this had already taken place. Hilda Johnson is also contacting various bodies to highlight the situation.	

	Work on care plans is suspended until after the Person Centred Planning Day on the 3 November 2017. It was agreed to consider a 1 page profile and link this to further work on care plans. Reviewed the updated Smoke Cessation Action Plan for which 3 service users are currently involved with the Smoke Free Task & Finish Group. The Citizens Jury report was due for review, however at the last meeting held on 10 Oct 2017 with the current Jury, it was advised that the report will now be delayed until 6th December 2017. Issues relating to the loss of such organisations as North Staffs Voice for Mental Health, Echo and Safer Spaces were raised. Phil Copestake advised Stakeholders were interviewed yesterday and a meeting with the CCG will take place with suggestions. Caroline Donovan highlighted she has also written to the CCG on behalf of the Trust. Membership and Equality & Diversity Strategy was discussed and agreed to look at adding to membership. Service User representatives identified for sub-Committees of the Trust Board, in particular: Wendy Dutton for Quality Committee, Hilda Johnson for People, Culture & Development Committee; Steph Pacey for Business Development Committee and Sue Tams for Finance, Performance & Digital Committee. ***Received***	
858/2017	**MEMORANDUM OF UNDERSTANDING WITH STAFFORDSHIRE UNIVERSITY** Dr Adeyemo, Executive Medical Director presented the report which provides a summary of developments and next steps for the Memorandum of Understanding. The Trust has begun to explore new opportunities for research, evaluation and partnership working to restore and reinvigorate academic links and collaborations with local Universities. Over the last 10 months there has been significant momentum and enthusiasm to progress this work forward. ***Received***	
859/2017	**NURSE STAFFING MONTHLY REPORT – September 2017** Maria Nelligan, Executive Director of Nursing & Quality presented the report and highlighted the following: This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during September 2017 in line with the National Quality Board requirements. The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during September 2017 was 85% for registered staff and 89% or care staff on day	

	shifts and 82% and 106% respectively on night shifts. Overall a 90% fill rate was achieved. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward manager supporting clinical duties. The data reflects that Ward Managers are staffing their wards to meet increasing patient needs as necessary. There were 10 incident forms completed by in-patient wards during September 2017 relating to nurse staffing issues. No harm to patients arose from these incidents. New Preceptorships have commenced and the rolling recruitment programme continues. The six month staffing review will come to the January 2018 Trust Board meeting which will in terms of retention and development of new roles going forward. The impact on ward and staffing of OICU next year will also be included. We have been invited to participate in the NHSI Retention Support Programme which we intend to pursue, as it provides us with the opportunity to learn from other Trusts and gain support. Maria Nelligan highlighted that there has been a high sickness percentage on Ward 1 and 2 there was a high percentage of sickness most of which was long term which has been addressed with the support of Human Resources. Tony Gadsby asked if we can expect a similar level of Preceptorships from Keele next year. Maria Nelligan advised there has been a reduction in applications nationally in applications for Registered Nurses. Maria confirmed there are discussions taking place with Chester University around Progressing Nurse Associate training. Chester will put on a programme for the Trust with UHNM. ***Received***	
860/2017	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 6** Suzanne Robinson, Executive Director of Finance, Performance and Digital, presented the report highlighting key points. The following performance highlights should be noted; • 98.6% of inpatient admissions have been gate kept by the crisis resolution/home treatment team • 64.9% of people accessing the IAPT service are moving to recovery (50% target) • 100% of RAID referrals have been seen within 4 hours	

	Exceptions • Agency Spend – 24.0% at Month 6. Ward 4 2% at M6 1% at M5. Core 11.0% at M6 7% at M5. ROSE 11.0% at M6 18% at M5. The trust is forecasting that the agency cap will not be achieved in 2017/18. • DTOC - 360 delayed days from 3,041 OBDs. AMH IP – 11.2% at M6 from 8.3% at M5. NOAP – 8.1% at M6 from 16.4%. There has been a significant reduction in NOAP DTOCs from 16.4% in August to 8.1% in September. Within NOAP, the delays continue to be associated with access to NHS or residential funding or placements and family choice There is an expectation that a larger number of delays will be reported in Month 7 as there is a current lack of or availability of nursing and residential placements. • CPA Reviews within 12 months - 92.2% at M6 from 94.5% at M5. It has been noted at previous Boards that we need to ensure we are recording all care plans. There has been a real focus on this in the last few months which is improving. • Bed Occupancy - 90.0% at M6 from 92.3% at M5. The high reported bed occupancy levels for ward 5 (Neuro) has been investigated revealing that the return leave end date has not been completed on Lorenzo. This is being rectified and will be compliant from Month 7. ***Received / Approved***	
861/2017	**QUARTER 2 SERIOUS INCIDENT REPORT** Dr Adeyemo, Executive Medical Director presented the report and highlighted the following. During Q2, 25 incidents were initially reported onto StEIS but after consideration with the CCG Quality Lead, 1 incident was downgraded. Therefore 24 incidents are undergoing SI investigation. There were 7 unexpected deaths in the Substance Misuse Directorate. This is an increase on the deaths reported in previous quarters. However due to new contracting arrangements, Combined Healthcare is now providing services within a wider geographical area as part of Stoke Substance Misuse Services and this has accounted for 2 of the deaths within the directorate. There were 7 incidents in the NOAP Directorate; this included 4 Slip, trip and fall incidents where the person suffered a fracture. The frailty of the client group on ward 4 remains a factor in the impact of falls severity. Investigations for Q2 SIs are ongoing and any learning identified will be actioned as appropriate and reported in subsequent quarterly reports. There are no themes or trends specifically identified in Q2 in terms of causative or linking factors. However there was an increase in the number of SIs reported during Q2. The learning that was found from the previous quarter and early quarter 2 investigations is outlined in the report. In Q2 there were 6 unexpected deaths where suicide was suspected. This is an increase from Q4 2016/17 when there were 3 suspected suicides. In comparison there were 11 suspected suicides in Q2 of 2016/17. In 2016/17	

	there was an average of 6 deaths by suspected suicide per quarter however for 2017/18 the average is 4.5 deaths per quarter. At the time of writing there are 20 incidents which are being investigated and consideration of the Duty of Candour requirements will be made as part of this process. As required by NHS England the Trust published its Mortality Surveillance policy on to the external website on October 2nd 2017. This is an amendment to the SI Policy and reflects the process to be used to review and learn from deaths that do not meet the criteria for SI investigation. Narrative regarding case reviews will be available in future quarterly reports. ***Received***	
862/2017	**CQC STATE OF CARE PROVIDER REPORT** Laurie Wrench, Associate Director of Governance presented the report and highlighted the following. The Care Quality Commission (CQC) has now completed its programme of comprehensive inspections of all specialist mental health services in England, which began in 2014, and has rated services provided by 54 NHS Trusts and 221 independent mental health locations. It was noted Common themes identified nationally are a reflection of our own inspection As of 31 May 2017, they had rated 68% of NHS core services as Good and 6% as Outstanding. Among independent services, 72% of core services were rated as Good and 3% as Outstanding. Services that needed to improve had made real progress when they had taken the CQC's findings on board and committed to tackling problems proactively and learning from others. Sixteen of the 22 NHS Trusts (73%) that were first rated as Inadequate or Requires Improvement improved their rating on re-inspection. Key findings from the report were: - Mental health services can be proud of their staff - Services need good leadership to become outstanding the CQC found 6 key themes that contributed to a rating of Good or Outstanding for Well-Led: • Leadership • A clear vision and set of values • A culture of learning and improvement • Good governance • Quality assurance • Engagement and involvement - Physical healthcare of people with mental health conditions	

	- Quality of care plans Areas of concern noted were: - Safety of services. At 31 May 2017, 36% of NHS and 34% of independent core services were rated as Requires Improvement for Safe. A further 4% of NHS core services and 5% of independent services were rated as Inadequate for Safe. - Persistence of restrictive practice - Access and waiting times - Poor clinical information systems ***Received***	
863/2017	**UPDATE ON STAFFORDSHIRE SECTION 75 AGREEMENT** Dr Fazal-Short, Acting Director of Operations presented the report which updates the Board on the current positon regarding the dissolving of the Staffordshire Section 75 Partnership Agreement following the decision by Staffordshire County Council to award the agreement to a preferred provider. North Staffordshire Combined Health Care Trust were informed by Dr Richard Harling, Director for Health and Social Care for Staffordshire County Council on the 23rd December 2016 of their intention to dissolve the Section 75 Partnership Agreement by awarding current social care provision to a preferred provider. It is suggested that the preferred provider identified by the Council is South Staffordshire and Shropshire Healthcare Foundation Trust. The partnership agreement with North Staffordshire Combined Healthcare NHS Trust contractually came to an end on 31st March 2017. We are continuing to deliver the service as contractually described on a month-by-month basis. North Staffordshire Combined Healthcare NHS Trust will work in partnership to ensure our contractual and legal obligations under TUPE rules, including the provision of data 28 days before anticipated handover date. Handover is anticipated 2nd February 2018 although there have been some changes to the timeline which could affect this. Dr Fazal-Short advised the Public consultation originally planned to commence in October 2017 has been put back. Consultation documents will be shared with key stakeholders and public meetings will be held if the Council feel they are required. Lorien Barber queried if the TUPE consultation had been delayed due to the timeline slippage. Dr Fazal-Short confirmed that whole process has now been delayed. Jenny Harvey commented it was naive to have a transfer engagement event meeting with staff and not expect them to have questions. There is a danger	

	that the TUPE transfer will be 'squeezed' and this raises concerns. It was confirmed that these concerns are being captured and communicated. Patrick Sullivan advised there appears to be no proposal around a new clinical model and what this means to provide services to the people of North Staffordshire. What we are effectively seeing is the work being done to integrate services is actually being de-integrated. This could have a serious impact on the people of North Staffordshire. Joan Walley asked if it would be timely for a meeting to be arranged with the Chief Executive of Staffordshire County Council to share these concerns and involve a member of the Service User Carer Council. Hilda Johnson advised she had been told Staffordshire County Council do not have a model of care from a service provider and they are not sure if they can deliver this kind of service. ***Received***	
864/2017	**DELEGATED AUTHORITY OF CHARITY ACCOUNTS** Laurie Wrench, Associate Director of Governance provided a verbal update. This is a formal request for the Board to approve delegated authority to the Audit Committee to support the Charity Accounts. ***Approved***	
865/2017	**EQUALLY OUTSTANDING** Paul Draycott, Director of Leadership and Workforce presented the Equality and Human Rights Practice Resource. The good practice guide by the CQC seeks to demonstrate how those services that have the improvement of equality and the recognition of human rights at their core, provide better services for the public. The document clearly sets out the ethical, economic, business and legal cases for approaches that put D&I at the centre of patient and staff experience. Paul Draycott highlighted the success factors within the document. Jenny Harvey discussed previous complacency in this area and advised she was pleased to some investment in this area and a dedicated person with the Trust for Equality and Diversity. The Board are asked to: • To consider the content and intent of the CQC report 'Equally Outstanding' and: o Consider potential application for the Trust o Recognise work already undertaken in enhancing our approach to diversity and inclusion. o Provide continued commitment and support for additional	

	development and embedding work to be undertaken by the Trust • Agree that People and Culture Development Committee will: o Oversee embedding this approach in to the Trusts Diversity and Inclusion Strategy by end of quarter 4 o Further embed the Equality Impact Analysis process and receive quarterly reports for assurance. ***Received***	
866/2017	**FINANCE REPORT – MONTH 6 (2017/18)** Suzanne Robinson, Executive Director of Finance, Performance and Digital, presented the report highlighting key points. The report summarises the finance position at month 6 (September 2017). The Trust Board is asked to note: - The reported surplus of £367k against a planned surplus of £176k. This is a favourable variance to plan of £191k. - The Trust has accepted the Control Total from NHS Improvement (NHSI) of £1.4m surplus which includes £0.5m from the Sustainability & Transformation Fund. - There are still some challenges around our CIP. M6 CIP achievement: YTD achievement of £638k (56%); an adverse variance of £495k; 2017/18 forecast CIP delivery £2,408k (75%) based on schemes identified so far; an adverse variance of £789k to plan; The recurrent forecast delivery at month 6 of £2,722k representing a recurrent variance to plan of £475k. - The cash position of the Trust as at 30th September 2017 with a balance of £6,603k; £1,222k better than plan. There has been some slippage in our capital programme. - Year to date Capital receipts for 2017/18 is (£119k) compared to a net planned capital expenditure of £351k; - The original operating plan submitted to NHSI in December 2017 planned net capital expenditure of £1,474k by Month 6. - Based on the NHSi plan the forecast underspend would be £667k. - Use of resource rating of level 2. This is positive. - Agency forecast is currently £286k above ceiling (£2,068k). There is a possibility we are not going to be able to hit our overall cap target. The Trust board are therefore asked to approve: - The month 6 position reported to NHSI. - Approve the forecast Agency Ceiling breach of £286k. ***Received / Approved***	
867/2017	**ASSURANCE REPORT FROM THE FINANCE, PERFORMANCE & DIGITAL COMMITTEE** Tony Gadsby Chair of the Finance, Performance and Digital Committee / Non-Executive Director presented the report for assurance from the meeting	

	that took place on 2nd November 2017. The Committee received an update on: ▪ The Patient Level Information Costing System (PLICs) in 2017/18 work programme to improve system quality, data quality and engagement. The Trust has engaged in a number of national projects including an early implementer of Patient Level Information Costing System; one of only 3 Mental Health Trusts in the country. The Trust has received some high praise from NHSI. The work of the team was acknowledged. ▪ The current utilisation of the 2017/18 Apprenticeship Levy. Based on the expected number of apprentices to be appointed, the Trust is expecting to utilise 23% of the 2017/18 levy of £233k. The Committee received an update for Cost Improvement for month 6 and were concerned that the total identified was still significantly short of the target. £2.722m is currently forecast to be recurrently delivered against the £3.197m target. This is a recurrent shortfall of £475k. A number of schemes in the CIP forecast not transacted, are higher value schemes which are expected to be realised before the end of the year. The Committee were assured that there was sufficient focus being placed on Cost Improvement but are unable to give assurance around the ability to deliver the target for 2017/18. The Committee were presented with the Agency utilisation report at M6 which showed a forecast breach of the Agency ceiling by £286k, mainly due to Medics and ROSE. The committee acknowledged the national shortage of medical locums but were assured that the trust was doing everything possible to recruit substantive posts. It was also noted that expenditure on ROSE agency was non recurrent. The Committee noted the significant reduction since April 2016 and was confident the Trust would deliver against the 2018/19 ceiling. It was also noted that the percentage Agency nursing as a % of total nurse pay was exceptionally low at 1.3%. The committee approved forecast breach to be reported externally. Performance - The report detailed M6 activity against plan using traditional reporting methods and clustering. An action plan was provided to address the Cluster 99 activity, which has increased month on month since the implementation of Lorenzo. The Committee is not able to give any assurance around the activity reported and noted the lack of progress being made, particularly around the use of Care Clusters, due to issues with the quality of recording by operational staff. A comprehensive Deep Dive has been requested to be provided to the next Committee. Delayed Transfers of Care has improved in month for NOAP but worsened for AMH Inpatients, mainly due a market shortage of Care home placements. The work on a system wide level for NOAP on Red to Green, as well as escalation to Social Care, has been widely successful in	

	driving improved performance. The Digital Maturity Self-Assessment measures the extent to which NHS organisations effectively use technology. Since the last review in 2015/16, the Trust has increased its digital capability by 62% as a result of implementing Lorenzo, E Rostering and E Prescribing. The Committee note that the increased capability is likely to support the Digital Exemplar bid, through demonstrating that significant progress has been made around IT infrastructure. ***Received***	
868/2017	**ASSURANCE REPORT FROM THE PEOPLE AND CULTURE COMMITTEE** Lorien Barber Chair of the People and Culture Committee / Non-Executive Director presented the report for assurance from the meeting that took place on 6th November 2017. The Committee reviewed the latest retention guidance from NHS Employers which reflects the work they have been doing since late 2016 with 92 trusts to identify and implement the actions required to reduce the rate of leavers. The review demonstrated that the Trust were already undertaking the majority of actions and were reviewing the 2 or 3 others to implement in coming months. The Committee received an update on the latest draft of the combined OD & People Strategy (which also links with the NHS Employers Retention Guide). This is a refresh process of the Strategy agreed at Board in August 2016 and has six themes. This will undergo further work before coming to PCD and Board 2018. The Committee also received the updated Communications Plan for 2017/18. The review is ongoing and an update will be brought to PCD and Board in January 2018. The Committee received the AHP strategy that describes how the Trust will harness the collective strengths and unique contributions of the AHP workforce to transform care, increase quality and embed a culture of improvement. Further work was suggested and an update will be brought to the next meeting. The good practice guide by the CQC seeks to demonstrate how those services that have the improvement of equality and the recognition of human rights at their core, provide better services to the public. The document received by the Committee clearly sets out the ethical, economic, business and legal cases for approaches that put Diversity & Inclusion at the centre of patient and staff experience. There is a considerable amount of good practice and learning from the document that the Trust is looking to capitalise on in our own plans.	**JMc**

	The Committee received a summary of the Trust's first Workforce Health & Wellbeing strategy. The strategy supports the Trust's overarching People Strategy which sets a commitment to become the best place to work by 2020. Through the strategy and supporting action plan, a framework will provide a proactive and engaging approach to enhancing the health and wellbeing of our staff. This will be achieved through wellbeing initiatives, employee support mechanisms and joint working with staff, Trade Union Representatives and local partners and address areas for improvement. This was approved by PCD. The Committee received the national FTSU Guardian's set of recommendations based on the findings of the first ever FTSU Guardian survey 2017. The Trust's second FTSU Guardian Mr Dan Platt has now taken up his role. The Committee were informed of the Trust's need to comply with the March 2018 deadline for the new gender pay data collection reporting requirements under the Equality Act 2010. Further details will be presented to PCD when they are available. Updates by exception were received by the Committee. It was noted that individual Directorates are submitting rectification plans to the SLT Performance management sessions to provide additional assurance that action is being taken and these are monitored on a monthly basis. Organisational Rectification Plans were submitted for Clinical Supervision, PDR, Vacancies and Agency and reviewed by the Committee. Whilst these were well received there is still an issue regarding assurance of Directorate ownership. It was therefore resolved that Heads of Directorates would be required to attend the Committee in January to discuss their workforce performance in areas of challenge. The Committee reviewed the Workforce & OD Risks: • 12 – Insufficient staff to deliver appropriate care to patients because of staffing vacancies and increased referrals increased to 16 • 1034 – Risk that staff are not effectively engaged, through not having an up to date PDR – new risk The Personal Development & Review policy was granted an extension to the end of March 2018. The following policies were approved by the Committee and the Trust Board are requested to approve them: • Mobile Devices Policy • Remediation Policy Board is asked to approve these recommendations ***Approved / Received***	

869/2017	**ASSURANCE REPORT FROM QUALITY COMMITTEE** Patrick Sullivan Chair of the Quality Committee / Non-Executive Director presented the report for assurance from the meeting that took place on 26th October 2017. The meeting opened with a story from the Trust's Outreach Team, Neuro and Old Age Psychiatry Directorate (NOAP). The presentation described a patient's journey following emergency admission to A&E and subsequent review by the Outreach Team. The ethos of the Outreach Team is to ensure that patients are reviewed in a timely way and receive assessment and on-going support in the most appropriate setting to meet their needs. It was highlighted that without the support of the Outreach Team it was likely the patient would have been transferred for EMI assessment with a view to 24 hour care. With the involvement of the Outreach Team the patient was able to return home with the support she required within 72 hours. It was noted that this was a really positive outcome and experience for the patient in this case. The presentation also described the on-going work to embed "Home First" principles with partners. This was a powerful story in terms of what can be achieved for the benefit of patients and was well received by the committee. Dr Tattum advised there is a caveat in the selection of which patients are put back into the community. Patients are often not selected appropriately and end up in a 'revolving door' situation. Dr Fazal-Short talked about the service that has been enhancing Assertive Outreach working with UHNM jointly accessing people to go home. Caroline Donovan thought it was imperative we focus on the outcomes and highlight them. Dr Adeyemo talked about the current pathway if people in a nursing home and experiencing any slight difficulties they come back to us as they are labelled as aggressive. It's at that point we need to be at that window to ensure they are in the right place. Suzanne Robinson highlighted the need to feed this back through our Commissioning response. The Committee received the latest safer staffing report. Reporting of Registered Nurse (R/N) and non-registered nurse staffing levels is a key requirement to ensure the Trust complies with National Quality Board standards. During August 2017, a fill rate of 82% for R/N staff and 94% for care staff on day shifts was achieved, with 84% and 105% respectively on night shifts. Taking skill mix into account, an overall 91% fill rate was achieved. Mental Health Act Reform. In October 2017, the Prime Minister announced an independent review of the Mental Health Act so that longstanding injustice of discrimination in the mental health system can be tackled. More information will be provided as this work develops.	

	Policy report – the recommendations supported by the Committee for ratification of policies by the Trust Board (for extension to the 31 March 2018 or otherwise stated as follows): ✓ 5.0 Health & Safety Policy – approve 3 years ✓ 5.08 First Aid at Work – approve 3 years ✓ 5.06 Waste Policy ✓ 5.09 Environment Policy ✓ 5.18 Risk Markers Policy ✓ R01 Policy on the use of restricted interventions – approve 3 years ✓ R03 Restrictive Holdings ✓ R07 CS Gas Policy ✓ 1.15 Dress and Appearance ✓ 5.14 Outdoor Activities ✓ 5.41 Lone Worker Policy ✓ 5.25 New Mothers Risk Assessment ✓ 1.19 Chaperoning Policy ✓ 4.32 Privacy and Dignity ✓ 4.33 Clinical Photography ✓ 4.41 Responding to Patient Opinion ✓ R02 Safe Use of Bedrails ✓ 1.81 Access to Services, waiting times and discharge – approve 3 years ✓ R10 – Teaching Physical Interventions to Carers ✓ 7.13 Data Quality Policy – approve 3 years ✓ 7.14 Safe Haven Policy – approve 3 years ✓ 7.17a Health Records Management – approve 3 years ✓ MHA27 Non-Medical Approved Clinician – approve 3 years ✓ MHA15 – Patient Rights S132 – approve 3 years ✓ 4.26 – Listening and Responding (PALS & Complaints) – approve 3 years. ***Approved / Received***	
870/2017	**TO RECEIVE A VERBAL UPDATE ON PROGRESS FROM ANDREW HUGHES, JOINT DIRECOTR OF STRATEGY, DEVELOPMENT AND ESTATES (NSCHT / GP FEDERATION)** Andrew Hughes highlighted that Alliances could become the formal delivery vehicles for the STP as well as for wider health and social care improvement and transformation and as a Trust we need to look at whatever opportunity any of us has to reinforce the Alliance as the drive forward.	
871/2017	**ANY OTHER BUSINESS** Paul Draycott wished to thank everyone for their wishes. Paul wished to add that North Staffordshire Combined Healthcare is a special organisation that has undergone immense changes in recent years. At the heart of everything the Trust does is the service users and carers which is what	

	makes the Trust so very special. It has been a pleasure working with you all.	
872/2017	**Date and time of next meeting** The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday, 25th January 2018 at 10:00am, in the Boardroom, Lawton House, Trust HQ.	
873/2017	*** 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 12.56pm

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
05-Oct-17	826/2017	Access and Home Treatment Spotlight - Dr Fazal-Short to look into high volume users capacity.	Carol Sylvester	25-Jan-18	
05-Oct-17	830/2017	Safer Staffing Nursing Report - August. Mr Rogers asked for trend to be illustrated in future reports	Maria Nelligan	25-Jan-18	09.11.17: 6 month staffing report to go to January Board including fill rate trend due to changes in shift patterns. 25.01.18 : The 6 monthly reportwas put on hold due to the management of change of the shift patterns being consulted upon - the next 6 monthly report is now due therefore an annual report is being produced in readiness for Quality Committee on 8th February 2018 to come to Trust Board 22nd February 2018.
05-Oct-17	841/2017	Partnership Strategic Plan - Mr Rogers asked to see the list of partners we have at a future Trust Board meeting.	Andrew Hughes	25-Jan-18	25.01.18 - Partnerships are a fundimental part of the one year plans which are being developed and will come to Trust Board in February 2018.
09-Nov-17	865/2017	PCD Assurance Report - Updated Communications Strategic Plan will be presented to PCD and Trust Board in January 2018.	Joe McCrea	25-Jan-18	25.01.18 - Some changes to be made following January PCD plan to go to February SLT and come to February Board.

North Staffordshire Combined Healthcare NHS Trust

REPORT TO TRUST BOARD

Enclosure No:4

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

Executive Summary:		Purpose of report	
This report updates the Board on activities undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☐
Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☒ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☒ 4. Encourage, inspire and implement research & innovation at all levels.☒ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☒ 7. Continually improve our partnership working. ☒		
Risk / legal implications: Risk Register Ref	N/A		
Resource Implications: Funding Source:	N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	N/A		
Recommendations:	To receive for information		

NHS
North Staffordshire
Combined Healthcare
NHS Trust

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

PURPOSE OF THE REPORT

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

LOCAL UPDATE

1. CARILLION

On 15th January 2018, after meeting with their bankers and lenders, Carillion announced its decision to initiate insolvency proceedings. The Official Receiver has been appointed by the court as liquidator along with partners at PwC that have been appointed Special Managers. The Rt Hon David Lidington CBE MP Minister for the Cabinet Office and Chancellor for the Duchy of Lancaster has also announced the government will continue to deliver all public sector services following the insolvency of Carillion PLC. The Government will provide the necessary funding required by the Official Receiver to maintain public services.

The Government announcement can be found at https://www.gov.uk/government/news/government-protects-essential-public-services-as-carillion-declares-insolvency

Our top priority is to keep services running safely for patients. Alongside NHS Improvement and our local partners, we planned extensively for this scenario with the aim of keeping any disruption to a minimum. We have successfully delivered this aim.

This announcement did not involve any staff directly employed by North Staffordshire Combined Healthcare. But being well aware of the concerns that staff employed by Carillion would have, we thanked them for their continued hard work and have kept talking to them via their line management. We sought and received reassurance that arrangements were in place to ensure staff will be available to deliver the services we require.

The services provided to our Trust by Carillion are primarily concerned with facilities management at Harplands Hospital, not direct medical treatment. A number of services, such as catering, cleaning and porters do have an impact on patients and care and arrangements are being put in place to ensure that these services will continue to be provided to the Trust without endangering patient safety or safety of our staff providing care.

We are working with our partners to put in place long term arrangements to address this situation.

Service users, their family members or carers have been advised in the first instance to contact the medical staff responsible for their care, who will be able to provide advice and reassurance. If they have any outstanding questions, they can submit them via our webform and we will endeavour to provide a full response.

2. CARE QUALITY COMMISSION INSPECTION

We are pleased to have received the draft findings from the Care Quality Commission Inspection. We are currently going through the process of factual accuracy checking before it is released by the CQC back to us and can be shared.

3. NHS ENGLAND BOARD VISIT HARPLANDS HOSPITAL

On behalf of the entire Trust and the Staffordshire Sustainability and Transformation Plan (STP) we were honoured to welcome the NHS Chief Executive Simon Stevens and his national Executive Team to Harplands Hospital on 7 December for a meeting of the NHS Executive Team.

The national NHS team were visiting Staffordshire to receive an update from the STP on how its plans are progressing, the challenges it is facing, and to hear direct about some of the great innovations going on at a local level. We were delighted to have the chance to spend some time showcasing our delivery of new partnerships and models of care via the North Staffordshire and Stoke-on-Trent Alliance.

Maria Nelligan, our Director of Nursing & Quality, also showed the National Director for Transformation and Corporate Operations, Emily Lawson, around Wards 4 and 6 to see some of our great staff in action. Thanks to all ward staff for showcasing our services so well.

We were proud to be the first mental HealthTrust to host such an event for the NHS Executive Team, an honour which was highlighted by NHS England themselves via their Twitter account.

4. CQC SYSTEM REVIEW FOR STOKE-ON-TRENT AND NORTH STAFFORDSHIRE

I have been appointed as the SRO for the Improvement Plan in response to the Care Quality Commission System Review of the Stoke-on-Trent health and care system on behalf of the local NHS and care partners. The review is one of 20 targeted local system reviews looking specifically at how older people move through the health and social care system, with a focus on how services work together.

Prior to sending the Plan off to the CQC, I presented the plan to the Health and Wellbeing Board. The plan was the result of excellent partnership working, with an enormous commitment shown by all and a real willingness to improve. A Combined Team led by Laurie Wrench and Zoe Grant provided fantastic support in pulling the Plan together against very challenging timescales and, moving forward, we will be providing the Programme Office function for the Plan.

The North Staffordshire and Stoke-on-Trent Alliance been confirmed as the delivery vehicle for the Improvement Plan and assurance will be given to the CQC on its delivery via the Health and Wellbeing Board.

5. REGIONAL STP MENTAL HEALTH LEADS MEETING

I have also been appointed to chair the NHS Midlands and East regional meetings of Staffordshire and Stoke-on-Trent Sustainability and Transformation Plan (STP) mental health leads. I chaired my first meeting in December, bringing together the STP leads with Health Education England, NHS England, NHS Improvement, Public Health England and the clinical networks. The meeting went very well. The group will focus on sharing strategy, influencing and focusing on workforce transformation. There is a national ask to increase the mental health workforce by 19,000 which is incredibly challenging. For Staffordshire, the plan requires a growth of 400 staff to be able to deliver mental health transformation.

6. EXECUTIVE TEAM

I am delighted that Alex Brett joined the Trust in December as our new Director of Workforce, Organisational Development and Communications. Alex's commitment to developing and building partnerships, as well as supporting a fantastic workforce, is perfectly aligned with our own values and the vision we are pursuing over the coming years. Alex brings a wealth of experience and award-winning achievement at Board in Organisational Development and HR from across the local NHS. She began her NHS career 28 years ago as a nurse in the then City General Hospital. Her values and personal drivers are grounded in clinical practice with patients at the very heart of what she does, having a strong clinical and managerial background, along with educational and organisational development skills. She is a qualified Coach and Team Coach and was the Health Education West Midlands Coach and Mentor of the Year 2016.

Congratulations also to Jonathan O'Brien, who has been appointed as our new Director of Operations. Jonathan will join us in March from Mid Cheshire Hospitals NHS Foundation Trust, where he is currently the Director of Operations, a role he has carried out since 2015. Over that period he has held responsibility for operational delivery, performance management and transformation across the Trust. He holds a Master of Business Administration and MSC in Healthcare Leadership and Management from the Manchester Business School. He has worked in the NHS at a senior operational level for over 13 years, having begun in the NHS Graduate Training Scheme. We are delighted to welcome someone of Jonathan's calibre and track record to the Trust.

I am also delighted to announce that Suzanne Robinson our Executive Director of Finance, Performance and Digital has been appointed as the Director of Finance for the STP. This is fantastic recognition of the work Suzanne has been leading here at the Trust and already within the STP. Suzanne will undertake this role on a part time basis alongside her role here at Combined.

7. LATEST AWARDS

Our Finance team followed up their success at last year's Healthcare Financial Management Association Awards with another win at this year's HFMA Awards, this time in the Havelock Training Award. The team have enjoyed many achievements over the past 12 months, not least of which the launch of the innovative Valuemakers programme, which empowers staff to help find savings to put back in to patient care. They also produced an excellent animated film of our 2016/17 Annual Accounts, which can be viewed via our YouTube channel.

Congratulations also to Julia Ford was recognised for her inspirational leadership of our CAMHS in Schools Team when she was shortlisted in the Clinical Leader of the Year

category at the HSJ Awards. The team works with a number of schools in Stoke-on-Trent on improving mental health and wellbeing, building resilience and providing early interventions. Julia has helped to facilitate collaborative working – engaging the whole school and local community in change.

8. RAID TEAM GOES 24/7

The Rapid Assessment, Interface and Discharge (RAID) Team is now operating 24/7 after funding that had been made available via NHS England to support the local health economy with winter pressures was brought forward. RAID provides a psychiatric service to patients aged 16 and over at Royal Stoke University Hospital and also offers teaching, support and advice to acute staff. The service will be working towards 'Core 24' standards set out in the Five Year Forward View for Mental Health which will involve a richer skill mix within the team as well as 24/7 capacity. Nationally, there is a commitment to deliver a Core 24 standard of mental health liaison services in at least 50% of acute hospitals by 2020-21.

9. OUR EVENTS

Our latest Non Medical Prescribing (NMP) conference was a great success. Held in conjunction with South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT), the event was chaired by Maria Nelligan, Director of Nursing and Quality, and featured a number of highly respected speakers, including Dr David Healy, Professor of Psychiatry at Bangor University, and Stephen Bazire MBE, an Honourary Professor at the University of East Anglia, who spoke about shared decision making in mental health. We also welcomed local carer Sue Tams, who gave a personal account of her experiences, and Dr David Shiers OBE, a Leek-based GP who spoke about the mental health journey he has been on with his daughter. Furthermore, our Research Manager Sue Wood gave a talk on the importance of research and tried to drum up volunteers for future studies.

10. OUR RESEARCH

Among our strategic objectives is to 'Encourage, inspire and implement research and innovation at all levels'. We have a challenging research recruitment target and our Research Team, in conjunction with staff throughout the Trust are working hard to recruit new participants to take part in our research studies.

Among the studies the team is involved in is a new study it has launched called Patient Preferences for Psychological Treatment – focussing on the preferences of patients for psychological help. The aim of the study is to use findings to refine and improve what is offered in the future, with the target population being people with a diagnosis of non-affective psychosis. Please contact the Research team for more information about this study or take part via email at r&d@combined.nhs.uk or by calling 0300 123 1535.

NATIONAL UPDATE

11. NHS WINTER CRISIS

In the month of December – there has been an increasing strain on the NHS – the usual winter pressures, combined with flu outbreaks also led to a significant focus on Stoke-on-Trent, including social media activity from an employee, and subsequent national coverage.

It continues to be a really challenging time for everyone in the local NHS. It appears that not a day passes without some article on the national or local news about the stresses we are having to cope with and the amazing lengths the staff of the NHS are going to deliver for patients, service users and their families. Whilst it's great to get public recognition and support for all our efforts and appreciation of how we go the extra mile and beyond, it doesn't mean it gets any easier. I have used my blog to stress to all our staff just how much we appreciate everything they - our staff - and our partners across the local health and care system are doing.

12. KINGS FUND SUGGESTS MENTAL HEALTH FUNDING GAP IS WIDENING

The King's Fund has published its analysis of mental health service spending titled 'Funding and staffing of NHS mental health providers: still waiting for parity'

It argues that the gap between spending on NHS acute hospitals and NHS mental health providers widened last year, despite increasing income for 84% of mental health trusts.

Income for mental health trusts rose by less than 2.5% in 2016/17 compared with over 6% for acute and specialist trusts.

It also reveals that the number of mental health nurses has fallen 13% since 2009. One in ten of all specialist mental health posts are currently vacant.

As a Trust, we are leading the STP Mental Health workstream and have contributed to a workforce plan that articulates our plans around the Mental Health Five Year Forward View. This plan pulls together the organisation's need to grow its workforce in a number of areas, services, professional and new roles to deliver on this plan. We along with the other organisations who contributed to the plan, have expressed that we are unable to do this within existing funding our plans are subject to further funding being made available.

North Staffordshire Combined Healthcare NHS Trust

REPORT TO: TRUST BOARD

Enclosure No:5

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

Executive Summary:		Purpose of report	
This report has been prepared to provide an update of the Service User & Carer Council since the last Business meeting held on 25 October 2017, Educational/Workshop on the 29 November 2017.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☐
Seen at:	SLT ☐	Date:	
	Execs ☐	Date:	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. ☐ 2. To provide the highest quality services. ☒ 3. Create a learning culture to continually improve. ☐ 4. Encourage, inspire and implement research & innovation at all levels. ☐ 5. Maximise and use our resources intelligently and efficiently. ☐ 6. Attract and inspire the best people to work here. ☐ 7. Continually improve our partnership working. ☒		
Risk / legal implications: Risk Register Ref	None identified		
Resource Implications: Funding Source:	None identified		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	The Service User & Carer Council supported the principle of increasing representation across the Protected Characteristics when reviewing the Diversity and Inclusion Strategy. They also committed to supporting inclusive services and workforce in their review of the Strategy.		
Recommendations:	The Trust Board receives the update for information and assurance.		

Version	Name/group	Date issued
1	Trust Board	25 January 2018

North Staffordshire Combined Healthcare NHS Trust

SERVICE USER AND CARER COUNCIL UPDATE
FOR TRUST BOARD ON 25 January 2018

1. The bi-monthly meeting format:

Items covered in Workshop November 2017, business meeting 20 December deferred to January 31st 2018

1.1 *November 2017*

Informal workshop
Reviewed Care Plans on Lorenzo, feedback and suggestions will be collated, fed through workstreams.
Update on Section 75, correspondence made - awaiting meeting with Accountable Officer

1.2 *20 December 2017*

Due to proximity to Christmas, recent hard work and membership illness deferred to 21st January

We will be looking at;

- Debate on 2nd Open Space Event
- Quality priorities 2018/19
- Update on Citizen's Jury report
- Review information pack developed by Sutherland Centre

Updates continued commitment SUCC to;

- Pursuing clarity CCGs action in relation to Section 75
- PICU
- Interviews, RAID, Ward 4, Director ops and more
- Inductions and preceptorship programme
- 1st session with 1st and 3rd year mental health students

Wendy Dutton
Chair
Service User & Carer Council

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO: OPEN TRUST BOARD

Enc. No: 6

Date of Meeting:	25 January 2018		
Title of Report:	Keele Medical School Q&A Outcome		
Presented by:	Dr Buki Adeyemo, Executive Medical Director		
Author:	Robert Walley, Medical Staffing Manager		
Executive Lead Name:	Dr Buki Adeyemo, Executive Medical Director	Approved by Exec	☒

Executive Summary:		Purpose of report	
On Thursday 19th October 2017, Keele Medical School visit NSCHT to undertake a Q&A with trainees, trainers, and medical management. This report highlights the feedback, recommendations and actions taken as a result of this visit.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☒ Execs ☐ Date: 12.12.17	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☒ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. ☐ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve. ☐ 4. Encourage, inspire and implement research & innovation at all levels. ☐ 5. Maximise and use our resources intelligently and efficiently. ☐ 6. Attract and inspire the best people to work here. ☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	Risk to the quality of student experience at North Staffordshire Combined Healthcare Trust		
Resource Implications: Funding Source:	The Trust receives funding through SIFT for the teaching of Medical students n/a		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	All tutors and firm supervisors do have equality and diversity training. Recently all printing done for medical students must be on cream paper and in a font of 12 and above to assist those students with disability,		
Recommendations:	For information and assurance		

1 Introduction

On Thursday 19th October 2017, Keele Medical School visit NSCHT to undertake a Q&A with trainees, trainers, and medical management. The visiting team included:

Professor Andrew Hassell (Head of School of Medicine, Keele University)
Dr David Palmer (Associate Dean GP Education Staffordshire and Shropshire, HEWM)
Dr Anne Taylor (Hospital Dean, County Hospital, Stafford)
Dr Stuart McBain (Academic Lead for Undergraduate Assessment Delivery)
Mr Phil Hartley (Lay Representative)
Miss Naomi Ditchfield (Student Representative)
Vanessa Hooper (School and Quality Assurance Manager and School Manager)
Mrs Angela Allen (Deputy Quality Assurance & Enhancement Manager)

The Keele panel met with the following Trust representatives:

Dr Buki Adeyemo, Paul Draycott, Lorien Barber, Caroline Donovan (Final Feedback)

Undergraduate Team: Dr Dennis Okolo, Dr Siraj Salahudeen, Lisa Lummis

Students: 13 Year 3 Keele Medical Students.

Foundation Doctors: 4 FY1 and 2 FY2 doctors.

Tutors and Consultants: Educational Supervisors, Clinical Supervisors, Teaching Fellows, Specialist Nurses, Trust Doctors, representing educators across Year 3.

The visit was primarily focused on the Mental Health provision for Undergraduate students, but a small group of Foundation doctors were also interviewed to gauge an impression of how their training is progressing.

The report was based on 5 themes:

1) Learning environment and culture
2) Educational governance and leadership
3) Supporting learners
4) Supporting educators
5) Developing and implementing curricula and assessments

2 Initial Feedback

The report from Keele highlighted their gratitude towards NSCHT for looking after the panel so well; “well run and extremely well attended, reflecting the positive engagement in the education of Keele medical students”.

The Panel were also impressed with the reported experiences of students and Foundation Doctors, which demonstrated a high level of satisfaction with the education they are receiving.

3 Commendations

The following good practices were commended:

3.1 It was an overwhelmingly positive visit with great engagement, ethos and climate demonstrated by the whole Trust team.

3.2 They offered congratulations to the Trust on their ‘CQC journey’ from ‘Needs Improvement’ to a ‘Good’ rating.

3.3 The Panel also noted the effort made by the Trust to improve and 'turn around' the concerns raised regarding certain aspects of undergraduate education provision in the time since the last QA Visit from the Medical School.

3.4 Students and Foundation Doctors have told us that they are welcomed and wanted by all parts of the Trust; they have good Inductions; the Teaching is excellent, especially key to students is the support offered by Junior Doctors; the students and Foundation Doctors feel safe and well supported by the Trust.

3.5 Specific areas mentioned by students as being excellent experiences included RAID, Greenfields and liaison with the Undergraduate Management Team and Undergraduate Administration Officer.

3.6 All of the Foundation Doctors who attended would recommend the posts at NSCHT.

4 Requirements for NSCHT

The Medical School made two recommendations to the Trust:

4.1 The Trust reviews its OOH first point of contact for off-site in-patient units elsewhere in North Staffordshire. This was identified as a potential patient safety issue and has been dealt with through that route.

4.2 To ensure all PIT alarms are working when initially handed out to students, and to put in place a rigorous process which guarantees all alarms are tested weekly.

It should be noted that the Trust raised its concerns at the way recommendation number 1 was raised, and Keele/HEWM acknowledged the concerns. It is standard practice across the region for trainees to be the first point of contact for off-site in-patient units with the support of Senior Trainees or Consultants on-call. This issue was discussed at a regional meeting and agreed to be standard practice.

5 NSCHT Actions on Requirements

5.1 The Trust agreed to undertake an audit on the number of calls the junior on-call receives from off-site in-patient units. The DSN will review incoming calls before forwarding the call on to the appropriate medical on-call support. Two weeks of audit review have resulted in no calls from external in-patient sites.

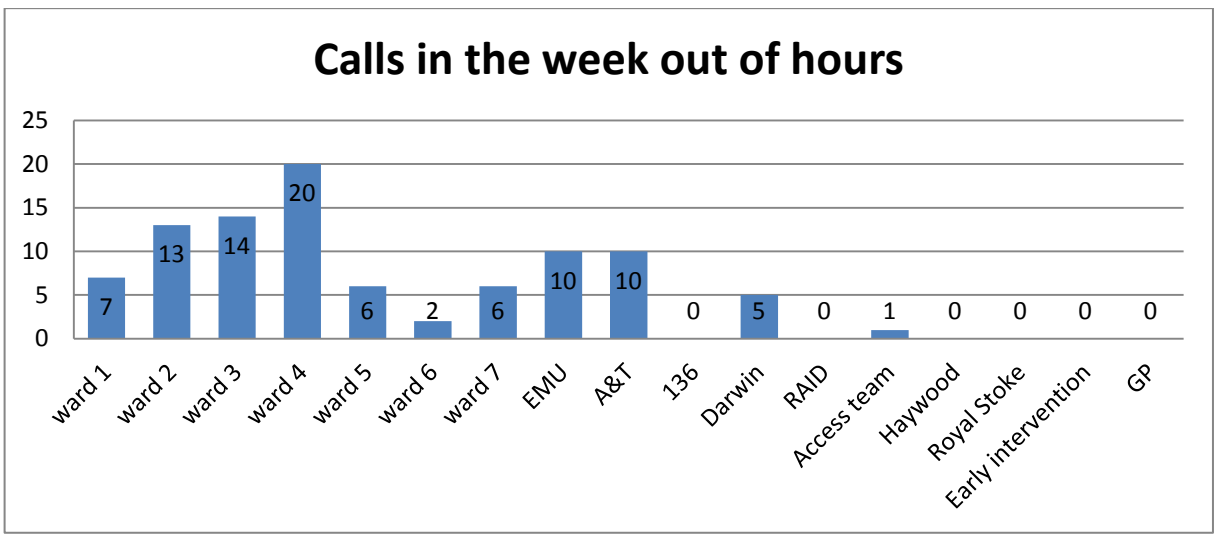
The feedback from this audit, and any actions the Trust takes, will be fed back to Keele and HEWM through HEWM's Action Plan and Progress Report, due in February 2018.

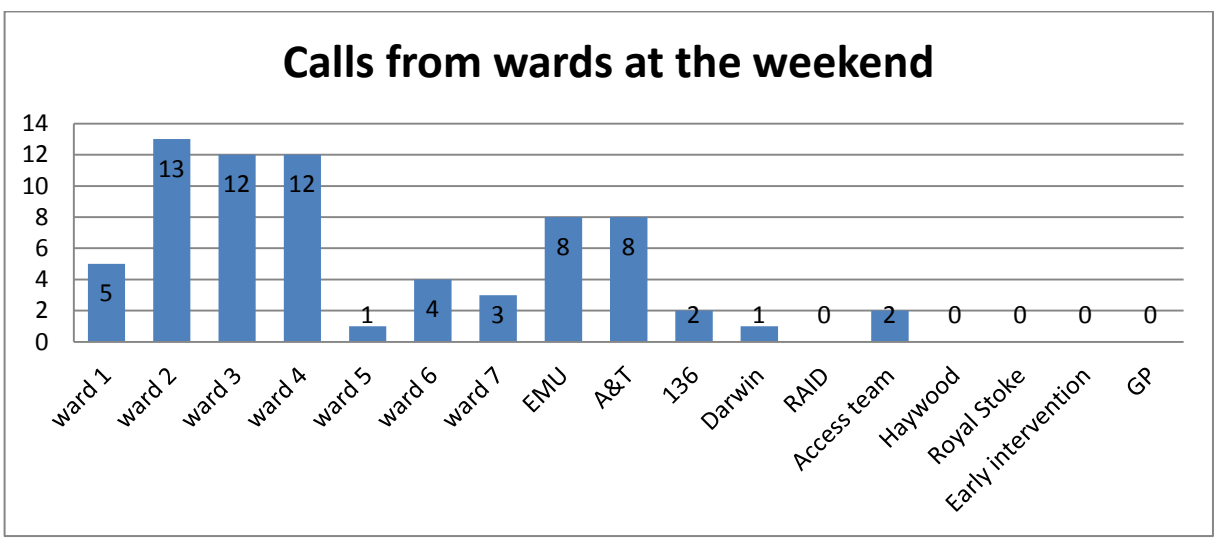
5.2 An audit will be conducted on all PIT alarms to ensure they are in working order before being distributed. Tests will be scheduled before rotations.

The final action plan submitted to HEE can is below:

No.	Identified Issue	Actions planned to address issue	Lead	Due by
1.	Concern raised by HEE that FY2 and GP trainees with less than 4 month's Psychiatry experience are taking calls for peripheral psychiatry units.	Trust has raised points around Consultant supervision was always available, the low frequency of these calls and potential patient safety concerns if 24 hour on call medical cover is unavailable to community inpatient units. In order to assess and review risks, the Trust will monitor calls from the community inpatients units for the period of 8 weeks. In the interim Trust will make arrangements for all calls from community inpatient units to be triaged by duty senior nurse.	Dr Shivamurthy	07/03/2018

Two weeks of audit were completed by Dr Sally Arnold (CT3 Doctor) for 24 hours a day, with a further 6 weeks of monitoring to take place. The results showed that no calls were received from the peripheral Psychiatry Units concerned:





6 NSCHT's Requirements for Keele

The Trust made a number of recommendations which Keele have taken into account:

6.1 Review requirements for ward induction of students attending Mental Health as the first block of the year (specifically the early morning nurse induction requirement).

6.2 Review guidance given to students on performing physical examinations on inpatients other than on admission (log book driven).

6.3 Year 3 Leads to attend some NSCHT Tutor meetings.

6.4 Explore greater strategic engagement with the Trust.

North Staffordshire Combined Healthcare NHS Trust

REPORT TO OPEN TRUST BOARD

Enclosure No:7

Date of Meeting:	25 January 2018		
Title of Report:	November 2017 Monthly Safer Staffing Report		
Presented by:	Maria Nelligan, Executive Director of Nursing & Quality		
Author:	Julie Anne Murray, Deputy Director of Nursing, AHP & Quality		
Executive Lead Name:	Maria Nelligan, Executive Director of Nursing & Quality	Approved by Exec	☒

Executive Summary:		Purpose of report	
This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during November 2017 in line with the National Quality Board requirements. The performance relating to fill rate (actual numbers of staff deployed vs numbers planned) during November 2017 was 86% for registered staff and 97% or care staff on day shifts and 87% and 106% respectively on night shifts. Overall a 94% fill rate was achieved. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward manager supporting clinical duties. The data reflects that Ward Managers are staffing their wards to meet increasing patient needs as necessary.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐	Date:	
	Execs ☒	Date:09.01.18	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. ☐ 2. To provide the highest quality services. ☒ 3. Create a learning culture to continually improve. ☐ 4. Encourage, inspire and implement research & innovation at all levels. ☐ 5. Maximise and use our resources intelligently and efficiently. ☒ 6. Attract and inspire the best people to work here. ☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	Delivery of safe nurse staffing levels is a key requirement to ensuring that the Trust complies with National Quality Board standards.		
Resource Implications: Funding Source:	Temporary staffing costs. Budgeted establishment and temporary staffing spend.		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None		
Recommendations:	To receive the report for assurance and information		

Version	Name/group	Date issued
1	Maria Nelligan	08 January 2018

1 Introduction

This report details the ward daily staffing levels during the month of November 2017 following the reporting of the planned and actual hours of both Registered Nurses (RN) and Health Care Support Workers (Care Staff) to Unify. Appendix 1 details the establishment hours in comparison to planned and actual hours.

2 Background

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

In addition to the monthly reporting requirements the Executive Director of Nursing & Quality is required to review ward staffing on a 6 monthly basis and report the outcome of the review to the Trust Board of Directors. The next 6 monthly review covering January to June 2017 is currently underway and is concentrating on workforce planning. This was originally planned to be reported to November Board however, due to the current management of change (MoC) relating to shift patterns, it was agreed at October Quality Committee to delay the report in order to capture the outcome of the MoC. Due to the timeline of the MoC, the Jul-Dec 2017 is now due to commence and therefore the 2 six monthly reports will be amalgamated into a comprehensive annual report for 2017.

3 Trust Performance

During November 2017 the Trust achieved a staffing fill rate of 86% for registered staff and 97% for care staff on day shifts and 87% and 106% respectively on night shifts. Taking skill mix adjustments into account an overall a 94% fill-rate was achieved. Where 100% fill rate was not achieved, staffing safety was maintained on in-patient wards by nurses working additional unplanned hours, cross cover, Ward managers (WMs) and the multi-disciplinary team (MDT) supporting clinical duties and the prioritising of direct and non-direct care activities. Established, planned (clinically required) and actual hours alongside details of vacancies, bed occupancy and actions taken to maintain safer staffing are provided in Appendix 2. A summary from WMs of issues, patient safety, patient experience, staff experience and mitigating actions is set out below.

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

4 Impact

WMs report the impact of unfilled shifts on a shift by shift basis. Staffing issues contributing to fill rates are summarised in Appendix 2.

4.1 Impact on Patient Safety

There were no incident forms completed by in-patient wards during November 2017 relating to patient safety and nurse staffing issues.

4.2 Impact on Patient Experience

Staff prioritise patient experience and direct patient care. During November 2017 it was reported that 2 activities were cancelled or shortened (and not rearranged) due to nurse staffing levels.

4.3 Impact on Staff Experience

In order to maintain safer staffing the following actions were taken by the Ward Manager during November 2017:

- 47 staff breaks were cancelled (equivalent to approximately 1% of breaks)
- No staff breaks were shortened
- 25 hrs of ward cross cover (nursing staff were reallocated to cover shortfall within other clinical areas).

4.4 Mitigating Actions

Ward Managers and members of the multi-disciplinary team have clinically supported day shifts to ensure safe patient care. Skill mix has been altered to backfill shortfalls. A total of 280 RN shifts were covered by HCSW where RN temporary staffing was unavailable. A total of 8 HCSW shifts were covered by RN staff where HCSW temporary staffing was unavailable. Additionally, as outlined in section 4.3, staff breaks have been shortened or not taken (time is given in lieu) and wards have cross covered to support safe staffing levels.

4.5 Staffing Trend

Examination of ward staffing for the past 17 months demonstrates a slight downward trend for overall RN staffing (table 1). There is a clear correlation between the opening of Ward 4, to support the local health economy, and the downward trend. The period prior to Ward 4 opening, June - November 2016, was showing an upward trend. The following actions have been taken to strengthen RN staffing:

- 18 RNs commenced preceptorship in October 2017
- Shift patterns are being altered in response to staff feedback
- Recruitment opportunities for RNs continue to be advertised (including bank)
- Increasing the presence of Duty Senior Nurses (DSN), Nurse Practitioners and WMs on wards

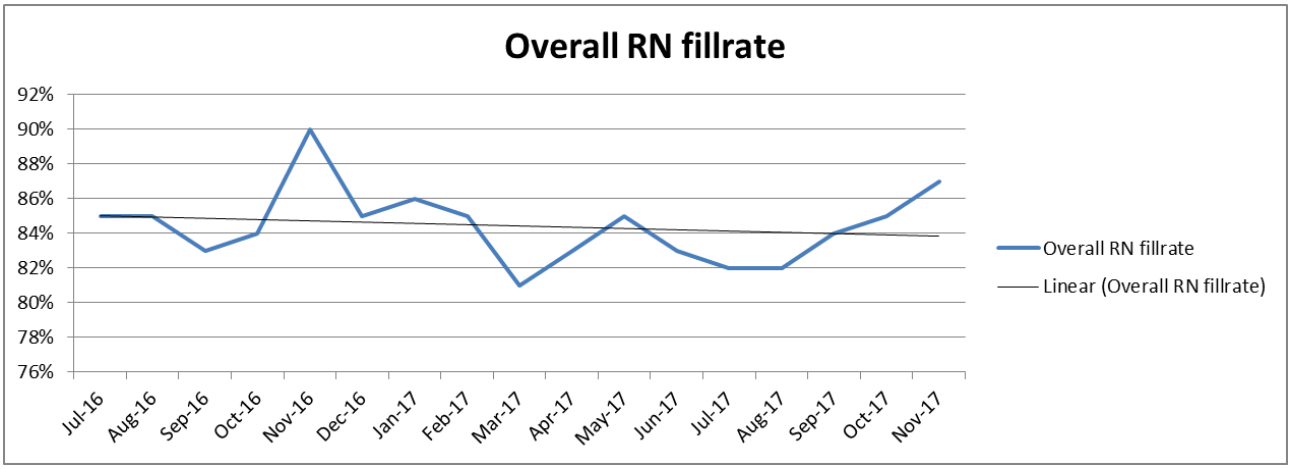


Table 1

5. Summary

Safe staffing reporting indicated challenges in staffing wards during November 2017. Vacancies across all wards have contributed to this. Additionally the use of temporary staffing to support Ward 4 has reduced the availability of temporary staff to backfill other wards. A significant number of RN vacancies have been filled by newly qualified RNs during October 2017; these nurses are going through a period of preceptorship. The Board should note the further challenges associated with the temporary increase of beds on Ward 4 in the response to the winter pressure in the health economy. Looking forward to next year, challenges will also be experienced with the planned opening of PICU therefore the annual 2017 nurse staffing review will make recommendations in relation to this. The Trust continues to employ alternate strategies with the support of the HR and communication teams to attract RNs during this national shortage.

The trust have joined the NHSI Retention Support Programme. A project team is being identified to deliver this programme and a visit from NHSI is arranged for January 2018.

6. Recommendations

The Trust Board is asked to:-

- Receive the report
- Note the challenges with recruitment and mitigations/action in place
- Note the challenge in filling shifts
- Be assured that safe staffing levels are maintained

Appendix 1 November 2017 Safer Staffing

2017 November	DAY						NIGHT						DAY		NIGHT							
Ward name	Registered nurses			Care staff			Registered nurses			Care staff			Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Overall RN fillrate	Overall HCSW fill rate	Overall fill rate	Safe staffing was maintained by:	Vacancies	Bed occupancy Movement	Provisional sickness data
	Establishment Hours	Clinically required Hours	Total monthly actual hours	Establishment Hours	Clinically required	Total monthly actual hours	Establishment Hours	Clinically required	Total monthly actual hours	Establishment Hours	Clinically required	Total monthly actual staff hours											
Ward 1	1508	1350	1220	1350	1350	1436	643	643	354	965	643	890	90%	106%	55%	138%	79%	117%	98%	Nurses working additional unplanned hours and altering skill mix.	1.4 B5, 1 B3	82% ↓	3.57%
Ward 2	1508	1508	1020	1350	1350	1574	643	643	418	643	643	847	68%	117%	65%	132%	67%	121%	93%	Nurses working additional unplanned hours and altering skill mix.	4.2 B5, 0.2 B3	94% ↓	5.46%
Ward 3	1515	1515	1350	1350	1410	1415	643	643	545	643	686	764	89%	100%	85%	111%	88%	104%	96%	Nurses working additional unplanned hours, cancelling non-direct care activity and altering skill mix. Cross cover was also provided to other wards.	0.8 B5, 0.64 B3, 1 B2	90% ↑	0.13%
Ward 4	1463	1463	1178	1350	1890	1715	563	563	516	843	843	843	81%	91%	92%	100%	84%	94%	89%	Altering skill mix.	6.6 B5 4.4 B3	95% ↓	0.00%
Ward 5	1046	1496	850	900	1425	1690	281	281	290	843	890	881	57%	119%	103%	99%	64%	111%	91%	Altering skill mix.	3.3 B5	108% ↑	1.97%
Ward 6	1103	1118	1151	1860	1860	1807	291	291	310	863	863	910	103%	97%	106%	105%	104%	100%	101%	Altering skill mix.	1.1 B5	100%	9.71%
Ward 7	1065	1170	720	1350	1350	1583	281	281	294	563	843	843	62%	117%	105%	100%	70%	111%	94%	Nurses working additional unplanned hours and altering skill mix. Cross cover was also provided to other wards.	1.8 B5	100% ↑	9.35%
A&T	1517	1322	1667	1350	1492	997	323	323	323	968	1387	1344	126%	67%	100%	97%	121%	81%	96%	Altering skill mix.	1.83 B5 6.11 B3	83% ↓	9.00%
Edward Myers	1113	1113	1074	930	930	874	281	281	291	563	563	570	97%	94%	104%	101%	98%	97%	97%	Altering skill mix.	0.3 B6 1.4 B5		0.16%
Darwin Centre	1290	1250	1082	1125	1263	1178	314	314	314	645	809	776	87%	93%	100%	96%	89%	94%	92%	Nurses working additional unplanned hours, cancelling and rearranging patient activities, cancelling non-direct care activity, multi-disciplinary team support and altering skill mix.	1.2 B5 0.2 B3	97%	6.81%
Summers View	983	974	943	900	814	750	322	322	313	643	632	643	97%	92%	97%	102%	97%	96%	97%	The mutli-disciplinary team supporting the nursing team.	1.2 B3	79% ↓	6.62%
Florence House	533	553	552	900	923	628	322	322	322	322	322	322	100%	68%	100%	100%	100%	76%	86%	The mutli-disciplinary team supporting the nursing team.	1.5 B3 1 B2	101% ↑	10.84%
Trust total	**14640**	**14829**	**12805**	**14715**	**16056**	**15645**	**4906**	**4906**	**4287**	**8503**	**9124**	**9632**	**86%**	**97%**	**87%**	**106%**	**87%**	**100%**	**94%**				

Appendix 2 Staffing Issues

- There have been challenges and limited success in recruiting band 5 adult RNs to Ward 4 therefore the team are seeking to recruit RNs from other fields who have physical health experience, this will be supported by an education programme.

- There are currently 24 WTE RN vacancies reported within in-patient wards. Of these, 16.6 WTE are in the recruitment process. We continue to advertise for the remainder.

- Ward 2 and 4 have the highest RN vacancies of 4.2 and 6.6 WTE respectively; 6 WTE of these have been recruited to. The remaining posts have been advertised externally and have been included within the recruitment events with limited success. Therefore we are reviewing skill mix and shift patterns.

- Ward teams are supported by Modern Matrons and a Duty Senior Nurse who are further supported by an on-call manager out of hours. These staff are not included in the safer staffing returns and are based on wards as opposed to Nursing Office from September.

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

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

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO Open Trust Board

Enclosure No:8

Date of Meeting:	25 January 2018		
Title of Report:	Performance & Quality Management Framework Month 8		
Presented by:	Director of Finance, Performance & Digital		
Author:	Performance & Information Team		
Executive Lead Name:	Suzanne Robinson	Approved by Exec	☒

Executive Summary:	Purpose of report	
The report provides an overview of performance for November 2017 covering Contracted Key Performance Indicators (KPIs) and Reporting Requirements. In addition to the performance dashboards a full database (Divisional Drill-Down) has been made available to Directorate Heads of Service and Clinical Directors to enable them to interrogate the supporting data and drive directorate improvement. This is summarised in the supporting PQMF dashboard. Data Quality (DQ) work is ongoing to validate and refine metrics reported in this paper, in relation to the transition to the Lorenzo EPR, which went live in May 2017.	Approval	☒
	Information	☒
	Discussion	☒
	Assurance	☐

Seen at:	SLT ☐ Execs ☒ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☒ • Finance & Performance Committee ☒ • Audit Committee ☐ • People & Culture Development Committee ☒ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☒ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	In Month 8 there are 3 target related metrics rated as Red and 2 target related metrics as Amber; all other indicators are within expected tolerances. All areas of underperformance are separately risk assessed and a rectification plan is developed, overseen by the relevant sub-committee of the Trust Board.		
Resource Implications: Funding Source:	There are potential contractual penalties if the Trust is not able to meet reporting requirements. There is an agreement with Commissioners for the Trust to have 6 months period following the implementation of the new EPR		

	in order to ensure that all reports can be made available, or to identify further actions and timescales for delivery agreed in the Data Quality Improvement Plan. There have been significant improvements in data completeness and data quality which have mitigated the risk and plans to address remaining issues for Month 8 and/to support further development in the DQIP.
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	The PQMF includes monitoring of ethnicity as a key national requirement. The Trust is seeking to ensure that all Directorates are recording in a timely way the protected characteristics of all service users to enable monitoring of service access and utilisation by all groups in relation to the local population.
Recommendations:	The committee is asked to • Receive the Trust reported performance, management action and committee oversight on the Month 8 position • Note the rectification plans received through Board sub-committees

NHS
North Staffordshire
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NHS Trust

PERFORMANCE & QUALITY MANAGEMENT FRAMEWORK
REPORT TO TRUST BOARD

Date of meeting:	25 January 2018
Report title:	**Performance & Quality Management Framework** **Performance Report – Month 8** **2017/18**
Executive Lead:	Director of Finance, Performance & Digital
Prepared by:	Performance & Information Team
Presented by:	Director of Finance, Performance & Digital

1 Introduction to Performance Management Report

The report provides an overview of performance for November 2017 covering Contracted Key Performance Indicators (KPIs) and Reporting Requirements.

In addition to the performance dashboards a full database (Divisional Drill-Down) has been made available to Directorate Heads of Service and Clinical Directors to enable them to interrogate the supporting data and drive directorate improvement. This is summarised in Appendix 1.

Data Quality (DQ) work is ongoing to validate date behind the KPI reported in this paper, following the transition to the new Lorenzo EPR, which went live in May 2017.

2 Executive Summary – Exception Reporting

The following performance highlights should be noted:

- **100%** of inpatient admissions have been gate kept by the crisis resolution/home treatment team
- All response times for RAID service have been met in Month 8; **95%** of RAID referrals to A&E were seen within 1 hour
- IAPT :
  - **99%** of service users referred were treated within 6 weeks of referral against target of 75% and **100%** have been treated within 18 weeks during 2017/18.
  - **66.3%** of people have moved to recovery against a target of 50%.

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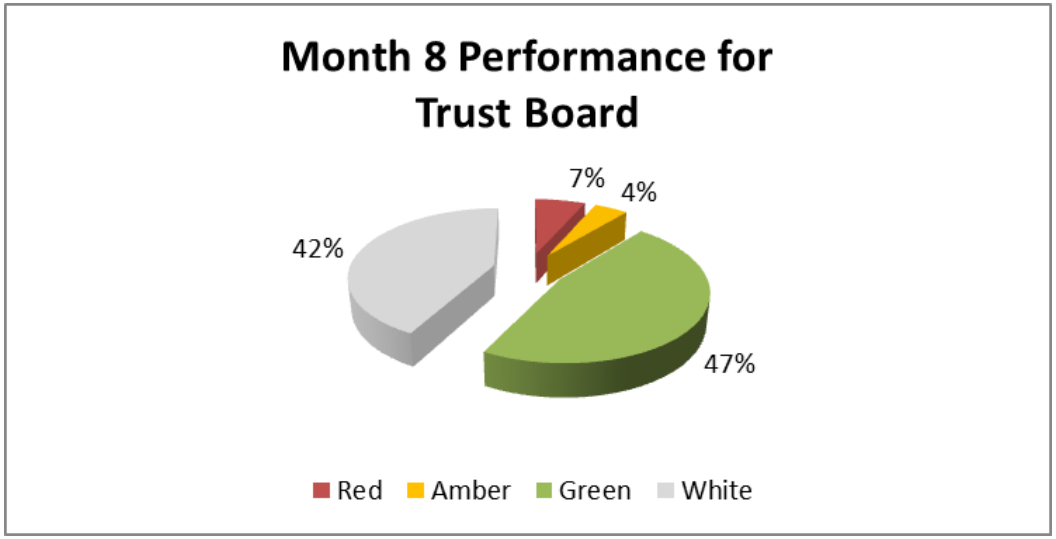
PROUD TO CARE

In Month 8 there are **3** target related metrics rated as **Red** and **2** as **Amber**; all other indicators are within expected tolerances.

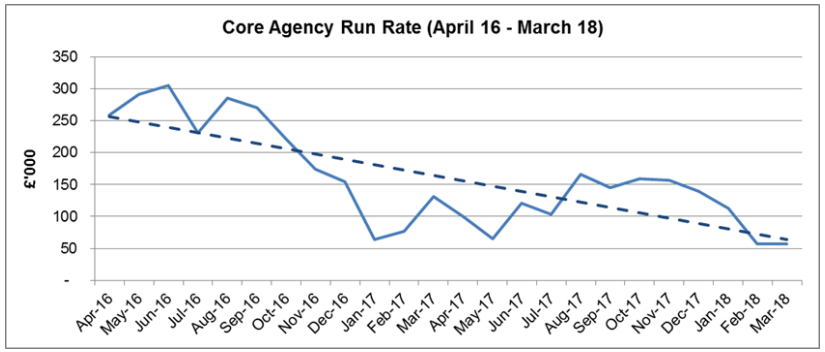
Contracted (National/Local CCG) & NHSI KPIs					
Metric	Red	Amber	Green	White	TOTAL
Exceptions – Month 6	4	2	21	20	47
Exceptions – Month 7	6	4	23	20	53
Exceptions – Month 8	3	2	21	19	45



3 Rectification Plans

Rectification plans are produced for any KPI classed as RED/AMBER, or where an individual directorate is classed as RED/AMBER, for a consecutive 2 month period. These offer a more detailed recovery position, focused actions and improvement trajectory and are scrutinised by Board Sub-Committees.

4 Exceptions - Month 8

KPI Classification	Metric	Exec	Target	M7	M8	Trend	Commentary
NHSI	Agency Spend: Year to Date Agency spend compared to YTD agency ceiling	Dir of Workforce and Leadership	0.0%	RED 28.0%	RED 30.4%	↗	30.4% at M8 from 28.0% at M7 The cumulative YTD plan is £1,525k against actual of £1,989k - £464k worse than plan (30%) The main drivers of the negative variances are: • ROSE: £143k: The Trust extended the use of additional agency staff as part of the implementation of the ROSE project to ensure a safe Transition. The use of agency has now ceased on this project. • Medical Locums - £282k: This reflects the national shortage of medics. The Trust is Exploring a number of ways to attract and retain medical staff. The Trust is forecasting that the agency ceiling will not be achieved in 2017/18, however the run rate has reduced significantly since April 2016 and therefore expects to deliver the 2018/19 ceiling. 

<table>
<tr><th>KPI Classification</th><th>Metric</th><th>Exec</th><th>Target</th><th>M7</th><th>M8</th><th>Trend</th><th>Commentary</th></tr>
<tr><td>NHSI</td><td>Delayed Transfers of Care:

Delayed Transfers of Care (DTOC)</td><td>Dir of Ops</td><td>7.5%</td><td>RED
13.5%</td><td>RED
12.5%</td><td>↘</td><td>12.5% at M8 from 13.5% at M7

AMH IP – 13.8% at M8 from 14.2% at M7
NOAP – 10.7% at M8 from 12.8% at M7
Ward 4 – EMI – 16.1% at M8 from 17.3% at M7

<table>
<tr><th>Trust - Reason for Delay</th><th>Total Pts</th><th>Total Days</th><th>Days as % of Total</th></tr>
<tr><td>Care Home Placement</td><td>15</td><td>131</td><td>25.6%</td></tr>
<tr><td>Patient or family choice</td><td>15</td><td>124</td><td>24.2%</td></tr>
<tr><td>Completion of assessment</td><td>11</td><td>95</td><td>18.6%</td></tr>
<tr><td>Public Funding</td><td>9</td><td>90</td><td>17.6%</td></tr>
<tr><td>Care package in own home</td><td>3</td><td>59</td><td>11.5%</td></tr>
<tr><td>Housing-patients not covered by NHS and Community Care Act</td><td>2</td><td>9</td><td>1.8%</td></tr>
<tr><td>Further non acute NHS care (including intermediate care rehabilitation etc.)</td><td>2</td><td>4</td><td>0.8%</td></tr>
<tr><td>Total</td><td>57</td><td>512</td><td>100.0%</td></tr>
</table>

There has been a decrease in NOAP to 10.7% in November from 12.8% in October. Adult Inpatient DToCs have decreased to 13.8% in November from 14.2% in October.

Delays continue to be mainly associated with system issues such as access to NHS or residential funding or placement and family choice. The Directorates are strengthening operational standards to ensure consistent approach across the trust.</td></tr>
</table>

KPI Classification	Metric	Exec	Target	M7	M8	Trend	Commentary
NHSI	Care Programme Approach (CPA): The proportion of those on CPA for at least 12 months having formal review within 12 months	Dir of Ops	95.0%	AMBER 90.3%	AMBER 94.1%	↗	94.1% at M8 from 90.3% at M7 1,411 eligible for review 1,328 people have received a review within 12 months 83 people have not received a recorded review within 12 months There has been an improvement in the Trust-wide and Directorate performance as business processes and Lorenzo reporting requirements are embedded. In addition, teams have worked hard to ensure that clinical reviews are scheduled well in advance to ensure that all patients receive a review within 12 months. The AMH Community Directorate's performance improved to 94.4% at M8 from 90.7% at M7. It is anticipated that this key national target will be met from January 2018.
CCG	CPA: All service users to have a care plan in line with their needs - % (on CPA) with a Care Plan	Dir of Ops	95.0%	GREEN 95.0%	AMBER 94.0%	↘	94.0% at M8 from 95.0% at M7 AMH Community – 94.1% at M8 from 95.2% at M7 LD – 100% at M8 same as M7 NOAP – 95.3% at M8 from 98.3% at M7 C&YP – 70.0% at M8 from 82.5% at M7 Action plans and trajectories are in place in AMH Community to ensure achievement of the standard in Month 9.

KPI Classification	Metric	Exec	Target	M7	M8	Trend	Commentary
CCG	Bed Occupancy: Bed Occupancy (including home leave) AMH Inpatient - 90% Other Wards – 85%	Dir of Ops	85%	RED 96.4%	RED 94.2%	↘	94.2% at M8 from 96.4% at M7 for other wards The pressure on acute older adult inpatient beds is impacted by the levels of delayed transfers of care. These are a consequence of internal factors and whole system pressures. An action plan is in place and monitored through the A&E Delivery Board to ensure effective management of whole system pressures. At M8, AMH Inpatients is below the 90% target occupancy at 89% (M7: 86%) and therefore does not feature as an exception.

5 Recommendations

The Trust Board is asked to;

- Receive the Trust reported performance, management action and committee oversight on the month 8 position
- Note the rectification plans received through Board sub-committees

Month: **November**
8
Key:-

PQMF Report to Trust Board

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

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

	Metric	Frequency	Target (2016/17) Revised 17/18 target	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
CCG	Average Length of Stay: North Staffs CCG	Monthly	No Target	18.0	31.6	30.0	22.7	40.1	26.1	32.7	53.9				
CCG	Adult IP	Monthly	No Target	15.7	21.4	15.0	11.1	32.6	8.1	24.9	36.8				
CCG	CYP	Monthly	No Target	0.0	67.1	122.5	81.4	129.3	56.7	13.0	100.1				
CCG	NOAP	Monthly	No Target	117.3	68.4	101.6	37.9	63.3	101.3	56.0	114.0				
CCG	LD	Monthly	No Target	0.0	157.5	2.6	131.7	4.0	3.2	3.2	367.1				
CCG	Average Length of Stay: Stoke CCG	Monthly	No Target	23.6	33.0	31.7	31.2	35.4	36.9	24.3	23.3				
CCG	Adult IP	Monthly	No Target	25.6	34.1	41.0	30.2	50.2	33.5	22.5	24.3				
CCG	CYP	Monthly	No Target	88.2	51.1	88.0	95.9	32.5	44.6	33.3	76.3				
CCG	NOAP	Monthly	No Target	106.3	86.3	86.5	95.7	66.4	116.9	79.1	70.6				
CCG	LD	Monthly	No Target	0.0	0.0	2.4	20.0	2.4	2.5	2.7	0.0				
CCG	Ward 4-EMI: Length of Stay	Monthly	No Target	62.0	99.0	64.0	74.0	62.0	90.0	49.0	81.0				
CCG	Ward 4-EMI: Number of Admissions	Monthly	No Target	8.0	3.0	9.0	4.0	10.0	6.0	12.0	7.0				
CCG	Bed Occupancy (Including Home Leave)	Monthly	85%	93.6%	89.4%	92.9%	92.6%	92.3%	90.0%	93.1%	93.3%				
CCG	AMH IP	Monthly	90%	94.0%	89.0%	97.0%	93.0%	96.0%	89.0%	86.0%	89.0%				
CCG	LD	Monthly	85%	100.0%	79.0%	71.0%	68.0%	76.0%	79.0%	88.0%	74.0%				
CCG	NOAP	Monthly	85%	94.0%	91.8%	93.4%	96.2%	95.7%	94.6%	98.9%	100.2%				
CCG	Old Age Psychiatry	Monthly	85%	95.0%	92.0%	90.0%	92.0%	92.0%	93.0%	98.0%	98.0%				
CCG	C&YP	Monthly	85%	94.2%	88.6%	98.0%	93.9%	77.2%	73.1%	97.2%	96.6%				
National	The proportion of those on Care Programme Approach (CPA) for at least 12mnths having formal review within 12mnths *NHSI*	Monthly	95%	94.3%	93.9%	91.5%	91.8%	94.5%	92.2%	90.3%	94.1%				
National	The proportion of those on Care Programme Approach (CPA) receiving follow-up contact within 7 days of discharge	Monthly	95%	95.7%	96.9%	91.2%	90.0%	86.7%	97.4%	92.9%	97.4%				
National	% clients in employment (completeness count)	Monthly	7%	10.5%	10.4%	10.2%	10.2%	9.8%	9.7%	9.2%	8.9%				
National	% of clients in settled accommodation (completeness count)	Monthly	67%	88.5%	48.5%	86.4%	86.4%	84.8%	80.5%	82.0%	81.7%				
CCG	Percentage of adults who have received secondary mental health services who were on a Care Programme Approach who have had at least one formal review in the last 12 months *CCG Measure*	Monthly	95%	95.3%	94.4%	92.3%	91.4%	95.4%	90.6%	90.0%	93.5%				
CCG	All Service Users to have a care plan in line with their needs % on CPA with a Care Plan	Monthly	95%	94.8%	97.7%	92.1%	91.8%	91.6%	88.5%	95.0%	94.0%				
CCG	IAPT: The proportion of people who have depression and/or anxiety disorders who receive psychological therapies (Target: 3.75% per quarter, 1.25% p/month)	Monthly	3.75% quarterly (1.25% monthly)	1.05%	1.28%	1.21%	1.29%	1.30%	1.25%	1.5%	1.3%				
National / CCG	IAPT : The number of people who are moving to recovery. Divided by the number of people who have completed treatment minus the number of people who have completed treatment that were not at caseness at initial assessment	Monthly	50%	67.1%	68.5%	65.1%	65.9%	69.5%	64.9%	60.8%	66.3%				
CCG	Improving Access to Psychological Therapies (IAPT) Programme: the percentage of service users referred to an IAPT programme who are treated within 6 weeks of referral	Monthly	75%	99.7%	99.3%	100.0%	100.0%	100.0%	99.7%	100.0%	99.0%				
CCG	Improving Access to Psychological Therapies (IAPT) Programme: the percentage of service users referred to an IAPT programme who are treated within 18 weeks of referral	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
CCG	S136 (Place of Safety) Assessments	Monthly	No Target	23.0	33.0	35.0	43.0	22.0	20.0	28.0	21.0				
CCG	- Formal Admissions	Monthly	No Target	4.0	6.0	2.0	5.0	4.0	0.0	4.0	6.0				
CCG	- Informal Admissions	Monthly	No Target	4.0	2.0	6.0	7.0	3.0	4.0	3.0	2.0				
CCG	- Under 18 Yrs Old	Monthly	No Target	0.0	0.0	0.0	1.0	1.0	0.0	1.0	4.0				
CCG	Patients seen within the access service (Stoke-on-Trent CCG): Emergency 1 hour	Monthly	No Target	New	New	New	New	New	New	New	New				
CCG	Patients seen within the access service (Stoke-on-Trent CCG): Urgent 4 hours (% of referrals that were reported as urgent)	Monthly	No Target	12.3%	8.1%	8.5%	5.9%	1.7%	4.0%	6.3%	4.1%				
CCG	Patients seen within the access service (Stoke-on-Trent CCG): Routine 24 Hours (% of referrals that were report as routine)	Monthly	No Target	7.9%	9.2%	10.5%	12.1%	12.2%	6.0%	9.2%	8.5%				
CCG	Patients seen within the access service (North Staffordshire CCG): Emergency 1 hour	Monthly	No Target	New	New	New	New	New	New	New	New				
CCG	Patients seen within the access service (North Staffordshire CCG): Urgent 4 hour hour	Monthly	No Target	12.3%	5.7%	8.3%	8.2%	2.1%	6.8%	4.9%	5.3%				
CCG	Patients seen within the access service (North Staffordshire CCG): Routine 24 hours	Monthly	No Target	21.0%	20.7%	32.6%	23.9%	31.4%	27.2%	27.2%	28.7%				
CCG	Medication Errors leading to Moderate/Severe harm/death	Monthly	No Target	0.0	0.0	0.0	0.0	1.0	1.0	0.0	0.0				
CCG	Preventing Future Deaths Regulation 28	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0				
CCG	Unexpected Deaths	Monthly	No Target	1.0	2.0	1.0	7.0	6.0	4.0	3.0	3.0				
CCG	Inpatient	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0				
CCG	Inpatient on home leave	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0				
CCG	Community Patient (in receipt)	Monthly	No Target	1.0	2.0	1.0	7.0	6.0	4.0	3.0	3.0				
CCG	Community patient (in receipt) within 3 months of discharge from service	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0				
CCG	Community patient who had an inpatient stay in last 3 months prior to death	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0				

	Metric	Frequency	Target (2016/17) Red= 17/18 target	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
CCG	Never Events	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0				
CCG	Use of Restraint: Number of patient restraints-prone	Monthly	No Target	1.0	4.0	5.0	0.0	3.0	1.0	2.0	1.0				
CCG	Self Harm Events: Inpatient	Monthly	No Target	48.0	25.0	35.0	44.0	34.0	33.0	51.0	54.0				
CCG	Self Harm Events: Community	Monthly	No Target	35.0	31.0	28.0	26.0	19.0	29.0	26.0	20.0				
CCG	Slips Trips & Falls	Monthly	No Target	43.0	23.0	45.0	31.0	27.0	30.0	34.0	27.0				
CCG	Slips Trips & Falls leading to Moderate/Severe harm/death	Monthly	No Target	6.0	4.0	1.0	2.0	2.0	0.0	1.0	1.0				
CCG	Suspected Suicides	Monthly	No Target	0.0	0.0	0.0	2.0	4.0	1.0	2.0	0.0				
CCG	Inpatient	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0				
CCG	Inpatient on home leave	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0	2.0	0.0				
CCG	Community Patient (in receipt)	Monthly	No Target	0.0	0.0	0.0	2.0	4.0	1.0	0.0	0.0				
CCG	Community patient (in receipt) within 3 months of discharge from service	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0				
CCG	Community patient who had an inpatient stay in last 3 months prior to death	Monthly	No Target	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0				
CCG	Preventing Category 3 and 4 Avoidable Pressure Ulcer	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0				
CCG	MRSA Screening (% of patients screened on admission)	Monthly	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
National	% Year to Date Agency Spend compared to Year to Date Agency Ceiling	Monthly	0%		7.0%	20.0%	10.0%	26.0%	24.0%	28.0%	30.0%				
National	Sickness Absence Percentage: Days lost	Monthly	5.1%	3.1%	3.5%	2.4%	3.9%	4.9%	4.8%	4.8%					
National	Corporate	Monthly	5.1%	1.8%	2.7%	2.6%	1.8%	3.4%	2.7%	2.4%					
National	AMH Community	Monthly	5.1%	3.8%	3.7%	2.7%	4.2%	4.7%	4.7%	4.5%					
National	AMH IP	Monthly	5.1%	4.4%	5.3%	2.8%	5.2%	7.6%	8.5%	9.2%					
National	C&YP	Monthly	5.1%	1.4%	2.6%	2.0%	2.9%	3.4%	3.3%	4.3%					
National	LD	Monthly	5.1%	0.9%	2.8%	1.9%	3.3%	4.8%	3.5%	5.2%					
National	Neuro and Old Age Psychiatry	Monthly	5.1%	3.8%	2.5%	1.7%	5.1%	4.9%	5.4%	4.7%					
National	Substance Misuse	Monthly	5.1%	6.4%	7.4%	3.5%	5.6%	8.9%	9.5%	5.8%					
National	Staff Turnover (% FTE)	Monthly	>10%	0.9%	1.1%	0.6%	0.6%	1.5%	1.4%	0.7%	0.3%				
National	Corporate	Monthly	>10%	0.8%	1.3%	0.4%	0.0%	3.8%	2.5%	1.0%	0.0%				
National	AMH Community	Monthly	>10%	0.7%	0.9%	0.6%	0.8%	1.4%	0.9%	0.5%	0.6%				
National	AMH IP	Monthly	>10%	0.7%	0.0%	1.3%	0.7%	0.0%	1.8%	0.0%	0.5%				
National	C&YP	Monthly	>10%	1.6%	1.6%	1.7%	0.9%	1.7%	0.0%	0.9%	1.1%				
National	LD	Monthly	>10%	0.9%	2.2%	0.0%	1.5%	0.9%	1.5%	0.9%	0.0%				
National	Neuro and Old Age Psychiatry	Monthly	>10%	0.8%	0.7%	0.7%	0.0%	0.9%	1.3%	0.4%	0.0%				
National	Substance Misuse	Monthly	>10%	2.2%	2.3%	0.0%	0.0%	0.0%	1.8%	1.5%	0.0%				
CCG	Zero tolerance RTT waits over 52 weeks for incomplete pathways	Monthly	0	0.0		0.0	0.0	0.0	0.0	0.0	0.0				
CCG	Compliance with 18 week waits (Referral to Treatment or Intervention) (Excluding ASD)	Monthly	92%	93.5%		82.4%	94.3%	95.1%	94.9%	92.5%	93.6%				
CCG	AMH IP	Monthly	92%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
CCG	AMH Community	Monthly	92%	89.0%		77.5%	91.9%	94.9%	95.9%	95.6%	91.6%				
CCG	Substance Misuse	Monthly	92%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
CCG	LD	Monthly	92%	100.0%		85.2%	100.0%	94.1%	92.3%	91.9%	90.0%				
CCG	NOAP	Monthly	92%	97.4%		82.3%	94.3%	94.9%	95.4%	90.5%	95.3%				
CCG	C&YP	Monthly	92%	100.0%		93.7%	100.0%	95.4%	90.3%	93.1%	92.2%				
CCG	Patients will be assessed within 12 weeks of referral to the Memory Assessment service	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
CCG	Number of people seen for crisis assessment within 4 hours of referral	Monthly	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
National	Mental health delayed transfers of care (target NHSI) (M1-4.7%, M2-4.5%, M3-4.2%, M4-4.0%, M5-3.7%, M6-3.5%) Target revised to 7.0% in M3	Monthly	7.5%	11.0%	8.4%	13.0%	12.7%	10.8%	8.8%	13.5%	12.5%				
National/Trust Measure	AMH IP	Monthly	7.5%	7.2%	9.1%	7.5%	5.8%	8.3%	11.2%	14.2%	13.8%				
National/Trust Measure	LD	Monthly	7.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%				
National/Trust Measure	NOAP	Monthly	7.5%	23.5%	24.1%	17.1%	19.0%	16.4%	8.1%	12.8%	10.7%				
CCG	RAID response to A&E referrals within 1 hour	Monthly	95%	94.0%	94.0%	97.0%	96.0%	98.0%	97.0%	96.0%	95.0%				
National	Early Intervention in Psychosis - A maximum of 2 week waits for referral to treatment (Target-17/18-50%, 18/19-53%)	Monthly	50%	76.9%	81.8%	63.6%	100.0%	70.0%	50.0%	62.5%	61.5%				
CCG	Early Intervention in Psychosis - A maximum of 2 week waits for referral to treatment (North Staffordshire CCG)	Monthly	50%	66.7%	50.0%	50.0%	100.0%	0.0%	66.7%	50.0%	80.0%				
CCG	Early Intervention in Psychosis - A maximum of 2 week waits for referral to treatment (Stoke on Trent CCG)	Monthly	50%	85.7%	88.9%	66.7%	100.0%	77.8%	33.3%	66.7%	77.8%				
Nationsl/CCG	Overall safe staffing fill rate	Monthly	No Target	95.2%	95.3%	94.8%	93.4%	91.2%	90.4%	91.8%	94.3%				
CCG	Mixed Sex Accommodation Breach	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0				
CCG	Duty of Candour Each failure to notify the Relevant Person of a suspected or actual Reportable Patient Safety Incident	Monthly	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0				
CCG	All service users who have been in hospital/long term inpatient health care for more than one year should have a physical health check	Quarterly	95%			100.0%			100.0%						
CCG	DNA Rate Analysis by Directorate (North Staffs CCG)	Monthly	No Target	4.9%	8.2%	8.2%	7.3%	7.4%	5.6%	5.4%	4.9%				
CCG	AMH IP	Monthly	No Target	0.0%	0.0%	9.4%	5.9%	0.0%	8.5%	4.1%	5.6%				
CCG	AMH Community	Monthly	No Target	5.6%	6.0%	11.1%	9.3%	9.2%	6.6%	6.0%	5.8%				
CCG	LD	Monthly	No Target	1.4%	1.2%	2.4%	2.2%	1.9%	3.0%	3.2%	4.3%				
CCG	NOAP	Monthly	No Target	4.3%	6.4%	4.1%	4.8%	4.3%	3.2%	3.3%	2.8%				
CCG	C&YP	Monthly	No Target	5.2%	6.0%	6.4%	6.6%	8.1%	6.4%	6.3%	5.8%				
CCG	DNA Rate Analysis by Directorate (Stoke on Trent CCG)	Monthly	No Target	6.2%	6.2%	7.1%	6.7%	6.7%	5.9%	5.0%	7.8%				
CCG	AMH IP	Monthly	No Target	4.5%	6.8%	4.8%	1.1%	2.7%	0.8%	7.2%	10.3%				
CCG	AMH Community	Monthly	No Target	6.4%	6.6%	7.8%	7.3%	6.7%	5.2%	5.0%	5.0%				
CCG	LD	Monthly	No Target	3.8%	2.3%	3.4%	2.8%	3.2%	6.5%	5.5%	3.2%				
CCG	NOAP	Monthly	No Target	5.4%	5.7%	6.6%	5.7%	5.9%	4.7%	3.6%	4.3%				
CCG	C&YP	Monthly	No Target	9.3%	8.3%	8.2%	9.2%	12.1%	10.7%	9.0%	7.8%				

	Metric	Frequency	Target (2016/17) Red= 17/18 target	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
CCG	Completion of Mental Health Services Data Set ethnicity coding for all Service Users	Monthly	90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
CCG	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS	Monthly	99%	99.8%	99.7%	99.3%	99.9%	99.9%	99.9%	100.0%	Awaiting publication				
CCG	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users, as defined in Contract Technical Guidance	Monthly	90%	96.0%	96.0%	96.0%	96.0%	96.0%	Awaiting publication	Awaiting publication	Awaiting publication				

REPORT TO OPEN TRUST BOARD

Enclosure No: 9

Date of Meeting:	25th January 2018		
Title of Report:	Quarter 3: Serious Incident Report		
Presented by:	Dr O Adeyemo, Executive Medical Director		
Author:	Jackie Wilshaw, Head of Patient & Organisational Safety		
Executive Lead Name:	Dr O Adeyemo, Executive Medical Director	Approved by Exec	☐

Executive Summary:		Purpose of report	
This report provides assurance to the Board of the Trust processes relating to Serious Incidents (SIs) and Duty of Candour. The report covers the period from 1st October 2017 to 31st December 2017 (Quarter 3. 2017/18)		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☒	Date:16.01.18	
	Execs ☐	Date:	
Committee Approval / Review	• Quality Committee ☒ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. ☐ 2. To provide the highest quality services. ☒ 3. Create a learning culture to continually improve. ☒ 4. Encourage, inspire and implement research & innovation at all levels. ☐ 5. Maximise and use our resources intelligently and efficiently. ☐ 6. Attract and inspire the best people to work here. ☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref			
Resource Implications: Funding Source:			
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	Consideration of matters relating to Diversity and Inclusion are included in the review of the SI investigations. No issues identified		
Recommendations:	For information / assurance		

1. Purpose of the Report

This report provides assurance to the Quality Committee of the Trust processes relating to Serious Incidents (SIs) and Duty of Candour. The report covers the period from 1st October 2017 to 31st December 2017 (Quarter 3. 2017/18) and details the following:

- The status of SI`s currently open and trend data for Q2 2017/18 and Q3 2017/18.
- Serious Incidents by category reported by quarter.
- Themes learning and change arising from Serious Incident investigations.
- The quarterly Duty of Candour report.

2. Serious Incidents Q3

Serious Incident investigations are undertaken following incidents involving people in receipt of services or who have been in receipt of services in the previous 12 months. This does not include those service users whose deaths are determined by HM Coroner to be as a result of natural causes. The table below illustrates the total number of SI`s reported by quarter for the period April 2016 to December 2017.

Table 1

Incident category	Q1	Q2	Q3	Q4	**Total 2016/17**	Q1	Q2	Q3	Q4	**Total 2017/18 YTD**
Slip, trip, fall	2	0	1	2	**5**	2	6	3		**11**
Pending review – Unexpected/potentially avoidable death	0	10	7	6	**23**	6	11	9		**26**
Apparent/actual/suspected self-inflicted harm meeting SI criteria (non-fatal)	0	1	1	1	**3**	1	0	2		**3**
Disruptive, aggressive behaviour meeting SI criteria	1	0	0	0	**1**	0	0	0		**0**
Apparent/actual/suspected self-inflicted harm meeting SI criteria (suspected suicide)	7	11	4	2	**24**	3	6	2		**11**
Unexpected/potentially avoidable injury causing harm	0	1	0	0	**1**	0	0	0		**0**
Apparent/actual abuse	0	0	0	0	**0**	0	1	2		**3**
Total	10	23	13	11	**57**	12	24	18		**54**

Table 2 below illustrates Serious Incidents by team for the period January 2017 to December 2017.

Serious Incidents reported by team and month. January 2017 to December 2017													
Team/month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Access Team	1			1			2			1			5
AHTT + CMHT							1			1			2
CJMHT					1			1					2
Greenfield Centre	2			1				1					4
NS Wellbeing	1									1			2
One Recovery East (Burton)					2		1	1					4
One Recovery North (Newcastle)		1					1					2	4
One Recovery North (Leek)	1						2						3
One Recovery (West) Cannock			1										1
RAID			1					1	1				3
Sutherland Centre					1	1		1					3
Ward 2					1		1				2		4
Ward 4	1		1	2			1	1				2	8
Ward 5								1					1
Ward 6								1		1			2
Stoke CDAS									2		1	3	6
Darwin									1				1
Lymebrook								1					1
Neuropsychiatry (Bennett)									1				1
A+T									1		1		2
Brandon Centre										1			1
Ashcombe Centre											1		1
Edward Myers Unit											1		1
Grand total	**6**	**1**	**3**	**4**	**5**	**1**	**9**	**9**	**6**	**5**	**6**	**7**	**62**

During Q3 18 incidents were reported onto StEIS and have undergone or are in the process of undergoing SI investigation.

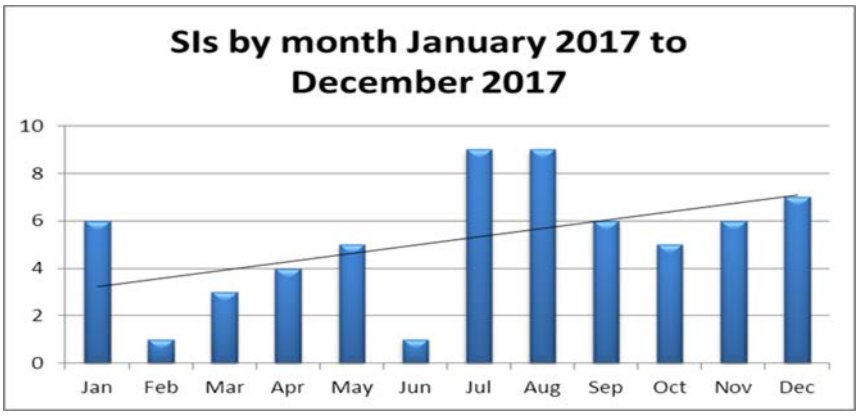
The main points to note are:

- There were 7 unexpected deaths in the Substance Misuse Directorate. There were a further 2 unexpected deaths where the person was open to other Trust services in addition to Substance Misuse Services. In these cases, the investigations underway are joint mental health (in-patient and community services) and substance misuse investigations.

- In the Adult Mental Health-Community Directorate there were 4 unexpected deaths and 1 incident of serious self-harm.
- In this quarter there was a slight reduction in the number of SIs involving slips, trips and falls in the NOAP Directorate. There were 2 incidents of fractures caused through falling and 1 incident of a lapsed section/illegal detention within the Directorate.
- Within the Adult In-Patient Directorate, there was 1 Mental Health Act (MHA) incident which resulted in a lapsed section/illegal detention. This was recognised and rectified within 24 hours of the section lapsing.

3. Themes and Trends

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



In Q3 there were 2 unexpected deaths where suicide was suspected. This is a reduction from Q2 2017/18 when 6 unexpected deaths were suspected suicides. However there were 9 unexpected deaths in the Substance Misuse Directorate. The addition of Stoke Community Drug and Alcohol Services has contributed to a rise in deaths in this Directorate over the last 6 months.

In Q2 2017/18, the Trust reported an incident involving MHA documentation. In this case a person's detention had not been reviewed in a timely manner and had resulted in an illegal detention due to a lapsed section. This incident was found to be due to unforeseen changes in practice following the launch of the electronic patient record and subsequent changes in practice at team level and within the MHA Law Team were put into place.

In Q3 2017/18, there have been 2 further incidents involving MHA documentation and which resulted in 2 individuals being unlawfully detained in hospital after the sections were allowed to lapse without timely review. From an initial review of all of the incidents it is possible to determine that each was very different in its cause. The initial learning indicated the following:

- The renewal date was misinterpreted by the Responsible Clinician (RC) who arrived to renew the detention the morning after the section had lapsed the previous midnight. This was determined to be human error. The lapse in legal detention had been recognised by the ward clinical team and interim measure implemented until the RC arrived on the ward and a full review and completion of section 3 MHA could be put into place.

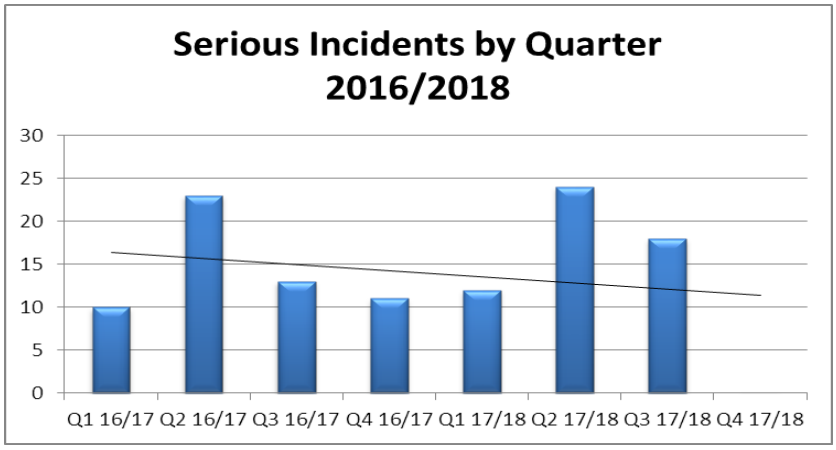
- Following the initial incident in Q2 2017/18, the MHA Law Team had put processes in place to alert teams to MHA renewal dates. The MHA Law Team contacted the RC and the ward to which the person had been admitted prior to the renewal date. However the person had been transferred to another ward who did not receive the reminder.

In response to the investigation findings, a checklist for use at ward reviews has been developed. This will be monitored through the In-patient Safety Matrix and reviewed at the Mental Health Act Law Governance Group.

The three incidents relating to compliance with the Mental Health Act will be reviewed separately and the findings of the investigations will be reviewed together with an overarching action plan to address any identified issues.

The addition of Stoke Community Drug and Alcohol Services (CDAS) has made an impact on the number of SI`s reported during Q3 as shown in table 2 above.

The graph below shows SIs per quarter for the period March 2016 to September 2017 with the trend line showing a reducing trend line.



SI`s arising from slips, trips and falls are showing an increasing trend over the last 12 months however in the last 2 quarters there has been a reduction in the number of falls meeting SI criteria. Actions to address issues relating to falls from the Falls Rapid Improvement Group and the AQuA (Advancing Quality Alliance) initiatives are on-going and under current review.

4. Learning from Serious Incidents

Recommendations and learning from investigations are disseminated on completion of the SI investigation. The learning that was found from the previous quarter and early Q3 investigations is outlined below:

- Improved knowledge around dual diagnosis remains an issue for some teams. This has been addressed through the development of substance misuse champions in some teams and the Trust held a listening event in October 2017, which aimed to support staff learning and development in dual diagnosis.

- A Practice Note was issued to staff as a reminder regarding the assessment of future risk following patients absconding from wards.

- The relevant ward is also going to discuss and take forward ideas from the Len Bowers 'safe wards' ideology, around the management of people who attempt to abscond from hospital.
- The need for improved internal communication in teams was noted by one Community Team in order to ensure that the relevant aspects of a person's care are known to the wider team.
- Improved co-production and management of care plans was recommended following one investigation.
- An investigation into a slip, trip and fall showed that the full version of the falls risk assessment had not been uploaded onto Lorenzo. The initial FRAT (falls risk assessment tool) was available to staff but the subsequent multifactorial risk assessment had been omitted from the final list of assessments. However this finding allowed staff the opportunity to review and revise the Trust Falls Policy and the multifactorial risk assessment as part of the rapid improvement work. The multifactorial risk assessment has now been agreed and is in use across the Trust.
- A Practice Note was issued to the One Recovery service. This was aimed at standardising practice across the partnership with regards to the documentation and provision of Naloxone.

As in previous reports there were a number of investigations where no recommendations for practice were made.

The next report will detail the dissemination and embedding into practice of learning from investigations.

5. Duty of Candour (Quarter 3 Report)

The Trust continues to strive for open and transparent practice in our delivery of mental health and learning disability services. All reported incidents are scrutinised at the Weekly Incident Review meeting. This meeting is facilitated by the Patient and Organisational Safety Team and aims to provide secondary monitoring and identification of all incidents which may potentially meet the criteria as Duty of Candour reportable incidents.

In the cases of the SI investigations, it is not always possible to determine which, if any of the deaths under investigation meet the Duty of Candour requirements. However should any investigation identify causal links between patient harm and service delivered, the Duty of Candour process would be initiated and a letter outlining the issues sent to the patient or next of kin. This process is currently undergoing further development as outline plans are in place to incorporate a review of the SI unexpected deaths into the Mortality Surveillance review process.

The table below shows the number of Duty of Candour incidents for Q3

Month	PSI identified as moderate or above	PSI downgraded following review	Meets DoC requirements	Managed through the SI policy	Managed through the Mortality Surveillance process	DoC requirement unclear – under review
October	18	14	1	3	0	0
November	24	14	0	4	1	0
December	33	23	1	7	1	1
Total	75	57	2	14	2	1

The Duty of Candour incident in October was in relation to a slip, trip, fall on one of the NOAP ward and a letter was sent to the next of kin. The letter apologised for the patient's experience and offered the family the opportunity to be involved in the feedback with regards to the incident.

The incident in December relates to an event which happened at the children's short break service. An error in patient manual handling resulted in a child having to be transferred for Jejunostomy (JEJ) tube replacement. A discussion was immediately held with the parents of the child. This was followed up with a letter of apology to the parents and an invitation to participate in the investigation and to receive feedback following completion of the investigation. This was further followed up by a personal visit to the parents by the Unit Manager to discuss the outcome of the investigation.

6. Conclusion

- The Trust continues to monitor all incidents on a weekly basis and this report demonstrates compliance with Trust policies and processes.
- There has been an increase in incidents relating to compliance with the Mental Health Act during this reporting timeframe and the findings of the 3 incidents reported between August 2017 and December 2017 will form the basis of an overarching action plan to address issues identified.
- The number of falls related SI`s has reduced in this quarter. The quality improvement work for falls prevention is on-going and the number and impact of all falls will be monitored by the NOAP senior clinicians and the Patient Safety Team.

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REPORT TO: OPEN TRUST BOARD

Enclosure No:10

Date of Meeting:	25 January 2018		
Title of Report:	Learning from Deaths Activity Report		
Presented by:	Dr Buki Adeyemo, Executive Medical Director		
Author:	Jackie Wilshaw. Head of Patient and Organisational Safety		
Executive Lead Name:	Dr Buki Adeyemo, Executive Medical Director	Approved by Exec	☒

Executive Summary:		Purpose of report	
This report provides a review of the unexpected deaths from Serious Incident Investigations and 'natural cause' deaths of service users which occurred during October to December 2017. This report has previously been included in the Serious Incident quarterly reports but in response to the national Learning from Deaths guidance, this analysis is now provided as a separate report.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☒ 16.01.18	Date:	
	Execs ☐	Date:	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. ☐ 2. To provide the highest quality services. ☐ 3. Create a learning culture to continually improve. ☐ 4. Encourage, inspire and implement research & innovation at all levels. ☐ 5. Maximise and use our resources intelligently and efficiently. ☐ 6. Attract and inspire the best people to work here. ☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref			
Resource Implications: Funding Source:			
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)			
Recommendations:	For Information		

Version	Name/group	Date issued
1	Dr O Adeyemo	16.01.18

1 Introduction

Following the publication of Learning, Candour and Accountability (CQC December 2016), from April 2017, the Trust has been required to publish a quarterly account of specified information on deaths.

This report includes information on those unexpected deaths which have been investigated under the Serious Incident (SI) framework and 'natural cause' deaths which are not determined to meet the criteria for SI investigation and reporting. This information has previously been reported within quarterly SI reports; prior to becoming a national requirement. In order to raise the profile of this important issue the Medical Director has requested that this separate Learning from Deaths report is submitted on a quarterly basis. This report will be published on the public facing area of the Trust website.

The Trust receives information with regards to unexpected deaths from the North Staffordshire Coroner's Office. If the deceased person is in receipt of Mental Health or Learning Disabilities services or had been in receipt of services in the preceding 12 months **and** is determined by HM Coroner to have died unnaturally, the Trust will complete an investigation through the Serious Incident process. There is governance in place around this process and identified actions are monitored by the relevant Directorate in conjunction with the Trust clinical commissioners. The learning from these deaths is disseminated throughout the Trust as part of the Learning Lessons framework. This process was subject to review by the Trust Auditors, RSM and the Trust received substantial assurance with regards to the strength of the process (September 2017).

Natural cause deaths (where the person is open to services at the time of death), as identified by HM Coroner do not meet the requirement for an SI investigation. Nevertheless the Trust undertakes local investigations in order to ensure that there are no gaps or omissions in service delivery and missed opportunities for learning. These investigations include those people whose deaths are related to excessive alcohol use.

The scope for mortality surveillance investigations will cover the following criteria:

- Deaths of people open to Mental Health services, where the person has a diagnosis of Serious Mental Illness and has died at an age which may be reasonably considered to be premature. Therefore the natural deaths of people over the age of 75 will not be included in learning from deaths investigations.
- Deaths of people open to Substance Misuse Services, where alcohol abuse is considered to be a factor

2 Learning from Deaths Group Activity

A Trust Learning from Deaths Group was established in November 2017, this group met to review the mortality surveillance screening of deaths which occurred between 1st August 2017 and 2nd October 2017.

The group reviews aspects of care such as assessment and care plan review dates, delays in planned care, consideration of physical health needs and safeguarding issues. The group take into account the cause of death* as determined by HM Coroner and are asked to consider the following question: is the death assessed as being 'more likely as not due to problems in care?'

This is known as the 'on balance' question, i.e. 'On balance was the person's death more likely than not to have been due to issues in care provided by the Trust'. Following the review any learning and actions identified will be shared with Teams/Directorates as necessary.

*not all deaths are reported to HM Coroner and the death certificate may be provided by the GP or acute hospital where the deceased was last known. In this case, the cause of death may not be known to the Trust.

The group reviewed the care of 6 people whose deaths had been confirmed as natural causes and which had occurred in the period 1st August 2017 to 2nd October 2017. The table below details the review findings.

Patient identifier	Standard of care	Code	On balance
A2	Good	UN1	N
B3	Good	UN1	N
C5	Poor	UN1	N
D6	Adequate	UN1	N
E8	Excellent	UN2	N
G10	Returned to reporter for more information	Returned to reporter for more information	Returned to reporter for more information

- UN1 unexpected natural death - death from a natural cause - sudden cardiac event/ CVA
- UN2 unexpected natural death - death from a natural cause which may have been preventable e.g. alcohol or drug dependency/care concerns

The group found that in four cases, the person was found to have died unexpectedly but of natural cause deaths. These deaths were reported as long term respiratory problems and cardiac problems. Cause of death in one case was as a result of a seizure. The cause of death is yet to be determined in one of the cases reviewed. However, the care given whilst the person was an inpatient was assessed as timely and appropriate. Staff ensured that medical care was sought and the person transferred to acute hospital care in a timely manner.

In four of the cases reviewed, the care provided by our clinical teams ranged from adequate to excellent. Care was provided in a timely and appropriate manner for the mental health care of the person. In one case the mental health care provided to the person was felt to be of a poor quality although the death occurred as a result of long term physical health issues. The issues in relation to the mental health care provided was subject to further investigation under alternative Trust processes. The group also reviewed the care of 8 people whose deaths had been reported and investigated under the SI framework. This was to provide completeness with regards to the Trust understanding of the 'on balance' question. The table below details the review findings.

Patient identifier	Standard of care	Code	On balance
SI4	Good	EU	N
SI16	Good	UU	N
SI17	Good	UN2	N
SI18	Good	UN2	N
SI19	Good	UN2	N
SI20	Good	UU	N
SI21	Good	UN2	N
SI22	Good	UN2	N

- EU - Expected Unnatural - deaths that were expected to occur in an expected timeframe e.g. Terminal illness. Unlikely to be preventable.
- UU - Unexpected Unnatural - suicide, homicide, abuse/neglect - preventable, investigated under the SI policy.

This review found that the care provided by our clinical teams was good and not related to death.

3 Unexpected deaths in Quarter 3 2017/18

The table below shows the total number of deaths reported during October to December 2017.

	Reported as SI	Open to services at time of death - natural causes	Substance Misuse Deaths			LD Deaths
			North Staffs	Stoke	Staffs	
Oct	3	3	0	0	0	0
Nov	4	2	2	2	0	2
Dec	4	2	1	3	0	0

The deaths shown above will be reviewed at the January Learning from Deaths Group. Initial reports do not indicate any issues of concern.

4 Conclusion

- The Trust has established a process to undertake mortality surveillance in line with national guidance.
- Deaths which meet the criteria for SI investigation and natural cause deaths are identified and processes are in place to monitor the care provided by the Trust clinical teams.
- It is recognised that the input and effectiveness of primary and secondary physical health care provision is not available to the reviewers but as far as is practicable, the Learning from Deaths Group identify the physical health aspects of care required and determine if the support offered by our clinical teams is person-centred and holistic in its approach.
- Therefore the Trust is asked to accept this report as assurance of that mortality surveillance processes are in place.

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO Trust Board

Enclosure No:11

Date of Meeting:	25.01.18		
Title of Report:	CQC - Local System Review Action Plan		
Presented by:	Laurie Wrench		
Author:	Laurie Wrench		
Executive Lead Name:	Caroline Donovan	Approved by Exec	☒

Executive Summary:	Purpose of report	
Between 4th and 8th September 2017, the Care Quality Commission (CQC) undertook a Local System Review of the Stoke-on-Trent health and care system. The Review considered system performance along a number of 'pressure points' on a typical pathway of care with a focus on older people aged over 65. In response to the publication of the report, NSCHT CEO on behalf of the system agreed to lead on the development of an action plan to address concerns raised within report. This action plan was shared with the Health and Wellbeing Board 14th December, CQC 18th December, Alliance Board 20th December and Stoke OSC 15th January.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☒ Execs ☐ Date: 16.01.18	Document Version No.	1
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently ☐ 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	Failure to implement improvements could result in risk to quality of service provision.		
Resource Implications: Funding Source:	None		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	Diversity and Inclusion is a significant consideration for the CQC when assessing the quality of services		
Recommendations:	That the Board receive the action plan for information and assurance.		

CARE QUALITY COMMISSION

STOKE-ON-TRENT LOCAL SYSTEM REVIEW

IMPROVEMENT PLAN

15 December 2017 V9

City of
Stoke-on-Trent

NHS
Stoke-on-Trent
Clinical Commissioning Group

NHS
University Hospitals
of North Midlands
NHS Trust

NHS
Staffordshire and
Stoke on Trent Partnership
NHS Trust

NHS
North Staffordshire
Combined Healthcare
NHS Trust

INTRODUCTION AND PURPOSE

Between 4th and 8th September 2017, the Care Quality Commission (CQC) undertook a Local System Review of the Stoke-on-Trent health and care system. The Review considered system performance along a number of 'pressure points' on a typical pathway of care with a focus on older people aged over 65.

The Review was carried out following a request from the Secretaries of State for Health and for Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The CQC will produce a national report for government to bring together key findings from across the 20 local system reviews.

The Local Summit was held on Thursday 9th November. Senior leaders from the five organisations – Stoke-on-Trent City Council, Stoke-on-Trent Clinical Commissioning Group, North Staffordshire Combined Healthcare NHS Trust (NSCHT), University Hospitals of North Midlands NHS Trust (UHNM), and Staffordshire and Stoke-on-Trent Partnership NHS Trust (SSOTP) – committed at the Summit to work together to develop an Improvement Plan in response to the Review Report. The Chief Executive Officers (or equivalent) are meeting weekly to monitor development of the Plan, which is being co-ordinated by NSCHT.

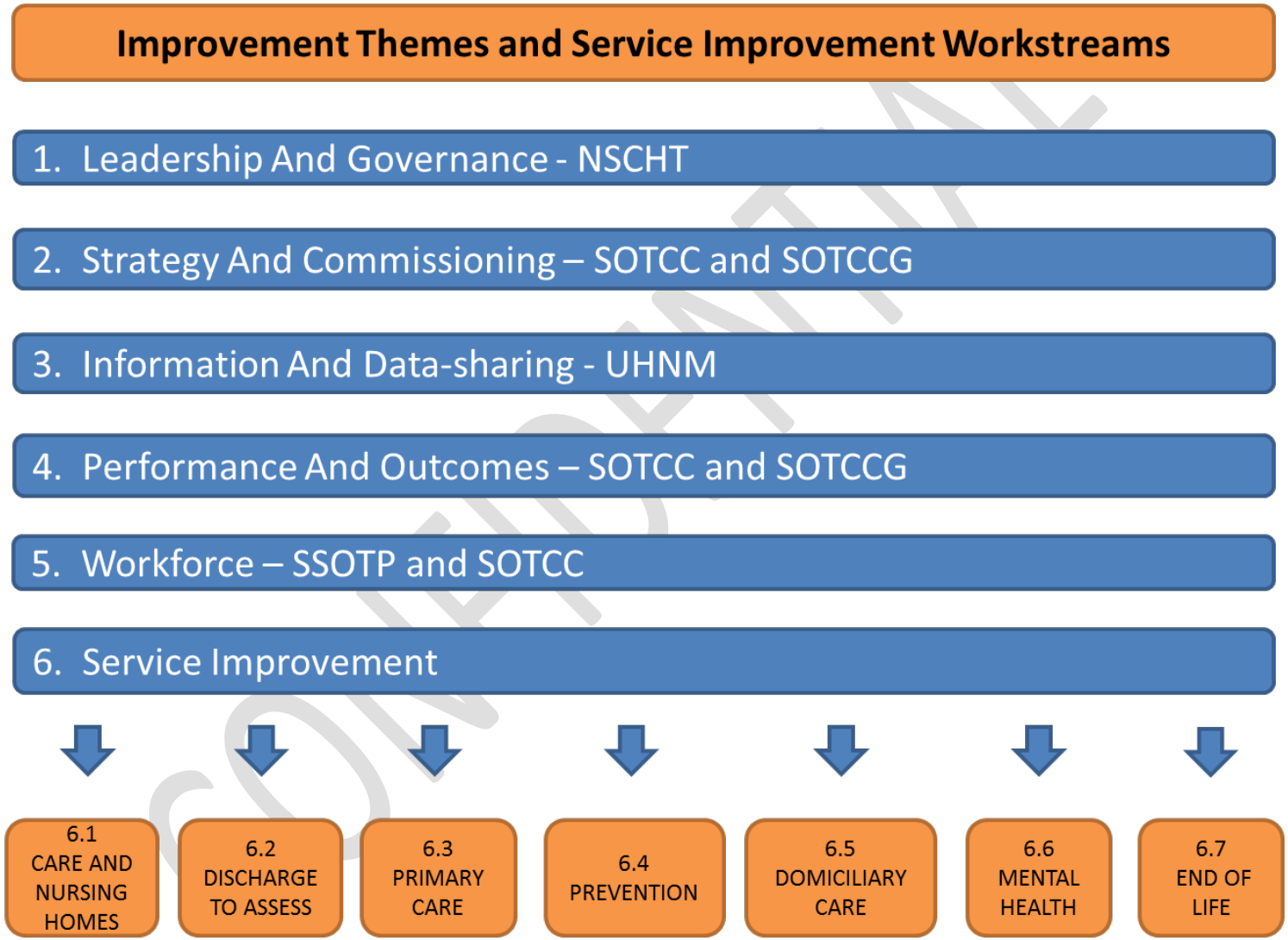
Two workshops will be held, facilitated by Richard Jones, at which the details of the Improvement Plan will be populated. Attendees will be:

- Trish Rowson – Associate Chief Nurse, Quality and Safety, UHNM
- Rebecca Bowley - Strategic Manager, Commissioning and Partnerships, Stoke-on-Trent City Council
- Becky Scullion - Deputy Director of Commissioning, North Staffordshire CCG
- Claire Bailey - Acting Director Strategy, Business and Redesign, SSOTP
- Simmy Akhtar - Chief Executive, Healthwatch Stoke-on-Trent
- Andrew Hughes – Joint Director of Strategy & Development, NSCHT and North Staffordshire GP Federation
- Jane Munton-Davies – Head of Directorate for Neuro and Old Age Psychiatry, NSCHT
- Charlotte Bennett - Strategic Liaison Officer Health, VAST
- Andrew Brown - Programme Manager - Staffordshire Shared Care Record, UHNM

The Improvement Plan will be approved by the Stoke-on-Trent Health and Wellbeing Board, which will be responsible for assuring the Plan's delivery.

Key Milestones:

The Plan is based on six key themes and seven service improvement workstreams as shown in the figure below.



Improvement Theme 1: **LEADERSHIP and GOVERNANCE**

Lead Organisation: North Staffordshire Combined Healthcare NHS Trust

Explanation: The CQC identified deficiencies within the system, particularly relating to inter-organisational, partnership working. The aim is to create a system where leadership is visible and coherent and where there is clarity in direction of travel, delivery and assurance. Our review of existing structures and arrangements will address the best solutions for system leadership, joint Decision-making, accountability, collaboration and delivery.

CQC Identified Issue(s)	Intended Outcome	Actions to Address			Assurance	Progress	RAG
		Action	Responsible	Timeline			
The governance structure does not always enable system partners and the local community to hold each other to account regarding performance and delivery. The Health and Wellbeing Board (HWB) is a forum for reporting progress on service delivery and	An integrated governance structure that defines clear and separate responsibilities for: setting direction of travel; delivery against agreed plans and outcomes; assurance and performance monitoring; and communication and	Define and introduce a governance system that will deliver the improvement plan and foster sustained integrated working. Key features will include: • A reconstituted Health and Wellbeing Board to lead and assure delivery of the system improvement.	NSCHT All partners City Director, Stoke-on - Trent City Council	January 2018 January 2018	Arrangements agreed by all Boards and Councils New Board convened with revised membership and Terms of Reference		

does not function as a driver for change. Partnership working is under-developed, and relationships are fragile. There is little evidence of a joint approach to service design and delivery. There is siloed working coupled with cross-organisational tensions. The views of the voluntary sector are not always responded to, impacting on the credibility of delivery.	engagement with citizens and their representative bodies.	• A formal role for the North Staffordshire and Stoke-on-Trent Alliance ("the Alliance") as the delivery vehicle for the improvement plan specifically and enhanced partnership working and integrated care more generally. This will interface with the Alliance's responsibility to the STP	Chair of the Alliance Board	January 2018	Formal sign off of revised membership and Terms of Reference		
		• Establish a PMO to manage and monitor the delivery of the action plan	SRO / CEO, NSCHT	January 2018	Dedicated PMO oversight of the action plan		
		• An expanded and formalised role for the Voluntary sector to ensure that plans and projects are co-produced and co-developed.	Chair, The Health and Wellbeing Board	February 2018	The Voluntary sector 'Strategic Engagement Group' is constituted and convened.		

		• Healthwatch are members of the Health and Wellbeing Board • A public engagement strategy is developed and implemented	Chair, The Health and Wellbeing Board	June 2018	The voice of the citizen is at the heart of the system Terms of reference of Alliance Board and Health and Wellbeing Board.		
Front line staff feel they would benefit from visible and clear senior leadership. There has been no period of stability to enable relationships to embed, particularly in the last year where there had been numerous changes in leadership.	Chief Executives (or their equivalent) behave in a way that demonstrates a united and integrated system.	Stoke-on-Trent system CEOs attend the Health and Wellbeing Board	• CEO, UHNM • CEO, SSOTP • CEO, NSCHT • AO, CCG • City Director, SOTCC	December 2017	CEOs commit their respective organisations to delivery of the improvement plan and commit personally to the process		
There is no coherent structure to describe learning from best practice across the system.	It will be a learning system that uses service improvement methodologies to deliver continuous quality improvement.	Develop agreed approach to service improvement	Director of Leadership and Workforce, NSCHT	February 2018			

Improvement Theme 2: **STRATEGY and COMMISSIONING**

Lead Organisations: Stoke-on-Trent City Council and Stoke-on-Trent Clinical Commissioning Group

Explanation: The CQC identified deficiencies and inconsistencies within the system, with no clear line of sight between commissioning approaches and to the wider Staffordshire priorities. The aim is to create a system where strategy, policy and commissioning intentions are consistent and targeting the same priorities.

CQC Identified Issue(s)	Intended Outcome	Actions to Address			Assurance	Progress	RAG
		Action	Responsible	Timeline			
There must be effective joint strategic planning based on the needs of the population with clear shared and owned outcomes Strategic commissioning should be aligned to the agreed strategic plans and must include primary care System leaders should ensure effective delivery of their integrated	• Clear strategic vision with strategies aligning to STP, JSNA, BCF and Stronger Together vision and priorities • Co-designed asset based strategies which deliver improved outcomes, improved quality, better efficiency and reduced duplication across the system. • Implement an Integrated commissioning approach within	Deliver a joint, integrated health and adult social care commissioning strategy/plan for Stoke-on-Trent supported by pooled budgets / programme budgeting The strategy will include a joint approach to build capacity and embed the Voluntary Sector within the health and social care system. A senior, joint	Director of Commissioning, CCG Assistant Director-Commissioning Health and Social Care, SOTCC AO, SOTCCG / City Director, SOTCC	March 2018 January 2018	Strategy approved through CCG and LA governance routes and reported through Health and Wellbeing Board		

CQC Identified Issue(s)	Intended Outcome	Actions to Address			Assurance	Progress	RAG
		Action	Responsible	Timeline			
strategic plans.	Stoke-on-Trent. • Reduced fragility of the care market as a result of integrated approaches including market development and collaboration with new models of care. • Improved quality / CQC ratings • Improved coordination of voluntary sector engagement and commissioning across health and social care.	commissioning post will be appointed to for an initial period of six months					
		Develop voluntary sector engagement strategy co-produced between health, social care and voluntary sector representatives	Accountable Officer and Director of Commissioning CCG Assistant Director-Commissioning Health and Social Care, SOTCC	June 2018	Strategy approved through CCG and LA governance routes and endorsed by Voluntary Sector Chief Officers Group		
		Establish a clinically led group including voluntary sector and statutory services	Director of Nursing and Quality Medical Director, CCG	February 2018	Group convened and terms of reference agreed and in place Overseen by Alliance Board		

CQC Identified Issue(s)	Intended Outcome	Actions to Address			Assurance	Progress	RAG
		Action	Responsible	Timeline			
		The group will define and implement an improved frailty pathway	Director of Nursing and Quality Medical Director, CCG	February 2018 – February 2019	Pathway implemented and KPIs / milestones for implementation and intended outcomes are monitored and achieved in the agreed timeframes		

Improvement Theme 3: **INFORMATION and DATA SHARING**

Lead Organisation: University Hospitals of North Midlands NHS Trust

Explanation: The CQC identified that the system in unable and potentially unwilling to share critical management and user information. The aim is create a system where information securely flows between professionals to enable improved and more responsive care and to reduce hand-offs within and between organisations.

CQC Identified Issue(s)	Intended Outcome	Actions to Address			Assurance	Progress	RAG
		Action	Responsible	Timeline			
Systems do not share records through digital interoperability or use the NHS number. Service users have to tell their story numerous times.	Integrated care record is operationalised across all health and social care organisations. There will be joined-up data systems that place the service user at the centre of the system. Service users will have access to their own records.	Procure and Implement Integrated Care Record	STP Digital Workstream Chair	Procure – January 2018 Fully implemented - December 2019	ICR delivered across all organisations Overseen by STP Digital Workstream Board		
Accessing help and support is confusing. There are issues with the local authority website and signposting.	There will be a clear system wide website for people to access. People are able to maintain independence longer by receiving appropriate support and signposting.	Co-design and implement an online information / e-market place system. • *Design functionality* • *Procure website*	Assistant Director of Commissioning, SOTCC	Sept 2018	Online e-market place in operation and utilised Overseen by SOT CC Operational Business		

		• *Work with market*			Meeting		

Improvement Theme 4: **PERFORMANCE and OUTCOMES**

Lead Organisations: Stoke-on-Trent City Council and Stoke-on-Trent Clinical Commissioning Group

Explanation: The CQC identified a lack of coherence in performance planning and delivery aligned to inconsistencies and contradictions in reporting and outcomes. The aim is to create a system that is measuring and reporting on the key outcomes within strategy, policy and commissioning intentions and is therefore able to demonstrate improvement in quality, safety and delivery.

CQC Identified Issue(s)	Intended Outcome	Actions to Address			Assurance	Progress	RAG
		Action	Responsible	Timeline			
Information governance is not joined up across the system. There is no evidence of shared management information. Data and intelligence are not routinely shared. There are no integrated care records. Leaders and frontline staff feel that management information is	There is clear and agreed management information demonstrating performance. Data-sharing protocols will be agreed that normalise the safe and secure transfer of information between professionals and across organisations.	We have a whole system view of numbers of patients by location in the health and care system and what they are waiting for	Director of Commissioning, CCG	December 2017	Information is shared every day with all partners at 4pm		

guarded.							
Attention will be given to long-term strategic planning across the system with an agreed performance framework. There isn't a system-wide approach to winter planning, system leaders	Timely and evidenced based planning in place, owned by all system partners and contributing to improved performance	Gain system wide agreement of the essential system KPI'S which will be owned by the Health and Wellbeing Board and used to monitor the delivery and development of the joint Health and Social Care Strategy	Director of Commissioning CCG Assistant Director-Commissioning Health and Social Care, SOTCC	Dashboard developed February 2018	Dashboard in place and reported to Health and Wellbeing Board from 12 March 2018 meeting		

have not developed common data sets which are routinely shared and key performance indicators can be conflicting.	There will be one agreed version of the truth. The dashboard will be live and include the relevant performance data from all partners to enable the West A&E Delivery Board to assure itself of the outputs from agreed actions	Develop and agree KPIs and associated dashboard which will provide assurance to the Health & Wellbeing Board of the achievement of CQC Action plan milestones	City Director SOTCC Director of Commissioning, CCG	March 2018	KPIs delivered as agreed		
		Implement a whole-system live urgent care dashboard and report through West Staffordshire A&E Delivery Board from December 2017.	Deputy Chief Operating Officer, UHNM	January 2018	West Staffordshire A&E Delivery Board		
		Utilise the Operational Group reporting to the AEDB to implement evidence based, system-wide plans to manage periods of surge including winter planning. This will	Director of Commissioning, CCG	Commencing December 2017	Agreed plans in place for managing periods of surge		

		include representation across the local health economy including the voluntary sector.					

Improvement Theme 5: **WORKFORCE**

Lead Organisation: Staffordshire and Stoke-on-Trent Partnership NHS Trust / Stoke-on-Trent Council

Explanation: The CQC identified a lack of any unified approach to workforce planning or recruitment and limited evidence of inter-organisational multi-disciplinary working. The aim is to create a system that can attract, train and retain the best quality workforce to deliver its shared strategy.

CQC Identified Issue(s)	Intended Outcome	Actions to Address			Assurance	Progress	RAG
		Action	Responsible	Timeline			
There is no evidence of a collaborative approach to workforce planning. System leaders do not work together to ensure that the workforce has the right skills to support people across services. There is no single strategic workforce plan. There are significant pressures on GP and Domiciliary Care recruitment. There are particular pressures on OT, Domiciliary Care,	The system will ensure the right skills in the right place at the right time to deliver on its shared strategy: • Immediate response to capacity issues for domiciliary services • Increased supply into domiciliary care workforce • Attraction and retention to existing roles, morphing in to a sustainable market that meets local demand	• Develop a strategic workforce plan which is aligned to the STP workforce work stream. The strategic system workforce plan will include:	CEO, SSOTP Acting Director – Strategy, Business & Redesign, SSOTP	May 2018	See below		

SALT and GP caseloads.	• A workforce plan that identifies immediate needs and future provision (new roles, skill set) and reflects GP sustainability and New Models of Care • A workforce fit for purpose with applicable skills and competencies	1. Domiciliary care - Implement the 'Workforce Taskforce Action Plan Focus Two: Improved entry level recruitment with a focus on domiciliary care action plan [Also refer to Domiciliary care workstream plan 6.5]	Assistant Director for Commissioning (SOT CC)	June 2018	Increase in ratio of employed domiciliary care workers versus care agency Reduction in turnover of domiciliary care workers (contributing to reduction in ASC turnover from 31% to 27.4%)		
		2. Primary Care – develop the role of Physician Associates in primary care [Also refer to Primary Care workstream plan 6.3]	Chair of the Alliance Board	June 2018	Increase in Physician Associates identified for SOT from 1 to 4		
		3. Multidisciplinary Local Care Hub Team – MDT teams are formed across primary care, social care and mental health- with focus on End of Life and Frailty	Chair of the Alliance Board	January 2018	Commenced phased implementation of multidisciplinary local care hubs		

Improvement Theme 6: **SERVICE IMPROVEMENT**

Explanation:

The CQC identified areas of under-performance in seven workstreams – Care and Nursing Homes, Discharge to Assess, Primary Care, Prevention, Domiciliary Care, Mental Health and End of Life. The aim is to create a system that is a beacon of high quality inter-organisational system delivery, and which builds on the areas of emerging or existing good practice identified by the Review Team:

- Good support at the front of A&E to help prevent avoidable admissions.
- Extra care housing scheme.
- A willing workforce that is keen to work collaboratively.
- A voluntary sector that is willing to engage and support the system.
- GPs delivering ward rounds in care homes.
- Video technology in care homes, linking GPs with residents.
- A Care Home Matron.

The Service Improvement principal issues and intended outcomes are shown in the table below. Delivery will be monitored and assured by the Health and Wellbeing Board.

Service Improvement Workstream Leads

1. Care and Nursing Homes - North Staffordshire GP Federation
2. Discharge to Assess - SSOTP
3. Primary Care - SOT CCG / North Staffordshire GP Federation
4. Prevention - SOTCC / Voluntary Sector
5. Domiciliary Care - SOTCC
6. Mental Health - NSCHT
7. End of Life - SOT CCG

Service Improvement Workstream 6.1: **CARE AND NURSING HOMES**

Lead Organisation: North Staffordshire GP Federation

Explanation: The CQC identified that the system has too many residential care homes, nursing care homes and social care homes are rated as Inadequate or Requires Improvement. The aim is to increase the quality of care provided, reduce the number of admissions from care and nursing homes to A&E and for more patients to die in their place of preference.

CQC Identified Issue(s)	Intended Outcome	Actions to Address				Progress	RAG
		Action	Responsible	Timeline	Assurance		
There are no dedicated primary care delivery models for care homes. Too many residential care homes, nursing care homes and social care homes are rated Inadequate or Requires Improvement.	Care and Nursing Homes' CQC ratings reflect higher quality care.	• Develop an integrated care home and nursing home quality improvement strategy including the review of contractual requirements of care homes e.g. admission criteria, trusted assessments	City Director, SOTCC and Accountable Officer, SOTCC	January 2018	• Increase in the number of homes moving from Inadequate/RI to good/outstanding • In the next round of CQC inspections no care home will be rated as inadequate.		
		• Pilot Care Excellence Framework through UHNM with the "Safe Harbour" group of care homes. If successful this will be rolled out to other care homes in North Staffordshire if commissioned.	Director of Nursing, Quality and Safety, UHNM	Commenced January 2018			

		• Develop training through the Care Home project	Head of Directorate, NSCHT / CCG	Commenced January 2018			
	There will be fewer patients admitted to A&E from the top 28 care homes	Commence Care Home Co-ordination Centre to support reduction in unplanned admissions. This will be a 7 day, 8am-8pm rapid primary care and MDT response.	Head of Directorate, NSCHT / CCG	December 2017	A reduction in unplanned attendances at A&E from the top 28 care homes by 50%.		
	Patients will die in dignity in their place of preference.	Support Care homes to ensure that all patients have appropriate ceilings of care and advanced decisions in place.	Director of Commissioning CCG Assistant Director-Commissioning Health and Social Care, SOTCC	January 2018	• Reduction in the number of patients admitted to Royal Stoke from a care home who then die in hospital • An increased % of patients in care homes with an advanced decision.		

Service Improvement Workstream 6.2: **DISCHARGE TO ASSESS**

Lead Organisation: Staffordshire and Stoke-on-Trent Partnership Trust

Explanation: The CQC identified that the system did not have a cross-sector D2A delivery plan nor that there were robust mitigation plans should D2A not deliver as anticipated. The aim is to create a system that enables people to follow robust pathways for safe and effective discharge.

CQC Identified Issue(s)	Intended Outcome	Actions to Address				Progress	RAG
		Action	Responsible	Timeline	Assurance		
There is no evidence of a cross-sector D2A delivery plan or that there are robust mitigation plans should D2A not deliver as anticipated. The total delayed days per 100,000 18+ population averaged 32 compared to England average of 14, and 11 in similar areas. CHC referral conversion rate and assessment conversion rates were much lower that	A robust pathway that informs and supports patients throughout their acute journey and enables a prompt, safe and effective discharge from acute services to their community setting	Embed high impact change action plan which includes: • Patient Choice Strategy • Continuing Healthcare and complex assessments completed outside hospital • Embed track & triage within acute hospital, • Roll out D2A/Home First model • Trusted Assessor	CEO, SSOTP	January 2018	Patient choice delays are equal to or less than the national average (from 7.3 delayed days per 100,000 population to the England average of 1.5 delayed days per day). DTOCs are reduced from 964.2 (baseline) to 571.4 (per 100,000 population) Health care funding assessments will be streamlined and the time of completion will be reduced from 3.3 delayed days (per 100,000 population)		

England and North Midlands regional averages. Patient choice delays accounted for on average 7.3 delayed per 100,000 population compared to 1.5 delayed days across England Systems for discharging people from hospital did not always protect people from harm. Discharge summaries were not always available at the time of discharge for both social care providers & community pharmacies. There were delays in medication reviews post discharge. Social workers were not routinely involved					towards 2.5 Admission to residential and nursing care homes reduces to 670 per 100,000 population		
	People are supported and enabled to have a safe and effective discharge to their community setting, and ensures that they receive the right care in the right place at the right time.	Implement High Impact Change action plan – patient profile form	All organisational leads	January 2018	There is an increase in the number of patients that are discharged to their planned destination.		
		Implement short term mitigation for IT interface/methodology for sharing discharge summaries (and reflective of in hours/out of hours operational services)	Information sharing & data work stream	May 2018	100% discharge summaries will be completed prior to discharge and be available in the integrated record.		
		Introduce Pharmacy technician in Track & Triage Team	Clinical Director Pharmacy Services, SSOTP	March 2018	D2A patients have MARS form in care file. Care files include authorisation to administer forms. Technician has already commenced in post however will be available 7 days a week from March		

in MDT care planning, particularly re D2A.					2018.		
		Strengthen MDT approach via D2A with a lead coordinator of care & interventions.	CEO, SSOTP	February 2018	The percentage of people who receive reablement services and are still at home after 91 days post discharge is equal to or higher than the national average of 82.7% (currently 74.5%).		

Service Improvement Workstream 6.3: **PRIMARY CARE**

Lead Organisation: Stoke-on-Trent CCG / North Staffordshire GP Federation

Explanation: The CQC identified that the system lacked effective clinical engagement with primary medical services with people experiencing difficulties accessing services both in and out of hours. The aim is to create a system focused on the sustainability of primary care, which is integrated with wider health and care services.

CQC Identified Issue(s)	Intended Outcome	Actions to Address				Progress	RAG
		Action	Responsible	Timeline	Assurance		
There is no effective clinical engagement with primary medical services (PMS), which has resulted in a lack of confidence from GPs in the CCG. There is a shortage of GPs with GPs managing large caseloads. Local people experience difficulty in gaining a GP appointment in a timely way.	The system is focused on the sustainability of primary care, which is integrated with the wider health and care system.	Ensure the Alliance Board acts as the coherent forum for integrated working led by Primary Care.	Accountable Officer, Stoke-on-Trent CCG	March 2018	Primary Care trust and confidence in the CCG increases as measured by LMC members.		
		Ensure that Vocare, the provider of out of hours GP services, meets the requirements of the service specification.	Accountable Officer, Stoke-on-Trent CCG	March 2018	The service provided is in accordance with the service specification and KPIs resulting in patients having timely access to high quality primary care services out of hours		

		Improve access to primary care services in hours, building on the successes of the Meir and Hanley Primary Care Access Hubs and review of the additional in-hour capacity that has been commissioned	Accountable Officer, Stoke-on-Trent CCG Director of Commissioning, CCG	March 2018	Patients have timely access to high quality primary care services in hours. Performance information demonstrates increase in timely access to services. New approach to care homes piloted through North Staffordshire GP Federation. Additional capacity is delivered as commissioned.		

Service Improvement Workstream 6.4: **PREVENTION**

Lead Organisation: Stoke-on-Trent City Council / Voluntary Sector

Explanation: The CQC identified that the local population encountered barriers to maintaining their health and wellbeing through inconsistent access to services. The aim is to create a system that empowers individuals to take responsibility to look after themselves and to live independently for longer.

CQC Identified Issue(s)	Intended Outcome	Actions to Address				Progress	RAG
		Action	Responsible	Timeline	Assurance		
There is little evidence of pathways across primary, community and secondary care that support the wider objectives of health maintenance. People living in Stoke-on-Trent encounter barriers to maintaining their	• A system that empowers individuals to look after themselves and to live independently for longer. • People will take responsibility for their own health but will be supported by the highest quality	Redesign adult social care structure based on a strengths based model that aligns to the system wide development of MCPS including the local voluntary sector offer	Assistant Director-Commissioning Health and Social Care, SOTCC Strategic Liaison Officer – Health, VAST	February 2018	New staffing structure implemented Vision for Adult Social Care developed with partners		

health and wellbeing through inconsistent access to services. The system is the 10th highest (women) and 17th highest (men) nationally for emergency admissions due to falls	services when needed. • Improved integration of pathways, assessments and processes • Integrated health and social care strategies for maximising opportunities within the voluntary and community sector • Reduction in falls related harm	Develop an integrated approach to social prescribing on a North Staffordshire footprint to ensure that a sustainable model is developed which is community based and owned.	Director of Primary Care, CCG	Septemb er 2018	Working group established Approach agreed and implemented Social prescribing is in place		
		Redesign falls pathways to focus on prevention: • procure on a Prime Provider model basis • design a universal assessment tool • incorporate falls assessment within other services provision to make every contact count (e.g. GP reviews etc)	Director of Commissionin g, CCG Assistant Director-Commissionin g Health and Social Care, SOTCC	April 2018	Written pathways in place and understood by professionals There is an improved national position for the number of emergency hospital admissions due to falls. Falls related injuries are reduced by 5% in 2017/18		

Service Improvement Workstream 6.5: **DOMICILIARY CARE**

Lead Organisation: Stoke-on-Trent City Council

Explanation: The CQC identified that the domiciliary care market was fragile and there was no clear plan of how to manage operational pressures. The aim is to create a system that has high quality domiciliary care services where people who would benefit from a domiciliary care package have timely access to one.

CQC Identified Issue(s)	Intended Outcome	Actions to Address				Progress	RAG
		Action	Responsible	Timeline	Assurance		
The domiciliary care market is fragile and there is no clear plan of how to manage operational pressures	• Domiciliary Care CQC ratings reflect high quality care. • People receive high quality care from experienced and skilled staff • All people who would benefit from a domiciliary care package have timely access to it. • Model promotes improved income viability for providers which in turn will improve care worker	Develop joint CCG / LA Market Position Statement for care market including the voluntary sector	Assistant Director-Commissioning Health and Social Care, SOTCC Director of Commissioning CCG Strategic Liaison Officer – Health, VAST	April 2018	Published Market Position Statement		

	recruitment and retention • Financial penalties for failure to deliver against key performance targets and contract requirements • Will support smaller businesses to develop and provide more frequent opportunity for businesses to enter into a contract with the council • Service specification focuses upon wellbeing and person centred care, and is compliant with the Care Act • There is an integrated commissioning approach to domiciliary care	Undertake strategic review of direct payment policy and practice to inform service redesign/ commissioning intentions and explore opportunities for integrated personal health budget and direct payment support offer	Assistant Director-Commissioning Health and Social Care, SOTCC Director of Commissioning CCG	April 2018	Strategic review report completed and recommendations identified and considered		
		Implement new domiciliary care model from July 2018 to incentivise optimum outcomes and makes best use of the resources we have available.	Assistant Director-Commissioning Health and Social Care, SOTCC Strategic Liaison Officer – Health, VAST	Commencing July 2018 March 2019	New contracts commenced and services mobilised 'Awaiting care package in own home' delays are equal to or less than the England national average (from 9.3 delayed days per 100,000 population to the England average of 3.1 days). Improved market stability by purchasing guaranteed hours		

					(70% of current demand) Fast track palliative care KPIs are agreed and achieved		

Service Improvement Workstream 6.6: **MENTAL HEALTH**

Lead Organisation: North Staffordshire Combined Healthcare NHS Trust

Explanation: The CQC identified that acute and community inpatient settings did not always take into account the mental health needs of patients. The aim is to create a system where mental health needs are considered equally to physical health needs.

CQC Identified Issue(s)	Intended Outcome	Actions to Address				Progress	RAG
		Action	Responsible	Timeline	Assurance		
People's mental health needs, when in an acute / community inpatient setting, are not always met. Access to effective Liaison Psychiatry 24/7 Education programme to increase knowledge and skill of acute staff in supporting patients with mental health needs. Reflection of mental health resource requirements to	• Timely access to mental health assessments and signposting to services • Specialist advice and guidance available at all times of day and night. • Parity of esteem for Mental Health in the Acute Trust • Holistic completion of assessment documentation • Adequate specialist resource to support patient pathways	• RAID to operate 24/7 from 1/12/17	Head of Directorate, NSCHT	December 2017	Service accessible 24/7 95% or above compliance with the one hour response target in A&E		
		• Education programme underway through RAID across the acute trust.	Head of Directorate, NSCHT	Ongoing	Improved quality of assessment documentation and patient profile forms demonstrated through audit and peer review Improved staff awareness of dementia and improved patient experience on acute older		

support discharge to assess services					peoples wards		
		• Strengthen mental health skills in D2A resources with the CCG	Head of Directorate, NSCHT / CCG	January 2018	Skill mix of D2A resource will reflect mental health demands		

Service Improvement Workstream 6.7: **END OF LIFE**

Lead Organisation: Stoke-On-Trent CCG

Explanation: The CQC identified that the provision of end of life care could be improved across the system.

CQC Identified Issue(s)	Intended Outcome	Actions to Address				Progress	RAG
		Action	Responsible	Timeline	Assurance		
Concerns were expressed about the timeliness of discharges for people who were on end-of-life care pathways. Older people in Stoke-on-Trent have suffered a poor experience of care - because the local health and social care services have not been working together effectively.	• Reduction in the number of frail and older residents who could receive care within their own home attending A&E • Improvement in the development of advanced care planning • Holistic approach to the last 12 months of life linking with Staffordshire EOL strategy	All key stakeholders will work collaboratively to develop and deliver an end of life pathway including a focus on: • Training and skills development for staff in collaboration with hospices • Provision of support for people to experience a dignified death • Community support to enable people	Director of Nursing and Quality Medical Director, CCG	March 2018	Group convened and terms of reference agreed and in place Pathway implemented and KPIs / milestones for implementation and intended outcomes are monitored and achieved in the agreed timeframes		

		to die at home					

NHS
North Staffordshire
Combined Healthcare
NHS Trust

REPORT TO Trust Board

Enclosure No:12

Date of Meeting:	25/01/2018		
Title of Report:	Finance Position Month 8		
Presented by:	Mike Newton - Deputy Director of Finance		
Author:	Lisa Dodds - Assistant Director of Finance		
Executive Lead Name:	Suzanne Robinson - Executive Director of Finance, Performance and Digital	Approved by Exec	☒

Executive Summary:	Purpose of report	
The report summarises the finance position at month 8 (November 2017)	Approval	☒
	Information	☐
	Discussion	☒
	Assurance	☐

Seen at:	SLT ☐ Execs x Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee X • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently. X 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	None applicable		
Resource Implications: Funding Source:	None directly from the report None applicable		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	There is no direct impact on the protected characteristics as part of the completion of this report.		
Recommendations:	The Trust Board is asked to: Note: The reported YTD surplus of £724k against a planned surplus of £563k. This is a favourable variance to plan of £161k.		

	The M8 CIP achievement: • YTD achievement of £1,021k (58%); an adverse variance of £744k; • 2017/18 forecast CIP delivery of £2,646k (83%) based on schemes identified so far; an adverse variance of £551k to plan; • The recurrent forecast delivery at month 8 of £2,804k representing a recurrent variance to plan of £393k. The cash position of the Trust as at 30th November 2017 with a balance of £5,824k; £639k better than plan Agency forecast is currently £372k above ceiling (£2,068k) Year to date Capital receipts for 2017/18 is £471k compared to a net planned capital expenditure of £1,317k; • The original operating plan submitted to NHSI in December 2016 planned net capital expenditure of £2,201k by Month 8. Use of resource rating of 2 against a plan of 2.

NHS
North Staffordshire Combined Healthcare NHS Trust

Financial Overview as at 30th November 2017

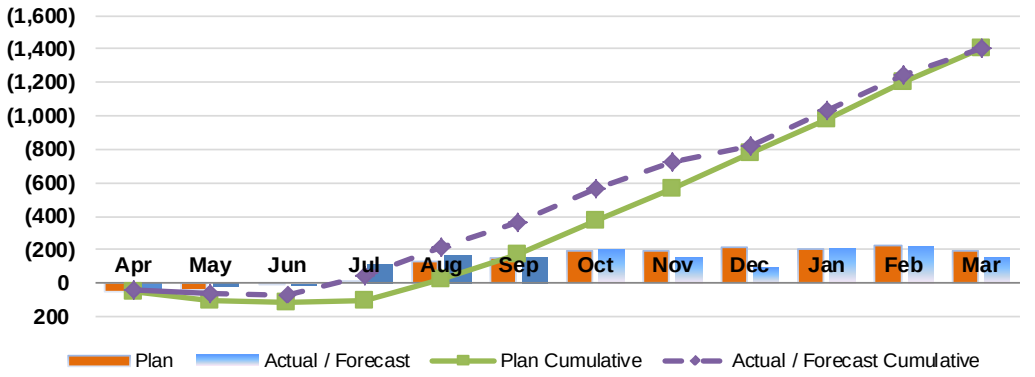
Income & Expenditure - Control Total (Surplus) / Deficit

£000	Plan	Actual	Var	%	RAG
YTD	(563)	(724)	(161)	(29)	G
FOT	(1,400)	(1,400)	(0)	0	G

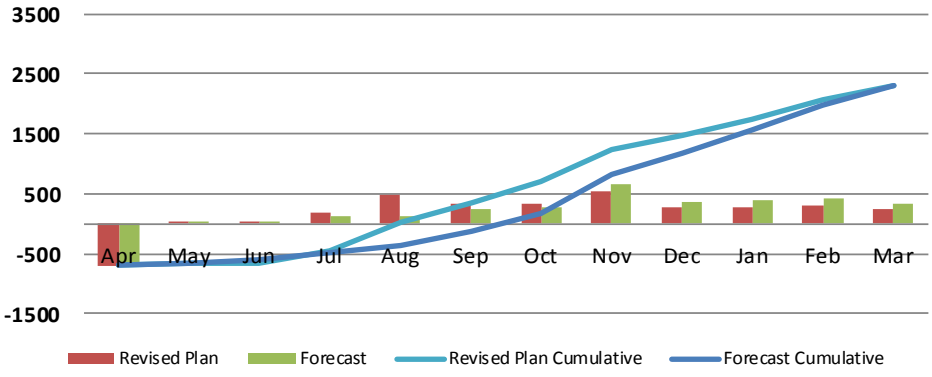
Charge to CRL

£000	Plan	Actual	Var	%	RAG
YTD	2,201	471	(1,730)	21	G
FOT	2,979	3,130	151	105	G

Retained (Surplus) / Deficit Run Rate 2017/18



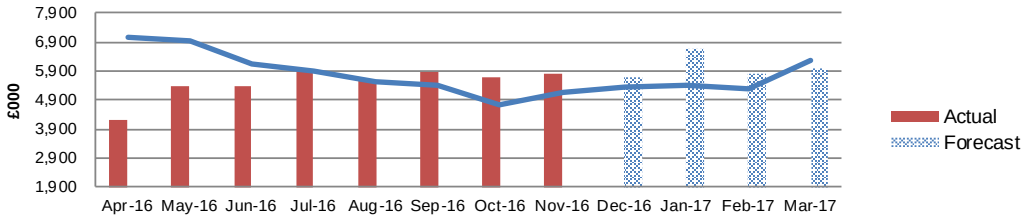
Net Capital Expenditure - Plan / Forecast 2017/18



Cash Balances

£000	Plan	Actual	Var	%	RAG
YTD	5,185	5,824	639	11	G

Cash Balances - Actual/Forecast against Plan 2017/18



Cost Improvement

£000	Plan	Actual	Var	%	Rec Var	RAG
Clinical	1,406	907	(499)	(35)	(628)	R
Corporate	359	114	(245)	(68)	235	G
Total	1,765	1,021	(744)	(42)	(393)	R

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

1. Introduction:

The Trust's 2017/18 financial plan is to deliver a trading position of £0.9m surplus. The Trust has accepted the Control Total from NHS Improvement (NHSI) of £1.4m surplus which includes £0.5m from the Sustainability & Transformation Fund.

2. Income & Expenditure (I&E) Performance

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

- During month 8, the trust had an in month trading position of £105k surplus against a plan of £144k surplus; **showing a £39k deficit**. Sustainability and Transformation funding has been assumed at £50k for month 8, bringing the overall trust control to a £155k surplus against plan of £194k; **showing £39k deficit to plan**.

- The trust has a year to date trading position of £449k surplus against a plan of £288k surplus; **a favourable variance to plan of £161k**. After Sustainability and transformation funding (£275k), the trust has a Control Total surplus of £724k against a planned surplus of £563k; **a favourable variance to plan of £161k**.

- To reduce overall reliance on Agency and improve resilience post EPR implementation, the trust has utilised substantive staff to support the implementation of the ROSE programme where possible. There is a benefit to the financial position of £180k YTD through not backfilling these posts during implementation. This non-recurrent benefit accounts for the majority of the YTD surplus.

		Month 8			Year-to-Date			Forecast		
Table 1: Summary Performance	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
Income	(82,753)	(6,844)	(6,841)	2	(55,190)	(54,998)	192	(82,431)	(82,108)	323
Pay	62,126	5,169	5,238	68	41,890	40,059	(1,831)	62,267	60,186	(2,080)
Non Pay	17,063	1,314	1,283	(31)	11,214	12,683	1,469	16,601	18,314	1,714
EBITDA	**(3,563)**	**(360)**	**(321)**	**40**	**(2,086)**	**(2,257)**	**(171)**	**(3,564)**	**(3,607)**	**(44)**
Other Non-Op Costs	2,664	216	216	(1)	1,798	1,808	10	2,664	2,707	44
Trading Surplus	**(900)**	**(144)**	**(105)**	**39**	**(288)**	**(449)**	**(161)**	**(900)**	**(900)**	**(0)**
Sustainability & Transformational Funding	(500)	(50)	(50)	0	(275)	(275)	0	(500)	(500)	0
Control Total	**(1,400)**	**(194)**	**(155)**	**39**	**(563)**	**(724)**	**(161)**	**(1,400)**	**(1,400)**	**(0)**

3. Income

Table 2 below shows the trust income position by contract:

- The NHS Stoke-on-Trent CCG and NHS North Staffordshire CCG contracts are set on a block basis. The Trust is showing an under performance of £42k year to date on Stoke-on-Trent CCG's, relating partly to invoice disputes for 2016/17;
- £80k under recovery on Out of Area Treatments (OATs) mainly due to the underperformance of the sale of substance misuse beds;
- Stoke on Trent Public Health is under performing by £33k. Following the reduction in referrals from community service provided by Lifeline to Substance Misuse Inpatients in the first part of this year, activity in alcohol has picked up but drugs and titration are still below target.
- STF is earned quarterly for trusts operating within its agreed control. The total for 2017/18 is £500k and is phased 15% for Q1, 20% for Q2, 30% for Q3 and for 35% Q4. **£275k is reflected at month 8**.

		Month 8			Year-to-Date			Forecast		
Table 2: Income	**Annual Budget £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**	**Budget £'000**	**Actual £'000**	**Variance £'000**
NHS Stoke-on-Trent CCG	(35,837)	(2,959)	(2,959)	0	(23,725)	(23,683)	42	(35,718)	(35,676)	42
NHS North Staffordshire CCG	(24,480)	(2,024)	(2,024)	0	(16,153)	(16,153)	(0)	(24,419)	(24,419)	(0)
Specialised Services	(3,077)	(259)	(280)	(21)	(2,043)	(2,094)	(51)	(3,077)	(3,128)	(51)
Stoke-on-Trent CC s75	(3,947)	(329)	(329)	(0)	(2,632)	(2,632)	(0)	(3,947)	(3,947)	(0)
Staffordshire CC s75	(1,056)	(88)	(88)	0	(704)	(704)	0	(880)	(880)	0
Stoke-on-Trent Public Health	(1,392)	(134)	(130)	4	(858)	(825)	33	(1,392)	(1,334)	58
Staffordshire Public Health	(613)	(51)	(51)	0	(409)	(409)	0	(613)	(613)	0
ADS/One Recovery	(1,497)	(125)	(125)	0	(998)	(998)	0	(1,497)	(1,497)	0
Associates	(756)	(63)	(47)	16	(504)	(423)	80	(756)	(644)	112
OATS	(760)	(63)	(76)	(12)	(507)	(427)	80	(760)	(635)	125
Total Clinical Income	**(73,415)**	**(6,094)**	**(6,108)**	**(13)**	**(48,531)**	**(48,348)**	**183**	**(73,059)**	**(72,774)**	**285**
Other Income	(9,338)	(749)	(734)	16	(6,659)	(6,651)	8	(9,372)	(9,334)	37
Total Income	**(82,753)**	**(6,844)**	**(6,841)**	**2**	**(55,190)**	**(54,998)**	**192**	**(82,431)**	**(82,108)**	**323**
Sustainability Transformation Funding	(500)	(50)	(50)	0	(275)	(275)	0	(500)	(500)	0
Total Income Incl. STF	**(83,253)**	**(6,894)**	**(6,891)**	**2**	**(55,465)**	**(55,273)**	**192**	**(82,931)**	**(82,608)**	**323**

4. Expenditure

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

Table 3: Expenditure	Annual Budget £'000	Month 8 Budget £'000	Month 8 Actual £'000	Month 8 Variance £'000	Year-to-Date Budget £'000	Year-to-Date Actual £'000	Year-to-Date Variance £'000	Forecast Budget £'000	Forecast Actual £'000	Forecast Variance £'000
Medical	7,519	626	497	(129)	5,032	4,360	(672)	7,519	6,625	(894)
Nursing	28,006	2,319	2,404	85	18,802	18,322	(480)	28,128	27,289	(838)
Other Clinical	14,771	1,235	1,214	(21)	9,833	8,637	(1,196)	14,630	13,178	(1,451)
Non-Clinical	10,926	942	945	3	7,345	6,751	(594)	10,916	10,359	(557)
Non-NHS	903	47	178	131	878	1,989	1,111	1,075	2,440	1,365
Total Pay	**62,126**	**5,169**	**5,238**	**68**	**41,890**	**40,059**	**(1,831)**	**62,267**	**59,891**	**(2,376)**
Drugs & Clinical Supplies	2,374	195	179	(16)	1,576	1,482	(93)	2,374	2,279	(95)
Establishment Costs	1,682	118	136	18	1,121	999	(122)	1,664	1,555	(109)
Information Technology	562	49	74	25	391	609	218	562	756	194
Premises Costs	2,099	177	205	28	1,403	1,421	18	2,099	2,286	188
Private Finance Initiative	4,087	341	354	13	2,725	2,832	108	4,087	4,244	157
Services Received	3,338	281	297	16	2,235	2,232	(3)	3,338	3,402	64
Residential Payments	1,708	142	83	(59)	1,139	1,281	142	1,708	2,270	561
Consultancy & Prof Fees	465	73	57	(16)	354	511	157	473	654	181
Unacheived CIP	(1,520)	(158)	0	158	(743)	0	743	(552)	0	552
Other	2,269	96	(103)	(199)	1,014	1,316	302	847	1,164	317
Total Non-Pay	**17,063**	**1,314**	**1,283**	**(31)**	**11,214**	**12,683**	**1,469**	**16,601**	**18,610**	**2,009**
Finance Costs	1,293	108	108	0	862	862	0	1,293	1,293	0
Local Government Pension Scheme	0	0	0	0	0	0	0	0	0	0
Unwinding of Discounts	0	0	0	0	0	0	0	0	0	0
Dividends Payable on PDC	561	47	47	0	374	384	10	561	580	19
Investment Revenue	(14)	(1)	(1)	0	(9)	(6)	3	(14)	(10)	4
Fixed Asset Impairment	0	0	0	0	0	0	0	0	0	0
Depreciation (excludes IFRIC 12)	824	63	62	(1)	572	569	(2)	824	844	21
Total Non-op. Costs	**2,664**	**216**	**216**	**(1)**	**1,798**	**1,808**	**10**	**2,664**	**2,707**	**44**
Total Expenditure	**81,853**	**6,700**	**6,736**	**37**	**54,902**	**54,550**	**(352)**	**81,531**	**81,208**	**(323)**

4. Directorate Summary

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

Table 4: YTD Expenditure	Pay			Non Pay			Income			Total		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
AMH Community	11,679	10,613	(1,066)	2,865	3,096	231	(1,470)	(1,486)	(16)	13,073	12,223	(850)
AMH Inpatients	4,306	4,366	60	74	254	180	(96)	(99)	(3)	4,284	4,521	238
Children's Services	4,217	3,814	(403)	427	506	79	(429)	(394)	35	4,215	3,926	(289)
Substance Misuse	1,886	1,816	(70)	628	556	(72)	(314)	(243)	71	2,199	2,128	(71)
Learning Disabilities	3,570	3,259	(311)	222	203	(20)	(37)	(35)	2	3,755	3,427	(328)
Neuro & Old Age Psychiatry	7,348	7,226	(121)	524	425	(99)	(646)	(689)	(43)	7,226	6,962	(264)
Corporate	8,885	8,964	79	8,273	9,452	1,179	(52,473)	(52,327)	145	(35,315)	(33,911)	1,404
Total	**41,890**	**40,059**	**(1,831)**	**13,012**	**14,491**	**1,479**	**(55,465)**	**(55,273)**	**192**	**(563)**	**(724)**	**(161)**

5. Cost Improvement Programme

The trust target for the year is £3.2m, as reported to NHSI. This takes into account the requirement to deliver a £1.4m control surplus for 2017/18. The table below shows the achievement by Directorate towards individual targets at M8. The Trust wide CIP achievement is 58% at M8 compared to plan.

		YTD M8			Forecast					
CIP Delivery	Annual CIP Target 2017/18	Plan	Transacted	(Under)/Over Achievement	Plan	Total Schemes	(Under)/Over Achievement	RAG	Recurrent Transacted	Recurrent Forecast
	£'000	£'000	£'000	£'000	£'000	£'000	£'000		£'000	£'000
Clinical										
AMH Community	1,084	598	284	(314)	1,084	875	(209)	81%	422	812
AMH Inpatients	379	209	8	(201)	379	31	(348)	8%	24	44
Children's Services	333	184	184	(0)	333	292	(41)	88%	332	332
Learning Disabilities	256	141	153	12	256	258	2	101%	260	260
NOAP	495	273	277	4	495	495	0	100%	470	470
Total Clinical	**2,547**	**1,406**	**907**	**(499)**	**2,547**	**1,952**	**(595)**	**77%**	**1,509**	**1,919**
Corporate										
CEO	26	14	5	(9)	26	13	(13)	51%	8	23
Finance, Performance & Digital	61	34	45	11	61	69	8	112%	71	71
MACE	62	34	13	(21)	62	20	(42)	33%	22	22
Operations	29	16	22	6	29	34	5	116%	35	35
Quality & Nursing	13	7	8	1	13	14	1	107%	14	14
Strategy (Core)	10	6	10	5	10	17	7	168%	20	20
Trustwide	388	214	0	(214)	388	467	79	120%	1	638
Workforce & OD	61	34	10	(23)	61	61	0	100%	21	62
Total Corporate	**650**	**359**	**114**	**(245)**	**650**	**694**	**44**	107%	**192**	**885**
Total	**3,197**	**1,765**	**1,021**	**(744)**	**3,197**	**2,646**	**(551)**	**83%**	**1,701**	**2,804**

Below 75%	
Below 90%	

Target	**3,197**
Variance	**(393)**

- The 2017/18 year to date CIP achieved stands at £1,021k against a plan of £1,765 (58%)
- The **recurrent value** of schemes transacted is **£1,701k** against £3.2m target. The **recurrent forecast** as at M8 is £2.804m (88%); this represents a recurrent shortfall against the target of **£393k** (12%).

6. Statement of Financial Position

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

Table 6: SOFP	31/03/2017 £'000	30/09/2017 £'000	31/10/2017 £'000	30/11/2017 £'000
Non-Current Assets				
Property, Plant and Equipment	28,037	28,156	28,395	28,621
Intangible Assets	222	252	228	252
NCA Trade and Other Receivables	1,426	1,426	1,426	1,426
Other Financial Assets	897	897	897	897
Total Non-Current Assets	**30,581**	**30,732**	**30,946**	**31,195**
Current Assets				
Inventories	88	88	84	81
Trade and Other Receivables	5,146	5,952	5,928	6,925
Cash and Cash Equivalents	6,964	6,602	6,407	5,825
Non-Current Assets Held For Sale	0	0	0	0
Total Current Assets	**12,198**	**12,641**	**12,419**	**12,832**
Total Assets	**42,780**	**43,373**	**43,365**	**44,027**
Current Liabilities				
Trade and Other Payables	(7,472)	(7,999)	(7,831)	(8,387)
Provisions	(333)	(259)	(256)	(245)
Borrowings	(457)	(633)	(633)	(633)
Total Current Liabilities	**(8,262)**	**(8,891)**	**(8,720)**	**(9,265)**
Net Current Assets / (Liabilities)	**3,937**	**3,750**	**3,699**	**3,567**
Total Assets less Current Liabilities	**34,518**	**34,482**	**34,645**	**34,762**
Non Current Liabilities				
Provisions	(474)	(474)	(474)	(474)
Borrowings	(12,189)	(11,785)	(11,746)	(11,708)
Total Non-Current Liabilities	**(12,663)**	**(12,259)**	**(12,220)**	**(12,182)**
Total Assets Employed	**21,855**	**22,223**	**22,425**	**22,580**
Financed by Taxpayers' Equity				
Public Dividend Capital	7,648	7,648	7,648	7,648
Retained Earnings reserve	3,987	4,354	4,556	4,711
Revaluation Reserve	9,323	9,323	9,323	9,323
Other Reserves	897	897	897	897
Total Taxpayers' Equity	**21,855**	**22,223**	**22,425**	**22,580**

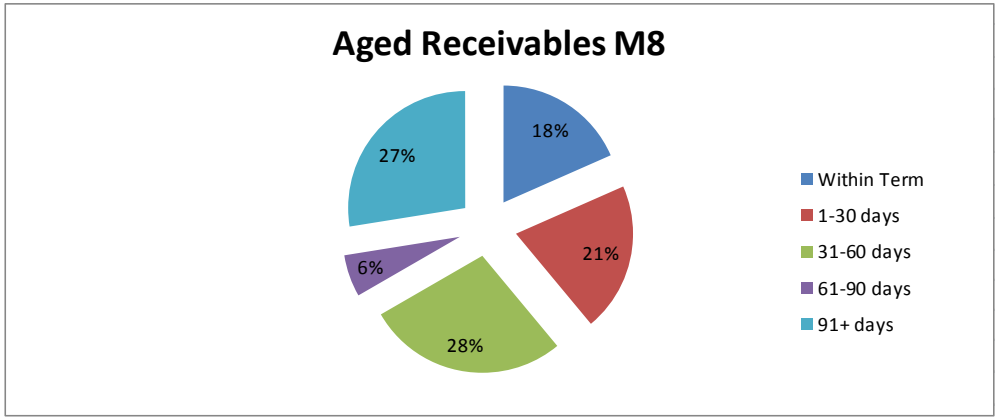
Current receivables are £6,925k, of which:

- £3,751k is based on accruals (not yet invoiced) and relates to income accruals for services invoiced retrospectively at the end of every quarter.
- £3,174k in awaiting payment on invoice. (£584k within terms)

£1,937k is overdue by 31 Days or more and therefore subject to routine credit control processes;

- £3k has been escalated to management /solicitors;
- £1,934k has not been formally disputed and full payment is anticipated.

		Days Overdue				
Table 6.1 Aged Receivables/Payables	Within Term £'000	1-30 Days £'000	31-60 Days £'000	61-90 Days £'000	91+ Days £'000	Total £'000
Receivables Non NHS	238	466	470	77	406	1,657
Receivables NHS	346	187	409	107	468	1,517
Payables Non NHS	826	92	31	5	32	986
Payables NHS	567	109	54	40	154	924

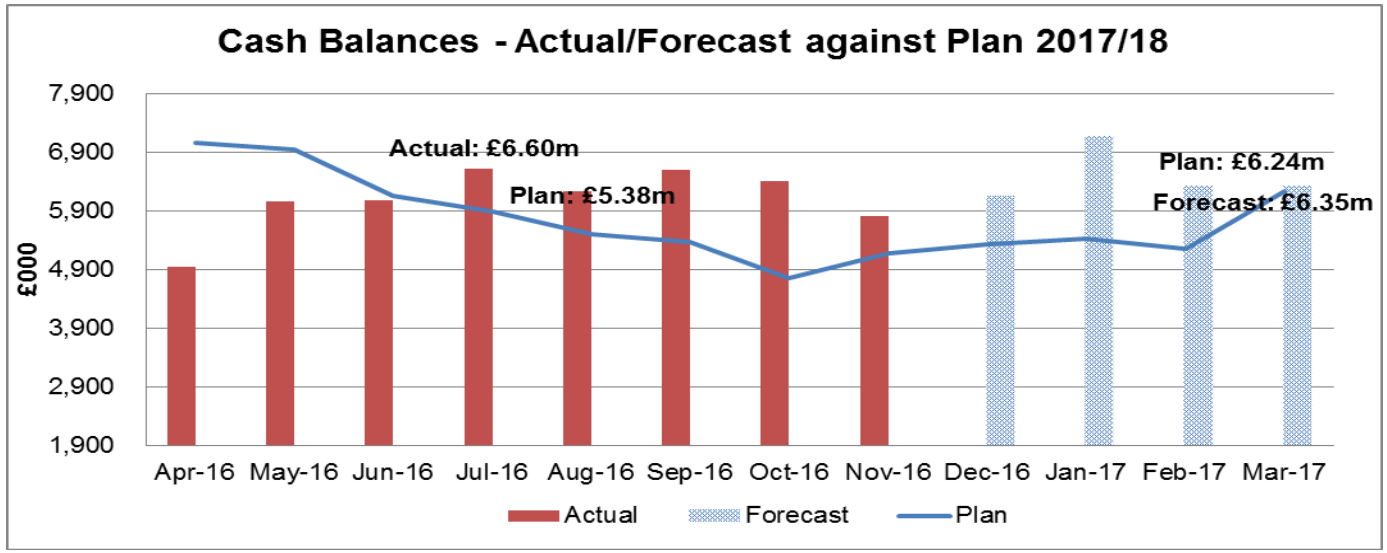


7. Cash Flow Statement

The cash balance at 30th November 2017 has decreased to **£5.824m** due to an increase in the value of receivables; the Trust cash position at 30th November 2017 is **£639k higher than planned** due to slippage in capital expenditure**.** The Trust anticipates to be slightly better than plan by March 2018.

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

Table 7: Statement of Cash Flows	Apr-16 £'000	May-16 £'000	Jun-16 £'000	Jul-16 £'000	Aug-16 £'000	Sep-16 £'000	Oct-16 £'000	Nov-16 £'000
Net Inflows/(Outflow) from Operating Activities	(2,674)	1,184	116	702	(221)	635	121	(234)
Net Inflows/(Outflow) from Investing Activities	692	(31)	(45)	(120)	(134)	(237)	(279)	(311)
Net Inflows/(Outflow) from Financing Activities	(38)	(38)	(38)	(38)	(38)	(38)	(38)	(38)
Net Increase/(Decrease)	**(2,019)**	**1,115**	**32**	**544**	**(393)**	**360**	**(196)**	**(583)**
Opening Cash & Cash Equivalents	**6,964**	**4,945**	**6,059**	**6,092**	**6,636**	**6,243**	**6,603**	**6,407**
Closing Cash & Cash Equivalents	**4,945**	**6,059**	**6,092**	**6,636**	**6,243**	**6,603**	**6,407**	**5,824**
Plan	7,064	6,964	6,164	5,889	5,517	5,381	4,756	5,185
Variance	**2,119**	**905**	**72**	**(747)**	**(726)**	**(1,222)**	**(1,651)**	**(639)**



8. Capital Expenditure

The Trust's permitted capital expenditure agreed within the 2017/18 plan is £2.979m. Table 8 below shows the planned capital expenditure for 2017/18 as submitted to NHSI.

		Year to Date @ M8			Forecast		
Table 8: Capital Expenditure	**Original Plan £'000**	**Plan £'000**	**Actual £'000**	**Variance £'000**	**Affordability Plan £'000**	**Actual £'000**	**Variance £'000**
A&T Refurbishment	400	0	0	0	0	0	0
Hazelhurst Unit Development	325	0	0	0	0	0	0
Substance Misuse Additional Beds	125	0	0	0	0	0	0
Place of Safety	0	0	9	9	100	100	0
Temporary Place of Safety	0	83	6	(77)	94	113	19
Psychiatric Intensive Care Unit	2,120	1,483	980	(503)	2,153	2,037	(116)
E-rostering	102	82	88	6	102	121	19
Information Technology	50	235	7	(228)	235	238	3
Environmental Improvements (backlog)	120	40	47	7	120	120	0
Reduced Ligature Risks	300	7	7	(0)	200	200	0
Equipment	50	0	0	0	0	0	0
Darwin	0	0	52	52	26	84	58
Ward 4	0	30	0	(30)	30	30	0
Lymebrook MHRC	0	43	2	(41)	43	43	0
NOAP Airlock	0	27	0	(27)	27	27	0
VAT Recovery on 2016/17 Schemes	0	0	(1)	(1)	0	(7)	(7)
Ward 4 Furniture	0	0	4	4	0	4	4
Dementia Pods	0	0	0	0	0	20	20
Bit Jam	0	0	(19)	(19)	0	0	0
Contingency	100	0		0	0	0	0
Total Gross Capital Expenditure	**3,692**	**2,030**	**1,183**	**(847)**	**3,130**	**3,130**	**0**
Bucknall Hospital (Part)	(713)	(713)	(713)	0	(818)	(818)	0
Total Capital Receipts	**(713)**	**(713)**	**(713)**	**0**	**(818)**	**(818)**	**0**
Total Charge Against CRL	**2,979**	**1,317**	**470**	**(847)**	**2,312**	**2,312**	**0**

- The **Operating Plan** as reported to NHSI forecast there would be a total charge against the CRL of £2,201k by month 8, including (£713k) Capital Receipts for the sale of Bucknall Hospital and £2,914k Capital Expenditure.
- **Actual Capital Expenditure** as at month 8 is £1,183k against an updated Capital Expenditure plan of £2,030k

9. Use of Resource Metrics

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

Table 9: Use of Resource	Year to Date Plan	Year to Date Actual	RAG Rating
Liquidity Ratio (days)			
Working Capital Balance (£000)		3,485	
Annual Operating Expenses (£000)		52,742	
Liquidity Ratio days		16	
Liquidity Ratio Metric	**1**	**1**	
Capital Servicing Capacity (times)			
Revenue Available for Debt Service (£000)		2,539	
Annual Debt Service (£000)		1,550	
Capital Servicing Capacity (times)		2	
Capital Servicing Capacity Metric	**3**	**3**	
I&E Margin			
Normalised Surplus/(Deficit) (£000)		724	
Total Income (£000)		55,275	
I&E Margin		1.3%	
I&E Margin Rating	**2**	**1**	
I&E Margin Variance from Plan			
I&E Margin Variance		0.26	
I&E Margin Variance From Plan	**1**	**1**	
Agency Spend			
Providers Cap (£000)		1,589	
Agency Spend (£000)		1,988	
Agency %		25	
Agency Spend Metric	**1**	**3**	
Use of Resource	**2**	**2**	

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

10. Better Payment Practice Code

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

At month 8, the Trust has under-performed against this target for the number of invoices, having paid 87% of the total number of invoices, and paid 94% based on the value of invoices

Table 10 below shows the Trust's BPPC performance split between NHS and non-NHS suppliers.

	2016/17			2017/18 Month 8			2017/18 YTD		
Table 10: Better Payment Practice Code	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**
Number of Invoices									
Total Paid	508	13,183	13,691	39	1,020	1,059	415	7,089	7,504
Total Paid within Target	459	11,610	12,069	34	937	971	347	6,178	6,525
% Number of Invoices Paid	90%	88%	88%	87%	92%	92%	84%	87%	87%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-4.6%**	**-6.9%**	**-6.8%**	**-7.8%**	**-3.1%**	**-3.3%**	**-11.4%**	**-7.9%**	**-8.0%**
Value of Invoices									
Total Value Paid (£000s)	6,860	29,380	36,240	330	2,517	2,847	4,588	21,114	25,702
Total Value Paid within Target (£000s)	6,385	27,914	34,299	313	2,431	2,744	4,077	19,977	24,054
% Value of Invoices Paid	93%	95%	95%	95%	97%	96%	89%	95%	94%
% Target	95%	95%	95%	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**-1.9%**	**0.0%**	**-0.4%**	**-0.2%**	**1.6%**	**1.4%**	**-6.1%**	**-0.4%**	**-1.4%**

11. Recommendations

The Trust Board is asked to:

Note:

- The reported YTD surplus of **£724k against a planned surplus of £563k**. This is a favourable variance to plan of £161k.

- The M8 CIP achievement:
  - YTD achievement of £1,021k (58%); **an adverse variance of £744k**;
  - 2017/18 forecast CIP delivery of £2,646k (83%) based on schemes identified so far; an adverse variance of £551k to plan;
  - The recurrent forecast delivery at month 8 of £2,804k representing a **recurrent variance to plan of £393k**.

- The cash position of the Trust as at 30th November 2017 with a **balance of £5,824k**; £639k better than plan

- Agency forecast is currently £372k above ceiling (£2,068k)

- Year to date Capital receipts for 2017/18 is £470k compared to a net planned capital expenditure of £1,317k;
  - The original operating plan submitted to NHSI in December 2016 planned net capital expenditure of £2,201k by Month 8.

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

Approve:

- The month 8 position reported to NHSI.

- Approve the forecast Agency Ceiling breach of £372k.

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REPORT TO Public Trust Board

Enclosure No:13

Date of Meeting:	25th November 2018		
Title of Report:	Finance & Performance Committee Assurance Report		
Presented by:	Chair of Finance & Performance Committee		
Author:	Deputy Director of Finance		
Executive Lead Name:	Suzanne Robinson	Approved by Exec	☒

Executive Summary:		Purpose of report	
This paper details the issues discussed at the Finance, Performance and Digital Committee meeting on the 11 January 2018. The meeting was quorate with minutes approved from the previous meeting on the 30th November 2017. Progress was reviewed and actions confirmed from previous meetings.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	SLT ☐ Execs X Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee X • Audit Committee ☐ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services X☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.X 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	Oversees the risk relevant to the Finance & Performance Committee		
Resource Implications: Funding Source:	None applicable directly from this report		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	There are no direct impact of this report on the 10 protected characteristic of the Equality Act		
Recommendations:	The Trust Board is asked to note the contents of this report and take assurance from the review and challenge evidenced in the Committee.		

North Staffordshire Combined Healthcare NHS Trust

Assurance Report to the Trust Board
Thursday, 25th January 2018

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

This paper details the issues discussed at the Finance, Performance and Digital Committee meeting on the 11 January 2018. The meeting was quorate with minutes approved from the previous meeting on the 30th November 2017. Progress was reviewed and actions confirmed from previous meetings.

Executive Director of Finance, Performance and Digital Update

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

- The draft 2018/19 Financial Plan and Budget. This described the inflationary assumptions assumed, the drivers of 2018/19 CIP and draft revenue position, reflecting anticipated changes in income as part of 2018/19 contract negotiations. A draft Capital Plan for 2018/19 to 2022/23 was also presented. The committee supported the draft financial plan and endorsed the revised innovative "Matrix" approach to cost improvement.

- A year end internal reporting timetable, which aligns internal deadlines with key national deadlines submission of statutory accounts and annual report.

- A paper presented at Board Development on 18th December, detailing a proposal to increase the year end control total to £1.6m (including £500k STF) which is £200k better than the original 2017/18 plan. The stretch is made possible through a non-recurrent "payback" of PFI obligations in 2017/18 and will allow the Trust to fully utilise the national STF incentive scheme.

Finance

- **Monthly Finance Report – Month 8**

The Finance position was presented showing a position that is £161k better than plan. This is supported non-recurrently through benefits associated with ROSE implementation. The Trust is forecasting to meet its agreed control surplus.

- **Cost Improvement Programme (CIP)**

The Committee received an update for Cost Improvement for month 8 and were concerned that the total identified was still significantly short of the target. £2.804m is currently forecast to be recurrently delivered against the £3.197m target. This is a recurrent shortfall of £393k.

There has been a number of workshops with Directorates throughout November and

December to support the identification of recurrent schemes to bridge the gap.

The Committee were assured that there was sufficient focus being placed on Cost Improvement but are unable to give assurance around the ability to deliver the target for 2017/18.

- **Agency Utilisation Report**

The Committee were presented with the Agency utilisation report at M8 which showed a forecast breach of the Agency ceiling by £372k, mainly due to Medics and ROSE. The committee acknowledged the national shortage of medical locums but were assured that the trust was doing everything possible to recruit substantive posts. It was also noted that expenditure on ROSE agency was non recurrent.

The Trust has been successful in recruiting a medical post in AMH Inpatients and created a medical bank, with agreements with 3 of the current locum consultants to join.

The committee noted the significant reduction since April 2016 and was confident the Trust would deliver against the 2018/19 ceiling. It was also noted that the percentage Agency nursing as a % of total nurse pay was exceptionally low at 1.4%.

Performance:

- **Activity Report**

The report detailed M8 activity against plan using traditional reporting methods and care clustering. The SLA and PbR activity reports are within contract tolerances.

The Cluster 99 activity has significantly increased since the implementation of Lorenzo due to operational staff not assigning care clusters on assessment and/or reviewing all care clusters within cluster review period. In view of remaining data quality issues, the Committee is not able to give any assurance around the activity reported and noted the lack of progress being made due to issues with the quality of recording by operational staff. A Task and Finish Group has been established and an action is in plan in place to improve compliance with clustering guidance.

The Committee requested an update on action plan implementation to be provided to the next Committee meeting. This is to include a breakdown of the issues around compliance and data recording by Directorate, and a trajectory for the elimination of Cluster 99s.

- **Performance Report (PQMF)**

The report provides the Committee with a summary of performance to the end of Month 8 (November 2017)

Compliance remains an issue in respect of CPA 12 month reviews undertaken, with performance improving in month 8. Guidance has been fully embedded to encourage staff to use quick reference guides, and this is resulting in a reduction in the number of recording errors.

Delayed Transfers of Care has improved in month for NOAP and AMH IP, which is thought to be the impact of additional beds being commissioned over winter. There is a notable difference between Stoke and Staffordshire Local Authority in terms of DTOC performance, which the committee requested oversight of at the next meeting.

Trust vacancies remain a challenge, however it is on an improving trajectory, thought to be due to the implementation of TRAC.

Digital:

- **Lorenzo Exemplar Update**

The Trust has been selected to move to the mobilisation phase of the Lorenzo Digital Exemplar programme with a digital proposal for Children's services along with two other Trusts. The Committee received the report for information which gave a high level overview of deliverables, scope, governance and mobilisation. The resource requirements are to be agreed. The committee congratulated the team on their success and noted the likely positive impact on Trust reputation.

Other Reports and Updates

The Committee received additional assurance reports as follows:

- Capital Report M8
- Digital Maturity Assessment
- Finance Performance and Digital Risk Register
- New Business Opportunities (for information)
- Finance and Performance Monitoring Schedule (for information)
- Cycle of Business (for information)

Recommendation

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

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

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REPORT TO OPEN TRUST BOARD

Enclosure No:14

Date of Meeting:	25 JANUARY 2018		
Title of Report:	Register of Board Members – Declarations of Interest		
Presented by:	Laurie Wrench, Associate Director of Governance		
Author:	Lisa Wilkinson, Acting Corporate Governance Manager		
Executive Lead Name:	Caroline Donovan, CEO	Approved by Exec	☐

Executive Summary:	Purpose of report	
The report provides an update as at the 31st October 2017 of current Board members interests given the change in membership since the last report of the 30th April 2017. It is the Trust Board's responsibility to ensure the Trust operates its services in an open and transparent way. In line with the Code of Conduct and Accountability for NHS Board members and the Trust's Standards of Business Conduct Policy this information is published on the website and available for public view.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☒ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☐ 2. To provide the highest quality services ☐ 3. Create a learning culture to continually improve.☐ 4. Encourage, inspire and implement research & innovation at all levels.☐ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☐ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	The register is in line with current legislation		
Resource Implications: Funding Source:	N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	N/A		
Recommendations:	To receive for assurance and information prior to ratification at Trust Board and uploading to the Trust external website.		

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NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST

REGISTER OF DIRECTORS' DECLARED PRIVATE INTERESTS

As at 31st October 2017

NAME OF DIRECTOR	INTEREST DECLARED
D Rogers Chairman	**Crystal Care Solutions Ltd** Chairman and Stakeholder **Staffordshire Wildlife Trading** Member of the Board
T Gadsby Non-Executive Director	**MedicAlert Foundation, British Isles and Ireland** Chairman of Trustee Board **MedicAlert Trading, British Isles and Ireland** Director
P Sullivan Non-Executive Director	**Care Quality Commission** Mental Health Act Reviewer **Health, Education and Social Care Chamber (Mental Health)** Fee-paid Specialist Lay Member of the First-tier Tribunal **HMP Drake Hall** Member of Independent Monitoring Board
J Walley Non-Executive Director Commenced 01/12/16	**City Learning Trust** Vice Chairperson **Burslem Regeneration Trust** Chairperson **Carrick Court Freehold Company** Director **Aldersgate Group** Chairperson
L Barber Non-Executive Director Commenced 01/12/16	**Macmillan Cancer Support** Employee
K Tattum GP Associate Director	**Baddeley Green GP Surgery** Senior Partner **BGS Medical Ltd** Director/owner **North Staffordshire Local Medical Committee** Member
J Harvey Staff Side Representative	**No interests declared**

C Donovan Chief Executive	**No interests declared**
Dr B Adeyemo Executive Medical Director	**Staffordshire University** Honorary Lecturer
P Draycott Director of Leadership & Workforce (*non-voting*)	**No interests declared**
M Nelligan Director of Nursing & Quality	**Hospice of the Good Shepherd** Company Director
S Robinson Director of Finance and Performance	**No interests declared**
L Wrench Associate Director of Governance	**Wrench Fine Jewellery (t/a Timecraft)** Family business
A Hughes Joint Director of Strategy & Development	**Joint Director of Strategy & Development** Joint post with GP Federation **Partners in Paediatrics** Chair **Teenage Cancer Trust** Safeguarding Trustee (Non-Executive Director), **Meant Ltd** Owner and Director **Meant Consortium Ltd** Owner and Director **The Village Rainbow Ltd** Owner and Director **Ashbourne Retailers Association** Member **School of the Built Environment, Oxford Brookes University** Specialist Lecturer
J McCrea Associate Director of Communications	**J B McCrea Ltd** Managing Director **East Leicestershire and Rutland GP Federation** Member of the Board
G Mahadea Non-Executive Director	**General and Medical Accountants Ltd** Director

Dr Nasreen Fazal-Short Acting Director of Operations	**No interests declared**

Guidance issued by NHS England in February 2017 regarding NHS Conflicts of Interest outline the definition for a 'conflict of interest' and this may be *Actual* or *Potential*. Interests can arise in a number of different contexts and fall into the following 4 categories :

Financial interest	Non financial professional interests	Non financial personal interests	Indirect interests
Direct financial benefit from the consequences of a decision	Non financial professional benefit	Personal benefit	Close association with someone who has an interest

REGISTER OF ACCEPTANCE OF THE CODE OF CONDUCT AND CODE OF ACCOUNTABILITY IN THE NHS

In November 2007, the Trust Board requested that a formal register of acceptance of the Code of Conduct and Code of Accountability in the NHS is established.

All Directors have provided a signed declaration of their acceptance of the Code of Conduct and Code of Accountability in the NHS to the Trust Secretary

The Code of Conduct and Code of Accountability in the NHS can be viewed on the Department of Health website at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4116281

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REPORT TO Trust Board

Enclosure No:15

Date of Meeting:	25th January 2018		
Title of Report:	Register of Signed and Sealed Documents		
Presented by:	Laurie Wrench, Associate Director of Governance		
Author:	Mandy Brown		
Executive Lead Name:	Caroline Donovan	Approved by Exec	☐

Executive Summary:	Purpose of report	
The attached table provides a report on the use of the common seal of the Trust in the period 1 January 2017 to 31st December 2017. The Standing Orders require that a report on the Register of Sealing shall be made to the Board at the least half yearly. Section 8 of the Standing Orders governs the sealing of documents and the Register of Sealing.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

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

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In accordance with regulation 9.4 of the Trust's Standing Orders, listed below are the documents that have been officially sealed for the period 1 January 2017 – 31 December 2017

The addition of the minute reference column is a mechanism for reference to the original Board approval of the scheme/ project.

SEAL REF	DATE OF SEAL	DETAILS OF DOCUMENT SUBJECT TO THE OFFICIAL	VALUE IF KNOWN	MINUTE REF
CHS 54/17	9/3/17	Land by Greenfields sold to Brighter Futures Contract of sale	£5000	225/13
CHS 55/17	February 2017	NSCHT & GP Federation Partnership agreement	N/A	604/2017
CHS 56/17		Homes and Community Agency, Secretary of State & Keepmoat Ltd 1st annual payment – Sale of Bucknall Hospital	£712,889	477/2015
CHS57/17	March 2017	Purchase of A&T Telford Staffordshire Housing	£428,144.00	116/2015
CHS 57/17	September 2017	Homes and Community Agency, Secretary of State & Keepmoat Ltd Part 3 payment – Sale of Bucknall Hospital (Verity House)	£105,030	477/2015

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REPORT TO OPEN TRUST BOARD

Enclosure No: 16

Date of Meeting:	25th January 2018		
Title of Report:	PCD Summary		
Presented by:	Lorien Barber, Non-Executive Director		
Author:	Alex Brett, Director of Workforce, OD and Communications		
Executive Lead Name:	Alex Brett	Approved by Exec	☒

Executive Summary:	Purpose of report	
A summary of the People & Culture Development Committee meeting held on Monday 15th January 2018 and chaired by Mrs Lorien Barber. It received a number of reports for assurance and approval including: • Committee Review and AQUA well led committee review recommendations • Director of Workforce, OD & Communications Update • Board Assurance Framework • Workforce Strategy • Staff Story • Diversity & Inclusion Action Plan • Directorate Workforce Performance and "deep dive" directorate presentations • CQUIN Health & Wellbeing Update • Medics Recruitment & Retention • Keele School of Medicine QA Visit • HR Disciplinaries/Grievances/Management of Change • Towards Outstanding Update • Staff Survey update • Workforce and OD Risks • Policies for approval	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☐ • People & Culture Development Committee ☒ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. ☒ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve. ☒ 4. Encourage, inspire and implement research & innovation at all levels. ☐ 5. Maximise and use our resources intelligently and efficiently ☒ 6. Attract and inspire the best people to work here ☒ 7. Continually improve our partnership working. ☐		
Risk / legal implications: Risk Register Ref	A number of risks are monitored and reviewed through the Committee. The current risks identified and mitigation plans in place are: Risk 12 – There is a risk that there is insufficient staff to deliver appropriate		

	care to patients because of staffing vacancies and increased referrals. This has a consequence of potential failure to achieve performance targets, inability to deliver service user expectations and increase pressure upon existing staff. Risk 722 – There is a risk to mandatory and e-learning training compliance. Due to staff confusion because we are currently running face to face and 3 e-learning systems, these are ESR, E-learning for health and LMS, resulting in a potential negative impact on compliance data. This is further exacerbated by a risk to the current management and maintenance of the LMS system due to potential deficit skill mix. The consequence is a risk of the system remaining static, and not being able to develop new and bespoke education as planned. Risk 868 – There is a risk that the Trust will breach its Agency cap for the use of temporary staffing with a consequence of increased spend and reputational harm due to reduced segmentation by NHSi. Risk 900 – There is a risk that the Trust does not provide inclusive services that recognise the diverse nature of our service users, therefore services may not be accessible or of sufficient quality. relating to temporary staffing Risk 901 - There is a risk that the Trust does not have an inclusive and diverse workforce impacting on our ability to support the needs of diverse communities and ability to attract and retain staff Risk 1034 – There is a risk that staff are not effectively engaged, do not have sufficient clarity of purpose and do not realise their potential through not having an up to date PDR. This can adversely affect their ability to work efficiently and effectively and impacting upon delivery of services. Risk 1072 – There is a risk that staff may not be accessing clinical supervision on a regular basis to ensure that professional responsibilities and as a result may not feel supported in practice.
Resource Implications: Funding Source:	N/A
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	The Committee plays a huge role in actions and assurance related to Diversity and Inclusion and the oversight of the Public Sector Equality Duty under the Equalities Act. This duty requires the Trust to • Eliminate unlawful discrimination • Advance equality of opportunity • Foster good relations
Recommendations:	The Board are asked to approve the policies identified and receive the summary for assurance.

North Staffordshire Combined Healthcare NHS Trust

Summary to Trust Board
People & Culture Development Committee
Monday 15th January 2018, 9.30 – 12.35pm

The meeting was chaired by Mrs Lorien Barber.

1. Staff Story

The Committee received a positive staff story regarding an individual who has accessed training, leadership and education courses over her 16 years in nursing with the Trust. The Committee then discussed more effective methods of publicising staff stories within the Trust, and the possibility of using videos/recordings more effectively. Key to this item going forward is how these stories link to, and inform, the work of the Committee and how we learn from these.

2. Committee Review

The Committee reviewed the findings of the Well Led Development review conducted by AQUA between August and October 2017 and their suggested improvements for the Committee to consider. The Committee will review how it operates in line with these recommendations and will align its programme of work to the refreshed Workforce Strategy and Board Assurance Framework. Risk will feature more dominantly in the meetings, whilst the Terms of Reference and Cycle of Business will also be refreshed in line with the review findings.

3. Director of Workforce, OD and Communications Update

The Committee was updated on the following issues:

- Carillion
- NHSI case study publication
- Health Education England Workforce Strategy Consultation

4. Workforce Strategy

The strategy currently has six themes:

- Attract Retain and Develop
- Well-being, Inclusion and Diversity
- Leadership, Engagement and Culture
- Sustainability and Partnership
- Improvement Development
- Digital Workforce

The Committee was informed that the strategy required some additional work around service improvement to form a coherent strategy. The revised document would be re-submitted to the Committee once finalised following Board Development sessions in February and March.

5. Board Assurance Framework

The framework is being reviewed to ensure accuracy. Greater emphasis will be placed on the Board Assurance Framework to inform the Committee agenda moving forward.

6. Workforce & OD Risks

A number of risks are monitored and reviewed through the Committee. The current risks identified and mitigation plans are in place are:

Risk 12 – There is a risk that there is insufficient staff to deliver appropriate care to patients because of staffing vacancies and increased referrals. This has a consequence of potential failure to achieve performance targets, inability to deliver service user expectations and increase pressure upon existing staff.

Risk 722 – There is a risk to mandatory and e-learning training compliance. Due to staff confusion because we are currently running face to face and 3 e-learning systems, these are ESR, E-learning for health and LMS, resulting in a potential negative impact on compliance data. This is further exacerbated by a risk to the current management and maintenance of the LMS system due to potential deficit skill mix. The consequence is a risk of the system remaining static, and not being able to develop new and bespoke education as planned.

Risk 868 – There is a risk that the Trust will breach its Agency cap for the use of temporary staffing with a consequence of increased spend and reputational harm due to reduced segmentation by NHSi.

Risk 900 – There is a risk that the Trust does not provide inclusive services that recognise the diverse nature of our service users, therefore services may not be accessible or of sufficient quality.

Risk 901 - There is a risk that the Trust does not have an inclusive and diverse workforce impacting on our ability to support the needs of diverse communities and ability to attract and retain staff.

Risk 1034 – There is a risk that staff are not effectively engaged, do not have sufficient clarity of purpose and do not realise their potential through not having an up to date PDR. This can adversely affect their ability to work efficiently and effectively and impacting upon delivery of services.

NEW Risk 1072 – There is a risk that staff may not be accessing clinical supervision on a regular basis to ensure that professional responsibilities and as a result may not feel supported in practice.

7. Performance Reports

The Heads of Directorate for CYP, Adult Community, LD and NOAP attended the meeting to provide assurance on their Directorate workforce metrics and to provide rectification plans for the areas of non-compliance. Adult Inpatients and Substance Misuse position was presented by the HR Business Partner.

Discussions took place around concerns with recruitment and lack of qualified medics and nurses, agency spend, cost pressures and the recording of clinical supervision. It was noted that there is a national shortage of medics and nurses which was exacerbating the situation locally, and options to ensure accurate recording of supervision were discussed.

Stress, anxiety and depression has increased in a number of areas and this was highlighted as an increasing issue. Support mechanisms are in place but this needs to continue to be a focus around health and wellbeing and staff.

8. HR Disciplinaries/Grievances/Management of Change

The Committee was updated with the current progress and timescales of anonymised casework.

9. Diversity & Inclusion Action Plan

The Committee was updated on the action plan for 2017-18 which had emerged from the Trust's D&I annual review process in 2016-17. Considerable progress has continued in 2017 with key highlights including:

- Securing of £50k for Staffordshire STP BAME Leadership Development
- Launch of the Trust's BAME Staff Network
- Successful launch of the Gender Identity and Dysphoria Support group (GIDS)

The action plan will continue to be monitored on a quarterly basis by the Committee.

10. Towards Outstanding

The Committee was updated on the progress of the Towards Outstanding Engagement initiative. Cohort 1 which consisted of 16 teams, mainly self-nominated will end their 26-week journey in January 2018, and will share their experiences and the impact of completion of the programme at a celebration event to be held at the Bentilee Neighbourhood Centre on February 26th. The Chief Executive, Executive Team, HoDs and CDs have all been invited to this event.

11. Staff Survey

The Committee were informed that the unweighted nationally embargoed Staff Survey results have been received, the detailed results which will be shared at the next meeting.

12. CQUIN Health & Wellbeing

The Committee noted the CQUIN update against the three elements required:

- Goal 1a: Health and wellbeing for staff
- Goal 1b: Healthy food for NHS staff, visitors and patients
- Goal 1c: Improving the uptake of flu vaccinations for frontline clinical staff

The Committee also received details of the improvements made in terms of nutrition for both staff and patients. It was noted that uptake for the flu campaign currently stands at 65% which is slightly short of 70% target; not meeting this target will have a financial impact and is important to protect staff and patients. The trust has seen a significant increase in flu cases. All measures are being taken to ensure that those staff members still wishing to have the vaccine have access to the roving vaccinators.

13. Medics Recruitment & Retention

The Committee was updated on the difficulties being experienced in recruiting to consultant posts, although this was recognised as a national problem. The Trust was working with Consultants to gain views of what we can do differently to enhance the ability to recruit.

14. Keele School of Medicine QA Visit

The Committee was updated on the positive Quality Assurance visit. The one issue that had been raised on the day of the visit with regard to outlying areas was responded to, but will continue to be monitored.

15. Policies

The following policy was approved by the Committee and the Trust Board are requested to approve it:

- Flexible Working & Employment Break Policy Mobile Devices Policy

Board is asked to approve these recommendations

16. Date & Time of Next Meeting

- Monday 12th March 2018, at 9.30 am, Boardroom, Trust HQ, Lawton House, Trentham

North Staffordshire Combined Healthcare NHS Trust

REPORT TO: Trust Board

Enclosure No:17

Date of Meeting:	25th January 2018		
Title of Report:	Assurance Report from the Quality Committee		
Presented by:	Patrick Sullivan Non-Executive Director and Chair of Quality Committee		
Author:	Pat Smith, Executive PA		
Executive Lead Name:	Dr Buki Adeyemo, Executive Medical Director	Approved by Exec	☒

Executive Summary:		Purpose of report	
This report provides a high level summary of the work of the committee during December 2017 and request for the Trust Board to ratify policies and endorse recommendations in the report.		Approval	☐
		Information	☒
		Discussion	☐
		Assurance	☒
Seen at:	Approved by Chair of Quality Committee and Executive Lead	Document Version No.	
Committee Approval / Review			
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement. 2. To provide the highest quality services 3. Create a learning culture to continually improve. 4. Encourage, inspire and implement research & innovation at all levels. 5. Maximise and use our resources intelligently and efficiently. 6. Attract and inspire the best people to work here. 7. Continually improve our partnership working. The business of the Quality Committee is applicable to all strategic objectives.		
Risk / legal implications: Risk Register Ref	None identified		
Resource Implications: Funding Source:	N/A N/A		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	None identified		
Recommendations:	To note policy approval		

North Staffordshire Combined Healthcare NHS
NHS Trust

Key points from the Quality Committee meeting held on 21 December 2017 for the Trust Board meeting on 25 January 2018

1. Introduction

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

2. Patient Story

The meeting opened with a story from the Trust's CYP Team. The presentation described a patient`s journey through CAMHS which was illustrated through a series of photographs set in a Photo Book. This is being published. The Photo Book will be available in CAMHS waiting rooms.

It was noted that this individual's story was very inspirational and demonstrates how far she has come with excellent support from the CAMHS service. This was a powerful story illustrating what can be achieved for the benefit of patients and was well received by the Committee.

3. Safer Staffing Monthly Reports

The Committee received the latest safer staffing report. Reporting of Registered Nurse (R/N) and non-registered nurse staffing levels is a key requirement to ensure the Trust complies with National Quality Board standards. During October 2017, a fill rate of 87% for R/N staff and 91% for care staff on day shifts was achieved, with 81% and 105% respectively on night shifts. Taking skill mix into account, an overall 92% fill rate was achieved.

The report indicates a challenge in staffing wards with vacancies contributing to this. It was noted that 18 Registered Nurses commenced Preceptorship in October 2017. The Committee also noted the further challenges associated with the temporary increase of beds on Ward 4 in response to winter pressures in the health economy.

4. Quality Impact Assessment on Cost Improvement Programme

The report indicates the Project Initiation Document (PID) and Quality Impact Assessment (QIA) position for the delivery of the 2017/18 CIP programme as at November 2017. The report gives assurance that all Cost Improvement Programmes transacted have been quality assessed. Also included in the paper are initiatives undertaken over the last quarter. The Trust will be strengthening the quality monitoring within the next few months and produce a tracker system to support this.

5. Performance & Quality Management Framework Month 7 2017/18

Committee members discussed performance by exception and the rectification plans in place. Month 7 was noted to have 5 targets rated as red and 1 as amber, with all other indicators within expected tolerances. The following performance highlights were noted as follows:

- 97.5% of inpatient admissions have been gate kept by the Crisis resolution/Home Treatment Team.
- 60.8% of IAPT service users have moved to recovery against a target of 50% and 100% referred to an IAPT programme were treated within 5 weeks of referral.

The following targets rated as red with mitigation plans for improvement noted:

- Care Programme Approach
- Section 136
- Access
- Vacancy Rate
- Clinical Supervision

6. Reports received for Assurance

6a Director of Quality Report

The Committee received the Director of Quality Report under the SPAR qualities priorities with notable items as follows:

Safe:

- **Chief Coroner: Annual Report.** The fourth annual report covering the period 1 July 2016 - 30 June 2017 has been published. The report provides an excellent overview of the operation of Coroner Services, reflecting on the past year and identifying areas to move forward. The full report has been reviewed to identify any learning from the summary cases for the Trust and how this information may be used to further develop working arrangements with the local Coroner.

- **Secret Recordings - can they be used in Court?** This is an increasingly common scenario in Courts. In essence covert recordings can be admissible as evidence, however the Judge`s permission is required. A recent case highlighted a Social Worker was recorded and this was viewed in a negative light by the Court. More detailed guidance can be provided and this development has been welcomed and should clarity when recordings may be deemed to be useful and valuable sources of information. More information will be shared with the Committee in due course.

Personalised:

- **Be careful of making urgent court applications.** A Community Trust obtained an Order out of hours (and without notice) from the Family Division of the High Court. It is important to note that the patient had capacity in respect of medical treatment and care. The Order authorised Police and medical professionals to enter the patient`s home and transport by ambulance to hospital for the purposes of receiving medical treatment and deprived the patient of their liberty. The patient subsequently issued proceedings against the Community Trust. It is noted that the Trust has a process in place in terms of making applications to Court. Early review and mitigating actions is key prior to any application to court which includes negating the need for urgent and out of hours applications.

- **Changes to the provisions regarding Places of Safety under the Mental Health Act 1983)**
  The Department of Health and Home office have produced new guidance for Police Forces, Mental Health Services, Clinical Commissioning Groups, Ambulance and emergency services, on the practical application of changes to provisions in the Mental Health Act 1983, made by the Policing and Crime Act 2017, on Police powers and Places of Safety. This comes into force on 11 December 2017. The impact of the changes and emerging issues will be discussed at the Staffordshire County wide Policy Working Group and issues escalated to the Mental Health Law Governance Group accordingly.

Accessible and Recovery Focussed:

- **Update on New Bill: Mental Health Units (Use of Force) 2017-19).** An MP has introduced this Bill and wants Parliament to pass what he calls `Seni`s law` to protect mental health patients. The Bill was introduced after a constituent died in a Mental Health Unit and had been subject to physical restraint by 11 Police Officers. Further information will be shared with the Committee in due course regarding the progress of this Bill and subsequent action the Trust will take in response.
- **Civil Liability Bill.** Reforms are currently underway in respect to personal injury claims. In terms of what this may mean for the Trust, we may see an increase in the number of potential claims being brought by LIPS (could we write out in full not sure what this is)given the intention to offer more support to LIPS and a streamlining of the process. We have however already embraced a way of working advocated by HS (could we write out in full again not sure what this is)Resolution which is to seek early investigation and resolution of issues raised by ensuring good complaint handling and timely resolution to mitigate possible escalation to the claims process.

6b Reports received for review, information and/or approval

- ***Data Quality Forum Update.*** The Committee received minutes from the October and November 2017 Data Quality Forum, providing information on the business discussed by the group.

- ***Data Quality Forum Terms of Reference.*** The Committee received the Terms of Reference which have been reviewed at the Data Quality Forum meeting on the 20 November 2017 which had minor changes made to reflect the membership. The minimum number required for a quorate meeting has been reduced from 6 to 4 as a result of Finance and HR representatives to attend as required rather than being formal members.

- ***Clinical Effectiveness Report.*** Noting outputs of the work of the Mental Health Law Governance Group, Medicines Optimisation, Clinical Records and System Design Group, Research and Innovation Steering Group and the Clinical Effectiveness Group.

- ***Substance Misuse Staff Survey.*** Given the significant changes that have taken place within the Substance Misuse Directorate and service over the last few months, the Directorate`s Clinical Director and Head of Directorate were keen to explore how this may have affected a range of areas. A staff survey was undertaken to look at the impact of staff who continue to work on the clinical side of the service. It is noted that the results were quite positive considering the circumstances which is a credit to the Directorate.

- ***Diversity and Inclusion - Workforce Race Equality Standards, Action Plan Update 2017/18***. The Committee noted the report and action plan with further reports on progress planned. A programme of work will address some of the hot spots and a Trust over-arching project is being set up.

- ***Sepsis Action Plan Update***. The full action plan remains on target and progress will be presented at future Committee meetings.

- ***Q2 report on Safeguarding Activity.*** This detailed report provided information to the Committee on current case reviews, themes and trends in safeguarding and pertinent issus from the Trust`s Safeguarding Team.

6c **Policy Report -** the recommendations supported by the Committee for ratification of policies by the Trust Board (approval for 3 years otherwise stated as follows:-

- 1.67 - Smoking Policy - Review of current arrangements – new policy comes into force on 1 April 2018.
- 1.52a - Research Governance and Management Policy.
- Commercial Research Policy
- R01 - Policy on Restrictive Interventions
- R03 - Policy on Restrictive Holding - this was reviewed alongside R01 Policy - contents amalgamated with R01 - remove as separate policy is no longer applicable.
- 5.41 - Lone Worker Policy
- 7.10 - Clinical Coding
- 1.46 - Prevention of Management of Slips, Trips and Falls
- 1.02 - Professional Registration
- Choice - new policy

7. Learning from Experience Report October/November 2017

The Committee received this bi-monthly learning from experience report detailing emerging issues, including learning and action taken following the feedback from Trust services. The following points were noted:

- There is a slight increase in incidents compared to previous months and in the monthly average this year, however they are all either of minor harm or no harm.
- 10 complaints received and investigated.
- Received 566 compliments. Using Friends and Family Test to ensure that all compliments or otherwise is captured. 91% of people would recommend receiving treatment at Harplands Hospital.
- 4 compliments and one negative feedback received through NHS Choices.

8. Directorate Performance Reports

Each Directorate presented in detail their performance as part of the new reporting arrangements to the Committee. Committee members continue to feel that this new style of reporting, capturing information from performance reviews enables a much more focussed discussion around cross cutting issues. The focus of the discussion centred on good practice and achievements, new developments and innovations, current and potential challenges.

9. IPC Strategy 2017-2020 (ON A PAGE)

The previous submission of the above to Quality Committee is that it has been updated to include Sepsis.

10. Falls Reduction - Update on Policy and Work Plan

The Executive Director of Nursing & Quality commissioned the above report regarding the progress to date in relation to the Falls Improvement Programme for 2017/18. There is an ambition to achieve the 30% reduction in avoidable falls by 1 April 2018. There are still a number of actions to be taken forward regarding the environment, however all practice related actions have been completed. The Falls Rapid Improvement Group has now concluded its work and updated the policy and risk assessments. There is also currently a Falls Reduction Project on-going with AQuA.

11. Infection, Prevention and Control 2017/18 Report

The Committee received assurance against the above on Q2 IPC activity and summarises the arrangements and innovations in place since January 2017. The Assurance Framework has been updated with KLoE and the regular standards overlaps with the Sepsis and IPC Strategy.

12. CQC Unannounced Visits

The Committee received an update and discussion took place regarding the CQC Inspection.

Trust Risks to Quality Committee

Committee members considered the report for quality risks and how they interrelate to Directorate risks. Risk treatment plans and actions being taken were noted**.**

13. Next meeting:
Thursday 8 February 2018 at 2pm

On behalf of the Committee Chair, Mr Patrick Sullivan, Executive Director
Patricia Smith, Exec PA to Executive Director of Nursing & Quality
15 January 2018

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REPORT TO TRUST BOARD

Enclosure No:18

Date of Meeting:	25th January 2018		
Title of Report:	Summary of the Audit Committee held on 30th November 2017		
Presented by:	Tony Gadsby, Chair / Non Executive		
Author:	Laurie Wrench, Associate Director of Governance		
Executive Lead Name:	Suzanne Robinson	Approved by Exec	☒

Executive Summary:	Purpose of report	
This report provides a summary of the key headlines from the Audit Committee held on the 30th November 2017. The full papers are available as required to members.	Approval	☐
	Information	☒
	Discussion	☐
	Assurance	☒

Seen at:	SLT ☐ Execs ☐ Date:	Document Version No.	
Committee Approval / Review	• Quality Committee ☐ • Finance & Performance Committee ☐ • Audit Committee ☒ • People & Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐ • Digital by Choice Board ☐		
Strategic Objectives (please indicate)	1. To enhance service user and carer involvement.☒ 2. To provide the highest quality services ☒ 3. Create a learning culture to continually improve.☒ 4. Encourage, inspire and implement research & innovation at all levels.☒ 5. Maximise and use our resources intelligently and efficiently.☒ 6. Attract and inspire the best people to work here.☒ 7. Continually improve our partnership working. ☒		
Risk / legal implications: Risk Register Ref	To ensure that the committee meets its terms of reference by receiving reports of the work of its sub groups		
Resource Implications: Funding Source:	n/a n/a		
Diversity & Inclusion Implications: (Assessment of issues connected to the Equality Act 'protected characteristics' and other equality groups)	n/a		
Recommendations:	Receive for information and assurance purposes		

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Summary Report of the Audit Committee

30th November 2017

Board Assurance Framework – Q2

The committee received the Board Assurance Framework Q2. The BAF aligns the Trust's new strategic objective to the quality priorities and key risks. The BAF provides details of the key control and assurances to ensure delivery of the seven strategic objectives.

The committee noted there were 146 deliverables in total; 71 deliverables (49%) due at Q2 of those 59% are green and 28% amber with 13% red.

The deliverables rated as red are as follows and are linked into the Risk Register:

- Friends and Family
- Vacancies and Recruitment
- Mental Health compliance
- Talent Management
- Agency Spend
- Our recurrent CIP

The BAF for this year includes a stretch target RAG rating to help to acknowledge assurances that are more challenging. The committees and board have oversight on the delivery of the BAF.

Risk Assurance Report

The committee received this report which provided information and assurance regarding the systems and processes used within the Trust to manage risk.

The Trust has continued to strengthen team level risk registers and have shared both corporate and clinical risks with the CQC during the well led inspection. A risk mapping exercised has been undertaken to align directorate 12+ risks to trust wide risks and the BAF.

Audit Recommendations – Progress Report

The committee received the report detailing the Internal Audit actions and progress in terms of implementation as of November 2017.

The committee noted the following:

- 53 actions completed in total
- 28 actions not yet due
- 6 actions for extension which were approved by the committee
- 2 reports completed with no recommendations

Further Reports Received:

The committee received the following reports:

- Register of Declared Interests - for information
- Freedom of Information Report Q2 – for information
- Phishing Report – for information – an improvement was noted by the committee since the last phishing exercise was undertaken

Policy Approval

The following policies were approved for 3 years:

- Case and Treasury Management
- Anti-Bribery policy

The committee ask for final ratification by the Board

RSM Internal Audit Progress Report

RSM Internal Audit, presented this report which included the agreed action plans in respect of the finalised reports since the last Audit Committee meeting.

In terms of delivery, 9 reports have been finalised with executive summaries and action plans as follows:

1. Unexpected Deaths – Incident Management (substantial assurance)
2. Child and Adolescent Mental Health Services – RTT Data Quality and waiting list (reasonable assurance)
3. Risk Assessment (reasonable assurance)
4. Creditors (substantial assurance)
5. General Ledger and Budgetary Reporting (substantial assurance)
6. Credit Cards (reasonable assurance)
7. Income and Debtors (substantial assurance)
8. PFI contract (partial assurance)
9. Follow up – Phase one (substantial assurance)

LCFS Progress Report

The committee received the report which provided an update in respect of Counter Fraud work undertaken within the Trust since 31 May 2017. Work is currently ongoing with Finance, HR and IT in respect of Fraud Risk Assessment to develop a Fraud Risk Register

The committee noted the launch of the NHS Counter Fraud Authority on 1 November 2017, which replaces NHS Protect.

Ernst and Young External Audit

Ernst and Young have commenced a programme of work for Financial Statements and Value for money (VFM) for 2017/18.

Charitable Funds Audited Annual Accounts and Audited Annual Report 2016/17

The Charitable Funds Annual Accounts and Report were presented to the committee having been completed and ratified at the CFC on 22 November 2017. Trust Board have delegated approval authority to the Audit Committee to allow submission to the Charity Commission in January 2018.

The letter of representation was signed by Mr Gadsby on behalf of the Chairman.

Waivers over £20k Report

Members noted the report and that there were only two waivers issued in Q2 totalling £56k.

Information Governance Breach Action plan

The committee noted the final action plan and were informed that the incident has now been closed down by the Information Commissioner.

Standing Business Items:

As per standing business items, the committee received the following:

- Summary of the Quality Committee – 31 August and 26 October 2017
- Summary of the Finance, Performance and Digital Committee – 31 August, 28 September and 2 November 2017
- Summary of the People and Culture Development Committee - 4 September and 6 November 2017
- Summary of the Business Development Committee – 22 September 2017
- Minutes of the Information Governance Steering Group – 14 August and 2 October 2017
- Minutes of the Data Quality Forum – 21 August and 18 September 2017

Laurie Wrench

Associate Director of Governance on behalf of

Mr Tony Gadsby, Chair and Non-Executive Director

10th January 2018