North Staffordshire Combined Healthcare NHS
NHS Trust

MEETING OF THE TRUST BOARD

TO BE HELD IN PUBLIC ON THURSDAY 04 JUNE 2015, 10:00AM, BOARDROOM, LAWTON HOUSE, TRUST HEADQUARTERS, BELLRINGER ROAD, TRENTHAM LAKES SOUTH, STOKE ON TRENT, ST4 8HH

	AGENDA	
1.	**APOLOGIES FOR ABSENCE** *To NOTE any apologies for absence*	Note
2.	**DECLARATION OF INTEREST RELATING TO AGENDA ITEMS**	Note
3.	**DECLARATIONS OF INTERESTS RELATING TO ANY OTHER BUSINESS**	Note
4.	**MINUTES OF THE OPEN AGENDA – 30 APRIL 2015** *To APPROVE the minutes of the meeting held on 30 April 2015*	Approve Enclosure 2
5.	**ACTION MONITORING SCHEDULE & MATTERS ARISING FROM THE MINUTES** *To CONSIDER any matters arising from the minutes*	Note Enclosure 3
6.	**CHAIR'S REPORT** *To RECEIVE a verbal report from the Chair*	Note
7.	**CHIEF EXECUTIVE'S REPORT** *To RECEIVE a report from the Chief Executive*	Note Enclosure 4
	TO DELIVER HIGH QUALITY PERSON CENTRED MODELS OF CARE (Strategic Goal)	
8.	**SPOTLIGHT ON EXCELLENCE** *To PRESENT the Spotlight on Excellence Team and Individual Awards to staff* *To be introduced by the Chief Executive and presented by the Chair*	Verbal
9.	**PRESENTATION FROM TRUST SUPPORT SERVICES TEAM** *To RECEIVE an introduction to the team led by Mr. A Rogers, Director of Operations and Mrs. A Melville, Support Services Supervisor*	Verbal
10.	**STAFF RETIREMENTS** *To EXPRESS our gratitude and recognise staff who are retiring.* *To be introduced and presented by the Chair*	Verbal

11.	**QUALITY COMMITTEE REPORT** *To RECEIVE the Quality Committee assurance report from the meeting held on 19 May 2015 from Mr. P Sullivan, Chair of the Quality Committee*	Assurance Enclosure 5
12.	**NURSE STAFFING MONTHLY REPORT – April 2015** *To DISCUSS and APPROVE the assurance report on the planned versus actual staff variances from Mr. M Dinwiddy, Interim Director of Nursing & Quality*	Assurance Enclosure 6
	TO BE ONE OF THE MOST EFFICIENT PROVIDERS (Strategic Goal)	
13.	**FINANCE REPORT – Month 1 (2015/16)** *To RECEIVE for discussion the month 1 financial position from Ms. A Harrison, Interim Director of Finance*	Assurance Enclosure 7
14.	**ASSURANCE REPORT FROM THE FINANCE & PERFORMANCE COMMITTEE CHAIR** *To RECEIVE the Finance & Performance Committee Assurance report from the Committee Chair, Mr. T Gadsby from the meeting held on 28 May 2015*	Assurance Enclosure 8
15.	**2014/15 ANNUAL ACCOUNTS** • *To formally adopt the Annual Accounts* • *To agree the Management Representation Letter* • *To agree the Annual Governance Statement* • *To note the ISA 260*	Approval Enclosure 9 ***To follow post Audit Committee meeting***
16.	**2015/16 OPERATING PLAN** *To formally adopt the 2015/16 Operating Plan, presented by Mrs. C Donovan, Chief Executive*	Approval Enclosure 10
17.	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 1** *To RECEIVE the month 1 Performance Report from Ms. A Harrison, Interim Director of Finance*	Assurance Enclosure 11
18.	**SELF CERTIFICATIONS FOR THE NHS TRUST DEVELOPMENT AGENCY** *To APPROVE the Self Certifications for the TDA from Ms. A Harrison, Interim Director of Finance*	Assurance Enclosure 12
19.	**ASSURANCE REPORT FROM THE AUDIT COMMITTEE** *To RECEIVE for assurance the Audit Committee report from the meeting held on the 02 June 2015 from Mr. D Rogers, Committee Chair*	Approve Enclosure 13 ***To follow post Audit Committee meeting***
	TO BE A DYNAMIC ORGANISATION DRIVEN BY INNOVATION (Strategic Goal)	
20.	**PEOPLE AND CULTURE DEVELOPMENT COMMITTEE REPORT** *To RECEIVE the People and Culture Development Committee assurance report from the meeting held on the 18 May 2015 meeting from Mr. P. Sullivan, Vice Chair*	Assurance Enclosure 14

21.	**UPATE OF THE ASTON TEAM LEADER PROGRAMME – MAY 2015** *To RECEIVE an update of the Aston Team Leader Programme from Mr P. Draycott, Director of Leadership and Workforce*	Assurance Enclosure 15
22.	**To *DISCUSS* any Other Business**	
	QUESTIONS FROM MEMBERS OF THE PUBLIC	
23.	*To ANSWER questions from the public on items listed on the agenda*	
	DATE AND TIME OF THE NEXT MEETING	
	The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday 04 June 2015 at 10:00am.	
24.	**MOTION TO EXCLUDE THE PUBLIC** *To APPROVE the resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admissions to Meetings) Act 1960)*	
	THE REMAINDER OF THE MEETING WILL BE IN PRIVATE	

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

	DECLARATIONS OF INTEREST	Note
	DECLARATIONS OF ANY OTHER BUSINESS	Note
	SERIOUS INCIDENTS	Assurance
	CEO UPDATE	Note
	LEADERSHIP & WORKFORCE UPDATE	Note
	INTEGRATED BUSINESS PLAN, LONG TERM FINANCIAL MODEL AND BUSINESS CASES	Approval
	ANY OTHER BUSINESS	

North Staffordshire Combined Healthcare NHS
NHS Trust

TRUST BOARD

Minutes of the open section of the North Staffordshire Combined Healthcare NHS Trust Board meeting held on Thursday, 30 April At 10:00am in the Boardroom, Trust Headquarters, Lawton House Bellringer Road, Trentham, Stoke on Trent, ST4 8HH

Present:

Chairman:

Mr K Jarrold
Chairman

Directors:

Mrs C Donovan
Chief Executive

Mr D Rogers
Non-Executive Director

Dr B Adeyemo
Medical Director

Mr P Sullivan
Non-Executive Director

Ms B Johnson
Non-Executive Director

Ms A Harrison
Interim Director of Finance

Mr P Draycott
Director of Leadership &Workforce

Dr K Tattum
GP Associate member

Mr A Hughes
Interim Director of Strategy and Development

Mr M Dinwiddy
Interim Director of Nursing and Quality

Mr A Rogers
Director of Operations

Mr T Gadsby
Non-Executive Director

In attendance:

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

Mrs J Scotcher
Executive PA

Ms J Harvey
UNISON

Mrs A Roberts
Head of Communications

Team Spotlight:
Priority Referral Team – Children and Young People's Directorate
Sue Wheatcroft
Dr J Barton

Individual spotlight
Dr Christine Leaman – Consultant Psychiatrist

Jackie Clowes – Matron, AMH Inpatient Services

Julie Elden- Team Manager, Criminal Justice Mental Health Team

Members of the public:
Hilda Johnson - North Staffs User Group
Karen Carter – JANSEN

The meeting commenced at 10:00am.

01/2015	**Apologies for Absence** Apologies were received from Mr O'Hagan	**Action**
02/2015	**Declaration of Interest relating to agenda items** There were no declarations of interest relating to agenda items.	

03/2015	**Declarations of interest relating to any other business** There were no declarations of interest.	
04/2015	**Minutes of the Open Agenda –26 March2015** The minutes of the open session of the meeting held on 26 March 2015 were approved as a correct record, with the exception of ; Under Performance and Quality Management Framework Report (PQMF) Month 11, page 19 – Dr Adeyemo commented that in respect of the Early Intervention metric, the patients were being seen within two weeks, it was the other aspects of guidance that we need to improve on. Under Staff Survey 2014 – Detailed Analysis and Action Proposal, page 22, third paragraph, 'skewered' is incorrect this should ready skewed. Under 'Any other Business,' page 23, Mrs Johnson noted that Stoke commissioners have withdrawn funding for advocacy for 'informal' patients only.	
05/2015	**Matters arising** The Board reviewed the action monitoring schedule and agreed the following:- ***451/2015 – Safe Staffing Monthly report*** – Mrs Donovan requested that for the next Trust Board, the Community Teams be included in respect of the level of vacancies. Mr A Rogers noted that there are some recognisable caseload tools which we are giving priority to and Mr Dinwiddy confirmed 'Caseloads' are one of the 6 big ticket items. ***Mr Dinwiddy confirmed that there would be more community data visible in these reports going forward and this was a big ticket item in terms of reviewing Caseloads.*** ***452/2015 – Risk Management Committee Summary – 11 March 2015 –*** Mr Sullivan raised the discussion held at the Risk Management Committee regarding an incident with a gentleman form South London, this has further been discussed at the Quality Committee and was there a report available yet? Mr A Rogers confirmed that a joint meeting with the police was being completed. ***A report will be presented to the Quality Committee in May 2015 and will subsequently be reported to the***	

	Trust Board in June 2015. - *Remove from schedule* ***Staff Survey 2014 –*** Mr Draycott stated that a further update to come in next month's May/June. ***On today's agenda*** – remove from schedule	
06/2015	**Chair's Report** This month, the first month of our new financial year 2015/16 and just a week before the election, the Chair noted that he wanted to share two articles. Brought together he believes that the articles have a powerful message for us and for our country. The first article is a survey published by the Observer on the 19th of April. The headline is Britain Uncovered – the state of our nation and it reports on a major survey of public opinion and attitudes. The two points that he wanted to highlight concerned the NHS. First 95% of people said that it was important to them that free healthcare remains available to all throughout the NHS – 78% said that it was very important. Second 65% of people said that they had a high level of trust in the NHS. This was the highest level of trust in any institution. The next most trusted were the universities 51%, the monarchy 49% and the police 46%. As he reflected on these figures he reminded himself what a privilege it has been to spend 46 years of his life in our country's most trusted institution which is founded on a principle which has overwhelming public support. The second is a guest blog prepared by Phillippa Hentsch the Chief Policy Advisor for funding and resources at NHS Providers, the organisation that represents NHS Trusts. The Chair thanked Annie Roberts for bringing it to his attention. Phillippa sets out, in stark terms, the scale of the challenge faced by the next government. Here are some of the main points; • The NHS has been required to absorb the shock of moving from 14 years of average real terms increases of 5.6% to the past four years of 0.8% increases	

	• 54% of all Trusts and 76% of acute trusts are in deficit. The total deficit at the end of March is likely to have been £850m • 2015/16 is the most challenging year in recent NHS history the projected deficit is £2 to £2.5 billion. If we bring these two articles together there is a very important task for whoever forms the next government and that is to talk honestly to the British people about how we sustain and properly fund the country's most trusted institution which is founded on a principle that has overwhelming public support. ***Received***	
07/2015	**Chief Executive's Report** Mrs Donovan, Chief Executive, presented this report which provides an update on the activities undertaken since the last meeting in March 2015 and draws the Board's attention to any other issues of significance or interest. **Pass it On Event** The Pass it on Event was excellent and celebrated the 15 staff led teams involved with the Listening Into Action programme. The headlines for success were; • The Access Team which is now a 24/7 service with a dedicated GP line set up which has had very positive feedback. • Introducing a more streamlined and speedier recruitment process for new employees of the Trust. • We are continuing to strengthen how we learn lessons from complaints. • Work is ongoing with improving technology and what can be invested with the HIT squad. Work with services users around 136 suite. • Involving North Staffordshire's Young Person's Council in the design of a poster raising awareness of attend (DNA) appointments. • Every GP now has a named Consultant within the Trust's Community Mental Health Teams.	

CQC Quality Assurance
There has been an announcement of our CQC inspection which is 7 – 11 September 2015. As part of its quality assurance programme and to ensure a more robust approach in line with the CQC's fundamental standards, a Quality Assurance Programme Board has been established. In addition, a six big ticket programme has been established which will be led as part of the Listening into Action programme. Each area is sponsored by an Executive Director with a person responsible to ensure delivery using a structured project approach.

- Improving Staff Supervision
- Caseload management systems
- Reducing ligatures and improving safety in inpatient environments
- Strengthen our transition between services
- Improving our bed management systems
- Mental Health Act and record keeping

Aims Accreditation
The Trust's rehabilitation and recovery units; Summers View in Tunstall and Florence House at the Sutherland Centre, have been recognised with a National accreditation for inpatient services.

Aston Team Development CQUIN
The Trust has agreed with commissioners that this will be a CQUIN. It was also noted that 84% of teams have demonstrated an improvement and we are continuing to embed this development.

Business Strategy and Development
The Trust has submitted the draft One Year Business Plan to the NHS Trust Development Authority. The final plan will be submitted in May 2015.

2015/16 Contract
The Trust has been negotiating with Stoke and North Staffs CCGs around funding and we have now signed the contract and had additional funding of £1m. The main priority to invest in is increased staffing and a targeted recruitment process, particularly for inpatient areas is underway.

Appointments
Agreement has been made to work with Stoke-on-Trent City Council to develop a joint management structure across the Council and Trust Learning Disability services. Amanda Lovatt, Strategic Manager for Learning Disability Services at the council and Dr Matt Johnson, LD Clinical Director, are currently working through the detail of when and how this new exciting partnership will begin.

Mr Steve Blaise has been appointed to the post of Deputy Director of Finance.

Ms Lesley Whittaker has taken up the post up of Interim Complaints Manager

Health Education West Midlands' Mental Health Institute
Mrs Donovan confirmed that she has been appointed to Chair the Health Education West Midlands' Mental Health Institute Local Education and Training Council (LETC) following the current Chair's retirement.

Focus on Nutrition and Hydration
There was a National Awareness Campaign supported by the Trust at the end of March. The Trust's commitment to providing high quality nutrition and hydration to those using its services was reflected in its most recent Patient Led Assessment Care Environment (PLACE) report; the Trust recorded 97.12% score, which is above the national average.

Change of name of Section 136 Suite at Harplands to Place of Safety
This has already been mentioned previously.

Car Parking at Harplands Hospital
In order to make best use of the car parking facilities at the Harplands we are introducing an Automatic Number Plate Recognition camera on site. There will be prominent signage around the place making it clear that unauthorised parking will be subject to a parking notice, there will be an appeals system in place to address any concerns.

Healthcare People Management Association Awards
We have been shortlisted in two categories ;

1. Contribution for organisational change

2. Team based working category

	Reach Awards The Trust's Annual Recognising Excellence and Achievement in Combined Healthcare (REACH) Awards will be held on Wednesday, 9 September 2015. **National updates** • An updated Health and Social Care Act has now become law from 1 April 2015, Andy Oakes to come to June Trust Board to present changes and what this means to the Trust • Building the NHS Five Year forward view – this is the Business Plan from NHS England and will be discussed in the closed session The Chair thanked Mrs Donovan for her updates and in particular commented on the good news for the Trust that the she is taking on the Chairing of the Health Education West Midlands Mental Health Institute, Local Education and Training Council (LETC). ***Received***	
08/2015	**Spotlight Awards - April 2015** **Individual Spotlight Award** **Dr Christine Leaman – Consultant Psychiatrist, Ward 3** **AMH In Patient Directorate** Christine has worked on Ward 3 for the last two years, and has found working with women with complex mental health needs challenging and rewarding. Her approach to mental health issues is holistic, with a compassionate interest in the psychological and interpersonal aspects of patients, as well as the biological and social. On Ward 3, many women have suffered significant trauma in the past, which impacts on their mental health and how they function as patients, Christine has introduced clear care-planning, with boundaries that are supportive for patients and for staff. She encourages all members of the multidisciplinary team to contribute to understanding the patients' needs and strengths, and to ensuring that admissions are purposeful and beneficial. She has emphasised the importance of maintaining high standards in all 'routine' ward activities, including physical health care which has resulted in improved standards in this area. She has encouraged team-working across the wards, introducing the	

	weekly joint handover, and the Senior Clinical Team meeting, which includes an educational element. Christine's work demonstrates a very strong link with the Trust value of "working together for better lives". She has led the multi-disciplinary team through challenging times, and demonstrated excellent capacity to improve the lives of many people, especially those with challenging behaviours and personalities. All this she has achieved with openness, integrity, dignity and honesty. The Chair noted how fortunate the Trust is to have Dr Leaman working for us and also noted her excellent leadership and chairmanship of the Senior Medical Team, who have embraced the Aston Team Leadership. **Team Spotlight Award and Presentation** **Priority Referral Team – Children and Young People's Directorate** The Priority Referral Service provides emergency assessment and care for children, young people and families during working hours. The team work with young people presenting in crisis as a result of mental health problems. This is challenging work and requires a high level of skill and expertise. The team comprises senior clinicians from across our Tier 3 Child and Adolescent Mental Health Service from a variety of professional backgrounds. The team exemplify the Trusts values. All young people are treated as individuals and the team work to agree personalised care plans that reflect each young person and their family's needs. They often work in challenging circumstances and are creative in delivering high quality care to young people who are at times hard to reach and engage. They liaise with colleagues to ensure continuity of care and also frequently liaise with partner agencies to ensure holistic care packages. Open and honest discussions with young people and their families about risk are crucial to the assessment and management of those presenting in crisis. All the team exceed expectations to ensure the delivery of high quality care to children, young people and their families. It was noted that Andy Reid is part of the team but is not present today due to personal circumstances. The number of referrals to the Priority team were compare and noted the increase since this time last year ; Q4 last year 35 Q4 this year 73	

	Dr Tattum commented on the goodwill of staff working out of hours and was this being monitored? Sue Wheatcroft confirmed this is monitored and there is back up with a telephone system. The new pathway has helped to review the data and put forward what resources will be needed to be more proactive rather than reactive. Mr Hughes queried if we did not have Priority Referral service what would happen? Dr Barton confirmed that the Paediatrician would discharge and then refer into the community. CAMHS are reviewing how we can support people at A&E level. Mr Dinwiddy commented that it is very interesting around our partnerships with local hospitals, especially in terms of skill sharing and shadowing of staff. Dr Barton commented that CAMHS have worked with the Acute hospital with regard to staff training and support. Sue Wheatcroft also noted that shadowing with a RAID worker and Priority Team worker is carried out and vice versa. Mr Dinwiddy to discuss further outside of the meeting. Mr D Rogers noted the increase in demand and was this due to incidents increasing or whether we were identifying people more efficiently. This can also be overwhelming for staff. Sue Wheatcroft confirmed discussions had been held with the Acute hospital and there has been a significant increase. There is evidence for this and the reasons. GP shadowing may also be advantageous. Mr A Rogers commented and empathised on the difficulties with capacity in the team which only equates to 1 WTE in total, plus capacity with Tier 4 beds. Clearly, there are some issues and although we have the skills and expertise, there is further scope for more resources into this service. Dr Barton stated that the new pathway is being utilised, but sometimes it is a combination of other issues. Mrs Donovan queried what was the impact from Stafford or Mid Staffs. Dr Barton stated that statistics were available from when Stafford closed A&E. It was noted that we need to transparency for commissioners ;Mr A Rogers to take forward. Secondly, Mrs Donovan queried what was the majority being discharged and what % come back to CAMHS Tier 3. Dr Barton commented that all have at least one follow up. Thirdly, Mrs Donovan commented with regard to A&E and RAID, is there a stronger connection? Dr Barton agreed we have done some work and we need to take forward and share skills.	Mr A Rogers

	It was noted by the board that re-referrals are possible, as long as these fall within a certain timeframe. Each patient is discharged with a Safety Plan. Dr Adeyemo was pleased to see that the intervention of the new pathway had helped the service. The Chair thanked Dr Barton and Sue Wheatcroft and noted the impact for all concerned at times of crisis, such as individuals, friends and families. It is clear there is a national major issue about the level of resources for children and mental health. ***Received***	
09/2015	**Staff Retirements** Mrs Donovan recognised 5 staff who are retiring this month as follows, unfortunately these staff were not able to attend today : **<u>Elizabeth Ayre</u>** Liz began her nurse training at St Edward's Hospital on September 4th, 1978. After qualifying she worked as a staff nurse on the Psychiatric Unit at the City General Hospital (mainly on night duty), for more than ten years before going back to St Edwards to work in Rehab and at Malloy House. She began working with the Psychology Service at the City General Hospital for one day a week in 1994, initially on a temporary contract whilst continuing to work as a nurse. She was given a permanent contract as a psychological therapist with Psychological Services from 1995 and has remained in this role to the present day. **<u>Angela Barton</u>** Angela has worked contributed some 39 years, latterly as a Senior Practitioner at the Sutherland Centre and has been an important part of ensuring that we have properly looked after those who needed our care. She commenced with the local authority as a Social Worker and transferred into the Trust in 2008. Amongst her many talents, she is an Allied Mental Health Practitioner, a Practice Educator and has worked within several teams across the Trust. All her colleagues wish her well and the very best for the future. **<u>Anita Purdy</u>** Anita has worked with the Trust since qualifying as a Staff Nurse in early 1990s. She has held a Senior Nursing Position for nearly 15 years of her career. Anita will be sadly missed by all her staff that she manages and her colleagues who have worked alongside her. She has also been extremely well thought of by	

	GPs, Consultant Psychiatrists and other professionals and has been very modest in her achievements. **Helen Quarterly** Helen joined our organisation in 1999 as a Community Psychiatric Nurse based a Lymebrook Resource Centre and moved to her latest position 3 years ago when the Wellbeing Service, originally known as IAPT, was implemented in Earl House, Newcastle-Under-Lyme. Helen has always demonstrated commitment and dedication to patient care and has always been extremely popular with her peers. She will be missed by all the team. **Stephanie Porter** Stephanie joined the organisation in 2001 and is due to leave on 31 May 2015. She worked as a Community Psychiatric Nursing for the Wellbeing Service and previous to this worked at Lymebrook Resource Centre in the same capacity. Stephanie will be greatly missed by all her colleagues and we wish her well for the future. The Chair stated the importance that we acknowledge the length of service and also recognise the massive amount of continuity of service.	
10/2015	**Quality Committee Summary held on 21 April 2015** Mr Sullivan, Non-Executive Director, presented the summary of the Quality Committee held on 21 April 2015 for assurance purposes. The committee received information on policies and these are recommended for ratification today for a period of 3 years or to be extended or withdrawn as follows: • 4.37 External Placements – withdraw as local procedure not a policy • IC19 CDIFF • Volunteer Policy • 4.19 Equality Scheme – withdraw, replaced by Equality Delivery System • 1.04 Complementary Therapies • Interpretation and Translation Services 7.12 – withdraw, incorporated in information on the Staff Information Desk • MHA12 Section 17 Leave Procedure • R05 Restricted Access and Locked Doors – extend until 30 June 2015	

	• 1.03 Medicines Management Policy • 1.34 Pulse Oximetry Guidelines • 1.70 Managing Allegations of Abuse • 4.22 Children Visiting mental health and LD settings ***Ratified*** As part of the Director of Quality Report, the Quality Committee reviewed the New Confidential Enquiry Report, which summarises the findings of a report published in March 2015. The report focuses on inpatient suicides during January 2006 – December 2012. In terms of reports for assurance, the Quality committee reviewed; Quality Impact Assessment on Cost Improvement Programme (CIPs) in particular report 2014/15, which did not identify any specific issues of concern, however there was general agreement to monitor quality impact more closely and working with the dashboard will assist with this. Nurse Staffing Performance Monthly report – March 2015 was received for assurance purposes. Eliminating Mixed Sex Accommodation Action Plan – Q4 2014/15 the Trust is compliant and declaration will be posted onto the Trust's website. Quality Metrics reviewed from Performance Quality Management Framework Report (PQMF) Month 12 Infection Prevention and Control (IPC) Action Plan update.. Domain reports received in terms of Patient safety, Clinical effectiveness, Organisational safety and efficiency and Customer focus. The committee scrutinised Risks to Quality of Service – M12. Received the Directorate Performance Reports. The Quality Committee received an update on the change in the delivery of current model of day hospital services concerning Marrow House and Abbots House. This was a Commissioner lead process – Update and progress regarding the CQC Quality Assurance Programme.	

	Finally, Mr Sullivan noted that the Quality Committee discussed in some detail the importance of having Patient Stories as part of their agenda and having appropriate patient representation; Mr Dinwiddy to report back to the Quality Committee next month. ***Received***	
11/2015	**Safe Staffing Monthly report** Mr Dinwiddy, Interim Director of Nursing and Quality, presented the assurance report which outlines the monthly performance of the Trust in relation to planned vs actual nursing staffing levels during the data collection period (1 – 31 March 2015) in line with the National Quality Board expectation. The performance relating to the fill rate (actual numbers of staff deployed vs numbers planned) on the wards for March was 98.4%: being a total fill rate of 96.25 for registered nurses and 100.5% for HCSWs. The position reflects that ward managers are effectively deploying additional staff to meet increasing patient needs as necessary. The Board noted the following; • Six monthly report due at next month's Trust Board meeting • As we go forward, this report will include increasing numbers of easy read metrics • Community teams are currently being assessed and methodology being developed in order to measure staffing requirements by team. (This is not included today) • It was highlighted again that we have deployed 98.4%, • slightly less for Registered nurses and more for HCSWs. • Incidents on ward 1 have increased, however level of harm decreased. • Telford – sickness rate has increased however this will be improved at the time of the next report	

	• Several vacancies in Darwin, though two posts have been recruited to with imminent start dates. • Ward 2 – 17 year old admitted and has required high level of staffing – admitted in late March and discharged in April 2015. Admission to an adult ward was clinically appropriate. Mr Sullivan commented on the recruiting to vacancies and the importance of their progress, in addition he noted the percentage of temporary staff is not acceptable. Mr Sullivan was pleased to hear that community teams would be included and welcomed the increased data and metrics for further assurance and scrutiny by the board. He further noted that he would like to see complaints and incidents contained within the report in order to gain an overview and review the quality of service and safety. Mrs Donovan thanked Mr Dinwiddy and stated that the report is improving month on month. Mr Dinwiddy alerted the Board that the TDA had raised concerns regarding some data supplied via the national reporting method, which showed us to be down on our fill rate. On analysis, it appeared that there has been some anomalies (due to some services being reported wrongly, eg Chebsey Close showing 0% rather than being reported as no longer being provided, which has now been rectified. Furthermore, Mr Dinwiddy noted a meeting is scheduled with the TDA and colleagues on 11 May 2015 to discuss further. Mr Draycott gave assurance with regard to Mr Sullivan's comments on recruitment. He confirmed that an advert has gone out for a campaign locally and surrounding areas and will interview in late May and June. The plan is to hold two interview days, to fill 23 vacancies with a *'One Stop Shop'* to include occupational health, DBS checks, intended to speed up the process. The Chair requested that the Board receive a regular report on recruitment and Mr Draycott agreed that he would take this forward Mrs Johnson asked if the two members of staff from Ward 1 were back at work following the serious incidents that had occurred with distressed patients?	Mr Dinwiddy Mr Draycott

	Dr Adeyemo confirmed the members of staff were now back at work. Mrs Donovan noted that she had written out to the individuals concerned. Mr A Rogers commented that the report includes more data which is very helpful, however this is data without assurances. Mr Dinwiddy noted that the reports are evolving and will further help to strengthen the information and assurance to the Board. Ms Harvey commented that the report gave clear information and wondered how we can improve how we share these reports. She queried whether this could come to JNCC in order to share with trade unions. It was agreed this would be very beneficial and logical. Mr Dinwiddy to forward to Ms Harvey. Mrs Hilda Johnson further commented and thanked the board for the informative report. It was noted that she had already spoken with Rachel Nicolaou, Ward Manager, on Ward 2 as noted at last month's meeting for her tremendous efforts to maintain safe staffing levels. The possibility of inserting a link on Newsround in respect of staffing levels was also considered. Mrs H Johnson also noted that she had had conversations with Mr Oakes regarding staffing levels within community services and that the complexity of caseloads should also be considered, which was noted to be part of the six big ticket work. Finally, the Chair commented on the meaningful reports which have become much improved and moving in the right direction. The recruitment campaign is also crucial and high profile. ***Received***	Mr Dinwiddy
12/2015	**Financial Performance – Month 12** Ms A Harrison, Interim Director of Finance, presented this report and highlighted the headline performance for the period to the end of 31 March 2015 The Trusts financial performance is a retained surplus of £0.425m and £0.768m surplus at 'adjusted financial performance'. This performance is a favourable variance against Plan and delivers the Trust's statutory duty for the year. The Trust is reporting an achievement in full against the CIP plan of £4.08m. The cash balance as at 31 March 2015 was £6.8m. The net capital expenditure is a negative £0.741m, which represents an undershoot of £2.241m against the CRL of £1.5m. The Continuity of service Risk Rating is reported as 3 in line with the plan.	

	The Board is asked to note the 1% surplus the Trust has achieved with CIPs, albeit with the high value of non-recurrent CIPs addressing 2015/16. The Board is also asked to note the capital expenditure position of an undershoot against the Trust's Capital Resource Limit. However, we have a much better platform for more innovating capital schemes going forward. Ms Harrison was pleased to note the Accounts were finished and prepared on 23 April 2015, in readiness for the Auditors to commence their review and we do not anticipate any issues. Overall, it is essentially very good news all round. ***Received***	
13/2015	**Assurance Report - Finance and Performance Committee Report – 23 April 2015** Mr Gadsby, Non-Executive Director, presented the assurance report to the Trust Board from the Finance and Performance Committee held on 23 April 2015. Mr Gadsby reiterated the achievements with the financial targets for 2014/15. He noted that he had subsequently met with the Finance team and conducted a page turn for the submission of the Accounts and gave assurance that he did not expect anything that is material to come out of the audits. It was noted that the Trust had delivered its 2014/15 CIP target of £4.08m, however Mr Gadsby noted that there is a significant element of non-recurring (over a third) which is unacceptable and that going forward a review of CIP should be more robust to provide the board with the assurance it needs in this regard. With regard to Capital, the Finance and Performance Committee will have a standing agenda item for capital reporting going forward. Mr Hughes and Mr Gadsby will also be working together in this area in order to invest in the growth of the organisation. The Chair and Mrs Donovan echoed the Finance and Performance Committee's congratulations to all the finance staff for their achievements and noted the remarkable position the Trust is in. The Chair and Mrs Donovan also personally thanked Ms Harrison. It was proposed to write thank you letters to all those concerned.	Mrs Donovan

	Received	
14/2015	**TDA Accountability Framework 2015/16** Ms Harrison, Interim Director of Finance, presented this report which is produced each year by the Trust Development Authority (TDA) for guidance purposes for the Trust Board. It was noted that the number of measures have increased by approx 20. The focus is on Friends and Families and 18 weeks referral to treatment. This will form part of work with the balanced score card report. Mrs Donovan requested that this document be summarised to understand how it links into our 5-Year plan going forward. Mr Hughes to bring back. ***Received***	
15/2015	**Performance and Quality Management Framework Report (PQMF) Month 12** Ms Harrison, Interim Director of Finance, presented this report. The report provides the Board with a summary of performance to the end of Month 12. It was noted there is a range of 95 metrics in place to monitor performance, quality and outcomes. At month 12, 58 metrics were rated as Green, 1 rated as Amber, 6 rated as red and 28 unrated due to the absence of targets which are monitored to identify and respond to trends. Ms Harrison commented that the report has not changed significantly but there are 2 new reds identified in relation to prevention of pressure ulcers and admission of a young person under 18 to an adult wards. Discussion took place regarding the ***Pressure Ulcers metric*** – which is normally a rare event in the Trust. Mr Dinwiddy commented that this was in respect of a patient on Ward 7, while it is not clear exactly where this occurred, we have chosen to report it. This was picked up when the patient was admitted to University Hospital North Midlands. . The Chairman noted his disappointment with this, particularly all the work that had been undertaken, led by Norah Smith, who has since left the Trust. Mr Dinwiddy noted that action has been taken to review our links with the Tissue Viability Team and this is being led by Ward Manager Janet Taylor on Ward 5. A further update will be	M Dinwiddy

	reported to the Board next month. Further debate took place regarding the ***IAPT metric*** - Mrs Donovan confirmed we have had some more resources in this area. In addition, we are measuring performance of SLAs with Mind and Changes. Mr Rogers noted the good improvements with data for IAPT. In relation to the presentation from the CAMHS Priority Team, Mr A Rogers noted that CPA performance held by the TDA is lower than ours and this is currently being validated. The issue also is about the timing of the data and fundamentally, as this is late data it was agreed that we need to input all data within 6 weeks of CPA in a more timely way, plus when Payment by Results is introduced, we will not get paid for late submissions. It was noted that work is underway to develop standard operating procedures, therefore at this time it is difficult to plan or forecast an improvement. Mr Rogers noted however, that admission on this occasion was the safest solution for this individual. Mrs Donovan drew attention to this metric and further stated that the Standard Operating Procedure had been discussed at the SLT group. Mr Sullivan queried whether this was justified as a clinically appropriate admission. Dr Adeyemo re-confirmed that it was clinically appropriate but due to reporting requirements it would still need be recorded as a serious incident. Mr Sullivan made some observations and raised some concerns in that there are a number of reds increasing month on month. In some areas these do not have direct impact on patient care and patient services, however it is important we see improvements, ie ***Mental Health Tribunal Process*** ; not writing reports on time, this is not acceptable because it is likely that the patient is not receiving an acceptable level of service. Mrs Donovan agreed with Mr Sullivan and noted that these issues should be transparent, hence the reporting metric. In addition, a policy had been agreed by the Senior Leadership Team for further review and learning in this area. Dr Adeyemo noted that there has been an improvement from the previous month from 25% to 60% and Clinical Directors were leading on taking this forward. Mrs B Johnson noted that the action plan lacked timescales for deadlines. Ms Harrison to ensure included for future reports to the Board. The Chair commented on the strong focus on timescales for the red items.	Ms A Harrison

	Mr A Rogers drew attention to Appendix 1 – Update on Changes to Access and Crisis Team, this paper updates the Board and evidences and identifies the following elements; • Recognising that the change is newly embedded, initial data is overwhelmingly positive. • Commissioners have now recurrently funded the change and it will therefore be continued. Mr Draycott commented on the remarkable improvements and commended the whole team in particular, Nicky Griffiths' leadership and the Access Team. Mr Sullivan queried whether we are measuring increased face to face actual assessments? Mr A Rogers noted that further information could be provided, in the meantime he drew attention to the detailed statistical information contained within the appendices. The Chair commented on the good news with the improvements to the Access Team. He further requested that Dr Adeyemo share this report with the LMC. ***Received***	Ms A Harrison Dr Adeyemo
16/2015	**Self-Certifications for the NHS Trust Development Agency** Mrs Harrison, Interim Director of Finance, presented the executive summary on behalf of the author, Mr Sargeant, Head of Performance and Information. The summary indicates that the Executive Team have reviewed, with one change from last month's position of compliance to report Declarations include ; • Fit proper directors • Registration with CQC • Provision of integrated care • Effective arrangements for monitoring and continually improving the quality of healthcare • Compliance with TDA Accountability framework Mrs Donovan noted that based on March 2015 data, the Trust is declaring compliance with all requirements following successful delivery of the action plan to address the CQC requirement (declared non-compliant last month as recommended by the CQC). The Trust will send this information to the TDA with the self-certification return.	

	Received	
17/2015	**Assurance Report form the Audit Committee** Mr D Rogers, Chair of the Audit Committee/Non-Executive Director presented this report which is a summary of the Audit Committee meeting held on 16 April 2015. The Audit Committee received a paper detailing the key milestones and dates associated with the production of 2013/14 Annual Accounts. A first draft of the Annual Governance Statement was also received. The final version will be approved at the Audit committee in June 2015. Members of the Audit Committee also received the draft Quality Account. Mr D Rogers noted that this would become a public document once finalised in June 2015. He also noted that the Trust should be assured the quality of services are adequate and the systems we have are approachable. The Quality Committee also have a role to play in reviewing the content of the report and giving assurance to the board about its accuracy. Other areas of assurance were received with the Principal Risk Register Assurance Report. The Internal Audit Strategy and Audit Plan for 2015/16 were approved noting that there was a contingency built into the plan to help respond to any emerging issues during the year. It was noted that some of the core internal audit work will be spread out over 3 years in order for the Trust to focus on other areas of more risk based assurance Mr D Rogers noted the Audit Committee was observed by the Good Governance Institute and that there will be a review of the current format of the Audit Committee in order to process matters more effectively and reduce agendas. Mr Sullivan also commented on the Quality Account document is well written and informative and that this had been reviewed by the Quality Committee. Mrs Storey drew attention to the Internal Auditors conclusion for the Annual Governance Statement : ***'There are no significant control issues reported for the Trust in 2014/15 and the draft Head of Internal Audit opinion is that significant assurance can be given that there is generally a sound system of internal control designed to meet the organisations' objectives and that***	

	controls are generally being applied consistently'. This positive position was acknowledged by the Chair on behalf of the Board. ***Received***	
18/2015	**People and Culture Development Committee Report** Mr Sullivan, Vice Chair of the PCD Committee/ Non-Executive Director, presented this report which is a summary from the People and Culture Development Committee meetings which took place on 23 March 2015 and 20 April 2015. Mr Sullivan chaired the meeting on 20 April 2015 and commented as follows ; There were 2 policies approved ; • The Retirement Policy • Shared Parental Leave policy ***Ratified*** The PCD committee received presentations by exception from each of the directorate leads on their performance against key workforce indicators. Key elements were discussed sickness and absence and mandatory training. Workforce and Organisational development risks reviewed. Assurance received in respect of Violence against staff statistics 2013/14 with considerable reductions. Action plan for the Staff Survey received which is also on today's agenda. Information received on Stress Reduction plan, whereby the committee received a presentation from Prof Ruth Chambers, Clinical Tele-health Lead for Stoke on Trent CCG, this was extremely helpful. Benchmaking data with workforce metrics. Psychiatry Workforce Review, in summary the report outlined a projected shortfall of Consultant Psychiatrists as time moves on. Sickness and Absence Update received and how this is being monitored and mandated across directorates.	

	Mr Draycott also drew attention to the Equality Monitoring Data Analysis Report 2014, received by the committee lead by Val Stronach. The report was very comprehensive and work will be further developed across the Trust. Ms Harvey commented that she was a member of the committee and she was pleased to see that stress is high on the agenda. She also commented on the Equality Monitoring Data Analysis report and that it was interesting to note the pay bands by gender. Furthermore, it was recognised that we need to attract local communities in respect of health professionals ie medical staff. Mr Draycott commented that improving workforce representation within these areas has been incorporated into the Integrated Business Plan. Mr Draycott also commented that through the reconfiguration of the Workforce Directorates we are appointing an Inclusion Lead to take forward this important work Ms Harvey welcomed the appointment of this post. The Chair noted under Stress Reduction Plan and the stress tool implemented by Zoe Grant called 'Zoe's Zokens'. This was a good initiative and hoped to see this rolled out to other areas. ***Received***	
19/2015	**Staff Survey Action Plan** Mr. Draycott, Director of Leadership and Workforce, presented this report which is an action plan in response to the Staff Survey, the results of which were received at the previous meeting. The Action plan had been discussed at the People and Culture Development Committee and JNCC and continues to evolve at Trust level and as Directorates formulate their specific targeted local action which are still be developed in some areas. Members of the Board are asked to gain assurance form the Action Plans at Trust and Directorate level and the progress made todate. Ms Harvey commented that it is frustrating and the danger is to focus on smaller items. She confirmed that Staff Side have committed to be more proactive in helping to improve the response rates, which tends to be low. Mr Draycott confirmed that each directorate had completed their action plans and that these would be monitored through the	

	PCD and feedback to Board through PCD. It is anticipated that measurable outputs will be next year's Staff Survey. ***Received***	
20/2015	**Any other business** **NSUG Updates** Mrs H Johnson remarked on the PLACE inspection at Summers View, which had been very positive with Anne Melville. She also noted more volunteers had been involved **CQC visit** Mrs H Johnson also remarked on the forthcoming CQC visit and advised the Trust to ***'carry on doing what you do every day and the Trust will be fine'.***	
21/2015	**Date and time of next meeting** The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday, 4 June 2015 at 10:00am, in the Boardroom, Lawton House, Trust HQ.	
22/2015	*** Motion to Exclude the Public** The Board approved a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted.	

The meeting closed at 12.30 pm

Signed: _____ Date_____

Chairman

Board Action Monitoring Schedule (Open Section)

Trust Board - Action monitoring schedule (Open)

Meeting Date	Minute No	Action Description	Responsible Officer	Target Date	Progress / Comment
30-Apr-15	08/2015	**Priority Referral Team - CYP Directorate -** Mrs Donovan queried what was the impact from Stafford or Mid Staffs.. Dr Barton stated that statistics were available from when Stafford closed A&E. It was noted that we need to transparency for commissioners ;Mr A Rogers to take forward to provide more information to the Board.	Mr A Rogers	04-Jun-15	
30-Apr-15	11/2015	**Safe Staffing Monthly Report** - Mr Sullivan was pleased to hear that community teams would be included and welcomed the increased data and metrics. He further noted that he would like to see complaints and incidents contained within the report.	Mr Dinwiddy	04-Jun-15	To review as part of the development of the monthly / six monthly report
30-Apr-15	11/2015	**Safe Staffing Monthly Report** - The Chair requested that the Board receive a regular report on recruitment. Mr Draycott to take forward.	Mr Draycott	04-Jun-15	
30-Apr-15	11/2015	**Safe Staffing Monthly report** - Ms Harvey commented that the report gave clear information and wondered how we can share better? She queried whether this could come to JNCC in order to share with trade unions. It was agreed this would be very beneficial and logical. Mr Dinwiddy to forward to Ms Harvey.	Mr Dinwiddy	04-Jun-15	Completed - sharing of report in place with JNCC
30-Apr-15	12/2015	**Assurance Report - Finance and Performance Committee - 23 April 2015 -** (FINANCE TEAM) - It was proposed to write thank you letters to all those concerned for the impressive year end position	Mrs Donovan	04-Jun-15	
30-Apr-15	15/2015	**PQMF Month 12** - Mr Dinwiddy noted that action has been taken to review our links with the Tissue Viability Tem and this is being led by Ward Manager Janet Taylor on Ward 5. A further update will be reported to the Board next month	Mr Dinwiddy	04-Jun-15	
30-Apr-15	15/2015	**PQMF Month 12** - Mrs B Johnson noted that the MH tribunal action plan lacked timescales for deadlines. Ms Harrison to take forward	Ms Harrison	04-Jun-15	
30-Apr-15	15/2015	**PQMF Month 12 -** Sharing good news story with regards to the Access Team with LMC	Dr Adeyemo	04-Jun-15	

Board Action Monitoring Schedule (Open Section)

Meeting Date	Minute No	Action Description	Responsible Officer	Target Date	Progress / Comment

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: Open Trust Board

Date of Meeting:	Thursday 4 June 2015
Title of Report:	Chief Executive's Report to the Trust Board
Presented by:	Mrs Caroline Donovan
Author of Report: **Name:** **Date:** **Email:**	Caroline Donovan, Chief Executive Caroline Donovan 28 May 2015 Caroline.donovan@northstaffs.nhs.uk
Purpose / Intent of Report:	• For Information
Executive Summary:	This report updates the Board on activities undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest.
Which Strategy Priority does this relate to: **How does this impact on patients or the public?**	• Customer Focus Strategy • Clinical Strategy • ~~IM and T Strategy~~ • Governance Strategy • ~~Innovation Strategy~~ • ~~Workforce Strategy~~ • ~~Financial Strategy~~ • ~~Estates Strategy~~
Relationship with Annual Objectives:	To ensure safe provision of clinical services
Risk / Legal Implications:	N/A
Resource Implications:	N/A
Equality and Diversity Implications:	N/A
Relationship with Assurance Framework [Risk, Control and Assurance]	N/A
Recommendations:	To receive this report for information

North Staffordshire Combined Healthcare Trust

Chief Executive's Report to the Board of Directors
4 June 2015

1. PURPOSE OF THE REPORT

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

LOCAL UPDATE

2. QUALITY ASSURANCE

The date for our CQC Comprehensive Inspection has been confirmed for 7th – 11th September 2015. The inspections – which are carried out by a mixture of inspectors, clinicians and Experts by Experience – will assess whether the service overall is: safe, effective, caring, responsive to people's needs and well-led. Following the inspection, each provider will receive an overall rating of either: Outstanding, Good, Requires Improvement or Inadequate.

Over the course of the next 14 weeks, there will be a number of actions in preparation for our inspection. To prepare for their visit, the CQC inspectors request a significant amount of data. The first and second data requests for documents included commissioner details, patient and service user representative group details, staffing information and data on serious incident. Clinical teams have been asked to complete self- assessments, and we are holding a series of 'CQC, quality & you' workshops, with two dedicated workshop for doctors.

All teams have been self-assessing their services, identifying their strengths and areas of improvement and rolling out peer-review visits looking at quality improvement.

The clear message for staff is that the CQC inspection is an opportunity to showcase the excellent services and care they provide across North Staffordshire and Stoke on Trent. CQC inspectors will be reviewing our services to ensure they are caring, responsive, effective, well-led and safe. If you have any feedback on any of these areas, or would like to speak to someone about the CQC inspection, please contact Claire Holmes, Project Lead, via 0300 123 1535 FN1390 or email CQCquality@northstaffs.nhs.uk

3. ENHANCEMENTS IN ACCESS TO SERVICES

I am delighted to report that the series of measures recently put in place to strengthen access to services and enhance the service delivered by the Access Team are making a positive impact.

The Access Team is the single point of contact and access for all Trust services and provides the following:

- Qualified health and social care staff who work together to provide assessment, advice and sign-posting to support recovery and promote well-being
- Support for individuals and referrers to assist them to get access to the right services
- Support for people with mental health illness who are experiencing difficulties when the stability of their mental health has been interrupted by crisis

In January 2015, the Access Team's hours of operation increased from 8am-8pm midweek and 9am-5pm weekends to a 24/7 service, covering all crisis response activity. The Team was restructured to provide an assessment service, releasing the Acute Home Treatment Team to focus on intervention rather than assessment.

The following data highlights the outcomes as a result of the changes put in place:

- 63% increase in the number of crisis referrals seen in 4 hours
- Trend indicates increasing number of people receiving Home Treatment
- Ward occupancy averaged below 100% for three consecutive months for first time in over a year
- 21% increase in ward admissions and 23% increase in discharges
- 18% reduction in average length of stay on wards
- 5% reduction in detentions on wards
- No increase in serious incidents or complaints across AMH services
- 20% increase in readmissions

We will continue to review the way in which services are provided, to ensure that all people requiring help or support will be able to access it at their time of need. Two dedicated lines have been put in place; one for primary care colleagues, to allow for easy referral when a client is seen by a GP and requires additional support and one for gatekeeping, to allow speedy access to an inpatient bed if needed.

The improvements we have seen have taken place subsequent to a review, reported on in May by Healthwatch Stoke-on-Trent, into the experience of people in Stoke-on-Trent when they are accessing Mental Health services. The report focuses on the experiences of users of the Access service in the six months prior to the report publication.

Overall, the experiences captured highlighted a mixture of views, many of which have already been addressed as a result of the Listening into Action work undertaken by the Access Team, including:

- A need for pathways to be clearer for the user to understand
- Lengthy waits for return phone calls

It was acknowledged by the Healthwatch team that the Trust provided a detailed and comprehensive response to the report, which identifies steps already taken and plans for the future. In light of this, the Healthwatch team included the Trust response in the final version of the report, to show that NSCHT responded positively and is already making changes based on the recommendation suggested.

4. BUSINESS STRATEGY AND DEVELOPMENT

We have submitted our final one-year business plan to the NHS Trust Development Authority. The plan sets out how we will deliver safe, high quality services over 2015/16.

We also continue to develop our five-year plan, setting out our direction of travel for the organisation as a sustainable key partner in the local health economy.

5. RECRUITMENT OF ADDITIONAL NURSING STAFF

The contract for 2015/16 has been agreed with our commissioners. Negotiations have been ongoing to secure national Forward View funding to deliver parity of esteem.

I am really pleased to report that we have agreed this additional funding for a number of areas, including staffing for acute inpatient wards, in order to support the high level of occupancy. We are committed to ensuring the right number of staff with the right skill mix are in place and we need to continually develop our strategies to plan ahead for change

We have already begun a targeted recruitment process to provide improved stability, particularly in inpatient areas. We have already appointed 12 Health Care Support Workers and four registered nurses into our Adult and Neuro and Old Age Psychiatry Directorates, with further interviews scheduled for Thursday, 4 June

6. LISTENING INTO ACTION

Through listening to our staff, we have recently completed improvement across 15 of our Clinical and Trust-wide teams and we have just launched phase two with 12 new teams.

Early signs from surveying our staff are showing very encouraging improvements in our staff engagement scores. We also recognise that developing an open and transparent culture is really important to how staff feel about the way they are listened to and able to contribute.

Following the Trust's hugely successful Listening into Action (LiA) Pass it On event, at which the progress of its first phase of 15 Pioneering Teams and Enabling our People Teams, the second phase has been launched.

Three teams will continue with ongoing support from the LiA team and Sponsor Group and will go forward into the second phase. Of the other 12 teams, some will continue to finish off outstanding actions, while others have concluded, having completed all their original goals.

The Second Wave of teams will be covering:

- Supervision
- Improve record keeping around the Mental Health Act in line with current legislation
- Transitions between services
- Caseload management
- Zokens wellbeing tool
- Deaf awareness
- Improving safety in inpatient environments
- Improving bed management
- Values and behaviours

- Junior Doctors
- Support staff
- Ownership of quality environments
- Recruitment
- No change About me without me

Through the LiA process, we are working hard to create a more open and transparent culture across the Trust.

As part of this, we have launched a shadowing programme to really help us to understand each other's roles more; members of the Executive Team will be shadowing a range of professionals, including nurses, healthcare support workers, caseload managers and others. I am also encouraging Clinical Directors and Heads of Directorates to shadow across a range of teams, to better understand the frontline challenges across services. Each week, I will be sharing feedback from the shadowing experience, via my CEO Blog.

7. HEALTHWATCH REPORT INTO WARD 4

In March, Stoke-on-Trent Healthwatch undertook an 'Enter and View' on Ward 4, our relatively new Shared Care Ward.

The objectives of the visit were to:

- Learn more about the operation of 'shared care' on this ward
- Check the ward environment to ensure its suitability for the 'Shared Care' Scheme.
- Support Healthwatch Stoke-on-Trent's contribution towards the 'Step up and Step down New Model of Care' Consultation currently being undertaken by Stoke-on-Trent Clinical Commissioning Group.

We have now received the Healthwatch report into this visit and I am delighted to share the findings with you.

As part of the visit, the Healthwatch team spoke to staff, patients and visitors and had a look around one of the bedrooms, went into one of the quiet rooms and also went into the dayroom which is where they spoke to most of the patients. Feedback from those that the Team spoke to showed staff were enthusiastic about the Ward and enjoyed working there, patients found it very comfortable and reported being well looked after. Relatives also fed back that the ward is "brilliant", said it was much calmer and liked the fact that their relative was able to wear their own clothes and move around more, which was good for them. They also said that because visiting time was open it meant they could visit at a time suitable for them.

The report highlighted that patients on this shared care ward are able to have home leave, where staff could assess them better, which had meant that some patients were able to return home rather than going into a care home or nursing home; this option wasn't possible at UHNM.

The summary of the report stated that "Ward 4 provides a quiet, calm, caring environment for patients; a 'step down' for patients who no longer need an acute setting but may need some further help, towards physical and mental improvement including any medication

reviews. It provides 'shared care' which works well with the appropriate skill mix to help patients with both physical and mental health needs. The time spent here also supplies the opportunity to ensure that an accurate, suitable care package is provided so that instead of moving directly to a Care Home patients may be given the opportunity to live more independently and happily at home. It was interesting to note that all staff, patients, and relatives spoken to were all very enthusiastic about the Ward, the only difficulty being that some patients wanted to remain there."

I'm delighted to share such positive feedback with the Board and have passed on my thanks to staff on Ward 4 for their hard work and commitment, which has resulted in such an excellent report.

8. DEAR CAROLINE

The Dear Caroline website was launched within the Trust on 20th February 2015 in order to provide our staff with an additional mechanism to raise concerns in an anonymous way.

The introduction of the Dear Caroline website underpins the Trusts commitment to the recommendations set out in the Freedom to Speak Up report, recently published by Sir Robert Francis QC.

I am really pleased that our staff are responding via this new mechanism and that we are receiving feedback in an honest and non-defensive way. Each directorate has welcomed the feedback and are using information to continually improve their services.

I made a commitment to share with staff and the wider public the themes of the Dear Caroline website. Of those received to date, the main themes have been:

Leadership and management
Submissions within this category have been received from across the Trust. To date, themes include reference to a lack of leadership and management or an unclear/inconsistent direction set by managers. In general, this relates to managers at team level and includes aspects of poor communication.

Staffing levels and workload
Submissions within this category have been received from clinical areas only. Concerns include volume of referrals/admissions, high caseloads, competing demands, low staffing levels and over reliance on bank staff.

Many of the issues raised were already in hand and have been picked up in the Listening into Action workstreams. An action plan has been set up to address the areas which have been raised via Dear Caroline that haven't emerged through other feedback mechanisms.

9. HEALTHCARE AWARDS

Following a presentation by our HR team to a national panel, I'm pleased to update you that we have passed to the next stage of the two national awards in the Healthcare People Management Association (HPMA) Awards and are now finalists. The HPMA Excellence Awards 2015 recognise and reward outstanding work in healthcare human resource management.

We have also been shortlisted in the HSJ Value in Healthcare Awards for the partnership working between our Community Triage Team and Staffordshire Police. I'll update you on both of these prestigious national awards as we progress through the judging process.

10. EARLY INTERVENTION TEAM CELEBRATES PROGRESS

The Trust's Early Intervention Team celebrated its progress supporting young people with early psychosis at a special event.

The event shared some of the innovative approaches to working with younger people experiencing a first episode of psychosis that have helped develop the service.

The service's achievements include the development of a tiered psychology pathway ensuring that all clients have access to required psychological interventions to enhance their experiences of engagement with the service.

The team's parent and child group is a family intervention bringing parents together who find engagement difficult due to childcare issues; while volunteers are helping to support community based groups, including previous young people who have accessed the service.

The Early Intervention Team serves young people with early psychosis who are aged 14–35 and their families. The programme bridges youth and adult mental health services and links community with hospital in the North Staffordshire and Staffordshire Moorlands area.

Early Intervention in Psychosis is a current focus with the introduction of the new Access and waiting time's standards. Those affected by a first episode will be expected to be seen and put on a NICE approved pathway within two weeks. The primary aim is to improve the life chances of those affected by psychosis, and include raising awareness of what psychosis is and how it can affect people, to challenge stigma and promote social inclusion.

11. NEW BEGINNINGS EVENT AT EDWARD MYERS UNIT

The independent service user and carer group supporting people with drug and alcohol dependence held its latest Open Morning at the Edward Myers Unit during May.

The New Beginnings event was formally opened by Trust Chair Ken Jarrold CBE and marked the work of the group since its most recent Open Morning in November 2014.

Led by a group of people who have used addiction support services, New Beginnings works with NSCHT to provide support for people experiencing issues with drugs, alcohol and other

addictive substances and is also involved in helping to develop the Trust's substance misuse services.

The event heard a number of inspiring stories from those who have experience of using the Trust's substance misuse services and are now on the path to recovery thanks in part to the support of New Beginnings.

12. FESTIVAL IN SUPPORT OF MENTAL HEALTH AWARENESS WEEK

To support Mental Health Awareness week, I'm pleased to report that staff across the Trust held a series of events showcasing the work that they do.

Mental Health Awareness Week, which is run by the Mental Health Foundation annually, focused this year on the theme of Mindfulness.

The Moorlands Mental Health festival was held at Foxlowe Arts Centre, in Market Place, Leek. It featured a range of activities, including workshops in mindfulness, creative writing, music, healthy eating and collage; complementary therapies; and a smoothie bike. There were also stands from local organisations providing important information on mental health awareness and support.

Mindfulness is an integrative, mind-body based training that helps people to change the way they think and feel about their experiences – especially stressful experiences – and is recommended as a treatment for people with mental health problems.

The festival is a partnership between the Trust, Borderland Voices, Rethink Mental Illness, Changes, One Recovery Staffordshire, Brighter Futures, Samaritans, North Staffs Users Group, Early Interventions, Moorlands Therapists, Your Moorlands and the police neighbourhood team.

13. TRUST AND FIRE SERVICE PARTNERSHIP DROP-IN EVENT

The focus of a drop-in event run by Staffordshire Fire & Rescue Service in partnership with the Trust in May was supporting people with mental ill health to be better protected from the risks of fire.

Fire and rescue service representatives were on hand at Harplands Hospital in early May, to provide advice and promote fire safety and prevention to people using the Trust's services and their carers.

I'm pleased to share that all those visiting the event were offered referrals for free Home Fire Risk Checks to be carried out to identify and mitigate any potential fire risks, fit free life saving equipment such as smoke alarms and fire guards and put together an escape plan in the event of a fire.

The event forms part of the wider partnership working between NSCHT and the fire service to promote a greater awareness to Trust staff of the fire risks that might exist in the homes

of service users they visit. Once identified, action can be taken by the fire service to address them and make a home safer from fire.

It is really important that both our service users and staff are safe from fire. Staffordshire Fire & Rescue Service is a key partner and the event was an ideal opportunity to see how we can support one another around fire safety. By working together we have the opportunity of preventing fire-related deaths and injuries for the most vulnerable.

NATIONAL UPDATES

- Launch of the 2010 to 2015 government policy: harmful drinking
- Launch of the 2010 to 2015 government policy: carers' health
- Launch of the 2010 to 2015 government policy: dementia

Caroline Donovan
Chief Executive
Thursday 28 May 2015

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: **Open Trust Board**

Date of Meeting:	02 June 2015
Title of Report:	Summary of the Quality Committee meeting held on the 19 May 2015
Presented by:	Mr Patrick Sullivan, Chair of Quality Committee
Author of Report: Name: Date: Email:	Sandra Storey, Trust Secretary, Head of Corporate and Legal Affairs 21 May 2015 sandraj.storey@northstaffs.nhs.uk
Purpose / Intent of Report:	• For decision / assurance
Executive Summary:	This report provides a high level summary of the key headlines from the Quality Committee meeting held on the 19 May 2015. The full papers are available as required to Trust Board members
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Customer Focus Strategy • Clinical Strategy - • Governance Strategy
Relationship with Annual Objectives:	Ensure provision of safe clinical services
Risk / Legal Implications:	N/A
Resource Implications:	N/A
Equality and Diversity Implications:	N/A
Relationship with Assurance Framework [Risk, Control and Assurance]	The Quality Committee has an integral relationship with Improving Quality/ Registration.
Recommendations:	• To note the contents of the report • Ratify the policies highlighted in the report

Key points from the Quality Committee meeting held on 19 May 2015 for the Trust Board meeting on the 4 June 2015

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

2. **Director of Quality Report**
   The Director of Quality Report was received with notable items as follows:

- **New Audit of Schizophrenia –** The sample eligibility criteria was for all adults (aged 18 years or over) who were being treated in the community and who had a diagnosis of schizophrenia or schizoaffective disorder for at least 12 months. 200 service users were then randomly selected to receive a postal survey and a carer's survey. A summary document was presented to the committee to share the results. This noted areas of good performance and areas for improvement (receipt of CBT, intervention for identified physical health problems and prescribing practice). The report noted the actions that have been taken to address the required improvements.

3. **Policy Review**
   The committee received a policy progress report noting the status of policies that fall under the responsibility of the committee. Members discussed the position and noted the significant progress made, particularly by Val Stronach in the Nursing Directorate, in reviewing and updating Trust policies and procedures. There was also a forward view of policies up to 2018 which highlighted a number of policies requiring review later this year. A further report will be presented to the June meeting to give further assurance on progress being made in the review and update of policies**.**

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

- **MHA 18 DOLS**
- **MHA01 Community Treatment Order**
- **MHA02 Responsible Clinicians**
- **MHA03 Nurse Holding Power**
- **MHA04 Holding Powers of Doctors and Approved Clinicians**
- **MHA06 Guidance on Conflict of Interest**
- **MHA09 Section 117 Aftercare**
- **IC2b Sources of Advice for Infection Control**
- **IC6 Notifiable Diseases**
- **IC3 Standard Precautions**
- **5.19 Zero Tolerance**
- **5.31 Legionella**
- **5.35 Medical Devices**

- **1.46 Falls Policy**
- **4.40 Being Open (incorporating Duty of Candour)**
- **1.27 Rapid Tranquilisation**
- **5.37 PITS Procedure**
- **1.71 Duty to Cooperate with MAPPA – approve until 31.03.2016**
- **1.52a & 1.52a Research & Development Strategy and Policy – approve until 31.03.2016**
- **1.55 Advance Decisions and Statement**
- **1.72 Direction on Choice – withdraw, no longer required**
- **5.38 Lockdown Policy**
- **4.25 Consent to Examination**
- **1.28 Non acute delays Protocol**
- **1.67 Smoking Policy – approve for 12 months**
- **4.38 Reimbursement – approve for 12 months**

4. **Patient Stories and Representation at the Quality Committee**
   The committee discussed the importance of hearing patient stories and how this could be reintroduced to the committee. Mr Dinwiddy will bring a paper to the next meeting of the committee setting out proposals for this taking forward this important piece of work. Members also discussed patient representation at the committee and it was agreed that it would be appropriate for this to be raised at the meeting of the Patient Council in order to agree how best this can be taken forward.

5. **Quality Impact Assessment of Cost Improvement Schemes (CIPs)**
   Dr Adeyemo and the Clinical Directors provided an update on the 2015/16 schemes. It was noted that there were a couple of areas reporting amber (LD & CAMHS) and the action being taken to progress these schemes accordingly. The Directorates will continue to closely monitor the metrics to ensure that they remain positive.

6. **Nurse Staffing Performance monthly report – April 2015**
   The committee received the nursing staff performance on a shift by shift basis for the month of April 2015. This noted that the fill rate for registered nurses was 99.9% and 102% with Health Care Support Workers. Committee members discussed the fill rate for the Assessment and Treatment service and received assurance regarding the actions taken in respect to recruitment.

7. **Quality Metrics from the Performance Quality Management Framework Report (PQMF) month 1 2015/16**
   The committee reviewed the quality metrics extracted from the wider PQMF. As noted previously, the role of the committee is to consider the impact of metrics potentially going off track. Of note were the IAPT metrics showing red and the actions being taken to improve current performance.

8. **Quality Account 2014/15**
   By 30th June 2015, all organisations are required to develop and publish a Quality Account which if designed well will assure commissioners, patients and the public that trust boards are regularly scrutinising each and every one of their services. The committee received the second

draft of the Quality Account for review and comment. It was noted that feedback from external stakeholders has been sought to help inform the report. The final version will be presented to the next meeting of the committee in June 2015.

9. Clinical Effectiveness Annual Report 2014/15

The committee received the annual report which is a summary of the work undertaken in the previous year. The report also provides details of all projects completed and those underway, summarises progress against 2014/15 goals and introduces goals for 2015/16. This is in line with the requirements of the Trust's Clinical Audit and Effectiveness Strategy.

10. Clinical Audit Programme 2015/16

The committee received a draft clinical audit programme developed in accordance with the Trust's Clinical Audit policy. The committee reviewed and approved this programme of work which had been discussed previously in Directorate meetings and approved by the Clinical Effectiveness Group in April 2015.

11. Self Harm and Ligature Incident Analysis

An analysis of incidents noted that self harm incidents have remained relatively stable in overall number over a 23 month period despite monthly variation. There has been an increase in the number of ligature incidents during Q3 2014 requiring further exploration at team level to understand the reasons for this. The report concluded with a number of recommendations and arrangements for ongoing monitoring of future data and action planning.

12. Mental Health Act Code of Practice and Mental Health Law Update

The Committee received an update on the progress being made to implement the new Mental Health Act Code of Practice. All Mental Health Act policies have been updated to Code of Practice compliant. Training and information was also discussed and the action being taken, such as developing leaflets for staff outlining key changes and obtaining copies of the Code of Practice for all clinical areas.

13. Report by Healthwatch exploring access to mental health services

Healthwatch Stoke on Trent explored on a small scale the experience of local people when they are accessing mental health services. This work was carried out as concerns had been identified by members of the mental health sub-group from patients who had experienced problems when trying to access support from the Access Team.

Overall the experiences captured highlighted a mixture of views. These include the need for pathways to be clearer for the user to understand and some efforts to address lengthy waits for return phone calls. Healthwatch also acknowledged that at the time of writing there was already work underway to develop the Access Service and improvements being made to service user experience.

14. Update on Out of Area patient from South London & Maudsley

The committee received a report on an out of area patient who had contact with Harplands Hospital during March 2015. The report noted that the patient had been managed appropriately within available resources and without incident. However, there were several

learning points, legal and clinical, that were highlighted to improve joint working in the event of further incidents. This is being progressed with external agencies during May and June 2015.

15. Serious Incident Trend Review April 2011 – March 2015

It was noted that the committee had asked for this report to provide assurance that the Trust has a longer term overview of serious incident trends over and above weekly, monthly, and quarterly reporting. This report provided a four year overview, noting a total of 304 serious incidents. The report noted the top five reported serious incidents by category and on two occasions where there was spike in the number of incidents reported, though this did not conclude with any particular theme or trend emerging. The report also highlighted that any increase were subject to additional scrutiny including internal and external independent review.

16. Risks to Quality of Services – M1

Committee members considered the report for quality risks, noting the risk treatment plans in place. Risks have been mapped to the new annual objectives and 5 year objectives and trend arrows have been included. Risks carried forward from the previous year were noted and assurance was given that there is increased ownership and visibility at the Risk Review Group and Senior Leadership Team meetings.

17. Directorate Performance Reports

The Committee received the monthly performance reports from each of the Directorates including information on key risks, serious incidents and complaints. Committee members also received this information in the newly presented directorate performance dashboards which will continue to evolve over time in order to give the information and assurance required by the teams and committee.

18. CQC Quality Assurance Programme Update

The paper summarised the progress in terms of achievements to date, key priority actions, recent inspection activity and an update in terms of the Trust's registration. The paper also included an information update around CQC publications and national mental health inspections.

19. Patient Council Update

The next meeting of the Patient Council will take place on the 2 June 2015. Terms of reference have been set and a proposal for the Council to have a patient / service lead attached to each of the Directorates. Attendance at Trust Board meetings is also being considered as this link to the Board was felt to be highly important.

20. NHS TDA Desk Top Review

The Nursing Director and Medical Director have received an invitation from the TDA to engage in a Desk Top Review exercise in July to help identify any areas for development or support. The Committee will be kept informed of the work in this regard.

21. Kings Fund Report – Reconfiguration of Clinical Services

The reconfiguration of clinical services had attracted public and political controversy over the life of the NHS. Financial and workforce constraints now and in the future suggest that the

pressure to reconfigure services will continue to grow. The Kings Fund report received by the committee for information purposes provides new insights into the drivers of reconfiguration and the underpinning evidence. It builds on a major analysis, commissioned by the National Institute for Health Research, of reviews of service reconfigurations conducted by the National Clinical Advisory Team.

22. Domain Updates

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

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

The committee will take a "deep dive" into the Clinical Effectiveness domain at its next meeting to gain a further understanding of the work being undertaken and any issues raised.

23. Next meeting: 16 June 2015

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

Sandra Storey
Trust Secretary / Head of Corporate and Legal Affairs
19 May 2015

Report to: Trust Board

Date of Meeting:	4 June 2015
Title of Report:	Nurse Staffing Performance on a shift-by-shift basis
Presented by:	Mark Dinwiddy; Interim Director of Nursing & Quality
Author of Report: Date: E-mail:	Carol Sylvester, Interim Deputy Director of Nursing May 2015 Carol.sylvester@northstaffs.nhs.uk
Purpose / Intent of Report:	• For Assurance
Executive Summary:	This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during the data collection period (1st -31st May 2015) in line with the National Quality Board expectation that: *"The Board:* *• Receives an update containing details and summary of planned and actual staffing on a shift-by-shift basis* *• Is advised about those wards where staffing falls short of what is required to provide quality care, the reasons for the gap, the impact and the actions being taken to address the gap* *• Evaluates risks associated with staffing issues* *• Seeks assurances regarding contingency planning, mitigating actions and incident reporting* *• Ensures that the Executive Team is supported to take decisive action to protect patient safety and experience* *• Publishes the report in a form accessible to patients and the public on their Trust website (which could be supplemented by a dedicated patient friendly 'safe staffing' area on a Trust website)".* • The performance relating to the fill rate (actual numbers of staff deployed vs numbers planned) on the wards for April 2015 being a total fill rate of 99.8% registered nurses and 102% for HCSWs. • Unify data will reflect that the Trust achieved safer staffing levels based on total fill rates • The report will detail fill rates broken down by inpatient areas for registered nurse and care staff attaching a RAG rating based on percentage fill rate. • Telford Unit will reflect an amber rating based on fill rate of 87.3%. Shortfall of registered nurse day shift cover has affected the overall fill rate. • The report will present additional quality related metrics for monitoring against the staffing fill rate and will provide Ward Manager narrative on key issues for each clinical team. • The report will provide an update on the developments in community safer staffing
Which Strategy Priority does this relate to?	• Customer Focus Strategy • **Clinical Strategy** • **Governance Strategy**

How does this impact on patients or the public?	• **Workforce Strategy** • **Financial Strategy**

Relationship with Annual Objectives	Supports the delivery of the Trust's Annual Objectives and the delivery of high quality care
Risk / Legal Implications:	Delivery of safe nurse staffing levels is a key requirement to ensuring that the Trust complies with National Policy direction
Resource Implications:	Further assessment of the use of bank and agency staff is planned to inform a review of baseline establishments against the current level of acuity

March 2015 (inc last 3 months for comparison)

Ward	Performance (% planned vs actual) staffing numbers (March 2015)		Performance (% planned vs actual) staffing numbers (February 2015)		Performance (% planned vs actual) staffing numbers (January 2015)	
	Registered Nurses (%)	**Healthcare Support Workers (%)**	**Registered Nurses (%)**	**Healthcare Support Workers (%)**	**Registered Nurses (%)**	**Healthcare Support Workers (%)**
Ward 1	106	82	107.3	99	105.95	161.2
Ward 2	95.12	131.5	87.5	136.3	90.55	100
Ward 3	94.5	159	98.7	143.75	95.1	127.2
Ward 4	98	82.4	91.6	119.5	74.9	106.8
Ward 5	101.4	99	96.75	155	94.5	177.65
Ward 6	104.5	87	101.8	93.5	107.5	93.5
Ward 7	90	93	88.8	100	100.5	111.4
Assessment & Treatment	71.65	113.3	77.5	112	101.35	110.8
Telford Unit	80	89.75	80	87.5	98.45	110.15
Edward Myers	99.5	80.8	100.5	82.5	102.5	98.25
Darwin Centre	97.5	99.1	92	123	94.15	114.9
Summers View	104	102.5	96	87	86.15	113.8
Florence House	111	89.25	91.5	89	100.5	92.85
Dragon Square	94.3	93	103.5	91.5	104.85	92.2
TRUST AVERAGE/ TOTAL	**96.25%**	**100.5%**	**93.8%**	**108.5%**	**96.92%**	**107.9%**

North Staffordshire Combined Healthcare NHS
NHS Trust

In patient safer staffing metrics-April 2015

Ward	Performance (% planned vs actual)		Overall fill rate%	RAG rating	Bed Occupancy (including home leave)	Sickness %	Mandatory training	PDR	Incidents	Serious Incidents	Complaints	PALS
	Registered Nurse %	HCSW %	RAG rating >90% GREEN <90% AMBER <80% RED									
One	116%	92.2%	104.1%		95%	8.29%	72%	93%	116	0	1	0
Ward Manager summary: Ward 1 has seen high acuity with slight over occupancy and an increase in sickness some of which has occurred from ward based violent incidents both of which have been reported as serious incidents, one in January and one will reflect in May. 62 shifts have been lost to sickness. The ward has a number of vacancies (3x staff nurse and 3x HCSW posts) all of which we anticipate to be filled as part of the recruitment drive currently underway. We aim to fill the HCSW post immediately by recruiting bank staff in to substantive posts. Where needed, vacancy and sickness has been covered by the use of bank shifts resulting in a total fill rate of 104.1% for April. Incident rates peaked in the second week in April with 46 incidents reported with a decrease since. A review of the skill mix in terms of staff experience is underway in consultation with inpatient areas with the aim of ensuring sufficiently confident and experienced staff are evenly distributed across the inpatient areas. In spite of high acuity, supervision, debrief and mandatory training have all gone ahead as planned. 12 DSN shifts have been covered during April											
Two	92.9%	152 %	122.7%		103%	7.12%	73%	83%	20	0	0	6 **
Ward Manager summary: Ward 2 have seen slight over occupancy on beds during April. The ward has a total of 3xstaff nurse vacancies, 2 of which have been appointed to and 1 HCSW post appointed to. The ward has had an under fill on registered nurses and on overfill of HCSW duties resulting in a total fill rate of 122.7%. A total of 24 DSN shifts have been covered, 16 of which by a band 6 currently on secondment to the DSN role. 17 shifts have been lost to sickness The ward has received a number of compliments via the PALS department.												

Three	100.5%	104.6 %	102.55%		99%	8.33%	77%	100%	6	0	0	0
Ward Manager summary: The ward has been over occupied on several occasions during April however; the ward activity has reduced with a reduction in incidents and an average monthly occupancy of 99%. The ward has 2x staff nurse and 1x HCSW vacancies which have all been recruited to and awaiting start dates. The ward has a total fill rate for April of 102.55% 13 DSN shifts have been covered during April.32 shifts in total have been lost to sickness Mandatory training has gone ahead as scheduled.												
Four	103.7%	84.5%	94.1%		70%	0.00%	85%	50%	12	0	0	0
Ward Manager summary: Bed occupancy has been created due to a number of patients awaiting transfer from UHNM who could not transfer due to an outbreak of Norovirus at the UHNM. Due to the nature of the ward, there is no agreed staffing establishment at present however, the ward have recruited to band 3 fixed term post for a 6 month period and are aiming to replicate this with band 5 posts. The ward have achieved a fill rate of 94.1% 10 DSN shifts have been covered, some of which entailed shadowing for the Band 6 ahead of being included in the DSN rota.												
Five	104.25%	130.4%	117.3%		100%	2.86%	77%	96%	9	0	1	0
Ward Manager summary: The ward manager reports that the ongoing acuity of the ward indicates that the established staffing level of 5/5/3 is insufficient and therefore the ward has been working consistently on a level of 6/6/4 this being reflected in the fill rate of 117.3%. There are no vacancies in line with the current staffing establishment. There have been no DSN shifts covered in this period.												
Six	115.5%	80.25%	97.8%		95%	5.43%	77%	94%	13	0	0	7
Ward Manager summary: The ward has reported no over occupancy. There are 2xstaff nurse vacancies, one post recruited to and 1 post has been advertised. 20 shifts have been lost through sickness, mainly short term sickness. The ward has an overall fill rate of 97.8% PALS activity predominantly relates to a high number of compliments received about the ward.												
Seven	100.4%	96.85%	98.6%		93%	00.0%	85%	88%	13	0	0	0

Ward Manager summary: The ward manager reports 1x staff nurse vacancy currently being recruited to. 30 shifts have been lost to sickness. All mandatory training has gone ahead as scheduled. 7 DSN shifts covered. Ward Manger has covered some of the qualified shift shortfalls												
EMC	101.5%	83.5%	92.5%		77%	6.53%	85%	84%	6	0	0	0
Ward Manager summary: The ward manager reports that there is 1 band 7 vacancy currently being covered as an acting up arrangement. The post will be advertised shortly. Temporary staff covering the IOU now in substantive posts. The unit have a total fill rate of 92.5% Some staff moves from the IOU have occurred due to pressures elsewhere on the site. This is kept under review in terms of impact and incident forms submitted to reflect this. 4 DSN shifts have been covered.												
A&T	80.4%	101.4%	90.9%		82%	3.81%	94%	93%	10	0	2	0
Ward Manager summary: Please note that this narrative will incorporate A&T and Telford Unit due to the cross allocation of staffing for the units. The unit manager reports a loss of 80 shifts due to sickness in April. The units continue to experience challenges in maintaining registered nurse fill rates although it is noted that much of the shortfall has been covered by non-registered nurses with additional registered nurse support from the unit manager and deputy unit manager. A total of 18 DSN shifts have been covered in April, predominantly with the Deputy Unit Manager providing a period of two week night cover. There are no current vacancies however, the Clinical Director is liaising closely with the units to monitor and report on any impact on quality and mitigating actions including the potential agency fixed term recruitment to longer term sickness posts. The amber rating is based on an overall fill rate of 87.3% for the Telford Unit with the Assessment and Treatment Unit showing a total fill rate of 90.9%											
Telford	81.25%	93.4%	87.3%		75%	11.53%	98%	100%	13	0	0	0
Ward Manager summary: Please see above												
Summers View	98.25%	99%	98.6%		105%	10.36%	76%	100%	8	0	2	2
Ward Manager summary: The ward has an overall fill rate of 98.6%. The unit have 3 band 3 staff members sick at present. A total of 5 DSN shifts have been covered. The unit has a total fill rate of 98.6% and report no quality impact concerns.												

Florence	116%	91%	103.5%		44%	5.03%	90%	100%	10	0	0	0
Ward Manager summary: The ward has an overall fill rate of 103.5% with a monthly sickness total of 37.50 hours. There are no current vacancies and the unit do not cover any DSN shifts.												
Darwin	92.5%	113.75%	103.1%		100%	4.50%	86%	97%	79	0	0	0
Ward Manager summary: The unit have 3xstaff nurse vacancies with 2 recruited to and awaiting start dates to be confirmed and the third to be advertised again. The unit has lost 37.5 hours due to sickness. The total fill rate is 103.1%. The unit has experienced ongoing challenges in the high acuity of the requirement to deliver naso-gastric feeding to three youngsters using restrictive physical holding and additional coverage for shifts not always achieved due to non-availability of bank or agency staffing.												
Dragon Square	95.25%	96.4%	95.8%		83%	0.00%	72% **	100%	2	0	0	0
Ward Manager summary: The unit have a total fill rate of 95.8% with no vacancies or sickness reported during this period.												

*Please note that sickness figures are incomplete where reflected in the above table as 0.00%. The extract from the EASY payroll system is only available after the 21st of each month and this full information is unavailable for the submission of this report.

Total Trust fill rate Registered Nurse for April 2015 99.8%

Total Trust fill rate Care Staff for April 2015 102%

The table below details the UNIFY submission for the period April 2015 and will be posted on the Trust website.

Inpatient area	Day				Night			
	Registered nurses		Care staff		Registered nurses		Care staff	
	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual
Ward 1	900.00	1011.45	1800.00	1304.30	324.40	389.46	956.30	1073.26
Ward 2	900.00	767.75	675.00	1237.00	321.60	323.31	642.90	760.80
Ward 3	900.00	882.00	1350.00	1382.25	321.60	332.31	642.90	910.03
Ward 4	1350.00	1511.59	1800.00	1103.50	553.50	528.85	841.83	914.33
Ward 5	900.00	934.30	1350.00	1551.00	281.10	296.77	562.20	820.86
Ward 6	930.00	1085.00	1860.00	1605.00	290.47	337.41	871.35	805.81
Ward 7	900.00	908.70	1350.00	1266.00	281.10	281.10	562.50	562.81
A&T	900.00	547.75	1182.00	1215.75	150.50	150.50	1139.50	1139.50
Telford	768.00	479.75	1200.00	1042.50	172.00	172.00	473.00	473.00
Edward Myers	900.00	931.00	900.00	660.94	281.11	281.11	562.22	526.29
Darwin Centre	1020.00	868.50	1110.00	1086.00	385.00	385.00	602.00	784.25
Summers View	750.00	695.00	750.00	750.00	260.75	271.58	531.50	521.07
Florence House	450.00	595.00	900.00	740.00	312.90	312.90	312.90	312.90
Dragon Square	480.00	468.00	1122.00	1120.00	277.50	259.00	277.50	259.00

Community Safer Staffing

The Trust has undertaken a community based acuity tool exercise undertaken in a Community Mental Health Team with the summary findings due to be summarised in June and a report to the Quality Committee in July.

Additionally, the Director of Nursing is leading a task and finish group to standardise a caseload management tool. This will detail caseload size, dependency, frequency of visits. This tool is being developed across all professional groups and directorates and will be presented to the Quality Assurance Programme Board in June. This tool will enable progress in identifying caseload size and complexity on a team and individual basis.

An update on progress of this work will be presented to the July Trust Board together with a set of metrics for all community teams reflective of the inpatient safer staffing reporting and will include vacancy, sickness, PDR, mandatory training.

Carol Sylvester

Interim Deputy Director of Nursing and Quality

May 2015

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO TRUST BOARD (OPEN)

Date of Meeting:	4 June 2015
Title of Report:	Monthly Finance Reporting Suite – April 2015
Presented by:	Ann Harrison, Interim Director of Finance
Author of Report: Name: Date: Email:	 Andy Turnock 28 May 2015 andrew.turnock@northstaffs.nhs.uk
Purpose / Intent of Report:	Performance monitoring
Executive Summary:	The attached report contains the financial position to 30 April 2015. The Trusts financial performance is a retained deficit of £0.127m and £0.084m deficit at 'adjusted financial performance'. This performance is a favourable variance against Plan of £0.01m. The in-year cost improvement target is £2.6m. The cash balance as at 30 April 2015 was £7.96m. The capital expenditure is £0.012m, which is slightly behind the Plan of £0.02m. The Continuity of Service risk rating is reported as 3 in line with the plan.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Financial Strategy
Relationship with Annual Objectives:	Financial Reporting
Risk / Legal Implications:	n/a
Resource Implications:	As above.
Equality and Diversity Implications:	n/a
Relationship with Assurance Framework [Risk, Control and Assurance]	

Recommendations:	***The Board is asked to:*** • ***note that the financial performance to date is on plan, with a small favourable variance reported of £0.01m*** • ***note the in-year cost improvement target is £2.6m*** • ***note the cash position of the Trust as at 30 April 2015 of £7.96m*** • ***note the capital expenditure position as at 30 April 2015 is a small under spend against plan*** • ***note the year to date Continuity of Service risk rating of 3***

DRAFT FINANCIAL OVERVIEW as at 30 April 2015

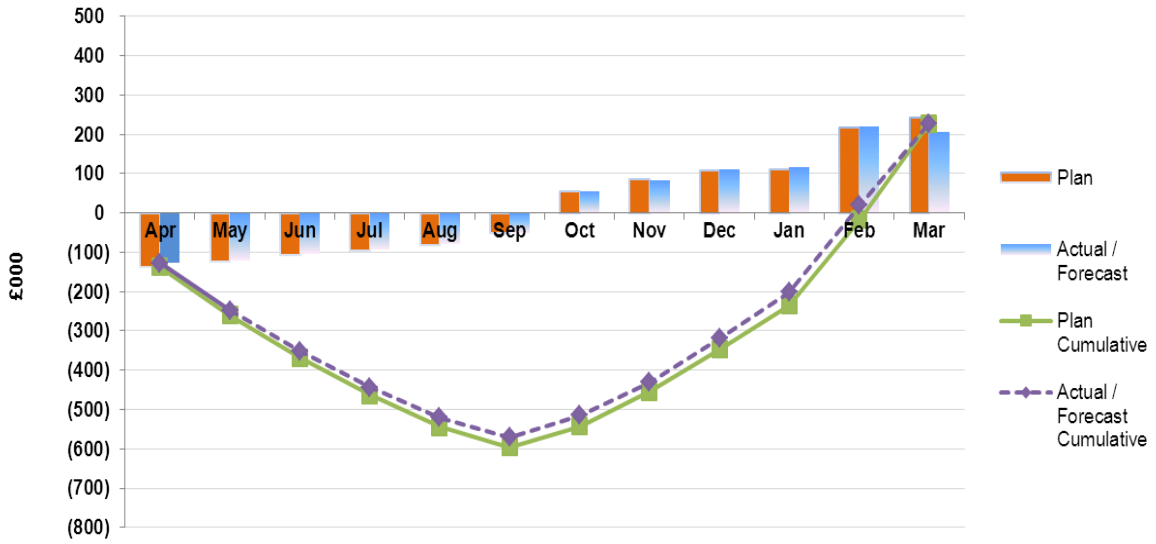
Income & Expenditure - Retained Surplus / (Deficit)

£000	Plan	Actual	Var	%	RAG
YTD	(137)	(127)	10	7	G
Forecast	227	227	0	0	G

Net Capital Expenditure

£000	Plan	Actual	Var	%	RAG
YTD	20	12	(8)	(40)	G
Forecast	1,530	1,530	0	0	G

Retained Surplus / (Deficit) Run Rate 2015-16



Cash Balances

£m	Plan	Actual	Var	%	RAG
YTD	7.5	8.0	0.5	7	G

Continuity of Service Risk Rating

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

Notes

Risks:	Non achievement of income targets
	Non delivery of CIP requirement
	Managing cost pressures
	Under performance against activity targets
Assumptions:	Clinical income targets are predominately achieved.
	Charges against provisions provided for last year do not exceed the value provided.

1. Financial Position

1.1 Introduction

The Trusts financial Plan submission to the National Trust Development Authority (NTDA) showed a retained surplus position of £0.227m.

The Trust's 'Adjusted Financial Performance' for 2015/16 is a surplus of £0.750m (£0.227m plus IFRIC 12 adjustment of £0.523m). This is in line with the requirement to deliver a 1% surplus on the Trust's turnover.

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

1.2 Income & Expenditure (I&E) Performance at Month 1

At the end of Month 1, the Trusts budgeted plan was a retained deficit of £137k (£94k deficit at adjusted financial performance level). The reported retained position is a deficit of £127k, giving a favourable variance of £10k against plan.

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

Table 1: Statement of Comprehensive Income

Detail	Full Year Annual Budget £000	Current Month £000			Year to Date £000		
		Budget	Actual	Variance	Budget	Actual	Variance
Income	73,820	5,984	6,068	84	5,984	6,068	84
Pay	(55,448)	(4,749)	(4,536)	214	(4,749)	(4,536)	214
Non pay	(14,842)	(1,096)	(1,385)	(288)	(1,096)	(1,385)	(288)
EBITDA	**3,530**	**138**	**148**	**10**	**138**	**148**	**10**
Other Costs	(2,780)	(232)	(231)	1	(232)	(231)	1
Adjusted Financial Performance	**750**	**(94)**	**(84)**	**10**	**(94)**	**(84)**	**10**
IFRIC 12 Expenditure	(523)	(43)	(43)	0	(43)	(43)	0
Retained Surplus / (Deficit) prior to Impairment	**227**	**(137)**	**(127)**	**10**	**(137)**	**(127)**	**10**
Fixed Asset Impairment	0	0	0	0	0	0	0
Retained Surplus / (Deficit)	**227**	**(137)**	**(127)**	**10**	**(137)**	**(127)**	**10**

Contained within non-pay budgets are the CIP targets for directorates, some of which have been transacted in budgets prior to the release of month 1 budget reports.

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

Table 2: Reserves Held Centrally

Description	Annual Budget (£000)
Contingency	367
Cleanliness in Hospitals	15
Quality & Reform	670
Other Earmarked reserves	722
Total	**1,774**

The Quality and Reform reserve has been set aside to fund specific costs within the financial year, including safer staffing of circa £0.45m. In addition, £0.3m of the Other Earmarked reserves is forecast to be utilised to deliver the new national minimum waiting time / target activity associated with the Improving Access to Psychological Therapies service (IAPT).

1.3 Forecast Year End Performance

At this point in the financial year a worked up forecast outturn has yet to be undertaken and as such the forecast outturn position is a retained surplus of £0.227m (£0.750m at adjusted financial performance level) in line with latest Plan submission. This forecast position has been shared with the NTDA as part of their financial monitoring regime.

1.4 Cost Improvement Programme

The in-year target for the year is £2.6m and takes into account the requirement to deliver the 1% surplus referred to above.

Further information of the identified programme will be reported at future meetings.

2. Summary of Financial Position

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

2.1 Fixed Assets

Property, Plant & Equipment and Intangible assets balances of the Trust have remained relatively static.

2.2 Cash

As at 30 April 2015, the Trust's cash position was £7.96m which represents an increase during the month of £1.1m. The updated monthly cash profile, taking account of the actual year end start figure, will be incorporated within the report from next month.

2.3 Other Working Balances

The only material change within the working balances is the increase in creditors of £1.9m. This is predominately a result of the prepayment in March 2015 of £1.5m in respect of tax, pension and national insurance contributions, the impact of which was a reduced level of creditors in March, with the balance in April being a return to normal levels.

3. Capital Expenditure and Programme

The Trust's permitted capital expenditure in 2015/16 is £2.3m; this is the combination of the Trust's £1.53m Capital Resource Limit (CRL) and its asset sales of £0.77m. The capital expenditure for the year as at 30 April 2015 is £0.012m which represents a slight underspend against the profiled capital expenditure of £0.02m shown in the Plan submitted to the NTDA.

Appendix A, page 3 details the outline capital programme for 2015/16.

4. Continuity of Services Risk Rating Risk Rating

As reported in the Plan, the Trust is planning to achieve a Continuity of Service Risk Rating of 3 by the end of the financial year. As at month 1, this is calculated as 3.

Appendix A, page 4 shows the separate metrics and the outputs in detail.

5. Recommendations

The Board is asked to:

- ***note that the financial performance to date is on plan, with a small favourable variance reported of £0.01m***

- ***note the in-year cost improvement target is £2.6m***

- ***note the cash position of the Trust as at 30 April 2015 of £7.96m***

- ***note the capital expenditure position as at 30 April 2015 is a small under spend against plan***

- ***note the year to date Continuity of Service Risk Rating of 3.***

Statement of Comprehensive Income – Trust Wide

	Full Year Budget £000	< < < Current Month > > > Actual £000	Budget £000	Variance £000	< < < Year to Date > > > Actual £000	Budget £000	Variance £000
Income:							
Revenue from Patient Care Activities	66,732	5,382	5,364	18	5,382	5,364	18
Other Operating Revenue	7,088	686	620	66	686	620	66
	73,820	6,068	5,984	84	6,068	5,984	84
Expenses:							
Pay							
Medical	-6,749	-488	-563	75	-488	-563	75
Nursing	-25,536	-2,155	-2,204	48	-2,155	-2,205	49
Other clinical	-13,428	-1,039	-1,158	119	-1,039	-1,157	118
Non-clinical	-9,363	-694	-777	83	-694	-777	83
Non-NHS	-372	-159	-48	-111	-159	-48	-111
Cost Improvement	0	0	0	0	0	0	0
	-55,448	-4,536	-4,749	214	-4,536	-4,749	214
Non Pay							
Drugs & clinical supplies	-1,844	-206	-160	-46	-206	-160	-46
Establishment costs	-1,925	-109	-161	53	-109	-161	53
Premises costs	-1,970	-226	-171	-55	-226	-171	-55
Private Finance Initiative	-3,865	-333	-322	-11	-333	-322	-11
Other (including unallocated CIP)	-3,465	-512	-283	-229	-512	-283	-229
Central Funds	-1,774	0	0	0	0	0	0
	-14,842	-1,385	-1,096	-288	-1,385	-1,096	-288
EBITDA *	**3,530**	**148**	**138**	**10**	**148**	**138**	**10**
Depreciation (excludes IFRIC 12 impact and donated income)	-827	-70	-70	0	-70	-70	0
Investment Revenue	12	2	1	1	2	1	1
Other Gains & (Losses)	0	0	0	0	0	0	0
Local Government Pension Scheme	0	0	0	0	0	0	0
Finance Costs	-1,364	-114	-114	0	-114	-114	0
Unwinding of Discounts	0	0	0	0	0	0	0
Dividends Payable on PDC	-601	-50	-50	0	-50	-50	0
Adjusted Financial Performance - Surplus / (Deficit) for the Financial Year **	**750**	**-84**	**-94**	**10**	**-84**	**-94**	**10**
IFRIC 12 Expenditure ***	-523	-43	-43	0	-43	-43	0
Retained Surplus / (Deficit) for the Year	**227**	**-127**	**-137**	**10**	**-127**	**-137**	**10**

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

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

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

Statement of Financial Position – including forecast

Detail	Period End Dates 31/03/2015 £000	30/04/2015 £000	Forecast 31/03/2016 £000
NON-CURRENT ASSETS:			
Property, Plant and Equipment	30,863	30,762	31,799
Intangible Assets	52	52	66
Trade and Other Receivables	0	0	0
TOTAL NON-CURRENT ASSETS	30,915	30,814	31,865
CURRENT ASSETS:			
Inventories	86	77	86
Trade and Other Receivables	3,017	3,675	3,298
Cash and cash equivalents	6,805	7,956	6,416
SUB TOTAL CURRENT ASSETS	9,908	11,708	9,800
Non-current assets held for sale	2,520	2,520	1,750
TOTAL ASSETS	**43,343**	**45,042**	**43,415**
CURRENT LIABILITIES:			
NHS Trade Payables	-864	-823	-676
Non-NHS Trade Payables	-4,374	-6,272	-5,757
Borrowings	-351	-351	-346
Provisions for Liabilities and Charges	-1,682	-1,679	-882
TOTAL CURRENT LIABILITIES	-7,271	-9,125	-7,661
NET CURRENT ASSETS/(LIABILITIES)	5,157	5,103	3,889
TOTAL ASSETS LESS CURRENT LIABILITIES	**36,072**	**35,917**	**35,754**
NON-CURRENT LIABILITIES			
Borrowings	-12,992	-12,963	-12,647
Trade & Other Payables	-558	-558	-558
Provisions for Liabilities and Charges	-604	-604	-404
TOTAL NON- CURRENT LIABILITIES	-14,154	-14,125	-13,609
TOTAL ASSETS EMPLOYED	**21,918**	**21,792**	**22,145**
FINANCED BY TAXPAYERS EQUITY:			
Public Dividend Capital	7,998	7,998	7,998
Retained Earnings	814	687	1,041
Revaluation Reserve	13,664	13,664	13,664
Other reserves	-558	-558	-558
TOTAL TAXPAYERS EQUITY	**21,918**	**21,792**	**22,145**

Capital Programme

Detail	2015/16 £000
Psychiatric Intensive Care Unit	400
Low Secure unit with rehabilitation	500
Assessment & Treatment and Telfold Unit	600
Dragon Square Upgrade	250
Information Technology	100
Equipment	80
Other	270
Environmental Improvements	100
Total Capital Expenditure	**2,300**
Funded by:	
Capital Resource Limit	1,530
Asset Sales	770
Total Funding	**2,300**

Continuity of Service Risk Rating

Continuity of Services Risk Ratings	Metrics Actual
	£000s
Liquidity Ratio (days)	
Working Capital Balance	2,506
Annual Operating Expenses	5,920
Liquidity Ratio Days	12.70
Liquidity Ratio Metric	4.0
Capital Servicing Capacity (times)	
Revenue Available for Debt Service	150
Annual Debt Service	193
Capital Servicing Capacity (times)	0.8
Capital Servicing Capacity metric	1.0
Continuity of Services Rating for Trust	3.0

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

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: Trust Board – Open Section

Date of Meeting:	4 June 2015
Title of Report:	Finance and Performance Committee Report – Committee Meeting 28 May 2015
Presented by:	Tony Gadsby – Committee Chairman
Author of Report: Name: Date: Email:	 Steve Blaise 28 May 2015 Steve.blaise@northstaffs.nhs.uk
Purpose / Intent of Report:	• For Decision ✔ • Performance monitoring ✔ • For Information ✔
Executive Summary:	The attached report provides a summary of the Committee meeting held on the 28 May 2015 and provides assurance to the Board over the level of review and challenge provided by the Committee of financial and other reporting as well as forecasting.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Customer Focus Strategy • IM and T Strategy ✔ • Governance Strategy ✔ • Workforce Strategy ✔ • Financial Strategy ✔ Helps ensure appropriate resources are directed to and protected for appropriate patient care services.
Relationship with Annual Objectives:	Supports achievement of financial targets, the monitoring of CQUIN requirements and the delivery of efficiency programmes
Risk / Legal Implications:	Principle risk register reviewed via committee and reported separately to the Board
Resource Implications:	
Equality and Diversity Implications:	None
Relationship with Assurance Framework [Risk, Control and Assurance]	Provides assurance over the Trust's arrangements for sound financial stewardship and risk management.
Recommendations:	The Trust Board are asked to: • Note the contents of the 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, 4 June 2015

Finance and Performance (F & P) Committee Report to the Trust Board – 28 May 2014

This paper details the issues discussed at the Finance and Activity Committee meeting on 28 May 2015.

The meeting was quorate, approved the minutes from the meeting on the 23 April 2015 and reviewed the progress and actions taken from previous meetings.

The Committee received the financial update for month 1 (April 2015) 2015/16. It was recognised that a limited set of supporting schedules was available to the Committee which is accepted practice for the month 1 pack, as a consequence the reporting responsibilities linked to 2014/15.

The income and expenditure position to Month 1 was ahead of plan at a deficit of £0.127m (£0.084m deficit at "adjusted financial performance" level) against a plan deficit of £0.137m, a favourable variance of £0.010m. The paper also reported that the year-end forecast was in line with the planned position of £0.227m surplus, equating to a £0.750m surplus at adjusted financial performance level.

The Trust's cash balance at the end of April was £8.0m, which is £1.2m higher than the position at the end of March 2015.

The Capital Resource Limit (CRL) for 2015/16 is £1.5m. The planned capital expenditure for the year is £2.3m funded by £1.3m depreciation, £0.8m of asset sales and cash in hand.

The report also noted that the Trust was forecasting the 2015/16 Continuity of Service overall risk rating at level 3.

The Committee received an update of the 2015/16 Cost Improvement Programme (CIP) schemes. The paper highlighted the requirement to deliver £2.60m of CIP with plans in place to deliver £2.62m. The Committee debated and agreed the format for future months CIP reports.

The Committee also received papers summarising the base case Long Term Financial Model (LTFM) key metrics for the period 2015/16 to 2019/20 together with the LTFM metrics following the application of downside and mitigations assumptions over the same period. Following discussion on the assumptions and mitigations on the Base and Downside metrics the Committee recommend acceptance of these scenarios to the Trust Board.

Other Reports and Updates

The Committee received additional reports and verbal updates as follows:

- Report detailing the Statutory and Mandatory training requirements for clinical staff. The Committee noted the Trust's commitment to review the level of this training that could be provided on an E-learning platform.

- The verbal report from the Director of Finance included an update of the External Audit review undertaken on the Trusts 2014/15 Annual Accounts along with other items for information.

- The minutes and report from the Trust's Capital Investment Group (CIG) were not available. The Committee requested the Executive team reviewed the way the Trust plans, monitors and reports on its capital programme. The committee reiterated that it wishes to receive monthly updates on the Trusts Capital Programme including minutes from CIG meetings.

- A Performance Management report including TDA metrics, agreed targets, trends and a revised RAG rating. The report noted that, at month 1, there were 5 metrics rated as Red and 1 as Amber. The Committee were briefed on the issues within these areas.

- Report on the pay protection within the Trust as a result of a number of Management of Change processes. The Report outlined the costs associated with Pay Protection and gave an overview of the organisational changes that gave rise to the protection cost. Currently there are 42 members of staff who were able to be retained under the protected pay scheme which has allowed the Trust to retain skills whilst mitigating the cost of redundancy.

- A report was tabled and discussed updating the Committee on the Trust's current tender activity. The Committee noted that the content of this report had been modified to reflect tenders where there is current activity taking place or where there is a definite intention to move to tender with a significant impact or benefit. Particular reference was made to the current Substance Misuse inpatient tender where notification had been received notifying the Trust of a delay in awarding this tender.

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

North Staffordshire Combined Healthcare NHS Trust

The Board is asked to note 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 and Performance Committee

Steve Blaise – Deputy Director of Finance

28 May 2015

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: **TRUST BOARD (OPEN)**

Date of Meeting:	4 June 2015
Title of Report:	Operating Plan 2015/16
Presented by:	Caroline Donovan, Chief Executive
Author of Report: Name: Date: Email:	Andrew Hughes – Interim Director of Strategy & Development 28 May 2015 Andrew.hughes@northstaffs.nhs.uk
Purpose / Intent of Report:	• For Decision - ✓ • Performance monitoring • For Information
Executive Summary:	The Operating Plan brings together our clinical and quality ambitions and describes the workforce, financial and wider infrastructure implications of achieving them. We are working to produce our Integrated Business Plan for 2015/16 to 2019/20, which will be published in June 2015. This Operating Plan describes the detail of the first year of that next strategic period and is fully aligned with our aim to be an independent health and social care provider. The Trust is expecting final comments from the TDA on 15/16 June but these are likely to be supportive of the plan.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Customer Focus Strategy • Clinical Strategy - ✓ • IM and T Strategy • Governance Strategy • Innovation Strategy • Workforce Strategy - ✓ • Financial Strategy - ✓ • Estates Strategy
Relationship with Annual Objectives:	Supports delivery of the above plans.
Risk / Legal Implications:	N/A
Resource Implications:	N/A
Equality and Diversity Implications:	N/A

Relationship with Assurance Framework [Risk, Control and Assurance]	Links to the annual objectives that helps inform the Trusts compliance with the Board Assurance Framework and Annual Governance Statement.
Recommendations:	The Board is asked to formally adopt the one year Operating Plan.

North Staffordshire Combined Healthcare NHS

NHS Trust

Operating Plan

2015/16

May 2015

Version Control

The following table details the document version changes:

Version	Date	Author	Description of Change
1	21.1.15	KD	First Initial Draft
2	19.2.15	PMO	Updates from HR/ plus re-ordered document
3	23.2.15	PMO	Changes/ updates
4	24.2.15	PMO	Changes/ updates
5	6.3.15	PMO	Change/ updates
6	23.3.15	PMO	Changes/ updates
7	30.3.15	PMO	Changes/updates
8	07.4.15	PMO	Draft for issue to TDA
9	21.04.15	PMO	Changes/ updates
10	28.04.15	PMO	Changes/ updates
11	29.04.15	PMO	AH Changes for Version to Board
12	13.5.15	PMO	Changes/Updates for TDA/Board
13	14.5.15	PMO	Final Version for Issue to TDA

Document Distribution

The table below details the distribution of the Operating Plan:

Version	Date of Issue	Name	Notes
1	21.1.15	Working Team	Submitted
3	23.2.15	Executive Team	Submitted
4	25.2.15	Trust Board	Submitted
5	25.3.15	Trust Board	Submitted
8	07.04.15	Submission to TDA	Submitted
11	29.04.15	Trust Board	Submitted
12	13.5.15	Trust Board	Submitted
13	14.5.15	TDA	Submitted

Contents

Welcome

We are pleased to present our Operating Plan for 2015/16. The Operating Plan brings together our clinical and quality ambitions and describes the workforce, financial and wider infrastructure implications of achieving them.

We are working to produce our Integrated Business Plan for 2015/16 to 2019/20, which will be published in June 2015. This Operating Plan describes the detail of the first year of that next strategic period and is fully aligned with our aim to be an independent health and social care provider.

Our Operating Plan is written at a time of significant change in the local health economy and in the context of obvious uncertainty regarding the national Policy and Political agendas.

It is also written during a year of real progress and achievement for the Trust, however. During 2014/ 15 we have:

- Appointed a substantive Chief Executive and seen further changes in our Executive Team.
- Introduced a new Directorate structure, which has enhanced clinical leadership and decision-making within our services.
- Strengthened staff engagement and team working through our involvement in the *Listening into Action* programme and the Aston team-working model.
- Rolled-out Team Brief to our larger sites, delivered directly by our Executive Team.
- Defined quality themes that will drive our ambitions for excellence.
- Initiated important Digital and Estates infrastructure projects.
- Concluded the first phase of the clinical pathways project.
- Received the results of our first stakeholder survey.
- Been successful in winning new business in Substance Misuse and Child and Adolescent Mental Health services.
- Received positive performance and assurance results.
- Been recognised as an improving organisation shortlisted for Board of the Year.
- Continued to innovate in the way we deliver services, e.g., through the use of cameras in memory services.

Our Operating Plan is the product of an ambitious, confident and improving organisation. This is an exciting time to be involved in the delivery of mental health, learning disabilities and social care services – with the particular emphasis that senior policy leaders have placed on them – and we have demonstrated in 2014/15 the difference we can make to deliver solutions for challenges in the acute sector.

We have set ourselves a challenging agenda and clear outcomes by which we will measure our success. Our Plan is deliberately succinct, paring down the narrative to be clearer on what we are aiming to achieve, by when and with what resources.

As we publish our plan we commit to:

- Engaging with staff, service users, partners and carers.
- Being amongst the very best in the country at developing and delivering services, with the ability to understand and communicate their impact.
- Focussing on the core skills and knowledge that we need to be the best at what we do.
- Making sure that we have the right resources in place so we can deliver on our promises.

We thank you for your support and for your interest.

Ken Jarrold, CBE
Chairman

Caroline Donovan
Chief Executive Officer

Introduction

North Staffordshire Combined Healthcare NHS Trust provides mental health and learning disability services to people predominantly living in the city of Stoke on Trent and in North Staffordshire, with a small number of services that are provided to a larger population throughout the county and beyond.

We work from both hospital and community premises, operating from approximately 30 sites. Our main site is Harplands Hospital, which opened in 2001 and provides the setting for most of our inpatient units. Children and young people's inpatient services are provided from the Darwin Centre. We also provide a range of clinical and clinical support services to our acute healthcare partners at the Royal Stoke Hospital, part of University Hospitals of North Midlands NHS Trust.

Our closing income for 2014/15 was £75.5m and we have a team of 1,230 whole time equivalent (1,646 headcount) staff.

Our main NHS commissioners are the two local Clinical Commissioning Groups (North Staffordshire and Stoke on Trent CCGs) although we also work with specialist commissioners for inpatient children's mental health services. Our substance misuse and some learning disability services are commissioned through the Local Authorities.

We are proud of our partnerships with a number of agencies that support people with mental health problems, including North Staffs Users Group, Approach, ASSIST, Brighter Futures, Changes, EngAGE, North Staffs Huntington's Disease Association, Mind, North Staffs Carers' Association, Reach and the Beth Johnson Association.

Our research and education partners include: The West Midlands Workforce Deanery, Keele University Medical School, Keele University and Staffordshire University.

Staffordshire is one of the eleven local health economies recognised as being financially challenged and was subject to a review during the summer of 2014 by KPMG. It is certain that there will need to be system reform in the coming months to address the significant financial issues that have been identified and we are committed to working with partners to identify the best future configuration for care.

Our consistent delivery within financial balance, demonstrated over a number of years, puts us in a unique position in North Staffordshire. We feel that we have the capacity to operate along more of the patient pathway, in a lead integrator role, enhancing our capacity and capability to deliver change by realising the potential of existing and developing new partnerships. Where it makes clinical and/or financial sense we will maximise our share of the mental health, learning disability and social care market, while constantly striving to improve efficiency through better use of technology and a reduced estate footprint.

2014/15 was a challenging period for the local health economy but our operational performance remained consistently high with key targets hit. During 2014/15 the TDA defined the Trust performance as category 1 (no identified concern).

Our Plans for 2015 /16

2014/15 was a landmark year for the Trust during which we recreated our strategic story, completed a major review of clinical pathways with our commissioners and other partners, and demonstrated, once again, our ability to manage successfully and to deliver high quality patient care within a balanced budget. Those successes set the context for an exciting year ahead.

We have agreed eleven principal objectives for 2015/16, which fully align with our emerging Integrated Business Plan.

1. Focussing on quality and safety
2. Engaging in national research programmes
3. Developing academic partnerships and education and training initiatives
4. Being an employer of choice
5. Becoming Digital by Choice
6. Reviewing and rationalising our accommodation
7. Protecting and consolidating our local services
8. Growing our specialised services
9. Ensuring good governance
10. Developing effective and relevant alliances and partnerships
11. Delivering our financial plan

Focussing on quality and safety

We are committed to providing the highest quality mental health services. Our Board's business is driven by the quality agenda and, during 2014, our Trust Board has defined a new emphasis for the organisation based on four strands of quality that we are calling SPAR:

- Our services will be consistently ***safe***
- Our care will be ***personalised*** to the individual needs of our service users
- Our processes and structures will guarantee ***access*** for service users and their carers
- Our focus will be on the ***recovery*** needs of those with mental illness

We will be receiving a formal Inspection under the terms of the Care Quality Commission's Chief Inspector of Hospital's regime between 7 and 9 September. We have targeted a "Good" rating for this Inspection and our Board has already approved a governance structure to allow us to prepare under each of the five domains.

The new programme of work will build on the foundations that have already been laid within the organisation including the development of the new clinical directorates and pathways. A new Quality Assurance Programme Board has been established, chaired by the Chief Executive, with the purpose of overseeing the delivery of service improvement.

The inspection is only a milestone, however, and will not distract us from plans that we had already developed as part of our improvement journey under the SPAR headings. Our current performance is only the baseline from which we will continually strengthen our capacity and capability to learn lessons across incidents, complaints and staff and service user feedback. One example of poor practice or bad attitude or difficulty accessing services is one example too many. Doing the right thing at the right time and getting it right first time for our service users is essential. Solving issues

before they escalate into concerns, complaints or harm supports a good patient experience and saves resource. Our Service User Standards are predicated on this approach to care.

During 2015/16 we will continue on our quality improvement journey by:

SAFE

- Developing a range of quality metrics to focus our key areas of quality and safety for improvement across all directorates and quality forums (by June 2015).

- Strengthening our mental health and physical health needs by the appointment of Clinical Skills Educator working closely with inpatient and community teams to further develop the importance of physical health and wellbeing (by September 2015).

- Updating the current supervision policy and developing a management supervision policy, ensuring structures are in place at all levels of the Trust identifying supervisors for all staff. We will develop a data system whereby supervision can be recorded and set supervision targets which are monitored through the directorate performance dashboards (by September 2015).

- Reviewing the Ligature Risk Review policy and environmental risk assessment tool, together with all risk assessment plans from wards and clinical areas to identify gaps/ problems (by September 2015).

- Undertaking monthly surveying of appropriate patients (as defined by the NHS Safety Thermometer guidance) to collect data in community settings on medication safety issues that can result in harm. Examples include: omission, medicines reconciliation, allergy status and high risk medicines use.

  The day of data collection will be varied to maximize the number of patients included. Sources of data will include: medicines charts, patient clinical records, patient assessment and conversations with patients and their carers.

  We will report to our commissioners on a monthly basis and aim to hit the following targets.

    - By the end of June 2015, Medicines Safety Thermometer to be rolled out across half of all appropriate community teams (details to be agreed by 1 May 2015).
    - By the end of August 2015, data collected and reported throughout the preceding three months.
    - By the end of September 2015, Medicines Safety Thermometer rolled out across all remaining community teams.
    - At the end of December 2015 and March 2016, re-assessment of the data collection and reporting for the preceding three months, together with reports describing lessons learned and any required service or process changes.

- Increasing the 'maturity' (as defined by the Manchester Patient Safety Framework - MaPSaF) of our safety culture as part of a wider focus on patient safety metrics. MaPSaF offers objective insight into key behaviours such as how patient safety incidents are investigated, staff education, and training in risk management.

We will report to our commissioners on a quarterly basis and aim to hit the following targets.

- By the end of June 2015:
  - Pledge to Speak Out Safely and Sign Up To Safety, and publicise that commitment on our website;
  - Use MaPSaF with our Board, inpatient areas and two community teams to facilitate self-reflection on safety culture maturity.
- By the end of August 2015:
  - Develop Heat Maps / Safety Dashboards for use in our Quality Committee and the commissioners' Clinical Quality Review Meeting to evidence that our clinical teams understand their own safety culture.
  - Identify higher and lower maturity teams to buddy up to share best practice.
  - Evidence that action planning has been facilitated through a series of half day workshops for the Board and identified teams.
  - Implement selected initiatives from Sign Up To Safety such as "what matters to me" and "safe, clean and personal boards".
  - Publish an Openness and Honesty report on our website.
- By the end of December 2015, self-assess on progress with production of a report to Board relating to activities in inpatient areas and the two community teams.
- By the end of March 2016, update our MaPSaF self-assessment to understand what progress has been made and report to commissioners on how safety profiles and culture has changed through intervention and critical appraisal.

PERSONALISED

- Developing a Patient Council to ensure the service user voice and view is incorporated in to our everyday business (by June 2015).
- We will develop a strategy to ensure that the newly developed Service User Standards are embedded as part of the expected culture and behaviour of our staff (by September 2015).
- Implementing the Health Equality Framework (HEF) to capture how interventions have resulted in improvements for people with learning disabilities.

The HEF provides an objective assessment of how the systems around service users are ensuring that needs are being identified and that appropriate support is being given, based on the five determinants of health inequalities set out by the Public Health Observatory (social determinants, genetic and biological determinants, communications and health literacy, behaviour and lifestyle, deficiencies in access to and the quality of healthcare).

We will report to our commissioners on a quarterly basis and aim to hit the following targets.

- By the end of June 2015:
    - 75% of staff in the Community Learning Disabilities Team, 50% of staff in the Intensive Support Service and 50% of staff in the inpatient unit will have received HEF awareness training.
    - All CLDT duty staff and 50% of all registered inpatient staff will have completed a HEF assessment.
    - We will have evidenced links with other services to identify areas of best practice.
- By the end of August 2015:
    - HEF will be used for all new admissions and referrals.
    - An electronic database will record HEF assessments and key related information.
    - We will have worked with our two Local Authorities to identify potentials for shared learning and information exchange.
- By the end of December 2015:
    - Report on areas of low scoring against the HEF and confirm what interventions have been implemented to address these issues, using 25 case studies as evidence.
    - 50% of all referrals to CLDT will receive a HEF review at the point of discharge from the service.
- By the end of March 2016 provide a report to commissioners to demonstrate how care plans for service users are informed by lower scoring domains on the HEF, the interventions that have been implemented, and the improvement post-intervention.

ACCESSIBLE

- Embedding routes of access to services by reconfiguring our Crisis Response and Access Team to deliver a 24 hour, 7 day service with a single point of contact, continuing work started in January 2015.
- Developing a caseload management system use and embed this across all teams. Undertake a skills mix review in community teams (by September 2015).
- Developing a Transition policy for Children & Young People to Adult & Adult to Older People's services, and review transitions between learning disabilities and mental health services. Review systems and inter team working to identify issues and improve the pathway for patients (by September 2015).
- Reviewing the Bed Management processes to identify blockages in the system and also undertake a capacity and demand exercise. Establish and embed the bed management and establish metrics for success in relation to out of area bed usage, length of stay and readmission rates.

RECOVERY FOCUSSED

- Using 5 W (Who? What? When? Where? Why?) methodology as a focus on measuring outcome and recovery for service users in selected community teams within the CQUIN quality improvement framework (embedded by July 2015).

- Identifying key areas to improve in relation to Mental Health Act & Record Keeping, which could be case file responsibility, Section 17 leave, Section 132 Patient rights and Section 58 Consent to treatment (by September 2015).

- Embedding the Short Warwick and Edinburgh Mental Well Being Scale (SWEMWBS) for all new referrals in care clusters 4 to 7, delivered at initial assessment or first appropriate appointment by our Access team or through our Community Mental Health Teams (CMHTs), at the time of review (by CMHTs) and at exit from the service (by CMHTs).

  The following indicators will be measured:

  - Implementation of SWEMWBS to all CMHTs.
  - Proportion (%) of service users that found the tool helpful in measuring their wellbeing.
  - Proportion of service users receiving SWEMWBS at an appropriate time, i.e., not at time of crisis.
  - Proportion of services users receiving SWEMWBS at review or exit from the service.
  - Proportion of service users reporting an improvement in their wellbeing over a defined period of time, with case studies to evidence.
  - Increase and decrease in wellbeing with evidence to demonstrate an understanding of what has worked well, what has contributed to decreased wellbeing, and what has been done to offer additional supporting packages of care.

  We will report to our commissioners on a quarterly basis and aim to hit the following targets.

  - By the end of August 2015, > 90% of service users at first appropriate appointment are offered the chance, where it is clinically appropriate, to complete the tool.

  - At the end of December 2015, an audit of 100% of the case notes of service users who reached a review point or were discharged from the service in the preceding three months to demonstrate the implementation and efficacy of the tool. The aim is that no more that 10% of service users will report deterioration in score and a poor experience.

  - At the end of March 2016, re-assessment of the previous two targets.

Engaging in national research programmes

We will continue to participate in national and international research studies working collaboratively with the NIHR Local Research Networks as a member organisation in addition to working alongside the West Midlands Academic Health Science Network. Our portfolio of studies covers a range of topics including, addiction, dementia, Huntingdon's Disease, psychosis, children and genetics with a number of clinical trials for dementia planned for the coming 12 months.

Developing academic partnerships and education and training initiatives

We have four key themes under which we will act in 2015/16:

- **Team Based Working:** we will continue to develop and embed team based working and leadership practices through Aston Team development and people management programmes – ensuring that those with ambition and ability are encouraged to further develop and use their leadership skills.
  - All outstanding team leaders will be invited to attend the Aston Team Development programme
  - Alumni events will be planned to keep existing team leaders up to date
  - Team development will be included in the annual business planning dashboard for team leaders
  - Continuing support will be available for existing team leaders

- **Mentor Pool**: we will develop our own internal mentor pool.
  - Existing mentor pool will be refreshed.
  - New mentors will be offered a choice of distance learning or face to face preparation for this role.
  - Active advertising and promotion of mentoring will be carried out.
  - Successful matching of mentor and mentees will be monitored.

- **Clinical Placements:** we will recruit a mentor support practitioner who will scope additional placement opportunities following service redesign and provide appropriate support to students and mentors, increasing placements by 1%.

- **Widening participation**: we will identify a lead for widening participation and fully scope for future development opportunities.

Being an employer of choice

FUTURE WORKFORCE CHANGES

A number of workforce schemes are planned for 2015/16 including initiatives to re-design services more efficiently to better meet anticipated future needs, to undertake skill mix reviews and to maximise opportunities to income generate via service expansion. The Workforce Plan is a working document and as such it continues to be developed and refined as change scheme progress, and to ensure that they meet cost saving and service delivery requirements.

The Workforce schemes are presented within the tables below, and are broken down Growth and CIP by Directorate and by staff group. It is important to note that the WTE presented below is based on budgeted establishment figures. It is anticipated that we will operate with a 98% fill rate, allowing for a 2% vacancy factor throughout the year, accounting for turnover and subsequent recruitment. In addition, where applicable, many of the schemes (particularly growth schemes) will be achieved through a phased approach, in order to reflect the realities of recruitment activity and varied start dates of new recruits.

As such, the numbers within the revised workforce numeric template submission will present a 98% fill rate and a concomitant 2% vacancy factor with support from the use of bank staff and substantive employees undertaking overtime where appropriate.

The Growth Schemes scheduled within 2015/16 are presented below (using budgeted establishment figures):

Growth Schemes – Total

2015/16	
Directorate	**Growth**
Adult Community	16.3
Adult Inpatient	9.8
Learning Disability	2
Neuropsychiatry, Old Age Psychiatry (NOAP)	44.13
Grand Total	**72.23**

2015/16	
Staff Group	**Growth**
Add Prof and Tech	1
Additional Clinical Services	2.4
Admin & Clerical	3
Ancillary	1
Junior Doctors	0.5
Nursing	57.35
Occupational Therapist	1
Physiotherapist	0.98
Social Work	5
Grand Total	**72.23**

The most significant area of substantive WTE growth during 2015/16 will be seen within the Nursing staff group, primarily arising from our Safe Staffing review and subsequent increases to establishment within Inpatient areas, additional funding within our Staffordshire based Deprivation of Liberty and Best Interest Assessors Service (Adult Community) and the development of a Shared Care Facility (NOAP).

We recognise that recruitment to a significant number of Nursing posts may be challenging and as such have launched an innovative recruitment campaign, using the local press and social media and engaging with educational providers to support post-qualification employment. In order to maintain a workforce fit for purpose, skill mix is also regularly reviewed and opportunities to develop Band 1-4 roles (including peer support workers and assistant practitioners) are being explored to provide opportunities for existing non-registered clinical staff and to provide a rounded, appropriate care package to our service users.

We will also continue to capitalise on opportunities to income generate via service expansion such as through the ongoing development of growth schemes such as in IAPT (Community), which will see small growth in Additional Professional and Technical Services, Administration and Additional Clinical Services in order to meet increasing demand.

Workforce and Finance colleagues work closely in order to ensure that plans are triangulated and regular meetings are scheduled to review plans and to review timescales and deliverability. Whilst the growth schemes modelled into the workforce plans will result in an increased budgeted establishment, it is noted that not all growth schemes will significantly impact upon pay costs. For example, we are currently providing a Dual (Shared) Care facility which was initially established in order to provide mutual aid to the Local Health Economy during a challenging period and as such does not currently have a substantive WTE assigned to it. It is, however, planned that the Service will be commissioned on a substantive basis within 2015/16, resulting in a significant increase to WTE; however, this will also see a concomitant reduction in the usage of Bank Staff, overtime and Agency spend as recruitment progresses throughout the year.

The CIP schemes within 2015/16 are presented below using budgeted established:

CIP Schemes – Total

2015/16 Directorate	CIP
Adult Community	-1.5
Corporate	-5.96
Children and Young People	-4.34
Learning Disability	-5.5
NOAP	-2
Trustwide	-19
Grand Total	**-38.3**

2015/16 Staff Group	CIP
Additional Clinical Services	-1.5
Admin & Clerical	-3.45
Ancillary	-1
Psychology	-2.91
Manager	-4.26
Nursing and Midwifery	-24.18
Physiotherapist	-1
Grand Total	**-38.3**

In terms of key areas for service change, some of the more significant schemes scheduled within the next year include redesign which will release efficiencies in community clinics (Adult Community), a systematic review of CAMHS (Children and Young People) and ongoing reviews within the Learning Disability Teams; the main staff groups affected by these changes are Nursing and Midwifery, Management and Admin and Clerical.

Where possible, opportunities to retain staff are explored including providing opportunities to re-train and/or to gain work experience in a different area. Workforce Plans are managed with a project management methodology and opportunities presented by growth schemes are considered in order to minimise the loss of the skills and expertise within the current workforce.

We will also continue to review corporate management structures, in order to support efficiency requirements and reflect more integrated delivery of care; for example through introducing joint management ventures with Local Authorities and working more closely with the voluntary sector. In addition, we will continue to review the skill mix within teams to ensure that tasks and responsibilities are undertaken at the appropriate level, maximising efficiency.

These planned changes span the current workforce and will inevitably present challenges with regard to ensuring that the motivation and morale of the workforce is maintained during a period of continuous change. It is imperative that the support and commitment from staff is gained to drive a cultural shift, fostering and embracing new ways of working. We will continue to work in partnership with Union and professional organisation colleagues to provide comprehensive support to staff and in addition, our Staff Support and Counselling Services provide invaluable support to the workforce via individual and group sessions.

STAFF ENGAGEMENT

Workforce Strategy
We are committed to being a good employer, maintaining a healthy balance of staff retention versus staff turnover and have staff committed to delivering to the best of their ability across the organisation.

In 2015/16 we will:

- Reduce sickness absence to below 4% (lower than average)
- Improve the Staff Survey results in 25% of categories
- Reduce by 10% the number of people off sick with work related stress/ anxiety

Appraisal / Performance Development Review (PDR)
We will additionally roll-out 85% of our PDR 'Cascade' within the first 6 months of the 2015/16 financial year. We have further appraisal skills training for line managers and appraisers planned for March, April and May 2015, ready for the 2015 PDR cascade.

We will improve staff survey response to quality of appraisal score by 10%.

Health and Wellbeing
Throughout 2015, we will be enacting a programme of work around Stress and Work-pressure (led by the People and Cultural Development Committee), designed to provide support and tools to staff to recognise, cope with and challenge stress and work pressure for the benefit of our staff and our patients/service users.

This Stress Less Campaign through 2015 will include the following:-

- A new, improved Wellbeing section for staff on our intranet site (SID), a focus on 'Stress Less' in Springs edition of Junction (our staff magazine) and sharing of Wellbeing+ magazine.

- A Staff Health and Wellbeing Event for 11 March 2015 – NHS Change Day; focusing on a wide range of aspects of staff health and wellbeing and the support and facilities available.

- Support and training for staff, including a range of stress awareness / management training for both individual staff, teams and managers.

- Our Aston Effective Team Leadership Programme will continue to promote healthy team working approaches to help teams work effectively and to be able to better address and respond to challenges and stressors in the workplace (and outside of work) for staff.
  We aim to have team-ness scores for all teams with 75% showing improvement by the end of 2015/16.

- Promotion of facilities and offers including access to the Harplands Gymnasium, salary sacrifice schemes and discounts at local Gyms. The Trust regularly promotes national initiatives (e.g. Dry January campaign, National Stress Awareness Day etc.) to inspire and motivate staff to take action on various aspects of healthier living. Staff participation in charitable events is regularly featured and celebrated in Newsround and Junction.

Becoming Digital by Choice

We want to become a 'Digital by Choice' organisation with a national reputation as a leader in the use of digital technology that enables: the delivery of excellent care services; service users and carers to recover; staff and partners to work together easily and effectively; and innovation in the delivery of healthcare services.

During 2015/16 we will continue this journey towards becoming a Digital by Choice organisation, which we started in 2014/15. We are partnering with the Staffordshire and Shropshire Health Informatics service in this endeavour. Key objectives for 2015/16 include:-

- Establishing a Service Management Group to replace the *Listening into* Action Digital Hit Squad (April 2015).
- Appointing a Chief Information Officer (June 2015).
- Appointing a Clinical Lead/Chief Clinical Information Officer (September 2015) and Head of Portfolio Management (Autumn 2015).
- Exploring predictive text analysis capability in partnership with SAS, concluding with an agreed project (by September 2015).
- Developing a service user app, in partnership with Staffordshire University, (piloted in Summer 2015 and launched in Autumn 2015).
- Clarifying our requirements for Electronic Patient Record, which may result in a bid for central funding supported by CSC (October 2015).
- Defining a Portfolio Programme, which will clarify key objectives and prioritise investment for the next two year (by December 2015).

Reviewing and Rationalising our Accommodation

The scope and geographical spread of our services means it is inevitable that we have a number of buildings from which we deliver care and support services. The management that portfolio of accommodation is a continuing process.

During 2014/15 we have made a number of improvements to sites including the following:

- In partnership with our soft facilities management provider Carillion, opened level 1 Café on the Harplands site
- Made a number of upgrades to infrastructure to improve privacy and provide a safe operating environment on the Harplands site.

- Disposed of a further 4 properties, reducing occupancy cost and bringing revenue into the Trust.

- Agreed plans in partnership Brighter Futures to develop land adjacent to the Greenfields Centre to enhance rehabilitation services.

In 2015/16 we will:

- Complete the sale of the site of the former Bucknall Hospital, reducing maintenance costs further and achieving a Capital receipt of *circa* £2million (September 2015).

- Surrender our lease on the Boathouse property, reducing occupancy cost by up to £50,000 (September 2015).

- Refurbish and reconfigure Dragon Square to accommodate children services from Boat House and Ashlands (September 2015).

- Vacate Abbots House and in partnership with Stoke City Council locate services at the Dementia Centre at Marrow House (December 2015).

- Finalise the business case for and move to construction of the new PICU on the Harplands site (from August 2015).

- Purchase the Assessment & Treatment and Telford Building on our Harplands site (Autumn 2015).

- Present commissioners with a Business Case for a Dual Care Ward and Outreach service to support people with co-morbid physical and mental health needs and subject to commissioner support bring this fully into operation in 2015/16 (from July 2015).

- Review the options to upgrade or relocate our CAMHS Tier 4 service and develop a business plan for this purpose (Autumn 2015).

- Focus on better management of our PFI contract at Harplands Hospital, ensuring contractual compliance and achieving value for money (continuing).

Protecting and consolidating our local services

The Clinical Pathways was a key piece of work achieved in 2014 along with commissioners and key partners Pathways were broadly agreed for the following areas:

- Access to services including crisis intervention.
- Adult Mental Health including Acute, Rehab and Community.
- Raid
- Older people and dementia
- CAMHS
- Neuro-psychiatry.
- Substance misuse
- Learning Disability

The clinical pathways continue to be a high priority during 2015/16 and we continue to work with commissioners to finalise any outstanding areas on delivering the pathways and more importantly work together to cost all of the pathway deliverables.

We are developing the service areas for 2015/16:

Adult Mental Health Inpatient Directorate will:

- Develop business case for PICU and move to construction stage with a view to opening in 2017.
- Reconfiguration of Harplands wards 1-3 to better meet patient need.
- Develop plans to re repatriate rehab services users, to local solutions including a low secure (locked) rehabilitation unit.

Adult Mental Health Community Directorate will:

- Embed 24/7 access service and change role and function of home treatment teams.
- Fully implement ASD Service.
- Reconfigure and reduce the number of community teams, moving from 4 bases to 2.
- Implement a plan to meet national mental health waiting times for first episode in Psychosis and IAPT to be fully operational from 1st April 2016.
- Focus on productivity and efficiency of our community teams.
- Develop our Social Care Offering.
- Grow IAPT share outside of geographical boundaries.
- Develop a community-supported rehabilitation service.
- Develop a Supported Living pathway for people with mental health issues.

Growing our specialised services

Substance Misuse Directorate will:

- Further develop the range of innovative service models and partnerships with third sector organisations including ADS, Adsis, Arch, Brighter Futures and Changes
- Market our specialist SM Detox beds further and subject to commissioning intentions develop a case for increased provision
- Development of services that interface with Physical Health – continue work of Intoxication Observation Unit (IOU) and Hospital Alcohol Liaison Team (HALT), and aim for this model to develop in other hospitals in Staffordshire
- Support the transfer of commissioning for IOU in Stoke-on-Trent from NHS England to Stoke on Trent CCG (for North Staffs already sits with North Staffs CCG, so this would bring it in line.)
- Using our specialist expertise, aim to grow our business by tender, including for local services within Stoke on Trent (community, inpatient and recovery), and Staffordshire (Inpatients).
- Tender for Prison in reach services
- Develop work with CAMHS services to deliver substance misuse services.

- Work with the neuropsychiatry team and UHNM to scope interventions for alcohol related brain injury.

Learning Disabilities Directorate will:

- Embed ISS service to provide high intensity targeted support to people in need.
- Enhance the physical environment of A&T and Telford Unit to better support repatriation of more complex service users.
- Establish Telford Unit as a Challenging Behaviour Unit.
- Repatriate out of area clients through A&T and into placements in North Staffordshire and Stoke on Trent

Neuropsychiatry and Older People Directorate will:

- Develop our offering to support people with mental and physical health co-morbidities including:-
    - With commissioners, review the effectiveness of the Dual care Ward funded out of Resilience funding and subject to commissioning intentions develop a business case to provide on a substantive basis and embed service.
    - Expansion of RAID service at community hospitals and Royal Stoke.
- Enhancement of Intensive support Services to include Integrated Specialist Teams with Local Authority (Includes Day Hospital Closure)
- Further development of Services for Older People with Dementia including Care Home Liaison, Vascular Wellbeing, Memory Services and Shared Care/Shared Outreach
- Embed Stoke on Trent dementia primary care liaison service.
- Further explore appetite for Acquired Brain Injury Unit.

Children and Young People Directorate will:

- Implement the revised clinical pathway to support Children & Young People with Mental Health needs
- Complete the whole service redesign based on pathways to enable resources to be utilised more effectively and better match capacity and demand.
- Embedding CAPA model to support the above work
- Roll out the Referral Hub to become a Single Point of Access for the organisation from 1st April 2015 with a view to supporting the wider system during 15/16.
- Move the service to one primary location and decommission Boat House.
- Embed Yellow House as part of the block contract.
- YOS becomes part of the block contract.
- Review with commissioners the opportunity to development Tier 3+ services.
- Move further towards use of technology including Skype/FaceTime and online delivery

Ensuring good governance

During 2014/15 our good governance was validated by:

- ✓ An externally validated score of 2.5 for our Quality Governance Assurance Framework. A score of 3 or lower is required for organisations seeking to become Foundation Trusts.
- ✓ A risk rating of 4 from the NHS Trust Development Authority (TDA), our Regulator, which signals no financial deficit or quality concerns.
- ✓ A risk banding of 4 (lowest risk) based on the Care Quality Commission's intelligent monitoring process.
- ✓ A green rating from the local health economy's Quality Surveillance Group.
- ✓ A history of delivering 100% of CQUINs (quality standards agreed with the commissioners who pay for our services), demonstrating year on year improvements in the quality of care.
- ✓ Achievement of national & local key performance indicators remains strong with 51 green, 3 red and 2 amber indicators.
- ✓ AIMS Accreditation for our adult inpatient services, demonstrating peer confidence in the service that we provide.
- ✓ Community mental health survey results within the expected range.
- ✓ Financial balance or better in 18 of the last 20 years.
- ✓ A strong patient safety culture with 99% of serious incidents investigated within NPSA guidelines in the last 2 years.

In 2015/16 we will enhance our arrangements through:

- Continued work with the Good Governance Institute, which we started in Autumn 2014, which will strengthen our integrated governance and risk management.
- Better engagement with our service users through the Patient Council, which we introduced in February 2015. Through the Council we aim to involve service users in decision-making on key next steps in our development as an organisation.
- Appointment to a substantive Director of Finance.
- Appointment to a substantive Director of Nursing.
- Appointment to a substantive Director of Strategy & Development.

In 2015/16 we will also continue our efforts to embed devolved accountability through our new Clinical Directorate structure.

- **CQC and quality maintenance**. We will develop Key Lines of Enquiry, using the CQC methodology to self-assess our clinical areas, identify improvement methods and lead clinical actions for each area. Complete by September 2015. The outcome will be a populated schedule of self-assessments and evolving methodology available to all teams.

- **Risk assessment**. We will ensure clear and robust ligature risk assessments are completed, actions applied and clinically led process of monitoring safety is embedded through clinical teams and the board using Good Governance methodology. The Deputy Director of Nursing will complete this for inpatient areas by April 2015 and for community areas by May 2015. The outcome will be that every directorate will have a detailed plan with mitigating actions and risk rated mitigating plans will be in place for low risks.

- **Safer staffing.** We will provide a detailed monthly graphic reporting system that links staffing levels to acuity, including incidents, staff sickness and other key indicators. This will be shared with all staff leaders and will be embedded in safe staffing culture through actions monitoring and reporting to Board. The Director of Nursing will complete this by July 2015. The outcome will be that every ward will be able to demonstrate quality of provision through metrics.

- **You said, we did.** Clinicians will be making decisions to spend and use additional resource in their own clinical areas in response to identified needs in safer staffing reports. The Director of Nursing and Director of Finance will ensure that investment is available to ward areas to match safe staff need.

- **Nursing Structures.** We will embed clinically driven ideas through active engagement with Clinical Directors in order to embed a Senior Nurse structure that will lead the Nursing, Governance and Psychology agenda. The Director of Nursing will complete this by August 2015. The outcome will be that every directorate will have a named senior nurse.

- **Co-Production.** We will engage and involve patients, carers and staff in coproduction as we develop a patient's council.

Developing effective and relevant alliances and partnerships

As a good organisation performing well, we are striving for continual improvement so that we realise our full potential as an agile and innovative organisation. In recent months we have developed three key relationships and we see the potential for them to evolve into more formal partnerships with:

- Salford Royal NHS Foundation Trust to learn lessons in efficiency, productivity and service improvement.
- Birmingham and Solihull Mental Health NHS Foundation Trust to share best practice in core mental health and learning disability services and to prepare for our CIH Inspection.
- Airedale NHS Foundation Trust to maximise the potential of the digital agenda.

Our future will be underpinned by the partnerships and relationships that we forge with others. We do not see ourselves as limited to the public and academic sector marketplaces; we imagine that our size and the scale of our ambition will make us an attractive partner to the commercial sector and we are keen to explore this potential, for instance in the field of technology and innovation.

We also real potential in the concept of alliance contracting (Oldham, 2014) and have joined Staffordshire and Stoke-on-Trent Partnership Trust in a bid to deliver a pilot for co-commissioning of Tiers 2 and 3 CAMHS.

Our firm belief is that a person's individual health should not be segregated into physical and mental health, services should be delivered in the most integrated way possible. For this to happen we need to work in active partnerships with NHS, social care, General Practice and the voluntary sector.

Delivering our Financial Plan

Overall Planned Position

We are planning to achieve our statutory duty to break-even in 2015/16 and will deliver an adjusted financial performance retained surplus of 0.7% of turnover and an EBITDA of £3.3m. This is a slight reduction compared to the 1% adjusted financial performance surplus forecast in 2014/15.

The planned adjusted financial performance surplus in 2015/16 is achievable taking into account the efficiency target that the Trust must deliver and the cost pressures it faces.

Surplus/(Deficit) Position	Forecast 2014/15 £m	Plan 2015/16 £m
Net Surplus / (Deficit)	0.3	0.0
Add Back IFRIC 12 Adjustment	0.5	0.5
Adjusted Net Surplus / (Deficit)	**0.7**	**0.5**
Adjusted Net Margin	1.0%	0.7%

Income

Planned income for 2015/16 is based upon:

- the application of the net tariff deflator of -1.2%:
  - tariff inflation added at 2.3%;
  - tariff CIP reduction of -3.5%;
- CQUIN remaining at 2.5% of baseline contract values;
- full-year effect of contract variations/service developments that started during the 2014/15 financial year; and
- funding for other cost pressures and developments.

We have decided to opt for the Enhanced Tariff Option (ETO) and the application of the net tariff deflator and other assumptions reflect this decision.

Clinical budgets for SLAs with NHS organisations have been reduced in line with the net tariff deflator of -1.2%.

Non-clinical income budgets have been set based upon SLAs and relevant agreements for Education, Training and Research.

Income is shown in more detail in the following two tables:

Income	Actual 2014/15 £m	Plan 2015/16 £m
Clinical Income	66.8	66.5
Other Income	8.7	8.3
Total Income	**75.5**	**74.8**

Clinical Income	Actual 2014/15 £m	Plan 2015/16 £m
NHS England	2.8	3.0
Clinical Commissioning Groups	55.6	54.6
Local Authorities	6.1	6.0
Non NHS: Other	2.3	2.9
Total Income	**66.8**	**66.5**

Expenditure

Planned expenditure for 2015/16 takes into account the impact of:

- inflation based upon TDA planning guidance;
- cost pressures, such as the impact of the safe staffing review;
- service developments; and
- Cost Improvement Programmes to delivery efficiency savings.

Pay budgets have been calculated based upon the agreed establishment, including the cost of living pay rise as detailed in the pay circular issued on 13 March 2015.

The PFI agreement has been uplifted by RPI of 1.1% in line with the contractual terms and conditions.

A Cost Improvement Programme of £2.6m has been factored in across pay and non-pay.

Expenditure	Actual 2014/15 £m	Plan 2015/16 £m
Employee Benefit Expense	(53.9)	(53.7)
Drug Cost	(1.9)	(2.0)
Clinical Supplies and Services	(0.2)	(0.2)
Services from NHS Bodies	(2.4)	(2.5)
Other Expenses	(9.5)	(8.9)
PFI Operating Expense	(3.9)	(4.0)
Total Depreciation & Amortisation	(1.3)	(1.4)
Interest expense on overdrafts and working capital facilities	0.0	0.0
Total interest payable on Loans and leases	(1.4)	(1.4)
PDC Dividend	(0.5)	(0.6)
Total Expenditure	**(75.1)**	**(74.6)**

Surplus / (Deficit) Position	Actual 2014/15 £m	Plan 2015/16 £m
Net Surplus / (Deficit)	0.4	0.2
Add Back IFRIC 12 Adjustment	0.3	0.5
Adjusted Net Surplus / (Deficit)	**0.8**	**0.8**
Adjusted Net Margin	1.0%	1.0%

Cost Improvement Programme

We are not alone in facing significant efficiency targets. Despite this we have demonstrated that we are able to achieve these targets through the delivery of a cost improvement programme in prior years and are on track to do so in 2014/15.

In 2015/16 we will continue to focus our delivery of the majority of CIP schemes on a recurrent basis. We have a robust process in place to ensure efficiency targets are met and where there is any slippage, remedial action will be taken.

The tables below show the CIP target split by directorate and by recurrent and non-recurrent.

Cost Improvement Programme by Directorate	Plan 2015/16 £m
Adult Mental Health Inpatient	0.1
Adult Mental Health Community	0.1
Substance Misuse	0.0
NOAP	0.5
Learning Disability	0.2
Children & Young People	0.3
Corporate / Trust-wide	1.5
Total CIP	**2.6**

Cost Improvement Programme by Recurrent/Non-recurrent	Plan 2015/16 £m
Recurrent	2.2
Non-recurrent	0.4
Total CIP	**2.6**

Capital Programme

Our Capital Programme has been developed to enable investment in projects that will improve the quality and range of our services and tie in with our aim to increase the portfolio of services we provide.

The planned capital expenditure is within the total capital funds available to the Trust and will still allow the Trust to maintain a healthy cash balance.

Capital Programme	Plan 2015/16 £m
Total Capital Funds	**5.5**
Ward Reconfiguration & Improvements	(1.6)
Dragon Square Upgrade	(0.3)
Information Technology	(0.1)
Equipment	(0.1)
Other	(0.3)
Total Capital Expenditure	**(2.3)**
Underspend / (Overspend)	**3.2**

Balance Sheet

The balance sheet below is based upon the income, expenditure and capital expenditure plans as detailed above. While we are planning to spend £4.2m in capital during 2015/16, we are still planning to maintain a healthy cash balance of £4.6m by the end of the 2015/16 financial year. Non-current liabilities reflect the obligation regarding the PFI scheme.

Balance Sheet	Actual 2014/15 £m	Plan 2015/16 £m
NON-CURRENT ASSETS:		
Property, Plant and Equipment	30.9	31.8
Intangible Assets	0.1	0.1
Trade and Other Receivables	0.0	0.0
TOTAL Non Current Assets	**30.9**	**31.9**
CURRENT ASSETS:		
Inventories	0.1	0.1
Trade and Other Receivables	3.0	3.3
Cash and Cash Equivalents	6.8	6.4
Sub Total Current Assets	**9.9**	**9.8**
Non-Current Assets Held For Sale	2.5	1.8
TOTAL Current Assets	**12.5**	**11.6**
TOTAL ASSETS	**43.4**	**43.4**
CURRENT LIABILITIES:		
Trade and Other Payables	(5.3)	(6.4)
Provisions	(1.7)	(0.9)
Liabilities arising from PFIs / LIFT / Finance Leases	(0.4)	(0.3)
Total Current Liabilities	**(7.3)**	**(7.7)**
NET CURRENT ASSETS/(LIABILITIES)	**5.2**	**3.9**
TOTAL ASSETS LESS CURRENT LIABILITIES	**36.1**	**35.8**
NON-CURRENT LIABILITIES:		
Trade and Other Payables	(0.6)	0.0
Provisions	(0.6)	(0.4)
Borrowings	(13.0)	(12.6)
Total Non-Current Liabilities	**(14.2)**	**(13.6)**
ASSETS LESS LIABILITIES (Total Assets Employed)	**21.9**	**22.1**
TAXPAYERS EQUITY:		
Public Dividend Capital	8.0	8.0
Retained Earnings reserve	0.8	1.0
Revaluation Reserve	13.7	13.7
Other Reserves	(0.6)	(0.6)
Total Taxpayers Equity	**21.9**	**22.1**

Key Metrics

Overall we are RAG rated as green for 2015/16.

Against all but one of the key metrics the Trust is rated as green, with the only the Planned Financial Performance being rated as amber. This is due to the Trust planning to deliver and adjusted financial performance of 0.7%.

Key Metrics	Actual 2014/15	Plan 2015/16
Planned Financial Performance	GREEN	GREEN
Planning to access permanent PDC Other funding?	GREEN	GREEN
Percentage of High Risk Efficiencies		GREEN
Percentage of Unidentified Efficiencies		GREEN
Efficiencies as a % of Planned Spend	AMBER	GREEN
Planned Underlying Financial Position	GREEN	GREEN
Continuity of Services Risk Rating	GREEN	GREEN
Key Metrics Overall RAG Rating	**AMBER**	**GREEN**

Our Continuity of Service Risk Rating remains RAG rated as green

Continuity of Service Risk Rating	Actual 2014/15	Plan 2015/16
Liquidity Ratio (days)	4.0	4.0
Capital Servicing Capacity (times)	2.0	2.0
Overall Continuity of Services Risk Rating	3.0	3.0
Continuity of Services Risk Rating	**GREEN**	**GREEN**

Measuring Financial Success

In 2015/16 we will:

- Achieve our statutory duty to break-even by spending within the Trust's Revenue Resource Limit;
- Implement a capital programme that is within the Trust's Capital Resource Limit;
- Uphold our statutory duty to spend within the Cash Resource Limit; and
- Achieve or exceed the Better Payments Practice Code target.

Managing our risks

We have assessed our strategic, operational, financial, digital, estates and workforce risks based on our Directorate and Trust-wide SWOTs and market assessment. During 2014/15 we further increased our focus on reviewing our risk profile and considering the risks to the safety, quality and viability of our services. As at 31 March 2015, our residual high and significant principal risk were:

- Lack of investment in mental health services as a member of a challenged health and social care economy.
- Failure to achieve 'good' as an outcome of the CQC inspection.
- Failure to comply with safe staffing requirements and to establish safe staffing in clinical areas.
- Failure to deliver a culture change in staff engagement and other internal and external relationships.
- Failure to develop and implement processes that fully support payment by results.

We are refreshing our Board Assurance Framework as the vehicle through which our Trust Board manages our strategic risks with reference to key assurances and controls. This process will complete in June 2015 and key risks will be defined under each of our objectives.

Emerging risks are:

- ***Focussing on quality and safety:*** The Trust fails to improve patient safety, eliminate avoidable harm and deliver high quality services, resulting in reputational harm, increased scrutiny and regulatory restrictions.
- ***Consistently meeting standards:*** The Trust fails to hit required performance targets and is placed under a greater scrutiny and regulatory regime.
- ***Protecting our core local services:*** The Trust fails to consolidate its position as the local provider of local mental health and learning disability services, loses business to other providers and is not clinically, financially or operationally sustainable.
- ***Growing our specialised services:*** The Trust fails to exploit its potential in specialised services and compromises its clinical, financial and operational sustainability.
- ***Engaging in national research programmes:*** The Trust fails to exploit its potential in research activities and loses credibility and reputation in the healthcare community.
- ***Developing academic partnerships and education and training initiatives:*** The Trust fails to exploit opportunities, resulting in loss of positive reputation and staff are not developed.
- ***Being an employer of choice:*** The Trust fails to manage relationships with its staff, to improve communications and engagement and to enhance inclusion, resulting in higher turnover and poor staff survey results, threatening clinical and operational sustainability.

- ***Becoming Digital by Choice:*** The Trust fails to invest appropriately in its infrastructure meaning that it is unfit for the future and unable to deliver its business goals and objectives.
- ***Reviewing and rationalising our accommodation:*** The Trust fails to invest appropriately in its infrastructure meaning that it is unfit for the future and unable to deliver its business goals and objectives.
- ***Ensuring good governance:*** The Trust fails to meet key regulatory compliance requirements and is placed under a greater scrutiny and regulatory regime.
- ***Delivering our financial plan:*** The Trust fails to meets its financial responsibilities and/or fails to deliver year one of its Long Term Financial Model, resulting in greater scrutiny from regulators and commissioners and the threat of financial non-sustainability.

Important documents

Foundation Trust Network (2014). *On The Day Briefing: NHS England Five Year Forward View.*

KPMG (2014). *Final report for Staffordshire LHE.*

Mental Health Foundation (2013). *Starting today: The future of mental health services.*

NHS England et al. (2014). *Five Year Forward View.*

NHS England (2015). *Building the NHS of the Five Year Forward View. The NHS England Business Plan 2015-2016.*

NHS Providers (2014). *Providing for the future: Building a Healthy NHS around people's needs.*

NHS Trust Development Authority (2015). *Delivering for Patients: the 2015/16 Accountability Framework for NHS trust boards.*

Oldham, Sir J et al (2014). *One person, one team, one system.*

Royal College of Psychiatrists (2014). *Making parity a reality: Six asks for the next government to improve the nation's mental health.*

Staffordshire County Council, City of Stoke-on-Trent, et al. (2014). *Mental Health is Everybody's Business.*

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: Trust Board

Enclosure 11

Date of Meeting:	4 June 2015
Title of Report:	Month 1 Performance Management Report
Presented by:	Kevin Daley, Performance Development Manager
Author of Report: Name: Date: Email:	 Kevin Daley 22/05/15 Kevin.Daley@northstaffs.nhs.uk
Purpose / Intent of Report:	• Performance monitoring • For Information
Executive Summary:	This report provides the committee with a summary of performance to the end of Month 1 (April 2015). Performance against the TDA metrics and key National Targets is included within the report. At month 1 there are 3 metrics rated as Red, and 1 rated as Amber; figures for remaining metrics will be determined once the performance report format is finalized by the Executive Team and technical guidance received from the TDA.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Governance Strategy The Performance & Quality Management Framework measures performance across National and local indicators, presented against the Trust's enabling strategies, commissioning contract and the TDA's proposed assurance framework.
Relationship with Annual Objectives:	The Performance & Quality Management Framework measures performance across all annual objectives
Risk / Legal Implications:	All areas of underperformance are separately risk assessed and added to the risk register dependent on the outcome of the risk assessments.
Resource Implications:	Not directly as a result of this report
Equality and Diversity Implications:	Not directly as a result of this report
Relationship with Assurance Framework [Risk, Control and Assurance]	The Performance & Quality Management Framework is a key control within the Assurance Framework

Recommendations:	The committee is asked to • Note the performance reported including the forecast position • Note that all national targets are being met • Review areas of underperformance as summarised in this report and identify further action required

PERFORMANCE MANAGEMENT REPORT TO FINANCE & PERFORMANCE COMMITTEE

Date of meeting:	4 June 2015
Report title:	**Performance & Quality Management Framework** **Performance Report – Month 1 2015/16**
Executive Lead:	Interim Director of Finance
Prepared by:	Kevin Daley, Performance Development Manager
Presented by:	Glen Sargeant, Head of Performance & Information

1 Introduction to Performance Management Report

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

- An Executive Summary (this report)
- Overall performance of metrics with targets (App A)

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

2 Executive Summary – Exception Reporting

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

At month 1 there are 3 metrics rated as Red, and 1 rated as Amber; figures for remaining metrics will be determined once the performance report format is finalized by the Executive Team and technical guidance received from the TDA.

Month 1			
Red	Amber	Green	Unrated
3	1	*48*	*No rating*

3 Exception Reports

Metric	Exec/Op Lead	Target	M1 Perf	YTD Perf	Forecast Outturn	Trend	Commentary
TRAINING: % staff compliant with mandatory training	Workforce Dir Op Lead B Dawson	**95%**	AMBER **87%**	AMBER **87%**	AMBER	↔	**87% @ month 1 same as month 12** Month 1 breakdown Corporate Services = 88% AMH Community = 90% AMH In Patient = 81% Substance Misuse = 97% CYP = 85% Learning Disabilities = 92% NOAP = 86% Trust is proactively taking action with teams to ensure that all staff attend statutory & mandatory training and maintain their compliance.
IAPT: - Min data set	Dir of Ops Op Lead S oodall	**90%**	RED **83%** (@M10)	RED **83%** (@M10)	GREEN	↗	**NB/ Latest available data from HSCIC** for this metric is **83% @ M10, same as M9.** The Trust data is **84%** which is above the national average **(74%)** and is in the top cohort of Trusts in terms of data completeness, rated 'Green' using HSCIC data validity measures. The data for IAPT Services will not currently reach 90% target as a number of clients will step out of the service and initial assessment is not completed where the therapist complete min data set. Agreed Plan: • 3 demographics (Religion, Sexual Orientation, ethnicity) are reported on the HSCIC as 'not stated' for clients not being initially assessed in the service, HSCIC to be contacted for data quality guidance by Healthy Minds Data Lead. • Meeting arranged for 28th May 2015 with CSU, commissioner data lead, Healthy Minds data lead to address data quality issues.

- No. moving to recovery		**46%**	**RED 36.9%**	**RED 36.9%**	**GREEN**	↗	**36.9% @ month 1 from 36.4% @ month 12** Agreed Plan to improve recovery outlined below: • Improved caseload management/supervision policy in line with NHS Review • Review of DNA data to improve therapist performance • Assistant Psychologist Audit to drill down drop out and recovery in the service Development of new evidence based clinical pathway
Metric	**Exec/Op Lead**	**Target**	**M1 Perf**	**YTD Perf**	**Forecast Outturn**	**Trend**	**Commentary**
MH Tribunal process: % compliant returns within 3 weeks	Medical Director Op Lead S Dawson	**100%**	**RED 67%**	**RED 67%**	**GREEN**	↗	**NB/ This data is only available a month in arrears.** **67% @ March reporting from 60% @ February reporting** There has been an increase in performance from last month; a 'Practice Notice' has been developed which has been circulated to all relevant staff by the Medical Director. The trajectory for compliance with this requirement is **June 2015 data**.

4 Risk Ratings

The TDA measures Trust performance in five categories:
At month 1 we have maintained our rating of **Level 4** (out of 1 to 5), where 5 is best.

5 Recommendations

The Committee is asked to:

- Review areas of underperformance as summarised in this report and identify further action required

The following metrics are formally monitored during 2015/16; they will be live from 2016/17:

Metric	Exec/Op Lead	Target	M1 Perf	YTD Perf	Forecast Outturn	Trend	Commentary
IAPT: - % of people referred treated within 18 weeks	Dir of Ops Op Lead: S Woodall	**90%**	AMBER **87.8%**	AMBER **87.8%**	GREEN	↗	**87.8% @ month 1 from 88.8% @ month 12** An action plan and trajectory is in place to close the gap.
Early Intervention: % of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks.	Dir of Ops Op Lead S Wilson	**50%**	RED **28%**	RED **28%**	GREEN	↗	**28% @ month 1 same as month 12** These figures relate to current working practice, where allocations onto caseload are through the weekly team meeting – the Operational Lead is reviewing processes and an action plan is in place to close the gap.

Internal stretch target (not contracted):

18 WEEKS: – ASD (Autistic Spectrum Disorders)	Dir of Ops Op Lead tbc	**95%**					18 week RTT figure overall for the Trust currently stands at **97% @ M1**. We have however identified a tranche of ASD waits that need to be addressed and are not currently included in this measure. (If included, the overall measure internally would stand at **89% @M1**.) Investment is in place and an action plan has been created to treat the waits, which affect the Children and Young People directorate.

RAID: A&E Emergency Portal referrals seen within 1 hour All other referrals seen on same day or within 24 hours	Dir of Ops Op Lead D Carr		**75%** **81%**	**75%** **81%**			Given the strategic importance of RAID and links to the urgent care system we have introduced monitoring at Board level. Given the growth of Urgent Care activity at UHNM, the service has increasingly been picking up out of area activity. NSCHT is currently in discussion with commissioners via the RAID steering group to agree response targets, which will be added as agreed.

Appendix A Trust Dashboard									
Month:	Apr-15								
1									
Contract & National Indicators including TDA (2015/16)									
TDA Domain - Responsive									
KPI	Metric	Metric Driver	Executive lead	Target	Apr	YTD	Trend	Forecast Year End	Commentary
TDA	Referral to Treatment Admitted	TDA	Dir of Ops		Query				Is this applicable to Trust?
TDA	Referral to Treatment Non Admitted	TDA	Dir of Ops		Query				Is this applicable to Trust?
TDA	Referral to Treatment Incomplete	TDA	Dir of Ops		Query				Is this applicable to Trust?
TDA	Referral to Treatment Incomplete 52+ Week Waiters	TDA	Dir of Ops		Query				Is this applicable to Trust?
TDA	Diagnostic waiting times	TDA	Dir of Ops		Query				Is this applicable to Trust?
O1.OP7	Compliance with 18 week RTT -Trust excluding ASD Analysis by Directorate	COM	Dir of Ops	95%	97%	96.9%	↗		75 patients waiting more than 18 weeks @ M1
	AMH IP				100%	100.0%	↔		No patients waiting more than 18 weeks @ M1
	AMH Community				93%	93.4%	↘		52 patients waiting more than 18 weeks @ M1
	Substance Misuse				0%	0.0%	↔		No patients waiting more than 18 weeks @ M1
	LD				99%	98.9%	↘		1 patient waiting more than 18 weeks @ M1
	Neuro and Old Age Psychiatry				97%	96.9%	↗		22 patients waiting more than 18 weeks @ M1
	C&YP				89%	89.0%	↘		91 patients waiting more than 18 weeks @ M1
	RAID - A&E Emergency Portal referrals seen within 1 hour	COM	Dir of Ops	100%	75%	75%	↗		
	RAID - Referrals in FEAU, other portals and urgent wards seen within 4 hours			100%	100%	100%	↔		
	RAID - All other referrals seen on same day or within 24 hours			100%	81%	81%	↗		
TDA	Mental health delayed transfers of care	TDA	Dir of Ops	7.50%	3.49%	3.49%	↘		
TDA	The proportion of those on Care Programme Approach(CPA) for at least 12 months Having formal review within 12 months	TDA	Dir of Ops	95%	95%	95.00%	↔		
TDA	The proportion of those on Care Programme Approach(CPA) for at least 12 months Having a (HONOS) assessment within the last 12 months	TDA	Dir of Ops	90%	88%	88.30%	↘		
TDA	Admissions to inpatient services who had access to Crisis Resolution	TDA			100%	100.00%	↔		
O1.OP1	Number of people referred for CRHT	COM	Dir of Ops	Awaiting Agreed Target	99	n/a	↔		99 seen of 99 referals seen within 4hrs = 100%
TDA	IAPT % of people treated within 18 weeks of referral	TDA		95.00%	87.84%	87.84%	↘		
TDA	IAPT % of people treated within six weeks of referral	TDA		55.00%	56.86%	56.86%	↗		
TDA	IAPT Operational recovery indicator (in development)	TDA			n/a	n/a			Awaiting TDA technical guidance
TDA	% of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral	TDA	Dir of Ops		28%	28%	↔		

KPI	Metric	Metric Driver	Executive lead	Target	Apr	YTD	Trend	Forecast Year End	Commentary
	Provider outpatient cancellation rate	TDA	Dir of Ops		n/a	n/a	↔		Awaiting TDA technical guidance
O11.11	S136 (Place of Safety) Assessments	DoH/COM	Dir of Ops	No target	21	21	↗		YTD is based on cumulative total of previous months
	- Formal Admissions				1	1	↔		YTD is based on cumulative total of previous months
	- Informal Admissions				3	3	↘		YTD is based on cumulative total of previous months
	- Under 18 Yrs Old				1	1	↗		April 2015 - 1 female 17 yrs old
	Section 136 Suite Closures	Trust	Dir of Ops	0	0	0	↔		YTD is based on cumulative total of previous months. Incident forms are raised for each closure
	Data completeness of MHLDDS - Trust	DoH/COM	Dir of Ops	95%	99.8%	0%	↗		YTD is based on overall compliance over the previous months
	Early Intervention Services Total Caseload	COM	Dir of Ops	149	156		↗		YTD is total caseload at month end
TDA Domain - Effective									
TDA	Emergency re-admissions within 30 days following an elective or emergency spell at the trust	TDA			5.10%	5.10%	↘		12 Of 234 Eligible discharges = 5.1%
TDA	Emergency re-admissions within seven days following an elective or emergency spell at the trust	TDA			n/a	n/a			Awaiting TDA technical guidance
TDA	Emergency re-admissions within 14 days following an elective or emergency spell at the trust	TDA			n/a	n/a			Awaiting TDA technical guidance
TDA	Emergency re-admissions within 28 days following an elective or emergency spell at the trust	TDA		7.50%	5.10%	5.10%	↘		12 Of 234 Eligible discharges = 5.1%
TDA	% clients in settled accommodation	TDA			89.60%	89.60%	↔		
TDA	% clients in employment	TDA			12.70%	12.70%	↔		
TDA	Suicides and undetermined injury / people in contact with services	TDA			0	0.00%			
TDA	Percentage Mental health re-admissions of less than seven days out of total admissions	TDA			n/a	n/a			Awaiting TDA technical guidance
TDA	The proportion of those on Care Programme Approach(CPA) receiving follow-up contact within 7 days of discharge	TDA	Dir of Ops	95%	100%	100.00%	↔		
O11.8	Number on CPA (AMH)	COM	Dir of Ops	No target	2896	0	↗		
	Percentage on CPA with a Care Plan (AMH)	COM	Dir of Ops	95%	96.90%	96.90%	↗		Ytd is the level of compliance at the end of the most recent month
TDA Domain - Caring									
TDA	Staff FFT Percentage Recommended – Care (Quarterly)	TDA			n/a	n/a			Quarterly reported
TDA	Staff FFT Percentage Not Recommended – Care (Quarterly)	TDA			n/a	n/a			Quarterly reported
TDA	Inpatient Scores from Friends and Family Test – % positive	TDA			97%	97.00%	↗		
TDA	Inpatient Scores from Friends and Family Test – % negative	TDA			0%	0.00%	↘		
TDA	FFT Mental Health	TDA			n/a	n/a			Awaiting TDA technical guidance

KPI	Metric	Metric Driver	Executive lead	Target	Apr	YTD	Trend	Forecast Year End	Commentary
TDA	Complaints – rate per bed days, MH contacts	TDA	Dir of Nursing	0.05%	0.01%	0.01%	↘		
TDA	Mixed Sex Accommodation Breaches	TDA			0	0	↔		
	EMSA Plan Breaches by exception Breach of an EMSA Plan milestone (TBA)	COM	Dir of Ops	0	0	0	↔		
O5.2	Number of PALS contacts	COM		228	18	18	↘		YTD is based on cumulative total of previous months
O5.3	PALS-Number of issues raised	COM		299	18	18	↘		YTD is based on cumulative total of previous months
O5.4	Number of Complaints	COM		101	2	2	↘		YTD is based on cumulative total of previous months
O5.6	Complaints acknowledged in timescale			100% in 3 days			↔		
15.1	Percentage of complaints responded to in line with timescale agreed with complainant			95%			↔		
	Percentage of complaints closed in timescale agreed with complainant			100%			↔		
	Number of complaints where timescale was extended			0%	0		↔		
	Number of complaints still open beyond agreed timescale			0%	0		↔		
O5.1	Trust Discharge Survey: Overall satisfied or very satisfied. Quarterly	COM	Dir of Nursing	95%	n/a		↔		Quarterly reported
TDA Domain - Safe									
TDA	C Diff Variance from plan -Trust	DoH/COM/TDA	Director of Nursing	0	0	0	↔		YTD is based on cumulative total of previous months
TDA	Cases of C Diff	DoH/COM/TDA	Director of Nursing	0	0	0	↔		YTD is based on cumulative total of previous months
TDA	MRSA Screening	DoH/COM	Director of Nursing	100%	100%	100%	↔		YTD is based on overall compliance over the previous months
TDA	Cases of MRSA - Trust	DoH/COM/TDA	Director of Nursing	0	0	0	↔		YTD is based on cumulative total of previous months
TDA	Never Events	DoH/COM	Dir of Nursing	0	0	0	↔		YTD is based on cumulative total of previous months No preventing future deaths notices received to YTD
TDA	Never Events - Incident rate	DoH/COM	Dir of Nursing	0	0	0	↔		YTD is based on cumulative total of previous months No preventing future deaths notices received to YTD
TDA	Never Events - Time since last event	DoH/COM	Dir of Nursing	0	0	0	↔		YTD is based on cumulative total of previous months No preventing future deaths notices received to YTD
TDA	Never Events - Repeat events	DoH/COM	Dir of Nursing	0	0	0	↔		YTD is based on cumulative total of previous months No preventing future deaths notices received to YTD
	Number of Reported Sis		Dir of Nursing	79	4	4	↘		
TDA	Reported SI Rate	COM	Dir of Nursing		n/a	0	↔		Awaiting TDA technical guidance

KPI	Metric	Metric Driver	Executive lead	Target	Apr	YTD	Trend	Forecast Year End	Commentary
	Medication Errors Total (Quarterly)	DoH/COM	Medical Dir	108	7	7	↘		
	Medication Errors leading to Moderate/Severe harm/death	DoH/COM	Medical Dir	47	0	0	↘		
TDA	Proportion of reported patient safety incidents that are harmful				n/a	n/a			Awaiting TDA technical guidance
TDA	Composite of patient safety (MyNHS)*				n/a	n/a			Awaiting TDA technical guidance
TDA	Potential under-reporting of patient safety incidents				n/a	n/a			Awaiting TDA technical guidance
TDA	Potential under-reporting of patient safety incidents resulting in death or severe harm				n/a	n/a			Awaiting TDA technical guidance
TDA	Consistency of reporting to the National Reporting and Learning System (NRLS)*				n/a	n/a			Awaiting TDA technical guidance
TDA	NHS Staff Survey – KF15. The proportion of staff who stated that the incident reporting procedure was fair and effective*				n/a	n/a			
TDA	CAS alerts outstanding				0	0			
TDA	CAS alerts outstanding – time to closure*				n/a	n/a			Awaiting TDA technical guidance
TDA	VTE Risk Assessment				n/a	n/a			Awaiting TDA technical guidance
TDA	Percentage of Harm Free Care				97.22%	97.22%	↗		
TDA	Percentage of new Harms*				1.39%	1.39%			
TDA	Admissions to adult facilities of patients who are under 16 years of age				0	0	↔		
O1 IP1	Admissions to Adult wards: patients < 16 years	DoH/COM	Dir of Ops	0	0	0	↔		YTD is based on cumulative total of previous months
	Admissions to Adult wards: patients 16/17 years	DoH/COM		0	0	0	↔		Due to the unavailability nationally of a CAMHS bed, 17 year old boy has been admitted to Ward 2, Harplands Hospital. Serious Incident 2015/11881 raised 30/04/15
TDA	Mental health Absconds/AWOL – rate* Total (Quarterly)	DoH/COM	Medical Dir	10	8	8	↔		
TDA	Mental health Absconds/AWOL – time since last*				n/a	n/a			Awaiting TDA technical guidance
	Total Incidents (Monthly)			358	366	366	↗		
	Incidents leading to Moderate/Severe harm/death			49	31	31	↗		
O1.IC2	Cases of MSSA	DoH/COM	Director of Nursing	0	0	0	↔		YTD is based on cumulative total of previous months
O1.IC3	Cases of E Coli	DoH/COM	Director of Nursing	0	0	0	↔		YTD is based on cumulative total of previous months
O1.IR1	Duty of Candour Each failure to notify the Relevant Person of a suspected or actual Reportable Patient Safety Incident	COM	CEO	0	0%	0%	↔		
O1.IR4	Preventing Future Deaths Regulation 28 (Formerly rule 43 letters from the Coroner)	COM	Dir of Nursing	0	0	0	↔		YTD is based on cumulative total of previous months
O1.IR6	NRLS Reported Incidents	DoH/COM	Dir of Nursing	199	33	33	↘		
	NRLS Reported Incidents leading to Moderate/Severe harm/death			32	3	3	↘		
	Proportion of patients who had recorded incidents of physical assault to them			24	7	7	↘		

KPI	Metric	Metric Driver	Executive lead	Target	Apr	YTD	Trend	Forecast Year End	Commentary
	Proportion of patients who had recorded incidents of physical assault to them leading to Moderate/Severe harm/death			1	0	0	↘		
	Proportion of Staff who had recorded incidents of physical assault to them			33	17	17	↘		
	Proportion of Staff who had recorded incidents of physical assault to them leading to Moderate/Severe harm/death			1	2	2	↗		
O1 IR8	Slips Trips & Falls	DoH/COM		388	22	22	↘		
	Slips Trips & Falls leading to Moderate/Severe harm/death	DoH/COM	Dir of Nursing	23	0	0	⇔		
	Self Harm Events	DoH/COM		61	84	84	⇔		
O1 IR9	Self-Harm Events leading to Moderate/Severe harm/death	DoH/COM	Dir of Nursing	8	8	8	↗		
O1.OP7	DNA Rate - Trust Target are previous years out turn as per agreement with Commissioners Analysis by Directorate	COM	Dir of Ops		7.00%	7.00%	↘		Target was previously based 2013/14 out turn
	AMH IP				7.00%	7.00%	↘		Target was previously based 2013/14 out turn
	AMH Community				8.00%	8.00%	⇔		Target was previously based 2013/14 out turn
	Substance Misuse				0.00%	0.00%	⇔		Target was previously based 2013/14 out turn
	LD				3.00%	3.00%	⇔		Target was previously based 2013/14 out turn
	NOAP				5.00%	5.00%	⇔		Target was previously based 2013/14 out turn
	C&YP				10.07%	10.07%	⇔		Target was previously based 2013/14 out turn
O1 IP2	Average Length of Stay - :Stoke CCG	DoH/COM	Dir of Ops	No Target	28	28	↘		Target needs to be agreed - YTD is based on an average of previous months
	:Staffs CCG	DoH/COM		No Target	19	19	↘		Target needs to be agreed - YTD is based on an average of previous months
O2 BE1	Preventing Category 3 and 4 Avoidable Pressure Ulcer	COM	Dir of Nursing	0	0	0	⇔		
O2 BE2	All service users who have been in hospital/long term health care for more than one year should have a physical health check at least annually (Quarterly)	DoH/COM	Dir of Nursing	95%	n/a	n/a	↔		Quarterly reported

KPI	Metric	Metric Driver	Executive lead	Target	Apr	YTD	Trend	Forecast Year End	Commentary
O2 BE3	Service users receiving all eight aspects of a physical health check (quarterly)	DoH/COM	Medical Dir	95%	n/a	n/a	↔		Quarterly reported
TDA Domain - Well Led									
TDA	Temporary staff spend on nurse and medical staffing	TDA			n/a	n/a	↔		Awaiting TDA technical guidance
TDA	Composite risk rating of ESR items relating to staff sickness rates*	TDA			n/a	n/a	↔		Awaiting TDA technical guidance
TDA	Individual elements of Composite risk rating of ESR items relating to staff sickness rates	TDA			n/a	n/a	↔		Awaiting TDA technical guidance
TDA	Composite risk rating of ESR items relating to staff registration*	TDA			n/a	n/a	↔		Awaiting TDA technical guidance
TDA	Individual elements of Composite risk rating of ESR items relating to staff sickness rates	TDA			n/a	n/a	↔		Awaiting TDA technical guidance
TDA	Composite risk rating of ESR items relating to staff turnover*	TDA			n/a	n/a	↔		Awaiting TDA technical guidance
TDA	Individual elements of Composite risk rating of ESR items relating to staff turnover	TDA			n/a	n/a	↔		Awaiting TDA technical guidance
TDA	Composite risk rating of ESR items relating to staff stability*	TDA			n/a	n/a	↔		Awaiting TDA technical guidance
TDA	Individual elements of Composite risk rating of ESR items relating to staff stability	TDA			n/a	n/a	↔		Awaiting TDA technical guidance
TDA	Composite risk rating of ESR items relating to staff support/ supervision*	TDA			n/a	n/a	↔		Awaiting TDA technical guidance
TDA	Individual elements of Composite risk rating of ESR items relating to staff support/ supervision*	TDA			n/a	n/a	↔		Awaiting TDA technical guidance
TDA	Composite risk rating of ESR items relating to ratio: Staff vs bed occupancy*	TDA			n/a	n/a	↔		Awaiting TDA technical guidance
TDA	Individual elements of Composite risk rating of ESR items relating to ratio: Staff vs bed occupancy*	TDA			n/a	n/a	↔		Awaiting TDA technical guidance
	Sickness Absence Percentage: Days lost -Trust Analysis by Directorate	COM	Workforce Dir	4.95%	3.8%	3.81%	↔		Target is 2013 national average for mental health trusts of 4.95%. YTD Average = 4.16% YTD based on 12 months rolling total = 4.27% Please note Month 8 is provisional and liable to change due to early extraction
	Corporate				3.6%	3.60%	↗		
	AMH IP				8.2%	8.17%	↗		
	AMH Community				3.9%	3.87%	↗		
	Substance Misuse				3.3%	3.32%	↗		
	LD				3.5%	3.50%	↗		
	Neuro and Old Age Psychiatry				2.5%	2.47%	↘		
	C&YP				1.2%	1.24%	↘		
	Staff turnover (FTE) Analysis by Directorate				0.63	12.22%	↘		YTD is rolling 12 months
	Corporate				0.95	18.90%	↘		YTD is rolling 12 months
	AMH IP				0.37	10.03%	↗		YTD is rolling 12 months
	AMH Community				0.74	5.79%	↗		YTD is rolling 12 months
	Substance Misuse				0.00	16.36%	↘		YTD is rolling 12 months
	LD				0.00	26.82%	↘		YTD is rolling 12 months
	Neuro and Old Age Psychiatry				0.73	9.42%	↗		YTD is rolling 12 months

KPI	Metric	Metric Driver	Executive lead	Target	Apr	YTD	Trend	Forecast Year End	Commentary
	C&YP				0.84	10.61%	↘		YTD is rolling 12 months
TDA	Staff FFT response rate*	TDA			n/a	n/a			Awaiting TDA technical guidance
TDA	Inpatient FFT response rate	TDA			24%	0.24			
TDA	Daycases FFT response rates*	TDA			n/a	n/a			Not applicable
TDA	FFT – Mental Health response rate*	TDA			24%	0.24			Awaiting TDA technical guidance
TDA	FFT – Community response rate*	TDA			n/a	n/a			Awaiting TDA technical guidance
TDA	Composite FFT response rate*	TDA			n/a	n/a			Awaiting TDA technical guidance
TDA	Staff FFT response rate* (Quarterly)	TDA			n/a	n/a			Quarterly reported
TDA	Staff FFT Percentage Recommended – Work* (Quarterly)	TDA			n/a	n/a			Quarterly reported
TDA	Staff FFT Percentage Not Recommended – Work* (Quarterly)	TDA			n/a	n/a			Quarterly reported
TDA	Overall safe staffing fill rate*	TDA			n/a	n/a			Awaiting TDA technical guidance
TDA	Safe staffing fill rate – wards with <80% fill rate*	TDA			n/a	n/a			Awaiting TDA technical guidance
TDA	Safe staffing fill rate – fill rate variance*	TDA			n/a	n/a			Awaiting TDA technical guidance
O8.6	Statutory & Mandatory Training -Trust Analysis by Directorate			95%	87.39%	87.39%	↔		Ytd is the level of compliance at the end of the most recent month
	Corporate				88.39%	88.39%	↘		Ytd is the level of compliance at the end of the most recent month
	AMH IP				80.68%	80.68%	↗		Ytd is the level of compliance at the end of the most recent month
	AMH Community				89.90%	89.90%	↗		Ytd is the level of compliance at the end of the most recent month
	Substance Misuse	COM	Workforce Dir		97.22%	97.22%	↘		Ytd is the level of compliance at the end of the most recent month
	LD				92.03%	92.03%	↗		Ytd is the level of compliance at the end of the most recent month
	Neuro and Old Age Psychiatry				86.21%	86.21%	↗		Ytd is the level of compliance at the end of the most recent month
	C&YP				84.63%	84.63%	↘		Ytd is the level of compliance at the end of the most recent month
	DBS Compliance Rate Analysis by Directorate			90%	99.2%	99.2%	↗		Ytd is the level of compliance at the end of the most recent month
	AMH IP				100.0%	100.0%	↔		
	AMH Community				98.7%	98.7%	↔		
	Substance Misuse				96.9%	96.9%	↗		Ytd is the level of compliance at the end of the most recent month
	LD				100.0%	100.0%	↔		Ytd is the level of compliance at the end of the most recent month
O8.7	Neuro and Old Age Psychiatry	COM	Workforce Dir		99.6%	99.6%	↔		Ytd is the level of compliance at the end of the most recent month
	C&YP				100.0%	100.0%	↔		Ytd is the level of compliance at the end of the most recent month
	Bank				99.1%	99.1%	↗		Ytd is the level of compliance at the end of the most recent month
	Corporate				98.6%	98.6%	↔		Ytd is the level of compliance at the end of the most recent month
	Annual appraisal and personal development plan Analysis by Directorate		Workforce Dir	90%	91.25%	91.2%	↘		Ytd is the level of compliance at the end of the most recent month
	Corporate				92.0%	92.0%	↘		Ytd is the level of compliance at the end of the most recent month

KPI	Metric	Metric Driver	Executive lead	Target	Apr	YTD	Trend	Forecast Year End	Commentary
	AMH IP				92.4%	92.4%	↘		Ytd is the level of compliance at the end of the most recent month
	AMH Community				90.6%	90.6%	↘		Ytd is the level of compliance at the end of the most recent month
O8.4	Substance Misuse	COM			85.9%	85.9%	↘		Ytd is the level of compliance at the end of the most recent month
	LD				92.11%	92.1%	↘		Ytd is the level of compliance at the end of the most recent month
	Neuro and Old Age Psychiatry				90.64%	90.6%	↘		Ytd is the level of compliance at the end of the most recent month
	C&YP				95.0%	95.0%	↘		Ytd is the level of compliance at the end of the most recent month
TDA Domain - Finance									
TDA	Bottom line I&E position – Year to date actual compared to plan		Finance Dir	£68k surplus	n/a	n/a	↔		Month 12 Draft: £413k surplus achieved against a plan of £268k
TDA	Actual efficiency recurring/non-recurring compared to plan – Year to date actual compared to plan		Finance Dir	£3,685k surplus (M11)	n/a	n/a	↔		
TDA	Actual efficiency recurring/non-recurring compared to plan – Forecast compared to plan		Finance Dir	£4,080k	n/a	n/a	↔		
TDA	Forecast underlying surplus/deficit compared to plan		Finance Dir	£915k	n/a	n/a	↔		Month 12 draft: 1,152k forecast against a plan of £915k = £237k surplus
TDA	Forecast year end charge to capital resource limit		Finance Dir	£1.5m	n/a	n/a	↔		Month 12: (£741k) actual against a plan of £1,500k = £2,241k undershoot
TDA	Is the Trust forecasting permanent Public Dividend Capital for liquidity purposes?		Finance Dir	No	No	No	↔		No
Internally reported only Indicators (2015/16)									
	Overall compliance with the MH tribunal process	Trust	Medical Dir	100%	67%	67.00%	↗		<u>Please note reported a month in arrears</u> March Compliance 8 applications – 5 regraded - of the 3 remaining 2 were fully compliant with 3/52 rule which equates to = 67% compliance
	Number of AMH patients sent out of area in month where a locally commissioned service is offered	Trust	Dir of Ops	0	0	0	↔		JN– 5/3/15 admitted to the Priory in Birmingham as no female bed available at Harplands. Detained under Sec2 of MHA. Returned to Ward 1 Harplands on 17/3/15. CM-7/3/15 admitted to Norbury Ward Stafford as no female beds at Harplands. Detained under Sec 2 of MHA. Returned to Ward 3 on 13/03/15. Gentleman admitted out of area between 16th Jan – 19th Jan On 19th Jan admitted/transferred to Ward 2 Harpland's and discharged from there on the 27th Jan.
	Number of AMH patients sent out of area in month where a locally commissioned service is offered Number brought back in month	Trust	Dir of Ops	100%	0	0	↔		

KPI	Metric	Metric Driver	Executive lead	Target	Apr	YTD	Trend	Forecast Year End	Commentary
	Number of AMH patients sent out of area in month where a locally commissioned service is offered Number out of area as at month end	Trust	Dir of Ops	0	1	1	⇔		
	Number of AMH patients sent out of area in month where a locally commissioned service is offered Average LOS out of area	Trust	Dir of Ops	<5 days	0	0	⇔		
	North Staffs Wellbeing Service (IAPT) - HI Services	Trust	Dir of Ops		n/a	0			2015/16 Month 1 activity not available at time of drafting this report
	North Staffs Wellbeing Service (IAPT) - Counselling	Trust	Dir of Ops		n/a	0			2015/16 Month 1 activity not available at time of drafting this report
	North Staffs Wellbeing Service (IAPT) - CBT	Trust	Dir of Ops		n/a	0			2015/16 Month 1 activity not available at time of drafting this report
O9.1	Compliance with the CQC essential standards	Trust	Dir of Nursing	100%	94%	94%	⇔		Trust is currently compliant with 15 of the 16 CQC standards
O3 CQ1	GOAL 1: Nationally mandated Physical Health CQUIN	CQUIN	Dir of Nursing	Provide report	n/a		⇔		
O3 CQ2	GOAL 2: Mental Health Outcomes CQUIN		Medical Dir	Provide report	n/a		⇔		
O3 CQ3	GOAL 3: Medecines Safety Safety Thermometer CQUIN		Medical Dir	Provide report	n/a		⇔		
O3 CQ4	GOAL 4: Safety Culture		Dir of Nursing	Provide report	n/a		⇔		
O3 CQ5	GOAL 5: HEF LD		Dir of Nursing	Provide report	n/a		⇔		

Enclosure 12

REPORT TO TRUST BOARD

Date of Meeting:	4 June 2015
Title of Report:	NHS Trust Development Authority (NTDA) Monthly Self Certifications.
Presented by:	Ann Harrison, Interim Director of Finance
Author of Report: Name: Date: Email:	Glen Sargeant, Head of Performance and Information 29 May 2015 glen.sargeant@northstaffs.nhs.uk
Purpose / Intent of Report:	Information and approval
Executive Summary:	This paper confirms that the monthly NTDA self-certification documents have been reviewed by the executive team and are ready to be submitted, Declarations include: • Fit & proper directors • Registration with CQC • Provision of integrated care • Effective arrangements for monitoring and continually improving the quality of healthcare • Compliance with TDA Accountability Framework In all there are 26 self-certification declarations and these form part of the NTDA Oversight and Escalation Process. Based on April 2015 data, the Trust is declaring compliance with all requirements
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Clinical, Finance and Governance. There is no direct impact on patients or the public.
Relationship with Annual Objectives:	5: Robust plans delivering quality and sustainable services
Risk / Legal Implications:	None
Resource Implications:	None identified

Equality and Diversity Implications:	None identified
Relationship with Assurance Framework [Risk, Control and Assurance]	Supports the wider framework
Recommendations:	The Board is asked to : • Approve the submission for April 2015 data declaring compliance with all requirements. And for this to be sent to the NTDA

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: **Trust Board**

Date of Meeting:	04 June 2015
Title of Report:	People and Culture Development Committee Report
Presented by:	Mr Patrick Sullivan, Vice Chair of the People and Culture Development Committee
Author of Report: Name: Date: Email:	Sandra Storey, Trust Secretary / Head of Corporate & Legal Affairs 21 May 2015 Sandraj.storey@northstaffs.nhs.uk
Purpose / Intent of Report:	• For approval / assurance
Executive Summary:	This report provides a summary of the meeting of the People and Culture Development Committee that took place on the 18 May 2015. The report highlights key points discussed and agreed outcomes.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Workforce Strategy • Governance Strategy • Customer Focus • Clinical
Relationship with Annual Objectives:	Cuts across all objectives
Risk / Legal Implications:	N/A
Resource Implications:	N/A
Equality and Diversity Implications:	None in this report
Relationship with Assurance Framework [Risk, Control and Assurance]	Provides assurance to the Board that the committee is working in according with its Terms of Reference
Recommendations:	• To receive for information and assurance purposes. • Ratify policy noted in the report

Summary to Trust Board of the People and Culture Development Committee meeting held on the 18 May 2015

1. **Workforce Directorate Performance – March 2015**

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

Members discussed areas such as sickness absence across the services which had risen slightly in comparison to the previous month. The main reason for the absence across the Trust related to anxiety and stress and accounted for 30% of the absence (29% in February 2015). The use of overtime and in particular agency and bank spend was noted to have increased significantly during the reporting period.

Full compliance was noted with the DBS requirements as well as a slight increase in statutory and mandatory training. It was noted that compliance with statutory and mandatory training still needed to improve and members discussed some of the reasons why at times there was difficulty in staff attending training. It was agreed that compliance was important and members agreed to reinforce with their teams the need to improve performance in this area.

2. **Policy Review**

The committee considered the revised Personal Development Review (PDR) policy, noting minor word changes but mainly to align it to the new Pay Progression Policy. It was **recommended to the Trust Board that this policy should be ratified for a period of 3 years.**

3. **Workforce & Organisational Development Risks – May 2015**

The committee received the workforce and OD risks at May 2015, which included those risks that had been carried forward from the previous year. The source of each risk, its risk rating and progress on action plans to mitigate those risks was discussed. No particular issues were highlighted. It was noted that the risk scores had decreased for two of the total of three risks that the committee oversee. The risk to ensuring safe staffing levels is also kept under review by the Quality Committee given the potential risk to quality and safety of service provision.

Members of the committee will also consider any other risks that need to be added to the risk register and will report back to the committee as well as the Trust's Risk Review Group.

4. **Revalidation – Quality Assurance Framework for Responsible Officers**

The Framework of Quality Assurance for Revalidation is an Annual submission to NHS England designed to support Responsible Officers in fulfilling their statutory duty, providing means by which they can demonstrate the effectiveness of the systems they oversee. The committee considered and approved the questionnaire that had been completed on behalf of the Trust, which noted compliance with the Regulations. This will be submitted in time for the deadline of the 29 May 2015.

5. Review of Psychological Services

The committee received a presentation from Dr Nasreen Fazal-Short, Head of Psychological Services. The review undertaken focused on two key objectives:

- To carry out a strategic review of delivery of psychological services in each of the Directorates

- To improve patient experience and pathways.

The plans for building strengths, reducing weaknesses and taking opportunities were highlighted. It was noted that waiting lists have started to be managed but needs consistent attention everywhere. Directorate leads and heads of service are organising a service of internal CPD workshop to update staff on caseload tool, caseload agreement and contact activity agreements. There is work ongoing with the local acute Trust to create new posts and generation of service level agreements.

Examples of Improved patient pathways to date:

- In Adult and the Children's Directorate, there has been an establishment of a Dialectical Behaviour Therapy Service which engages with users and young people who self-harm repeatedly;
- In adult services the establishment of an evidence based recovery from OCD group programme and recovery from depression group programme, to be followed by a recovery from psychosis and recovery from bipolar programmes;
- All waits in physical health and adult services being managed actively and therapy service users seen more quickly;
- In Stoke Healthy Minds, establishment of a recovery from OCD group running in the evening offering more access.

Key messages: a need for consistency in terms of a standard approach and outcomes. Practice based data with national tools will assist with this. It was noted that there is the beginning of a cultural change in terms of the way things are done, but recognition of the fact that there may well be some differences across each of the services given the nature of the service. The committee noted the progress made and welcomed further updates.

6. Other Business

- **Listening into Action – Pulse Check** – reminder for staff to complete
- **Library Service Level Agreement** – noted
- **Workforce plan** – 2 year plan mirror Integrated Business Plan and Operating Plan. The committee were asked to review the document ahead of submission to the CCGs. Comments to Miss A Garside before 28 May 2015.

7. Development Session – LIA Big Conversation – Values and Behaviours Equality Monitoring Data Analysis Report 2014

The committee were asked to hold a conversation taking the LIA approach in respect to the Trust's values and behaviours in line with the three standard questions:

- What are the current frustrations?
- What can we stop doing
- What can we start doing

The committee held a lengthy and rich discussion in respect to the Trust's current values, first asking if these are the right values currently for the organisation and if staff understand those values and what is expected from them both personally and professionally. It was agreed that this was a start of a much broader discussion required within the organisation and that the outputs from this session will help to inform whether a new set of values should be introduced linked to expected behaviours. The Chair welcomed this discussion and requested progress to be reported to the committee in due course.

8. **Next meeting: 15 June 2015**

On behalf of the Vice Committee Chair, Mr Patrick Sullivan and Mr Paul Draycott, Director of Leadership & Workforce

Sandra Storey
Trust Secretary / Head of Corporate and Legal Affairs
20 May 2015

North Staffordshire Combined Healthcare NHS
NHS Trust

Enclosure 15

REPORT TO:- Trust Board June 2015

Date of Meeting:	4th June 2015
Title of Report:	May 2015 update of the Aston Team Leader Programme
Presented by:	Paul Draycott
Author of Report: Name: Date: Email:	Beverley Dawson 28/5/2015 Beverley.dawson@northstaffs.nhs.uk
Purpose / Intent of Report:	For assurance on progress and plans for future embedding of the team development process
Executive Summary:	This report presents a summary of the Aston Team Leaders programme and related CQUIN, as at May 2015 with recommendations for action in terms of achieving the maximum return on investment.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Workforce Strategy Effective leadership of highly effective teams leads to increased productivity, staff engagement and positive service user outcomes (research evidence of Professor Michael West)
Relationship with Annual Objectives:	Supports the strategic goal to be a provider of high quality care.
Risk / Legal Implications:	Amongst other effects the risk of not developing highly effective teams carries consequent outcomes of lower productivity, higher absenteeism, reductions in staff wellbeing and lack of innovation
Resource Implications:	
Equality and Diversity Implications:	Non anticipated
Relationship with Assurance Framework [Risk, Control and Assurance]	Not applicable
Recommendations:	1. Line managers and HR Business Partners to continue to work with teams in their business areas and to offer support as part of their regular communication with their teams 2. Alumni master classes will be provided throughout the year to update team leaders on the latest thinking in relation to team development. It is planned that this will

	be supported through NHS ELECT master classes on management style, resilience and putting conflict to work 3. Latest thinking about team development will be published on SID each quarter. 4. A plan is being developed to further embed effective team working.

Aston Team Leader Programme Update For Trust Board

May 28th 2015

5/28/2015
Combined Healthcare
Dawsob

Introduction

Over the past 12 months the Trust has invested in development of effective team working skills by inviting all team leaders to attend the Aston Team development programme and to lead their teams through the Aston Team Journey. The team journey uses evidence based practice in the development of effective team working and provides a measure of the progress teams are making in embedding these practices.

This report provides assurance on progress and a summary of plans for future embedding.

Current Position

91 team leaders have confirmed that they are actively participating with the team journey and of these 79 teams have progressed through their team journey and are each at differing stages. This shows slight movement from the last report where 78 had started their journey and highlights the need to continue to undertake activities to embed the team development process.

A further 19 team leaders have been invited to attend cohort 9 of the Aston Team Leader programme which will commence in May and complete in September 2015. These leaders were identified following the re-alignment exercise as either new to post or unable to attend the previous 8 cohort dates. Of these, 11 have accepted the invitation, with 3 of these receiving individualised learning sessions to accommodate their availability to attend. There is currently a waiting list of 6 people.

Directorate Mapping of Teams

An exercise has been completed to map Directorate teams working through the Aston Team Journey. The outcomes show some gaps where team leaders have not yet attended the programme and are not able to attend cohort 9. Directorate leads have been informed where this is the case and requested to nominate an alternative representative for cohort 9 or future cohorts.

The 2 newly appointed HR business partners will be updated on the Aston Team Development process by the Training Manager at the earliest convenient opportunity.

On-going Support for Teams

All teams have access to their own on line support package (Aston team journey), their immediate line manager, HR business partner or OD and Training team for on-going support. Additional support will be communicated in the update messages on SID, newsround and team brief.

The top tips for senior managers have been re-circulated to directorate leads with a request that encouragement of regular team effectiveness activities continues.

Exploration with the workforce information officer is underway to determine the most effective method to routinely report on effective team working metrics, in a way that is accessible to line managers. Particular attention is focussed on finding a reporting mechanism for data generated on the Aston OD online data collection tool as this does not connect to ESR.

Teamness Components Analysis

The teamness components analysis shows only minor changes due to the small number of additional scores that have been added since the last report.

72 (1 more than last report) Teams have completed their first ART+ score, 42 (1 more than last report) have completed the second score and 25 (2 more than last report) have completed their third score. The analysis below is based on an average of all of these scores and indicates the relative order of each of the team working factors for our teams. Red text indicates those areas of team working falling below 4 – areas to pay particular developmental attention in Directorates and when working with teams. Further, this will enable the OD and training team to plan in activities to bridge the gap in future leadership development interventions.

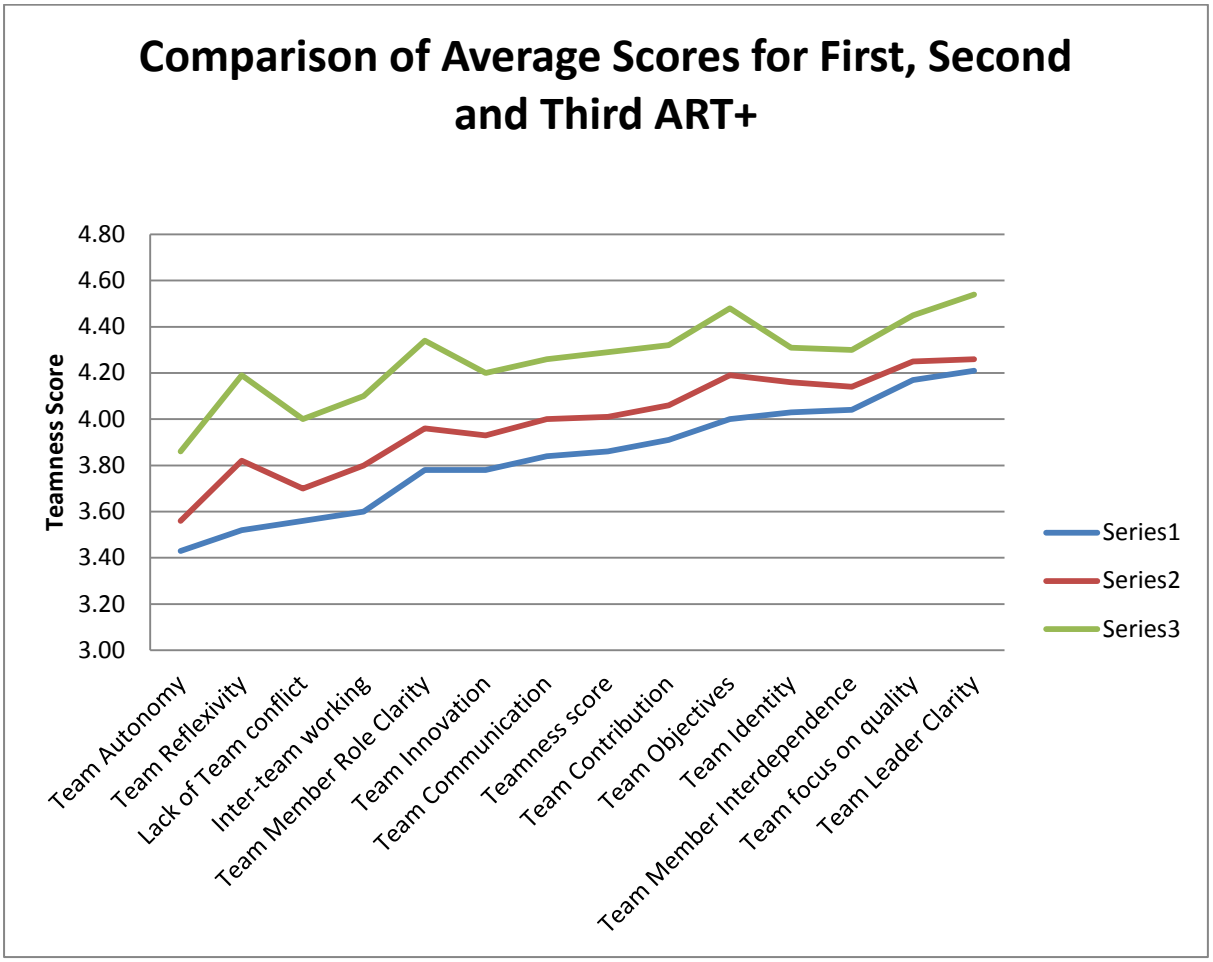
There has been some slight changes in the relative order of factors, team leader clarity remains consistently the highest factor and team autonomy consistently the lowest.

Factor	Average Score
Team Autonomy	3.62
Lack of Team Conflict	3.75
Inter team working	3.83
Team Reflexivity	3.84
Team innovation	3.97
Team Member Role Clarity	4.03
Team Communication	4.03
Team contribution	4.10
Team member interdependence	4.16

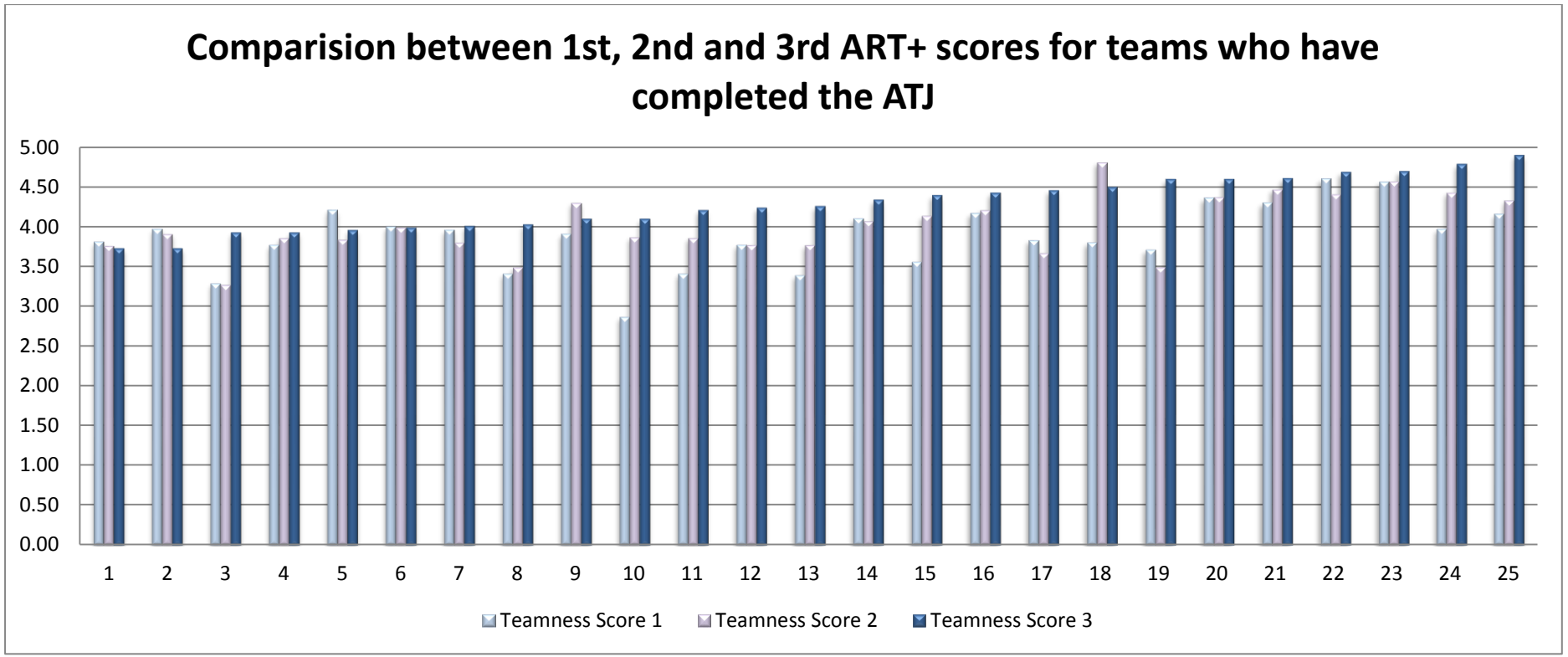
Team Identity	4.17
Team objectives	4.22
Team focus on Quality	4.29
Team Leader Clarity	4.34

Variance between first and second ART+ scores

This is the second report where analysis of the variance between first, second and third ART+ scores has been possible. The graph below shows a comparison of first score averages (based on returns from 72 teams) second score averages (based on returns from 42 teams) and third score averages (based on returns from 25 teams). As with the last report the three areas where 3rd scores show the most improvement are reflexivity, team member role clarity and team objectives.



This is the second time that it has been possible to include a more detailed analysis of the increases and decreases for specific teams between first, second and third ART+ scores. Again there are few changes in this data because of the small number of additional ART+ scores received between the two reports.



The graph continues to show that for the majority of teams there has been an increase between the first and the third score. Some teams show a dip in the middle score, which fits with Edmondson's research that increased awareness, can affect early team working efforts. There are a small number of teams where there has been a decrease between the first and third score; in each of these cases the team has experienced significant change, a change in leader or a specific challenge to intra team working.

CQUIN Update

The CQUIN target has been achieved. Of the 25 CQUIN teams 21 evidenced an improvement in effective team working which far exceeds the 50% improvement required for this CQUIN. The teams where improvement was not evident were all experiencing significant change or leadership change during the year.

All team leaders have been thanked by E-mail for their hard work in achieving this gratifying result. The table below summarises the results submitted to the commissioners for the 4th Quarter CQUIN results.

Team	ART+ 1	ART+ 2	ART+ 3	Variance
1	**3.41**	**3.86**	**4.21**	0.80
2	**3.97**	**4.43**	**4.79**	0.82
3	**3.71**	**3.49**	**4.60**	0.89
4	**3.81**	**3.76**	**3.73**	-0.08
5	**4.30**	**4.47**	**4.61**	0.31
6	**3.80**	**4.81**	**4.50**	0.70
7	**3.83**	**3.67**	**4.46**	0.63
8	**4.56**	**4.57**	**4.70**	0.14
9	**4.17**	**4.21**	**4.43**	0.26
10	**3.29**	**3.27**	**3.93**	0.64
11	**4.16**	**4.33**	**4.90**	0.74
12	**3.41**	**3.49**	**4.03**	0.62
13	**4.21**	**3.84**	**3.96**	-0.25
14	**4.10**	**4.07**	**4.34**	0.24
15	**4.60**	**4.41**	**4.69**	0.09
16	**3.91**	**4.30**	**4.10**	0.19
17	**3.77**	**3.77**	**4.24**	0.47
18	**3.97**	**3.91**	**3.73**	-0.24
19	**4.00**	**3.99**	**3.99**	-0.01
20	**2.87**	**3.87**	**4.10**	1.23
21	**3.39**	**3.77**	**4.26**	0.87
22	**3.96**	**3.80**	**4.01**	0.05
23	**4.36**	**4.37**	**4.60**	0.24
24	**3.77**	**3.86**	**3.93**	0.16
25	**3.56**	**4.14**	**4.40**	0.84

Shortlisted for HPMA team based working award

The Trust has been short listed in Category 8 – Effective Team Based Working, for an HPMA award. Combined Healthcare representatives made a presentation to a panel of experts on 29th April. The outcome of the award will be notified on June 18th.

Planned Future Actions

1. Line managers and HR Business Partners to continue to work with teams in their business areas and to offer support as part of their regular communication with their teams

2. Alumni master classes will be provided throughout the year to update team leaders on the latest thinking in relation to team development. It is planned that this will be supported through NHS ELECT master classes on management style, resilience and putting conflict to work

3. Latest thinking about team development will be published on SID each quarter.

4. A plan is being developed to further embed effective team working practices.