North Staffordshire Combined Healthcare NHS
NHS Trust

MEETING OF THE TRUST BOARD

TO BE HELD IN PUBLIC ON THURSDAY, 30 OCTOBER 2014, 10:00AM, BOARDROOM, TRUST HEADQUARTERS, BELLRINGER ROAD, TRENTHAM LAKES SOUTH, STOKE ON TRENT, ST4 8HH

	AGENDA	
1.	**APOLOGIES FOR ABSENCE** *To NOTE any apologies for absence*	Note
2.	**DECLARATION OF INTEREST RELATING TO AGENDA ITEMS**	Note
3.	**DECLARATIONS OF INTERESTS RELATING TO ANY OTHER BUSINESS**	Note
4.	**MINUTES OF THE OPEN AGENDA – 25 SEPTEMBER 2014** *To APPROVE the minutes of the meeting held on 25 September 2014*	Approve Enclosure 2
5.	**ACTION MONITORING SCHEDULE & MATTERS ARISING FROM THE MINUTES** *To CONSIDER any matters arising from the minutes*	Note Enclosure 3
	TO DELIVER HIGH QUALITY PERSON CENTRED MODELS OF CARE (Strategic Goal)	
6.	**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
7.	**TEAM SPOTLIGHT - PRESENTATION FROM THE NON PSYCHOSIS – RESETTLEMENT AND REHABILITATION TEAM** *To RECEIVE a presentation led by Andy Oakes, David Smith and Melanie Wetton*	Verbal
8.	**NURSE STAFFING MONTHLY REPORT** *To DISCUSS and APPROVE the assurance report on the planned versus actual staff variances from Mr. P Draycott.*	Approve Enclosure 4
9.	**RISK MANAGEMENT COMMITTEE REPORT** *To REVIEW for the assurance purposes the summary from the Risk Management Committee meeting held on the 8 October 2014 from Mrs. B Johnson, Committee Chair*	Assurance Enclosure 5

10.	**Q3 PRINCIPAL RISK REGISTER REPORT 2014/15** *To DISCUSS and APPROVE the Q3 Principal Risk Register from Mrs. C Donovan, Chief Executive*	Approve Enclosure 6
11.	**KPMG REVIEW OF THE TRUST'S QUALITY GOVERNANCE ARRANGEMENTS AND ACTION PLAN** *To RECEIVE the report and action plan from Dr. O Adeyemo, Medical Director*	Assurance Enclosure 7
	TO BE ONE OF THE MOST EFFICIENT PROVIDERS (Strategic Goal)	
12.	**FINANCE REPORT – Month 6 (2014/15)** *To RECEIVE the month 6 financial position from Mr. S Blaise, Acting Deputy Director of Finance*	Assurance Enclosure 8
13.	**FINANCE & PERFORMANCE COMMITTEE REPORT** *To RECEIVE for assurance the Finance & Performance Committee report of the meeting held on 23 October 2014 from Mr. T Gadsby, Committee Chair*	Approve Enclosure 9
14.	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 6** *To DISCUSS and APPROVE the month 6, Performance Report from Mr. S Blaise, Acting Deputy Director of Finance*	Assurance Enclosure 10
15.	**SELF CERTIFICATIONS FOR THE NHS TRUST DEVELOPMENT AGENCY** *To APPROVE the Self Certifications for the TDA from Mr. S Blaise, Acting Deputy Director of Finance*	Approve Enclosure 11
16.	**FEEDBACK FROM QUALITY SURVEILLANCE GROUP MEETINGS, SHROPSHIRE & STAFFORDSHIRE AREA TEAM - JULY & AUGUST 2014** *To RECEIVE for assurance the summaries of the outcomes from the Quality Surveillance Group meetings from Mrs. C Donovan, Chief Executive*	Assurance Enclosure 12
17.	**CHARITABLE FUNDS COMMITTEE REPORT** *To RECEIVE a summary report from the Charitable Funds Committee meeting held on the 17 October 2014 from Mr. S Blaise, Acting Deputy Director of Finance*	Assurance Enclosure 13
	TO BE A DYNAMIC ORGANISATION DRIVEN BY INNOVATION (Strategic Goal)	
18.	**PEOPLE AND CULTURE DEVELOPMENT COMMITTEE REPORT** *To RECEIVE the assurance report from the People and Culture Development Committee from the meetings held on 22 September and 20 October 2014 from Mr. P O'Hagan, Committee Chair*	Assurance Enclosure 14
19.	**LISTENING INTO ACTION (LiA) THEMES** *To RECEIVE a progress report from Mr. P Draycott, Acting Director of Leadership & Workforce*	Assurance Enclosure 15
20.	**STAFF ENGAGEMENT UPDATE** *To RECEIVE a position statement from Mr. P Draycott, Acting Director of Leadership & Workforce*	Assurance Enclosure 16

21.	**CHAIR'S REPORT** *To RECEIVE a verbal report from the Chair*	Note
22.	**CHIEF EXECUTIVE'S REPORT** *To RECEIVE a report from the Chief Executive*	Note Enclosure 17
23.	**To *DISCUSS* any Other Business**	
	QUESTIONS FROM MEMBERS OF THE PUBLIC	
24.	*To ANSWER questions from the public on items listed on the agenda*	
	DATE AND TIME OF THE NEXT MEETING	
25.	*The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday 27 November 2014 at 10:00am.*	
26.	**MOTION TO EXCLUDE THE PUBLIC** *To APPROVE the resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admissions to Meetings) Act 1960)*	

THE REMAINDER OF THE MEETING WILL BE IN PRIVATE

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

	SERIOUS INCIDENTS	
	WORKFORCE UPDATE	
	FINANCE & PERFORMANCE	
	STAKEHOLDER SURVEY	

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

Present:

Chairman:

Mr K Jarrold
Chairman

Directors:

Mr T Gadsby
Non-Executive Director

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

Mr A Hughes
Interim Director of Strategy and Development

Mr P Draycott
Acting Director of Leadership &Workforce

Mr A Rogers
Director of Operations

Ms K Wilson
Executive Director of Nursing and Quality

Dr D Shepherd
GP Associate Director

In attendance:

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

Mrs J Scotcher
Executive PA

Ms J Harvey
UNISON

Mr S Blaise
Acting Deputy Director of Finance

Team Spotlight:
Corporate Finance Team

Members of the public:

Hilda Johnson
NSUG

Chris Fieldhouse
Crisis Team

Kate Dacosta & Karen Carter
Janssen

Paul Edden
Home Instead Senior Care

Bernard Welsh
Stoke LiNK

The meeting commenced at 10:00am.

227/2014	Apologies for Absence	Action
	Apologies were received from Chris Calkin, Interim Director of Finance, Dr Tattum, GP Board Associate and Peter O'Hagan, Non-Executive Director. Mr Blaise was present for Mr Calkin.	

228/2014	**Declaration of Interest relating to agenda items** There were no declarations of interest.	
229/2014	**Declarations of interest relating to any other business** The Chair declared an interest in respect of the NHS Retirement Fellowship in his role as Patron of the Fellowship.	
230/2014	**Minutes of the Open Agenda – 31 July 2014** The Chair began the meeting by congratulating Mrs Donovan on her appointment as Chief Executive. The minutes of the open session of the meeting held on 31 July 2014 were approved as a correct record.	
231/2014	**Matters arising** The Board reviewed the action monitoring schedule and agreed the following:- ***85/2014 – PALS/Complaints Report - consideration to be given to bring together various sources of information. It was agreed that this issue will be addressed and brought back in due course via the Quality Committee.–*** A proposal will be presented to the July meeting of the Quality Committee meeting and then at the Trust Board in September 2014. To leave this action on the schedule. ***It was noted that this was on the agenda, however this paper has been withdrawn as work is ongoing. The revised paper will be presented to the next Trust Board meeting.*** ***127/2014 – F&A Committee Report – 17 April 2014 (Annual Accounts)*** Mr Gadsby commented that he had now received the Annual Accounts, but had yet to give them scrutiny. A meeting was due to be held with Mr Gadsby, Mr Lappin and Mr Blaise to go through the accounts in more detail. In the absence of Mr Gadsby, Mr Sullivan advised that a meeting to discuss the cost improvement programme had been arranged for the following week. ***Completed – remove from schedule***	

	193/2014 - Summary of Quality Committee meeting held on 17 June 2014 and 15 July 2014 - A meeting will take place with the Non-Executive Director members of the Quality Committee in order to look further at the rationale around some of the cost improvement schemes and for the Directors to feel assured about the robustness of the scrutiny process. ***Completed – remove from schedule*** ***193/2014 - Summary of Quality Committee meeting held on 17 June 2014 and 15 July 2014*** - Mr Sullivan made reference to the KPMG independent review of the Trust's Quality Governance arrangements. The report will be helpful in some development work at the next meeting of the committee in September where members will spend part of the meeting to review its effectiveness and progressing the recommendations in the KPMG report. ***On the agenda today*** **- remove from schedule** ***196/2014 - Finance Report - Month 3 (2014/15)- Workforce Analysis*** - Level of bank nursing in June reduced significantly although this is yet to be investigated to determine if it is either a delay in time sheet submission or reduced demand. Mr Calkin noted that he is working with Mr Draycott on systems and processes to improve reporting on the use of Bank staff. ***On the agenda today – remove from schedule*** ***200/2014 Annual Report and Financial Statements 2013/14*** – Mrs Storey added that external auditors provided good feedback on the report. The report will form a suite of documents for presentation to the AGM, which will include the Quality Account and summary versions of the Annual Report. ***On today's agenda – remove from schedule*** ***147/2014 Choice of Mental Health Provider at first appointment.*** Mrs Johnson enquired about progress against this programme of work. Ms Wilson noted that this was part of the Choice agenda and that there is a trust wide event at the end of October. Key stakeholders and staff have been invited and so far there has been a good response to this. ***A report will be presented to the November Trust Board meeting***.	**K Wilson**
232/2014	**Chair's report** The Chair noted that he wanted to comment on two matters that had occurred since the last Trust Board meeting.	

	The Chair remarked on the naming ceremony in which the Trust HQ was named as Lawton House. It was noted that the plaque is now mounted on the wall so that Edith Lawton can be remembered every time people are present in the room and notice her name on the wall. It was further noted that the external signs are now in place. It was a lovely occasion and the Chair stated that he was most grateful to Karen Bradley MP for joining the Trust and unveiling the plaque together with Hillary Whalley our longest serving member of staff who has completed 49 years of service to the NHS in North Staffordshire. The Board were advised that Karen Bradley was born in Cheddleton, where Edith spent her life of service and most of her retirement, and so has a close personal link with the constituency she now represents. Unfortunately, John Lawton and his wife Fay were not able to join the Ceremony but were able to come in later in the day and it was a joy to meet them and to hear their stories of the remarkable Miss Lawton. It was very moving to hear that when Edith was in her nursing home in Stone she could see from her window the cottage in which she had been born and that Edith died in that room. That is indeed a completed circle of life. The Chair stated he was glad that we have remembered, and celebrated, Edith's life of service and the powerful example that she set for us all. The Chair also said that if ***he was spared, as his Mother would have said, to write his history of the NHS and its management, Edith will be an important part of the story.*** Secondly, the Chair commented on the Annual General Meeting that had taken place the day before. The attendance was excellent and he thanked everyone who joined the meeting. He also thanked Mrs A Roberts and Mr M Fletcher for the excellent way in which they pulled together the videos and other material for the AGM. Further noting that if we ever doubted it, we now know that there is nothing more powerful than giving service users and carers a voice and listening when they speak for themselves. The Chair continued to comment how moving it was to listen to service users whose lives have been transformed by our services and to carers who have been acknowledged and have become part of the service delivery and improvement process. He stated that it reminds us of all the years when service users have not been listened to and carers have not been	

	acknowledged and, sadly, we know that still happens in our own services and throughout the NHS. Furthermore the Chair noted that he sensed a real commitment in the Trust to learn, to listen to, and to acknowledge, those who receive our services and those carers who, like Edith, give a lifetime of service to those they care for. The Chair said that we should always remember that carers do not work 8, or even 12 hour shifts, they work a shift that can last for decades. ***Received***	
233/2014	**Chief Executive's Report** Mrs Donovan, Chief Executive, updated the Board on activities since the last meeting. The key highlights from the report are:- **Chief Executive Appointment** Mrs Donovan noted that she was delighted to present this as her first Chief Executive report following her substantive appointment to the post on the 17 September 2014. Mrs Donovan thanked those who gave their time to be involved in the appointments process and for the support received following her appointment. **NSCHT Annual General Meeting** Mrs Donovan also remarked on the success of the AGM held yesterday on 25 September 2014, previously mentioned by the Chair. **Clinical Pathways Redesign Project Update** Mrs Donovan confirmed that the clinical and commissioning leads for the 8 pathways presented to the CCGs' Commissioning Board on 27 August 2014. The presentations were well received. Mrs Donovan thanked all those participating and working with our partners. The next stage is to work with commissioners to look at the implications of this work and how this is taken forward. The Board will continue to receive updates on this important piece of work. **Organisational Structures** Mrs Donovan confirmed that the consultation in respect to the structures within our clinical services has now been completed. The redesign is to speed up decision making and to reduce tiers of management; this will reduce the tiers of management from 4 to 3. It was further noted that in response to the consultation we have listened and revised the structure accordingly. There will now be 6 Clinical Directors representing the 6 clinical Directorates.	

Listening into Action
Mrs Donovan confirmed that there have now been 5 'BIG conversations' which she has personally led on. The sessions are helping to radically change the way we engage with staff. Nationally there are 43 trusts that are taking part in this. Our Trust has had an excellent attendance with approximately 400 people taking part in the 'Big Conversations'. The initial pulse check was not positive, however the subsequent attendance and feedback has been encouraging and the important work is to act on the feedback.

Improving Mental Health Services for Young People in North Staffordshire
Mrs Donovan noted that as part of the clinical pathway work, we have launched a Young Person's forum working with CHANGES giving children and young people a much greater involvement in how mental health services are shaped and delivered. It was noted that there has been 14 different pathways identified and the opportunity for the renaming of the pathways was underway. Mrs Donovan passed on thanks to Dr Clare Halsey and Sam Haywood for their work in this regard.

The Chair commented on this initiative and stated how inspiring it was that young people are helping to rename the pathways. This is extremely valuable to children and adolescents with mental health problems and he commented that Dr Halsey and her team are exceptional.

Section 136 suite at Harplands Hospital
At the end of August, Police and crime commissioner, Matthew Ellis raised a number of concerns via the local media regarding the availability of beds at Harplands Hospital for people brought to the suite under Section 136 arrangements with Staffordshire Police. The Trust has acknowledged the difficulties and further commitment to work with police to ensure service users can access the service in a more timely way is progressing. Mr Rogers, Director of Operations is working closely with Staffordshire Police. It was further noted the Trust has in place a Community Triage Team, which has helped to reduce S136 admissions.

Patient Led Environment Assessments – Place
Mrs Donovan remarked on the positive results of our annual Patient Led Care Environment (PLACE) report. The Trust received high scores above the national average in relation to cleanliness, food and hydration, privacy, dignity, wellbeing and maintenance etc. In particular, the following areas ;
Dragon Square and Chebsey received 100% for cleanliness

	Duty of Candour session to be delivered by Mills and Reeves Post Mid-Staffordshire NHS Trust and learning from the Francis Inquiry Report, we now have the statutory Duty of Candour. In line with our commitment to openness and transparency we will be shortly be holding a further briefing for staff. Mrs Storey also commented that the intention of the session would be for staff to understand their duties and responsibilities in respect to this new statutory duty. The intention is that staff "own" this and ensure that this is disseminated accordingly within the clinical team. The contact points for this session are Mrs Storey or Ms Carol Sylvester. **Accountability session at Staffordshire County Council** The Chairman and the Executive Team presented to the Healthy Staffordshire Select Committee as part of its annual calendar of Accountability Sessions held with all NHS organisations across Staffordshire on 10 September 2014. The session was robust with detailed discussions. The Trust received positive feedback about our values as a Team and a Trust. **NHS England Chief Executive committed to improving Dementia Diagnosis** NHS England is committed to pushing up dementia diagnosis rates, Simon Stevens, CEO has told the Alzheimer's Society Conference. The pledge comes as NHS England publishes a new Dementia Toolkit aimed at helping GPs make more timely diagnosis. The Trust will continue to work in partnership with GPs. ***Received***	
234/2014	**Spotlight on Excellence Awards** **Individual Spotlight Award – Rob Buckley,** **Community Nurse (Sensory Specialism), Learning Disabilities Service Line** The individual spotlight award was presented to Rob Buckley, Community Nurse. Mr Buckley will collect his award at the next Trust Board meeting in October 2014. Members noted that Rob is a Learning Disability Community Nurse, who has a career spanning over 30 years. Rob has specialist skills in sensory impairment and has achieved some great outcomes for clients ensuring they get the best, most up to date and modern assistive aids available.	

	It was noted that during his long career, Rob has never lost his enthusiasm for the job, striving to improve access to healthcare for the clients with his person centred approach. His role is quite unique and looks specifically at hearing impairment for clients with learning disabilities and also significant communication difficulties. His hard work and commitment is highly valued. Families and carers benefit greatly from his service and always show this through their letters of thanks and great appreciation; as having a hearing impairment in conjunction with a learning disability can be very limiting and when clients pain is relieved, or their hearing improved the dividends are very significant. Through signposting and promotion of Learning Disability services and by highlighting the individual and unique needs of a person with a learning disability Rob has made a real difference to how clients are supported within acute hospital services. Rob has also introduced a training schedule to upskill other team members. This is in recognition of the need to succession plan and provide skills to a broader range of staff, enabling a more flexible and responsive approach to supporting clients who have a diagnosed sensory impairment. He has also worked closely with colleagues to reinstate a comprehensive student nurse induction package which has resulted in a hugely positive impact on those who have been allocated to the team. This work was recently commended during student placement reviews and was more formally highlighted through student led presentations within the University. Rob clearly demonstrates that he is 'Working together for better lives' through his commitment to improve service quality, supporting staff development and addressing a potential future service deficit by engaging a broad range of staff and working collaboratively with acute health services. Dr Adeyemo commented that Rob has helped with patients in her clinic with dementia and has been invaluable to her team. Ms Harvey also commented that Rob had helped her to support patients when she was in the catering department approximately 20 years ago. His work is exceptional. Both Dr Adeyemo and Ms Harvey noted that they have both been touched by his work ***Received***	

235/2014	**Team Spotlight Award and Presentation** **Finance Team, Corporate Services** The team spotlight Award and presentation was from the Finance and Contracting Team at Lawton House. Mrs Donovan noted that the Finance & Contracting Team provides a support service to Clinical and Corporate areas within the Trust for all aspects relating to finance. This includes financial planning, internal & external monitoring and reporting of financial performance, budget setting, and management and advice to the Trusts budget holders. The Team also completes the Trusts Annual Accounts and other regular financial returns both internally and external to the Trust. Additionally, they manage the Trusts cash, ensuring that staff and suppliers are paid promptly and appropriately. The Contracting section of the team provides support to the Trusts Commissioning process including the negotiation, pricing and monitoring of the Trusts Clinical contracts. The Contracting section also produces the Annual Reference Cost and other costing returns, and is working on Service Level Reporting & Payment by Results developments. They have been selected for the spotlight because they delivered upon their objectives consistently throughout 2013/14 despite changes in significant personnel, while at the same time continuing to develop and enhance the financial services provided to clinical colleagues and their teams. Members then received the presentation in relation to the work of the Finance Team delivered by Steve Blaise, Mrs J Salmon and Ms N Khan-Lewis. Mr Blaise commented on the challenges of the previous year including the difficulties arising from the Trusts transaction process, additionally mid-year there was a number of senior changes within the team, with the Director, Deputy Director and Project Manager moving on to new roles. Mr Blaise also commented on the progress made to further enhance the profile and effectiveness of the team including; • Shadowing clinical colleagues; • Finance open day ; • Running surgeries with managers and budget holders; • Committed to LiA; • Different approach with clinical teams. Mrs Donovan thanked the finance team for their participation with the Aston Team Leaders programme, how they have embedded that process and were helping to change the culture	

	of the team. Mrs Johnson acknowledged the recognition given to back office staff, in particular the Finance team. Dr Adeyemo thanked the finance team on behalf of her colleagues. She made reference to the LiA process with clinicians who have recognised the importance of their work and for the invaluable support they provide in the Finance Team. Mr Draycott thanked the finance team and recognised that the team had maintained good relations and customer focus through a difficult period. Mr Gadsby noted that during the 5 years he has been with the Trust, finance has become much more integrated into the business of the Trust making considerable and important contributions . Additionally, the external perspective from KPMG is always extremely positive and they speak highly of the finance team, always delivering results. Ms Harvey commented on the important role of the finance team and other corporate teams. She noted that whatever role one carries out within the NHS, this is always focusing on patient care. Mr Sullivan and Mr Rogers noted the work that the finance team achieve with their support with business cases. Mr Rogers noted the exceptional work of the finance team and their flexibility to adapt within the organisation. Finally, Mrs Donovan thanked the finance team and commended them for the change in culture, their development and their 'can do' attitude. The Chair thanked the finance team and commented on the excellent presentation, he particularly liked the section about knowing the business is fundamental. He stated that *knowing the business is a key to a successful organisation* ***Received***	
236/2014	**Summary of the Quality Committee meeting held on 15 April 2014** Mr Sullivan, Non-Executive Director, provided the Board with a summary report from the meeting held on 16 September 2014 and reported that the committee received assurance in a number of areas.	

	The following policies were approved by the committee for a further 3 years to be ratified by the Trust Board; 5.05 Fire policy 7.08 Information Governance Policy 7.08a Information Governance Strategy 7.14 Safe Haven 7.05 Information sharing Protocol – to be rescinded as replaced by the One Staffordshire Protocol 1.12a & b Safeguarding Procedures IC 10 Manage of Pulmonary tuberculosis The committee then received the Director of Quality Report which included ; • Extended remit for duty of candour – for information discussed earlier • Clinical pathways update- for information • CQUINs - update • Dementia diagnoses increasing rapidly – for • information. The Quality Committee scrutinised; • The Compliance with Emergency Planning, Resilience and Response – self assessment of Core standards – • Scrutiny of the Serious Untoward Incident report • Received the Integrated Quality Report • Risks to Quality of Services • Divisional reports • CQC Ward 4 Visit, Ward 6 visit and overarching Action Pal **Domain Reports** • Patient Safety • Clinical Effectiveness • Organisational Safety and efficiency • Customer focus All received for assurance purposes.	

	Finally, Mr Sullivan commented that the Quality Committee spent some time discussing the current arrangements and its effectiveness. It was agreed that the current Terms of Reference for the Quality Committee be extended for a further 3 months to allow the committee to complete its programme of work for delivering the revised agenda. The work will be completed in December 2014 with the outputs reported to the Trust Board in January 2015. ***Received and approved***	
237/2014	**Safe Staffing Monthly report** Ms Wilson, Director of Nursing and Quality, presented this report which outlined the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during data collection – 1 July 2014 – 31 August 2014 in line with the National Quality Board expectation. During the current data collection 71.3% (for July) and 66.4% (for August) of shifts have been staffed as planned. It was noted that where shifts have not been filled as planned, the variance is often minimal (ie less than 1-2 hours per shift and where the figure is higher than this staffing levels have remained at safe levels by short term adjustments in the ward grade mix. In addition, there has also been an extensive recruitment campaign to improve numbers of staff available to the bank so more people are available to ease pressure on wards and ease short-term staffing issues. Ms Wilson noted that there has been a varying picture month on month and that the team continues to review the way the information is gathered. For this period, overall areas to focus on are Ward 1. It was noted that on ward 4 there has been additional levels of complexity. There needs to be more understanding around the performance indicators in order to help better reflect patient need (acuity). Both Ms Wilson, and her deputy, Mr Eley will be meeting with Ward Managers to undertake a 'deep dive' and further review of their establishments. The six-monthly more detailed report will be presented to the November meeting of the Trust Board. Ms Wilson stated there seems to be an emerging pattern; this would require discussions with commissioners regarding establishments. In addition, to this the main focus is also	

	looking at utilising the right skill mix in response to acuity. At this moment in time, some utilisation of staff (redesign of skills) may bring some additional benefits. What is most important is that we have been able to deliver on our requirement to ensure safe staffing against our original baseline. Ms Harvey queried are the figures collated on the number of staff at the start of shift? Ms Wilson commented that data is collected at the end of each shift. Mr Hughes queried what assurance can the Board take where there are identified shortages and impact on safety. Ms Wilson added that in addition to the escalation process additional metrics will be included in the report that will come to the Board in November 2014. This will aid triangulation of information pertaining to staffing levels and impact on safety. Mr Sullivan asked about the use of bank and agency staff to support the position on establishments. Ms Wilson stated that discussions had taken place to set the establishments with wards managers. However the original assumptions made were now forming part of the review of the staffing position. Some ward managers have identified the need to supplement their baseline establishment with additional bank staff to manage the demands of the ward when acuity increases and/or when vacancies exist. Ms Wilson stated that high level of bank use is a concern but that in the main these staff already hold a substantive contract within the Trust and therefore were familiar with patients and the environment. Mr Sullivan raised a query in relation to community staffing establishments. Ms Wilson reported that this will be further work to be undertaken in the future. At the present time, the focus was on inpatient areas only. Mrs Johnson stated she was pleased to hear that there had been a recruitment campaign. The Chair commented that we all understand the fundamental issues of patient and service user care together with safety and financial control, all these areas have to be balanced and it has be to a safe service within resources. However, in relation to Appendix A, the Chair noted that he understood this process was in its early stages, but the table has two columns relating to % but the third column is a number – should this also be a % to better understand the figures? Ms Wilson agreed to amend this	Ms Wilson

	in order to improve the way the information is presented going forward. The Chair also noted that the report does not give full assurance in relation to the second bullet point on the Executive Summary ' *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'* Mr D Rogers suggested a more radical approach with pictorial presentation ie pie chart/graph, in order to give the board assurance. Ms Wilson noted that it was intended for the six monthly report to provide the level of detail the Board required and therefore assurance. However it was accepted that the monthly report needed further work. Ms Wilson thanked the Board for their feedback and noted that the monthly report will be revised accordingly. ***Received***	
238/2014	**Risk Management Committee Report** Mrs Johnson, Non-Executive Director, presented this report to receive a summary from the Risk Management Committee held on 13 August 2014. The Risk Management Committee received a report from Ms Wilson, Director of Nursing and Quality, in relation to the Risk Review Group and that risks are now having increased scrutiny and ownership by Directorate staff. In addition, the meetings have now moved from quarterly to monthly for more continuity and focus. The Risk Management Committee received the Q2 2014/15 Principal risk register – ratings, mitigations and actions were revised for some of the risks and also it was felt the format in which risks were presented should be made clearer. In respect to the risk of failing to maintain clinical effectiveness and operation of safe clinical services, members discussed the programme of work that is in place to ensure ongoing compliance with the CQC's standards of care and preparations for inspection. It was further noted that the 3 areas where risks were high; 1. IT systems	

	2. Finance – PbR 3. Operational – estates and redesign of services Work is progressing in these areas to further mitigate these risks accordingly. The Risk Management Annual Statement was also received for the previous year 2013/14 which included the Risk Review Group undertaking a review of its effectiveness and compliance with its Terms of Reference. ***Received***	
239/2014	**Q2 Principal Risk Register Report 2014-15** Ms Wilson, Director of Nursing and Quality presented the Q2 Principal Risk Register for review by the Board. Members reviewed the contents as follows: ***Risk 288*** ***Insufficient funding to meet the cost base for service provision arising from the financial impact of CIP, Bucknall site and LD Changes*** – Mr A Rogers updated the Board in terms of ability and assurance on delivering the CIP programme.. There is an element of non-recurrent. There are meetings scheduled with divisions and bring forward details plans for the following year. Mrs Donovan commented that in relation to LD exit costs we are continuing to mitigate this risk. Mr Blaise confirmed a paper had been submitted to the Finance and Activity Committee with regard to Payment by Results (PbR) and the clinical engagement on the Patient Level Costing system (Plics). ***Risk 10*** ***Failure to develop and implement fit for purpose information systems that provide real-time information for patients and fully support PbR, mobile working and efficiency –*** Mr Hughes commented that the risk scoring will be revised downwards given the programme of work underway. ***Risk 131*** ***Significant financial impact in 2014/15 as a result of future model of LD services –*** previously discussed under 288. ***Risk 130*** ***Work undertaken in the roof spaces at Harplands may lead to potential disruption in clinical areas and or harm to***	

	patients and staff – Mr A Rogers gave assurance work is progressing, Estates are approximately two thirds of the way through the programme. Ward 4 due to commence. – Mr Ball, Head of Estates, is operationally managing this risk and still remains an issue, hence remaining of the risk register at this time. ***Risk 129*** ***Risk of patients using ligature points in inpatient unit at Harplands Hospital resulting in potential harm*** – Mr A Rogers commented that the risk treatment plans are reducing the risks. Environmental risk assessments have been introduced to ensure standardisation with stepped up training for staff. Mr A Rogers gave assurance that he would carry out a further walk around the Harplands Hospital site with estates to address any environmental issues. Mr Sullivan asked for further assurance on ligature points in relation to a programme of work commissioned. Mr A Rogers confirmed this was correct and this would involve a review of the whole of the estate, the outputs of which would be presented to the Quality Committee and onto the Trust Board. Mr Hughes queried how does the Principal Risk Register align with the board assurance framework? Mrs Storey noted that the management of risk is a component part of the assurance framework. The detailed framework sets out the risks to meeting annual objectives, any gaps in control or assurance. This detailed report used to be presented to the Trust Board. It was noted that the reports are presented for assurance on the robustness of our processes to the Audit Committee, however, it was agreed that it would be helpful to have more transparency of this information again at the Board. ***Risk 286*** ***Future organisational form is unable to deliver sustainable services –*** The chair noted that under the mitigation column the TDA Risk rating is now 4 ***Received***	**Mrs Storey/ Ms Wilson**
240/2014	**Infection Control Annual Hygiene Declaration** Ms Wilson, Executive Director of Nursing and Quality, presented this position statement for approval. The Code of Practice sets out the ten criteria against which the Care Quality Commission judges a registered provider. The position statement provides a summary of the Trust's position benchmarked against the criteria detailed in the Code, which is required to be reported to the Trust Board on an annual basis.	

	Ms Wilson noted that this report is assurance that the Trust is compliant and with the Board's approval this declaration will be made. ***Approved***	
241/2014	**Patient Advice and Liaison Service (PALs) and Complaints Report - Quarter 1 Report 2014-15** Withdrawn as work is ongoing and a report will be made to the next meeting of the Trust Board.	
242/2014	**Assurance Report - Finance and Activity Committee Report** Mr Gadsby, Non-Executive Director, presented the assurance report to the Trust Board from the Finance and Activity Committee held on 18 September 2014. Mr Gadsby reported on the following ; • Positive position with the income and expenditure for Month 5 currently ahead of plan. • Year-end forecast was in line with planned position of £0.288m surplus. There are a few caveats against that; in that cash balance continues to remain high. The Capital programme is currently behind plan, the Finance and the Executive Team will be undertaking a mid-year review in this area. In order to revise its end of year forecast and advise the TDA of this revision. It was noted that there are some outstanding business cases to come back to the Finance and Activity committee. With regard to the Cost improvement programme 2014/15 the headlines are positive; the requirement is to deliver £4.08m with plans in place to deliver £4.06m. Mr Gadsby noted that looking forward to the next financial year 2015/16 the Trust is in a much healthier position with £3.7 m identified, however it was noted that there is £1.8m non-recurrent carried forward from 14/15 which would need addressing. The Finance and Activity committee noted that 40 new schemes outstanding for Quality Impact Assessment (QIA) with a total value of £1.67m this needed addressing as a matter of urgency.	Dr Adeyemo/ Ms Wilson

	Additional and verbal reports received in relation to ; • Patient Level Costing (PLiCs)- good progress made • Payment by Results (PbR) – further work required, however Mr Calkin has re-established the Trust Wide PbR group. It was also noted, that following a CHIPS redesign commissioned from the Health Informatics Service, PbR compliant data will be available from November 2014. The Finance and Activity Committee reviewed their Terms of Reference for a further 12 months and agreed it was appropriate for this committee to review performance data in the future. The committee sought approval from the Trust Board to rename the committee to the Finance and Performance Committee. It was noted that quality metrics will still be monitored by the Quality Committee. ***Received and approved***	
243/2014	**Financial Performance – Month 5** Mr Blaise, Acting Deputy Director of Finance, presented this report on behalf of Mr Calkin, Interim Director of Finance and highlighted the headline performance. Headline performance is: • A retained deficit of £0.738m, giving a favourable variance against plan of £0.013m. • A year-end forecast that indicates an achievement of a retained surplus of £0.288m (£0.754m surplus at adjusted financial performance level), representing a favourable variance of £0.02m against Plan. • A year to date Continuity of Service Risk Rating of 3, with a year-end forecast rating of 3. • CIP target of £4.08m, with a forecast that this will be delivered but noted the level of CIP schemes delivered on a non-recurring basis. • Capital expenditure of £0.017m to date and a forecast gross expenditure of £2.64m but subject to revision • A cash balance of £5.9m at the end of August 2014. Mr Blaise asked the Board to note that the financial performance to date is ahead of plan and the year-end forecast that the Trust will achieve its planned position this financial year. Members also noted that the workforce details on page 4 have been included in this month's report as previously requested.	

	Mrs Donovan commented that at the last Open session of the Trust Board it was proposed that greater transparency between non – recurrent and recurrent be visible. Mrs Donovan also gave assurance that there had been a whole programme of CIP meetings held with corporate divisions and further meetings with divisions held by Mr Rogers and Mr Calkin. Mr Rogers confirmed progress had been made with Adult Mental Health Division who had the biggest gap. Significantly some schemes have not yet had an impact. Mr Rogers also commented on the implementation of a new group PMS in order to focus on performance and keep on track with divisional accountability. This will help to strengthen our dialogue with commissioners. Members of the Trust Board reviewed the recommendations and noted the good position ***Received***	
244/2014	**Performance and Quality Management Framework Report (PQMF) Month 5** Mr A Rogers, Director of Operations, presented this report on behalf of Mr Calkin, Director of Finance. The report provides the Board with a summary of performance to the end of Month 5 It was noted there is a range of 122 metrics in place to monitor performance, quality and outcomes. There are three areas reported as underperforming (amber) and three reported as significantly under performing as at end of August 2014. Members noted the proposed TDA Framework, Mr A Rogers commented that not all targets have been populated. Members then noted the Exception reports where compliance with KPIs which support the strategic goals and key trust targets (KTO) are below expected levels of performance and require further action; ***KPI O1 1P4 Readmissions rate (28 days) for all inpatient settings reported by speciality (monthly)*** – Mr Rogers gave assurance that we will always ensure people have a bed when they need a bed; we are off track and we have agreed with commissioners to do a drill down to review on a patient by patient basis, deadline 10 October 2014. The information will be submitted to the Clinical Quality Review Meeting CQRM. Dr Okolo has also reviewed this area. ***CQUIN goal 5 – Listening and Responding to feedback*** – Ms Wilson stated that she was confident this would be back on track. A meeting with commissioners is scheduled and	

	agreement reached in principal, just metrics to include how staff can register their opinions going forward. ***Completion of IAPT minimum data set outcome date for all appropriate service users as defined in contract technical guidance -*** – Mr Rogers stated that the issue is running at 25% higher than currently commissioned. Commissioners have recognised this and are working with us to help address this. The Chair noted that IAPT is one of the areas that has been dealt with very well. ***KPI 08.5 – Annual appraisal -*** Mr Draycott that the cascade this year had started later than planned. This is being carefully monitored with fortnightly reports and information from ESR system to help improve the level of performance. ***Received***	
245/2014	**Self-Certifications for the NHS Trust Development Agency** Mrs Donovan, Chief Executive presented this report on behalf of Mr Calkin, Interim Director of Finance. The report provides the self-certifications for the TDA for Board approval. Based on August 2014 data, the Trust is declaring compliance with all requirements. ***Received***	
246/2014	**NHS Trust Development (NDTA) Oversight Ratings and Guidance** Mrs Donovan, Chief Executive, presented this report on behalf of Mr Calkin, Interim Director of Finance. The report provides the monthly NTDA Oversight ratings that are prepared by the TDA and discussed during its Integrated Delivery Meetings with the Trust, together with the TDA's guidance document. This is the first time we have received this report. Based on the latest data provided by the TDA (June 2014) the Trust is currently rated a 4, which is the second lowest risk category achievable. The Trust is continuing to work towards achieving level 5. Debate took place regarding the scoring and it was positive to note the Finance score as green and Quality Score as overall 5 (the individual quality domains scoring also noted). **Received**	

247/2014	**Audit Committee Report** Mrs Johnson, Non-Executive Director, presented this report to receive a summary of the Audit Committee meeting held on 11 September 2014. Members of the Audit Committee reviewed ; • Audit Committee Terms of Reference (on today's agenda) members to review the process of signing of Charitable Funds Accounts and the responsibility for risk has now changed to Executive Director of Nursing and Quality. • Audit Committee Annual Report (on today's agenda) • Implementation of Audit Recommendations – Performance Management Report. Mr Rogers explained why two recommendations had been reported as complete though work was still ongoing. This was as a consequence of staff changes, however, the recommendations have now been fully implemented. • Risk Management Strategy and Policy – received with no changes, however it was noted that the Executive responsibility for risk now falls with the Executive Director of Nursing and Quality. • Healthcare Quality Standards Assurance Report – satisfied with process • Policy Review - Anti-bribery Policy (approved) - Cash and Treasury Management (approved) - Local Counter Fraud Policy (approved) - Trust's Scheme of Delegation – changes in relation to revenue spending limits were supported however tendering, contracting and purchasing arrangements would remain unchanged. Mr Blaise to provide an analysis to the committee prior to approving.	

	• Internal Audit Progress Report – received • Annual Audit letter 2013/14 – on today's agenda • Single Tender Waiver report – received • Preparing for the National Fraud Initiative 2014/15 – the trust is participating ***Received and approved***	
248/2014	**Audit Committee Annual Report 2013/14** Mrs Johnson, Non-Executive Director, presented this report to give assurance that the Audit committee has met its Terms of Reference ***Received***	
249/2014	**Audit Committee Terms of Reference** Mrs Johnson, Non-Executive Director, presented the Terms of Reference for the Audit Committee for approval. These were supported by the Trust Board and approved for a further 12 months. ***Approved***	
250/2014	**Annual Audit Letter 2013/14** Mr Blaise, Acting Deputy Director of Finance, presented the Annual Audit Letter 2013/14 from KPMG, which summarises the key issues arising from the KPMG audit 2013/14. The audit concluded that the Trust has in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources and was noted to be a good outcome for the Trust. ***Received***	
251/2014	**Digital by Choice Programme** Mr Hughes, Interim Director of Strategy and Development, presented this report in order to brief the Board of Directors on the predicted timescales for the Digital Choice Programme and to advise on details for the Board Development Workshop on 8 October 2014 (agenda attached). Mr Hughes stated that this document was being presented for assurance to the Board in relation to progress with the IT	

	strategy. It was also noted that it was emerging from the LiA sessions that IT is one of the main frustration's for staff, hence the need to address this. The paper outlines the steps that have been taken so far and the progress made since the commissioning of the External consultant, Mr G Thomas. Members noted the contents and the Chair in particular, welcomed this report and the efficiencies to service quality, which is absolutely fundamental. Mrs Storey noted that there may be a starting timing issue with the Board Development workshop on 8 October 2014, due to the Risk Management Committee being held on the same day. Mrs Storey will discuss this with Mr Hughes outside of the meeting. ***Received and noted***	
252/2014	**NHS Compliance with Emergency Planning, Resilience and Response (EPRR) Self Assessment of Core Standards** Mr A Rogers, Director of Operations, presented this report as part of the new health changes Trust's now have to follow the Emergency Preparedness Resilience and Response (EPRR) Framework. Mr A Rogers noted that the Trust is mainly compliant in this area. There is some progress to be made with several areas currently rag rated as amber, however he gave assurance to the Board that he was confident all areas would be closed off and this would be discussed at the SLT meeting. It is anticipated all areas will be green by January 2015 ***Received and approved for submission***	
253/2014	**People and Culture Development Committee Report** Mr Sullivan, Non-Executive Director, presented this report on behalf of Mr O'Hagan, Non-Executive Director. The report was a summary report from the People and Culture Development Committee meeting which took place on 18 August 2014. Mr Sullivan stated the meeting had taken the format of a development session. Members of the PCD received a number of reports as follows ; • Workforce Service Line performance	

	• Incident reporting • Horizan Scan –Leadership and Workforce update ▪ Industrial action ▪ Leadership recognition awards ▪ Compassionate leadership and talent exchange projects ▪ West midlands HR Streamlining ▪ Partnership work with Staffordshire University • Committee Development Mr Draycott reported on the forthcoming industrial action by UNISON for a planned 4 hour strike on 13 October 2014 relating to the pay award for staff. Mr Draycott noted that plans are being made to reduce the impact and the working to rule approach. A paper is being drafted which will be circulated to Board members and meetings within HR are taking place. Ms Harvey stated that further ballot results from Unite are due in by the end of the week. There are a number of unions involved, but they do not all have membership within our Trust. It was further noted that full action is not intended, however, most unions feel there is no other option. The plan is that this will be a long campaign and because of how the law is, we have to take action with this window. Ms Harvey confirmed she would keep members updated. Concerns were raised with regard to service delivery and safety and Ms Wilson requested further assurance regarding safety supported with risk assessments, in order that we can work together. The Chair stated that it was key to understand and respect the actions and work constructively with all involved. ***Received***	
254/2014	**Staff Retirements** Mr Draycott, Acting Director of Leadership and Workforce presented this paper in relation to recognising staff retirements. Mr Draycott stated this report builds on long service and the importance of recognising staff retirements. There has been some feedback that the gift is quite limited. It was agreed at PCD to acknowledge at Board those members of staff retiring and that a lead person in each area liaise with them and in order	

	to purchase a gift on their behalf. It was also agreed with the recommendations from PCD, that the Trust would fund a buffet for retiring staff to the cost of up to £100 in addition to the gift. The final recommendation to invite retirements to the Board was also agreed. Mrs Donovan also noted that it would be beneficial to present staff retirements at the REACH Awards ceremony. At this point, the Chair declared an interest as Patron of the NHS retirement fellowship. Ms Harvey also mentioned that thought should be given to those staff who have long service and may be TUPED across to other organisations. We should ensure that their service is recognised. ***Received***	P Draycott
255/2014	**Learning and Development Approaches for Healthcare Support workers** Mr Draycott, Acting Director of Leadership and Workforce presented this progress report on the development plan for Health Care Support Workers. Mr Draycott stated this was an update following the initial implementation in February 2014, following the Francis report and subsequent Cavendish Review which made clear recommendations about the need to provide effective training and development opportunities for support workers. Members were pleased to note the contents and the recommendations. Ms Harvey commented on the valuable role a Health Care Support Worker has, often providing many skills that registered nurses do not have. This has helped to raise Health Care Support Workers as a profession in itself and has given pride to the workforce. The Chair queried whether we are able to assess how much training our existing support workers have received? Mr Draycott confirmed this was accessible via the ESR system and will give an update subsequently. ***Received***	**Mr Draycott**
256/2014	**Questions from the public** **Hilda Johnson** Mrs Johnson stated she was pleased to hear that we are	

	reviewing staffing levels at the Harplands Hospital. She was also pleased that we are reviewing the use of bank staff. However she raised concerns with staff being pulled from the community to inpatient services as this has an impact and puts them under pressure. Mr Draycott stated that we would normally use our own staff on the bank, however there is a mixture. If they are new staff they will receive an induction to the organisation and service accordingly. Mrs Johnson stated that if there is anyway NSUG can be involved in this process, then please contact her direct. This was acknowledged. **Mr Williams** Do you happen to know what the bed availability is at Harplands Hospital? Mr A Rogers stated that 119 out of 128 beds were occupied **Mr Williams** I have heard via a member of staff that there are a number of patients placed out of area - any truth in that? Mr A Rogers stated that predominately we are a service for local people and there are very few occasions that people go out of area. He stated sometimes this may be as a consequence of the Trust not being commissioned to provide a particular service, such as a psychiatric intensive care unit (PICU). With regards to CAMHS, we are regional provider and patients are placed would be placed here appropriately. The Chair stated that our policy with commissioners is to repatriate patients where we can and work is ongoing to ensure this happens where it is appropriate to do this. Ms Wilson commented that we would strive to get someone back within 24-48 hour period who had for whatever reason been admitted to a service out of the local area. **Mr Williams** There are rumours going around about a resource centre possibly reopening – is it the Ashcombe Centre? Mr A Rogers confirmed that the Ashcombe Centre is not reopening as a resource centre. There is a proposal for our	

	Neuropsychiatry unit to provide services from the Ashcombe Centre. The principal of Resource centre without beds will remain.	
257/2014	**Any other business** There was no other business to be discussed.	
258/2014	**Date and time of next meeting** The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday, 30 October 2014, at 10:00am, in the Boardroom, Lawton House, Trust HQ.	
259/2014	*** Motion to Exclude the Public** The Board approved a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted.	

The meeting closed at 1.15pm.

Signed: _____ Date_____

Chairman

Board Action Monitoring Schedule (Open Section)

Trust Board - Action monitoring schedule (Open)

Meeting Date	Minute No	Action Description	Responsible Officer	Target Date	Progress / Comment
27-Mar-14	85/2014	PALS / Complaints report - consideration to be given to bringing together various sources of information. It was agreed that this issue will be addressed and brought back in due course via the Quality Cte	Karen Wilson	30-Oct-14	It was noted that this was on the agenda, however this paper has been withdrawn as work is ongoing. The revised paper will be presented first to the next Quality Committee meeting in October 2014.
25-Sep-14	147/2014	147/2014 Choice of Mental Health Provider at first appointment. Mrs Johnson enquired about progress against this programme of work. Ms Wilson noted that this was part of the Choice agenda and that there is a trust wide event at the end of October. Key stakeholders and staff have been invited and so far there has been a good response to this. A report will be presented to the November Trust Board meeting	Ms Wilson	27-Nov-14	
25-Sep-14	237/2014	Safe Staffing Monthly Report - in relation to Appendix A, the two columns relating to % but the third column is a number – should this also be a % to better understand the figures? Ms Wilson agreed to amend this in order to improve the way the information is presented going forward.	Ms Wilson	30-Oct-14	On today's agenda
25-Sep-14	242/2014	Assurance Report Finance and Activity Committee Report - The Finance and Activity committee noted that 40 new schemes outstanding for Quality Impact Assessment (QIA) with a total value of £1.67m this needed addressing.	Dr Adeyemo/Ms Wilson	30-Oct-14	Verbal update at meeting
25-Sep-14	254/2014	Staff Retirements - Ms Harvey stated that thought should be given to those staff who have long service and may be TUPED across to other organisations. We should ensure that their service is recognised. Mr Draycott agreed to consider this.	Mr Draycott	30-Oct-14	verbal update at meeting
25-Sep-14	255/2014	Learning and Development Approaches for Healthcare Support Workers - The Chair queried whether we are able to assess how much training our existing support workers have received? Mr Draycott confirmed this would be actioned	Mr Draycott	30-Oct-14	verbal update at meeting

Report to:	TRUST BOARD MEETING (Open)
Date of Meeting:	30th October 2014
Title of Report:	Nurse Staffing Performance on a shift-by-shift basis
Presented by:	Prepared by Steve Eley, Deputy Director of Nursing. Presented by Paul Dracott, Executive Director of Leadership and Workforce Development
Author of Report: Date: E-mail:	30th October 2014 (UPDATED REPORT)
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 September – 30th September 2014) in line with the National Quality Board expectation for Trust Boards to receive an update containing details and summary of planned and actual staffing on a shift-by-shift basis • The performance relating to the fill rate (actual numbers of staff deployed vs numbers planned) on the wards for September was 103.33%: being a total fill rate of 100.86% for registered nurses and 105.8% for HCSWs. The position reflects that ward managers are effectively deploying additional staff to meet increasing patient needs as necessary. • During the current data collection period 1st September – 30th September 2014: 82.11% (n=739/900) of shifts have been staffed as planned. The board are asked to: Receive the monthly nurse staffing report in line with the National Quality Board's expectations.
Which Strategy Priority does this relate to? How does this impact on patients or the public?	• Customer Focus Strategy • Clinical Strategy • Governance Strategy • Workforce Strategy • Financial Strategy
Relationship with Annual Objectives	Supports the delivery of the Trust's Annual Objectives and the delivery of high quality care
Risk / Legal Implications:	Delivery of safe nurse staffing levels is a key requirement to ensuring that the Trust complies with National 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

NURSE STAFFING LEVELS ON A SHIFT BY SHIFT BASIS
REPORT FOR TRUST BOARD

Purpose

This paper provides the monthly ward nurse staffing data detailing the Trust's performance for September 2014.

Current Performance

During the current data collection period (1st September 2014 – 30th September 2014), 82.11% (n=739/900) have been staffed as planned. It should be noted that where shifts have not been filled as planned, the variance is often minimal (i.e. less than 1-2 hours per shift and where the figure is higher than this staffing levels have remained at safe levels by short-term adjustments in the ward grade mix. The recruitment campaign to improve numbers of staff available to the bank to ease pressure on wards and ease short-term staffing issues continues and will assist this pressure.

The performance relating to the fill rate (actual numbers of staff deployed vs numbers planned) on the wards in September was September was 103.33%: being a total fill rate of 100.86% for registered nurses and 105.8% for HCSWs. This demonstrates that the wards are utilising additional nursing resources via the use of bank staff to meet fluctuating patient acuity and other demands by deploying additional staff where appropriate.

Specific Issues

Within the overall picture there continues to be a number of variances within the recorded data for individual ward areas that require longitudinal investigation and analysis.

Ward 1

The position of ward 1 (acute adult inpatient) for example suggests an ongoing significant rise in activity against the agreed establishment. In addition, long-term sickness and vacancies have been a factor. The ward nurse manager has recently been able to appoint to cover a band 5 vacancy, band 5 maternity leave and a band 5 secondment, but these individuals only started in post in October. However, appropriate lifts in staffing to meet this demand have been delivered resulting in actual shift usage remaining significantly raised beyond normal expected planned activity during this period. At the rate seen in September this continues to be the equivalent of needing a further 8.4wte to cover ward activity.

Ward 7

Ward 7 have made greater use of non-registered staff to cover the shortfalls in registered nurse requirements to meet the demand and acuity of patients being admitted, which has included accommodating patients from other wards when they have been over established.

Summers View

Summers View data suggests significant issues with a number of shifts appearing to be below planned numbers. Occasionally due to unplanned absence the ward have to use bank and make slight reconfigurations of Qualified / Unqualified ratios, but the planned numbers recorded are above the optimum working figures for staffing and apparent shortfalls have no detrimental impact on patient care. The service tries to profile planned staffing figures that ensures they can offer a seamless, holistic and dynamic service for the client group. However, further work is required to ensure data reporting is consistently applied across all reporting areas so as to capture any nuances of this nature.

Edwin Myers Unit

In the Edwin Myers Unit, 22 shifts are recorded below planned levels. The service confirmed that throughout the month of September staff were moved from the IOU for a total 136.3 hours to cover shortfalls throughout the rest of the Harplands Hospital site. This position will require further assessment to ensure service input at Edwin Myers is not altered due to pressures in other service lines, both to prevent costs being cross-subsidised and ensure a consistent quality of service to this client group. If this continues more detailed appraisal will be presented for the Board's consideration.

Assessment & Treatment Unit (A&T)

During the reporting period A&T were fully occupied with 5 patients. Observation and safeguarding issues had meant that agreed minimal numbers were modified in September to reflect a 6/6/4 pattern (a.m.; p.m.; night). All the clients within A&T have complex behavioural presentations reflecting high dependency needs. A 6/6/4 pattern equates to 18.6 wte pattern). A&T's establishment for this period equalled 14.74 wte for planned duties; leaving significant short falls that have been picked up as bank shifts which reflects the figure of 149% care staff activity above planned levels recorded. The planned /actual figures should become more aligned from mid-October as the Service have appointed an additional 4 wte on 6 month contracts due to this identified need and 'planned data' will need to reflect this going forward.

This performance information for all areas can be seen in more detail at Appendix A.

Summary

The Board should be assured that it is receiving live data reflecting actual activity. However, clearer performance indicators to capture activity that accurately reflect acuity, vacancy and other factors will be brought forward to the Board as they are developed and recommendations around these processes will come to the Board in due course.

Further consideration and analysis of the recorded data continues within the Safer Staffing Group. This work will form part of the ward establishment analysis on a ward-by-ward basis to be provided to the Board in November 2014 as planned.

Recommendations to the Board

The board is asked to:

- Receive the monthly report on nurse staffing levels
- Approve the approach taken where:
    a. Ward managers are being asked to account for and demonstrate effective management of staffing resource including variations dependent upon the demands of patient acuity and needs
    b. Matrons being accountable for ensuring that patient safety is managed through the deployment of the available nursing resource
    c. Refining data collection and analysis is being developed to provide more informed analysis of activity going forward

September 2014

Ward	Performance (% planned vs actual) staffing numbers		Number of shifts below planned numbers	Reasons for variance in performance
	Registered Nurses	**Healthcare Support Workers**		
Ward 1	102%	140%	13	Patient need / sickness
Ward 2	103%	102%	06	Patient need / sickness
Ward 3	99%	102%	08	Patient need / sickness
Ward 4	100%	100%	12	Patient need / sickness
Ward 5	91%	98%	20	Patient need / sickness
Ward 6	99%	95%	14	Patient need / sickness
Ward 7	116%	123%	0	Patient need / sickness
Assessment & Treatment	101%	149%	0	Patient need / sickness
Telford Unit	101%	110%	0	Patient need / sickness
Edward Myers	103%	82%	22	Patient need / sickness
Darwin Centre	108%	101%	07	Patient need / sickness
Summers View	94%	96%	43	Patient need / sickness
Florence House	100%	98%	02	Patient need / sickness
Dragon Square	99%	99%	0	Patient need / sickness
Chebsey Close	97%	94%	14	
TRUST AVERAGE/ TOTAL	**100.86%**	**105.8%**	**161**	

North Staffordshire Combined Healthcare NHS
NHS Trust

Encl 5

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

Date of Meeting:	30 October 2014
Title of Report:	Report from the Risk Management Committee held on 8 October 2014
Presented by:	Mrs. B Johnson, Chair of the Risk Management Committee
Author of Report: Name: Date: Email:	Sandra Storey, Trust Secretary, Head of Corporate and Legal Affairs 2014 17 October 2014 sandraj.storey@northstaffs.nhs.uk
Purpose / Intent of Report:	• For assurance
Executive Summary:	This report provides a summary of the Risk Management Committee meeting held on the 8 October 2014
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Customer Focus Strategy • Clinical Strategy - • Governance Strategy
Relationship with Annual Objectives:	Ensure provision of safe clinical services
Risk / Legal Implications:	N/A
Resource Implications:	N/A
Equality and Diversity Implications:	N/A
Relationship with Assurance Framework [Risk, Control and Assurance]	Risk Management is an integral part of the Trust's Board Assurance Framework and informs the Annual Governance Statement
Recommendations:	To note the contents of the report

Risk Management Committee Summary Business Report to the Trust Board of the meeting held on 08 October 2014

1. Report from the Risk Review Group

Ms Wilson, Director of Nursing & Quality presented this report which provided an update of the work of the Risk Review Group from their meeting in October 2014.

The report noted that during the month of August 2014 transitional arrangements were made to support the Director of Nursing and Quality taking over the management of the risk agenda from September 2014. Risk Management Committee members discussed the transition of responsibility of risk and some of the difficulties fulfilling this due to capacity issues. It was acknowledged that the infrastructure to support risk needed addressing and arrangements would be reported back to the committee and the Board in due course.

The Risk Review Group will review its Terms of Reference at its next meeting to give further assurance to the Risk Management Committee that it is effectively discharging its responsibilities. The review will include aligning the group membership to the new Directorate structure and risk reporting arrangements. The good Directorate attendance at the Risk review meeting was welcomed by committee members.

It was noted that the Risk Review Group had received a summary overview of the Trust's Operational Risk Register for information and triangulation purposes. There were no significant trends or emerging issues arising from this review. Future reports from the Directorates will provide a further drill down of their operational risks to help better inform their summary overview.

Mr O'Hagan commented on the discussions held at the last meeting of the People and Culture Development Committee in September 2014 in relation to stress related staff absences. It was agreed that this would be discussed further at next People and Culture Committee development session in October 2014 with regards to actions being taken to further reduce the number of absences. This was welcomed by Mr Jarrold.

At the Risk Review Group meeting updates were received from the Directorates and corporate team setting out actions taken to review risks since the group had last met. Each risk with a residual score of 12+ was discussed in detail and representatives provided updates and assurance regarding risk treatment plans. It was agreed to update these on the local risk registers on that basis with relevant controls and assurance reflected in the next iteration of the group.

Ms Wilson advised committee members that the group had agreed that it would be helpful to hold a workshop on risk designed to review and further improve all areas of risk management and quality governance, including hierarchy of risk registers and associated systems of internal control. The group also acknowledged that it would help support the work recently discussed at the Board of Directors meeting in September 2014, in respect to

the strategic development of four quality themes (access, safety, recovery and personalised care) and the associated risks in achieving these. This was welcomed by the committee.

2. Q3 2014/15 Principal Risk Register

Ms Wilson presented this paper, supported by Mr Sargeant. It was noted that the description of some of the risks had been revised following the review of the risk register at the last committee meeting.

Committee members reviewed the Principal Risk Register and risk treatment plans and discussed at length the significance of the risks being presented at Q3 and those potentially going forward into Q4.

It was noted that the severity of three risks, 280, 309 and 131 had all reduced due to the risk treatment plans in place.

Committee members considered escalation of risks to the Principal Risk Register. This included provision of a place of safety under section 136. Committee members discussed the difficulties that have been experienced and the positive progress that has been made to improve the situation.

Committee members also discussed business cases and those requiring external support. Following assessment by the Directorates the outcomes will be reported in the next risk report to the Risk Review Group and committee.

3. Cycle of Business

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

The committee will review its Terms of Reference at its next meeting in December 2014.

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

North Staffordshire Combined Healthcare NHS
NHS Trust

Enclosure 6

REPORT TO: Trust Board (open)

Date of Meeting:	30 October 2014
Title of Report:	Q3 Principal Risk Register Report 2014/15
Presented by:	Director of Nursing and Quality
Author of Report: Name: Date: Email:	Glen Sargeant, Head of Performance and Information 22 October 2014 Glen.sargeant@northstaffs.nhs.uk
Purpose / Intent of Report:	• For review and approval
Executive Summary:	The enclosed principal risk register was discussed in detail and agreed by the Risk Management Committee at its meeting on 8 October 2014
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Governance Strategy Robust risk management supports the effective delivery of safe and high quality services.
Relationship with Annual Objectives:	The Risk Management Framework measures and facilitates the management of risk across all annual objectives.
Risk / Legal Implications:	Addressed by this report
Resource Implications:	Not directly as a result of this report
Equality and Diversity Implications:	Not directly as a result of this report
Relationship with Assurance Framework [Risk, Control and Assurance]	The Risk Management Framework is a key control within the Assurance Framework.
Recommendations:	The Board is asked to : - Review and confirm the principal risks and their gross risk scoring - Review and confirm the accuracy of the residual risk assessments - Identify any known risks not contained within this report

2014/15 Principal Risk Register - Q3

Ref	Strategic Risk	Annual Objectives / Committee	Controls	Lead	Impact	Likelihood	Gross Risk	Impact	Likelihood	Residual Risk Q3	2014/15 Mitigation Plans
STRATEGIC PLANNING											
1	**Failure to maintain clinical effectiveness and operate safe clinical services:** The Trust fails to develop an outcome focus which is integral to clinical practice; Fails to implement methods to assess clinical effectiveness; Fails to assess outcomes; Fails to deliver services that improve outcomes; failure to implement robust and safe clinical services, fails to deliver a culture where patient safety is continually reviewed and improved; failure to maintain infection prevention & control: failure to safeguard children & vulnerable adults.	**1,3,4,5,6** Quality	15, 18, 20, 22, 27, 32, 34, 52, 53, 55, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 111, 124, 127,	Med Director & Dir Nursing & Quality	5	3	**15**	5	1	**5**	Trust level and Team level outcome measurement framework established and will continue to be enhanced moving forward. Full implementation of the new processes to learn from disparate quality systems in an integrated manner. External quality reports (e.g. DoH, TDA, CQC) are viewed alongside internal performance reports to ensure the Trust is on track in the key areas. Service Line Management / Reporting - Local focus on compliance and safety established. (Dir of Leadership & Workforce). Increased focus on quality & governance is in place at divisional level – e.g. Q&G leads and Q&G infrastructure built in to the wider Divisional Governance Framework Data Quality arrangements are continually monitored and enhanced where possible (Dir of Finance). As a result of the Phase 2 public consultation, investment in additional community support has been established to support more patients to be supported within the community. Home treatment team & Crisis Resolution work closely with acute wards to facilitate discharge & ensure by providing timely interventions that support admission avoidance where appropriate and embed the 'recovery model' of care for users and their carers. Significantly more robust divisional and service line risk management structures are now in place. Enhanced community teams in AMH and NOAP. Some staff have been moved from community to inpatient settings in order to reduce the need for bank usage. In NOAP enhancements to the community service have led to a reduced demand for user beds. The Trust has an integrated process for the reporting of safeguarding activity, which is embedded within the Trust incident reporting system which allows performance to be effectively managed. Further to increased incident reporting of falls across older adult services, plans for improving safety, reducing incidents and improving standards in this area are currently being implemented.The trust has recently received a positive outcome from the TDA inspection into the control and management of infection and prevention and currently responding to actions identified. Actions will be monitored by the infection control committee and reported through the quality committee.
316	**Failure to achieve 'Good' as an outcome of the CQC inspection:** Potential impact on quality and safety of services	**1, 2** Quality	4, 15, 18, 20, 22, 27, 32, 34, 52, 53, 55, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 111, 124, 127,	Chief Executive	3	3	**9**	3	3	**9**	Trust has advised the TDA that its target is to achieve an overall outcome rating of 'Good' in the CQC inspection. Recognised internally that this is a challenging target however the Trust has a robust compliance framework in place that has been audited favourably on several occasions. Further work is taking place under the leadership of the Director of Nursing to review the framework and compliance levels and further strengthen the processes as necessary. Significant preparation is also planned to cope with the practical challenges that a full inspection under the CQC's new process will present.
2	**Failure to jointly develop clinical pathways and develop a clinical strategy which informs the future direction of the Trust:** The Trust fails to develop appropriate and effective, or develops undeliverable, clinical pathways and a clinical strategy	**2,3** Risk Management	1, 2, 3, 4, 5, 6, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 38, 40, 43, 44, 45, 48,	Chief Executive	4	3	**12**	4	2	**8**	Within the LHE, the CELG group meet to align plans and the development of strategy across the economy with a commitment to a 'whole system' approach to service redesign and transformation. Recent LHE agreement has been reached for the formation of an IBP LHE Group. A Trust commissioning board, chaired by CCGs, meets monthly. 8 clinical pathway groups established with clear clinical or commissioning leads. Clinical pathways presentations and report delivered to August 2014 Commissioning Board. Commissioning Intentions recently received by commissioners; to be discussed in October Commissioning Board and will inform IBP and subsequent refresh of clinical strategy.
286	**Future organisational form is unable to deliver sustainable services:** impacting on future provision and delivery of patient care	**2,5** Risk Management	1,3,5,6,13,14,15,16, 20,25,26,40, 43,46,47,50, 56,57,58	Chief Executive	4	3	**12**	4	2	**8**	Agreement with Commissioners and TDA to refresh clinical strategy currently under way to develop robust, integrated clinical pathways that support integration with physical healthcare and social care. Clinical pathway work will inform the decision for future organisational form. 2-year plan developed and broadly supported by TDA with minimal concerns raised. 5-year plan developed and submitted in June 2014 to describe and model future services. TDA risk rating for Trust reduced from 3 to 2. TDA agreed with Trust that a rewrite of IBP and LTFM needs to describe clinical pathways and demonstrate sustainable services.
317	**Lack of investment in Mental Health services as a member of a challenged health & social care economy:** Impact on service quality and delivery	**1, 2, 5** Quality	1,3,5,6,13,14,15,16, 20,25,26,40, 43,46,47,50, 56,57,58	Chief Executive	4	4	**16**	4	4	**16**	Chief Executive to be a member of proposed joint accountability group responsible for delivery of LHE distressed health economy KPMG report recommendations. Chief Executive member of CELG which is to be redeveloped as North Staffordshire Transformation Board. Trust will be member of newly created integrated IBP group across LHE. Initial Commissioning intentions outline some investment for mental health. KPMG report specifically excluded consideration of mental health services although reduction of back office functions costs and a 1% CIP have been factored into the financial plan for this Trust. Therefore: i) need to ensure NSCHT is represented in all discussions regarding the implementation of the health economy wide plan (ii) ensure that NSCHT develop proposals that support and enable the implementation of the plan and exploit any opportunities that arise (iii) seek an agreement that mental health services are ring fenced(iv) consider developing a communication plan and support of 3rd sector organisations/other stakeholders.
4	**Failure to maintain the confidence of commissioners and deliver outcomes together:** The Trust fails to meet the ongoing expectations of commissioners; Fails to work jointly in an effective manner to deliver agreed outcomes	**2,3** Risk Management	13, 14, 15, 20, 23, 28, 40, 41, 42, 43, 44, 45, 52, 58, 125, 126,	Dir of Operations	4	4	**16**	4	3	**12**	Clinical pathways have been delivered in partnership with local commissioners to jointly determine the direction of travel of this. Director of Operations and Director of Nursing hold regular 1:1 meetings with the lead commissioners for Staffordshire and Stoke Where issues do occur, items are escalated to the Commissioning Board for further discussion and agreement. At NSCHT's request the Commissioning Board's focus has been extended to include CAMHS service in order to be fully inclusive. The Commissioning Board has also been extended to include Stoke on Trent City Council. CIP and longer-term service change plans are shared and agreed with commissioners to help inform clinical pathway work. Clinical pathway outputs delivered to commissioners on time and as agreed. Update 1/10. Commissioners have shared commissioning intentions for 15/6. Work is commencing to work through what these mean in practice to underpin service delivery in 2015/6. Contract negotiation framework established for 15/16 contract to run between Oct 14 and contract signature Jan/Feb 15.

Ref	Strategic Risk	Annual Objectives / Committee	Controls	Lead	Impact	Likelihood	Gross Risk	Impact	Likelihood	Residual Risk Q3	2014/15 Mitigation Plans
322	**Potential reputational risk of unavailability of S136 suite due to closure or inability to provide assessment resulting in admission of people on a 136 into Police Custody Suite**	**2** Risk Management	13, 14, 15, 20, 23, 40, 43, 44, 45, 52, 58,	Dir of Operations	4	4	**16**	4	2	**8**	Director of Operations attendance at Strategic Group with Police (NB as of 22nd October this meeting was out on hold by the Police) 136 Suite only closed with Executive Director Approval LIA group formed to review 136 issues with key clinical and service leads supported by Director of Operations AMH reviewing closer working between IOU and S136 Suite as well as ability to provide assessment on ward to increase variety and availability of S136 provision. Continued work of Community Triage team to support police having a positive impact on reducing S136 attendance Community Triage team supporting S136 in respect of advice and where appropriate attendance on Harplands site Ongoing dialogue with commissioners in respect of adequacy of commissioned service (1 bed to support both Adults and Children)
323	**Potential impact on Older People's Service redesign (Community team ehhancement and ward closure) and consequently ability to deliver benefits of new service and impact on CIP if unable to gain support from Overview and Scrutiny Committees (OSC).**	**2,5** Risk Management	4, 13, 14, 15, 20, 23, 28, 40, 43, 44, 45, 52, 58,	Dir of Operations	4	3	**12**	3	3	**9**	OSC Briefing Paper Produced and distributed to OSCS at Staffordshire, Stoke, Moorlands and Newcastle Additional information request from Regular contact with Scrutiny Officers by Director of Operations OSC Presentation dates booked as follows:- - Stoke 30.10.14 @ 10am including attendance by Chair - Moorlands 5.11 @ 2pm - Newcastle 19.11.14 @ 7pm Additional request for information from Staffordshire OSC responded to.
5	**Potential impact of CIP on quality:** The Trust fails to ensure that arrangements are in place to prevent any reduction in quality of services during the delivery of the CIP.	**4,5** Quality	2, 4, 5, 15, 20, 27, 28, 29, 32, 33, 39, 60, 61, 64, 65, 66, 68, 69, 70, 71, 72, 73, 74, 75, 76, 87, 89, 124,	Med Director/Dir Nursing & Quality	4	3	**12**	4	2	**8**	Top level Board commitment to maintaining Quality is recorded in public minutes and message is disseminated through the organisation via Trust communication (plenary/ team brief etc) Review of clinical change and any negative impact by Clinical Directors/Senior Nurses at least a monthly basis . Review of incidents and specifically to see if there is any correlation with where CIP is being delivered. Consultation and scrutiny of plans (Exec Team). Continue the regular monitoring of any impact on quality as a result of delivering the CIP (SMT). Increased focus on quality & governance at divisional level - i.e. Q&G leads and Q&G infrastructure. Close scrutiny of all plans from a clinical perspective; confirm and challenge meeting held with commissioners - in year post implementation review. All CIP schemes are quality impact assessed by Clinical Directors and signed off by the Medical and Nursing Directors. The Trust Quality committee reviews CIP implementation plans on a quarterly basis to ensure that the implementation of CIP plans is monitored for their impact on quality. A new control mechanism has been introduced to strengthen the assurance requirements which will be piloted during the month of September. A process has now been established to operate a Star Chamber to assess the delivery and impact of identified CIPs. This first is scheduled to take place in November. Divisions have been asked to complete outstanding work on CIPs to enable quality impact assessment to be completed by the Nursing and Medical Directors
287	**Failure to deliver a culture change in staff engagement and other internal / external relationships:** The Trust fails to engage staff and other internal / external partners in the planning and delivery of services; Fails to communicate its plans in a clear and compelling way that builds confidence	**3,4,6** People & Culture	15, 20, 23, 27, 28, 60, 61, 65, 75, 76, 87, 111, 124, 125, 126,	Dir Leadership & Workforce	4	3	**12**	4	2	**8**	People and Culture Development Committee in place to help promote strategic leadership and guidance. Introduction of Aston Team Based Working Programme across the Trust - first 2 cohorts and Execs completed now with all cohorts completing by December 2014 Introduction of Listening into Action and a dedicated lead assigned to drive forward the programme - pulse check and conversations completed - actions and quick wins to be complpublicised w/c 13 October 2014. Regular bulletins and updates for staff on SID and in staff newsletter. Monthly Chair and Chief Executive –led plenary sessions continue to engage with senior managers across the organisation (and all staff by cascade). Monthly Team Brief sessions delivered face-to-face in teams to ensure 2-way dialogue is generated. Now commenced with "Exec Team on the Road" to deliver Team Brief. Updated Staff Friends and Family Test rolled out in Q1 2014/15, taking a structured approach to ensure that all staff (including agency, bank and locum workers) have the opportunity to feed back at least once a year in addition to the National Staff Survey. Regular programme of 'Board to Ward' visits in place to facilitate open discussion and more informal feedback. CDs, Business Managers and Service Line Managers support robust organisational leadership. Staff at all levels are empowered to influence and help deliver the strategic direction of the Trust. Identified as an organisational objective for 2014/15.
280	**Failure to develop effective 5-year strategic plan:** The Trust is unable or lacks ability to develop an effective 5-year strategic plan, impacting on services and on the future form of the Trust; Trust fails to take sufficient advantage of opportunities presented by the current market environment	**5** Risk Management	1, 2, 3, 4, 5, 6, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 43, 56, 57, 58, 63, 88,	Dir of Finance & Dir of Strategy	4	4	**16**	4	3	**12**	The Trust is developing its Strategic Plans with deep involvement of commissioners, particularly our host CCGs. This action will ensure both commitment from commissioners to fund the outcome of Clinical Pathway work and commitment from the Trust to deliver the outcomes aligned to the commissioners' Clinical Strategy. Agreement reached to develop new IBP/LTFM based on current uderstanding of Commissioners' position to demonstrate clincial, operational and financial viability.
FINANCIAL											
288	**Insufficient funding to meet the cost base for service provision arising from the financial impact of CIP, Bucknall site and LD changes:** This could result in insufficient income to maintain service provision and to inform contract negotiations on an ongoing basis, as we progress towards a Payment by Results regime.	**5** Finance & Activity	16, 24, 26, 29, 39, 46, 47, 50, 51, 53, 54, 56, 97, 98, 109, 111, 116, 117, 121,	Dir of Finance	5	4	**20**	5	2	**10**	The Trust has developed a robust CIP regime which involves both an assurance of deliverability and a quality impact assessment to ensure appropriate quality standards are maintained. The Trust is progressing the implementation of PbR in line with national requirements and is working with commissioners to progress this agenda. Significant work has been completed in clustering activity on the patient information system in preparation for the new regime. The PLICS system provides service line information combining financial and non financial information at patient, service line, divisional and Trust level. Details are continually being refined with individual service lines. In advance of tariff being developed for Mental Health, in order to better understand the potential contribution of individual services, the Trust is currently undertaking an exercise to match costs and income by service utilising block contract data. Majority of CIP identified for for 2014/15. Reserves will be used to meet any unexpected shortfall. Work commencing to review 2015/16 schemes.

Ref	Strategic Risk	Annual Objectives / Committee	Controls	Lead	Impact	Likelihood	Gross Risk	Impact	Likelihood	Residual Risk Q3	2014/15 Mitigation Plans
309	**Lack of control, management, monitoring and governance of Non Clinical Service level Agreements due to absence of agreed signed Non Clinical SLAs**	**5** Finance & Activity	2,3,4,5.26,41,45,50,53,56,58,91	Dir of Finance	3	4	**12**	3	2	**6**	Register of Non Clinical SLAs established - completed Establishment of Reporting process to provide relevant high level KPIs to Finance and Activity Committee on a quarterly basis 95% complete as at end of September 2014. All with the exception of Psychology either signed or with reviewing Trust for signature, agreement having been reached. The Trust is aware that SSoTP may potentially give notice on the Estates Agency SLA; this situation will be monitored.
INFORMATION MANAGEMENT & TECHNOLOGY											
10	**Failure to develop and implement fit-for-purpose information systems that provide real-time information for patients and fully support PbR, mobile working and efficiency:** The Trust fails to develop electronic information systems, including the technical skills, which are fit for purpose; Fails to effectively manage information; Fails to develop an electronic patient record (EPR); fails to support clinicians through ensuring there are integrated electronic recording systems.	**4,6** Finance & Activity	19, 109, 111, 112, 114, 116, 117, 118, 119, 121, 122, 123,	Dir of Finance & Dir of Strategy	4	5	**20**	4	4	**16**	A Director of Strategy has been appointed to help drive forward actions to mitigate this risk. The Trust has also held a series of diagnostic meetings between key staff and an external IT consultant to gain a better understanding of the issues facing staff and the potential solutions, including a full-day workshop on 3 July 2014 to agree the next steps. A data quality forum is in place to ensure quality is driven up, for current systems. Training is provided for both clinical and non-clinical staff - including clinical coding, records maintenance, system usage etc. Investment in information Technology is planned and the IM&T strategy includes plans to increase mobile and flexible working and also to identify an electronic patient record solution. In the medium term Investment in IT remains a priority for the use of the Trust's Capital Resource. In the interim a significant amount of work is being undertaken to update CHIPS. This has included rationalising coding and improving reporting. This has enabled release of significant amounts of data to support development of PBR to commissioners and mitigated the risk significantly. In addition a proposal has been written to add a patient notes function to CHIPS, which would then facilitate a functional, if basic, patient record system that can be used to unlock some of the efficiencies possible from mobile working. Discussions about the feasibility and time to implement this are ongoing with HIS. In recent years there has been little investment in IT infrastructure and hardware, largely linked to the former transaction timetable. This will also be reviewed during 2014/15 in the light of ongoing discussions in respect of organisational form. The Trust is also investing in a range of IT support systems e.g. Big Hand (voice dictation), electronic whiteboards etc. HIT Squad programme about to be implemented. Three phase approach. First phase will deliver 300 PCs and 20 Laptops to front line staff.
WORKFORCE											
12	**Failure to comply with safe staffing requirements and establish safe staffing levels in clinical areas:**The Trust fails to review and implement safe and effective levels of clinical staff to meet patient needs in clinical services.	**5,6** Quality People & Culture	1, 17, 34, 35, 36, 39, 55, 97, 101, 102, 103, 128	Dir Nursing & Quality	3	3	**9**	3	2	**6**	The Trust Board is accountable in ensuring that the Trust has sufficient levels of clinical staff in place to provide safe, effective care to all its patients. The Trust has reviewed staffing levels and is implementing an action plan to strengthen arrangements. A Safer Staffing Workgroup has been established to take forward this agenda. Steps taken to assure the Trust board to date are: Ward staffing review of wards 1 -7 at the Harplands hospital, which indicated an under-establishment in some areas. Recruiting to vacancies across the Harplands site, recruiting to the Nursing Bank to ensure availability of resource when needed, reducing bed number on wards which are under occupied, improving HR process to effectively manage sickness absence. A 6-monthly overview paper and the first monthly review paper (M2 data) were presented to June 2014 Trust Board. These have also been uploaded to a dedicated page on the Trust's website with a link to the staffing level data on NHS Choices and staffing levels are clearly displayed at each inpatient site in accordance with national requirements. Monthly report on activity regarding safer staffing submitted to July Trust Board. The Executive Director of Nursing and Deputy Director of Nursing are currently undertaking a 'deep dive' into the original assumptions made on staffing levels at the beginning of the year. This will inform the report scheduled for the Board in November 2014. The data for September shows that staffing levels are being maintained in line with the original establishments agreed with frontline services earlier this year however the use of bank staff is a key enabler to this given that recruitment to substantive posts has been on hold pending organisational change. Bank staff in the main are sourced from existing employees familiar to the services provided.

Ref	Strategic Risk	Annual Objectives / Committee	Controls	Lead	Impact	Likelihood	Gross Risk	Impact	Likelihood	Residual Risk Q3	2014/15 Mitigation Plans
ESCALATED FROM OPERATIONAL RISK REGISTER											
131	**Significant financial impact in 2014/15 as a result of future model of LD services**	**5** Risk Review Group	-	Dir of Finance	5	4	**20**	5	2	**10**	Ongoing TUPE discussions taking place with relevant parties; support team in place to help manage process. Escalated to Trust's Principal Risk Register in view of potential cost impact. Risk has been escalated to the chair of the LD Project Board and raised with the Commissioning Board. HR 'task and finish' group and an Assertive Outreach Support Team have been established to support the care to clients through the Transaction period. Our host commissioners are supporting the Trust in securing other commissioners' 'fair share' contributions towards exit costs. (There is considerable uncertainty over whether other commissioners will pay.) The Trust has enhanced its accounting provision to align with current anticipated redundancy costs.Last client had now been relocated and Chebsy closed and handed back.
130	**Work undertaken in the roof spaces at Harplands may lead to potential disruption in clinical areas and / or harm to patients and staff**	**1, 5** Risk Review Group	-	Dir of Operations	5	3	**15**	5	2	**10**	Standstill agreement in place (to extend warranty period while investigation / resolution of the issues is undertaken). Legal advice sought. Practical steps taken to minimise risk of leaks through maintenance work - plastic sleeves and fluorescent tape to make valves (weak points) more obvious; isolation vale location and bleed valve placements actively highlighted in pre-briefs. Ongoing discussions between Estates, Carillion and PFI partners - Exec led by Dir of Operations. Risk escalated to PRR for wider consideration. Update 1.10.14 Work on Wards 1 and 3 complete. Central Heating piping on Ward 4 still to be completely replaced. Final timescale to be agreed as ward is now at low occupancy and it may be possible to do whilst empty, which would reduce risk further. Inspection work around rest of the site is nearing completion and the Trust awaits a report following this during October 2014
129	**Risk of patients using ligature points in in-patient unit at Harplands resulting in potential harm**. Previous audits had assessed this risk in areas where it was most likely (i.e. bedrooms) and concluded it to be low risk. This has been increased following a recent suicide on Ward 1 where a bedroom door handle was used as an anchorage point.	**1, 5** Risk Review Group	-	Dir of Operations	4	4	**16**	4	3	**12**	Annual risk assessments in respect to ligature points are in place and have been undertaken. External review undertaken week beginning 15th July 2013. Action plan developed and actions expedited following receipt of review. All staff have been made aware that door handles are a potential anchorage point and observation levels for service users at risk will be assessed against this potential. Roll out of values based risk assessment to ward staff. Bedroom, bathroom and en-suite door handles have been replaced on Wards 1,2, and 3. In addition window grills have been fitted to acute patient windows. Environmental Risk task and finish group carried out initial work. Now transferred to Patient safety Group. This has widened the focus to cover clinical other areas of focus, including roof access, security of magnalocks. The patient and organisational safety team identify any patient safety incident trends at the weekly incident review group and any concerning trends should be escalated to Senior Management Team meeting for discussion and action. Additional values-based sessions delivered. Regular reviews of agenda with in Patient Safety Group. Risk Assessment Policy reviewed by Deputy Director of Nursing Sep 2014. Ward based risk assessments being re-run during October 2014. External wider piece of work on future estate requirements commissioned and commences October 2014.
279	**Failure to effectively manage the PFI contract for Harplands Hospital impacts on quality of patient care:** Trust fails to manage the contract effectively, leading to potential safety issues through checks / updates / replacements not being undertaken in a timely manner.	**1, 2, 5** Risk Review Group	-	Dir of Operations	4	4	**16**	4	3	**12**	Audit recommendations for 13/14 implemented. Introduction of Exec Director lead Strategic review meetings. External support in PFI contract Management to be obtained as follows 1. Head of Estates has linked into UHNS to understand processes there via UHNS Director of Facilities 2. PFI review commissioned with a focus on improving understanding of the contract and making recommendations as to how best manage the contract Monthly contract monitoring meetings. Escalated to PRR for further review and monitoring.

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

Overall Risk Rating

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

Top 20 Controls for Principal Risks:

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

North Staffordshire Combined Healthcare NHS
NHS Trust

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

Date of Meeting:	30 October 2014
Title of Report:	KPMG Independent Review of the Trust's Quality Governance Arrangements and Action Plan
Presented by:	Medical Director and Nursing Director
Author of Report: Name: Date: Email:	Sandra Storey Trust Secretary / Head of Corporate and Legal Affairs 20 October 2014 Sandraj.storey@northstaffs.nhs.uk
Purpose / Intent of Report:	• For information and assurance
Executive Summary:	Monitor's *Quality Governance Assurance Framework* was introduced in 2010 in response to the lessons learned from the failings at Mid Staffordshire NHS Foundation Trust and tighter public finances. The Framework has been embedded into the Monitor assessment process for aspirant foundation trusts (FTs) since August 2010 and included in the *Compliance Framework* for existing FTs from April 2011. The Trust uses Monitor's Quality Governance Assurance Framework to assess the robustness of its quality governance arrangements. Given the trust's commitment to the continual improvement of its arrangements external auditors KPMG were asked to undertake an independent assessment. This work, led by the Trust Secretary, considered the Trust's position against the four domains of Strategy, Capabilities & Culture, Processes & Structures and Measurement and ten questions that form Monitor's Quality Governance Framework. The auditors interviewed Executive and Non-Executive Board members and senior staff from corporate and clinical Divisions. In addition, a staff focus group capturing staff views from various services was held and a substantial review of evidence provided by the Trust. As reported to the Trust Board in July 2014, the audit concluded that the Trust meets Monitor's governance requirements with a favourable score of 2.5, which shows a continued improvement from the last independent assessment score of 3.5. A rating of less than 4 is required to progress through the Monitor process. The Trust Development Agency has also praised the Trust for its very strong Quality Governance Assurance Framework, which they referred to as the strongest they had recently seen. The report and action plan has been considered by the Quality Committee at its meeting in September 2014 and is being presented to the Trust Board for information and assurance on the work that is ongoing.

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:	Cuts across all annual objectives
Risk / Legal Implications:	As above
Resource Implications:	N/A
Equality and Diversity Implications:	N/A
Relationship with Assurance Framework [Risk, Control and Assurance]	Informs the Annual Governance Statement
Recommendations:	Receive for information and assurance purposes.

KPMG

cutting through complexity™

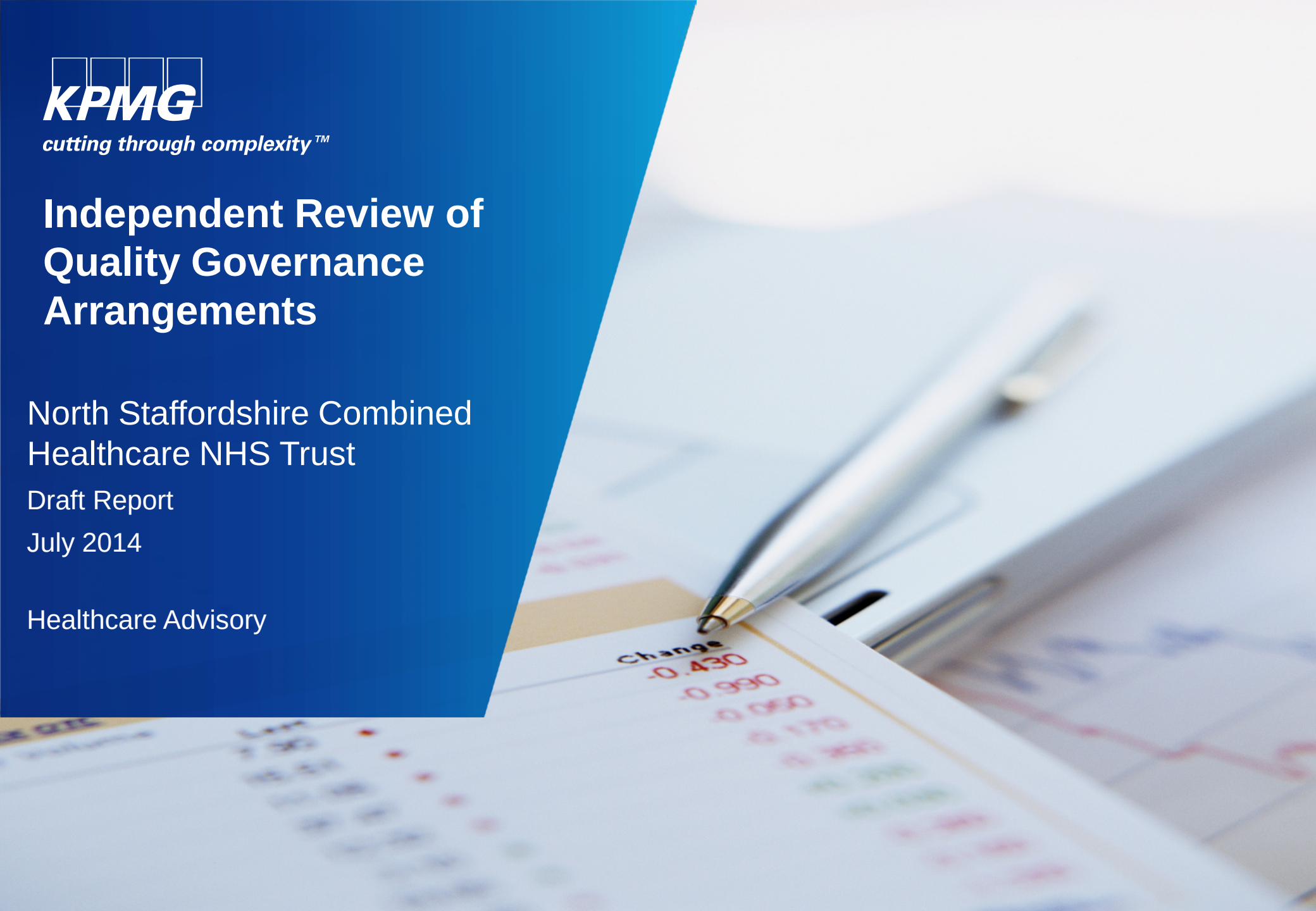
Independent Review of Quality Governance Arrangements

North Staffordshire Combined Healthcare NHS Trust

Draft Report

July 2014

Healthcare Advisory



Contents

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Executive summary

Context

North Staffordshire Combined Healthcare NHS Trust was established in 1994 following the merger of four directly managed units, providing adult and older people mental health, learning disability, and primary care services. The Trust employs 1,600 staff and turnover is approximately £76 million. The Trust is currently undergoing modernisation of its mental health services and have over the last six months been subject to two consultation processes to support proposals around changing the delivery of services and models of care.

The Trust is working collaboratively with its commissioners in order to ensure that local services are delivered for local people. In 2012/13 the Trust made progress with its Foundation Trust (FT) application. However, in November 2012, in the context of the financial challenges facing the local health economy, combined with the size of the Trust, the Trust decided to look at the alternative options available to them, whilst in a position of strength, both financially and clinically.

The Trust concluded that the best option for them was to be acquired by a larger NHS mental health Foundation Trust and were working closely with the NHS Trust Development Authority (NTDA) to progress this. The Trust believed that that being part of a larger Trust would be in the interest of service users and carers, in so much as it provides a stronger voice for mental health and learning disability services across Staffordshire. The Trust were also confident that this option provides a critical mass, bringing opportunity for the long term financial stability that is required to deliver safe, high quality services across North Staffordshire. However in discussions with the TDA and Commissioners, different options are being sought, and the Trust has been given a timescale of 6 months to working on reviewing and developing eight clinical pathways to consider future service integration of mental health, physical health and social care. The Trust are now working hard to undertake this work which will define its future options. Meanwhile services continue to be delivered and the Trust were keen to gain external assurance on its Quality Governance arrangements.

This report has considered the Trust's position against the four domains and ten questions that form Monitor's Quality Governance Framework. We interviewed Executive and Non-Executive Board members and senior staff from the Divisions. We held 1 staff focus group capturing staff views from various services and reviewed evidence provided by the Trust. We also observed the Trust's Quality Committee on 15 April 2014. We have commented on the areas of good practice identified at the Trust, and the areas for improvement. We have included 10 detailed recommendations, informed in part by our experience at other Trusts, on how to improve arrangements to assist compliance with Monitor's Quality Governance Framework. We have also considered the Trust's performance against the recent (April 2013) Monitor document 'Quality Governance: How does a Board know that its organisation is working effectively to improve patient care?'

Summary of findings

The Trust had recently updated their self assessment of performance against Monitor's Quality Governance Framework, although they had not scored the assessment. We used our interviews, focus group and review of evidence to triangulate the self assessment. This report follows the format of the four domains within the framework: Strategy; Capabilities and Culture; Process and Structure; and Measurement. Under these sit 10 key questions for review.

We have assessed and scored the Trust's position using Monitor's scoring methodology as detailed in "Applying for NHS Foundation Trust Status-Guide for Applicants" (July 2010). We have scored each of the 10 questions. Our findings have identified no 'Red 'scores; no 'Amber/Red' scores, 5 'Amber/Green' scores and 5 'Green' scores.

Based on current findings we have calculated the Trust's overall score as being 2.5.

Monitor require Foundation Trusts to self assess against their Quality Governance Framework and maintain performance of a score of 3.5 or less. On the basis of this guidance, and the evidence you have provided to us, your score of 2.5 would mean that currently you are likely to meet Monitor's requirements for Quality Governance.

Executive summary – your results

The table below details KPMG's scores following our review. Following our interviews and review of evidence we have assessed and scored the Trust's position at 2.5

Monitor's Quality Governance Framework question		KPMG score August 2013	NSC self assessment Nov 2013	KPMG score June 2014
1A	Does quality drive the Trust's strategy?	0	0	0
1B	Is the Board sufficiently aware of potential risks to quality?	0.5	0.5	0.5
2A	Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?	0.5	0.5	0.5
2B	Does the Board promote a quality focussed culture throughout the Trust?	0.5	0.5	0
3A	Are there clear roles and accountabilities in relation to Quality Governance?	0	0	0
3B	Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?	0.5	0	0
3C	Does the Board actively engage patients, staff and other stakeholders regarding quality?	0.5	0	0.5
4A	Is appropriate quality information being analysed and challenged?	0.5	0.5	0.5
4B	Is the Board assured of the robustness of the quality information?	0.5	0.5	0.5
4C	Is information used effectively?	0	0.5	0
Total		**3.5**	**3**	**2.5**

Monitor's authorisation criteria are such that a Trust must score 3.5 or less and have no overall domain with all questions rated entirely amber/red. On the basis of this guidance your current score of 2.5 indicates that the governance arrangements for the Trust are at this time likely to meet Monitor's requirements for Quality Governance.

Executive summary

In the table below we have summarised the key findings for each of the 10 questions.

The Trust has developed some good processes to support compliance with the quality governance framework. However, some areas require further strengthening.

Rating	Monitor's Quality Governance Framework
1. STRATEGY	
Green (0)	**1A. Does quality drive the Trust's strategy?** ✓ The Trust has a series of organisation-wide quality priorities, that encompass patient safety, clinical effectiveness and patient experience. ✓ The Trust's performance targets are aligned to its goals and priorities. This assists with monitoring of progress. ✓ The Assurance Framework has been updated to align with the Trust's principal objectives. ✓ The Clinical Strategy sets out the vision, values, strategic goals and enablers that underpin the Trust's commitment to continually drive service improvements, quality, safety and value for money across all clinical functions
Amber / Green (0.5)	**1B. Is the Board sufficiently aware of risks to quality?** ✓ A well developed Performance Management Report is presented at Board. ✓ Board agendas are clearly driven by quality and key risks to the Trust. ✓ A well functioning Quality Committee addresses the key risks to quality and safety and escalated to Board as appropriate. ✓ The Board has increased its visibility around the Trust's services and staff are positive regarding this. ✓ A programme of Board to Ward visits is in place including paired visits for Executive and Non-Executive members of the Board. This includes both unannounced and planned visits. ▪ Outcomes from Board to Ward visits could be better presented at Board, with issues aligned to the CQC's new methodology domains. ▪ There is an embedded process for undertaking quality impact assessments and this is in place for cost improvement initiatives. However metric development to assess risk and effectively monitor schemes during and post implementation requires further work to strengthen the process.

Executive summary

Rating	Monitor's Quality Governance Framework
2. CAPABILITIES AND CULTURE	
Amber / Green (0.5)	**2A. Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?** ✓ There is evidence of robust challenge at Board and sub-committees. ✓ The Board has an ongoing development programme that covers key aspects of Monitor's quality governance framework. This has been useful with the recent changes in membership at the Board. • Board membership has changed significantly in the last 6 months and this has been unsettling. Additional Board Development sessions will be required to develop relationships once all positions, which includes the Chief Executive, have been recruited to.
Green (0)	**2B. Does the Board promote a quality focused culture throughout the Trust?** ✓ The Trust holds REACH Awards ceremony to congratulate individuals and teams for making an outstanding contribution above and beyond their jobs. ✓ The Clinical Strategy sets out the expected quality outcomes for the Trust, and these are monitored through the performance management framework. ✓ The Trust has performed well with attainment of its target appraisal rate and staff report an increased level of satisfaction with this process. ✓ The Trust is introducing Listening Into Action to assist with staff engagement and further develop its aim to extend staff involvement in the quality agenda. ✓ A comprehensive report to summarise the Trust's action and learning from recent national reports eg Francis II; Berwick and Cavendish has been published. This links the national themes to the Trust's values and objectives and enabling strategies.

Executive summary

Rating	Monitor's Quality Governance Framework
3. PROCESS AND STRUCTURE	
Green (0)	**3A. Are there clear roles and accountabilities in relation to quality governance?** ✓ The Trust has an established Quality Committee that plays a key role in overseeing quality issues and providing the Board with assurances. The Committee has a new chair with a clinical background and the performance of this Committee is much improved. ✓ The structure below the Quality Committee has been reviewed and key issues are reported to the Committee. ✓ Governance Leads are in place in Divisions and contribute to the quality and safety agenda. ✓ In September 2013, the Trust Board approved the establishment of a stand-alone Risk Management Committee of the Board. This committee has appropriate membership and is reported to function well.
Green (0)	**3B. Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?** ✓ Staff in our focus group were knowledgeable regarding how to raise concerns and manage risk. This was also evident in our visits to clinical areas. ✓ Senior Management Team meetings are held in which Executive Directors meet with Divisional Clinical Directors and Business Managers to gain assurance, challenge performance against plans and assess risks. ✓ The Trust has developed 'lessons learnt ' bulletins to share learning from serious untoward incidents. ✓ A weekly incident reporting group assesses all incidents. Root cause analysis is undertaken for serious untoward incidents with feedback to staff. ✓ Clinical Risk Management Training has been developed in conjunction with Keele University and is in the process of delivery to applicable staff.
Amber / Green (0.5)	**3C. Does the Board actively engage patients, staff and other key stakeholders on quality?** ✓ Through its external website, the Trust makes its annual Quality Account; the Integrated Quality Report; performance reports; outcomes of consultations and Board minutes available to all stakeholders. ✓ Patient experience is presented via PALS and complaint reports; Board to Ward analysis and a strategy that aims to develop and support patient experience and involvement. ▪ Patient stories are not routinely used to open Board meetings. This is an important vehicle to gain additional assurance on the quality of care provided throughout the Trust's services and should occur at every Board meeting.

Executive summary

Rating	Monitor's Quality Governance Framework
4. MEASUREMENT	
Amber / Green (0.5)	**4A. Is appropriate quality information being analysed and challenged?** ✓ The Performance Management Report is well presented and details targets and trends in performance. ✓ A broad range of performance data is available to the Board. ▪ Information in Divisions for service lines requires improvement in terms of what is available at a more granular level. ▪ Data contained in performance reports is not as up to date as required and this requires attention to enable decisions made at Board and in the Divisions to be based on the most appropriate and up to date information. ▪ IT platforms and infrastructure are not sufficiently mature. The Trust's clinical information systems do not support future requirements of the organisation.
Amber / Green (0.5)	**4B. Is the Board assured of the robustness of the quality information?** ✓ Data quality is reported to have improved over the last 12 months. Executive Directors view and sign off the data prior to it being presented in Board reports. ✓ The Performance Management Report contains a RAG rated assessment of the data quality of each metric presented. This has increased the level of confidence placed on the metrics presented to the Board. ▪ The Trust would benefit from an Information Assurance Framework that sets out details behind indicators that appear in the Integrated Quality Performance Report, including definitions of calculations and sources of data.
Green (0)	**4C. Is quality information used effectively?** ✓ Senior Manager Team meetings are held with the Divisions and use the available data to identify any areas of underperformance, establish plans to mitigate risks, and drive improvement. ✓ Performance reports are well presented and detail quality performance measures. ▪ The Trust actively seeks information in order to benchmark performance to drive service improvements although this could be extended.

Methodology - our approach to assessing quality governance

Our approach to the review of the governance arrangements draws upon the Monitor's Quality Governance Framework and our experience.

The scoring outlined in Monitor's 'Applying for NHS Foundation Status –Guide for Applicants' (July 2010) will be applied.

In line with Monitor's Quality Governance Framework, we will compare the quality governance arrangements at the Trust against good practice examples. For each of the ten components we will provide a RAG rating based on our findings. The criteria fall across four ratings, as used by Monitor (Red, Amber/Red, Amber/Green and Green) as detailed in the table below.

Monitor guidance for clinical governance assessments: Key questions			
Strategy	**Capability and culture**	**Processes and structure**	**Measurement**
1a Does quality drive the Trust's strategy?	2a Does the Board have the necessary leadership and skills and knowledge to ensure delivery of the quality agenda?	3a Are there clear roles and accountabilities in relation to quality governance?	4a Is appropriate quality information being analysed and challenged?
1b Is the Board sufficiently aware of potential risks to quality?	2b Does the Board promote a quality focused culture throughout the Trust ?	3b Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	4b Is the Board assured of the robustness of the quality information?
		3c Does the Board actively engage patients, staff and other key stakeholders on quality?	4c Is quality information being used effectively?

Risk rating	Scoring	Definition	Evidence
Green	0	Meets or exceeds expectations.	Many elements of good practice and there are no major omissions.
Amber/Green	0.5	Partially meets expectations but confident in managements capacity to deliver green performance within a reasonable time frame.	Some elements of good practice, has no major omissions and robust action plans to address perceived short falls with proven track record of delivery.
Amber/Red	1	Partially meets expectations, but with some concerns on capacity to deliver within a reasonable time frame.	Some elements of good practice, has no major omissions. Action plans to address perceived shortfalls are in an early stage of development with limited evidence of track record of delivery.
Red	4	Does not meet expectations.	Major omission in Quality Governance identified. Significant volume of action plans required and concerns about management capacity to deliver.

Detailed Findings: Quality Governance Framework

1. STRATEGY		
The Board should look to identify, on a regular basis, how quality drives the overall Trust strategy. Systematic processes should be in place to create a strategy that the whole Trust can sign up to. Once identified, and implemented, the Board needs to receive assurance that the processes are working. Quality goals should be consistently consulted on and effectively communicated across the Trust and wider stakeholder group.		
1A. Does Quality Drive the Trust Strategy?	**NSC score 0**	**KPMG score 0**

Issue	Trust evidence	KPMG findings and recommendations
Does the Trust's strategy contain quality goals?	The Annual Business Plan sets out the Trust's strategic goals and annual objectives, which focus on high quality person centred models of care, working in partnership and engagement with local communities to ensure the plans reflect the community it serves.	The Trust has six organisation-wide quality objectives that encompass patient safety, clinical effectiveness and patient experience. These link to the five organisational goals. The Trust's performance targets are aligned to its goals and objectives. This assists with monitoring of progress. The Assurance Framework has been updated to align with the Trust's principal objectives. The Framework is a 'live' document, and is reviewed and updated to manage emerging issues. Board members were aware of the key risks.
Are the quality goals widely communicated and understood across the Trust?	Monthly Plenary with top 200 senior staff to shape strategy and progress learning from national inquiries (such as Francis report).	Divisional business plans link the Trust's overall objectives to service priorities. The Clinical Strategy sets out the vision, values, strategic goals and enablers that underpin the Trust's commitment to continually drive service improvements, quality, safety and value for money across all clinical functions. It has been refreshed in light of the Clinical Pathways work currently underway to modernise services in order to take the Trust forward, and links to the Trust's Integrated Business Plan. The progression of this work is crucial to the future of the Trust and design of services and requires monitoring. **Recommendation 1.** The Trust has had to work hard to manage the communications that have been distributed to staff regarding the long term future of the Trust and the work on the Clinical Pathways and the way that this is communicated has assisted in the staff's understanding of the options available. Staff who attended our focus group were articulate around the Trust's strategic goals, objectives and ambitions.
How does the Board monitor these goals?	There is quarterly reporting to the Board on the delivery of the annual objectives.	Quarterly reports are presented to the Board on the delivery of the annual objectives . This enables the Board to take action if any areas are off target or at risk of failure in meeting quality objectives. For 2013/14 the Trust met all of its objectives and were able to evidence this through the monitoring that was presented at Board.

Detailed Findings: Quality Governance Framework

1. STRATEGY

The Board should look to monitor and understand current and future risks to quality and take steps to address these. This should include: maintaining oversight of risks to compliance with essential standards of quality and safety; regular review of risk estimates; and taking further action to pinpoint underlying issues. The risk register should be supported and fed by quality issues captured in Directorate risk registers, and linkages should be clear.

1B. Is the Board Sufficiently Aware of Risks to Quality? NSC score 0.5 KPMG score 0.5

Issue	Trust evidence	KPMG findings and recommendations
Are the Board sufficiently aware of the risk to quality and take appropriate action?	The Trust has a well established Assurance Framework which is independently assessed by external auditors each year to ensure that the Board Assurance Framework remains fit for purpose as a tool for the effective and focussed management of the risks that threaten the delivery of the annual objectives. Trust Risk Register – in September 2013 the Trust Board established a standalone Risk Management Committee supported by a Risk Review Group which has strengthened the management of risk and enables the Board to have time to drill down on the individual risks that threaten achievement of the annual objectives and a forward look and remedial action on emerging risks. Ward visits – Board to ward visits take place on a regular basis which includes a programme of announced and unannounced visits. This enables the Board to 'connect' with the clinical teams. While the Trust has a Risk Management Strategy and Policy in date until 2016, this is reviewed annually to ensure fit for purpose. A recent review looked at escalation processes to ensure that any local or corporate risks are properly escalated and mitigated accordingly Divisional Risk Registers – the Divisions take ownership of their local risk registers and these are discussed on a monthly basis at the Trust's Risk Review Group which reports to the committee's of the Board (for each committee's area of risk) and is managed centrally by the Trust's Risk Management Committee meeting.	A well developed Performance Management Report is presented at Board featuring 121 metrics. 120 of which are all on target. Board agendas are clearly driven by quality and key risks to the Trust. A well functioning Quality Committee addresses the key risks to quality and safety and highlight reports escalate issues to the Board as appropriate. We attended this Committee during the course of this review . It was well led and robust challenge occurred around areas where issues were off target or not sufficiently evidenced enough in the papers. Generally reports were well constructed and the data was up to date. A programme of Board to Ward visits is in place including paired visits for Executive and Non-Executive members of the Board. This includes both unannounced and planned visits. The outcomes of these are reported to the Quality Committee however the reporting could be improved by aligning findings and improvement actions to the CQC's new methodology domains: ▪ Is it safe; ▪ Is it caring; ▪ Is it effective; ▪ Is it responsive; and ▪ Is it well led. This would assist in a more consistent approach across the Trust's services and ensure that staff become familiar with the areas for future CQC formal inspection. **Recommendation 2.** The Board has increased its visibility around the Trust's services. Staff were positive regarding this.

Detailed Findings: Quality Governance Framework

1. STRATEGY		
1B. Is the Board Sufficiently Aware of Risks to Quality? (continued)		
Issue	**Trust evidence**	**KPMG findings and recommendations**
Are CIPs assessed and monitored with regard to their potential impact on quality?	Cost improvement plans (CIPs) and quality impact assessments (QIA's) – in 2012 a quality assurance process was introduced to ensure that the medical and nursing directors and clinical directors quality assure all CIP schemes to satisfy themselves that any proposals do not negatively impact on the quality of services	There is a process for undertaking quality impact assessments and this is in place for cost improvement initiatives. Sign off of QIAs is undertaken by the Medical Director and Director of Nursing. The development of metrics to assess risk and effectively monitor schemes during and post implementation requires further work to strengthen the process. **Recommendation 3.** A STAR chamber approach is used for assessment of cost improvement schemes and the potential impact on quality . Non-Executive Director involvement in this process could add additional challenge and increase levels of Board assurance. **Recommendation 4.**
Are front-line staffs' concerns captured?	Whistleblower policy – the Trust has an established policy supported by Non Executive Directors, to support staff who may wish to raise concerns anonymously. A register is maintained which is independently reviewed by the CQC.	Staff we spoke to in our focus group stated that they were confident if they reported issues to management they are appropriately managed. Staff commented on an open culture throughout the Trust's services they worked in. Awareness of the importance of reporting concerns had been reinforced in sessions that had been held with staff groups post publication of Francis 11. Staff were aware of the whistle blowing policy and how to access and raise concerns through it.

Detailed Findings: Quality Governance Framework

2. CAPABILITIES & CULTURE		
The culture of a Trust and the commitment to quality of all members of staff is a crucial determinant of quality performance. Boards have a key role in fostering this culture through their own focus on quality issues and through bringing the knowledge and skills needed to provide an informed challenge to the Trust. The Board needs to see the full quality picture. Indicators presented to evidence performance need to be comprehensive with any gaps clearly flagged.		
2A. Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?	**NSC score 0.5**	**KPMG score 0.5**
Issue	**Trust evidence**	**KPMG findings and recommendations**
Are appropriate NEDs and Executives in place to lead the delivery of the quality agenda?	The Trust's committee structure is reviewed annually to ensure that there is no unnecessary duplication or gaps in business. A People and Culture Development Committee has recently been established. The Board has a strong clinical professional background including GP Associate members.	Board membership has changed significantly in the last 6 months with an Acting Chief Executive in post; a new Director of Nursing and a new Director of Operations. Non-Executive positions have also changed in the last six months with a further new appointment expected in the Autumn. The Board now has membership with an expanding range of skills and experience. The Board describe themselves as a cohesive group and although significant change has occurred members report it as a good foundation to progress the Trust. Recruitment is underway for the permanent Chief Executive position. The Board has an ongoing development programme that covers key aspects of Monitor's quality governance framework. Once all Board positions have been filled the Board will need to refocus on roles and responsibilities to ensure clarity. Additional Board development sessions should be considered at this time. **Recommendation 5.**
Are Board members aware of the key risks the Trust is facing?	Sub-committee minutes are presented at Board to ensure all members are aware of key issues. The Integrated Quality Report ensures key risks are reported to Board members.	In our interviews Board members were articulate regarding the top risks that the Board is facing. These were consistent views and also feature in discussions at the Board and its sub-committees. Serious incident reports are discussed on a monthly basis by the Trust Board so members are sighted on the incidents occurring and any themes or trends emerging.
Is there rigorous challenge on quality governance issues?	New appointments at Board have increased the level of appropriate challenge.	There is evidence of robust challenge at Board and sub-committees. From out attendance at the Quality Committee we saw robust challenge that was delivered appropriately. Where challenge had occurred this resulted in additional action or information requested to minimise the concerns raised.

Detailed Findings: Quality Governance Framework

2. CAPABILITIES & CULTURE	NSC score 0.5	KPMG score 0

The Board needs to demonstrate an active leadership role on quality. This includes the articulation of an organisational vision and set of values; structured walk rounds by Board members; visible Board leadership of specific quality initiatives; positive feedback to staff; the integration of a range of patient feedback into key performance indicators; the building of quality objectives and impact statements into all business development plans; and taking a structured approach across the organisation to raising awareness of what is required to achieve compliance with essential standards of safety and quality and to embed this with staff.

2B. Does the Board promote a quality-focused culture throughout the Trust?

Issue	Trust evidence	KPMG findings and recommendations
Do the Board take an active leadership role on quality?	The Board lead many activities that contribute to the quality and safety agenda. ▪ Leadership Programme – NED and Executive sponsor for each module ▪ Schedule of visits being embedded using the 15 steps methodology ▪ Compliance visits introduced across all service areas (undertaken by staff in performance team) and outcomes reported. The Trust was assessed by the NHSLA in November 2012 which looks at systems and processes for managing safe and effective services – the Trust achieved its highest score demonstrating that policies and procedures are embedded and owned by staff.	The Clinical Strategy sets out the expected quality outcomes for the Trust, and these are monitored through the performance management framework. There is a broad programme of unannounced visits to services and clinical areas, led by Executive Directors paired with Non-Executive Directors. All Board members participate in this. The Trust can evidence changes made to services as a result of these visits. A comprehensive report to summarise the Trust's action and learning from recent national reports eg Francis II; Berwick and Cavendish has been presented at the Board. This links the national themes to the Trust's values, objectives and enabling strategies.
Does the Board encourage staff empowerment on quality?	Underpinning the Trust's Integrated Business Plan (IBP) are a number of supporting strategies – innovation is one of them. An example of this was the introduction of text messaging to help patients manage their anxieties and reinforce their mental health plans after treatment.	The Trust is introducing Listening Into Action to assist with staff engagement and further develop its aim to extend staff involvement in the quality agenda.
Are staff comfortable with reporting harms and errors?	Staff receive initial training on incident reporting at induction and then via risk management training updates. An organisational safety group is in place that has a focus on incident reporting. Issues from this group are widely communicated .	There is a good incident reporting culture and staff we spoke to in our focus group and on wards we visited were knowledgeable regarding the system used and their responsibilities in this area.
Do internal communications regularly feature articles on quality?	Staff are communicated on quality matters eg seasonal letter to all staff; Team Bulletins; News Round newsletters. Staff area on intranet.	There is a broad range of information available to staff containing items on quality eg News Round; Lessons learnt bulletins; Team Bulletins.

Detailed Findings: Quality Governance Framework

3. PROCESSES & STRUCTURE	NSC score 0	KPMG score 0

Whilst capability and culture will underpin the successful implementation of a quality strategy, structures and processes make sure it happens and is embedded throughout the Trust. Without effective processes and structures that are recognised, understood and owned by Board members and staff, it will be impossible for the Trust to successfully govern for quality.
The responsibilities of different levels of management need to be clearly defined with processes and structures to support this. Quality should receive effective coverage both in Board meetings and in relevant committees/subcommittees below and at Board level. All Board members must recognise that they are accountable individually and severally for all aspects of governance.

3A. Are there clear roles and accountabilities in relation to quality governance?

Issue	Trust evidence	KPMG findings and recommendations
Do Board members understand their accountability for quality?	Board members' job descriptions all have a focus on quality.	Our interviews confirmed Board members are aware of their accountabilities for quality. The Board has reviewed its committee structure. In September 2013, the Trust Board approved the establishment of a stand-alone Risk Management Committee of the Board. This was as a consequence of the Trust's Quality Committee undertaking a review of its effectiveness and agreement of its members that the focus of the committee should be on addressing any risks that impact on the quality of services. The Risk Management Committee has appropriate membership and is reported to function well.
Is a quality focussed sub-committee in place?	A Quality Committee is in place. Terms of Reference have recently been revised. Thos Committee is chaired by a Non-Executive Director with a strong clinical (nursing) background.	The Trust has an established Quality Committee that plays a key role in overseeing quality issues and providing the Board with assurances. The Committee has a new chair with a clinical background and the performance of this Committee is much improved. The structure below the Quality Committee has been reviewed and key issues are reported to the Committee. From our review of papers, appropriate meetings are taking place to provide assurances that quality and safety are being adequately addressed at service level by senior level clinical and managerial staff.
Are there clear lines of accountability in the Divisions?	The Director of Operations holds regular performance reviews with the Divisions. Quality Governance leads are in place in the Divisions and standardised divisional agendas are in place to ensure a common approach and coverage of issues in the meetings.	The Divisional structure is now well embedded. Services sit under 3 Divisions led by Clinical Directors, supported by Business Managers and Nursing/Psychology leads. The service lines plan to decrease in size from eight to five care groups. The Director of Operations holds Senior Management Team meetings every two weeks with open invites to the Executive team. Divisional Management Teams are held to account in these meetings regarding performance of their services. Additional 1-2-1 meetings are also held. Divisions receive performance reports with granular service line data to enable management of their services.

Detailed Findings: Quality Governance Framework

3. PROCESSES & STRUCTURE

The Trust needs to make effective use of the processes already in place to identify opportunities for quality improvement. The Board need to be able to point towards examples of where these processes have resulted in demonstrable improvements. Processes already in place should include clinical audit, risk assessment processes, capture of patient and staff feedback.

3B. Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?	NSC score 0	KPMG score 0

Issue	Trust evidence	KPMG findings and recommendations
Are the Board clear about the processes for escalating quality performance issues?	A Performance and Quality Management Framework is in place. The new Risk Management Committee is established and its effectiveness is monitored as part of the Terms of Reference. The Trust has worked with Divisions to embed Risk Management processes. Recovery Plans are developed and presented to Quality Committee for areas that are underperforming. Timing of complaints reports improved and verified by internal audit opinion.	Staff in our focus group were knowledgeable regarding how to raise concerns and manage risk. This was also evident in our visits to clinical areas. Senior Management Teams are held in which Executive Directors meet with Divisional Clinical Directors and Business Managers to gain assurance, challenge performance against plans and assess risks. A weekly incident reporting group assesses all incidents and these are reported to Quality Committee. Serious incidents are reported quarterly to the Board. Clinical Risk Management Training has been developed in conjunction with Keele University and is in the process of delivery to applicable staff.
Are lessons learnt well from quality performance issues well documented and shared across the Trust?	Root cause analysis is undertaken for serious untoward incidents with feedback to staff. Incident reporting and management has been strengthened, with regular analysis of Serious Incidents and systematic dissemination of lessons learnt.	The Trust has developed 'lessons learnt ' bulletins to share learning from serious untoward incidents. These are well written, very informative and easy to read, drawing out key learning for all staff. Events are also held and open to all staff.
Is clinical audit well utilised?	A prioritised clinical audit plan is in place and signed off by the Clinical Effectiveness Group.	The Clinical Audit programme is well managed and is agreed by Clinical Effectiveness Group. The programme is on target with audits planned for each quarter of the year. The plan incorporates audits to address organisational risk.
Is an effective performance management system in place?	Appraisal and agreement of performance development plans are annual processes and are on track to deliver the target set.	The Trust has performed well with 95% of staff having appraisals and performance development reviews at year end 2013/14, the quality of these reviews is audited. The Trust has worked hard to improve the process linking the Trust's overall objectives to the service delivery areas. The results of the national staff survey report an increased level of satisfaction with this process and the Trust continue to revisit this to continually improve the experience for staff.

Detailed Findings: Quality Governance Framework

3. PROCESSES & STRUCTURE

Good quality governance would allow patients, carers, patient and carer organisations, staff, including governors, local authorities and the wider community to continually input in defining the quality strategy, monitoring outcomes and developing plans for quality improvement. Common mechanisms through which this is completed includes:

- ensuring full involvement of representatives of patients, staff and the wider community in developing and refreshing the quality strategy;
- involving patients, carers and staff in all service and process redesign;
- ensuring that all information on quality and process outcomes are made public without delay and are accessible to patients, staff and the wider community; and
- ensuring that patients and carers know how to give feedback, and are appropriately supported to do so.

3C. Does the Board actively engage patients, staff and other key stakeholders on quality?	NSC score 0	KPMG score 0.5

Issue	Trust evidence	KPMG findings and recommendations
Are patients engaged on quality issues?	There is a systematic framework for capturing patient and carer feedback. Service users' surveys occur each year and monthly discharge questionnaires capture user experience.	Through its external website, the Trust makes its annual Quality Account; the Integrated Quality Report; performance reports; outcomes of consultations and Board minutes available to all stakeholders. Patient experience is presented via PALS and complaint reports; Board to Ward analysis and a strategy that aims to develop and support patient experience and involvement. The Trust acts on outcomes from the complaints, PALs and other information such as patient survey to drive service improvements.
Do patient stories feature at the Board?	Patient story occur at Board as part of a team presentation / spotlight presentation. Patient stories feature at Quality Committee.	Patient stories are not routinely used to open Board meetings and this should be encouraged. This is an important vehicle to gain additional assurance on the quality of care provided throughout the Trust's services. **Recommendation 6.**
Are staff engaged on quality issues?	A Staff Engagement Strategy is in place and there are many communications/forums to engage staff on quality: Team Brief; Plenary sessions; Surveys at team level; Spotlight recognition on an individual and team approach in relation to care for patients; and Striving for excellence programme delivered with quality as key component.	The Trust holds REACH Awards ceremony to congratulate individuals and teams for making an outstanding contribution above and beyond their jobs. The Trust has an action plan from the findings of the annual staff survey, in addition the 'Mini Staff Survey' is a tool devised to ensure that the Trust is able to measure and respond to changes in staff experience/opinion on a more regular and timely basis than by the annual staff survey. The tool provides a 'snap-shot' or 'litmus test' of staff opinion on a monthly basis, based on a random sample of staff. Results are reported to the People and Culture Development Committee.
Are other stakeholders engaged on quality?	'Three steps to engagement' process in agreeing quality priorities in the Quality Account. This includes an on-line questionnaire and involvement with LINKS / OSCs.	The Trust is working well with Commissioners to develop relationships and work on future reconfiguration of services and clinical pathways. This is an area for continued development. **Recommendation 7.**

Detailed Findings: Quality Governance Framework

4. MEASUREMENT

Measurement to support quality improvement should underpin the quality governance approach. Boards should look to ensure they have the capability internally to do the work of analysis, benchmarking, presenting good, clear reports and that the capability they have is serving the functions that are most needed.

The Board requires assurance that the information they receive represents a comprehensive picture. Where information is chosen NOT to be considered, the Board should be aware of the risks associated with this. On a regular basis performance should be tracked against relevant national quality standards, peer organisations and the Trust's own track record.

4A. Is appropriate quality information being analysed and challenged? NSC score 0.5 KPMG score 0.5

Issue	Trust evidence	KPMG findings and recommendations
Are performance reports well constructed and presented at Board and its sub-committees?	Performance dashboards and the Integrated Quality Report have been further developed to meet service requirements. The Quality Committee regularly analyses and challenges information – an example of this is the granular work of the committee in respect to issues relating to waiting times for Referral to Treatment (RTT). Also closely reviewing performance data has made links to staffing levels, issues re access to services, and incidents.	The Performance Management Report is well presented and details targets and trends in performance. Narrative exception reports detail areas off target and actions to mitigate potential risks. A broad range of performance data is available to the Board and this is generally well presented. However data contained in performance reports is not as up to date as required and this requires attention to enable decisions made at Board and in the Divisions to be based on the most appropriate and up to date information. This is due to the immaturity of the IT platforms and infrastructure. The Trust's clinical information systems do not support future requirements of the organisation and this is now being addressed and investment is evident. The Trust require investment in IT to enable the significant changes that are required, external support has been sourced and this work should be progressed as soon as possible. **Recommendation 8.**
Are more granular reports available for sub-committees and Divisions?	Service line performance information is now available and this has enabled more granular data to be available to Divisions, however this requires expansion.	Information in Divisions for service lines requires improvement in terms of what is available at a more granular level. The work that is being undertaken as outlined above will drive this improvement. **Recommendation 9.**

Detailed Findings: Quality Governance Framework

4. MEASUREMENT

The Board should be continually assured with regards to ongoing information, accuracy, validity, timeliness and comprehensiveness. An array of tools can be used to provide this assurance including external good practice in clinical record keeping, audit and coding accuracy tests, analysis of outliers and data quality Indicators.

The quality of data should be understood with that data used to challenge performance on an ongoing and consistent basis.

4B. Is the Board assured of the robustness of the quality information? | **NSC score 0.5** | **KPMG score 0.5**

Issue	Trust evidence	KPMG findings and recommendations
Are controls in place to ensure data quality?	A data Quality Strategy and policy are in place. Data quality checks are undertaken by the Information Team who review and validate metrics, produced through the data warehouse, that are included in performance reports. Leadership has recently been strengthened in the performance team with associated review of performance report Information Governance Group reports to Audit Committee. The Internal audit plan includes reviews on data quality and action plans are in place to address any required areas of improvement.	Data quality is reported to have improved over the last 12 months. Executive Directors view and sign off the data prior to it being presented in Board reports. The Performance Management Report contains a RAG rated assessment of the data quality of each metric presented. This has increased the level of confidence placed on the metrics presented to the Board. The Trust would benefit from an Information Assurance Framework that sets out details behind indicators that appear in the Integrated Quality Performance Report, including definitions of calculations and sources of data. Such a document would increase a common understanding throughout the Trust and drive data completeness and accuracy. This may not be possible to progress within the current limitations of the IT systems but should be considered as soon as the IT platforms/ infrastructure allows. **Recommendation 10.**
Is the clinical audit programme flexible to allow audit of any emerging issues?	A prioritised clinical audit plan is in place and signed off by the Clinical Effectiveness Group.	The Clinical Audit programme is agreed by Clinical Effectiveness Group. The programme is on target with audits planned for each quarter of the year. The plan incorporates audits to address organisational risk. The plan is prioritised by level: ▪ External Mandatory Audits (New national targets / commitments, NCAPOP, Regulation requirements, CQUIN, Commissioner priorities, DoH requirements, NHSLA) ▪ Internal Mandatory Audits (organisational objectives, clinical risk issues, SUI / AI, PPI initiatives, complaints) ▪ Divisional Priorities (clinician interest agreed by Division, national audits not part of NCAPOP, locally adopted clinical standards) ▪ Clinician interest.

Detailed Findings: Quality Governance Framework

4. MEASUREMENT		
Quality information should be used to drive improvement in quality performance. Systematic processes for following up any issues should be in place. The Board needs to ensure that quality measurement is seen as mainstream business throughout the Trust, from Board level to those staff delivering care. The information team need to have the skills to be able to distinguish real issues from data anomalies, and identify innovative practice to support quality improvement.		
4C. Is quality information used effectively?	**NSC score 0.5**	**KPMG score 0**
Issue	**Trust evidence**	**KPMG findings and recommendations**
Is information in reports presented clearly and consistently?	Performance and Quality Management Framework (PQMF) - dashboard report – these are under regular review at Quality Committee to ensure they are fit for purpose. While the reporting is much improved, the committee is keeping this under review. All KPIs are scaled to Divisions in the Divisional dashboard reports. Performance and Information team members attend Divisional team meetings. The People and Culture Development Committee hold monthly meetings and discuss service line workforce metrics and target areas for improvement, and while where performance has improved.	Senior Management team meetings are held with the Divisions and use the available granular data to identify any areas of underperformance, establish plans to mitigate risks, and drive improvement. Performance reports are well presented and detail quality performance measures. The three Divisions use a common reporting approach whilst having some flexibility due to the configuration of services. Performance Team members have assisted in strengthening Divisional reports within the current limitations of the IT systems in place.
Is benchmarking data presented and utilised where appropriate?	Quality Account contains Benchmarking	The Trust actively seeks information in order to benchmark performance to drive service improvements although this could be extended.
Can the Trust demonstrate how reviewing information has resulted in improvements to quality?	The Trust has examples of using information effectively, eg setting up the Access Services based on the outputs from the Rapid Response Service.	The Trust has reviewed information to make significant changes to services, for example the work undertaken on staffing. The pathways work will use available service information to reconfigure and design future services.

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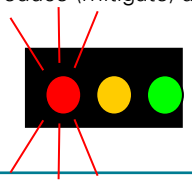
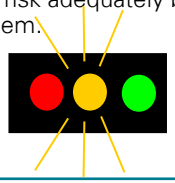
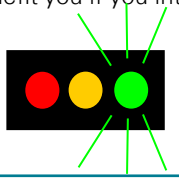
Appendices

1. Recommendations
2. Staff interviewed
3. Documents reviewed

Appendix 1
Recommendations

We have given each of our recommendations a risk rating as explained below and agreed with management what action you will need to take.

Priority rating for recommendations raised		
High risk: issues that are fundamental and material to your system of internal control. We believe that these issues might mean that you do not meet a system objective or reduce (mitigate) a risk. 	***Medium risk***: issues that have an important effect on internal controls but do not need immediate action. You may still meet a system objective in full or in part or reduce (mitigate) a risk adequately but the weakness remains in the system. 	***Low risk***: issues that would, if corrected, improve the internal control in general but are not vital to the overall system. These are generally issues of best practice that we feel would benefit you if you introduced them. 

QGAF domain	No.	Risk	Recommendation	Management response	Officer and due date
1A	1	● (Med)	**Clinical Pathways** The Clinical Strategy has been refreshed in light of the Clinical Pathways work currently underway to modernise services in order to take the Trust forward. The progression of this work is crucial to the future of the Trust and its design of services . This requires monitoring and regular reporting to the Board to ensure delivery is on track and any emerging risks are identified.		
1B	2	● (Med)	**Outcomes of Quality Visits** A programme of Board to Ward visits is in place including paired visits for Executive and Non-Executive members of the Board. The reporting of the outcomes of the visits to the Quality Committee could be improved. The reporting of outcomes should be aligned to the CQC's new methodology domains. This would assist in a more consistent approach across the Trust's services and ensure that staff become familiar with the areas for future CQC formal inspections.		

Appendix 1
Recommendations (continued)

QGAF domain	No.	Risk	Recommendation	Management response	Officer and due date
1B	3	(Med)	**Quality Impact Assessments** There is a process for undertaking quality impact assessments and this is in place for cost improvement initiatives. Sign off of QIAs is undertaken by the Medical Director and Director of Nursing. The process should be strengthened by the development of metrics to assess risk and effectively monitor schemes during and post implementation. This would be a source of additional assurance regarding potential risks to quality.		
1B	4	(Low)	**Presentation of Quality Impact Assessments** A move to a star chamber style approach for the presentation of cost improvement schemes could strengthen the process. Non-Executive Director involvement in this could add additional challenge and increase levels of Board assurance.		
2A	5	(Med)	**Board Development Programme** The Board has an ongoing development programme that covers key aspects of Monitor's quality governance framework. Once all Board positions have been filled the Board will need to refocus on roles and responsibilities to ensure clarity. Additional Board development sessions should be considered at this time.		
3C	6	(Med)	**Patient Stories** Patient stories are not routinely used to open Board meetings and this should be encouraged. This is an important vehicle to gain additional assurance on the quality of care provided throughout the Trust's services.		

Appendix 1
Recommendations (continued)

QGAF domain	No.	Risk	Recommendation	Management response	Officer and due date
3C	7	(Med)	**Commissioner Relationships** The Trust is working well with Commissioners to develop relationships and work on future reconfiguration of services/pathways. This is an area for continued development and the Board should seek additional opportunities to enhance engagement.		
4A	8	(Med)	**Information Systems** The Trust need investment in IT to enable the significant changes that are required to support the improvements required. External support has been sourced and this work should be progressed as soon as possible.		
4A	9	(Med)	**Availability and Use of Information in Divisions and Service Lines.** Information in Divisions for service lines requires improvement in terms of what is available at a more granular level. This will allow greater clarity and focus on areas where service improvements are required. This work should be progressed as soon as possible.		
4B	10	(Low)	**Information Assurance Framework** The Trust would benefit from an Information Assurance Framework that sets out details behind indicators that appear in the Integrated Quality Performance Report, including definitions of calculations and sources of data. Such a document would increase a common understanding throughout the Trust and drive data completeness and accuracy.		

Appendix 2
Staff interviewed

We interviewed the following individuals during the course of this review:

Name	Title
Ken Jarrold CBE	Chairman
Caroline Donovan	Acting Chief Executive
Kieran Lappin	Director of Finance
Andrew Rogers	Director of Operations
Dr Olubukola Adeyemo	Medical Director
Karen Wilson	Director of Nursing and Quality
Paul Draycott	Acting Director of Leadership and Workforce
Patrick Sullivan	Non-Executive Director and Chair of Quality Committee
Tony Gadsby	Non-Executive Director and member of Quality Committee
Sandra Storey,	Trust Secretary & Head of Corporate and Legal Affairs
Kenny Lang	Deputy Director of Nursing and Quality (has since left the Trust)

We conducted a focus group with staff from the Trust's services.

Appendix 3
Documents reviewed

- Trust Board papers
- Trust organisational structure, senior management team, divisional structure
- Board committee Structure
- Board committee Terms of Reference
- Board of Directors / Board Development Calendar 2014 & 2015
- Clinical Strategy
- Risk Management Policy
- Risk Management Strategy
- Risk Management Committee papers
- Risk Review Group papers
- Internal Audit Reports
- Sample Learning Lessons Bulletin
- Sample Newsround
- Annual Governance Statement 2013/14 (draft)
- Assurance Framework report – November 2013
- Whistleblowing procedure
- Annual Plan 2013/14
- Operating Plan 2014 – 2016
- Quality Account 2012/13
- Quality Account Project / Action Plan
- SI Trend Analysis report to Board
- SI report to Quality Committee and Action Plan
- Development of Health Care Support Workers
- Initiatives to reduce staff assaults
- Safeguarding – report to Board on new reporting system
- Report to Trust Board on response to Francis, national inquiries
- Annual Objectives 2013/14 year end statement to the Trust Board March 2014
- Annual Objectives 2014/15 draft to the Trust Board April 2014
- Complaints Annual Report 2012/13 (2013/14 is currently being prepared)
- Patient Experience Report (PALS & Complaints)
- Director of Quality Report
- Six month progress report and action plan – revalidation
- CIP QIA report to Quality Committee March 14.
- Duty of Candour Position
- CQC and Mental Health Act Visits log
- Quarterly review of risks to quality of services
- CQC report to Quality Committee
- CQC reports and action plan
- New CQC inspection approach – report to Quality Committee
- Community Mental Health Survey report and action Plan
- Suicide and self-harm Stakeholder event
- SI learning lessons newsletter
- Integrated Quality
- Safe Staffing Review
- Follow up to Clinical Summit (closed board summary – work on clinical pathways
- Patient experience including Board to Ward analysis report
- Board to team visits 2013/14
- Summary Quality Committee reports to Trust Board
- People and Culture Development Committee reports to Trust Board
- Communication updates
- Sickness action plan
- People and Culture Development Committee meetings
- Staff survey results and action plan
- Equality Monitoring Data Analysis Report
- Staff Involvement Engagement Strategy
- Communication and Membership Strategy
- Widening Participation report to People and Culture Development Committee
- Health check – mini staff survey report
- Infection control annual programme of work 2013/14
- Research and Development annual programme of work
- Information Assurance Framework (IG toolkit) – submission report 2013-14
- CQUIN targets (as per Quality Account) and KPIs as per performance reports (in Trust Board papers)
- Minutes from Senior Management Team Meetings March & April 2014
- Trust and Staff news (briefings to staff)
- Sample of SI alerts

KPMG Recommendations from the July 2014 Independent Review of the Trust's Quality Governance Arrangements

Each of the recommendations have been given a risk rating by KPMG: •High risk •Medium risk •Low risk

The action plan has also been mapped to the Trust's annual objectives.

No	QGAF domain	Recommendation	Risk	Lead	Due date	Link to 2014/14 Annual Objectives	Action / Progress
1	1A	**Does quality drive the Trust's strategy?** *The Clinical Strategy has been refreshed in light of the Clinical Pathways work currently underway to modernise services in order to take the Trust forward.* *The progression of this work is crucial to the future of the Trust and its design of services. This requires monitoring and regular reporting to the Board to ensure delivery is on track and any emerging risks are identified.*	• (Med)	Medical Director & Director of Nursing & Quality	Dec 2014	2	Significant progress on the development of the 8 clinical pathways in partnership with commissioners, stakeholders and service users . Of the clinical pathway work there is close monitoring and regular tracking to the Board to ensure delivery is on track. A dedicated Board development session took place in September 2014 to refresh the Board's approach to providing quality services and review of the top strategic risks to quality. The Trust's Quality Strategy will be generated from this process which will fully inform the work of the Trust. (By Dec 2014) Progress towards achieving an enhanced approach towards delivering the Trust's Quality Strategy is closely monitored and regular reporting to the Board occurs to ensure delivery is on track. (ongoing) Non-executives are key members of the Risk Management Committee (RMC) which ensures that challenge and objective scrutiny of emerging risks takes place. RMC discusses and determines risk treatment plans to ensure

				Director of Strategy & Dev	Nov 2014		any risks are appropriately mitigated. (ongoing) The Clinical Strategy will be refreshed again in light of the clinical pathways.
2	1B	**Is the Board sufficiently aware of potential risks to quality?** *Outcomes of Quality Visits Board to Ward – the reporting of the outcomes could be improved. The reporting of outcomes should be aligned to the CQC's new methodology domains. This would assist in a more consistent approach across the trust's services and ensure that staff become familiar with the areas for future CQC formal inspections.*	• (Med)	Director of Nursing & Quality	Dec 2014	1	The process for collation and analysis of the outputs from Board to Ward visits is under review. Enhanced metrics capturing this detail will feature as part of the Board's reporting mechanisms which will also capture patient experience. The internal inspection processes have been revised to mirror the new domains by the CQC. The outcome of these visits is presented on a Quarterly basis at the Divisional performance meetings (Senior Management Team now Senior Leadership Team) and earlier by exception. Improvements in methodology and outputs will feature in Board reports from Dec 2014.
3	1B	**Is the Board sufficiently aware of potential risks to quality?** *There is a process for undertaking quality impact assessments. Sign off of QIAs is undertaken by the Medical Director and Director of Nursing* *The process could be strengthened by the development of metrics to assess risk and effectively monitor schemes during and post implementation. This would be a source of additional assurance regarding potential risks to quality.*	• (Med)	Medical Director & Director of Nursing & Quality	Complete	1, 5	New business rule related to the delivery of CIP have been introduced. Key Performance Indicators (KPI) have been refreshed which will be monitored at Divisional performance management meetings, then to the formal Star Chamber meetings through to the Executive team and then at the Clinical Quality Review meeting.

4	1B	**Is the Board sufficiently aware of potential risks to quality?** *A move to a star chamber style approach for the presentation of cost improvement schemes could strengthen the process. Non Executive Director involvement in this could add additional challenge and increase levels of Board assurance*	• (Low)	Director of Nursing & Quality	Complete	1, 5	The enhanced CIP business rules include the introduction of a star chamber to assess the impact on quality of any proposed schemes. The star chamber includes non-executive contributions to provide additional assurance to the process.
5	2A	**Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?** Board Development programme – the Board has an ongoing development programme that covers key aspects of Monitor's quality governance framework. Once all Board positions have been filled the Board will need to focus on roles and responsibilities to ensure clarity. Additional Board development programmes should be considered at that time.	• (Med)	CEO	Ongoing	1, 2, 3, 4, 5, 6	Board Development programme planned for monthly sessions until the end of the financial year. Once all Board positions have been filled the board development programme will be updated accordingly.
6	3C	**Does the Board actively engage patients, staff and other stakeholders regarding quality.** *Patient stories are not routinely used to open Board meetings and this should be encouraged. This is an important vehicle to gain assurance on the quality of care provided throughout the Trust's services and should occur at every Board meeting.*	• (Med)	Director of Nursing & Quality	Dec 2014	1, 2, 3	While patient stories form part of the Spotlight presentations to Board, the process by which we gain assurance from patient stories will be reviewed and developed. Additional quality metrics are under development that will further refine and enhance the stakeholder contribution to quality. This will also include a broader range of indicators of people's experiences or perception of Trust services , (e.g. through complaints, surveys, audit and front-line collaborative work)

7	3C	**Does the Board actively engage patients, staff and other stakeholders regarding quality** *The Trust is working well with Commissioners to develop relationships and work on future reconfiguration of services / pathways. This is an area for continued development and the Board should seek additional opportunities to enhance engagement*	● (Med)	All Executive Directors	April 2015	2, 3, 6	The importance of this work is recognised and forms part of the Trust's annual objectives. The Board has committed in its work plan 2014/15 for: ➢ Integrated models of care evidenced by clinical strategy supported by commissioners and service users ➢ An improvement in stakeholder relationships and working, evidenced by stakeholder survey at the end of year ➢ An improvement in culture of staff engagement evidenced by improvements in key staff and survey indicators and improved team survey results.
8	4A	**Is appropriate quality information being analysed and challenged** *Information systems – the Trust needs to invest in IT to enable the significant changes that are required to support the improvements required. External support has been sourced and this work should be progressed as soon as possible.*	● (Med)	Director of Strategy and Dev & Director of Finance	Nov 2014	4	The Trust is committed to use technology as an enabler for high quality service provision evidenced by implementation of a refreshed IT strategy and real-time patient feedback systems. This is on the Trust's strategic risk register and there are detailed mitigations in place The Trust has invested in a new Director of Strategy & Development who will lead the redesign of technology. A digital strategy is currently being developed
9	4A	**Is appropriate quality information being analysed and challenged? Availability and use of information in Divisions and Service Lines** *Information in Divisions for service lines requires improvement in terms of what is available at a more granular level. This will allow greater clarity and focus on areas where service improvements are required. This work should be*	● (Med)	Director of Finance	Nov 2014	1, 4	The new divisional structure will be implemented from 1 October 2014. Directorate information will be available from November 2014.

		progressed as soon as possible					
10	4B	**Is the Board assured of the robustness of the quality information?** *The Trust would benefit from an Information Assurance Framework that sets out details behind indicators that appear in the Integrated Quality Performance report, including definitions of calculations and sources or data.*	● (Low)	Director Finance & Director of Nursing & Quality	Complete	4	The Integrated Quality Report serves as a ¼ performance report for commissioners. As this is a high level summary report, the intention is not to repeat the metrics, or indicators that are presented in other more detailed performance reports. As part of the review of performance information, risk etc, this could consider how this could act as a bridge to the Independent Quality Report. The Board Assurance Framework provides a register of key controls and assurances. In terms of information assurance, the Trust has a Data quality Forum and IG Steering Group. There is also a recently re-established PBR Steering Group,

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO THE TRUST BOARD (OPEN)

Date of Meeting:	30 October 2014
Title of Report:	Financial Performance – Month 6
Presented by:	Steve Blaise, Acting Deputy Director of Finance
Author of Report: Name: Date: Email:	 Andy Turnock 21 October 2014 andrew.turnock@northstaffs.nhs.uk
Purpose / Intent of Report:	Financial Performance monitoring for information
Executive Summary:	The attached report summarises financial performance for the period to the end of September 2014. Headline performance is: • A retained deficit of £0.742m, giving a favourable variance against plan of £0.029m. • A year-end forecast that indicates an achievement of a retained surplus of £0.292m (£0.758m surplus at adjusted financial performance level), representing a favourable variance of £0.024m against Plan • A year to date Continuity of Service Risk Rating of 3, with a year-end forecast rating of 3 • CIP target of £4.08m, with a forecast delivery • Capital expenditure of £0.017m to date and a forecast net capital expenditure of £0.545m • A cash balance of £6.4m at the end of September 2014.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Financial Strategy Not directly as a result of this report
Relationship with Annual Objectives:	Delivery of financial plan
Risk / Legal Implications:	Not directly as a result of this report
Resource Implications:	Not directly as a result of this report

Equality and D iversity Implications:	Not directly as a result of this report
Relationship with Assurance Framework [Risk, Control and Assurance]	Monitoring delivery of the financial plan
Recommendations:	The Board is asked to: • *note that financial performance to date is on plan, with a favourable variance reported of £0.029m* • *note the delivery of CIP is on plan, however this has been supported by the addition of a number of non-recurring schemes* • *note the cash position as at 30 September 2014 of £6.4m* • *note the year to date Continuity of Service Risk Rating of 3 and also the forecast rating of 3* • *note the capital expenditure position as at 30 September 2014 is currently behind plan and the forecast outturn has been revised to £0.545m net capital expenditure.*

FINANCIAL OVERVIEW as at 30 September 2014

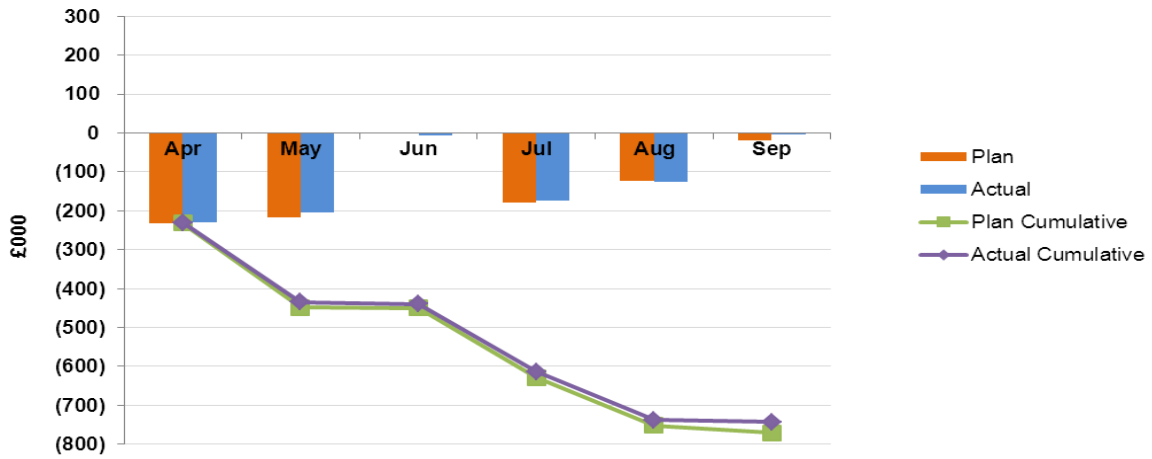
Income & Expenditure - Retained Surplus / (Deficit)

£000	Plan	Actual	Var	%	RAG
YTD Surplus / (Deficit)	(771)	(742)	29	3.8	G
FOT Surplus / (Deficit)	268	292	24	9.0	G

Net Capital Expenditure

£000	Plan	Actual	Var	%	RAG
YTD Exp	(260)	(243)	17	6.5	G
FOT Exp	1,500	545	(955)	(63.7)	R

Retained Surplus / (Deficit) Run Rate 2014/15



Cost Improvement

£m	Plan	Actual	Var	%	RAG
YTD	1.89	1.92	0.0	1.6	G
FOT	4.08	4.08	0.0	0.0	G

Cash Balances

£m	Plan	Actual	Var	%	RAG
YTD Balance	3.2	6.4	3.2	99.9	G
FOT Balance	4.5	4.5	0.0	0.0	G

Continuity of Service Risk Rating

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

Notes

Risks:
Achievement of income targets.
Delivery of the challenging CIP requirement.
Managing cost pressures.

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

1. Financial Position

1.1 Introduction

As detailed in the Operating Plan the Trust was planning to make a retained surplus of £0.268m in 2014/15.

This report details the Trust's performance against the Plan for the period ending 30 September 2014.

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

At the end of Month 6, the Trusts budgeted plan was a retained deficit of £0.771m. The reported retained position is a deficit of £0.742m, giving a favourable variance of £0.029m from plan.

Table 1 below shows this position in the Statement of Comprehensive Income (SOCI) for the Trust. A more detailed SOCI is shown in Appendix A, page 1. Further SOCI's for each division and also for the combined corporate functions are shown in Appendix A, pages 2 to 5.

Table 1: Statement of Comprehensive Income

Detail	Full Year Annual Budget £000	Current Month £000			Year to Date £000		
		Budget	Actual	Variance	Budget	Actual	Variance
Income	75,258	6,220	6,303	83	35,456	35,898	442
Pay	-55,049	-4,605	-4,564	41	-27,519	-26,851	668
Non pay	-16,690	-1,355	-1,476	-121	-7,073	-8,170	-1,097
EBITDA	**3,519**	**261**	**263**	**2**	**864**	**878**	**13**
Other Costs	-2,785	-243	-229	14	-1,404	-1,389	15
Adjusted Financial Performance	**734**	**18**	**34**	**16**	**-540**	**-511**	**29**
IFRIC 12 Expenditure	-466	-38	-38	0	-231	-231	0
Retained Surplus / (Deficit) prior to Impairment	**268**	**-20**	**-4**	**16**	**-771**	**-742**	**29**
Fixed Asset Impairment	0	0	0	0	0	0	0
Retained Surplus / (Deficit)	**268**	**-20**	**-4**	**16**	**-771**	**-742**	**29**

Contained within non-pay are the CIP targets for divisions and directorates. Work remains on-going to transact the majority of these negative budgets to reflect the CIP schemes within the respective divisions and corporately. As at month 6, only schemes with a high degree of complexity or uncertainty have yet to be transacted.

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

Table 2 also shows a reserves forecast budget of £1.7m, against which the Trust is forecasting expenditure of £0.835m. This highlights that the Trusts achievement of the forecast retained surplus of £0.292m is predicated on the support to the operational position from reserves totalling £0.871m.

Table 2: Reserves Held Centrally

Description	Forecast Annual Budget (£)	Committed within FOT (£)
Contingency (0.5% of Turnover per NTDA requirements)	281,000	40,000
Family & Friends	60,000	60,000
Cleanliness in Hospitals	61,808	20,000
Out of Area Treatments	100,000	0
Support from CCG's *	450,000	322,586
CCG developments **	392,200	392,200
Other Earmarked reserves	361,246	0
Total	**1,706,254**	**834,786**

* Support from local CCGs on a non-recurring basis

** Various developments (see below) included in the two main CCG contracts subject to full business cases.

1. Autism Assessment £0.1m
2. Dementia Service £0.15m
3. Healthy Minds £0.14m

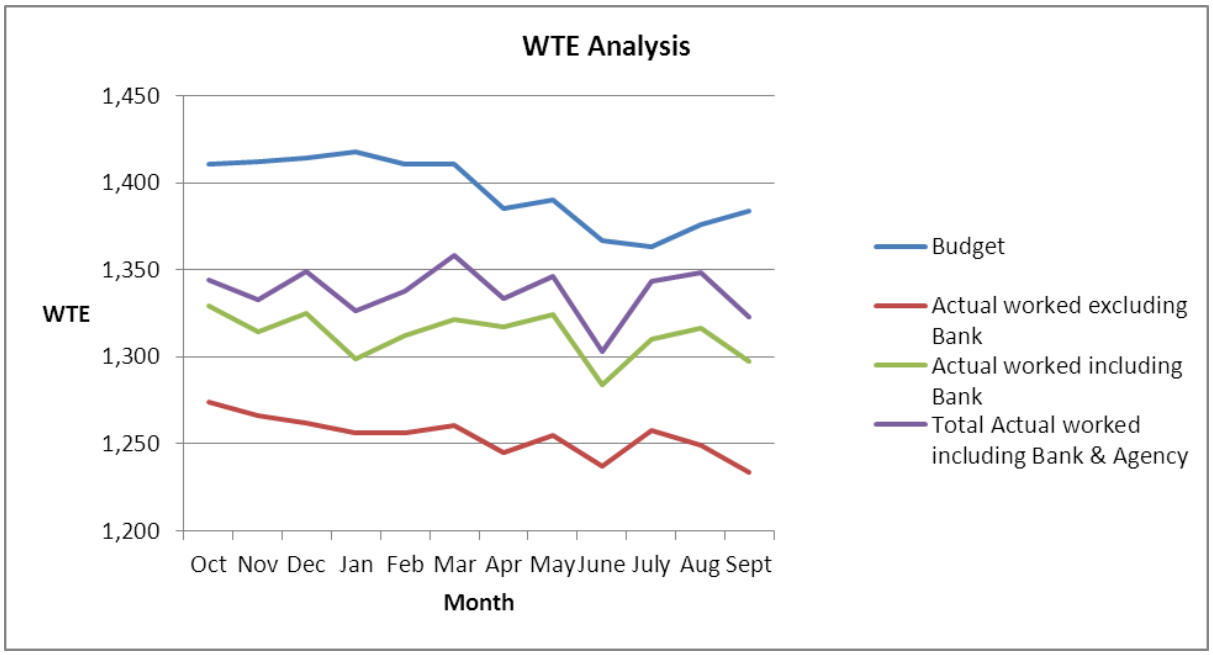
It should be noted that the receipt of the mandate for month six from our host commissioners did not include payment for a number of developments. They are awaiting the business cases to enable the funding to be released.

1.3 Workforce Analysis

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

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

Graph 1: WTE Anaylsis



Graph 2: WTE Anaylsis

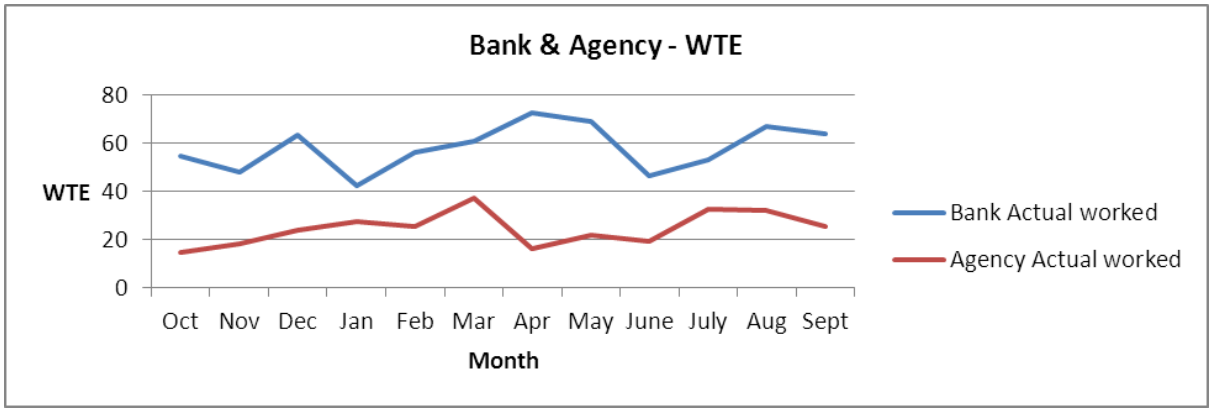


Table 3: WTE Analysis

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept
Bank Actual worked	54.76	48.13	63.33	42.18	56.12	60.74	72.68	69.09	46.28	52.86	66.99	63.72
Actual worked excluding Bank	1274.19	1266.19	1261.92	1256.31	1256.21	1260.30	1244.73	1255.17	1237.35	1257.55	1249.38	1233.55
Actual worked including Bank	**1328.95**	**1314.32**	**1325.25**	**1298.49**	**1312.33**	**1321.04**	**1317.41**	**1324.26**	**1283.63**	**1310.41**	**1316.37**	**1297.27**
Agency	14.89	18.45	23.97	27.62	25.42	37.21	16.21	21.71	19.05	32.68	32.10	25.29
Total Actual worked inc Bank & Agency	**1343.84**	**1332.77**	**1349.22**	**1326.11**	**1337.75**	**1358.25**	**1333.62**	**1345.97**	**1302.68**	**1343.09**	**1348.47**	**1322.56**
Budget	1410.70	1411.78	1413.87	1417.48	1410.78	1410.90	1384.91	1390.09	1367.02	1363.04	1375.82	1383.61

It is noticeable that there was an increase in bank WTE during the period January and May 2014, for which the reasons have previously been communicated. August's bank usage had increased due to vacancies in LDNOAP being held due to the planned ward closure as well as the impact of the delay in the transfer of clients from Chebsey.

1.4 Forecast Year End Performance

Following the finalisation of the month 6 position, a worked up forecast outturn has been undertaken which supports the required retained surplus. T he required retained surplus is now £0.292m (£0.758m at adjusted financial performance level) which is an increase of £0.024m compared to Plan. This revised surplus at adjusted financial performance level represents 1% of the Trusts anticipated turnover. This outturn position is dependent on achieving the cost improvement programme. This forecast position will be shared with the NTDA as part of their financial monitoring regime.

The Trust is forecast to over perform against its clinical and non-clinical income budgets. I n terms of clinical income, this over performance of circa £0.17m is predominately the anticipated Out of Area Treatments (OATs) and Non Contract Activity (NCA). Non-clinical income is forecast to over achieve by circa £0.2m due to an increase in services provided and recharges to other NHS bodies, including property and pay recharges.

1.5 Cost Improvement Programme

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

As at month 6, the Trust is reporting a position of £1.92m CIP delivery against a plan of £1.89m. It should be noted that the year to date performance has been supported by the addition of a number of non-recurring CIP schemes.

2. Summary of Financial Position

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

2.1 Fixed Assets

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

2.2 Cash

As at 30 September 2014, the Trust's cash position was £6.4m which represents an increase during the month of £0.4m. This comprises an increase in debtors of £4.0m and an increase in creditors of £4.4m. A monthly cash flow forecast is shown in Appendix A, page 7.

2.3 Debtors

Trade & Other Receivables balances have increased during the month by £4.0m. This movement relates to an increase in prepayments of £4.4m and other debtors of £0.2m and a decrease in NHS debtors and local authority debtors of £0.1m and £0.5m respectively.

Within the overall value, £6.8m relates to invoiced debt. Invoiced debt is summarised by age in Appendix A, page 8, along with the analysis of the stage of recovery.

2.4 Creditors

There has been an increase in the month of trade payables of £4.4m. This movement is due to an increase in accruals and deferred income of £4.3m, NHS Creditors of £0.3m and local authority creditors of £0.1m, as well as a decrease in other creditors of £0.3m.

2.5 Non-Current Liabilities

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

3. Capital Expenditure and Programme

The Trust's permitted capital spend in 2014/15 is £2.64m; this is the combination of the Trust's £1.5m Capital Resource Limit (CRL) and its planned asset sales of £1.14m. The gross capital expenditure for the year as at 30 September 2014 is £0.017m which represents an under spend against the profiled gross capital expenditure (excluding envisage proceeds from sales) shown in the Plan submitted to the NTDA.

The Trust continues to monitor the delivery of the planned schemes against the CRL and following a recent review the forecast net capital expenditure for the year has been revised to £0.545m (£1.345m expenditure less £0.8m capital receipts). This represents an under shoot of £0.955m against the CRL for the year, which is allowed. This under shoot will be reported to the NTDA as part of their month 6 financial monitoring returns.

Appendix A, page 9 shows the expenditure to date and the forecast outturn.

4. Risk Rating

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

As reported in the Operating Plan, the Trust is planning to achieve a Continuity of Service Risk Rating of 3 by the end of the financial year. As at month 6 this is calculated as 3 compared to the rating of 2 planned at this stage in the year. The forecast outturn rating is also 3, in line with the planned rating previously mentioned. Appendix A, page 10 shows the separate metrics and the outputs in detail.

5. Closure of Chebsey Close

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

Table 4: Chebsey Close Trading Account

Detail	£'000
Income	
Clinical Income	
North Staffs & Stoke-on-Trent CCG	651.4
East Staffs CCG	183.9
Staffs & Surrounds CCG	172.1
Cannock CCG	172.1
Telford & Wrekin	106.9
Total income	1,286.4
Expenditure	
Pay	-992.9
Non-pay	-38.8
Total expenditure	-1,031.7
Net Position Surplus / (Deficit)	**254.7**

6. Recommendations

The Board is asked to:

- ***note that financial performance to date is largely on plan, with a small favourable variance of £0.029m reported***

- ***note the delivery of CIP on a year to date basis is on plan, assisted by the identification of non-recurring schemes***

- ***note the cash position of the Trust as at 30th September 2014 of £6.4m***

- ***note the gross capital expenditure position as at 30th September 2014 is an under spend against plan and there is a forecast undershoot of £0.955m against the CRL for the year of £1.5m***

- ***note the year to date Continuity of Service Risk Rating of 3 and also the forecast rating of 3***

Appendix A – Page: 1

Statement of Comprehensive Income including Forecast Outturn – Trust Wide

	Full Year Budget £000	< < < Current Month > > > Actual £000	Budget £000	Variance £000	< < < Year to Date > > > Actual £000	Budget £000	Variance £000	< < < Forecast Outturn > > > Actual £000	Budget £000	Variance £000
Income:										
Revenue from Patient Care Activities	66,392	5,555	5,462	93	31,516	31,245	271	66,673	66,500	174
Other Operating Revenue	8,867	748	758	-10	4,382	4,211	171	9,070	8,866	204
	75,258	6,303	6,220	83	35,898	35,456	442	75,743	75,366	378
Expenses:										
Pay										
Medical	-6,459	-585	-527	-57	-2,984	-3,216	232	-6,258	-6,439	181
Nursing	-26,291	-2,130	-2,154	23	-12,966	-13,255	290	-25,615	-26,356	741
Other clinical	-12,951	-1,012	-1,128	116	-5,986	-6,386	401	-12,132	-12,970	838
Non-clinical	-9,023	-689	-754	66	-4,181	-4,459	278	-8,559	-9,142	584
Non-NHS	-351	-148	-43	-105	-735	-215	-520	-1,448	-351	-1,097
Cost Improvement	25	0	2	-2	0	12	-12	0	25	-25
	-55,049	-4,564	-4,605	41	-26,851	-27,519	668	-54,012	-55,233	1,221
Non Pay										
Drugs & clinical supplies	-1,909	-175	-161	-14	-909	-903	-7	-1,877	-1,909	33
Establishment costs	-1,947	-76	-160	84	-637	-947	310	-1,446	-1,953	507
Premises costs	-2,247	-252	-186	-66	-1,270	-1,108	-162	-2,648	-2,247	-400
Private Finance Initiative	-3,823	-321	-319	-3	-1,949	-1,911	-37	-3,893	-3,823	-70
Other (including unallocated CIP)	-4,926	-652	-529	-123	-3,405	-2,205	-1,200	-7,493	-4,975	-2,518
Central Funds	-1,839	0	0	0	0	0	0	-835	-1,706	871
	-16,690	-1,476	-1,355	-121	-8,170	-7,073	-1,097	-18,190	-16,613	-1,577
EBITDA *	**3,519**	**263**	**261**	**2**	**878**	**864**	**14**	**3,541**	**3,519**	**22**
Depreciation (excludes IFRIC 12 impact and donated income)	-884	-61	-75	14	-430	-444	14	-884	-884	0
Investment Revenue	11	1	1	0	8	6	2	13	11	2
Other Gains & (Losses)	119	0	0	0	50	50	0	119	119	0
Local Government Pension Scheme	0	0	0	0	0	0	0	0	0	0
Finance Costs	-1,400	-117	-117	0	-700	-700	0	-1,400	-1,400	0
Unwinding of Discounts	0	0	0	0	0	0	0	0	0	0
Dividends Payable on PDC	-631	-53	-53	-1	-316	-316	-1	-631	-631	0
Adjusted Financial Performance - Surplus / (Deficit) for the Financial Year **	**734**	**34**	**18**	**16**	**-511**	**-540**	**29**	**758**	**734**	**24**
IFRIC 12 Expenditure ***	-466	-38	-38	0	-231	-231	0	-466	-466	0
Retained Surplus / (Deficit) for the Year excluding Impairment	**268**	**-4**	**-20**	**16**	**-742**	**-771**	**29**	**292**	**268**	**24**
Fixed Asset Impairment ****	0	0	0	0	0	0	0	0	0	0
Retained Surplus / (Deficit) for the Year	**268**	**-4**	**-20**	**16**	**-742**	**-771**	**29**	**292**	**268**	**24**

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

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

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

Statement of Comprehensive Income including Forecast Outturn – Adult Mental Health

Adult Mental Health	Annual Budget £000	< < < Current Month > > > Actual £000	Budget £000	Variance £000	< < < Year to Date > > > Actual £000	Budget £000	Variance £000	< < < Forecast Outturn > > > Actual £000	Budget £000	Variance £000
Income:										
Revenue from Patient Care Activities	0	0	0	0	0	0	0	0	0	0
Other Operating Revenue	2,312	207	212	-5	1,204	1,185	19	2,344	2,311	33
	2,312	207	212	-5	1,204	1,185	19	2,344	2,311	33
Expenses:										
Pay										
Medical	-2,578	-229	-217	-12	-1,320	-1,279	-41	-2,730	-2,577	-153
Nursing	-13,469	-1,116	-1,098	-18	-6,706	-6,621	-85	-13,507	-13,467	-41
Other clinical	-6,841	-566	-605	40	-3,202	-3,329	127	-6,544	-6,841	297
Non-clinical	-1,432	-128	-117	-11	-763	-724	-39	-1,533	-1,553	20
Non-NHS	-149	-40	-9	-31	-190	-98	-92	-336	-149	-187
Cost improvement	25	0	2	-2	0	12	-12	0	25	-25
	-24,444	-2,078	-2,043	-35	-12,181	-12,039	-142	-24,651	-24,562	-89
Non Pay										
Drugs & clinical supplies	-1,450	-147	-129	-17	-708	-673	-34	-1,489	-1,451	-38
Establishment costs	-885	-48	-78	30	-308	-431	123	-649	-885	236
Premises costs	-566	-56	-50	-6	-324	-287	-37	-618	-567	-51
Private Finance Initiative	0	0	0	0	0	0	0	0	0	0
Other	-1,336	-234	-174	-60	-1,311	-685	-626	-2,364	-1,316	-1,048
Central Funds	0	0	0	0	0	0	0	0	0	0
	-4,237	-484	-431	-53	-2,651	-2,077	-574	-5,120	-4,219	-901
EBITDA *	**-26,369**	**-2,355**	**-2,263**	**-92**	**-13,628**	**-12,931**	**-697**	**-27,426**	**-26,470**	**-956**

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

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

Children's Services	Annual Budget £000	< < < Current Month > > > Actual £000	Budget £000	Variance £000	< < < Year to Date > > > Actual £000	Budget £000	Variance £000	< < < Forecast Outturn > > > Actual £000	Budget £000	Variance £000
Income:										
Revenue from Patient Care Activities	0	0	0	0	0	0	0	0	0	0
Other Operating Revenue	1,341	112	119	-7	667	705	-38	1,335	1,341	-6
	1,341	112	119	-7	667	705	-38	1,335	1,341	-6
Expenses:										
Pay										
Medical	-707	-49	-59	10	-289	-354	65	-583	-707	124
Nursing	-2,272	-180	-189	10	-1,084	-1,136	51	-2,176	-2,272	96
Other clinical	-2,451	-201	-206	5	-1,188	-1,221	32	-2,341	-2,451	110
Non-clinical	-489	-29	-41	12	-197	-241	43	-395	-489	94
Non-NHS	-100	-48	-10	-38	-290	-59	-231	-596	-100	-496
Cost improvement	0	0	0	0	0	0	0	0	0	0
	-6,019	-506	-505	-1	-3,049	-3,010	-39	-6,091	-6,019	-72
Non Pay										
Drugs & clinical supplies	-43	-10	-4	-6	-66	-21	-45	-132	-43	-89
Establishment costs	-213	-13	-19	6	-75	-110	35	-153	-213	60
Premises costs	-298	-23	-26	3	-148	-155	7	-326	-298	-28
Private Finance Initiative	0	0	0	0	0	0	0	0	0	0
Other	261	-10	20	-30	-53	107	-160	-139	261	-400
Central Funds	0	0	0	0	0	0	0	0	0	0
	-293	-55	-28	-27	-342	-180	-162	-750	-293	-457
EBITDA *	**-4,971**	**-449**	**-414**	**-35**	**-2,724**	**-2,486**	**-239**	**-5,506**	**-4,971**	**-535**

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

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

Learning Disabilities, Neuropsychiatry and Older Peoples Psychiatry	Annual Budget £000	< < < Current Month > > > Actual £000	Budget £000	Variance £000	< < < Year to Date > > > Actual £000	Budget £000	Variance £000	< < < Forecast Outturn > > > Actual £000	Budget £000	Variance £000
Income:										
Revenue from Patient Care Activities	0	0	0	0	0	0	0	0	0	0
Other Operating Revenue	383	33	34	-1	218	203	15	412	383	29
	383	33	34	-1	218	203	15	412	383	29
Expenses:										
Pay										
Medical	-1,258	-154	-87	-67	-651	-614	-37	-1,347	-1,258	-89
Nursing	-10,093	-780	-840	60	-4,947	-5,277	330	-9,443	-10,178	735
Other clinical	-2,319	-150	-197	47	-931	-1,124	193	-1,979	-2,319	340
Non-clinical	-799	-56	-62	6	-379	-389	11	-759	-798	39
Non-NHS	-15	-6	-1	-5	-33	-7	-26	-61	-15	-46
Cost improvement	0	0	0	0	0	0	0	0	0	0
	-14,484	-1,145	-1,186	41	-6,941	-7,413	472	-13,589	-14,568	979
Non Pay										
Drugs & clinical supplies	-415	-18	-28	10	-135	-208	72	-255	-415	160
Establishment costs	-383	-23	-22	-1	-147	-191	44	-316	-390	73
Premises costs	-200	-23	-5	-18	-120	-88	-32	-285	-200	-85
Private Finance Initiative	0	0	0	0	0	0	0	0	0	0
Other	614	-9	41	-50	-76	262	-338	-152	614	-766
Central Funds	0	0	0	0	0	0	0	0	0	0
	-384	-73	-14	-59	-478	-224	-254	-1,008	-390	-618
EBITDA *	**-14,485**	**-1,186**	**-1,166**	**-19**	**-7,201**	**-7,433**	**232**	**-14,186**	**-14,575**	**390**

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

Statement of Comprehensive Income including Forecast Outturn – Corporate Directorates

Corporate Directorates	Annual Budget £000	< < < Current Month > > > Actual £000	Budget £000	Variance £000	< < < Year to Date > > > Actual £000	Budget £000	Variance £000	< < < Forecast Outturn > > > Actual £000	Budget £000	Variance £000
Income:										
Revenue from Patient Care Activities	0	0	0	0	0	0	0	0	0	0
Other Operating Revenue	4,831	396	394	2	2,294	2,119	175	4,979	4,831	148
	4,831	396	394	2	2,294	2,119	175	4,979	4,831	148
Expenses:										
Pay										
Medical	-1,916	-153	-165	12	-724	-969	245	-1,598	-1,896	298
Nursing	-457	-55	-27	-28	-229	-222	-7	-489	-440	-50
Other clinical	-1,340	-96	-120	24	-664	-712	48	-1,267	-1,359	92
Non-clinical	-6,302	-476	-535	59	-2,842	-3,105	262	-5,871	-6,302	431
Non-NHS	-88	-54	-24	-31	-222	-50	-172	-456	-88	-368
Cost improvement	0	0	0	0	0	0	0	0	0	0
	-10,102	-834	-870	36	-4,680	-5,057	377	-9,682	-10,085	403
Non Pay										
Drugs & clinical supplies	0	0	0	0	0	0	0	0	0	0
Establishment costs	-466	7	-41	49	-108	-215	107	-328	-466	138
Premises costs	-1,182	-151	-105	-45	-678	-578	-100	-1,419	-1,182	-236
Private Finance Initiative	-3,823	-321	-319	-3	-1,949	-1,911	-37	-3,893	-3,823	-70
Other	-4,465	-399	-416	17	-1,964	-1,889	-76	-4,838	-4,533	-304
Central Funds	-1,839	0	0	0	0	0	0	-835	-1,706	871
	-11,776	-864	-881	18	-4,699	-4,593	-106	-11,312	-11,711	399
EBITDA *	**-17,047**	**-1,302**	**-1,358**	**56**	**-7,085**	**-7,531**	**446**	**-16,014**	**-16,964**	**950**

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

Statement of Financial Position – including forecast

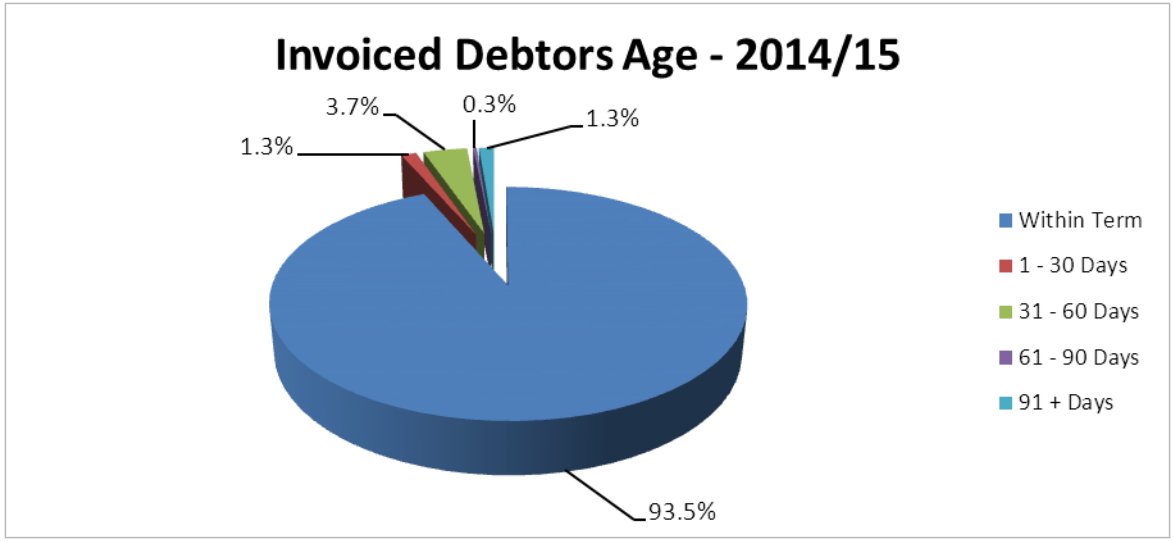
Detail	Period End Date 31/03/2014 £000	31/07/2014 £000	31/08/2014 £000	30/09/2014 £000	FOT 31/03/2015 £000
NON-CURRENT ASSETS:					
Property, Plant and Equipment	33,834	33,409	33,302	33,217	31,282
Intangible Assets	109	94	94	80	129
Trade and Other Receivables	52	52	52	52	52
TOTAL NON-CURRENT ASSETS	33,995	33,555	33,448	33,349	31,463
CURRENT ASSETS:					
Inventories	98	81	88	95	84
Trade and Other Receivables	3,525	5,042	5,083	9,038	3,491
Cash and cash equivalents	5,445	5,729	5,940	6,369	4,528
SUB TOTAL CURRENT ASSETS	9,068	10,852	11,111	15,502	8,103
Non-current assets held for sale	1,148	888	888	888	2,875
TOTAL ASSETS	**44,211**	**45,295**	**45,447**	**49,739**	**42,441**
CURRENT LIABILITIES:					
NHS Trade Payables	-929	-772	-621	-887	-754
Non-NHS Trade Payables	-4,880	-6,991	-7,438	-11,558	-5,443
Borrowings	-360	-360	-360	-360	-351
Provisions for Liabilities and Charges	-2,502	-2,365	-2,376	-2,317	-696
TOTAL CURRENT LIABILITIES	-8,671	-10,488	-10,795	-15,122	-7,244
NET CURRENT ASSETS/(LIABILITIES)	1,545	1,252	1,204	1,268	3,734
TOTAL ASSETS LESS CURRENT LIABILITIES	**35,540**	**34,807**	**34,652**	**34,617**	**35,197**
NON-CURRENT LIABILITIES					
Borrowings	-13,343	-13,223	-13,193	-13,163	-12,993
Trade & Other Payables	0	0	0	0	0
Provisions for Liabilities and Charges	-401	-401	-401	-400	-116
TOTAL NON- CURRENT LIABILITIES	-13,744	-13,624	-13,594	-13,563	-13,109
TOTAL ASSETS EMPLOYED	**21,796**	**21,183**	**21,058**	**21,054**	**22,088**
FINANCED BY TAXPAYERS EQUITY:					
Public Dividend Capital	7,998	7,998	7,998	7,998	7,998
Retained Earnings	150	-463	-588	-592	442
Revaluation Reserve	13,596	13,596	13,596	13,596	13,596
Other reserves	52	52	52	52	52
TOTAL TAXPAYERS EQUITY	**21,796**	**21,183**	**21,058**	**21,054**	**22,088**

Cash-flow Forecast

Statement of Cash Flows (CF)	Actual Apr 14 £000	Actual May 14 £000	Actual Jun 14 £000	Actual Jul 14 £000	Actual Aug 14 £000	Actual Sep 14 £000	Forecast Oct 14 £000	Forecast Nov 14 £000	Forecast Dec 14 £000	Forecast Jan 15 £000	Forecast Feb 15 £000	Forecast Mar 15 £000	2014/2015 Full Year £000
Cash Flows from Operating Activities													
Operating Surplus / (Deficit)	-62	-36	162	-56	44	164	*344*	*312*	*398*	*323*	*346*	*252*	**2,191**
Depreciation and Amortisation	123	123	85	125	107	99	*112*	*112*	*112*	*117*	*117*	*118*	**1,350**
Impairments and Reversals	0	0	0	0	0	0	*0*	*0*	*0*	*0*	*0*	*0*	**0**
Interest Paid	-117	-117	-117	-117	-116	-117	*-117*	*-117*	*-117*	*-117*	*-117*	*-114*	**-1,400**
Dividend Paid	0	0	0	0	0	-294	*0*	*0*	*0*	*0*	*0*	*-337*	**-631**
Inflow / (Outflow) prior to Working Capital	**-56**	**-30**	**130**	**-48**	**35**	**-148**	***339***	***307***	***393***	***323***	***346***	***-81***	**1,510**
(Increase) / Decrease in Inventories	13	-7	0	11	-7	-7	*-4*	*1*	*2*	*-5*	*1*	*16*	**14**
(Increase) / Decrease in Trade and Other Receivables	-754	239	-370	-632	-41	-3,955	*1,154*	*197*	*815*	*515*	*335*	*2,599*	**102**
Increase / (Decrease) in Trade and Other Payables	599	778	-555	924	243	4,627	*-2,905*	*-50*	*-814*	*-883*	*-216*	*-1,310*	**438**
Provisions (Utilised) / Arising	-23	-13	-66	-35	11	-60	*-762*	*-200*	*0*	*0*	*0*	*-943*	**-2,091**
Increase/(Decrease) in Movement in non Cash Provisions	0	0	0	0	0	0	*0*	*0*	*0*	*0*	*0*		**0**
Inflow / (Outflow) from Working Capital	**-165**	**997**	**-991**	**268**	**206**	**605**	***-2,517***	***-52***	***3***	***-373***	***120***	***362***	**-1,537**
Net Cash Inflow / (Outflow) from Operating Activities	**-221**	**967**	**-861**	**220**	**241**	**457**	***-2,178***	***255***	***396***	***-50***	***466***	***281***	**-27**
Cash Flows from Investing Activities													
Interest Received	1	2	1	1	1	2	*1*	*1*	*1*	*1*	*1*	*0*	**13**
(Payments) for Property, Plant and Equipment	-11	0	-5	0	-1	0	*-164*	*-155*	*-140*	*-234*	*-325*	*-310*	**-1,345**
Proceeds of disposal of assets held for sale (PPE)	0	0	0	310	0	0	*220*	*0*	*0*	*270*	*0*	*0*	**800**
Net Cash Inflow / (Outflow) from Investing Activities	**-10**	**2**	**-4**	**311**	**0**	**2**	***57***	***-154***	***-139***	***37***	***-324***	***-310***	**-532**
NET CASH INFLOW / (OUTFLOW) BEFORE FINANCING	**-231**	**969**	**-865**	**531**	**241**	**459**	***-2,121***	***101***	***257***	***-13***	***142***	***-29***	**-559**
Cash Flows from Financing Activities													
Capital Element of Payments in Respect of Finance Leases PFI	-30	-30	-30	-30	-30	-30	*-30*	*-30*	*-30*	*-30*	*-30*	*-28*	**-358**
Net Cash Inflow/(Outflow) from Financing Activities	**-30**	**-30**	**-30**	**-30**	**-30**	**-30**	***-30***	***-30***	***-30***	***-30***	***-30***	***-28***	**-358**
NET INCREASE / (DECREASE) IN CASH AND CASH EQUIVALENTS	**-261**	**939**	**-895**	**501**	**211**	**429**	***-2,151***	***71***	***227***	***-43***	***112***	***-57***	**-917**
Cash and Cash Equivalents (and Bank Overdraft) at YTD	**5,184**	**6,123**	**5,228**	**5,729**	**5,940**	**6,369**	***4,218***	***4,289***	***4,516***	***4,473***	***4,585***	***4,528***	

Aged Debtor Analysis

Analysed as	Within Term £000	1 - 30 Days £000	31 - 60 Days £000	61 - 90 Days £000	91 + £000	Overall Balance £000
NHS	5,498	48	196	7	39	**5,788**
Local Authorities	527	1	34	0	0	**562**
Other Debtors	320	38	22	13	46	**439**
Total	**6,345**	**87**	**252**	**20**	**85**	**6,789**



Analysed by Credit Control Stage	Within Term £000	1 - 30 Days £000	31 - 60 Days £000	61 - 90 Days £000	91 + £000	Overall Balance £000
No formal dispute received - full payment anticipated	6,345	87	196	7	39	**6,674**
Routine credit control processes activated	0	0	56	13	38	**107**
Resolved - Awaiting Credit Note to be issued	0	0	0	0	0	**0**
Escalated to Management / Solicitors	0	0	0	0	8	**8**
Total	**6,345**	**87**	**252**	**20**	**85**	**6,789**

Capital Programme and Expenditure

Site	Detail	2014/15 Original Scheme Value £000	Year to Date £000	Forecast Outturn £000
Schemes Committed				
Developments				
Ward 4 Upgrade		750	0	50
Acquired Brain Injury		150	0	10
Ward Upgrade		400	9	50
AT & T and Telford Unit		250	0	605
Tackling Green Issues		100	0	10
Victoria Surgery & other minor schemes		190	0	50
Total for Service Redesign schemes		**1,840**	**9**	**775**
Maintenance of Infrastructure				
Other	Other	200	8	20
Total for Maintenance of Infrastructure schemes		**200**	**8**	**20**
Other Schemes				
Other equipment purchases - IT	Various	100	0	250
Various	Various	400	0	0
Estate rationalisation - Childrens		0	0	20
Harplands - Ward 4/5		0	0	85
Harplands - Ed Myers	Additional beds	0	0	40
Parking		0	0	10
Harplands feasibility scheme		0	0	15
Electronic Patient Status Display		0	0	80
Total for Other Schemes		**500**	**0**	**500**
Not Yet Committed				
Harplands	Lifecycle	100	0	50
Total Expenditure		**2,640**	**17**	**1,345**
Disposals				
Sale of former Learning Disability properties		-1,140	-260	-800
Net Expenditure		**1,500**	**-243**	**545**

Capital Allocations	£000
Initial CRL (per NTDA Plan submission)	**1,500**
Revisions to Plan:	
None	-
Final CRL	**1,500**
Value of Schemes as at 30/09/14	**545**
Potential (Over) / Undershoot against CRL	**955**

Continuity of Service Risk Rating

Continuity of Services Risk Ratings	Current Month Metrics			Forecast Outturn Metrics		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Liquidity Ratio (days)						
Working Capital Balance	-358	285	643	-90	775	865
Annual Operating Expenses	34,939	35,021	82	69,514	72,202	2,688
Liquidity Ratio Days	-1.84	1.46	3.31	-0.47	3.86	4.33
Liquidity Ratio Metric	3	4	1	3	4	1
Capital Servicing Capacity (times)						
Revenue Available for Debt Service	953	885	-68	3,715	3,554	-161
Annual Debt Service	1,196	1,196	0	2,389	2,389	0
Capital Servicing Capacity (times)	0.8	0.7	-0.1	1.6	1.5	-0.1
Capital Servicing Capacity metric	1	1	0	2	2	0
Continuity of Services Rating for Trust	2	3	1	3	3	1

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:	30 October 2014
Title of Report:	Finance and Performance Committee Report – Committee Meeting 23 October 2014
Presented by:	Tony Gadsby – Committee Chairman
Author of Report: Name: Date: Email:	 Steve Blaise 24 October 2014 Steve.blaise@northstaffs.nhs.uk
Purpose / Intent of Report:	• For Decision ✔ • Performance monitoring ✔ • For Information ✔
Executive Summary:	The attached report provides a s ummary of the Committee meeting held on the 23 October 2014 and provides assurance to the Board over the level of review and challenge provided by the Committee of financial and other reporting as well as forecasting.
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 r eported 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, 30 October 2014

Finance and Performance (F & P) Committee Report to the Trust Board – 23 October 2014

This paper details the issues discussed at the Finance and Performance Committee meeting on 23 October 2014.

The meeting was quorate, approved the minutes from the meeting on t he 18 September 2014 and reviewed the progress and actions taken from previous meetings.

The Committee received the financial update for month 6 (September 2014) 2014/15.

The income and expenditure position to Month 6 was slightly ahead of plan at a deficit of £0.74m against a plan deficit of £0.78m, a favourable variance of £0.03m. The paper also reported that the year-end forecast was in line with the planned position of £0.292m surplus, equating to a £0.758m surplus at adjusted financial performance level.

The Trust's cash balance at the end of August was £6.4m, which is £0.4m higher than the position at the end of August 2014 predominately as a result of a £0.4m increase in the level of Creditors.

As previously reported, the capital programme position remains significantly behind plan. As a previously agreed, the Trust undertook a full review of its capital programme and the likely 2014/15 forecast outturn position. As a result of this review the Trust is now forecasting an under spend of £0.955m in 2014/15 which has been reported to the TDA as part of the Month 6 return.

The Committee noted this revision.

The Trusts Continuity of Service Risk Rating at month 6 was on overall rating of 3. The Trusts liquidity metric remains high (level 4) but the Trusts planned deficit at 30 September, reduces the Capital Servicing Capacity to level 1. This rises by the end of year to level 2 as the Trust moves back into surplus. This maintains the year end forecast overall rating of level 3.

The Committee received the Month 6 Cost Improvement Programme (CIP) 2014/15 report which incorporated elements of the Workforce paper linked to CIP schemes. The paper highlighted the requirement to deliver £4.08m of CIP with plans in place to deliver £4.08m.

The paper also showed a year to date position of £1.92m delivery against the plan of £1.89m although it was noted that a significant element of that year to date delivery was on non-recurring schemes from Corporate and Trust wide areas.

The Committee noted that all schemes had now been subject to a Quality Impact Assessment (QIA).

The report also included details of the CIP schemes that are being developed for the for 2015/16 financial year. It was noted that considerable progress had been made with these schemes and which totalled £3.7m. It was noted that the schemes, and those for the 4 following years, would need to be developed further for inclusion within the Trusts refreshed Business Plan and Long Term Financial Model which are due to be finalised before the end of the calendar year.

The Committee also noted that a revised CIP governance and accountability framework was to be presented to the next Senior Leadership Team (SLT) meeting. It was agreed that this framework would be presented to Committee when finalised and agreed by SLT.

Other Reports and Updates

The Committee received additional reports and verbal updates as follows:

- A report on 2014/15 Clinical Contract issues. The report highlighted the current over performance on the Trusts Child Tier 4 contract and Out of Area Treatments but gave details on the indicative under performance against the Stoke and North Staffs Contract.
- The Committee also received the action notes arising from Trusts Payment by Results Working Group. The Committee is to be presented with the PBR implementation project plan at a future meeting.
- The Committee received the Month 6 Performance Management Report which included performance against TDA metrics and targets, trends and revised RAG ratings. The Committee noted that nearly all the national targets are being met and discussed in some detail the targets currently rated red.
- A report which detailed the draft output from the 2013/14 Reference Cost submission. The Committee noted the draft Reference Cost Index figure is 107 (102 non Market forces Factor adjusted). It noted the decrease of clinical activity in that year and the impact that had on the index figure for the Trust.
- Minutes were received from the Capital Investment Group

- A report was tabled providing details of the Trusts improved Aged Creditor position. It was noted that the revised working arrangements with its Financial Shared Service had delivered a significantly improved position. The Committee requested a further report at a future committee detailing the full 2014/15 position.

- The Committee received a paper showing the current position in respect of the completion of Non Clinical Service Level agreements. It noted the progress made to date with the development of these SLA's and that a number were currently out with the partners for signature. The Committee requested that consideration was given to development of SLA's that covered longer period than 1 year.

- The Committee noted the current position of the Chebsey Close closure including the associated redundancy and mitigation consequences. The Committee requested a paper at a future meeting detailing the full redundancy and mitigation costs when all are available.

- The Committee received a brief update relating the settlement of a provision following legal negotiation and any potential similar cases.

- A report was tabled and discussed updating the Committee on the Trust's current tender activity. In was noted that the majority of potential tenders related to the Substance Misuse Service.

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

Tony Gadsby – Chair of Finance and Performance Committee

23 October 2014

North Staffordshire Combined Healthcare NHS
NHS Trust

Enclosure 10

REPORT TO TRUST BOARD

Date of Meeting:	30th October 2014
Title of Report:	Performance Report – Month 6 2014/15
Presented by:	Interim Director of Finance
Author of Report: Name: Date: Email:	 Kevin Daley, Performance Development Manager 22nd October 2014 Kevin.Daley@northstaffs.nhs.uk
Purpose / Intent of Report:	Performance Monitoring
Executive Summary:	This report provides the Board with a summary of performance to the end of Month 6 (September 2014) Performance against the TDA Accountability framework and key National Targets is included within the report, all indicators are on target. A range of 122 metrics is in place to monitor performance, quality and outcomes. The indicators are those set by our commissioners and local trust targets and aligned to the relevant Trust objectives. There are two areas reported as under-performing (amber) and three reported as significantly under-performing (red) as at end of September 2014. The attached summary by exception expands on the areas that are underperforming and Executive leads will provide a verbal update at the meeting, where appropriate.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Governance Strategy The Performance & Quality management Framework measures performance across National and local indicators, presented against the Trust's enabling strategies, commissioning contract and Monitor's compliance framework.
Relationship with Annual Objectives:	The Performance & Quality Management Framework measures performance across all annual objectives
Risk / Legal Implications:	All areas of underperformance are separately risk assessed and added to the risk register dependent on the outcome of the risk assessments.
Resource Implications:	Not directly as a result of this report
Equality and Diversity Implications:	Not directly as a result of this report
Relationship with Assurance Framework	The Performance & Quality Management Framework is a key control within the Assurance Framework
Recommendations:	The Board are asked to • consider and discuss reported performance with particular

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

1 Introduction to Performance Management Report

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

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

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

2 Executive Summary – Exception Reporting

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

At month 6 there are 51 metrics rated as Green and 2 rated as Amber, 3 rated as Red and 66 Unrated due to the absence of targets which are monitored to identify and respond to trends.

		Month 6			
Strategic Goal	**Key Trust Objective**	**Red**	**Amber**	**Green**	**Unrated**
	TDA	2	2	16	20
Strategic Goals					
SG1 Clinical Effectiveness	KTO 1	0	0	23	31
SG2 Partnership Working	KTO 2	2	1	4	26
SG3 Engagement	KTO 3	0	0	7	3
SG4 Innovation	KTO 4	0	0	0	0
SG5 Efficient Provider	KTO 5	0	0	12	0
	KTO 6	1	1	5	6
	Total	**3**	**2**	**51**	**66**

2.1 TDA Accountability Framework

The TDA accountability framework is included as these are the key performance indicators against which non foundation Trusts' performance is assessed. There are 40 **proposed** key quality indicators applicable to Mental Health Trusts. ***Please Note: Technical guidance has now been issued for most of these metrics.***

3 Exception Reports

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

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

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

Of the 54 metrics all are within accepted limits at month 6 however there are two CQUINs which whilst RAG rated as green at quarter two have risks which may manifest themselves in quarters three and four (see below).

CQUIN 2: GOAL 2: Nationally mandated Physical Health CQUIN: Following Q2 sign off meeting 21/10/14 all Q2 targets have been achieved. There does however remain a significant risk at Q4 as there are considerable stretch

targets of achieving 90% across 10 data items (one data item is currently scoring 0% at the baseline – reporting ICD 10 codes to GPs for secondary mental health diagnoses). The Trust is putting in mitigation plans but there are still significant risks to full achievement at Q4

CQUIN 5: GOAL 5: Listening and Responding to Feedback: Following Q2 sign off meeting on 21/10/14 all Q2 targets have been deferred to Q3 as a mutual decision with our commissioners. This will give the commissioners the opportunity to 'experience' culture shift for the many different measures introduced to demonstrate we listen and respond to feedback. The Trust has received positive feedback on our Q2 submissions to date and it was made clear that a decision to defer was not a negative decision.

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

KTO 2. Integrated models of care evidenced by clinical strategy supported by commissioners, partners and service users. (Medical Director) (SG2)
Of the 33 metrics all except the 3 below are within accepted limits at month 6

KPI	Metric	Exec	Op	Target	M6 Perf	YTD	Forecast Outturn	Trend	Comment
O11.8	Percentage of adults who have received secondary mental health services who were on Care Programme Approach who have had at least one formal review in the last 12 months	Dir of Ops		95%	AMBER **93.8%**	AMBER **93.8%**	GREEN	↘	**94% @ month 6 from 95% @ month 5** Month 6 3048 reviews of 3249 patients = 93.8% Flagged up with teams on a weekly basis as part of the weekly dashboard to teams. Detailed reports sent to Teams to identify which patients require review or where reviews undertaken have not been recorded.
	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users, as defined in Contract Technical Guidance	Dir of Ops	SW	90%	RED **81%**	RED **81%**	GREEN	↗	**81% @ month 6 from 75% @ month 5** Please note that the latest data from HSCIC website is provisional for June 2014 which indicates 81% compliance. The Trust is above the national average (78%) compliance levels at 81% and in the middle cohort of Trusts in terms of data completeness.

									Work ongoing within the teams to ensure that all relevant data fields are populated with valid coding which should show improvement in the reported activity for subsequent months.
PHQ13_05	The proportion of people who have depression and/or anxiety disorders who receive psychological therapies (PHQ16_01 / PHQ16_02	Dir of Nursing	SW	**Target to M6 6.8%**	**RED 1.02%**	**RED 5.1%**	**AMBER**	↗	**1.02% @ month 6 from 0.88% @ month 5** This service is provided in partnership with Changes and Mind Q1 stepped target = 3.3% Q2 stepped target = 3.5% M6 target = 3.5%/3 = 1.17% M6 performance = 1.02% YTD target = 3.3% + 3.5% = 6.8% @ M6 from 5.66% @ M5 YTD performance = 5.1% @ M6 from 4.11% @ M5 Performance query issued by Commissioners Met with Commissioners at Morston House 04/08/14 to review performance against the IAPT metrics and agree an action plan to bring the performance back on track. Nationally mandated waiting times targets for IAPT services to be introduced for 2015/16

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

KTO 3. Improve stakeholder relationships and working, evidenced by stakeholder survey at beginning and end of year. (Chief Executive) (SG3)
Of the 10 metrics all are within accepted limits at month 6

SG4 To be a dynamic organisation driven by innovation

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

SG5 To be one of the most efficient providers

KTO 5. Robust plans delivering quality and sustainable services evidenced by delivery of financial plan and TDA risk rating of maximum 2. (Dir of Operations) (SG5)
Of the 12 metrics all are within accepted limits at month 6

KTO 6. Improve culture of staff engagement evidenced by improvements in key staff survey indicators and improved team survey results. (Dir of Leadership & Workforce) (SG5)
Of the 13 metrics all except the 2 below are within accepted limits at month 6

KPI	Metric	Exec	Op	Target	M6 Perf	YTD	Forecast Outturn	Trend	Comment
O8.6	Percentage of staff compliant with mandatory training appropriate to their role	WF Dir	PD	95%	AMBER **89%**	AMBER **89%**	AMBER	↔	**89% @ month 6 from 89% @ month 5** Month 6 AMH = 88% LDNAOP = 90% CYP = 91% Corporate = 90% Trust is proactively taking action with teams to ensure that all staff attend statutory & mandatory training and maintain their compliance.
O8.5	Annual (Rolling 12 months) appraisal and personal development plan All Staff	WF Dir	PD	90%	RED **27%**	RED **27%**	GREEN	↘	**27% @ month 6 from 24.85% @ month 5** Month 6 AMH = 20.19% LDNAOP = 14.81% CYP = 47.97% Corporate = 51.26% The issue is the cascade process undertaken to ensure that all PDRs reflect the Trust objectives throughout the organisation. Trust is proactively taking action to ensure that performance returns to required levels over the next couple of months.

4 Recommendations
The Trust Board is asked to:

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

Enclosure 11

REPORT TO TRUST BOARD

Date of Meeting:	30 October 2014
Title of Report:	NHS Trust Development Authority (NTDA) Monthly Self Certifications.
Presented by:	Director of Finance
Author of Report: Name: Date: Email:	Glen Sargeant, Head of Performance and Information 21 October 2014 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, with no changes from last month's position of compliance and no exceptions to report. These self-certification declarations form part of the NTDA Oversight and Escalation Process. Based on September 2014 data, the Trust is declaring compliance with all requirements.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Clinical, Finance and Governance. There is no direct impact on patients or the public.
Relationship with Annual Objectives:	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 September 2014 data declaring compliance with all

	requirements. This is to be sent to the NTDA on or before the last working day of October 2014.

Encl. 12

REPORT TO TRUST BOARD

Date of Meeting:	30 October 2014
Title of Report:	Letters to Trust CEO from Quality Surveillance Group – July & August 2014
Presented by:	Caroline Donovan, Chief Executive
Author of Report: Name: Date: Email:	Shropshire & Staffordshire Area Team Quality Surveillance Group – July & August 2014
Purpose / Intent of Report:	Information and assurance
Executive Summary:	NHS England now uses a Surveillance Rating System. Both letters indicate that the Trust is rated as Green – Regular Surveillance – no specific concerns but watching eye on any dips in performance .
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Clinical, Finance and Governance.
Relationship with Annual Objectives:	Delivery of high quality, evidence based services.
Risk / Legal Implications:	None
Resource Implications:	None identified
Equality and Diversity Implications:	None identified
Relationship with Assurance Framework [Risk, Control and Assurance]	None
Recommendations:	The Board is asked to : • Receive for assurance purposes

NHS North Staffordshire
NHS Stoke on Trent
South Staffordshire PCT

Shropshire and Staffordshire Area Team HQ
Anglesey House
Anglesey Court
Towers Plaza
Wheelhouse Road
Rugeley
Staffs.
WS15 1UL

Tel: 011382 54629

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

Letters to CEOs post Quality Surveillance Group

Dear Caroline.

Following the Quality Surveillance Group held on the 24 July 2014. I am writing to inform you of the discussion which took place regarding your organisation.

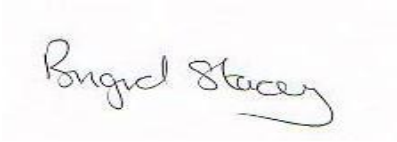
It was noted that there has been an increase in incidents on ward 4. Positive response from the Director of Nursing and the Trust and external review commissioned.

NHS England now uses a Surveillance Rating System and your organisation is rated as Green – Regular Surveillance. The definitions for the ratings are explained at the end of this letter.

Please do not hesitate to contact me if you wish to discuss this further.

With Kind Regards

Yours Sincerely.



Brigid Stacey
Director of Nursing and Quality
Shropshire and Staffordshire Area Team

Cc
Jan Warren, NSCCG
Lee George, NSCCG
Lorraine Cook, SOTCCG
Karen Wilson, NSCHCT

Definitions

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

Amber: Enhanced Surveillance:- Concerns need to be reviewed at every meeting due to existence of recover action plans/ increased visits/ contractual measures.

Red: Risk Summit Required:- Significant concerns beyond the need for enhanced surveillance, which reinstate further action in the form of a risk summit.

NHS North Staffordshire
NHS Stoke on Trent
South Staffordshire PCT

Shropshire and Staffordshire Area Team HQ
Anglesey House
Anglesey Court
Towers Plaza
Wheelhouse Road
Rugeley
Staffs.
WS15 1UL

Tel: 011382 54629

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

Letters to CEOs post Quality Surveillance Group

Dear Caroline.

Following the Quality Surveillance Group held on the 28 August 2014. I am writing to inform you of the discussion which took place regarding your organisation.

- No new concerns reported

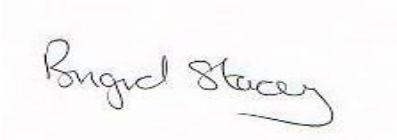
NHS England now uses a Surveillance Rating System and your organisation is rated as

Green – Regular Surveillance. The definitions for the ratings are explained at the end of this letter.

Please do not hesitate to contact me if you wish to discuss this further.

With Kind Regards

Yours Sincerely.



Brigid Stacey
Director of Nursing and Quality
Shropshire and Staffordshire Area Team

Cc
Jan Warren, NSCCG
Lee George, NSCCG
Lorraine Cook, SOTCCG
Karen Wilson, NSCHCT

Definitions

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

Amber: Enhanced Surveillance:- Concerns need to be reviewed at every meeting due to existence of recover action plans/ increased visits/ contractual measures.

Red: Risk Summit Required:- Significant concerns beyond the need for enhanced surveillance, which reinstate further action in the form of a risk summit.

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO THE TRUST BOARD (OPEN)

Date of Meeting:	30 October 2014
Title of Report:	Summary from the Charitable Funds Management and Scrutiny Committee meeting – 17 October 2014
Presented by:	Steve Blaise, Acting Deputy Director of Finance
Author of Report: Name: Date: Email:	 Sandra Storey Trust Secretary / Head of Corporate and Legal Affairs Sandraj.storey@northstaffs.nhs.uk
Purpose / Intent of Report:	For assurance and approval of Terms of Reference
Executive Summary:	The report is a summary of the meeting of the committee that took place on the 17 October 2014. The report highlights key points discussed and agreed outcomes.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	Financial and Governance Strategy
Relationship with Annual Objectives:	Delivery of financial plan
Risk / Legal Implications:	Not directly as a result of this report
Resource Implications:	Not directly as a result of this report
Equality and Diversity Implications:	Not directly as a result of this report
Relationship with Assurance Framework [Risk, Control and Assurance]	Monitoring delivery of the Trust's obligations under the charities act and of our governance and financial arrangements
Recommendations:	The Board is asked to: • *Note the contents of the report* • *Approve the Terms of Reference for a further 12 months*

Key points from the Charitable Funds Management and Scrutiny Committee meeting held on the 17 October 2014 to raise at the Trust Board meeting on the 30 October 2014

1. **Meeting and attendance**

   The meeting was quorate and represented by staff from Staffordshire and Stoke on Trent Partnership Trust (SSOTP) and North Staffordshire Combined Healthcare Trust (NSCHCT).

2. **Review of Audited 2013/14 Charitable Funds Accounts and Annual Report**

   Committee members reviewed these documents and agreed their circulation to the Trust's Audit Committee for approval. Following which they will be presented to NSCHCT's Board prior to submission to the Charities Commission by end of December 2014.

3. **Reserves Policy**

   The trustees have established a reserves policy as part of their plans to provide support to NSCHCT and SSOTP, for patient and staff benefits.

   It is the policy of the charity to maintain unrestricted funds which are the free reserves of the charity, at a level which equates to approximately 18 months management, administration and support costs and to respond to emergency applications for grants, which arise from time to time.

   It was discussed and approved that the reserves required for 2013-14 is £50,000 based on 18 months management, administration and support costs to respond to emergency applications for grants that arise from time to time.

4. **Trustee Arrangements and Trustee Training Requirements**

   Committee members discussed the arrangements in place for the training and support for trustees in respect to their role and responsibilities.

5. **Terms of Reference**

   Committee members discussed the current terms of reference and agreed their adoption for a further 12 months subject to minor changes. It was agreed that dates will be arranged for future meetings and that at the minimum at least 3 meetings will take place each financial year (terms of reference is a minimum of 2). Meetings will be scheduled to coincide with the Trust's Audit Committee and Board meeting dates where appropriate. The committee therefore request that the Trust Board approve the Terms of Reference for a further 12 months.

6. Future plans

Committee members discussed the arrangements for the management of the charity going forward given that the majority of the funds help are attributed to SSOTP. Members agreed to keep this on the agenda for discussion at the next meeting

7. Cycle of Business and Next meeting

Committee members reviewed and approved the cycle of business. The next meeting will take place in March 2015.

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

North Staffordshire Combined Healthcare NHS
NHS Trust

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

Date of Meeting:	30 October 2014
Title of Report:	People and Culture Development Committee Report
Presented by:	Mr Peter O'Hagan Chair of the People and Culture Development Committee
Author of Report: Name: Date: Email:	Sandra Storey, Trust Secretary / Head of Corporate & Legal Affairs 20 October 2014 Sandraj.storey@northstaffs.nhs.uk
Purpose / Intent of Report:	• For Assurance and Approval
Executive Summary:	This report provides a summary of the meetings of the People and Culture Development Committee that took place on 22 September and 20 October 2014. The report highlights key points discussed and agreed outcomes.
Which Strategy Priority does this relate to: How does this impact on patients or the public?	• Workforce Strategy • Governance Strategy • Customer Focus • Clinical
Relationship with Annual Objectives:	Cuts across all objectives
Risk / Legal Implications:	N/A
Resource Implications:	N/A
Equality and Diversity Implications:	None in this report
Relationship with Assurance Framework [Risk, Control and Assurance]	Provides assurance to the Board that the committee is working in according with its Terms of Reference
Recommendations:	• To ratify policies noted in the report • To discuss any items highlighted in the report

Summary to Trust Board of the People and Culture Development Committee meetings held on the 22 September and 20 October 2014

Summary of the Committee meeting held on 22 September 2014 meeting:

1. **Workforce Directorate Performance – July 2014**

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

Members discussed in detail areas such as sickness absence across the services which had increased slightly for the month of July 2014 to 3.8% but was still below the target of 5%. Committee members discussed the importance of the health and wellbeing of staff, the various means of help and support available, and could we be doing more. It was agreed that we needed to further raise awareness of the support available to staff and some of this would take place in response to the 'stress awareness week'. The committee will also hold a development session on organisational stress and work pressure, alongside stress related to personal circumstances, during October 2014.

Statutory and mandatory compliance was noted as improving but required ongoing commitment by teams to ensure this continues. Members agreed to report this back to their various teams and reinforce the need to improve performance in this area.

In respect to completion of individual Personal Development Reviews (PDR) it was noted at the previous meeting that the cascade from the Board down to teams started slightly later this year. Consequently the numbers completed were still lower than usual but were forecast to significantly rise over the coming months.

2. **Aston Team Leaders Update – first quarter**

The committee received a progress update from Mr Draycott on the Aston Team Leaders programme. The Aston Team Development programme is a 5 day programme focussed on developing "real teams" within an organisation. It is interspersed with a process called the team journey, which includes a number of tools and techniques for developing team effectiveness.

The Trust has agreed a CQUIN with the commissioners to report an improvement in 'teamness' score for at least 12 teams taken from a sub sample of 25 teams who are participating in the Aston Team Journey. The Trust is required to report quarterly on these measures.

Delivery of the Aston Team Development Training commenced in April 2014 with the Executive team and will roll out to all 8 cohorts by mid November 2014.

It was noted that some teams are experiencing change which has resulted in some participants no longer occupying team leader positions as the programme progresses and some original participants have moved out of the organisation. This is being addressed and the organisational development team are also providing additional support to staff to help them with aspects of work to complete their team journey. Further progress reports will be presented to the committee.

3. Interim report on the Health Care Support Worker Learning Programme

Mr Draycott provided the committee with an update on progress with this programme. Further national guidance is now available which will have implications for the way in which the programme is delivered in the future. A separate proposal has been commissioned to take these changes into account and a further report will be presented to the committee in November 2014.

4. Retirement and Long Service (20 years or more)

Mrs Smith advised the committee that feedback has been received from retiring employees that the limited choice of gift supplier is unsatisfactory.

It was proposed and agreed that upon provision of a receipt the employee will be reimbursed up to a maximum of £100 for a gift and that they will also receive £100 towards a buffet. To further recognise the achievement of long standing NHS service it was also agreed that eligible employees should be invited to attend the open section of the Trust Board meeting for presentation of a Long Service Certificate. This paper will be discussed further at the September 2014 Trust Board meeting.

5. Safe Staffing Update

Mrs Wilson provided the committee with an update on the work taking place by the Safer Staffing Review Group. The Director of Nursing and Deputy Director of Nursing are planning to meet with all ward managers as part of the review of the staffing establishment, taking account of factors such as acuity and skill mix. It was also noted that there were plans to complete this work with the community teams once an agreed methodology was in place. A six monthly report will be presented to the Trust Board in November 2014.

6. Annual Violence Against Staff – Statistics 2013/14

Mrs Whittaker presented this report which summarised statistical and trend detail for patient assaults against staff for the period April 2013 to March 2014. It was noted that this is an interim report because the national figures have not yet been published (due November 2014).

The 2013-14 annual staff assault figures demonstrate a major reduction in comparison to those submitted in 2012-13. The total number of assaults reported in 2013-14 was 390 compared to a total of 1046 in 2012-13. This represents a fall of almost 63% which team believe accounts for the focus on training, education and support for staff in dealing such situations.

Following publication of the national figures a further report will be provided to examine how the Trust compares to the national figures.

7. Potential Industrial Action

The Committee noted the potential industrial action that is imminent and plans in place to respond to this.

8. Management of Change – Update

Mr Draycott provided an update on the change from service lines to Directorates and how this is progressing. There will be six new clinical director positions and the interviews are taking place over the next few weeks.

Mrs Smith also updated the committee on developments regarding Chebsey Close in respect to the placement of patients and the redeployment of staff where it was appropriate to do so.

9. Dragons Den update

Mrs Roberts informed the committee that the closing date for applications was the 30 September 2014 and so far 4 very credible applications had been received. A more detailed report will be brought to the next meeting of the committee**.**

10. Staff Engagement update

This report provided a mid-year progress report on the Trust's Staff Involvement & Engagement Strategy, through the lens of ***Strand 3 - Listening and Responding to Staff***.

Specifically, the report reviewed developments in relation to the following:-

1. Listening into Action (LiA): Big Conversations
2. Annual NHS Staff Survey
3. Staff Friends and Family Test (SFFT)

It was agreed that given the importance of this piece of work, the Trust Board would receive this paper in full at its meeting in September 2014.

11. Annual General Meeting

Mrs Roberts provided the committee with a progress paper on the actions taken to prepare for the Trust's Annual General Meeting. The engagement of the service lines was noted and the event will be available to staff on YouTube after the event. The filming had been carried out by an external company and they had produced a really good set of videos.

12. Workforce and OD Risks

The committee received the workforce and OD risks for Month 5 and discussed the source of each risk, its risk rating and progress on action plans to mitigate those risks. Members discussed the level of sickness absence that had slightly increased this month and agreed to discuss this further as a development topic at the next meeting. Members of the committee will also consider any other risks that need to be added to the risk register and will bring this back to the committee as well as reporting these to the Trust's Risk Review Group.

Summary of the Committee Meeting held on the 20 October 2014:

13. Policy Update

The committee discussed and approved the following draft policies for ratification by the Trust Board:

• Harassment & Bullying at Work
• Maternity Suited Policy

It was agreed that the 'Raising Concerns Procedure', formerly Whistleblowing Policy and Flexible Working Policy would be discussed at the Senior Leadership Team Meeting first prior to approval and rollout.

14. Workforce - Directorate Performance

The committee received presentations from each of the Directorate leads on their performance against key workforce indicators. It was noted that there was a time lag with some of the information being reported and that every effort was being made to ensure that reports would be much more up to date to aid better understanding and discussion of Directorate performance.

15. Dragon's Den Shortlisting

The committee received the following applications:

- A Christmas Cracker
- Service User Input to Recruitment & Selection
- Added Value and Best Skills Matches for Generic Work
- Gatekeeping Streamlining
- Extending E-Rostering
- Ways to a Wellbeing Garden

The committee agreed that all applications would be shortlisted apart from E-Rostering as this was already a workstream within the Trust and the Chairman thanked those staff for taking the time and effort in putting forward their thoughts and ideas.

16. Committee Development

The main focus of the People and Cultural Development Committee meeting was for members to have time out to consider the Trust's approach to stress in the workplace and the wellbeing of its staff.

Mrs Faux and Mr Hook from Team Prevent provided the committee with a presentation. Members were asked to consider key point to help move the agenda forward.

NHS Employers Podcasts:

- ***'Sooner rather than later'*** – talks about the importance of talking to your manager and how individuals can stay mentally healthy at work, plus support for staff who have experienced a period of sickness related to mental health

- **'*The human approach'*** – is aimed at managers in the NHS and encourages them to approach mental health conversations as a human rather than a clinician.

Committee members also discussed the importance of stress management for managers, including:

- Working closely with your team and being well positioned to identify stress in others at an early stage.
- Being responsible for the uptake and roll-out of risks assessments for work stress within the team / department
- Being mindful of own management style.

The committee received data from a number of sources pointing to stress and work pressure:

- Annual NHS Staff Survey results
- Staff Friends and Family Test 2014
- Listening into Action 2014
- Trust Sickness Absence Data

Members discussed what we are doing now and agreed that while there are a number of processes and procedures in place to support staff, we can always do more. Ideas such as staff champions and making stress training mandatory were proposed. The session concluded with agreement that it had been timely and relevant to use the development part of the meeting to discuss this importance work. It was agreed that information would be collated into an action plan for presentation to the next meeting of the committee in November 2014.

17. Next meeting: 17 November 2014

On behalf of the Committee Chair, Mr Peter O'Hagan

Sandra Storey
Trust Secretary / Head of Corporate and Legal Affairs
22 October 2014

Enclosure 15

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: Trust Board

Date of Meeting:	Exec's 21st October 2014 & Board Meeting 30th October 2014
Title of Report:	Improving Staff Engagement – Listening into Action update
Presented by:	Mr Paul Draycott
Author of Report: Name: Date: Email:	 Josey Povey/Nicky Griffiths 10th October 2014 JosephineE.Povey@northstaffs.nhs.uk
Purpose / Intent of Report:	To provide a briefing to the Board on the progress of "Listening into Action"
Summary of Report:	The report provides feedback on the progress to date and outlines the next steps for implementation.
Which Care Quality Commission domain does this relate to:	• Effective • Caring • Responsive to people's needs • Well led
Which Annual Objective does this relate to:	• Improve culture of staff engagement
Risk / Legal Implications:	• None anticipated
Resource Implications:	• Continued support to deliver on the themes • Capacity and time of sponsor leads and workforce to contribute to pioneering teams
Recommendations:	The Board are asked to • Note the progress to date for assurance • Continue to endorse and model the LiA approach as one of its approaches to transformational and cultural change.

Improving Staff Engagement – Listening into Action update

1 Purpose

To provide a briefing to the Board on the progress of "Listening into Action" (LiA).

2 Introduction

Staff engagement has been identified by the Board as one of the six strategic objectives for 2014/15. It was agreed at the June 2014 Board that one way of improving engagement and empowerment was through the introduction of Listening into Action.

Listening into Action is a well evidenced approach to engagement that the Trust has been undertaking since agreement from the Board in June. The following diagram outlines the general approach.

We are currently entering the third phase of this approach "Empowering our teams to drive change" and this document provides an update on progress and future plans.

3 Progress to date

We have appointed 2 people (as a job share), Josey Povey and Nicky Griffiths as LiA leads. Led by the Chief Executive and supported by the LiA Sponsor Group (individuals selected for their enthusiasm and desire to change the way we do things) we have held five 'Big Staff Conversations' between 15th September 2014 - 23rd September 2014. All staff were invited to these events and positively encouraged to attend by a personal invitation form Caroline Donovan.

We undertook a Pulse Survey across the Trust to seek views of staff as to where we are currently as a Trust in respect of engagement. These results were fed back to staff at the Big Conversations.

A total of 325 people attended the big conversations (23% of workforce) with a good cross section of staff from front line, admin-support and clinical staff. Multiple techniques were used to engage staff in order to make the opportunity exciting and to create a sense of anticipation. We used personally addressed emails, payslips, posters, networking events and team brief to help publicise and encourage attendance.

Staff were asked to feedback on:

- "What day-day frustrations get in the way of us delivering the very best service/care for our patients and their families?"
- "What do we need to stop/fix tomorrow that adds no value for our patients and adds to our workload?"
- "What changes do we need to make in a multi-disciplinary team way – beyond these immediate fixes – to improve quality of care and the way we work?"

Some staff reported challenges in attending daytime events, and subsequently we planned a 6th conversation at the Harplands Hospital. This turned into a wider "walkabout" within the Hospital. Time was spent talking and listening to staff and the questions were left with the wards to enable them to contribute as they would have had they attended a conversation – 88 members of participated in the ward based discussions.

The final number of staff engaged in Big Conversation discussions was 413 people (29% of the workforce).

4 LiA and our approach to wider change initiatives

We are developing an approach to change building upon the NHS Change Model, developed by NHS Improving Quality as a starting point. The key components of this being;

- Creating a sense of common purpose
- Leadership
- Spread of Innovation
- Methodology
- Rigorous delivery
- Measurement
- System Drivers
- Engagement
- Values

Clearly LiA has a key role in underpinning our philosophy of change and further discussion on how we might grow and strengthen our approach to it in the longer term is planned. Engaging staff in undertaking personal change initiatives and taking responsibility for them, as well as contributing to the wider pioneering teams initiating change under the umbrella of LiA will be future key areas of our work.

We are in the process of linking LiA to work within the trust that focuses on change and engagement including the National NHS Change Day on March 15th 2015 ,and are identified as a West Midlands regional 'Hub' for this initiative.

5 Next steps

5.1 Quick wins

We have announced some Quick Wins already including

- Team Brief – 'on the road'
- Development of an I.T Hit Squad
- 'Team Credit Card'.

A list of 15 quick wins has been identified following the staff conversations (further ones are being explored) – these will be communicated across the Trust in the coming weeks.

5.2 Pioneering Teams

Following the engagement process 15 areas for development were identified and we are currently identifying members of the teams to deliver these in the next 20 weeks. The areas identified are:

- Develop a consistent approach all patients at the point of access to services.
- Every GP locality has a named consultant in CMHT.
- Reduce DNA rate and re-engagement rate.
- Implement one integrated assessment document including risk assessment.
- Safer in-patient environments
- Involvement of service users in planning services
- Improve access to psychological therapy
- Valuing people with lived experience through real time feedback and patient stories
- Improve how we learn lessons from incidents and complaints and improve ownership at time level.
- Current Section 136 provision
- Involve staff in change schemes from design
- Improved recruitment process and involvement of values based recruitment
- Ownership of high quality clinical environments at team level
- Technology improvements on frontline
- Support staff innovation- from ideas into reality to improve efficiency

These teams were launched on the 17th October 2014 ensuring that all LiA influencers and those who expressed an interest in becoming ambassadors and enablers of change through the LiA approach are involved. These enablers will be invited to engage and become mobilisers within one of the first 15 pioneering teams, these people will be our agents of change who will deliver positive changes within the next 20 weeks.

Following this event a series of master classes are planned to engage leaders, managers and supervisors around the LiA journey, focussing on “what matters to our staff” and build a sense of responsibility, ownership and pride in our work through collective action and joint leadership.

6 Recommendations

The Board are asked to

- Note the progress to date for assurance
- Continue to endorse and model the LiA approach as one of its approaches to transformational and cultural change.

Encl. 16

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: **TRUST BOARD**

Date of Meeting:	**30th October 2014**
Title of Report:	**Trust Staff Involvement and Engagement Strategy: Mid-Year Progress Review**
Presented by:	**Paul Draycott** **Acting Director of Leadership & Development**
Author of Report: **Name:** **Date:** **Email:**	**Organisation Development Team** **c/o Lesley Faux/Dawn Thompson** **September 2014** **Lesley.Faux@northstaffs.nhs.uk;** **Dawn.Thompson@northstaffs.nhs.uk**
Purpose / Intent of Report:	• **For information and decision making on highlighted aspects**
Executive Summary:	A recent report by the Kings Fund pointed to the clear business case for working to devolve greater decision-making power to staff, flattening hierarchies and empower staff as 'co-owners' to improve patient care. Approaches that provide a clear route from employee 'voice' to organisation action are, therefore, a key means of developing staff engagement (and hence organisation performance and service quality). This report provides a mid-year progress report on our Staff Involvement & Engagement Strategy, through the lens of ***Strand 3 - Listening and Responding to Staff***. Specifically, the report reviews developments in relation to the following:- 1. Listening into Action (LiA): Big Conversations 2. Annual NHS Staff Survey 3. Staff Friends and Family Test (SFFT)
Which Strategy Priority does this relate to: **How does this impact on patients or the public?**	• **Workforce Strategy** The Staff Involvement & Involvement Strategy aims to improve staff experience, and thereby patient experience and outcomes. There are now many studies which demonstrate clear links between staff engagement and service quality and safety, financial management and other performance outcomes.
Relationship with Annual Objectives:	Relates directly to Trust Objective No 6 (staff engagement), but also to objectives 1 and 5 as below in relation to evidenced correlation with staff engagement and quality of NHS services:- 6. ***Improve culture of staff engagement*** 1. ***Delivery of high quality evidence based services*** 5. ***Robust plans delivering quality and sustainable services***
Risk / Legal Implications:	As above.
Resource Implications:	No specific implications – managed within existing resources
Equality and Diversity Implications:	Supports the workforce strategy and delivery of the Equality Delivery System (EDS)
Relationship with Assurance Framework [Risk, Control and Assurance]	**As above**

Recommendations:	It is recommended that Trust Board members:- 1. Note the significant progress made and further programmes now underway in relation to Listening to and Responding to Staff. 2. Support the forthcoming Listening into Action (LiA) 'Big Conversation' sessions and participate in the positive communication about both 'quick wins' and plans to address emerging priority themes for action. 3. Actively support and promote the work of the 10 pioneering LiA teams across the Trust to action the emerging themes and objectives within a 20 week timeframe. 4. Personally take part in and champion participation in the annual NHS Staff Survey across own area of responsibility.. 5. Continue to support improvement in relation to the key themes identified in this report:- i. ***Maintaining and developing a workplace and services that staff are proud of*** ii. ***Developing excellent team work and effective leadership communication throughout the Trust*** iii. ***Addressing the causes of increasing work-pressure and work-related stress, and helping teams to cope*** 6. Demonstrate the role of the 'involving and engaging manager', listening to and responding to staff at every level, at every opportunity.

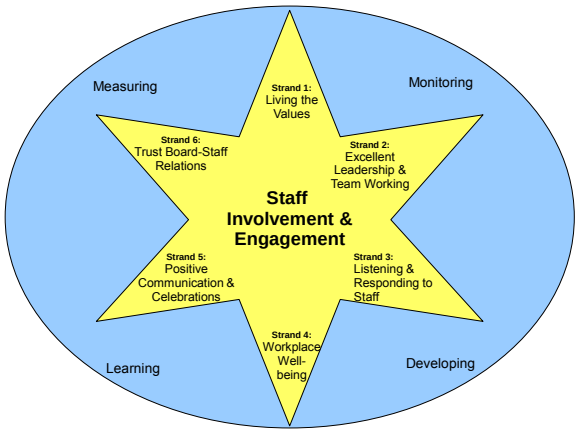
North Staffordshire Combined Healthcare NHS Trust

Workforce Directorate

Report to: **Trust Board – FULL SESSION**
Report by: Organisation Development Team
Date: September 2014
Subject: Trust Staff Involvement & Engagement Strategy Mid-Year Review

1. Introduction

This report is to provide a mid-year progress review on the Trust's Staff Involvement and Engagement (SI&E) Strategy, illustrated by the Trust's 6-pointed star model (see right).



This report focusses specifically on Strand 3 of the Strategy – Listening and Responding to Staff. Of course, there are clear linkages with other strands of the strategy, for example, changes to how Team Brief is delivered impacts on Strands 2 (Excellent Leadership and Teamworking) and Strand 6 (Trust Board-Staff Relations). Similarly, the outcomes of listening and responding to staff are likely to results in actions that impact on other areas of the Strategy star model (eg changes in working practices, support facilities etc).

A recent report by the Kings Fund, *Improving NHS Care by Engaging Staff and Devolving Decision Making* (15 July 2014), pointed to the clear business case for working to devolve greater decision-making power to staff, flattening hierarchies and empower staff as 'co-owners' to improve patient care. Approaches that provide a clear route from employee 'voice' to organisation action are, therefore, a key means of developing staff engagement (and hence organisation performance and service quality).

A number of key areas linked to the Listening and Responding to Staff strand of our Strategy will be covered in this progress report:-

1. Listening into Action (LiA): Big Conversations
2. Annual NHS Staff Survey
3. Staff Friends and Family Test (SFFT)

Effective action, and clear communication of this to staff, is anticipated to be central to delivering our *Trust Strategic Objective (number 6):* ***To improve the culture of staff engagement***.

2. Focussed Review of our 'Listening and Responding to Staff' Strand

As stated above, we will review progress in relation to the ***Listening and Responding to Staff*** strand of our Staff Involvement and Engagement Strategy by reviewing 3 distinct elements: Listening into Action; Annual NHS Staff Survey, and the new Staff Friends and Family Test.

2.1 Listening into Action: Big Conversations

Beginning in June 2014, our Trust has committed to 'Listening into Action' (LiA.) This is a 'whole-Trust' change approach to fundamentally shift the way our organisation works, leads and engages with its staff. This is being personally championed and led by Caroline Donovan, Chief Executive, alongside a team of dedicated individuals, including two LiA Lead Co-ordinators, and together they are known as the LiA "Sponsor Group".

Listening into Action is a well-evidenced, tried-and-tested successful way of changing how we work. Forty two NHS Trusts nationally having already used the methodology and approach. The Trust is engaging on this journey alongside 5 other NHS trusts including Manchester M/H and Social Care Trust, Isle of White NHS Trust, Northern Devon NHS Trust, Mid Yorkshire Hospitals NHS Trust and Rotherham NHS Foundation Trust. Together this group make up "Wave 6" as a cohort.

The fundamental ethos of LiA is about **putting staff, with their wealth of knowledge and expertise, "centre stage" and at the heart of the cultural change effort**, engaging people across the usual boundaries and being committed to change actions which improve the care we deliver to our patients.

The next phase of Listening into Action is to hold 5 "Big Staff Conversations". These will be delivered between 15th - 23rd September 2014. All staff have had a personal invitation to these events and are positively encouraged to attend.
A variety of approaches have been used to raise the profile of the LiA approach, e.g. E-mail, payslips, posters, networking events and team brief. To achieve the most effective engagement across shift patterns and staff groups, we are holding one session out-of-hours on the evening of the 24th September 2014 with a more informal booking process.

2.2 Annual NHS Staff Survey

In contrast to our new approach to *Listening into Action*, we also have a well-established means of listening and responding to staff within our Trust toolkit. The national NHS Staff Survey provides us with an annual opportunity both to monitor changes in what it feels like to work for the Trust over time and also to monitor changes in our performance in relation to that of other mental health trusts.

Key themes that emerged from the 2013 Staff Survey (agreed at Trust Plenary in March 2014) were as follows:-

1. Effective team working and team leadership
2. Delivering a health service that our staff are proud of
3. Visible, supportive leadership, at every level
4. Helping staff to deliver high quality services and to contribute to making improvements in how services are delivered
5. Addressing the causes of increasing work pressure and work-related stress

Additionally, a Staff Survey Task and Finish Group agreed as a mantra for work in responding to the 2013 staff survey: ***Doing what is right for our staff means doing what is right for our service users.***

Appendix 1 contains further a summary of details of the Trust's 2013 Staff Survey results.

Progress with Staff Survey Actions

The action areas below are broad programmes. They are likely to take time to take full effect and will need sustained and renewed energy over time. These broad themes relate to consistent feedback over recent years of the staff survey, and so will extend beyond the 12 month time-frame of the 2013 survey. They are likely to be refined and evolve and shape as other work programmes progress and in line with further feedback obtained from staff through a variety of sources (i.e. those covered within this report as well as other formal and informal feedback received).

The LiA approach will also support all strands of the Staff Survey Actions.

1. Effective team working and team leadership
   The Trust has prioritised development of team working and team leadership across the organisation through the roll-out of the Aston Team Leadership Programme through 2014-15. 148 leaders are currently participating in this programme. Participating teams are undertaking the Aston Real Team Profile+ to inform a baseline and to support us in identifying improvements over the period of the programme and 3-6 months after completion. The Trust has committed to achieving demonstrated improvement (measured by progress in Real Team Profile+ scores) in at least 50% of a sample set of 25 teams from the early cohorts of this programme by the end of March 2015, as part of our CQUIN programme.

   Feedback from participants on this programme has been very positive to date and team leaders are keen to see the approach embedded and sustained as part of our 'ways of working' across the Trust.

2. Delivering a health service that our staff are proud of
   This theme is at the heart of our ambitions for delivering quality health services and positive experiences for all our patients and service users. Actions to develop staff engagement and team working, and to develop effective organisation structures and service models to facilitate excellent care are important steps on this journey.

   Additionally, sharing information about excellent practice across the organisation is really important in shaping staff perceptions of what it is like to be cared for by, or work, in different teams across the Trust. Our programme of 'Positive Communication and Celebration' (Strand 5 of our engagement strategy) is essential in this regard, incorporating initiatives from the annual REACH Awards and monthly Spotlight, to how we share positive news across the information on a regular basis through Newsround; Team Brief; advance notice of Trust press releases and other all staff emails; Junction magazine; and other Trust, service, team or individual level communications to staff. We will continue to strive to maximise such opportunities for recognition of achievement at every level going forward. Indeed, a key theme from the Aston Team Leadership Programme is the importance of having a healthy balance of positive messages, for the effectiveness of both teams and individuals.

3. Visible, supportive leadership, at every level
   This action area links in with the first of the above themes and, as such, is supported by work to develop the Aston Effective Team Leadership approach. The Aston approach encourages a visible, supportive and engaging style of leadership, adapted as appropriate to circumstances, teams and individuals.

   Based on the findings of West's research we acknowledge that clarity of leadership is an important feature on highly effective teams and as part of the programme teams will clarify leadership and other roles within the team.

The Executive Team have now taken "Team Brief on the Road" every month, delivering Team Brief to 6 different locations.

4. Helping staff to deliver high quality services and to contribute to making improvements in how services are delivered

   This theme links with issues in theme 2 above (a health service to be proud of). Additionally, it focusses on harnessing the knowledge, ideas and enthusiasm of staff to bring about service improvements. The work the Trust is doing to continue to gather and respond to feedback from staff is the subject of this report and these large-scale programmes do not require further elaboration in this section. However, it is note-worthy that all feedback is relevant, at every level, and it is equally important that Trust appraisers, supervisors and team leaders listen to and respond to ideas and feedback at local level (e.g. through one-to-one discussions, team meetings, case reviews, PDR discussions etc.) as it is for the Trust to respond to feedback at the macro-level. A failure to do this at one level could easily undermine attempts to do so at the other.

5. Addressing the causes of increasing work pressure and work-related stress

   The Trust has been raising awareness around stress and work pressure through items in Newsround encouraging staff and managers to book onto training and support in relation to stress management (for a list of courses offered, see ***Appendix 4***), particularly in recognition of lower uptake of this training by Trust staff compared with partner Trusts who share our Staff Support and Counselling Service. This campaign continues and a presentation to managers at the People and Cultural Development Committee is planned to discuss the role of managers and how they can support their staff in relation to stress and work pressure and how to use the Stress Management Policy.

   Additionally, feedback from staff suggests that three significant causes of stress and work pressure relate to:

   1. the continuing uncertainty around the Trust's future (and that of services within it);
   2. the level/frequency of 'management of change' across the Trust, and
   3. workload related pressure on staff due to a combination of staffing cuts, colleague absence and increasing caseloads/service requirements.

   In relation to these, the Trust is now in a position to be able to communicate positive messages about growing support for the possibility of the Trust continuing as a stand-alone organisation. Staff need to continue to hear information and updates about the Trust's efforts to secure additional funding with commissioners and about our plan to conduct a review around safer staffing levels on a regular basis to assure staff that this issue is recognised and every effort is being made to try to address this issue. Whilst 'management of change' is likely to continue, the Trust will focus on ensuring that the right changes are implemented, in the right way, and given time for the benefits of the changes to take effect (another key message from the Aston programme).

2014 Staff Survey

We are now in the process of preparing for the 2014 NHS Staff Survey, which will be released towards the end of September (running through to early December).

This year the Trust was able to opt to use a combination approach for the issuing of staff survey. This means that the majority (approximately 65% of our staff) will receive the survey online via a link in an email. The remainder will receive the survey on paper as in previous years. Those receiving online surveys this year are: all staff at band 5 and above (with the exception of estates and ancillary staff) plus administrative/office based staff at bands 1-4.

Results of the 2014 survey are anticipated during February 2015. The themes and messages emerging from the 2014 staff survey will need to be pooled with those emerging from the Trust's Listening into Action Programme to ensure that the most effective action is taken to responding to both sets of feedback.

In addition to the national annual NHS Staff Survey, the NHS introduced from April 2014 a mandatory survey of NHS staff through quarterly surveys based around the 'friends and family test' questions from the annual survey. This survey is known as the Staff Friends and Family Test (SFFT) and is covered in the next section. Feedback from this new survey will also need to be managed in conjunction with the annual staff survey and the feedback from LiA.

2.3 Staff Friends and Family Test (SFFT)

The Trust replaced its local monthly 'Mini Staff Survey' with the new mandatory Staff Friends and Family Test from May 2014. Like the annual Staff Survey, the results of the SFFT will be benchmarked against other NHS organisations nationally. The first set of data was released on 25th September.

In the SFFT, staff are asked two key questions:-

1. How likely are you to recommend North Staffordshire Combined Healthcare NHS Trust to friends and family if they needed care or treatment?
2. How likely are you to recommend North Staffordshire Combined Healthcare NHS Trust to friends and family as a place to work?

Research shows that Trusts with stronger staff recommendation scores are also found to have stronger outcomes in terms of quality of patient care and experience, and that improvements in staff recommendation often correspond with improvements in the care experience. With each of the above questions, staff were asked to comment on the main reason for their answer.

Approximately one third of our workforce were invited to take part in the new quick survey during May, and another third in August. The final third will be surveyed in February 2015 (no SFFT survey in Quarter 3 as this is when the annual survey takes place).

In the first round of the survey (quarter 1, 2014-15 - conducted during May), staff with surnames beginning with the letters A-F were invited to take part, followed by letters G-O in August. In contrast to the annual survey, this survey specifically invited participation by Trust bank (only) staff and Trust volunteers, as well as Carillion staff working at The Harplands.

The SFFT survey has had a response rate of 29% in quarter 1 and 26% in quarter 2, which is believed to be on the positive side of average, in comparison with other Trusts.

Findings:-

The results of the first two SFFT surveys are summarised at ***Appendix 2***. In line with consistent findings from the annual staff survey, we have seen a much stronger staff recommendation of the Trust as a provider of care and treatment compared with the Trust as a place of work/employer. Responses were quite consistent in both quarters of the SFFT and, in both cases, were consistently higher than in the annual survey.

I would recommend the Trust..	
.. as a provider of care and treatment	**69%** in Q1; **68%** in Q2 (50% in staff survey 2013)
.. as a place of work	**50%** in Q1; **48%** in Q2 (41% in staff survey 2013)

In both months, text comments entered by staff were largely positive. Less positive and developmental comments were grouped into a range of common themes. ***Appendix 3***

illustrates a summary of the range of positive comments in quarters 1 and 2 of the survey, together with the issues and developmental themes emerging.

Some of the recent comments received from staff in the Quarter 2 survey were as follows (for further comments, see ***Appendix 3***): -

- ***'Great staff who care about service users. Many go the extra mile'***
- ***'Good service, prompt and caring staff'***
- ***'High quality of care'***
- ***'Friendly and helpful staff'***
- ***'I would trust the system and staff'***
- ***'I have worked with some of the most caring and understanding staff. I have the utmost respect for them in this very demanding job'***
- ***'I think we do an amazing job'***
- ***'Good care'***
- ***'I think NSCHT has brilliant staff'***
- ***'I have confidence that the services we provide are first class'***

Key themes for action emerging from the two rounds of the Staff Friends and Family Test to date can be summarised as follows:-

1. Maintaining and developing a workplace and services that staff are proud of
2. Addressing the causes of work pressure and work-related stress
3. Helping teams and individuals to cope with change and service pressures
4. Developing excellent team work and effective leadership communication throughout the Trust

The Trust is continuing to develop how it shares and responds to feedback from the Staff Friends and Family Test, including via Newsround and Team Brief and information on SID. We will also explore the use of posters and other media.

3. Conclusion and Recommendations

The above review sets out the considerable progress made in gathering and responding to feedback from staff to date. It also outlines the further feedback being gathered over the coming months through Listening into Action and the 2014 Staff Survey.

A key challenge for us will be to find ways of linking feedback from SFFT with that obtained from the annual survey, Listening into Action, and other feedback mechanisms so that we have 'joined up' approaches to action planning and that we do not overload staff with potentially conflicting 'feedback about their feedback'.

There are a number of common or over-lapping themes which have emerged from feedback from all 3 elements reviewed in this paper:-

Listening into Action	Staff Survey 2013	Staff Friends & Family Test Q1&Q2
1. Quality and safety	1. Effective team working and team leadership	1. Maintaining and developing a workplace and services that staff are proud of
2. Patient experience	2. Delivering a health service that our staff are proud of	2. Addressing the causes of work pressure and work-related stress
3. Enabling our frontline teams	3. Visible, supportive leadership, at every level	3. Helping teams and individuals to cope with change and service pressures
	4. Helping staff to deliver high quality services and to contribute to making improvements in how services are delivered	4. Developing excellent team work and effective leadership communication throughout the Trust
	5. Addressing the causes of increasing work pressure and work-related stress	

The above is summarised into the following 3 key themes (illustrated in diagram form at Appendix 5):-

Staff Engagement priorities from Staff Feedback over the past 12 months:-

1. ***Maintaining and developing a workplace and services that staff are proud of***

2. ***Developing excellent team work and effective leadership communication throughout the Trust***

3. ***Addressing the causes of increasing work-pressure and work-related stress, and helping teams to cope***

Recommendations:-

It is recommended that the Trust Board members:-

1. Note the significant progress made and further programmes now underway in relation to ***Listening to and Responding to Staff***.

2. Support the forthcoming Listening into Action (LiA) 'Big Conversation' sessions and participate in the positive communication about both 'quick wins' and plans to address emerging priority themes for action.

3. Actively support and promote the work of the 10 pioneering LiA teams across the Trust to action the emerging themes and objectives within a 20 week timeframe.

4. Personally take part in and champion participation in the annual NHS Staff Survey across own area of responsibility.

5. Continue to support improvement in relation to the key themes identified in this report:-

i. ***Maintaining and developing a workplace and services that staff are proud of***
ii. ***Developing excellent team work and effective leadership communication throughout the Trust***
iii. ***Addressing the causes of increasing work-pressure and work-related stress, and helping teams to cope***

6. Demonstrate the role of the 'involving and engaging manager', listening to and responding to staff at every level, at every opportunity.

End

APPENDIX 1 SUMMARY OF FINDINGS FROM 2013 NHS STAFF SURVEY

NSCHT Best and improved survey performance areas

The Trust performed in the best 20% of Trusts in its CQC category on 3 survey key findings measures (1-3 below). Our Trust's Top 5 ranking survey scores (in order) were as follows (2011 score in brackets):-

1. % of **staff working extra hours** - 61% (57%) '*TOP 20%'*
2. % of staff feeling **pressure to attend work** in the last 3 months - 17% (19%) '*TOP 20%'*
3. % of staff experiencing **discrimination at work** in the last 12 months – 8% (8%) '*TOP 20%'*
4. % of staff saying **hand washing materials** are always available – 59% (69%) '*BETTER THAN AVERAGE*'
5. % of staff experiencing **harassment, bullying or abuse from patients,** relatives or the public in the last 12 months – 28% (n/a) '*BETTER THAN AVERAGE'*

These 5 measures have scored consistently strongly since the 2011 staff survey.

NSCHT Bottom performance areas

The Trust performed in the worst 20% of MH Trusts on 5 of the 28 measures (18% of measures). These 5 measures were also our Bottom 5 ranking scores (in order) in relation to other mental health trusts:-

1. % of staff experiencing **physical violence from patients**, relatives or the public in the last 12 months – 29% (average = 20%)
2. % of staff reporting **good communication** between senior management and staff – 23% (average 30%; 19% in 2011)
3. **Work pressure** felt by staff – 3.13 (average = 3.02)
4. % of staff experiencing **physical violence from staff** in the last 12 months – 6% (average = 4%)
5. % of **staff recommending the trust** as a place to work or receive treatment – 3.29 (average = 3.54; 3.37 in 2011)

Key Themes for action

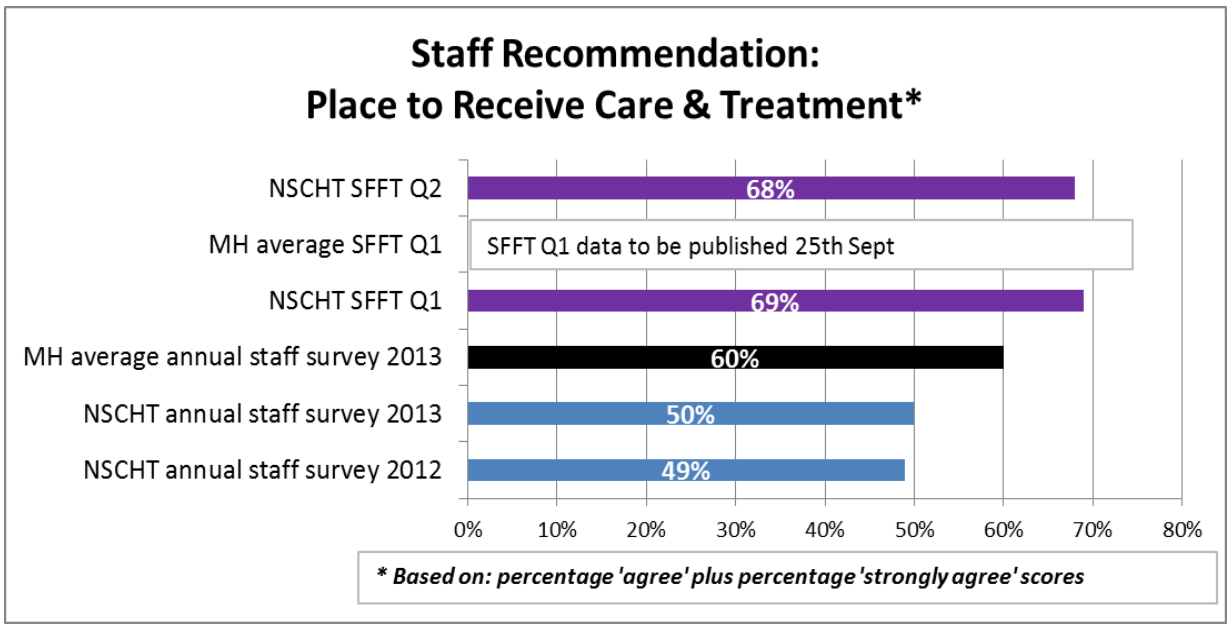
Key themes for action emerging from a staff survey task and finish group (February 2014) and Trust Plenary (March 2014) were as follows:-

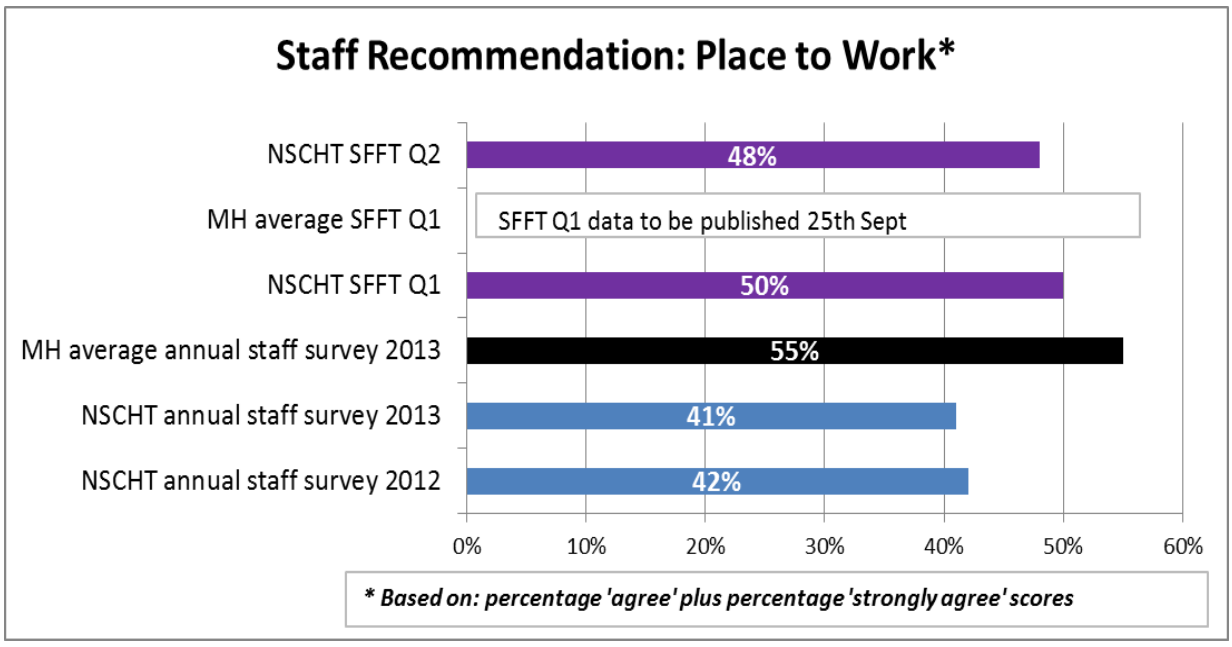
1. Effective team working and team leadership
2. Delivering a health service that our staff are proud of
3. Visible, supportive leadership, at every level
4. Helping staff to deliver high quality services and to contribute to making improvements in how services are delivered
5. Addressing the causes of increasing work pressure and work-related stress

The task and finish group agreed as a mantra for work in responding to the 2013 staff survey: ***Doing what is right for our staff means doing what is right for our service users***.

APPENDIX 2 **STAFF FRIENDS AND FAMILY TEST RESULTS Q1 & Q2**
(with comparison with annual staff survey results)

	NSCHT annual staff survey 2012	NSCHT annual staff survey 2013	MH average annual staff survey 2013	NSCHT SFFT Q1	MH average SFFT Q1	NSCHT SFFT Q2
q1 I would recommend the Trust to my friends and family.... if they needed care and treatment	49%	50%	60%	69%	to be published 25th Sept	68%
q2 I would recommend the Trust to my friends and family.. as a place to work	42%	41%	55%	50%	to be published 25th Sept	48%



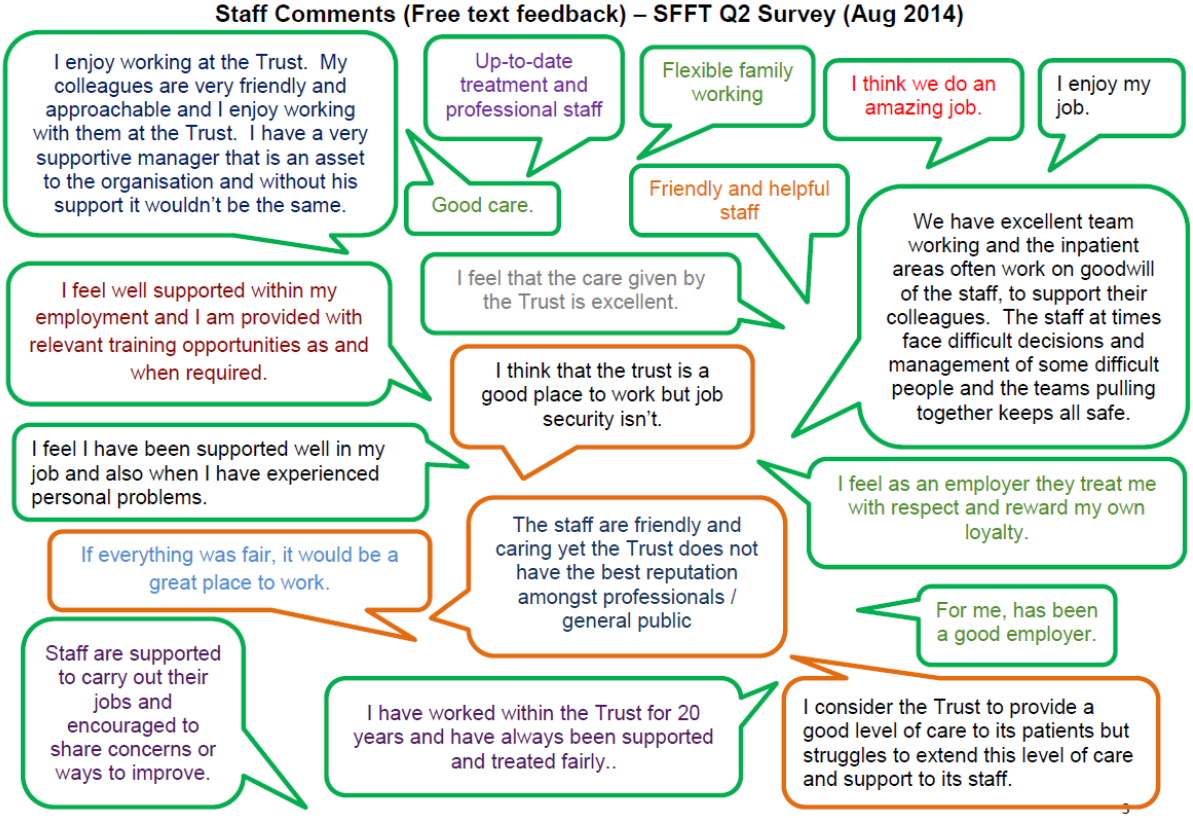


APPENDIX 3

Summary of Text Comments from Staff in SFFT Quarters 1 & 2, Key areas of Concern and What we are Doing in Response

Staff Comments (Free text feedback) – SFFT Q1 Survey (May 2014)

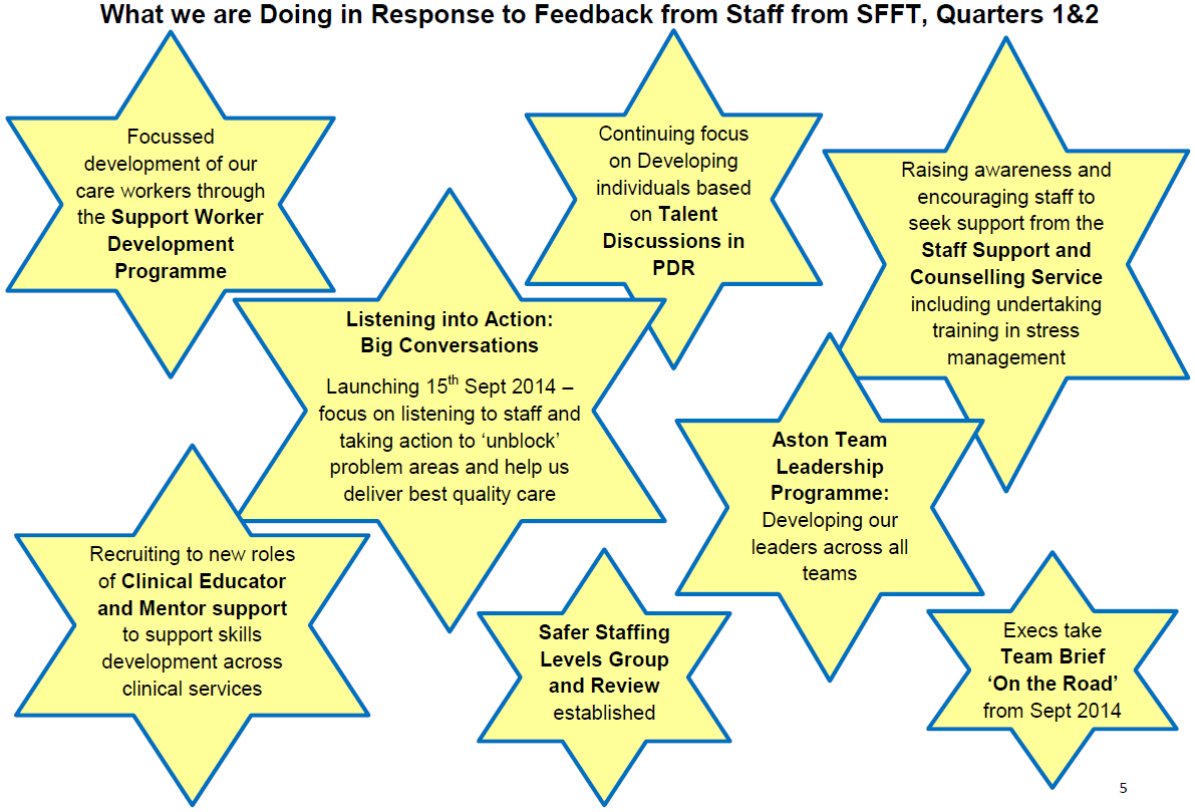
Staff Comments (Free text feedback) – SFFT Q2 Survey (Aug 2014)



Key Themes suggested by staff as areas of concern / for improvement

4

What we are Doing in Response to Feedback from Staff from SFFT, Quarters 1&2



5

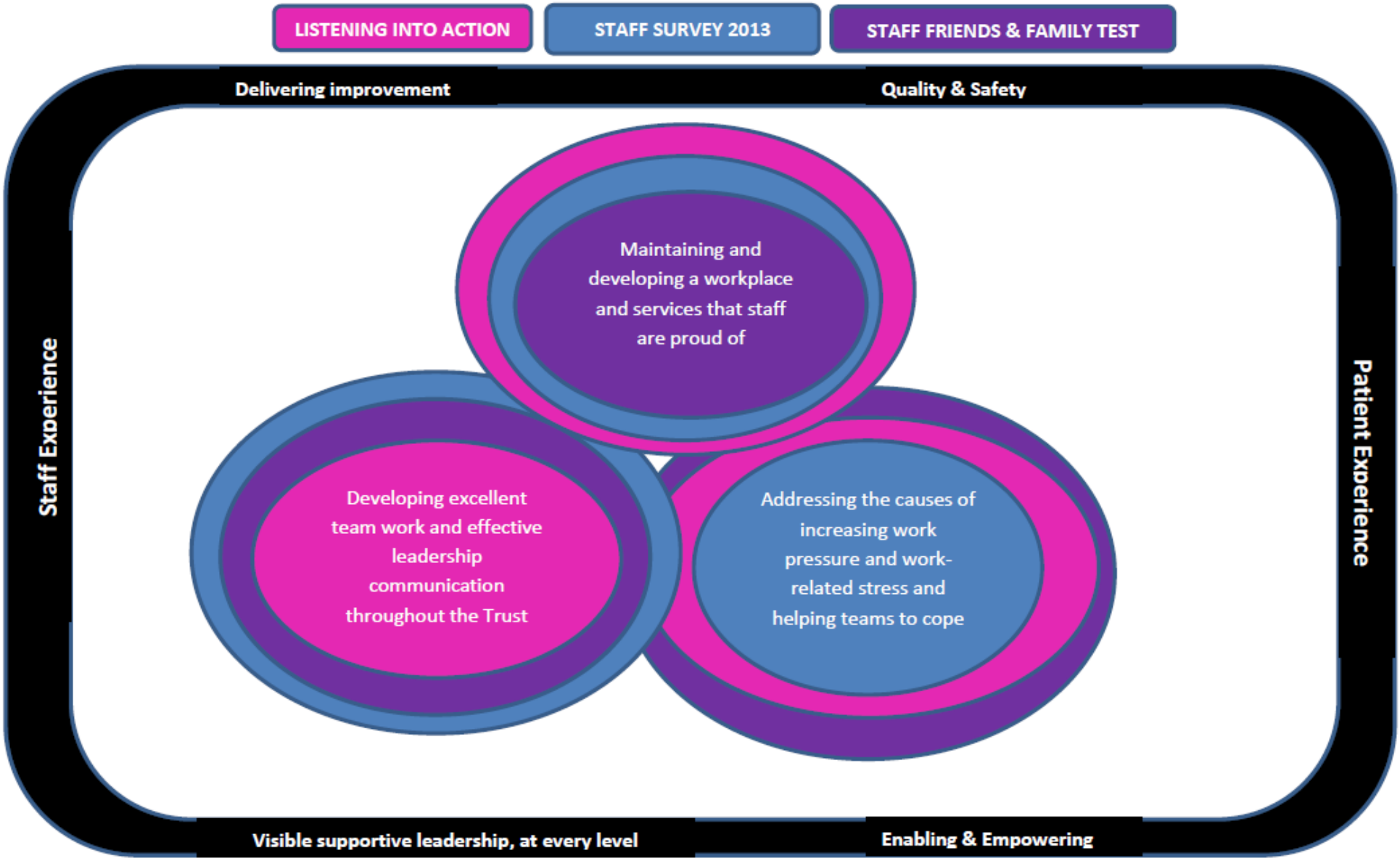
APPENDIX 4 **SUPPORTIVE WORKSHOPS OFFERED BY THE STAFF SUPPORT AND COUNSELLING SERVICE (with attendance figures 2013-14)**

Workshop	Total Attendances	NSCHT Attendances	% of all attendances from NSCHT
A Manager's Response to Stress in the Workplace	17	**4**	24%
Assertiveness & Communication	49	**8**	16%
Building Resilience in Changing Times	5	**3**	60%
Coping with stress - A CBT approach	21	**1**	5%
Developing Self Confidence	10	**3**	30%
Eating, Sleeping & Relaxing Yourself Well	11	**11**	100%
Handling Difficult People and Difficult Situations	20	**11**	55%
Mood Mapping	11	**6**	55%
Stop Stressing & Start Coping	59	**20**	34%
Stress MOT Day	16	**0**	0%
Taking Control of your Work Life Balance and Time Management Skills	8	**3**	38%
Understanding Yourself the TA Way	9	**6**	67%
Total Number of Staff	**236**	**76**	**32%**

Plus:-

- Bespoke support to teams on request
- National Stress Awareness Day Activities
- Stress Reduction Programme (4 x 3 hourly programme covering a range of interventions to allow individuals to look at reducing their stress levels and/or developing coping mechanisms to help at that time, including: stress recognition and management; CBT approaches; assertiveness and time management; mindfulness; health and wellbeing, resilience; diet, exercise and relaxation).

APPENDIX 5


LISTENING INTO ACTION
STAFF SURVEY 2013
STAFF FRIENDS & FAMILY TEST
Delivering improvement
Quality & Safety
Staff Experience
Patient Experience
Maintaining and developing a workplace and services that staff are proud of
Developing excellent team work and effective leadership communication throughout the Trust
Addressing the causes of increasing work pressure and work-related stress and helping teams to cope
Visible supportive leadership, at every level
Enabling & Empowering

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO: Open Trust Board

Date of Meeting:	Thursday 30 October 2014
Title of Report:	Chief Executive's Report to the Trust Board
Presented by:	Mrs Caroline Donovan
Author of Report: **Name:** **Date:** **Email:**	Caroline Donovan, Chief Executive Caroline Donovan 23 October 2014 Caroline.donovan@northstaffs.nhs.uk
Purpose / Intent of Report:	• For Information
Executive Summary:	This report updates the Board on activities undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest.
Which Strategy Priority does this relate to: **How does this impact on patients or the public?**	• Customer Focus Strategy • Clinical Strategy • ~~IM and T Strategy~~ • Governance Strategy • ~~Innovation Strategy~~ • ~~Workforce Strategy~~ • ~~Financial Strategy~~ • ~~Estates Strategy~~
Relationship with Annual Objectives:	To ensure safe provision of clinical services
Risk / Legal Implications:	N/A
Resource Implications:	N/A
Equality and Diversity Implications:	N/A
Relationship with Assurance Framework [Risk, Control and Assurance]	N/A
Recommendations:	To receive this report for information

North Staffordshire Combined Healthcare Trust

Chief Executive's Report to the Board of Directors
30 October 2014

1. PURPOSE OF THE REPORT

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

LOCAL UPDATE

2. INTERIM DIRECTOR OF FINANCE AND DIRECTOR OF NURSING & QUALITY

We have recently begun the recruitment process for our planned permanent appointment of our Director of Finance following the permanent appointment of our Chief Executive post. Chris Calkin, who was working with the Trust on an interim basis, has finished his contract and has been replaced by Ann Harrison, who is joining us on an interim basis from George Elliott Hospital NHS Trust.

Karen Wilson, Director of Nursing and Quality, has recently left the Trust following her resignation. I would like to take this opportunity to thank Karen for the contribution she has made to the Trust over the past nine months. This post is currently being recruited on a permanent basis.

3. WORLD MENTAL HEALTH DAY

With one in four people experiencing a mental illness, most of us will have some connection to someone who has been affected in some way or another.

On 10 October, colleagues across the Trust championed World Mental Health Day, the most important day in the mental health calendar, which this year shone the spotlight on 'living' with schizophrenia.

From those who face every day of their lives with it, to their families, friends, doctors and even society as a whole, we all have a part to play in raising awareness of schizophrenic illness. Schizophrenia affects how a person thinks, feels and acts, but is actually a word that describes a number of symptoms. Not everyone with schizophrenia has the same symptoms; the definition of the disorder is wide and includes a number of things.

Trust staff held a series of events to celebrate World Mental Health Day. Visitors to Harplands Hospital were able to read poetry written by patients at a special display outside Level One Café. Handmade crafts, cakes and other treats were also be available for sale, while a tombola offered prizes donated by local businesses.

At the 24/7 Clubhouse, in Hillcrest Street, Hanley, the Trust's Rehab CPN Team and Assertive Outreach Team ran balloon making and arts and crafts activities and the Recovery and Resettlement Service provided a tombola stall. The Lyme Brook Mental Health Centre, in Talke Road, Newcastle-under-Lyme, held a drop-in session, where visitors joined staff for a cuppa and cake and took part in a tombola to raise funds for the local Hearing Voices group.

More information is available about schizophrenia at
http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/schizophrenia.aspx

4. SUCCESSFUL CHILDREN'S SERVICE BID

I am delighted to be able to share that our Children and Young People's Division has been successful in securing the SUSTAIN tender to provide Specialist Integrated Physical and Mental Health Services to Looked-After Children across Staffordshire.

The Division, working in partnership with South Staffordshire and Shropshire Healthcare NHS Foundation Trust and Barnado's has been awarded the contract worth a total of approximately £2.4million.

I'd like to thank all those involved in the tendering process, and look forward to April 2015 when the service 'goes live'.

5. LISTENING INTO ACTION

At the beginning of October, the LIA Sponsor Group went to Birmingham for our third Navigation Day with colleagues from across the country who are also in Cohort 6 of the Listening into Action (LiA) programme.

The aim of the day was to focus on the themes from our Big Conversations. We broadly agreed our 10 'Pioneering Teams' and five 'Enabling Our People' schemes, which were launched in mid-October.

I am really looking forward to working with and supporting each of the teams in making significant improvements going forward which will make a real difference to our working lives.

One of the overwhelming themes from the LiA Big Conversations was staff frustration about technology; this will therefore be one of the Enabling Our People schemes. We have set up a 'Hit Squad'; a project group which will sort immediate frustrations. All staff have been asked to contribute to the Hit Squad priorities.

As technology is such a high priority for us, the Board spent the entire October Board Development session considering how to develop a digital strategy for the future shaped around our quality strategy for patients.

Our previous Board development session in September considered four strategic quality themes of Access, Safety, Recovery and Personal Care. Via our Plenary forum, staff views will be sought on these themes of quality to ensure we are aligned with front-line staff thinking.

6. OCCUPATIONAL HEALTH SERVICES – TEAM PREVENT

With effect from Wednesday 1 October 2014, the Trust's Occupational Health Service is now provided by Team Prevent UK. As part of its service, Team Prevent has introduced a new online portal for all staff with line management responsibilities. Managers are able to make referrals on behalf of their staff to ensure those colleagues experiencing health issues which impact on their ability to work have access to the necessary assessment and support.

Staff joining the Trust, or transferring to a new role, may be referred to the Occupational Health team to assess their fitness for work and if necessary provide immunisations and vaccinations to protect them against the risks of work related ill health. Staff declaring a health condition will be supported by the Occupational Health team and advice provided to Managers on any adjustments that the organisation may need to consider in order to support staff.

The specialist practitioners who make up the Occupational Health and Well Being Team have an ethical, professional and moral responsibility to remain completely impartial. They base their assessment on the information provided by a member of staff during the consultation, and the information provided by the Manager in the referral. The focus will always be on assessing what the individual can do and providing advice to the employer on any support that may help the member of staff deliver their role to the best of their ability.

We are delighted to be working with Team Prevent, with a focus firmly on ensuring the wellbeing of our staff.

7. LOCAL PHARMACY NETWORK EVENT

At the end of September, we were pleased to host an event held by the Shropshire and Staffordshire Local Pharmacy Network (LPN) at Harplands Hospital.

I'd like to thank Louise Jackson, Chief Pharmacist for NSCHT, who organised the event, which provided an opportunity for mental health trust colleagues and community pharmacists to come together to discuss how they can better help those with mental health issues.

A mental health resource pack was also launched at the event, providing helpful contact information, including details of Trust contacts and the choice and medication website - www.choiceandmedication.org/combined - which contains information on mental health medicines and conditions.

I'm delighted that the network felt it was important to hold these events, in order to give community neighbourhood pharmacists the confidence to fully assist someone with mental health needs. This is about achieving a parity of esteem between mental healthcare and physical healthcare and about working closely together for the good of patients.

Our Chairman, Ken Jarrold CBE, spoke at the event and acknowledged that pharmacists play a vital role in promoting, maintaining and improving the health of the communities they serve. Events such as the one held at Harplands Hospital ensure that community pharmacists have an opportunity to meet with those working in a mental health setting to provide support, in order to deliver an effective service to people with mental health issues.

The networking events are a really positive step to achieving this and I wish the network well in the next stage of its development.

NATIONAL UPDATES

8. CARE QUALITY COMMISSION PLACE OF SAFETY REPORT

The Care Quality Commission (CQC) has issued a report called 'A Safer Place to Be' which reinforces the need for the NHS to continue to improve access to and the operation of health-based places of safety for people experiencing a mental health crisis.

The CQC has issued a series of recommendations aimed at providers and commissioners alongside the findings from a survey of all NHS mental health trusts in England and two social enterprises providing health-based places of safety.

People detained by the police under section 136 of the Mental Health Act must be taken immediately to a safe place where a mental health assessment can be undertaken. This should be a 'health-based place of safety', located in a mental health hospital or an emergency department at a general hospital. They should only be taken to a police station in exceptional circumstances.

CQC has made a number of recommendations based on its findings, including that:

- Providers should identify areas in which national standards are not being met, working with local partners to address these shortfalls. This includes making sure appropriate arrangements are in place for young people, people who are intoxicated, or people exhibiting disturbed behaviour.
- Providers should improve data collection on how health based places of safety are used.
- Providers should ensure that appropriate levels of adequately trained staff are available to receive an individual brought to the place of safety at all times.
- Commissioners should establish whether local capacity is sufficient, and take action to drive improvements by the commissioning of services or specifying interventions that may prevent or reduce the use of section 136.
- Commissioners should ensure they are fulfilling their responsibilities around multi-agency groups and policies relating to health-based places of safety.
- Commissioners should ensure that ambulance arrangements for transporting people experiencing a crisis are appropriate and timely.
- Health and wellbeing boards should assess local need for health-based places of safety as part of their Joint Strategic Needs Assessments.
- Multi-agency groups should develop and monitor an action plan to address any shortfalls identified, including agreeing alternative arrangements when the place of safety is occupied, and auditing local intelligence on the operation of places of safety, promoting improvements in data quality where required.
- Organisations responsible for the availability of professionals to carry out MHA assessments should take action to minimise delays.
- NHS England should consider the use of capacity management systems to include real-time information on the availability of health-based places of safety, in order to help streamline the process for police and ambulances to access a place of safety.

As a Trust, we are carefully reviewing the findings in the report. Locally, we are working closely with Staffordshire Police to ensure frontline officers know how to recognise who might need detaining under a Section 136 arrangement to ensure people are brought to the Section 136 Suite at Harplands Hospital appropriately.

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

We have also put in place an Intoxication Observation Unit to support people who are too intoxicated to be assessed. Located at NSCHT's Edward Myers Unit, the unit comprises two beds which are used to allow intoxicated patients to become sober, assessed and properly cared for, without the need to be admitted to UHNS. The patients are observed by staff and, once recovered, are offered specialist help to tackle any underlying issues and referred to other agencies for ongoing support.

Between April 2012 and March 2014, there were a total of 1,102 admissions to the IOU, with almost three-quarters of the patients being male and the most prevalent age range being 46-50.
As well as helping to reduce the number of admissions to both A&E and the Clinical Decisions Unit at UHNS, the IOU is actively supporting people in their recovery from alcohol and helping to make valuable savings in the local health economy in the process.

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

9. THE NHS FIVE YEAR FORWARD VIEW

The NHS Five Year Forward View was published on 23 October 2014 and sets out a vision for the future of the NHS. It has been developed by the partner organisations that deliver and oversee health and care services including NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority. Patient groups, clinicians and independent experts have also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

The purpose of the Five Year Forward View is to articulate why change is needed, what that change might look like and how we can achieve it. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery. Everyone will need to play their part – system leaders, NHS staff, patients and the public – to realise the potential benefits for us all. It covers areas such as disease prevention; new, flexible models of service delivery tailored to local populations and needs; integration between services; and consistent leadership across the health and care system.

The Five Year Forward View starts the move towards a different NHS, recognising the challenges and outlining potential solutions to the big questions facing health and care services in England. It defines the framework for further detailed planning about how the NHS needs to evolve over the next five years.

As a Board, we will be carefully considering the implications the Forward View has for our organisation and due consideration will be given to the impact on our organisation's Integrated Business Plan.

10. EFFECTIVE ENGAGEMENT BETWEEN HEALTH AND WELLBEING BOARDS AND MAJOR PROVIDERS

Secretary of State for Health, Jeremy Hunt, has written to all NHS providers to encourage closer engagement with Health and Wellbeing (H&W) Boards.

The Better Care Fund plans were submitted on 19 September, building on the foundations of conversations taking place across H&W Boards and providers. A further review of engagement is underway to determine the strength of relationships and engagement between organisations and H&W Boards. For example, in some areas, providers have been included as full members on H&W Boards which has had clear advantages. Other areas have seen engagement work well through secondary mechanisms such as partnership groups, provider forums and workshops.

Here in Staffordshire, we have set up a Joint Accountability Board to take forward these discussions and to positively engage the local decision making process in an effective, timely and meaningful way.

11. DEMENTIA AMBASSADORS

A press release has been issued nationally by NHS England announcing details of the seven Dementia 'ambassadors' who will be promoting the importance of diagnosing more patients with dementia in a bid to help improve the quality of life of both patients and their carers.

The seven new 'ambassadors' are to begin spreading the word about the importance of diagnosing more patients with dementia in a bid to help improve patients' and their carers' quality of life.

The seven, who are based in London, the south, the north, the midlands, and Scotland, will be helping local GPs in England to use the best possible methods to diagnose more people.

Dr Sunil Gupta (Ambassador for Midlands and East), Dr Nick Cartmell, Dr David Findlay, Dr Elizabeth Barrett, Deborah Cohen, Dr Daniel Harwood, Dr Paul Twomey are NHS England's new network of clinical advisors or 'ambassadors', and are experts in dementia care from a wide variety of backgrounds.

Among them are GPs, commissioners and educators and they will be offering one to one support for Clinical Commissioning Groups (CCGs), or GP-led local health committees, to help boost their expertise in this area.

As our local Ambassador, Dr Sunil Gupta, begins to work with GPs across the area, we will be linking into the local network to provide support and share learning wherever possible.

12. VARIATION IN THE QUALITY OF CARE MEANS PEOPLE LIVING WITH DEMENTIA RISK RECEIVING POOR CARE

A major review of dementia care by the Care Quality Commission (CQC) says the unacceptable gap in the quality of care means it is likely that someone living with dementia will experience poor care as they move between care homes and hospitals. The CQC has also published a report on dementia services today which says there is an "unacceptable gap" in the quality of care given to dementia sufferers. A link to the release is here - http://www.cqc.org.uk/content/variation-quality-care-means-people-living-dementia-risk-receiving-poor-care.

Any learning from the report will be shared with our older people's Outreach and Community Teams, who already provide a liaison between care homes and hospitals locally.

13. 1.5M MEN OVER 50 WILL SUFFER SEVERE LONELINESS BY 2030

New research by the Independent Age charity, based on data from the English Longitudinal Study of Ageing, has indicated that the number of men over the age of 50 suffering from severe loneliness in England will rise to more than 1m in the next 15 years. More than 700,000 older men already report feeling a high degree of loneliness, and Independent Age said this will rise as the population of older men living alone is expected to rise by 65% to 1.5m by 2030. Widespread low expectations of the quality of life in old age meant that health service providers produce care plans for old people that do not include an element ensuring social connections are maintained. Health secretary Jeremy Hunt admitted last year that society has "utterly failed" to address the problem. More information here http://www.independentage.org/isolation-a-growing-issue-among-older-men/

We will be working closely with our third sector partners and commissioners to identify any implications this research may have on mental health services locally.

14. MENTAL HEALTH NETWORK NHS CONFEDERATION MANIFESTO

The Mental Health Network NHS Confederation, in conjunction with members of the Mental Health Policy Group (MHPG,) has recently launched a manifesto for mental health. The MHPG is a coalition of six leading national mental health organisations, including Mind, Rethink Mental Illness, Centre for Mental Health, Royal College of psychiatrists, Mental Health Foundation and the Mental Health Network.

The Mental Health Manifesto sets out five areas where each of the MHPG organisations, together, want to see a commitment to change from each political party. Specific proposals are included under each of the following headline themes:

- Ensuring fair funding for mental health
- Giving children a good start in life
- Improving physical healthcare for people with mental health problems
- Improving the lives of people with mental health problems
- Enabling better access to mental health services.

The Manifesto sits well with the work we have undertaken with partners on the eight Clinical Pathways. The headline themes reflect our focus on parity of esteem, integrated care, recovery and access and add strength to taking forward this work in partnership with our commissioners.

The manifesto can be viewed here - http://www.mentalhealth.org.uk/content/assets/PDF/publications/manifesto-better-mental-health-manifesto.pdf

Caroline Donovan
Chief Executive
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