North Staffordshire Combined Healthcare NHS
NHS Trust

MEETING OF THE TRUST BOARD

TO BE HELD IN PUBLIC
ON WEDNESDAY, 11 MAY 2016, 10:00AM,
BOARDROOM, LAWTON HOUSE, TRUST HEADQUARTERS, BELLRINGER ROAD, TRENTHAM LAKES SOUTH, STOKE ON TRENT, ST4 8HH

	AGENDA	
1.	**APOLOGIES FOR ABSENCE** *To NOTE any apologies for absence*	Note
2.	**DECLARATION OF INTERESTS RELATING TO AGENDA ITEMS**	Note
3.	**DECLARATIONS OF INTERESTS RELATING TO ANY OTHER BUSINESS**	Note
4.	**MINUTES OF THE OPEN AGENDA – 31 MARCH 2016** *To APPROVE the minutes of the meeting held on 31 March 2016*	Approve Enclosure 2
5.	**ACTION MONITORING SCHEDULE & MATTERS ARISING FROM THE MINUTES** *To CONSIDER any matters arising from the minutes*	Note Enclosure 3
6.	**CHAIR'S REPORT** *To RECEIVE a verbal report from the Chair*	Note
7.	**CHIEF EXECUTIVE'S REPORT** *To RECEIVE a report from the Chief Executive*	Note Enclosure 4
	TO DELIVER HIGH QUALITY PERSON CENTRED MODELS OF CARE (Strategic Goal)	
8.	**SPOTLIGHT ON EXCELLENCE** *To PRESENT the Spotlight on Excellence Team and Individual Awards to staff* *To be introduced by the Chief Executive and presented by the Chair*	***Verbal***
9.	**STAFF RETIREMENTS** *To EXPRESS our gratitude and recognize staff who are retiring* *To be introduced and presented by the Chair*	***Verbal***
10.	**PRESENTATION FROM SPOTLIGHT TEAM** *Presentation from the Adult Community (IAPT) Team presented by Ms S Woodall, Clinical Lead, Healthy Minds*	***Verbal***

11.	**ASSURANCE REPORT FROM THE QUALITY COMMITTEE REPORT** *To RECEIVE the Quality Committee assurance report from the meeting held on 26 April 2016 from Mr P Sullivan, Chair/Non-Executive Director* • ***Serious Incidents Quarterly Report Q4 2015/16*** *To receive the SI Q4 report from Dr Adeyemo, Medical Director*	Assurance Enclosure 5 Enclosure 5.1
12.	**NURSE STAFFING MONTHLY REPORT –March 2016** *To DISCUSS and APPROVE the assurance report on the planned versus actual staff variances from Ms M Nelligan, Director of Nursing & Quality*	Assurance Enclosure 6
13.	**SERVICE USER AND CARER COUNCIL** *To RECEIVE a verbal update from Mr A Cotterill, Chair of the Service User and Care Council*	***Verbal***
14.	**NURSING REVALIDATION PREPAREDNESS UPDATE** *To RECEIVE a report from Ms M Nelligan, Director of Nursing and Quality*	Information Enclosure 7
	TO BE ONE OF THE MOST EFFICIENT PROVIDERS (Strategic Goal)	
15.	**OVERALL BOARD ASSURANCE FRAMEWORK (BAF) 2015/16** *To RECEIVE the BAF 2015/16 from Mrs. L Wrench, Associate Director of Governance*	Assurance Enclosure 8
16.	**OVERALL BOARD ASSURANCE FRAMEWORK (BAF) 2016/17** *To RECEIVE the BAF 2016/17 from Mrs. L Wrench, Associate Director of Governance*	Assurance Enclosure 9
17.	**CARE QUALITY COMMISSION (CQC) ACTION PLAN** *To RECEIVE the CQC Action Plan from Mrs. L Wrench, Associate Director of Governance*	Assurance Enclosure 10
18.	**FINANCE REPORT – Month 12 (2015/16)** *To RECEIVE for discussion the month 12 financial position from Miss S Robinson, Director of Finance and Performance*	Assurance Enclosure 11
19.	**ASSURANCE REPORT FROM THE FINANCE & PERFORMANCE COMMITTEE** *To RECEIVE the Finance & Performance Committee Assurance report from the meeting held on 28 April 2016 from Mr T Gadsby, Chair/Non-Executive Director*	Assurance Enclosure 12
20.	**GOING CONCERN DECLARATION** *To RECEIVE for the Going Concern Declaration from Miss S Robinson, Director of Finance and Performance*	Note Enclsoure 13
21.	**PERFORMANCE AND QUALITY MANAGEMENT FRAMEWORK REPORT (PQMF) – Month 12** *To RECEIVE the month 12 Performance Report from Miss S Robinson, Director of Finance and Performance*	Assurance Enclosure 14

22.	**ASSURANCE REPORT FROM THE AUDIT COMMITTEE** *To RECEIVE the Audit Committee Assurance Report held on 28 April 2016 from Mr T Gadsby, Interim Chair/Non-Executive Director*	Assurance Enclosure 15
23.	**ASSURANCE REPORT FROM THE BUSINESS DEVELOPMENT COMMITTEE** *To RECEIVE the assurance report from the Business Development Committee held on 29 April 2016 from Mr P Sullivan, Interim Chair/Non-Executive Director*	Assurance Enclosure 16
	TO BE A DYNAMIC ORGANISATION DRIVEN BY INNOVATION (Strategic Goal)	
24.	**COMMUNICATIONS STRATEGY** *To RECEIVE the Communications Strategy from Mr P Draycott, Executive Director of Leadership and Workforce*	Assurance Enclosure 17
25.	**To *DISCUSS* any Other Business**	
	QUESTIONS FROM MEMBERS OF THE PUBLIC	
26.	*To ANSWER questions from the public on items listed on the agenda*	
	DATE AND TIME OF THE NEXT MEETING	
27.	*The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Thursday, 14 July 2016 at 10:00am.*	
28.	**MOTION TO EXCLUDE THE PUBLIC** *To APPROVE the resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admissions to Meetings) Act 1960)*	
	THE REMAINDER OF THE MEETING WILL BE IN PRIVATE	

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

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

North Staffordshire Combined Healthcare NHS
NHS Trust

TRUST BOARD

Minutes of the open section of the North Staffordshire Combined Healthcare NHS Trust Board meeting held on Thursday, 31 March 2016 At 10:00am in the Boardroom, Trust Headquarters, Lawton House Bellringer Road, Trentham, Stoke on Trent, ST4 8HH

Present:

Chairman:

Mr K Jarrold
Chairman

Directors:

Mrs C Donovan
Chief Executive

Mr D Rogers
Non-Executive Director

Dr B Adeyemo
Medical Director

Mr P Sullivan
Non-Executive Director

Mr P O'Hagan
Non-Executive Director

Ms A Harrison
Interim Director of Finance

Mr P Draycott
Executive Director of Leadership &Workforce

Dr K Tattum
GP Associate Director

Mr T Gadsby
Non-Executive Director

Ms M Nelligan
Executive Director of Nursing and Quality

Ms S Robinson
Director of Finance and Performance

Mr T Thornber
Director of Strategy and Development

Mrs B Johnson
Non-Executive Director

Mr A Rogers
Director of Operations

In attendance:

Mrs L Wrench
Associate Director of Governance

Mrs J Scotcher
Executive PA

Ms J Harvey
UNISON

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

Brian Goodfellow

Caroline Thomsett
Interim Associate Director of Communications

Team Spotlight:
CYP Central Referral Hub
Kath Clarke – Head of Directorate
CAMHS Maxine Buckingham
Karen Clowes
Sarah Hallam

Individual spotlight
Claire Lamb
Occupational Therapist

Staff Retirements
Bal Matharu,
Personal Assistant
Steve Blaise,
Deputy Director of Finance

The meeting commenced at 10:00am.

333/2016	**Apologies for Absence** Apologies were received from Dr Laws and Mr Cotterill. The Chair gave a warm welcome to Mrs Robinson, Director of	**Action**

	Finance and Performance and stated that the Board were delighted to see her today, Ms Harrison is still with the Trust at present, but will be working in a different capacity. The Chair thanked Ms Harrison for all her support and hard work The Chair also gave a warm welcome to Ms Thomsett, Interim Associate Director of Communications, who will be working with the Trust.	
334/2016	**Declaration of Interest relating to agenda items** There were no declarations of interest relating to agenda items.	
335/2016	**Declarations of interest relating to any other business** There were no declarations of interest.	
336/2016	**Minutes of the Open Agenda – 25 February 2016** The minutes of the open session of the meeting held on 25 February 2016 were approved as a correct record.	
337/2016	**Matters arising** The Board reviewed the action monitoring schedule and agreed the following:- ***218/15 - Safe Staffing Monthly Report -*** The Board will be aware of a staffing review in line with national quality expectations, the dates have been set before Christmas for Wards 1, 2, 3, Rehab and CAMHS. The findings of the review will be reported to the Board in January 2016, with a view to address the other wards, Learning Disabilities and Older people going forward. ***– on today's agenda remove from schedule*** ***297/16 -CEO Update*** - The Chair thanked Mrs Donovan for her update and stated that he was intrigued by Health Education England (HEE) in respect of the new nursing support role and would like to see our draft response for the Board, this is a moment of some significance. Ms Nelligan confirmed this would be presented on 9 March 2016 at the Board of Directors session prior to submitted on 11 March 2016. ***Completed – remove from schedule*** ***302/16 - Safe staffing Monthly report*** - The Trust is developing our own bank, as we move away from agency use. There is a requirement to be more robust in terms of bank usage. The report in March will have more detail in terms of recruitment and gaps identified. The report will also incorporate going forward, what kind of issues we	

	want to see in the monthly report. ***On today's agenda – remove from schedule*** ***302/16 - Safe Staffing Monthly report*** - Mrs B Johnson suggested that it may be beneficial to have a bank set up for Activity Workers. Ms Nelligan agreed to explore this proposal. ***On today's agenda – remove from schedule*** ***302/16 - Safe Staffing Monthly report*** - Mrs Donovan also raised concerns with occupancy levels on the adult acute wards and in comparison to benchmarking data this is high. Mr A Rogers is undertaking a piece of work with the new Head of Directorate and commissioners, in order to collect data on how many service users are being sent out of area. ***On today's agenda – remove from schedule*** ***309/16 - Committee Effectiveness Update*** - Mrs Wrench to do a further report to come back in March and April 2016. ***– On today's agenda – remove from schedule*** ***312/16 - Any other business -*** Junior Doctors Industrial Action- Mr Draycott raised the forthcoming Junior Doctors Industrial Action scheduled over a 48 hour period at 8am on 9 March 2016. On 10 March 2016 there is a Continuing Professional Development (CPD) session so this will reduce impact on patient care. ***On today's agenda – remove from schedule***	
338/2016	**Chair's Report** The Chair stated that this was his last Board and that it seems appropriate to reflect on where we are as a Trust. The Chair stated that he believed that we are well on our way on our journey of recovery, healing and renewal. The Chair further commented that he had some regrets. The biggest regret, by a margin, is the great difficulty we had in recruiting to the post of Director of Nursing. However, the Chair commented that he was delighted that Ms Nelligan joined the Trust in October 2015. His greatest satisfaction has been to have been involved in appointing Mrs Donovan as the Chief Executive and to see all that has followed including the strengthening of the Executive and Directorate Teams. The agenda ahead is demanding. 1. Implementing the CQC Report including the significant staffing increases in CAMHS and moving from the expected rating of "requires improvement" to "good" and, one day, to	

	"outstanding". 2. Building on all the initiatives in staff engagement and the improved staff survey scores including the scores for the . Friends and Family test. 3. Continuing to work on the pressures in the adult wards and safer staffing. 4. Working with everyone in the Adult Community services on the difficult issues of staffing, caseloads and process. 5. Strengthening our engagement with service users and carers including revitalising our approach to complaints and comments. 6. Build the future on four cornerstones. • Primary care and the GP Federations • Social care delivered by Stoke on Trent City Council and by Staffordshire County Council in Newcastle under Lyme and the Staffordshire Moorlands • University Hospital of North Midlands • Voluntary and third sectors. The Chair concluded that the future is not about fortress organisations, however successful. The future is about relationships across health and social care systems with service users, carers and front line staff at the centre of all we do. The Chair passed on all good wishes for the future. ***Received***	
339/2016	**Chief Executive's Report** Mrs Donovan, Chief Executive, presented this report which provides an update on the activities undertaken since the last meeting in February 2016 and draws the Board's attention to any other issues of significance or interest. **CQC** The CQC carried out the Trust's inspection in September 2015 and following the recent Quality Summit we can now share our overall rating of '*Requires improvement'* The Trust is on a journey of improvement. Our services were rated as '*Good*' in respect of Caring and '*Requires improvement*' in the four other domains of safety, responsiveness, well led and effectiveness, this is where we need to continue to improve. Most importantly, the Trust should be proud of our caring culture. Our 11 core services rated as follows ; 4 '*Good'* 5 '*Requires improvement'* 2 '*Inadequate'*	

	Our Older People's services and our Learning Disability Community services were rated as '*Good*' with Learning Disabilities services rated as '*Outstanding'* in terms of being responsive. There is the need for greater investment in Trust's CAMHS Community Services to enable more clinical staff to be employed and this was highlighted as a significant issue as to why the service was rated as 'inadequate'. The Trust has worked in partnership with commissioners who have agreed to extra funding in this area. The Trust is disappointed with the CQC's rating of 'inadequate' for our Crisis services which comprises ; • Access Team • Home Treatment • Place of Safety • RAID The Trust feels this is not a true reflection and has shared this view with stakeholders and the CQC. Mr O'Hagan commented that with the Trust's openness and transparency, for the CQC Action Plan/monitoring process should be part of the public board. This was agreed. **New Chairman - David Rogers** David Rogers, currently a Non-Executive Director, will take up his post as the new Chairman on 1 April 2016. The Board noted the retirement of Ken Jarrold, Chairman today and this was his final working day. The Chair gave enormous thanks for his retirement event held yesterday. **Staff Survey** The Trust has made good progress. However, there are still some areas not good enough and we need to improve on. In comparison to all results from last year, we are very pleased to note that in respect of mental health trusts we fall in the top quartile of mental health and learning disability trusts nationally. **Pan Staffordshire – Together we're better programme** There are changes in the governance arrangements and workstreams with 'Together We're Better Programme'. John MacDonald, Chair of the UHNM, has been appointed as the new chair and Penny Harris, as the interim Programme Director. The Trust will continue to play an active part to ensure services improve and are sustainable.	

Listening Into Action
The Trust has launched the third wave of the Listening into Action Pass it on Event with 14 teams involved to showcase the event. The event is scheduled for Friday, 6 May 2016, at Port Vale Football Club. The Trust will be inviting staff, service users, carers and key stakeholders accordingly.

Nutrition and Hydration week
Trust staff have taken part in supporting the national Nutrition and Hydration Week, which took place on 14 – 20 March 2016 and thanks to all staff for getting involved and supporting this important aspect of wellbeing.

Digital by Choice
A team of trust practitioners and project staff visited Norfolk and Suffolk NHS Foundation Trust to see how it has deployed the Lorenzo system with Electronic Patient Records (EPR). The visit has helped us to plan our implementation of Lorenzo and progress and use investment with EPR, engaging with all clinicians. It was noted that the second stage of the EPR Business Case has been submitted to the Department of Health.

Regional Mental Health Medical Directors' Forum
Dr Adeyemo, Medical Director, has been appointed as Chair of the West Midlands Medical Directors Group.

Diversity and Inclusion
The Trust is seeking to engage with patients, service users, carer and local communities to gather feedback about their experiences of using our services. The results of the survey will be used to support our Equality Delivery System assessment and will be published in the Spring 2016/17.

Cap on Agency Expenditure
NHS Improvement has contacted trusts to announce there will be a cap on the amount of money that can be spent during 2016/17 on agency and locum staffing. It was noted there are still challenges with safe staffing and the key issues are managing to attract staff and retain to vacancies.

Junior Doctors
Industrial action was carried out on 9 and 10 March 2016 and it is disappointing to note there is further action in April 2016. The Trust is continuing to work closely with junior doctors and consultants to ensure minimal impact.

Complaints
The Trust has reviewed the Complaints process and has produced an action plan to help strengthen and improve in this area. The Trust will be working with Healthwatch moving

	forward. Mrs H Johnson queried which Healthwatch was involved? Mrs Donovan clarified that it was Staffordshire, however this could be expanded to Stoke. **One Year Plan** It was noted that the One Year Plan will be discussed on today's agenda. The Trust has received positive feedback from the TDA that our plan is strong and credible and demonstrates clear commitment to improving quality. They have also acknowledged the Trust's strong delivery on financial performance. The Chair thanked Mrs Donovan for her report and stated that it is good evidence that we improving our performance and we are providing leadership to our health economy. The Trust is in a good position and this report confirms this. ***Received***	
340/2016	**Individual Spotlight Award** **Claire Lamb, Occupational Therapist, Dragon Square Learning Disabilities Directorate** Claire is an experienced Senior Occupational Therapist. She manages a busy complex caseload in the County Learning Disability Health Team as well as being a highly respected field work educator and a much valued manual handling trainer. However, more than this, Claire is a really committed project worker and it is for her shared leadership of three main projects this year that she has been nominated for the Individual Spotlight on Excellence award. Claire was instrumental in ensuring her team were trained in applying the Health Equality Framework (HEF) and were confident in its use, as well as being key to it being rolled out and embedded in all clinical areas throughout the Directorate. This framework is a nationally implemented outcome measure that was the focus of this year's Learning Disability CQUIN and Claire devised a guide that ensured all 35 clinicians have been able to use the tool with consistency and ease. Claire also had a pivotal role in rolling out the new Electronic Patient Records system and ensuring the user guides were available and staff were trained in an incredibly tight timescale. As with all her projects, Claire understands the importance of ensuring people understand the reasons for change, she is excellent at devising those much needed user guides and has a skill at providing visual aids to assist team learning. More	

	importantly Claire gives time and support whenever her colleagues need her so they can become empowered and independent as quickly as possible for the good of the service. Claire is special because she is a natural teacher, guiding and instructing staff with patience and humour whilst being mindful of the stress felt by staff during the transition to new systems. Mrs H Johnson commented that this is well deserved award and remarked on her support with the PLACE inspections.	
341/2016	**Staff Retirements** Mrs Donovan recognised two staff who are retiring this month as follows; **Bal Matharu – Personal Assistant** Bal Matharu is a valued and trusted member of the administrative team working in the management area of the Harplands Hospital. She has been working for the Trust over the last 17 years in a number of administration and now personal assistant roles. She has worked with learning disability services and also with a number of psychological services, including supporting trainee clinical psychologists placed in the Trust for many years. She is extremely professional and conscientious and always gives her best. She is well liked by everyone and will be missed. She intends to spend more time with her grandchildren and children and also to go on more trips after she has retired. **Steve Blaise - Deputy Director of Finance – retiring 30 April** Steve has completed 40 years dedicated service in the NHS, working 38 years in Stoke on Trent and 2 years in Stafford. Steve started his Finance career at North Staffs Health Authority in March 1976 based at The Limes, Hartshill. Steve stayed at the Limes progressing his Finance career until 1989, Steve then took a role for two years at the FHSA in Stafford. In 1991 Steve returned to The Limes as Deputy District Payments Manager. Steve was appointed as the Trust's Financial Controller in Dec 1993 and subsequently moved to Bucknall Hospital when the Trust was established in 1994. In 2002 Steve moved to the Finance Shared Service at Heron House, as Associate Director and was instrumental in the set up and success of the Shared Service function. Steve returned to the Trust in 2005 as Assistant Director of Finance and finally finishing his career as Deputy Director from July 2013 to present	

	time. Steve is extremely conscientious and hardworking; he has carried out all his duties and roles with dedication, integrity and above all a great sense of humour! In 2015, Steve was nominated for and won the HFMA "Lifetime Contribution Award" which deservedly and formally recognises and acknowledges his tremendous contribution to NHS Finance. As a Senior Manager within the Trust, he has consistently delivered on all aspects of the Financial Agenda, in conjunction with operationally managing and supporting the Finance Team. Steve will be sadly missed by all his colleagues and friends in Finance and the Finance team would like to take this opportunity, to thank him, for his invaluable support and direction as their Deputy. ***Received***	
342/2016	**Spotlight Awards - March 2016** **Team Spotlight Award and Presentation** **The Central Referral Hub** **Children's and Young Person's Directorate** Our Central Referral Hub was recognised for improving access to our Child and Adolescent Mental Health Services (CAMHS). The small team is an excellent example of going the extra mile to ensure that children, young people and their families are supported quickly and appropriately. Resourceful and hardworking, it is very responsive, enabling immediate contact wherever possible for families. It has the potential of becoming a centre of excellence. Comprising dedicated practitioners who have excellent relationships with their social care and third sector colleagues, the team ensure children are triaged, assessed and then supported to receive services from our Trust or externally. More resources have been given to increase the team - which is now based at the Bennett Centre - to take on additional tasks including CHOICE appointments and short-term interventions. Sometimes the team faces people who're unhappy with waiting times but the practitioners are consistently excellent in their professional response, supporting the families as well as communicating well with the directorate and external agencies. **Patient comment** Sadly, the patient who was due to attend at today's Board is unable to be here. However, two parents are happy to share their stories. The patient's mother was looking for help for her	

	son at a time of crisis. He had previously been known to CAMHS. She found the service through 'google' and immediately spoke to a clinician who, coincidentally, knew her son and was able to speak to him and help him calm down. An urgent CHOICE appointment was arranged for that day. His Mum described the clinician as doing 'an amazing job'. This led to a referral to psychiatry and her son was seen the following week. Another parent wrote about her autistic son who was eight when a referral was made. He struggles with all aspects of daily life and last summer became very upset about life and how hard it was to get through each day. He started to talk about suicide and began to self-harm. The family had to remove knives from the kitchen, as his angry outbursts were out of control, and it was in turmoil as to know what do. His mother said in her letter: "From my first initial phone call with the service, I was able to speak to someone about his behaviour and had follow-up calls, I felt like I was being listened to and was given practical advice over the phone, before we met someone in person". Both examples show the Central Referral Hub supporting parents and children to receive the help they need and how much they value it. Mrs Clark, Head of Directorate, led the presentation and introduced the team: Karen Clowes, CAMHS Service Manager for the Central Referral Hub, Maxine Buckingham, Mental Health Practitioner and Sarah Hallam, Practitioner from Younger Mind. Concerningly, the directorate had been issued with a Section 29a Warning notice following the CQC inspection. Mrs Clark gave the background in respect of the improvements made within the CAMHS Directorate. The directorate have taken steps to improve and enhance all areas and taking on board the recommendations made by the CQC. The Directorate have ; • Recruited additional staff Band 4 and Band 7 staff, with further plans for additional recruitment. • Worked with Neuro and Old Age Psychiatry Directorate undertaking peer reviews • Received external scrutiny from Healthwatch	

	Mrs Clarke urged for the Board to be their critical friends and invited the Board to visit. She gave further assurance that if the CQC inspectors were to come today, the directorate can evidence the significant improvements they have made. Dr Tattum commented on the improvements and made an observation from a GP perspective. There had been a phone call after surgery from a carer in a care home in respect of a young lady allocated to this area. There was obvious cause for concern, but the response was of a high quality and timely, with the patient safe demonstrating this as a superb example of how the team work. Mr O'Hagan congratulated the team on their improvements. Mr A Rogers referenced the estate and that the team are currently based at Dragon Square. There have been security issues which are being resolved. Mrs Donovan thanked the team on improving services for children and families in community. She asked if the team had visited other hub teams? Karen Clowes, recently appointed, confirmed that this was one of her plans. Mrs Clark also stated that the Hub could learn from the Access team model as well. The Chair thanked the team very much and stated that he made 3 observations. 1. To remind the Board of the background and scale of challenges that were found 2. It was splendid to see partnership working between young MIND and the Trust. ***3.*** The response time of the team when services users and carers is crucial ***Received***	
343/2016	**Quality Committee Summary held on 15 March 2016** Mr Sullivan, Chair of the Quality Committee/Non-Executive Director, presented the summary of the Quality Committee held on 15 March 2016 for assurance purposes. Policies approved as follows: 7.17 Health Records Management and Standards – 3 years 7.22 Registration Authority 12 months ***Ratified***	

	The Quality Committee received in terms of assurance and informance purposes ; • ***Director of Quality Report*** - under the SPAR quality priorities. • ***Letter to CEO Quality Surveillance*** – now amber in respect of CQC issues • ***CQC Quality Assurance Update*** • ***Update CQC intelligent Monitoring Report*** • ***Nursing Associate Roles*** – Proposals for the introduction of a new role to cover whole range of issues working alongside the Registered nurses and Care staff with a focus on direct care. • ***Quality Impact Assessment CIP*** – Position statement received. • ***PALS and Complaints report Q3 -*** assurance received with action being taken and work being done to respond to issues • ***Directorate reports –*** received • ***Safe staffing Monthly report*** – this was scrutinised • ***Terms of Reference - Information Governance Group –*** *approved* Mrs H Johnson stated that she had some concerns regarding the movement of Psychological Services team. Dr Adeyemo clarified that over the past 6 months psychologists have been integrated into individual community teams. She stated that she was not aware of any difficulties, however there are alternative arrangements to use at the Harplands Hospital, if this is more convenient. Mrs H Johnson confirmed reassurance. Mrs H Johnson also commented on whether NSUG could be more involved on the Trust developments with a PICU unit, Mr A Rogers to speak to Dr Fazal-Short. Mrs H Johnson noted how pleased she was to hear about the Nurse Associate roles being implemented.	**Mr A Rogers**

	The Chair was pleased to learn that Ms Nelligan and Mr Sullivan are monitoring complaints handling and that this is so important these matters are dealt with in a sensitive and timely manner. ***Received***	
344/3016	**Safe Staffing Six Monthly report** Ms Nelligan, Executive Director of Nursing and Quality, presented the safe staffing six monthly report. The report sets out the key recommendations from the six monthly review of ward nursing staffing establishment completed in February 2016 in line with NHS England and National Quality Board (NQB) requirements. Ms Nelligan drew the Board's attention to the level of work which goes into the report with support from ward level and the Deputy Director of Nursing Services. The main objective is to improve quality and safe staffing levels. Ms Nelligan further commented that she has been very impressed with the level of recording amongst teams and services. The report consists of quantitive and qualitative data and there has been no harm reported. Staff are encouraged to report in an open and transparent way. Ms Sylvester, Deputy Director of Nursing, was present for this item and highlighted the themes and recommendations. The review covers the period July 2015 – December 2015 and was undertaken across inpatient areas using the Telford model. Ms Sylvester noted that there has been some real challenges in respect of the impact of the lack of registered nurse vacancies. The following issues were noted : • Increasing frequency of the Ward managers delivering 'hands on' care. • Increased acuity, in particular on Ward 1 • Ward 1 are currently managing patients who are clinically appropriate for a PICU. • Ward 3 - high occupancy and high observation levels • Darwin Centre – increases in admissions with young people with eating disorders • Ward 5 and 6 complexity of physical conditions with mental health It was further noted that under-occupancy is not indicative of acuity.	

	In respect of the Place of Safety where there is unpredicted and unplanned activity with variable lengths of stay and observation, there has been an increase in detentions in 2015 in comparison to 2014. These being a total of 156 detentions, an increase of 57 from the same period in 2014. This will continue to be monitored. A rota system for the place of safety cover will further be enhanced upon recruitment to vacancies. In respect of ECT, there are twice weekly clinics with sometimes 3 or 4 patients who require escorts. A Task and Finish group has been set up to review flexibility according to need. The feedback with Activity Workers has been very positive in respect of patient experience and in some areas this has been extended cover to 7 days. There have been some challenges for night staff taking meal breaks. There is positive staff culture, with staff feeling supported in reporting staffing related incidents. Ms Sylvester noted to the Board that there is an increase in staffing incidents, but this is more about the positive reporting culture, as it is about challenges of vacancies. Ms Sylvester drew attention to Page 11, in respect of challenges with vacancies both nationally and locally. This gave a breakdown of vacancies for each ward, together with the assurance for the Trust's recruitment position. The Trust has developed a number of initiatives with the aim of attracting, recruiting and retaining Registered Nurses with a broader recruitment campaign and these are outlined within the report. There is a requirement for an uplift in establishments with Ward 5, the current shift pattern 5/5/3 and requires a revision to 6/6/4 approx 6.2 WTE. The review of Dragon Square concluded that additional support services staff are required to address the current arrangements of care staff predominately responsible for cleaning the unit apart from school holiday period and this will be considered by the staff team by review of skill mix. Finally, Ms Sylvester drew attention to Page 16, Recommended WTE adjustments and to note summary and recommendations; • Consider the staffing establishments and recommended WTE adjustments • To note the Trust compliance in meeting with National Quality Board requirements • Work required prior to the next 6 months; review of establishments in relation to Headroom and Registered	

	Nurse cover on night duty • Plans for recruitment and retention of in-patient staff • The Deputy Director of Nursing to work with the finance team to identify the resources required to meet the recommendations of this review.	
345/2016	**Safe Staffing Monthly report** Ms Nelligan, Executive Director of Nursing and Quality, presented the assurance report. This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during the data collection period (1 – 29 February 2016) in line with the National Quality Board expectation. During February 2016, the Trust achieved staffing levels of 103.08% for registered staff and 99.00% for care staff on night and day shifts. It was noted that there are a number of wards who have fallen below 100% fill rate. This is due to a number of factors, the main reason being the registered nurse vacancy rate, in addition, as identified in the 6 monthly review, headroom factor is required to support effective rostering allowing for leave and short term sickness. As a result, a number Ward Managers have undertaken increased direct clinical care to ensure delivery of safe services. There has been some challenges to care worker fill rate generally, with short term sickness, this has shown an impact on the fill rate, where we are unable to secure temporary staffing. From November 2015, further metrics have been added to the report with detail on patient safety and experience and staff experience. This includes a breakdown of any incident forms submitted within the month to which the report relates. In respect of the Patient experience impact, Activity workers have been rarely redirected to other care rather than activity. On Ward 1, the registered nurse night fill rate is recorded at 207%. Currently, one registered nurse is planned for the night shift and therefore any registered nursing shift over this will reflect in the overall fill rate however, additional resource has been required to support the Place Of safety facility and increased observation levels	

	Mr Sullivan gave thanks to Ms Nelligan and Ms Sylvester for the report. Both reports are very informative and comprehensive however there are a couple of areas he raised some concerns. It is not a criticism of Ward 1 and he commented that he had visited and been impressed. His concern is, the acuity appears to be higher, but we seem to be taking patients that are more difficult into an environment that has challenges in terms of the complexity of patients admitted and we need to be very supportive of staff and how they manage this. Added to that, they have more problems in reaching 100% staffing fill rates. Secondly, Mr Sullivan commented that he has concerns about temporary measures around seclusion. Ms Nelligan noted that there are plans to improve these areas and to ensure the specification of seclusion is correct. The training is carried out by Mr D Burgess and this will be picked up through the Quality Committee. Ms Nelligan further commented that she is working with Mr Draycott to enhance the recruitment campaign, as previously mentioned. Discussion took place regarding the strong effective efficient teams the Trust has and this is about investment in relation to vacancies and agency. The Trust is developing our own bank; however this needs quality and financial balance. Ms Nelligan further added that in her previous role this took approximately 18 months. Mr Gadsby queried what plans are being put in place to mitigate periods such as school holiday period and peak annual leave? Ms Nelligan confirmed that the Trust needs to fill vacancies and Headroom and this will have enabled the additional capacity to be filled. It was also noted that there is the development of an E-rostering system, which will help improve efficiencies. Ms Harrision is currently working with wards in respect of an electronic rota. Review of shift patterns is also underway, together with Policies around annual leave, to avoid the 'March' ballooning. Mr Draycott confirmed this had been discussed at JNCC in respect of the change of annual leave to make more flexible. This is under review and in discussions with our unions. He reiterated that the Trust is aiming to attract and retain with a broader recruitment campaign, working with CMS Advertising, not just locally but nationally. It is also anticipated to '*introduce a friend scheme'* with other incentive schemes being considered.	

	Ms Harvey commented in respect of E-rostering and this has previously been used in the past. She raised concerns that the system needs to work effectively ensuring capturing of all data. She further raised the recording of staff not taking breaks and this needs further clarity; was this that staff were being denied a break or choosing not to take a break? Ms Harvey suggested that the Trust look at ways of developing HCSW roles into registered nursing roles and that it is not easy for some staff to go down the student route. Ms Nelligan agreed that this was a good point to raise in respect of developing HCSW roles and this will be considered. There have been some discussions about open university for HCSW working jointly with UHNM, in addition maximising apprenticeships. Mrs H Johnson commented that bed occupancy is still high on Wards 1, 2 and 3 but this is reducing in some areas. She further praised staff on Ward 2 in that they have had some very complex patients and it is good that staff are managing that, with the sickness on the ward. The Chair noted that the level of scrutiny and time spent on these two reports is crucial and he thanked Board members for their input. He further noted the vital role of the Activity Workers and that he urged members to think about how they might feel as inpatients and that having something to do is really important and part of their recovery. Secondly, the Chair commented on the national focus for recruitment and whether there are any Schools of nursing who are trying to recruit their students and this should be considered. Finally, the Chair noted that 4 or 5 years ago, the Trust would never have had this discussion at board level and that he recognised all the hard work and support in preparation by Ms Nelligan, Ms Sylvester and Mr Draycott and their teams. The test of a good board meeting is if the frontline staff were here, this is what they would want us to discuss. ***Received***	**Mr Draycott /Ms Nelligan**
346/2016	**Service User and Carer Council** Mr Cotterill, Chair of the Service User and Carer Council, was not able to attend today. However, Ms Nelligan gave a verbal update on his behalf.	

	Thank you to the Chairman, Ken Jarrold, for his contribution to North Staffordshire and wished him a well earned retirement. The council were recently involved with the selection of the new Chairman and the best candidate had been chosen. The council welcomed the CQC report and will be actively involved with the roll out, continuing to work with staff, service users and carers. The council will actively take part in the Listening into Action involving all 6 directorates. At the last council meeting, there was a discussion regarding the triangle of care and recovery focus which will help to improve services. ***Received***	
347/2016	**Monthly Finance Reporting Suite –February 2016** Mrs Robinson, Director of Finance, presented this report which contains the financial position to 29 February 2016. The Trust's financial performance is a retained surplus of £0.120m against a planned deficit of £0.001m, a favourable variance of £0.121m. The in-year cost improvement target is £2.658m with a year to date performance of £0.05m behind plan. The cash balance as at 29 February 2016 was £6.3m. The net capital expenditure is £0.468m which is behind the Plan of £0.985m, an under spend of £0.517m. It was noted there delays with A&T Telford with legalities with NHS England, this will move into 2016/17 financial year and is justifiable. The Continuity of Service risk rating is reported as 3 in line with the plan. The cost improvement programme is slightly behind plan, with £232m being achieved against the target of £2.37m, with a high portion of non-recurrent element. ***Received***	

348/2016	**Finance and Performance Committee Assurance Report –24 March 2016** Mr D Rogers, Non-Executive Director, gave a verbal update from the Finance and Performance Committee held on 24 March 2016. Mr D Rogers clarified that the role of the Finance and Performance Committee is to challenge and scrutinise accordingly and those challenges were made at the meeting, specifically with performance . The Finance and Performance Committee discussed the Capital spend and noted that this is a significant issue. In respect of decision making, some aspects have been put on hold with the pending appointment of Mrs Robinson, Director of Finance, in order for her to give her opinion. Mrs Robinson noted that Contract had been received that morning. This will be reviewed later today and during the Opening Budgets section. Also on a positive note, Dr Adeyemo had negotiated an additional £100,000 at the recent Commissioning Board. The Chair thanked the Finance Team and on behalf of the Board stated that we need to continue to monitor the non-recurrent element closely. ***Received***	
349/2016	**Performance and Quality Management Framework Report (PQMF) Month 11** Mrs Robinson, Director of Finance, presented this report. The report provides the Board with a summary of performance to the end of Month 11. At Month 11, there are 4 metrics red and 6 amber. ***Delayed Transfers of Care (DTOC)-*** red rated although the performance has improved from last month. ***Nursing Agency spend*** – as discussed we have got plans in this area. ***MRSA Screening*** - Ward 1 reported a lapse in MRSA admission screening during February 2016, however no harm has come to patients. An Action plan is underway with ward staff	

	Complaints* –** there was a backlog which has been addressed. A strengthening process has been put in place. Mr A Rogers stated in respect of the DTOC, safe staffing we are above target. The actual figure may be revealed as higher than the target, but this is due to issues with the panels not taking place in a timely way, it is not always a specific delay. Dr Adeyemo gave further assurance with Mrs Munton- Davies is driving this forward and has a social care background. Mrs Donovan noted the disappointing CPA performance – 94.2% at Month 11 from 94.8% at Month 10, this needs to be improved. Mrs Donovan also noted under the Complaints – the target of '0' is incorrect. There are 13 complaints beyond agreed time scale, the second sentence under the commentary should read 'improvement' not 'important'. ***Received	
351/2016	**Opening Budgets 2016/17** Mrs Robinson, Director of Finance, gave a presentation in respect of Opening Budgets 2016/17. The Board presentation covered the following areas: Sustainability Challenges and Opportunities Planning Assumptions Funding Investment Income 5 Year Capital plan The Board noted the recommendations : – Noted the 2016-17 planning assumptions – Approved the 2016-17 Adjusted Financial Performance Surplus **£0.9m**. Approved the 5 Year Capital plan (2016 to 2021) of **£6.93m**, whilst noting all schemes are subject to approval through individual business cases. The Chair added that he was very pleased to see the Capital Programme. ***Received***	

352/2016	**People and Culture Development Committee Assurance Report – 21 March 2016** Mr O'Hagan, Chair of the People and Culture Development (PCD) Committee/Non-Executive Director presented the assurance report from the People and Culture Development Committee held on 21 March 2016. Mr O'Hagan commented on the positioning of this item on the agenda and requested this be discussed higher up on the agenda in future. Mr O'Hagan raised another concern in that Compassionate Leadership had not initially come through the PCD Committee, as this was one of their priorities. Policies discussed as follows; Management of Change Policy – ***Ratified*** Probationary Periods Policy – ***considered but needs amendment to come to next meeting*** Mr O'Hagan stated that there had been a long debate at the committee in respect of the Terms of Reference. Mr O'Hagan stated that he felt the Terms of Reference did not have clear alignment with our objectives, data and risk. Mr O'Hagan also urged that other Chairs of committees ensure there are no gaps. It was also noted that attendance is always very good. The PCD committee expressed the desire to continue to meet on a monthly basis and continue the current pattern of development one month and then business the next. ***Received***	**Mrs Wrench**
353/2016	**NHS Staff Survey Results 2015** Mr Draycott, Executive Director of Leadership and Workforce, presented the Staff Survey 2015 – detailed analysis and actions proposal. The results of the 2015 NHS Staff Survey were released from embargo on 23 February 2016. Overall, the results are positive. There has been an encouraging improvement in the scores in the vast majority of survey questions and key findings measures. The Trust was average or better for 26 (81.25%) of the 32 key findings measures and below average on 6 measures, representing a significant improvement on 2014. The Trust maintained or statistically significantly improved our scores in all but one survey measure in the 2015 survey.	

	Key areas for development action from the 2015 survey are: 1. Pride and recommendation of the Trust to our families (staff advocacy) 2. Staff feeling safe to raise concerns 3. Staff health and wellbeing 4. Presenteeism – pressure to attend work when feeling unwell 5. Violence and Aggression towards staff On page 7, the Board noted that the Trust falls into top quartile of Mental Health and Learning Disability Trusts as presented in the scatter map. The Board noted the contents of the Action plan at Appendix 3, which addressed the five key priorities as above and the Board needed to understand the reasoning behind some of the results. Discussion took place regarding the improved return rate which had been circulated in hardcopy format. Ms Harvey commented in respect of Presenteeism. Sometimes staff feel compelled to come into work, when they are clearly not well and the sickness policy could be managed in a more holistic way. Mr Draycott agreed that given the level of return on presenteeism, the board needed to understand the issue in more detail. Dr Tattum queried the percentage of those experiencing violence. Physical violence for staff and relatives is unacceptable and that within primary care there is a strict zero tolerance procedure which is reinforced. Mr Draycott stated that it is about getting the balance right and there has been some progress in this area by Mr D Burgess. This is also reported on a frequent basis to the Quality Committee reviewing all incidents and trends. Ms Harvey confirmed that in relation to staff to staff violence there was no evidence. Mr Gadsby raised the 'impact on patient care' results and that it appears that corporate teams do not consider having any impact on patient care and that is a concern. This is a large number of people who feel disconnected. Mr O'Hagan stated it may be worth focusing a Board of Directors' session in order to get consistency across the organisation. It was noted by Dr Adeyemo that the Aston Team programme is of benefit in reinforcing this point.	

	On page 11 and 12, the Directorate themes were noted. The Chair commented that this links with the results of the CQC results in that management and leadership mean a difference to staff with good performance for NOAP and LD directorates Mrs H Johnson noted that she would be able to support the Trust as much as possible in the areas for improvement. ***Received***	
354/2016	**Any other business** A member of the public, Brian Goodfellow, commented on today's meeting. He stated that in comparison to UHNM, this Trust is financially balanced and is going forward. However, he raised concerns regarding the presentation from the beginning of the meeting with the CAHMS Directorate and the findings of the CQC inspection. The Chair stated that this is a difficult balance as a Board, we remain keen to face up to the realities, we have tried very hard to be open and honest. It is very helpful for these comments Mr Goodfellow also commented that the Trust had pursued the Foundation Trust status some years ago and were unsuccessful but he could see no reason why this is not achievable now. The Chair commented that as we are all aware the Trust was one of the very first trusts to apply, but we failed. The Trust should have achieved this in 2005/06, we then tried again 2011/12 and unfortunately failed again. At that time national deadline was 2014 to become Foundation Trust, however at this stage the Trust began a process of acquisition and we put all our energies in getting our house in order. The Chair further added this organisation is now ready when the time comes to be a Foundation trust. There is a new national statement and there is is going to be a new route to Foundation Trust services launching this summer 2016.	
355/2016	**Date and time of next meeting** The next public meeting of the North Staffordshire Combined Healthcare Trust Board will be held on Wednesday, 11 May 2016 at 10:00am, in the Boardroom, Lawton House, Trust HQ.	

356/2016	*** Motion to Exclude the Public** The Board approved a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted.	

The meeting closed at 12.20 pm

Signed: _____ Date_____
Chairman

Board Action Monitoring Schedule (Open Section)

Trust Board - Action monitoring schedule (Open)					
Meeting Date	**Minute No**	**Action Description**	**Responsible Officer**	**Target Date**	**Progress / Comment**
31-Mar-16	343/2016	**Quality Committee Summary of meeting held on 15 March 2016** - Mrs H Johnson commented whether NSUG could be more involved on the Trust developments with a PICU unit. Mr A Rogers to speak to Dr Fazal-Short t	Mr A Rogers	11-May-16	
31-Mar-16	345/2016	**Safe Staffing Monthly report** - The Chair commented on the national focus for recruitment and whether there are any Schools of Nursing who are trying to recruit their students and this should be considered. Mr Draycott to follow up with regional School of Nursing	Mr Draycott	11-May-16	
31-Mar-16	352/2016	**People and Culture Development Committee Assurance Report - 21 March 2016** - Mr O'Hagan commented on the positioning of this item on the agenda and this should be discussed higher up in future	Mrs Wrench	11-May-16	

REPORT TO Trust Board

Enclosure 4

Date of Meeting:	11 May 2016
Title of Report:	Chief Executive's Report
Presented by:	Caroline Donovan, Chief Executive
Author of Report:	Caroline Donovan, Chief Executive
Purpose / Intent of Report:	For information/update
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.
Seen at SLT or **Exec** Meeting & date	SLT/EXEC: Date: Document Version number:
Committee Approval / Review	• Quality Committee ☐ • Finance and Performance Committee ☐ • Audit Committee ☐ • People and Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐
Relationship with: *Board Assurance Framework* *Strategic Objectives*	1. To provide the highest quality services ☐ 2. Create a learning culture to continually improve. ☐ 3. Encourage, inspire and implement research at all levels. ☐ 4. Maximise and use our resources intelligently and efficiently. ☐ 5. Attract and inspire the best people to work here. ☐ 6. Continually improve our partnership working. ☐ 7. To enhance service user and carer involvement. ☐ **Comments:**
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	-
Resource Implications: Funding source:	-
Equality & Diversity Implications:	-
Recommendations:	To receive the report for information

Chief Executive's Report to the Board of Directors
11 May 2016

PURPOSE OF THE REPORT

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

LOCAL UPDATE

1. CARE QUALITY COMMISSION (CQC)

The CQC have informed us that we will be receiving another comprehensive inspection commencing on Monday 12 September. This is part of a new round of repeat inspections and follows the completion of the first wave of all mental health trusts in England by June.

We had invited the CQC to come back to review our progress in September with the aim of achieving a 'good' overall rating. The comprehensive inspection gives us the opportunity to demonstrate our continued journey of improvement, to improve on our overall rating. We have asked all our services to set their own ambitions of the rating they would like to receive and to work to attaining their goal.

Meanwhile, we continue to make good progress on our action plans from the last inspection in September. A significant amount of work has gone into service improvements and this is very evident.

The CQC reviewed our progress on our Child and Adolescent Mental Health Services (CAMHS) on 26 April. This was an unannounced inspection and we are awaiting formal feedback. The high quality of our staff was commented on and there were no immediate concerns raised.

2. STRONG YEAR END FINANCIAL PERFORMANCE

The Trust has ended 2015/16 with a break-even position. This is the 17th consecutive year we've demonstrated strong financial performance and, in the current extremely challenging climate, is a testimony to the hard work of staff across the organisation. Our £2.6m Cost Improvement Programme (CIP) was also delivered. It did include some non-recurring savings, which have been added to our savings target for 2016/17.

3. DIGITAL BY CHOICE

Our ambition is to become a 'digital by choice' organisation with a national reputation as a leader in the use of digital technology.

An integral part of the programme is the introduction of a new electronic patient record (EPR), which we have named our ROSE programme – Raising our Service Excellence.

The Digital by Choice Programme Board have approved the third and final business case and this has been submitted to the Health & Social Care Information Centre (soon to be renamed NHS Digital) and NHS Improvement. Our previous business cases received very positive feedback and we hope to attract around £15m of support funding to implement the new system. A final decision is due shortly.

The new more comprehensive system will replace a range of software, revolutionising care with accurate up-to-date information that can be quickly and easily accessed at all locations, eliminating any need for paper records and improving both safety and efficiency. I will drive improvement across the organisation and raise the quality of our services.

We plan to go live with the new system in March 2017.

4. DEMENTIA DIAGNOSIS RATES

Our dementia diagnosis rates for people over 65 in Stoke on Trent are now the best in the Midlands and among the best nationally. Latest performance for the end of March from NHS England reveal that 87.9% of people living with dementia in the city have been diagnosed and are receiving treatment. In North Staffordshire, the diagnosis rate stands at 71.9% against a national target of 67%. The high rates are the result of hard work of the Trust's Memory Clinic Service which provides assessment, diagnosis and treatment for people with dementia and Alzheimer's disease.

5. CQUINS

The Trust has achieved 100% of its five Commissioning for Quality Innovations (CQUINs) for 2015/16. CQUIN is a national framework for agreeing local quality improvement schemes and makes a proportion of our total potential income from CCGs (2.5%) conditional on the achievement of ambitious quality improvement goals and innovations.

A big thank you goes to all our staff who have led on this achievement who I have also personally thanked

6. TOGETHER WE'RE BETTER PROGRAMME

The Together We're Better Staffordshire programme has recently completed its initial submission on the key areas of collaborative work that will improve the health of the population of Staffordshire and Stoke-on-Trent. Following positive feedback from NHS England and NHS Improvement, the work streams will move to the next stages of developing the county-wide plans to inform the Sustainability and Transformation Plan (STP).

This plan will enable all of our local organisations to share understanding of where we are now in terms of our priorities for change, as well as helping us develop our collective ambition for 2020 and the concrete transformation steps needed to get us there.

We remain a very active partner in the programme. I am the Senior Responsible Officer on the mental health, organisational development (OD) and system leadership and IT and technology workstreams. The first mental health board recently had its first meeting focussing on repatriation. We are also working closely with our partners on building the Multispecialty Community Providers (MCPs) locally and ensuring mental health is a key component of the new care models, which are designed to move specialist care out of hospitals into the community.

7. LEADING WITH COMPASSION

We have recently launched 'Leading with compassion' – a new scheme that empowers staff, service users, carers and others who have experienced an act of kindness or empathy from a colleague or member of Trust staff to nominate them.

There are countless acts of compassion that our hugely dedicated and passionate staff give to people using our services, carers or colleagues each and every day. Leading with Compassion is a really powerful way to recognise these and by nominating someone it says 'your act of kindness or empathy made a difference'.

Leading with Compassion scheme is led by the Trust and has been funded by Health Education West Midlands and the Shropshire and Staffordshire Local Education and Training Council and is being rolled out to other NHS organisations in Staffordshire and Shropshire.

The scheme is also providing opportunities for local organisations to collectively learn from each other and share best practice.

I have been encouraging our staff and would ask anyone who has come into contact with our services to nominate someone whose compassion has made a genuine impact. By doing this we can inspire a real movement for change and further improve the culture in which we both work and experience care in the NHS.

8. JUNIOR DOCTORS

I would once again wish to thank our staff for their support during the recent junior doctor industrial action. Plans were put in place to ensure our inpatient services at Harplands Hospital and our crisis services for people needing urgent help were maintained during the industrial action. A small number of clinics at the Sutherland Centre in Dresden and Greenfield Centre in Tunstall were cancelled in order to maintain high quality services across the Trust and appointments were rearranged with those affected.

We will continue to work closely with our junior doctors and our consultants to ensure the impact within the Trust is as minimal as possible and our priority will always remain the safety and welfare of everyone using or in need of our services.

9. ACCESS AND HOME TREATMENT JOIN TOGETHER TO PROVIDE MORE RESPONSIVE SERVICE

Our Access and the Home Treatment Teams have merged onto one site at Harplands Hospital in a move designed to streamline services and make it easier for our service users to access our services.

The Access Team - who are the first point of call for Trust services – have moved from the Hope Centre in Hanley. They are now working with the Home Treatment Team, who support people in their own homes providing packages of care as an alternative to hospital admission as well as assistance following discharge.

The services are now under a single management with the aim of providing an improved, more responsive and flexible service centred around the needs of patients and other people needing our care.

There will be no change for anyone using the Trust's services and the telephone numbers for both teams remain the same. People can still be seen at the Hope Centre if required.

10. PSYCHOLOGICAL SERVICES OPEN DAY

I was delighted to attend our first Psychological Services open day, held at the Britannia Stadium in Stoke-on-Trent. The event provided an opportunity for people to find out more about these services, how to obtain therapy and their plans for the future.

We have taken great strides to improve access to specialist psychological care in all of our clinical teams, enabling them to offer a variety of evidence based treatments under one umbrella. This in turn is helping to ensure a smoother journey of recovery.

With one in four of us experiencing a mental health problem in the UK each year, the need for these services is growing, so it is important to understand what is out there and how accessing psychological support and therapy can help.

Thank you to all staff from our Psychological Services for their hard work in making for a successful event.

11. LISTENING INTO ACTION

We will be marking the end of the third wave of our Listening into Action journey with a 'Pass it On' event on 6th May at Port Vale Football Club. The event marks the culmination of the 20-week mission of our 14 wave three LiA teams. The learning and progress they have made to improve services is due to be shared in a variety of fun and informative ways and the task now is to take this forward by fully embedding this into the way we do things in the Trust.

Thank you to our staff, service users and partners for their hard work in making this latest chapter of our LiA journey such a success.

12. NURSING AT ITS BEST @ COMBINED CONFERENCE

The Trust's first internal Nursing Conference - Nursing at its Best @ Combined – is being held on Thursday 12 May at the Britannia Stadium in Stoke-on-Trent. Held as part of the International Nurses Day celebrations, the event will shine a light on nursing from all areas of the Trust.

The event is being led by Maria Nelligan, our Director of Nursing and Quality..

13. GROWTHPOINT AND KNIVEDEN OPEN DAY

One of the highlights of the Trust calendar is the GrowthpoinT and Kniveden Open Day, which this year will be held on Friday 20 May at the Kniveden Partnership in Mount Road, Leek, from 11am-3pm. Both Kniveden and GrowthpoinT, which is located off Leek Road, in Stoke, provide opportunities for people with mental health issues to develop new skills to improve their self-esteem and confidence and get them involved in community projects and activities.

I would encourage as many people to attend this event as possible. As well as the abundance of flora and fauna on display, it also showcases the excellent jewellery, pottery, arts and crafts, planters and other items made by those who use the service. We are very proud to provide these services as they help to make a real difference to people's lives.

NATIONAL UPDATE

14. NEW FIVE-YEAR GP STRATEGY

NHS England has announced a multi-billion plan designed to get general practice back on its feet, improve access for patients and invest in new ways of providing primary care.

The *General Practice Forward View* has been developed with Health Education England and in discussion with the Royal College of GPs and other GP representatives. An extra £2.4billion a year will go to GP services by 2020/21 as well as a £500 million national 'turnround' package to support GP practices and additional funds from local clinical commissioning groups (CCGs). It is aiming to double the growth rate in GPs, through new incentives for training, recruitment, retention and return to practice.

15. NEW NATIONAL MENTAL HEALTH DIRECTOR

The Chief Executive of Central and North West London NHS Foundation Trust, Claire Murdoch, has been appointed as the new NHS National Mental Health Director. A registered mental health nurse for 34 years, she will play a key role in leading the implementation of the recently published report by NHS England's Mental Health Taskforce on the vision for mental health over the next five years.

16. IMPROVING ACCESS TO MENTAL HEALTH SERVICES

The National Audit Office (NAO) has published its first report in a planned programme of work on mental health. It says the Department of Health and NHS England are starting to make progress with the actions needed to implement access and waiting time standards for people with mental health conditions, but much remains to be done. In 2011, the government set an ambition to achieve parity of esteem between mental and physical health. In October 2014, a first set of standards was launched for the access to mental health services that people should expect and how long they should have to wait for treatment. However, the NAO says the full cost of implementing the new standards and meeting longer term ambitions for better services is not well understood.

17. HSCIC RENAMED AS NHS DIGITAL

NHS Digital will be the new name for Health and Social Care Information Centre (HSCIC) from July 2016. The move is designed to build public recognition, confidence and trust and will have the strapline 'Information and technology for better health and care'.

Noel Gordon, Non-executive Director and Chair of the Specialised Services Commissioning Committee at NHS England, has been appointed as the organisations new Chair. NHS Digital is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care.

18. MAKING CHOICE WORK IN MENTAL HEALTH

NHS Improvement has published a guide for people using mental health services on their legal right to choose a provider that best suits their individual needs and preferences. The guide offers advice based on four key principles that can make sure choice in mental health works: the right to choose the provider that best meets individual needs; choosing any provider of the services needed; when choice isn't appropriate for an individuals' care needs; how commissioners and healthcare professionals should be proactive in facilitating choice.

Enclosure 5

REPORT TO: Trust Board

Date of Meeting:	11 May 2016
Title of Report:	Summary of the Quality Committee meeting held on 26 April 2016
Presented by:	Patrick Sullivan Non-Executive Director and Chair of Quality Committee
Author of Report:	Sandra Storey, Associate Director MACE
Purpose / Intent of Report:	For assurance purposes To approve Policies highlighted in the report
Executive Summary:	This report provides a high level summary of the key headlines from the Quality Committee meeting held on the 26 April 2016. The full papers are available as required to Trust Board members
Seen at SLT or **Exec** Meeting & date	Reviewed by Chair of Quality Committee, Medical Director and Director of Nursing & Quality
Committee Approval / Review	• Summary of outputs from Quality Committee
Relationship with: *Board Assurance Framework* *Strategic Objectives*	• To provide the highest quality services • Create a learning culture to continually improve. • Encourage, inspire and implement research and innovation at all levels • Maximise and use our resources intelligently and efficiently • Attract and inspire the best people to work here • To continually improve our partnership working. • To enhance service user and carer involvement.
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	To ensure that the committee meets its terms of reference by receiving reports of the work of its sub groups
Resource Implications: Funding source:	N/A
Equality & Diversity Implications:	N/A
Recommendations:	• Receive for assurance purposes and approve policies highlighted in the report.

safe • personalised • accessible • recovery focused
spar

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

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

Key points from the Quality Committee meeting held on 26 April 2016 for the Trust Board meeting on the 11 May 2016

1. Introduction

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

2. Director of Quality Report

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

Safe:

- **CQC – NHS deaths to be investigated –** The CQC is to examine how the NHS learns from deaths of patients especially those with a learning disability or mental health problem. The nationwide review comes after inspectors found that Southern Healthcare NHS FT's review of deaths was not robust enough. The findings will be published in a national report towards the end of the year.
- **Preventing deaths in detention of adults with mental health conditions –** The Equality and Human Rights Commission has recommended that the statutory duty of candour is formally evaluated by the government in 2016 so that recommended improvements can be made and shared across other public services.
- **Healthcare Safety Investigation Branch –** On the 1 April 16 Regulations concerning the NHS TDA Healthcare Safety Investigation Branch came into force and they will be responsible for investigating incidents which evidence risks affecting patient safety. They will also be encouraging the development of skills used to investigate incidents including suggesting standards which may be adopted for such investigations.

Personalised:

- **High Court declares a 16 year old can prevent disclosure of personal information to parents**
  A landmark case has extended the principle that a young person can withhold not just medical information but all information from a parent. It found that where a young person is considered to have the appropriate age, understanding and maturity they can make decisions about disclosure and the parent's right to such information ceases.

Accessible:

- **New health and social care guidance to support young people as they become adults –** Overarching aim of developing a locally shared vision and policy for transition and the document very much envisages a person-centred joined up working approach**.**

Recovery focused:

- **Best Interests, not perfect solutions: residence under a deprivation of liberty –** This case questioned what does best interests mean when no option seems ideal. In terms of a placement for a disabled patient the case concluded that it should mean "best available", not "best imaginable". It can be difficult for the Court of Protection to draw a distinction between "not good" and "not good enough". The case concluded that a placement would have to be seriously inappropriate for it to be unlawful.

3. Policy Review

The recommendations were supported by the committee for ratification of policies by the Trust Board for 3 years or otherwise stated, as follows:

- 6.0 Incident Response and Recovery Plan (formerly Major Incident Plan)
- 7.03 Information Security and data protection
- 7.21 Information Risk Security Policy
- 1.52 & 1.52a R&D Strategy and Research Governance Policy – approved to 31 December 2015
- Access Policy – new policy review in 1 year
- R08 Personal Search- approved to 31 December 2015

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

The committee received the CIP Quality Impact Assessment Summary for 2016/17. Committee members took assurance from the refreshed framework that has been approved which has included strengthening the Project Initiating Document. Going forward the summary will be enhanced to provide further description of each scheme. The committee will continue to review the metrics linked to each CIP in the balance scorecard and their implications.

5. Nurse Staffing Performance monthly report – March 2016 Safe

The committee received the nursing staff performance on a shift by shift basis for the month of March 2016. During this period the Trust achieved staffing levels of 85.2% for registered staff and 97.0% for care staff on day shifts and 110% and 98.6 for nights respectively. Where 100% was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover and Ward Manager supporting clinical duties. It was noted that the six-month safer staffing report was finalised last month and circulated to the committee and Trust Board.

It was highlighted that the recruitment campaign is on-going with positive responses from recruitment fairs and national advert. The Director of Nursing will consider how we might partner with a European University to also attract further staff to the Trust.

6. Serious Incidents report Q4 2015/16

The report noted that in comparison to the same period in 2014/15 there was a 12% decrease in serious incidents and the trend line over the longer period continues to demonstrate a downward trend. No themes or trends were noted for this period. The reporting of duty of candour requirements is now more explicit in this report and the committee will receive a separate report highlighting the progress with duty of candour requirements, reporting, training and learning.

Committee members also reviewed the report following the thematic review undertaken to identify any themes and trends emerging in the Adult Community Mental Health Team. This concluded that there were no themes associated with each incident that may have altered the outcome for the patients concerned. The learning identified a need to strengthen approach to care planning and risk assessment and this has been taken forward by the Directorate. Care Planning and Risk Assessment is also a Listening into action (LIA) Wave 3 team and their work has involved reviewing the Trust's policy and procedure, how we educate and support staff as well as independently auditing and assuring ourselves in respect to safe and effective practices.

7. Access Team Response to Unannounced CCG visits January 2016

The CCG require assurance that the Access team will be able to implement and consistently deliver an improved service to people at the point they access mental health services. Part of this assurance is gained by conducting regular unannounced visits to the Access Team to test out improvement and monitor quality of service provision. The Committee received for assurance the action plan detailing points raised and progress against actions.

8. Complaint Handling Improvement Programme and Action Plan

The committee received an updated report providing assurance on progress against the action plan and proposed changes to the policy. The Service User and Carer Council will assist with the review of the complaints policy and this will be presented to the committee for further review following this work.

9. Ethics, Transparency and Audit Panel Mental Health Review

The committee received a further update following an incident in 2015 in which a patient was detained by Staffordshire Police and required significant resource. The patient was subject to a Care Treatment Order from a London Trust and required a PCIU bed which could not be sourced locally. The paper provided information to the committee on the actions by partner agencies, including the Police and Local Authority.

10. Board Assurance Framework

The committee received for assurance and information purposes the updated BAF with RAG ratings for the actions due during Q4 2015/16, and highlighting those that will carry forward to 2016/17. It was noted that the framework will be developed further during the year with a focus on making controls and assurances more measurable.

11. CQUINS 2015/16

Members were informed that the Trust had received confirmation that 100% of commissioning for quality and innovation goals (CQUINs) for 2015/16 had been achieved. It was noted the excellent work by the Directorates in this regard and the proposals for CQUIN schemes for 2016/17.

12. Friends and Family Test

The committee received a report highlighting the recommendations to strengthen and develop the Friends and Family Test initiative to ensure robust feedback processes are implemented and embedded in the organisation culture for service improvement.

13. Standing Operating Procedure – Toy Cleaning including books and games

The committee approved the guidance from the Infection Prevention and Control Team on the measures required to ensure that toys, games and books are clean and fit for purpose. This complies with the Hygiene Code and Health and Social Care Act 2008.

14. Quality Account 2015/16

By 30th June 2016, all organisations are required to develop and publish a Quality Account to assure commissioners, patients and the public that trust boards are regularly scrutinising each and every one of their services. The committee received the first draft of the Quality Account for initial review and comment. Members were assured that the project plan is on target to ensure completion by the publication deadline. The committee has delegated authority on behalf of the Trust Board to approve the final report on their behalf.

15. Directorate Performance Reports

Members discussed in detail the risks that were identified and assurances received. Of notes across all directorates were issues relating to recruitment and mitigating plans in place to help address these. Notable highlights for each directorate were:

- ***Adult Mental Health Community*** – the move went well to bring the Access Team and Home Treatment Team onto one site at the Harplands Hospital, the aim of which is to streamline services and make access easier for service users and carers;
- ***Adult Mental Health In-patient*** – due to hard work within the Directorate the team reported a significant improvement in clinical supervision, from 8% in 2015 to 96% in April 2016;
- ***Children and Young People*** – additional investment being made into the service, now planning for and recruiting to new posts to support revised structure and delivery of care pathways;

- ***Learning Disabilities*** – all teams continue to actively engage with the principles of the Trust's Digital Strategy and moving over from paper based records to electronic recording.
- ***Neuro and Old Age Psychiatry*** – Pathway work is progressing well and stakeholder meetings have taken place with good engagement from external partners.
- ***Substance Misuse*** –The Directorate management team have placed emphasis on the "5 to follow" for their Directorate meetings, namely, Supervision, Training, Care Plans and Risk Assessment, Personal Review and Serious Incident 60 day target.

16. Risk to Quality of Services - March 2016

Committee members considered the report for quality risks, particularly those scoring 12, which have been reported to the committee previously and how they interrelate to Directorate risks. Members discussed the risk treatment plans in place and assurance about the actions being taken.

17. CQC Quality Assurance Update

The committee received an update on the progress and position following the CQC comprehensive inspection in September 2015 and the actions being taken to achieve a rating of 'Good' by September 2016, with ultimately seeking to become 'Outstanding'.

The committee also received a paper providing an update on progress against the Core Service action plans detailing progress against the 'must' and 'should' do actions as described in each of the Core Service Reports.

18. Briefing on Safeguarding focused review by the Care Quality Commission April 2016

The CQC conducted a child safeguarding focused inspection in April 2016. They reviewed notes, interviewed staff and visited three Trust sites. Good progress was highlighted and recognition of the progress made since the comprehensive inspection in September 2015. The report also noted areas for strengthening and the actions taken.

19. Ward 4 Dual Care Ward – One Year Report 2015 -2016

The committee received a report on the Shared Care Service which has been in operation for the last 12 months. This report summarised that there has been positive outcomes for both patient and the local health economy, notably patients benefit from person centred care and a reablement philosophy that encourages independence.

20. Patient Experience Report including Domain Q4 2015/16 update

The committee received the learning from experience report that aggregates qualitative and quantitative analysis from key sources covering the period Q4 2015/16. The report also provided an update on the outputs of each of the groups that report into the Quality Committee.

21. Freedom of Information Act Report 2015/16

Received for information and assurance purposes

22. Mortality Surveillance Tool

The committee received the Trust's self-assessment against the NHS England Mortality Surveillance Tool. The Trust scored 100% (positive) demonstrating processes in place for the review of deaths.

23. Clinical Audit Programme 2016/17

The committee received the clinical audit programme 2016/17 prepared in accordance with the Trust's Clinical Audit Policy and approved by the Clinical Effectiveness Group on the 15 April 2016.

24. Next meeting: 28 June 2016

On behalf of the Committee Chair, Mr Patrick Sullivan, Non-Executive Director
Sandra Storey, Associate Director of Medical and Clinical Effectiveness,
28 April 2016

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO Trust Board

Enclosure 5.1

Date of Meeting:	11 May 2016
Title of Report:	Serious Incident Quarterly Report Q4 2015-16
Presented by:	Dr O Adeyemo
Author of Report:	Jackie Wilshaw
Purpose / Intent of Report:	For information
Executive Summary:	The report summarises statistical and trend detail for Serious Incidents requiring investigation for the quarter January 2016 to March 2016 The report will highlight the following key areas: • Summary detail of all STEIS categories of serious incident reported in Q4 • Trend line detailing total serious incidents reported by month covering the period April 2013 to March 2016. • The report will illustrate that there are no apparent seasonal or monthly trends • Comparison of serious incidents reported in the same period over a two year period by number and type. • The report will detail reported incidents by Directorate • Summary of contractual compliance for serious incident timescale management
Seen at SLT or **Exec** Meeting & date	SLT/EXEC: SLT Date: 19th April 2016 Document Version number: 1
Committee Approval / Review	• Quality Committee √☐ • Finance and Performance Committee ☐ • Audit Committee ☐ • People and Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐
Relationship with: *Board Assurance Framework* *Strategic Objectives*	1. To provide the highest quality services √☐ 2. Create a learning culture to continually improve.√☐ 3. Encourage, inspire and implement research at all levels.☐ 4. Maximise and use our resources intelligently and efficiently.☐ 5. Attract and inspire the best people to work here.☐ 6. Continually improve our partnership working. ☐

	7. To enhance service user and carer involvement.☐ **Comments:**
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	
Resource Implications: Funding source:	
Equality & Diversity Implications:	
Recommendations:	For information

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO TRUST BOARD

Date of meeting:	11 May 2016
Report title:	**Overview of Serious Incidents: 1st January to 31st March 2016 Q4**
Executive Lead:	Dr Buki Adeyemo-Medical Director
Prepared by:	Jackie Wilshaw. Head of Patient and Organisational Safety
Presented by:	Dr Buki Adeyemo-Medical Director

1 Purpose of Report

1.1. The Quality Committee will receive this report for the April 2016 meeting, detailing the trends in Serious Incidents from 1st January to 31st March 2016.

1.2 The report will illustrate serious incidents reported by month, represented as a trend line for the period between April 2013 and March 2016.

1.3 The report will detail incident status of all open serious incidents

1.4 The report will illustrate comparative trend data for Q4 and Q3 2016.

1.5 The report details Serious Incident trends by category 1st January to 31st March 2016.

1.6 The report will detail serious incidents trends by Directorate and Clinical team

1.7 The report will note serious incident categories by increase/decrease

1.8 The report will detail learning and change arising from serious incidents

2 Statement on SI investigation process

2.1 The Trust has submitted all investigations within the timescales agreed with commissioners; the Trust remains committed to ensuring that investigation completion dates are maintained in order to ensure that any learning from investigations is implemented in a timely manner.
Any exceptions to agreed timeframes are agreed in advance with the CCG/CSU ; examples of when this may happen include circumstances that would delay the progress of the information, for example, test results critical to an investigation, police involvement or by negotiation where we have established that further enquiries need to be made and facts established. The Trust recognises that the quality of the investigation report is critical in learning and improvement.

- At the time of generating this report (April), 16 SIs have been reported onto STEIS during Q4 and at the time of reporting there are 18 incidents open on STEIS.

At the time of this report the status of the serious incidents is as follows:

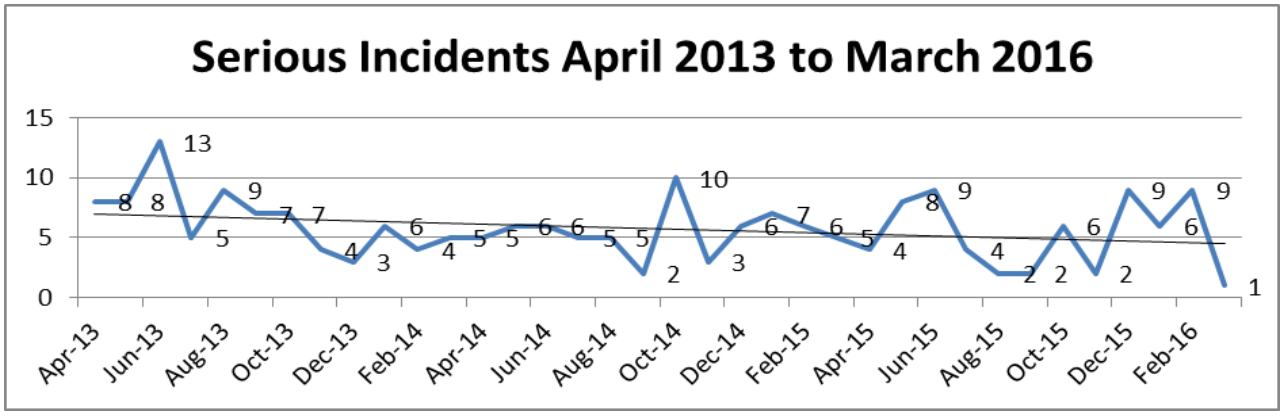
- Eight are on-going and within the 60 working days timeframe
- Two are open but are subject to extensions to the original timescales agreement (formerly known as 'stop the clock').

- Eight completed investigations have been submitted to the commissioners for closure to be agreed

2 Serious Incidents reported by month – April 2013 to March 2016.

2.1 The trends in serious incidents reported on to the national STEIS database are set out in the following table. Due to changes on STEIS, from 21st May 2015, with incident categorisation it is not possible to use the STEIS database for comparison of incident type against previous reports.

This table illustrates that, in comparison to the reporting for the same period in 2014/15, there was a decrease of 12% in 2015 (18 to 16 incidents). The trend line over the longer period continues to demonstrate a downward trend in SIs.



3. Serious Incidents

3.1 It should be noted that the changes to STEIS in May 2015 impacted upon the analysis of the data against previous quarters and the 2015/16 data cannot be read as a direct comparison against the previous year.
The table below illustrates total serious incidents reported by quarter for the period April 2014 to March 2016.

For example
Category: Apparent/actual/suspected self-inflicted harm meeting SI criteria has replaced the previously used category of unexpected death or attempted suicide.

	2014/15					2015/16				
	Qtr 1	**Qtr 2**	**Qtr 3**	**Qtr 4**	**Total 14/15**	**Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**	**Total (YTD) 15/16**
Suspected Suicide	5	4	4	2	**15**	0	0	0	0	**0**
Unexpected death of community patient	2	5	6	5	**18**	6	0	0	0	**6**
Unexpected death of inpatient	1	0	0	0	**1**	0	0	0	0	**0**
Attempted suicide by outpatient	0	0	1	0	**1**	0	0	0	0	**0**
Attempted suicide by inpatient	0	0	0	0	**0**	0	0	0	0	**0**
Serious incident by outpatient /community patient	3	1	1	1	**6**	0	0	0	0	**0**
Serious incident by inpatient	1	1	0	0	**2**	0	0	0	0	**0**
Allegation against healthcare professional	0	0	1	0	**1**	1	0	0	0	**1**
Homicide by Outpatient (in receipt)	0	0	1	0	**1**	1	0	0	1	**2**
Homicide by Outpatient (not in receipt)	0	0	1	0	**1**	0	0	0	0	**0**
Slip Trip Fall	5	1	1	2	**9**	0	1	1	2	**4**
Loss of confidential information	0	0	0	0	**0**	0	0	0	0	**0**
Pending review (a category must be selected before incident is closed)	0	0	0	0	**0**	4	7	8	0	**19**
Apparent/actual/suspected self-inflicted harm meeting SI criteria	0	0	0	0	**0**	4	0	8	13	**28**
Ward closure	0	0	3	2	**5**	2	0	0	0	**2**
Pressure Ulcer	0	0	0	1	**1**	0	0	0	0	**0**
Assault By inpatient	0	0	0	1	**1**	2	0	0	0	**2**
HAIC	0	0	0	2	**2**	0	0	0	0	**0**
Admission to Adult Wards by under 18s	0	0	0	2	**2**	1	0	0	0	**1**
Safeguarding Vulnerable Adult	0	0	0	0	**0**	0	0	0	0	**0**
Healthcare Acquired Infection	0	0	0	0	**0**	0	0	0	0	**0**
Fire (non- accidental)	0	0	0	0	**0**	0	0	0	0	**0**
Total	17	12	19	18	**66**	21	8	17	16	**62**

Q4 serious incident analysis is summarised below:

There have been 16 serious incidents reported and investigated in Q4. Breakdown of the category and summary detail of the incidents is summarised below. It is noted that, at the time of this report, a number of the investigations are ongoing.
The main points to note are:

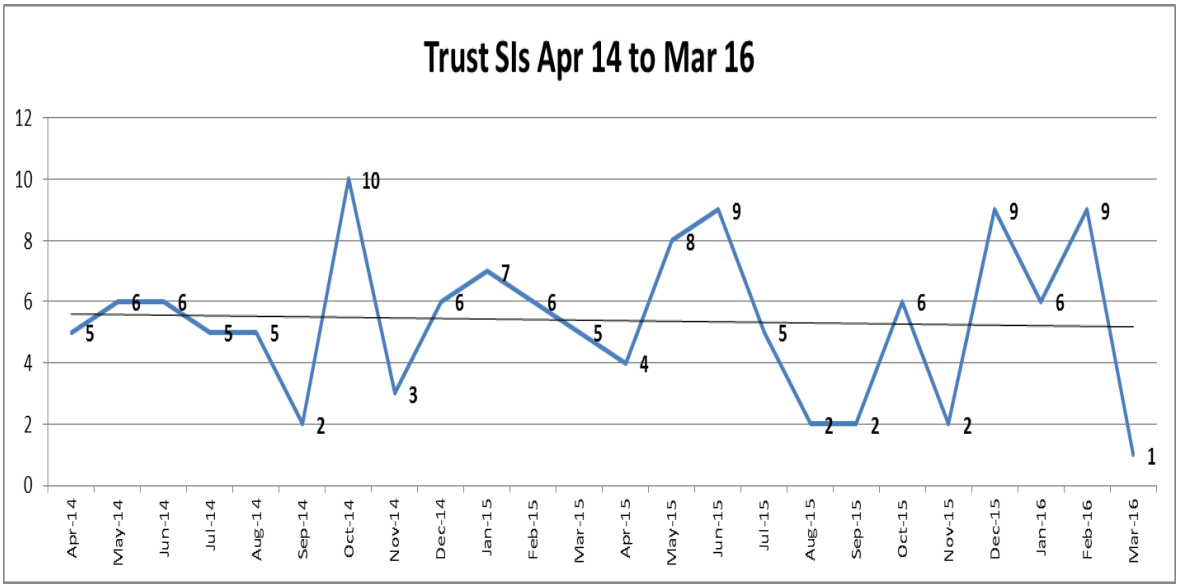
- There were 6 unexpected deaths in the substance misuse directorate: The directorate is currently working in partnership with other agencies including public health regarding possible measures to reduce the number of alcohol related deaths. These deaths are not currently investigated as SIs as they are classed as natural cause deaths, however the Trust completes local investigations in order

to ensure that any gaps in service delivery are quickly identified and remedial action can be implemented.

- There were 7 incidents in the Adult Community Directorate; 6 were investigated as SIs, the seventh incident was investigated but was downgraded from StEIS. There were 5 suspected suicides and further incident of domestic homicide.

- In the NOAP Directorate, there were 2 incidents of harm following falls and 1 suspected suicide. In the Children and Young People Directorate there was 1 suspected suicide.

4. Serious Incident by Directorate 2015/16

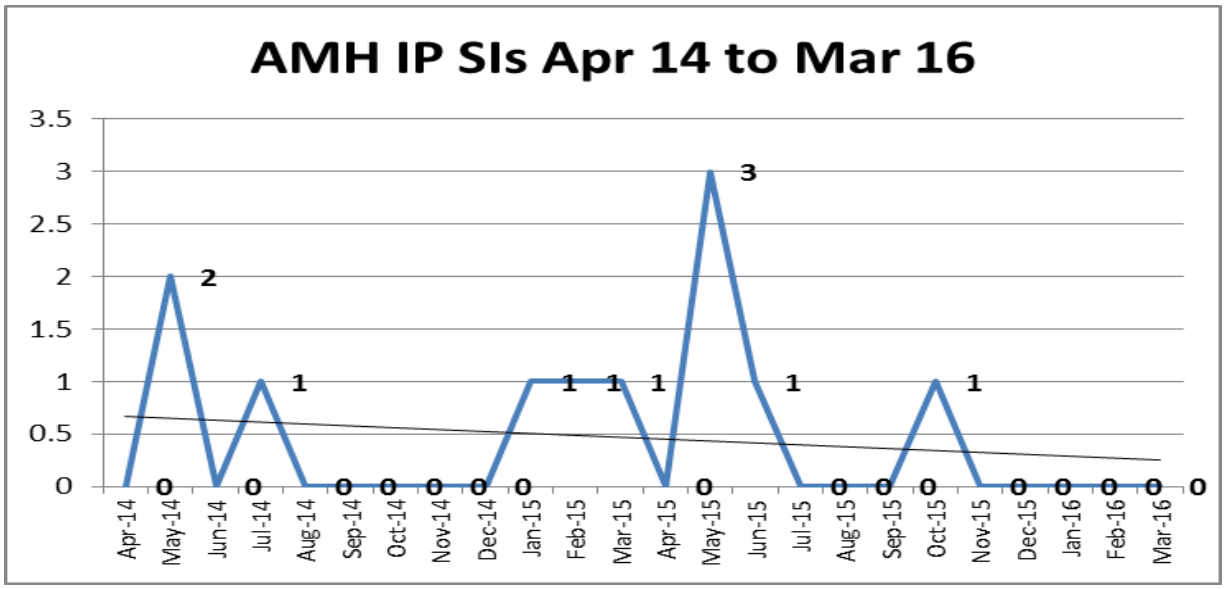


The above graph demonstrates the total number of Serious Incidents over the last 2 years; in this time the average number of SI's monthly has remained constant.

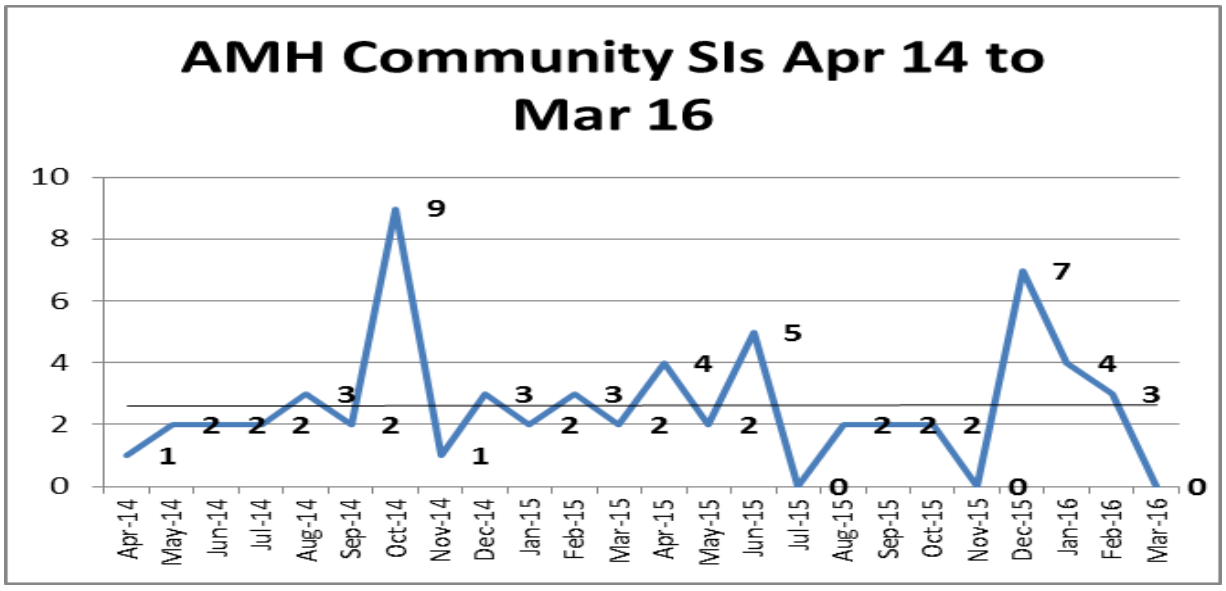
The following section demonstrates SIs by Directorate: the Adult Community Directorate continues to have the greatest number of serious incidents during 2015/16.

There is no service or care delivery issue creating a causal link between these incidents; in this quarter they range from the unexpected deaths of people known to services including suspected suicide, through to self-inflicted harm.

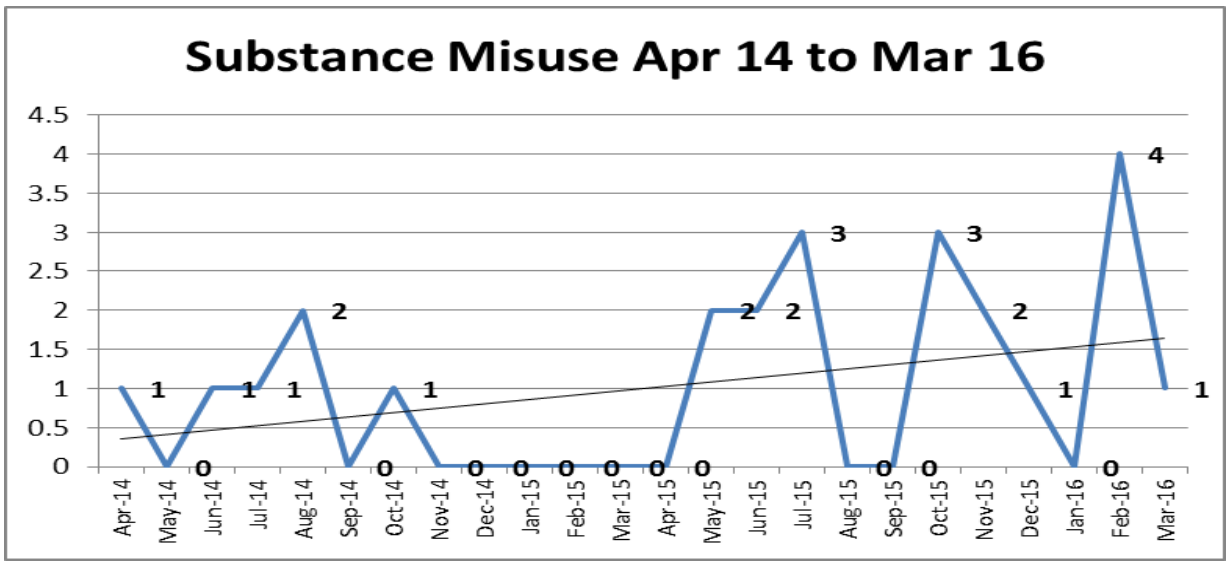
See individual Directorate graphs below. Narrative report by exception.



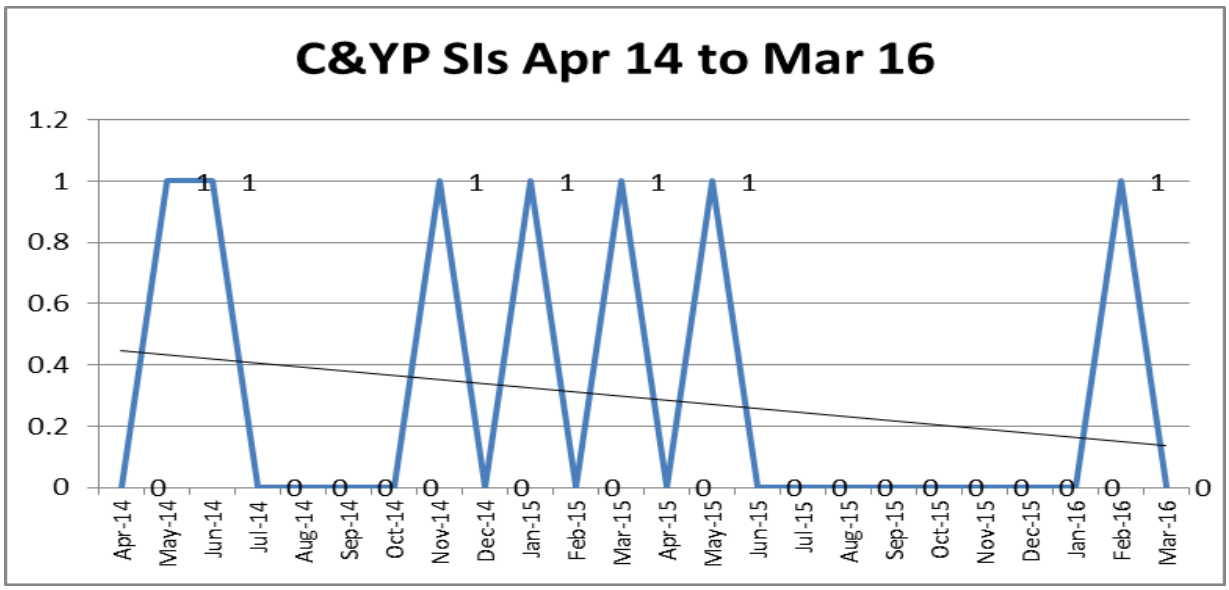
As previously stated, for the Adult Community Directorate, the spike in incidents in December relates to an increase in the number of unexpected deaths; the investigations have been completed but there are no causal links or similar learning arising from the investigations..



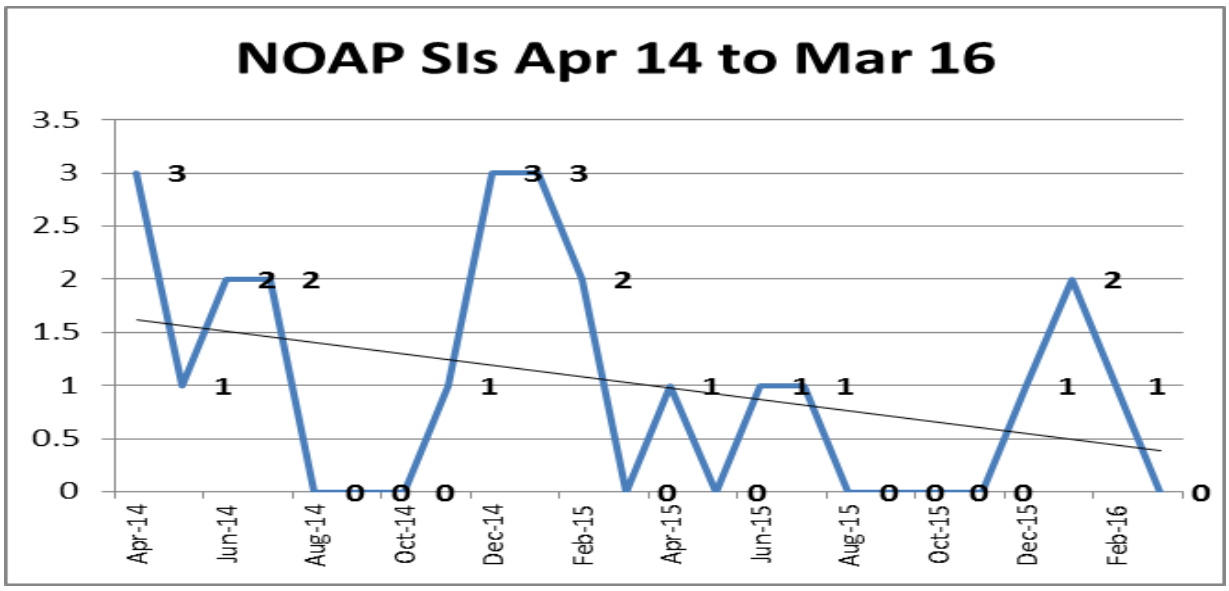
There was an increase in the number of SIs in the Substance Misuse Directorate over 2015/16; it is believed that the overall increase in SIs over the last year (5 in 2014/15 and 18 in 2015/16) relates to the extension of this service outside of the boundaries of the N Staffordshire. Whilst acknowledging that there has been a general increase in the number of deaths of people from within N Staffordshire (5 in 2015/15 and 9 in 2015/16), the overall figure has doubled due to the extension of the service boundaries.



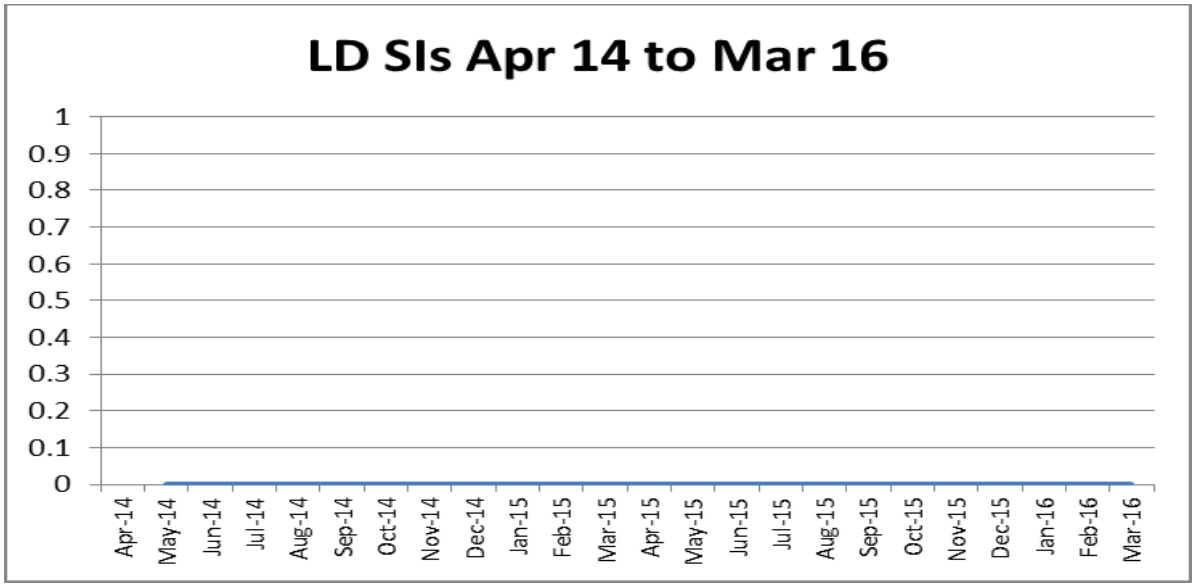
After almost 12 months without a Serious Incident, the Children and Young People's Directorate had one SI in February 2016.



Whilst there have been 3 SI's in the NOAP Directorate in Q4, the overall trend for this directorate has shown a reduction over the last 2 years. The majority of incidents relate to Slip, trip and falls in the inpatient areas and the directorate has been proactive in reviewing its falls assessments and care plans in order to minimise the risk of injury through falling in the inpatient population.



There have been no Serious Incidents in the LD Directorate over the last 2 years.



5. Themes and Trends

There are no themes or trends identified during Q4, however in order to identify emerging themes consideration must be taken over a longer period of time. Although it is noted that there is a spike in incidents in December 2015; as previously stated, this relates to an increase in suspected suicides/unexpected deaths is the adult community services. Four of the incidents in this directorate related to the service users of one of the resource centres however initial analysis of the incidents and as stated previously in the Q3 report, revealed that there were no links between the incidents as either causal links or contributory factors, however a thematic review is currently being undertaken by the Head of Directorate.

6. Duty of Candour

All incidents that have met the criteria for a contractual duty of candour have been processed accordingly via the serious incident investigation process in Q4.
For this quarter this includes the death following a fall and fracture of an elderly male.
The next of kin of all people whose deaths meet the SI criteria receive a condolence/DoC letter from the relevant directorate; whilst these deaths are easily identifiable as examples where DoC acknowledgment is required, the P+OS Team continue to highlight possible other cases with teams, as it appears that teams are still unsure of their responsibilities under DoC. Information leaflets/ LL articles and specific learning events on DoC have all been provided to staff and are available on the intranet.

The weekly incident review group review all moderate and above incidents with regards to the Duty of Candour requirements, in order to verify whether the incident is correctly graded; practitioners continue to grade incidents based on the 'emotional' aspect of the incident rather than the definition of harm caused. The definitions are clearly identified on the reporting form and individuals are contacted by the P+OS team to discuss the correct grading.

7. Learning Lessons from Serious Incidents

7.1 The Trust continues to develop its learning from all incidents; from January 2016, the Learning Lessons bulletin and learning events have become monthly in order to keep pace with new learning and to ensure its timely sharing across the Trust. These new style workshop events have been very well received with good attendance and positive feedback from staff.

As can be expected, the investigations did find areas of practice where improvements could be made; areas for action include the following, which are taken from the Q3 and Q4 investigations;

- Improved clinical risk training. The Trust is currently rolling out risk training to all frontline staff.
- Improved sharing of risk information with partnership agencies.
- Ensuring that verbally agreed risk management plans are documented in the clinical recorded as soon as possible after the discussion is held with the service user
- Improved management of long term physical health conditions; strengthening the partnership with primary care physical health teams
- Improved post falls care; actions to improve the handover process and ensuring that all relevant staff undertake the falls prevention programme
- A practice note was issued to staff regarding improved completion of referral and screening information.

However it must be said that investigations are also able to highlight areas of good practice;

- Off duty Care coordinator offering their services when concerns were raised about a service user.
- Comprehensive risk assessments and care plans
- Timely evidence-based therapeutic interventions
- Proactive engagement with service users; recognition that service users required more support than initially indicated
- Team working in challenging situations

In addition to learning from Serious Incident investigations; the Trust remains committed to learning from non-SI incidents. The Incident review group continues to meet weekly in order to review all incidents reported from the previous week; this group works to ensure any learning from incidents is explored and any actions requiring escalation are completed. The group recognises that some incidents may not have caused harm or may have been classed as 'near misses' but that it is still important to examine these events in order to ensure that potential actions to prevent future harm or occurrence are not overlooked.

Finally, work undertaken to support learning from SIs is not taken in isolation and the incidents and lessons learnt are part of the wider agenda to improve the 'safety culture' at NSCHT; as part of the initial ambition

of the current CQUIN goal: Embedding a safety culture, staff are facilitated to use the data generated through this and other reports to understand their incidents and how this understanding can be used to generate improvements in service delivery. UPDATE Q4: this CQUIN will rollover for 2016/17 with a greater emphasis on the involvement of the community teams

8. Mortality Surveillance

Following the publication of the Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015, the Trust has undertaken a review of all of the people with learning difficulties who have died since 2014. This is to ensure that the Trust can be confident that all unexpected deaths are reported and investigated appropriately and that the information contained within its databases is accurate and informs the Trust standard of transparency and accountability.

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

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

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

Therefore a mortality surveillance report will be produced monthly and will be discussed at the Clinical Safety Improvement Group; this will ensure that the Trust is sighted on all natural cause deaths, in addition to those deaths subject to Serious Incident investigation and that any gaps in service delivery/lessons learnt are discussed and cascaded for action as appropriate.

Jackie Wilshaw
Senior Nurse / Head of the Patient and Organisational Safety Team
April 2016

North Staffordshire Combined Healthcare NHS
NHS Trust

REPORT TO - Trust Board

Enclosure 6

Date of Meeting:	11 May 2016
Title of Report:	Safer Staffing Report (March 2016)
Presented by:	Maria Nelligan-Executive Director of Nursing and Quality
Author of Report:	Carol Sylvester-Deputy Director of Nursing and Quality
Purpose / Intent of Report:	For Assurance
Executive Summary:	This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during the data collection period (1-31 March 2016) in line with the National Quality Board expectation that: "The Board: • Receives an update containing details and summary of planned and actual staffing on a shift-by-shift basis. • Is advised about those wards where staffing falls short of what is required to provide quality care, the reasons for the gap, the impact and the actions being taken to address the gap. • Evaluates risks associated with staffing issues. • Seeks assurances regarding contingency planning, mitigating actions and incident reporting. • Ensures that the Executive Team is supported to take decisive action to protect patient safety and experience. • Publishes the report in a form accessible to patients and the public on their Trust website (which could be supplemented by a dedicated patient friendly 'safe staffing' area on a Trust website)". The performance relating to the fill rate (actual numbers of staff deployed vs numbers planned) during March 2016 was 85.2% for registered staff and 97.0% for care staff on day shifts and 110% and 98.6% nights respectively. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover, Ward Manager supporting clinical duties. The position reflects that Ward Managers are effectively deploying additional staff to meet increasing patient needs as necessary.

Seen at SLT or **Exec** Meeting & date	SLT/EXEC: Execs Date: 26 April 2016 & 10 May 2016 Document Version number: 2.0 10 May 2016
Committee Approval / Review	• Quality Committee √ ☐ 26 April 2016 • Finance and Performance Committee ☐ • Audit Committee ☐ • People and Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐
Relationship with: *Board Assurance Framework* *Strategic Objectives*	1. To provide the highest quality services ☐ 2. Create a learning culture to continually improve.☐ 3. Encourage, inspire and implement research at all levels.☐ 4. Maximise and use our resources intelligently and efficiently.☐ 5. Attract and inspire the best people to work here.☐ 6. Continually improve our partnership working. ☐ 7. To enhance service user and carer involvement.☐ **Comments:**
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	Delivery of safe nurse staffing levels is a key requirement to ensuring that the Trust complies with National Quality Board standards.
Resource Implications: Funding source:	Recruitment to vacant posts in progress. Budgeted establishment/temporary staffing budget
Equality & Diversity Implications:	None
Recommendations:	To receive the report for assurance and information.

Report subject:	**Ward Daily Staffing Levels – March 2016**
Report to:	**Trust Board**
Action required:	**Information and Assurance**
Date of meeting:	**Wednesday 11 May 2016**
Prepared by:	**Carol Sylvester, Deputy Director of Nursing**
Presented by:	**Maria Nelligan, Executive Director of Nursing & Quality**

1 Summary

This report details the ward daily staffing levels during the month of March 2016 following the reporting of the planned and actual hours of both Registered Nurses (RN) and Health Care Support workers (Care) to Unify (Appendix 1).

2 Background

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

In addition to the monthly reporting requirements, the Executive Director and Deputy Director of Nursing have completed a six monthly comprehensive review of ward staffing levels in Adult In-patient and Children`s tier 4 and Children`s Respite Services in line with NQB requirements and presented to the March 2016 Board.

3 Trust Performance

During March 2016 the Trust achieved staffing levels of 85.2% for registered staff and 97.0% for care staff on day shifts and 110% and 98.6% nights respectively. Where 100% fill rate was not achieved, safety was maintained on in-patient wards by use of additional hours, cross cover, Ward Manager supporting clinical duties. Details and summary from Ward Managers are set out below.

Ward	Performance (% planned vs actual)						Ward Manager Summary	Bed Occupancy % (including home leave)	Sickness
	Day %		Total %	Night %		Total %			
	R/N	Care		R/N	Care				
1	78.1	116.3	**97.2%**	247.1	90.5	**168.8%**	**Current vacancy: 4 x B5, 2 X B2** Challenges to covering planned RN shifts due to vacancies. Additional HCSW hours booked to achieve planned staffing levels. High levels of acuity and observation requiring increased staffing levels in addition to staff booked to manage Place of Safety. Night RN fill rate reflective of limited availability of HCSW. Block booking of RN agency and bank staff to backfill vacancies which are only available to work night shifts.	97↓	0.41% ↓
2	79.1	95.7	**87.4%**	106.5	84.0	**95.2%**	**Current vacancy: 4.6 x B5, 2.6 x B3** Vacant posts creating challenges to meet planned R/N day shifts. Increase in short term sickness has caused additional staffing shortfall. Shortfalls escalated via twice weekly safer staffing meetings to ensure proactive booking of bank/agency via the bank coordinator however, availability for day shifts remains an ongoing challenge with additional bank recruitment campaign planned.	103 ↔	17.3% ↑

Ward	Performance (% planned vs actual)						Ward Manager Summary	Bed Occupancy % (including home leave)	Sickness
	Day %		Total %	Night %		Total %			
	R/N	Care		R/N	Care				
3	81.1	118.1	**99.6%**	100.9	112.1	**106.5%**	**Current vacancy: 5.8 x B5 (2 staff commencing March/April), 1 x B3, 1 x B2.** Successful recruitment to 2 B5 posts awaiting start date. Ward Manager and Nurse Practitioner undertaking increased clinical interventions to meet patient need. Additional HCSW shifts booked to meet planned staffing levels where RN cover unavailable.	106 ↓	6.55% ↑
4	98.3	89.4	**93.8%**	78.9	114.2	**96.5%**	**Current vacancy: 7.1 x B5, 5.3 x B3, 1 x B6 mat leave** Successful recruitment to a number of the above posts awaiting confirmation of acceptance. Noted that there has been a number of agency shift cancellations by individuals flagged with MEDACS Agency. Two RN`s planned for night shift but unable to meet planned shifts due to unavailability of RN temporary staffing therefore planned shifts covered by HCSW.	91 ↓	0.00% ↔

Ward	Performance (% planned vs actual)						Ward Manager Summary	Bed Occupancy % (including home leave)	Sickness
	Day %		Total %	Night %		Total %			
	R/N	Care		R/N	Care				
5	69.9	122.2	**96.0%**	105.5	110.8	**108.1%**	**Current vacancy: 1 x B6 and 1 x B5 successfully recruited to.** RN shortfall on day shifts due to a combination of annual leave, short term sickness, vacancies (recruited but awaiting start date). Additional HCSW shifts utilised to cover planned shifts. Ward Manager contributed to covering high levels of observation during day shifts with additional staffing to meet increase in activity on night shifts.	102 ↑	5.04% ↓
6	78.2	100.5	**89.3%**	112.2	93.1	**102.6%**	**Current vacancy: 2.8 x B5** RN day shift shortfall due to vacancies, long term sickness and acuity due to high levels of observation and unavailability of RN temporary staffing. Unable to cover RN day shifts with HCSW during March due to unavailability.	99 ↔	8.16% ↓
7	81.2	90.7	**85.9%**	100	100	**100%**	**Current vacancy: 0.4 x B5** Challenges to meeting planned RN day shifts due to maternity leave, sickness. Additional hours worked by a number of RN`s. Ward manager provided direct clinical input for 2-3 shifts per week.	97 ↓	1.17% ↑

Ward	Performance (% planned vs actual)						Ward Manager Summary	Bed Occupancy % (including home leave)	Sickness
	Day %		Total %	Night %		Total %			
	R/N	Care		R/N	Care				
A&T	94.1	90.8	**92.4%**	100	97.5	**98.7%**	**Current vacancy: MoC in progress therefore vacancies will be held pending this process.** Additional day staffing levels required to meet high levels of observation (level 3 and 4). Challenges to backfilling vacant positions for RN and HCSW due to unavailability of bank /agency with internal sickness creating limitations on availability to work additional hours for unfilled shifts	80 ↔	6.57% ↑
Telford	63.2	97.8	**80.5%**	100	100	**100%**	**Current vacancy: MoC in progress therefore vacancies will be held pending this process.** Planned day staffing levels required to meet high levels of observation (all patients requiring level 3 observation) with challenges to backfilling vacant positions for RN and HCSW due to unavailability of bank /agency with long and short term sickness creating further shortfall.	50 ↓	14.4% ↑

Ward	Performance (% planned vs actual)						Ward Manager Summary	Bed Occupancy % (including home leave)	Sickness
	Day %		Total %	Night %		Total %			
	R/N	Care		R/N	Care				
EMC	89.2	92.9	**91.0%**	93.8	94.5	**94.1%**	**Current vacancy: 1 x B5, 2 x B5 mat leave.** R/N sickness on nights covered by movement from another area but not reflected in the actual fill rate therefore fill rate should reflect at 100% Long term sickness, vacancy, mat leave and excess of annual leave at financial year end created under filled RN and HCSW day shifts. Additional support provided by ward manager as required.	79 ↑	9.62% ↑
Darwin	100	97.9	**98.9%**	99.7	97.4	**98.5%**	**Current vacancy: 1.7 x B5, 1.8 x B3 1 x B5, 1x B3 on secondment.** No specific issues reported. Planned shifts flexed to reflect reduced occupancy and observation levels.	85 ↓	1.77% ↓
Summ View	97.2	77.1	**87.1%**	106.3	97.6	**101.9%**	**Current vacancy: 1x B5, 1x B3** HCSW day shifts unfilled due to current vacancy, short term sickness and secondment to non-clinical duties. Additional RN night cover booked to cover shortfall in HCSW fill rate	98 ↑	5.99% ↓

Ward	Performance (% planned vs actual)						Ward Manager Summary	Bed Occupancy % (including home leave)	Sickness
	Day %		Total %	Night %		Total %			
	R/N	Care		R/N	Care				
Flor House	85.2	72.0	**78.6%**	89.4	89.4	**89.4%**	**Current vacancy: No vacancies reported** Shortfalls in both RN and HCSW shifts discussed with ward manager. Staffing levels not flexed down to reflect low occupancy and activity during March due to patient home leave. Ward Manager aware to plan shifts based on patient need and not budgeted establishment for future reporting.	100 ↑	6.02% ↑
Dragon Square	98.1	97.4	**97.7%**	100	100	**100%**	**Current vacancy: No vacant posts** No issues to report	71 ↑	0.00% ↔
TOTAL	**85%**	**97.0%**	**91.1%**	**110%**	**98.6%**	**104.3%**			

4 Ward Managers report the impact of unfilled shifts on a shift by shift basis. These themes are summarised below

5 Issues leading to Staffing Gaps

Challenges in recruitment to vacant registered nurse posts continues to contribute to variance between planned and actual staffing levels. A number of new recruitments will commence employment in April within inpatient wards.

Planned day shifts have proved difficult to cover by use of additional hours both bank and agency due to availability though night shifts have been successfully covered where required. Day shifts have been further supported by ward manager cover on an as required basis.

The Trust received positive feedback on attendance at the Keele University Careers Fayre on April 13th. Conditional offers of employment have been made to 31 Mental Health and Learning Disabilities Student Nurses due to register in September 2016. A total of 22 placement preference forms have been returned suggesting acceptance. The remaining students have indicated that they have already secured jobs or will be returning to their home location post training.

The Trust will be attending the Staffordshire University Mental Health and Learning Disabilities Careers Fayre on 27 May 2016.

Occupancy and acuity challenges continue in wards 2, 3, 5 and additionally, high levels of observation in wards 1,3,5,6 have been reflected in the planned hours but actual fill rates reflect the challenges arising from vacancies, bank and agency availability, particularly on day shifts. The wider MDT input has ensured that therapies/activities have continued to ensure a positive patient experience.

A total of 100 RN shifts were covered by HCSW and 67 HCSW shifts covered by RN.

6 Impact on Patient Safety

A total of 20 incident forms were submitted during March relating to staffing shortfall. Of the 20 reported incidents, 14 relate to inpatient wards. All incidents were graded no harm. Incidents were reported by Wards 2, 5, 6, EMC, A&T and Florence House.

Themes included both short term sickness, bank unavailability, shift cancellation and longer term impact on service continuity due to vacant registered nurse posts.

7 Impact on Patient Experience

There have been no activities cancelled or rescheduled during March.

No concerns or complaints have been escalated through formal channels related to ward staffing levels.

8 Impact on Staff Experience

During March, a total of 63 staff breaks were either shortened or not taken as a result of RN cover availability or due to high acuity and breaks.

A total of 4 planned supervision meetings, 1 appraisal and 2 mandatory training sessions were cancelled.

A total of 45 cross cover arrangements occurred during the month of March 2016.

9 Summary

A recruitment campaign is on-going with an increased response received by the Trust in addition to Student Nurse Recruitment initiatives.

A high level of annual leave taken in March in part due to accrued annual leave and Easter break.

The planned to Ward Manager Task and Finish Group in May 2016 will review protocol to ensure clarity of processes for safer staffing reporting and ensuring planned shifts reflect patient need/acuity.

Meeting held with lead Duty Senior Nurse in respect of agency staff cancelled shifts and impact on service. A further meeting is planned with HR is respect of MEDACS management of cancelled shifts.

Unify return (Appendix 1)

Only complete sites your organisation is accountable for					Day				Night				Day		Night	
Hospital Site Details		Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
RLY88	HARPLANDS HOSPITAL	Ward 1	710 - ADULT MENTAL ILLNESS		1628.00	1272.00	1628.00	1894.00	323.00	798.00	1318.00	1193.00	78.1%	116.3%	247.1%	90.5%
RLY88	HARPLANDS HOSPITAL	Ward 2	710 - ADULT MENTAL ILLNESS		1395.00	1103.00	1395.00	1335.00	323.00	344.00	970.00	815.00	79.1%	95.7%	106.5%	84.0%
RLY88	HARPLANDS HOSPITAL	Ward 3	710 - ADULT MENTAL ILLNESS		1395.00	1132.00	1395.00	1648.00	326.00	329.00	977.00	1095.00	81.1%	118.1%	100.9%	112.1%
RLY88	HARPLANDS HOSPITAL	Ward 4	715 - OLD AGE PSYCHIATRY		1395.00	1371.00	1628.00	1455.00	583.00	460.00	583.00	666.00	98.3%	89.4%	78.9%	114.2%
RLY88	HARPLANDS HOSPITAL	Ward 5	715 - OLD AGE PSYCHIATRY		930.00	650.00	1395.00	1705.00	291.00	307.00	582.00	645.00	69.9%	122.2%	105.5%	110.8%
RLY88	HARPLANDS HOSPITAL	Ward 6	715 - OLD AGE PSYCHIATRY		1163.00	910.00	1680.00	1688.00	288.00	323.00	1030.00	959.00	78.2%	100.5%	112.2%	93.1%
RLY88	HARPLANDS HOSPITAL	Ward 7	715 - OLD AGE PSYCHIATRY		930.00	755.00	1395.00	1265.00	290.00	290.00	581.00	581.00	81.2%	90.7%	100.0%	100.0%
RLY88	HARPLANDS HOSPITAL	A&T	700- LEARNING DISABILITY		680.00	640.00	1530.00	1390.00	22.00	22.00	1312.00	1279.00	94.1%	90.8%	100.0%	97.5%
RLY88	HARPLANDS HOSPITAL	Telford	700- LEARNING DISABILITY		698.00	441.00	930.00	910.00	312.00	312.00	688.00	688.00	63.2%	97.8%	100.0%	100.0%
RLY88	HARPLANDS HOSPITAL	Edward Myers	710 - ADULT MENTAL ILLNESS		930.00	830.00	930.00	864.00	290.00	272.00	581.00	549.00	89.2%	92.9%	93.8%	94.5%
RLY86	DARWIN CENTRE	Darwin Centre	711- CHILD and ADOLESCENT PSYCHIATRY		1243.00	1243.00	895.00	876.00	335.00	334.00	869.00	846.00	100.0%	97.9%	99.7%	97.4%
RLY87	SUMMERS VIEW	Summers View	710 - ADULT MENTAL ILLNESS		930.00	904.00	930.00	717.00	331.00	352.00	661.00	645.00	97.2%	77.1%	106.3%	97.6%
RLY39	FLORENCE HOUSE	Florence House	710 - ADULT MENTAL ILLNESS		465.00	396.00	930.00	670.00	322.00	288.00	322.00	288.00	85.2%	72.0%	89.4%	89.4%
RLY36	DRAGON SQUARE COMMUNITY UNIT	Dragon Square	700- LEARNING DISABILITY		420.00	412.00	930.00	906.00	259.00	259.00	259.00	259.00	98.1%	97.4%	100.0%	100.0%

North Staffordshire Combined Healthcare NHS
NHS Trust

Enclosure 7

REPORT TO – Trust Board

Date of Meeting:	11 May 2016
Title of Report:	Trust Revalidation Preparedness Update
Presented by:	Maria Nelligan-Executive Director of Nursing and Quality
Author of Report:	Carol Sylvester-Deputy Director of Nursing and Quality
Purpose / Intent of Report:	For Assurance
Executive Summary:	A report was presented to the Executive Team in January 2016 detailing the national context for nurse revalidation development and preparation and to set out trust readiness in supporting staff to successfully revalidate. The purpose of this report is to update the Quality Committee on the trust revalidation performance and to provide a progress report on new and ongoing actions to ensure Trust readiness to meet the national requirements in relation to the implementation, monitoring and reporting of revalidation for registered nurses and/or midwives. The report details the overall trust RN revalidation numbers April to September 2016 by month and by directorate. The report notes initial positive feedback of registrants of the requirements. Feedback will be used through staff engagement forums and via dedicated revalidation folder on the trust website.
Seen at SLT or **Exec** Meeting & date	SLT/EXEC: Exec Date: 26th April 2016 Document Version number: 1.0 April 20th
Committee Approval / Review	• Quality Committee X • Finance and Performance Committee ☐ • Audit Committee ☐ • People and Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐
Relationship with: *Board Assurance Framework* *Strategic Objectives*	1. To provide the highest quality services ☐ 2. Create a learning culture to continually improve. ☐ 3. Encourage, inspire and implement research at all levels. ☐ 4. Maximise and use our resources intelligently and efficiently. ☐ 5. Attract and inspire the best people to work here. ☐

	6. Continually improve our partnership working. ☐ 7. To enhance service user and carer involvement.☐ **Comments:**
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	All Registered Nurses are required to revalidate to remain on the NMC register from April 1st 2016. Failure to register will result in reduced capacity for RN cover, potential impact on service continuity and quality and increase in temporary staffing costs
Resource Implications: Funding source:	Potential increases in temporary staffing costs
Equality & Diversity Implications:	None
Recommendations:	To receive the report for assurance and information.

North Staffordshire Combined Healthcare NHS
NHS Trust

Report subject:	**Trust Revalidation Preparedness Update**
Report to:	**Trust Board**
Action required:	**Information and Assurance**
Date of meeting:	**11 May 2016**
Prepared by	**Carol Sylvester Deputy Director of Nursing**
Presented by:	**Maria Nelligan Executive Director of Nursing**

Summary
A report was presented to the Executive Team in January 2016 detailing the national context for nurse revalidation development and preparation and to set out Trust readiness in supporting staff to successfully revalidate.

The purpose of this report is:

To update the Quality Committee on the trust revalidation performance.

To inform the Board members of new and on-going actions to ensure Trust readiness to meet the national requirements in relation to the implementation, monitoring and reporting of revalidation for registered nurses and/or midwives.

To highlight risks and challenges

Background
A new Nursing and Midwifery Council (NMC) process for renewal of nursing and midwifery registration came in to force in April 2016. In addition, a new NMC Code of was introduced in March 2015, which highlight the standards of behaviour and practice expected of nurses and midwives. Every three years, at the point of their renewal of registration, nurses and midwives will need to show that, as a professional, they are living by the NMC's new Code of standards of behaviour and practice.

Nurses and midwives who do not comply when their three year declaration is required will no longer be registered with the NMC and will therefore be unable to practise as a registered nurse and/or midwife as they will not be entered on to the NMC Professional Register.

The NMC have written to all registrants to identify the changes to the Professional Code and the requirements for Revalidation.

The NMC will check an undisclosed amount of portfolios each year with chosen portfolios requested within 24 hours of submitting a revalidation application.

Trust position and Compliance
The table below illustrates registered nurse totals, by Directorate who will be required to revalidate during 2016 and details that a total of 70 staff, 2 of whom are zero contract bank staff will be required to revalidate between April 2016 and September 2016.

This data previously submitted has been updated to reflect the ESR position at March 2016.

Directorate	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Adult In-patient	0	1	0	0	0	13	0	0	0
Adult Community	2	2	1	1	2	9	0	0	0
NOAP	1	2	2	0	0	14	0	0	0
Substance Misuse	1	0	0	0	1	3	0	0	0
CYP	2	0	0	0	1	6	0	0	0
Learning Disability	1	0	1	1	0	1	0	0	0
Corporate	0	0	0	1	2	1	0	0	0
Bank	1	0	0	0	1	2	0	0	0
Totals	**7**	**5**	**4**	**3**	**7**	**49**	**0***	**0***	**0***

*Data currently being refreshed
The table illustrates that the peak activity and preparation will occur in September 2016. This is due to annual student nurse intake and graduation occurring in September.

With the exception of a bank nurse no longer active on the nurse bank, all staff identified to revalidate in April have done so. All registrants have been contacted to summarise feedback and to establish any requested portfolios.

Update on Actions

1. On-going staff engagement strategy in conjunction with the communications with revised intranet location to enable easier access staff intranet dedicated revalidation page.
2. Dedicated page now includes all NMC revalidation resources to support portfolio completion.
3. Alerts sent by email 3 months prior to annual registration with reminder of revalidation date with NMC resource and training resource links included. This is in addition to the generated email from the NMC.
4. Status report circulated to Head of Directorate and Modern Matron/Senior Nurse for information and support.
5. Partnership with Royal Stoke NHS Trust to utilise the revalidation awareness raising/practical support sessions held at the UHNM.
6. ESR monthly, 3 monthly and 6 monthly update revalidation alerts and status reports.
7. Plenary dedicated to review and refresh of appraisal documentation to reflect revalidation related discussion.
8. Draft revalidation policy completed in conjunction with HR and currently out to consultation.
9. Power point presentation delivered to the Ward Manager Task and Finish Group and Senior Nurse Forum and utilised at team meetings.
10. Staff who have already revalidated invited to a Q&A session at the Annual Nurses Forum May 2016.
11. Deputy Director of Nursing has liaised with April registrants to scope any specific issues or difficulties with none reported.

Challenges, Risks and Mitigating Actions

Staff must register with NMC Online to commence revalidation process. This has been a point of emphasis on training sessions with assistance offered for any registrant with IT access difficulties.

Any potential lapses in renewal are flagged with registrant's line manager with daily checks in place until confirmation has been gained. There has been no lapses reported within the month of April.

Access to practical training resources provide advice and support in portfolio preparation to support registrants to meet the required standards.

Delivery of training to Ward Mangers and Senior Nurse Forum to ensure Managers are aware of confirmer role and responsibilities.

To ensure that preparations are in place for an increase in the number of registrants due to revalidate in September.

Summary

The Trust is committed to ensuring that Registered Nurses are supported to meet the requirements of the revalidation process to meet the national requirements. Feedback from both registrant and confirmer in the first month of revalidation has been positive and a commitment to offering peer support to future registrants.

Recommendations

For the Trust Board to receive the contents of this report .

REPORT TO TRUST BOARD Enclosure 8

Date of Meeting:	11th May 2016
Title of Report:	Board Assurance Framework Quarter 4 2015/16
Presented by:	Laurie Wrench, Associate Director of Governance
Author of Report:	Laurie Wrench, Associate Director of Governance
Purpose / Intent of Report:	Assurance and information.
Executive Summary:	The Board Assurance Framework (BAF) aligns the Trust strategic objectives to our quality priorities and key risks including the Board's level of risk appetite. The BAF provides an update and RAG rating for those actions due during quarter 4.
Seen at SLT or **Exec** Meeting & date	SLT/EXEC: Date: Document Version number:
Committee Approval / Review	• Quality Committee • Finance and Performance Committee • Business Development Committee • Audit Committee
Relationship with: *Board Assurance Framework* *Strategic Objectives*	1. To provide the highest quality services ☒ 2. Create a learning culture to continually improve.☒ 3. Encourage, inspire and implement research at all levels.☒ 4. Maximise and use our resources intelligently and efficiently.☒ 5. Attract and inspire the best people to work here.☒ 6. Continually improve our partnership working. ☒ 7. To enhance service user and carer involvement.☒ **Comments:**
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	The BAF describes the risks associated with the delivery of the strategic objectives
Resource Implications: Funding source:	None
Equality & Diversity Implications:	None
Recommendations:	• The Board receive the Quarter 4 Board Assurance Framework 2015/16 for assurance and information purposes. • The Board agree to close down the 2015/16 Board Assurance Framework

North Staffordshire Combined Healthcare NHS Trust

Board Assurance Framework (BAF) 2015/2016

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

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

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

Those key risks, mapped against our two strategic goals and 12 objectives are set out in the following pages. We have also categorised each objective against our quality priorities – SPAR.

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

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

Goal:	**To improve patient experience and pathways**											
Objective 1:	**Focusing on quality and safety**											
SPAR PRIORITY												
Exec owner:	Medical Director (MD) and Director of Nursing (DoN)											
Assurance Committee:	Quality Committee											
Risk appetite	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2			
	Safety		4		1		0		1			
***RISK:** The Trust fails to improve patient safety, eliminate avoidable harm and deliver high quality services, resulting in reputational harm, increased scrutiny and regulatory restrictions*	**Gross Risk (01/04/15)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/16)**					
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**			
	3	4	12	2	4	8	2	4	8			

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q4 RAG status**	**On Target RAG Status**	**End Year RAG Forecast**
1.1	Reduce medication errors.	10% reductions based on 31 March 2015 position. 2.5% reduction to be achieved per quarter	10% by end of Q4	30% reduction in dispensing errors achieved	MD	GREEN	GREEN	GREEN

1.2	Deliver CQUIN targets	Targets are fully delivered and milestones achieved.	All targets achieved by end Q4	Awaiting Quarter 4 outcome. All targets achieved to date	ADG	YELLOW	GREEN	GREEN
1.3	Perform QIA of all CIPs ensuring no impact on delivery of quality service	All CIP schemes have QIA scrutiny resulting in Directorate, MD and ND approval and ongoing monitoring of quality metrics.	July 2015.	Action complete. Has been agreed at monthly Care Quality Review Meeting with Commissioners Quality KPIs agreed for CIP is regular agenda item on the monthly performance monitoring meeting for Directorates	MD/DoN	GREEN	GREEN	GREEN
1.4	Improve the multi-disciplinary team approach.	Psychology embedded in all relevant directorates	March 2016	• 5/6 directorates embedded • Historically, there has been no resource for psychology in substance misuse	MD	GREEN	GREEN	GREEN
1.5	Raise the service user voice across the Trust.	Establish the Patient Council Service User to sit on Board Committees and on the Board.	March 2016	Council established Patient Experience Lead in post. Chair of council appointed and member of the Board	DoN	GREEN	GREEN	GREEN
		Family & Friends Test response rate increased by 30% 7.5% per quarter	30% by end Q4	As of end Q4, 30% increase not achieved. This will now be taken forward by the appointed Patient Experience Facilitator working with Service Users, Council	DoN	RED	RED	**RED**

				membership and Directorate Team Managers to agree a plan to address and encourage improvement in low return rates				
		PALs contacts increased by 10%.	10% by end Q4	Achieved target in full	DoN	GREEN	GREEN	GREEN
		Complaints reduced by 10%.	10% by end Q4	Targets achieved in full	DoN	GREEN	GREEN	GREEN
1.6	Ensure Nurse Revalidation.	Embed process with HR to ensure 100% assurance.	April 2016	Corporate Quality Lead nurse working alongside HR to embed this process NMC have confirmed state of readiness and revalidation commencement from April 2016.	DoN	GREEN	GREEN	GREEN
1.7	Reduce moderate harm incidents per 1,000 bed days.	Trust position, as measured by NRLS, reduced from average to better than average.	Ongoing	Improved position for October 1st 2014 to March 31st Moderate harm incidents- Trust average 3.2 harm incidents per 1000 bed days compared to a national average of 7.0	DoN	GREEN	GREEN	GREEN

1.8	Ensure infection free environments.	10% increase in number of patients vaccinated against Flu.	March 2016	Vaccination programme launched and being led by IPC Nurse. Target for 10% increase at end of Q4	DoN	GREEN	GREEN	GREEN
		Nil MRSA bacteraemia cases.		Nil identified in Quarter 4		GREEN	GREEN	GREEN

Goal:	**To improve patient experience and pathways**										
Objective 2:	**Consistently meeting standards**										
SPAR PRIORITY	 										
Exec owner:	Director of Operations (DO)										
Assurance Committee:	Finance and Performance										
Risk appetite	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2		
	Safety		4		1		0		1		
***RISK:** The Trust fails to hit required performance targets and is placed under a greater scrutiny regime by the TDA.*	**Gross Risk (01/04/15)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/16)**				
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**		
	3	3	9	3	3	9	2	3	6		

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q4 RAG status**	**On Target RAG Status**	**End Year RAG Forecast**
2.1	Delivery of new national mental health access targets.	Plan approved by Board EI September target is 20% - performance 23%	June 2015	Maintain performance	DO	GREEN	GREEN	GREEN

		IAPT 6 week target is 75% - performance 94.5% IAPT 18 week target is 95% - performance 100%						
2.2	Deliver operational KPIs.	Deliver (measures monthly and report to F&P committee) with rectification plans as needed.	March 2016	As of month 12, 85% operational KPIs were rated green	DO (CPA) DLW (MT)	AMBER	AMBER	AMBER

Goal:	**To improve patient experience and pathways**											
Objective 3:	**Protecting our core services**											
SPAR PRIORITY												
Exec owner:	Director of Strategy and Development (DSD)											
Assurance Committee:	Business Development											
Risk appetite	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2			
	Safety		4		1		0		1			
RISK: The Trust fails to consolidate its position as the local provider of local mental health and learning disability services, loses business to other providers and is not clinically, financially or operationally sustainable.	**Gross Risk (01/04/15)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/16)**					
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**			
	4	4	16	3	4	12	2	4	8			

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q4 RAG status**	**On Target RAG Status**	**End Year RAG Forecast**
3.1	Respond to commissioners' service development opportunities.	Produce approved business cases for PICU, high dependency rehabilitation, ward reconfiguration, learning disabilities and dual care.	June 2015 to Commissioners July 2015 approved by Trust Board	PICU business case approved. Detailed plans being produced LD business case pending commissioner review.	DSD	GREEN	GREEN	GREEN

				Ward reconfiguration model reviewed and no further action to be taken.				
3.2	Respond to tender opportunities and lead the bidding process as prime contractor.	Substance Misuse		Staffordshire inpatient substance misuse successfully awarded.	DSD	GREEN	GREEN	GREEN
		RAID	December 2015	RAID service funding of 250k awarded. Working up model with UHNM	DSD	GREEN	GREEN	GREEN
		IAPT	March 2016	Contract extended until March 2017	DSD	GREEN	GREEN	GREEN
		Co-operative Working	March	Successful 250k bid for cooperative working model across Stoke. To be closely aligned to MCP development in Stoke for delivery and sustainability	DSD	GREEN	GREEN	GREEN
3.3	PAN Staffordshire transformation engagement	Leadership at Pan Staffs themes 1. Caroline Donovan leading workforce agenda. 2. Dr Adeyemo appointed Clinical Lead for Specialist Mental	Transformation Programme Duration	Strong representation on pan Staffordshire Together We're Better Transformation group.	DSD	GREEN	GREEN	GREEN

		Health Services. 3. Dr Fazal-Short appointed to Clinical Lead for Long Term Conditions.						
3.4	Social Care Integration	The Trust is working with the Stoke City County Council on the opportunity around greater integration of social care services.	January 2017	Integrated Learning Disability Management achieved. Case for change made. Further discussions to be had by Stoke LA senior leadership	DSD	AMBER	AMBER	AMBER

Goal:	**To improve patient experience and pathways**											
Objective 4:	**Growing our specialised services**											
SPAR PRIORITY												
Exec owner:	Director of Strategy and Development (DSD)											
Assurance Committee:	Business Development											
Risk appetite	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2			
	Safety		4		1		0		1			
***RISK:** The Trust fails to consolidate its position as the provider of specialised mental health and learning disability services, loses business to other providers and is not clinically, financially or operationally sustainable.*		**Gross Risk (01/04/15)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/16)**				
		LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**		
		4	4	16	3	4	12	2	4	8		

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q4 RAG status**	**On Target RAG Status**	**End Year RAG Forecast**
4.1	Develop the Trust's capacity and capability for commercial change.	Appoint a substantive Director of Strategy & Development.	May 2015	Complete.	CEO	GREEN	GREEN	GREEN

		Establish a Business Development and Investment Committee.	November 2015	Complete	DSD	GREEN	GREEN	GREEN
		Produce a comprehensive business planning framework for annual business planning.	January 2016	Complete	DSD	GREEN	GREEN	GREEN
		Enhance horizon scanning and business opportunity identification.	December 2015	Drafts complete	DSD	GREEN	GREEN	GREEN
		Train SLT in core competencies: business case production and project management.	December 2015	NHS Elect engaged for SLT training programme, tender submissions and case writing.	DSD	GREEN	GREEN	GREEN
		Establish rules and principles for bidding.	November 2015	Drafts complete.	DSD	GREEN	GREEN	GREEN
4.2	Respond to tender opportunities and lead the bidding process as prime contractor.	Stoke on Trent Substance Misuse services.	June 2015	Inpatients retained. Community and Recovery not successful.	DSD	GREEN	GREEN	GREEN
		Staffordshire in-patient Substance Misuse services.	September 2015	Tender submitted and successful	DSD	GREEN	GREEN	GREEN

		Shropshire Community Substance Misuse services.	July 2015	Responded to the process however unsuccessful – Lessons learned process underway	DSD	GREEN	GREEN	GREEN
		Adult PICU repatriation + spot purchasing	March 2016	In line with specialist mental health commissioning theme, a review is underway of out of area patients	DSD	GREEN	GREEN	GREEN
4.3	Work with independent and third sector partners to implement new and innovative models of care.	Priory and Staffordshire Housing for CAMHS Tier IV	December 2015	Further meetings arranged	DSD	AMBER	AMBER	AMBER
		RAPT for prison in-reach services	December 2015	Stoke Heath Prison contract extended 2 years. Consideration around Wrexham 800 bed discussed with directorates	DSD	GREEN	GREEN	GREEN
		Develop proposal for ICO with Stoke-on-Trent Council	May 2015	Proposal complete, Presented to Council Executives , September 2015	CEO	GREEN	GREEN	GREEN
		Develop partnership with Northern Staffordshire GP Federation.	June 2015	GP Memorandum of understanding signed	CEO	GREEN	GREEN	GREEN
4.4	Primary Care Integration	1. Trust ambitions received positively by North Staffs Primary Care Strategy Group. 2. Leek Locality engagement in Mental	March 2016 April 2016	Two early adopter sites in place	DSD	GREEN	GREEN	GREEN

		Health Sponsored MCP 3. Primary Care Clinical Director identified	February 2016					
4.5	Secondary Care Integration	Exploration with UHNM of opportunities around urgent care pathway. Dual care wards and long term conditions. Intra organisational working group to be developed to deliver cross organisational developments.	March 2017	Setup working group. Develop joint proposals in line with Pan Staffordshire challenges. 1. Mental Health emergency care centre in development 2. Community dual care wards. 3. Long term conditions mental health integration 4. 24/7 RAID 5. Dual Care Ward	DSD	GREEN	GREEN	GREEN

Goal:	**To improve patient experience and pathways**											
Objective 5:	**Innovating in the delivery of care**											
SPAR PRIORITY												
Exec owner:	Medical Director (MD)											
Assurance Committee:	Quality											
Risk appetite	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2			
	Safety		4		1		0		1			
***RISK**: The Trust fails to exploit its potential in innovation and loses credibility and reputation in the healthcare community.*	**Gross Risk (01/04/15)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/16)**					
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**			
	4	3	12	3	3	9	2	3	6			

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q4 RAG status**	**On Target RAG Status**	**End Year RAG Forecast**
5.1	Raise the profile and influence of the Trust across region for	Chief Executive - Chair of Regional MHLETC.	June 2015	CEO chaired 1st Mental Health LETC and gave presentation to c200 stakeholders	CEO	**GREEN**	GREEN	GREEN

	innovation.	Chief Executive appointed as Workforce and OD lead for pan-Staffordshire programme	September 2015	Director of Leadership and Transformation appointed	CEO	**GREEN**	GREEN	GREEN
		Medical Director has been appointed as the clinical chair for the mental health pan-Staffordshire work stream	December 2015	Appointed as chair	MD	**GREEN**	GREEN	GREEN
		Director of Psychology has been appointed as the clinical chair for the long term conditions pan-Staffordshire work stream	December 2015	Appointed as chair	MD	**GREEN**	GREEN	GREEN
		Trust selected to be featured in Healthcare Parliamentary Review	March 2016	DoH contacted Trust	CEO	**GREEN**	GREEN	GREEN
		Director of Leadership and Workforce – Regional W/F planning lead.	June 2015	Trust DL&W is regional lead	DL&W	GREEN	GREEN	GREEN
		Medical Director – Regional Dementia Lead	June 2015	A Skills and Competency Framework has been agreed, as has a catalogue of the resources and courses which are available to train and educate staff. A tool has been piloted which can be applied to any health or care organisation to identify training needs. Gaps in dementia resources have been identified and work is currently underway to commission resources that will fill these gaps. The	MD	GREEN	GREEN	GREEN

				interactive dementia portal will now be developed as part of the future HEE national learning hub, with information being shared on a regional site in the interim. Work is also underway with universities to identify how the dementia framework is covered on current courses and enable to LETB to negotiate full coverage in the future.				
		Chief Executive – Leadership Lead for Shropshire & Staffordshire	June 2015	CEO leading on talent management and compassionate leadership across Shropshire and Staffordshire. CEO requested to lead workforce and leadership across Staffordshire. Director of Leadership and Workforce appointed Compassionate leadership scheme commenced	CEO	GREEN	GREEN	GREEN
5.2	Improve our approach to service improvement.	Establish service improvement capacity and capability within the Trust.	September 2015	Reconsidering approach to service improvement with introduction of Meridian Productivity	DLW	RED	RED	RED
		Demonstrate improvements in at least 10 services.	March 2016		DL&W	RED	RED	RED
		Train at least 30 staff in service improvement	March 2016		DL&W	RED	RED	RED

		LiA wave 2 Celebration event	December 2015	Celebration event held Plans for wave 3 developed	DL&W	GREEN	GREEN	GREEN
		Dragon's Den innovation session	December 2015	Dragon's Den innovation session delivered and all applicants have received feedback and where appropriate, funding	DL&W	GREEN	GREEN	GREEN
5.3	Participate in the Staffordshire wide research strategy and West Midlands academic health sciences network.	Enhance relationships with local partners on the development and delivery of research.	March 2016	R&D Workshop held with Keele University to refresh vision. The Trust is part of the ongoing Staffordshire Wide Research group and is currently leading on a research engagement project on behalf of the WM CRN. Continued active membership of the Cross Staffordshire Research and Development Group (partnership of primary and secondary MJS organisations, Staffordshire & Keele Universities) Dementia research partnership established with UHNM with a shared research co-ordinator post funded through NIHR for 12 months. LIA Wave 3 theme of enhancing our research culture with Pass it On event planned for May 2016. Dementia bid progressing with Ken Muir	DL&W until Q2 and then MD	AMBER	AMBER	AMBER

5.4	Encourage increased participation in research across all professional groups across the Trust.	Develop Trust wide information of all published research.	September 2015	Complete. To be updated annually.	MD	GREEN	GREEN	GREEN
		Recognize research as part of REACH awards.	September 2015	Complete. Assessed under innovation category for 2015 and will be a standalone recognition award in 2016	MD	GREEN	GREEN	GREEN
		Establish Trust wide research group with multi-professional membership.	December 2015	Currently research discussed at the Clinical Effectiveness group and R&D Steering Group. To strengthen our evidence based research culture a team has been established as part of the wave 3 Listening into Action.	MD	GREEN	GREEN	GREEN

Goal:	**To improve patient experience and pathways**											
Objective 6:	**Developing academic partnerships and education and training initiatives**											
SPAR PRIORITY												
Exec owner:	Director of Leadership and Workforce (DLW)											
Assurance Committee:	People and Culture Development											
Risk appetite	Quality	3	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2		
	Safety	4				1		0		1		

RISK: The Trust fails to educate and develop its workforce resulting in the failure to deliver safe quality services impacting on the ability to attract talent.	**Gross Risk (01/04/15)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/16)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	3	4	12	3	4	12	3	4	12

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q4 RAG status**	**On Target RAG Status**	**End Year RAG Forecast**
6.1	Improve our approach to education and development	Refresh the PDR process and ensure that 90% have a PDR and that we are above average in comparison with other MH Trust's for quality of experience as evidenced in the staff survey.	Quarterly	PDR compliance at 91% as of February 2016. Final end of year figures being finalised. Audit completed and informing future processes	DL&W	GREEN	GREEN	GREEN

		Business case for professorial unit	March 2016	Workshop held. Medical Director to maintain links with Keele. Business Case to be developed with the Director of Leadership and Workforce with support from the Director of Strategy and Development, led by the Medical Director. To carry forward into 2016/17 BAF.	DL&W until Q2 and then MD	RED	RED	RED
		Ensure that 95% of teams have undertaken the ARTP review process. Show improvement in 75% of the teams.	March 2016	92.3% of teams have now commenced ARTP and of those 85% have shown improvement in the ARTP scores. Additional work needed to continue to embed the process. To carry forward into 2016/17 BAF	DL&W	YELLOW	YELLOW	YELLOW
		Launch You Tube learning channel.	November 2015	NSCHT You Tube channel in place. Additional learning channels with a specific focus on key trust services being developed by OD and Communications	DL&W	RED	RED	RED

				Channel available but issues with technology preventing some staff from accessing YouTube therefore launch delayed until end of April 2016	DL&W	RED	RED	RED
		Improve education experience for learners within the Trust as demonstrated by improvement in all experience surveys. Improve JEST scores from good to excellent.	March 2016	JEST scores received in June achieved this. Two reported as 'needing attention' with all other scores at 'good' or 'excellent' A recent report from Keele University has raised some concerns	DL&W	AMBER	AMBER	AMBER
		All newly appointed Consultants allocated a mentor.	October 2015	System set up for a mentor to be allocated as part of the induction process. Objectives to be achieved set up for mentor and consultant with a quarterly review. Complete.	MD	GREEN	GREEN	GREEN
		Develop and implement an approach to Talent Management and Succession Planning that – • Gives an identified talent pool. Shows a succession plan with all key posts with an identified succession or a plan to address shortfalls	Revised date from July 2015 to September 2016	Survey submitted to SLT Dec/Jan 2016, Paper to SLT Jan 2016, data collection information circulated to Directorates February 2016	DL&W	RED	RED	RED

		Introduce E-Learning for Mandatory training where this is possible due to legislation/guidance.	March 2016	All members of the Trust now have access to E-Learning through OLM (Oracle). Currently there are technical problems in completing the on-line training; due Java Script and Google Chrome, IT are rolling out IE11 which is being tested at the moment – once this has been rectified – a full launch of E- learning can take place. A business case has been produced to ensure the competences are aligned with ESR for full automation.	DL&W	AMBER	AMBER	AMBER

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

***RISK**: The Trust fails to manage relationships with it is staff, to improve engagement and enhance inclusion resulting in higher turnover and reduced effectiveness of service delivery, threatening clinical and operational sustainability*	**Gross Risk (01/04/15)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/16)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	4	4	16	3	4	12	2	4	8

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q4 RAG status**	**On Target RAG Status**	**End Year RAG Forecast**
7.1	Become an employer of choice	Produce workforce plan that supports the Integrated Business Plan.	March 2016	Completed as part of the TDA and Health Education West Midlands submissions	DL&W	**GREEN**	GREEN	GREEN

		Refresh the workforce planning process to strengthen competency based workforce planning produces Directorate detailed workforce plans.	June 2015	Template for Directorate one year workforce plans produced and populated by directorates	DL&W	RED	RED	RED
		Reduce stress at work and sickness to below 4%.	March 2016	The staff survey demonstrates a significant reduction in stress at work although stress related sickness reasons have increased2015/16 = 4.65% compared to 2014/15 = 4.31%	DL&W	AMBER	AMBER	AMBER
		Reduce the average time taken to recruit new employees by half.	October 2015	• Part of LIA Team • 'One stop shops' in place for large campaigns • EDBS live in July • OH process streamlined Recruitment figures show we have reduced to 4 weeks from conditional offer to unconditional offer during since January Baseline 2014/15 = 52.81 calendar days 2015/16 = 31.34 calendar days therefore 41% reduction	DL&W	AMBER	AMBER	AMBER

7.2	Improve Communication and Engagement.	Improve the staff survey results in 25% of areas.	March 2016.	Staff survey results demonstrate a 50% improvement in a number of areas	DL&W	GREEN	GREEN	GREEN
		Improve satisfaction of staff with experience of change measured by improving the staff survey scores to above average for MH Trusts.	March 2016.	Staff survey has demonstrated improved scores in engagement from 3.55 to 3.70 however we still remain below the national average	DL&W	AMBER	AMBER	AMBER
		Develop a communication strategy for Communication and Engagement that is co-produced across the Trust and approved by the Board	March 2016	Strategy finalised	DL&W	GREEN	GREEN	GREEN
		Develop Corporate Accountability Framework (CAF).	October 2015	Not implemented	DL&W	RED	RED	RED
		Implement CAF in line with agreed plan	March 2016		DL&W	RED	RED	RED
7.3	Support and enhance inclusion.	Develop a strategy and plan to improve inclusion, diversity and equality within the Trust.	November 2015.	Appointment of dedicated lead in post. E&D Plan developed in full	DL&W	GREEN	GREEN	GREEN
		Implement approach to widening participation to ensure that we deliver: • 10 apprenticeships • Enable 10 people to use the process	March 2016.	Target for number of apprentices was 10, the Trust achieved 7. Seven assistant practitioners introduced.	DL&W	AMBER	AMBER	AMBER

		• Introduce Peer Support Workers						
		Every selection process across the Trust invites service user representation		Service user involvement in selection process	DL&W	**GREEN**	GREEN	GREEN
7.5	Review the Trust Values and Behaviours	Review the Trust values to ensure that they are fit for purpose and have been developed and agreed with the engagement of staff. Develop a behavioural framework to outline expectations within the Trust.	April 2016	Draft values developed Draft behavioural framework being developed	DL&W	AMBER	AMBER	AMBER

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

***RISK**: The Trust fails to secure an overall "good" rating in its CQC inspection, resulting in loss of reputation, reduced opportunity for development and greater scrutiny from regulators.*	**Gross Risk (01/04/15)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/16)**		
	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE
	4	4	16	4	4	16	4	4	16

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q4 RAG status**	**On Target RAG Status**	**End Year RAG Forecast**
8.1 NEW for Q3	Development of robust action plans to address draft CQC reports and ratings	a. Action plans reviewed by SLT overseen by CEO b. Thorough review of draft reports both internally and externally c. Ongoing assurance sought from directorates d. Seeking to maintain	December 2015	Quality Summit held 16th March 2016. TDA identified action plans and process for improvements as exemplar. Regular updates provided to the Board	CEO	GREEN	GREEN	GREEN

		relationship with lead inspector		Board Development session held January 2016 Action plans in place to address requirement notices Strategic themes identified and action plan developed.				
8.2 NEW for Q3	Factual accuracy checks and ratings challenge undertaken and submitted to CQC by required deadline	a. Legal support sought from Capsticks to ensure robust factual accuracy and ratings challenge b. Factual accuracy reports c. All deadlines achieved regarding Trust response to CQC	December 2015	Response produced for each core service and overall provider report A number of challenges accepted with a shift in ratings	CEO	GREEN	GREEN	GREEN
8.3 NEW for Q3	Community CAMHS Section 29A Warning Notice Action Plan and evidence	a. Robust action plan developed in response to notice b. Shared with the CQC on a monthly basis with corresponding evidence c. External assurance from KPMG on progress made d. Timeframes identified for actions to be completed e. Trust is able to evidence improvements	October 2015	Regular meetings to monitor progress Ongoing dialogue with commissioners regarding gap in funding for additional staff Ongoing assurance both internal and externally (KPMG) gives positive assurance against progress	CEO	GREEN	GREEN	GREEN
8.4 NEW for Q3	Action plans demonstrate improvements and the Trust is able to	a. Monitoring of progress against action plans both at Directorate meetings and at the Senior Leadership Team	End Q1 2016/17	Assurances to be introduced to enable the Trust to evidence improvements are made	CEO	GREEN	GREEN	GREEN

	evidence this	b. System introduced to track improvements are made and sustained c. Continual improvements achieved resulting in a CQC rating of 'good' for the Trust	Q4 2016/17	Regular updates to the Board on progress made Internal mechanisms to provide assurance on progress: • CQC self assessments • Peer review process • Clinical audit support • Monitoring of risks • Internal audit - RSM • Balanced scorecard and other performance metrics External mechanisms to provide assurance on progress: • External Auditors • Future CQC visits • MHA compliance visits • TDA • Intelligent Monitoring Reports				

Goal:	**To deploy our resources more efficiently and intelligently**											
Objective 9:	**Becoming digital by choice**											
SPAR PRIORITY												
Exec owner:	Director of Strategy and Development (DSD)											
Assurance Committee:	Business Development											
Risk appetite	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2			
	Safety		4		1		0		1			
***RISK**: The Trust fails to invest appropriately in its digital plan meaning that it is unfit for the future and the Trust is unable to deliver its business goals and objectives.*	**Gross Risk (01/04/15)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/16)**					
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**			
	4	4	16	3	4	12	2	4	8			

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q3 RAG status**	**On Target RAG Status**	**End Year RAG Forecast**
9.1	Establish a robust governance structure	Programme Governance Board in place. Information Sharing and Service Management Groups in place.	June 2015 June 2015	Achieved. Achieved.	DSD	GREEN	GREEN	GREEN

9.2	Enhance Trust internal capacity and capability.	Appointment of Chief Information Officer Appointment of Head of Portfolio Management. Appointment of clinical leads in each Directorate	June 2015 October 2015.	Achieved. Starts in post 27 July 2015. Interviews completed appointments made	DSD	GREEN	GREEN	GREEN
9.3	Develop key partnerships to initiate and build on lessons learned elsewhere and to implement change within the Trust.	Partnership working with: • CSC • NHS England • Salford co-ordination Centre • Bitjam	March 2016	Prioritisation of digital initiatives. Visit made to Norfolk and Humber to learn from good practice. Access programme under development Ongoing work with CSC and HSCIC in developing lead digital mental health trust.	DSD	GREEN	GREEN	GREEN
9.4	Progress on delivery of an electronic patient record for the Trust.	Business case development with CSC and approved by Trust Board.	October 2015	High quality LIC 2 as evidenced by HSCIC feedback and approved by HSCIC. LIC 3 in development.	DSD	GREEN	GREEN	GREEN
9.5	Health Economy Patient Care Record	Presentation to HIS board on NSCHT digital strategy.	January 2016	Trust is taking role in supporting a shared record Planned LHE workshop in May 2016	DSD	GREEN	GREEN	GREEN

Goal:	**To deploy our resources more efficiently and intelligently**											
Objective 10:	**Reviewing and rationalising our estate**											
SPAR PRIORITY												
Exec owner:	Director of Operations (DO)											
Assurance Committee:	Finance and Performance											
Risk appetite	Quality	Financial	3	Quality (Innovation)	2	Regulation	2	Reputation	2			
	Safety		4		1		0		1			
***RISK**: The Trust fails to manage its estate infrastructure, meaning that it's unfit for the future and the Trust is unable to deliver its business goals and objectives.*	**Gross Risk (01/04/15)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/16)**					
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**			
	4	4	16	3	4	12	3	4	12			

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q4 RAG status**	**On Target RAG Status**	**End Year RAG Forecast**
10.1	Sale of Bucknall Hospital.	Contract of sale exchanged.	June 2015	Exchange completed August 2015 (£200k non-refundable deposit paid by Keep Moat)	DF	GREEN	GREEN	GREEN
		Contract of sale completed.	December 2015	Completed	DF	GREEN	GREEN	GREEN

10.2	Produce an estates rationalisation plan.	Plan approved by Board, with clear trajectories and milestones to reduce accommodation footprint linked to a mixed economy of freehold and leasehold properties.	November 2015	• Presentation to January BoD session with outline of proposals. • Finalisation of Proposals during Q4 • Estates optimisation plan to carry forward into 2016/17 BAF	DO	AMBER	AMBER	AMBER
10.3	Master plan for Harplands Hospital.	Approved development control plan demonstrating medium to long term potential.	September 2015	Business cases for PICU, Darwin, Dragon Square have been achieved. In negotiation to finalise A&T plans with commissioners. Development away day with Directorates carried out during November to input to plans and next stage**.** Move to Dragon Square complete during December 2015 and Boathouse vacated. Ward reconfiguration paper due to be presented to SLT in Jan and Feb	DO	AMBER	AMBER	AMBER

				Board.				

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

***RISK**: The Trust fails to meet key regulatory and compliance requirements and is placed under a greater scrutiny regime by the TDA.*	**Gross Risk (01/04/15)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/16)**		
	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE	LIKELIHOOD	IMPACT	SCORE
	3	4	12	4	4	16	2	4	8

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q4 RAG status**	**On Target RAG Status**	**End Year RAG Forecast**
11.1	Develop a Board Assurance Framework.	BAF embedded and used to drive committee business.	June 2015 (achieved).	Achieved	CEO	GREEN	GREEN	GREEN
11.2	Maintain a strong Head of Internal Audit opinion.	No negative assurances in the annual governance statement Positive opinion, demonstrating robust system of internal	Ongoing	Positive opinions received for 2014/15 Work has commenced on statement for 2015/16	CEO	GREEN	GREEN	GREEN

		control.						
11.3	Maintain quality governance standards.	Maintain performance against Quality Surveillance Score green, CQC banding 1, TDA rating 4.	ongoing	CQC Risk banding at level 1 (low risk) TDA QSG score green for Q1-Q3 and rated amber for Q4	CEO	YELLOW	YELLOW	YELLOW
11.4	Strengthen contract management.	Review approach to contract management, led by the Head of Legal Services.	March 2016	As part of contract pre meeting in July and September the Commissioning Team will identify the level of support required by the Trust to ensure any legal issues relating to contracts are considered. The role of the Legal Advisor will be drafted.	DF	AMBER	AMBER	AMBER
11.5	Improve effectiveness of the audit committee.	Timely delivery of the internal audit plan and completion of audit recommendations.	Sept 2015	Ongoing review to follow up action on outstanding recommendations	DF	GREEN	GREEN	GREEN
11.6	Development of Emergency Planning Process	Further embed emergency planning into organisation by following. 1. Exec Team to undertake Gold Commander Training Q3 2. Development and submission of Trust Winter Plan Service level resilience plans (PARP) to be completed across services to be complete – Mar	March 2016	Exec Team undertook EP coaching session during Q2 2015/16 Gold Commander Training delivered to Exec Team during December 2015. Service level resilience plans in progress but not fully completed. The Trust developed a winter resilience plans and fed into the	DO	AMBER	AMBER	AMBER

		2016.		System resilience plan that has been managed through SRG. Review of lockdown procedures completed during Q4.				

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

***RISK**: The Trust fails to meet its financial responsibilities and/or fails to deliver year one of its LTFM, resulting in greater scrutiny from regulators and commissioners and the threat of financial non- sustainability.*	**Gross Risk (01/04/15)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/16)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	3	4	12	2	4	8	2	4	8

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q4 RAG status**	**On Target RAG Status**	**End Year RAG Forecast**
12.1a	Spend within cash resource limit.	CIP plans are robust and delivered to time and financial targets for 2015/16.	Q4 end March 2016	Q4 Year to date is on track Element of non-recurring CIP still remains	DO	YELLOW	YELLOW	YELLOW
		Budgets approved with a robust system of recording activity for payment by results.	May 2015	Complete	DF	GREEN	GREEN	GREEN

12.1b		Development of robust CIP plans for 2016/17	March 2016	CIP plan for 2016/17 shows gap of £400K as of end March. Plans to address gap underway QIA underway to finalise programme	DO	AMBER	AMBER	AMBER
12.2	Enhancing service line reporting	Embed the use of service line reporting for: • Costing • Contracting • Inclusion of balanced scorecard • Use by directorates to support better understanding of the data	May 2016	Balanced Scorecard is in place	DF	GREEN	GREEN	GREEN
12.3	Improve the Trust's performance management and reporting processes.	Board report developed to support better understanding of the Trust's financial position.	April 2016	Board report to be linked to Balanced Scorecard. Draft report was presented Finance and Performance Committee February 2016	DF	GREEN	GREEN	GREEN
		Enhance balanced scorecard reporting to include: • Increased automation of information via the data warehouse • Eliminate gaps in data relating to new / difficult to access data • Ability to extract data formats for internal/external reports • Continue with training for team recording	Ongoing	Completed as follows: • Quality – September • Performance - October • Workforce – January • Finance – March The Board will be able to fully access the electronic version once Board Pads have been acquired in May 2016	DF	YELLOW	YELLOW	YELLOW

		• Keep up to date with new requests for information, both internal and external						
		Responsibility for performance management transferred to the Director of Strategy and Development under the management of the Chief Information Officer and Digital by Choice.	November 2015	Deferred decision until commencement in post of new Director of Finance in March 2016	DF	YELLOW	YELLOW	YELLOW
12.4	Focus on Efficiency and Productivity.	Review the pharmacy service delivery model by undertaking a cost benefit analysis.	March 2016	Chief Pharmacist and DSD undertook high level review and advised on alternative process	MD	GREEN	GREEN	GREEN
		Seek best value for money in the PFI contract, identifying savings that could be realised.	September 2015.	Town Hospitals Limited have made a further offer of £50K per annum for the next four years. The Trust will continue to look for better value for money. As part of the scoping exercise we have identified that catering costs are high and are progressing a work programme in 16/17 to tackle this.	DO	AMBER	AMBER	AMBER
		Reducing Drugs overspend by 50%.	50% reduction by end Q4	50% reduction not achieved. Contract negotiations for increased income with	MD	RED	RED	RED

				commissioners regarding ADHD and Antipsychotic shared care arrangements.				
		Lead Psychiatrist identified for each GP locality	September 2015	Lead identified Standards for Leads to work to has been set and will be monitored to ensure consistency in approach	MD	GREEN	GREEN	GREEN
		Further embed improvement in GP relationships by increasing the use of GP support email by a further 20% from March 2015 baseline (March 2016).	20% increase by end Q4	Use of support email continues to increase achieving 20% increase. To carry forward into 2016/17 BAF	MD	GREEN	GREEN	GREEN
12.5	Completion of capital investment in line with plan	Progress reported to Finance and Performance Committee and Board to confirm progress	Quarterly	Small variance to capital programme remains on track. End of year forecast aligns to plan	DF	AMBER	AMBER	AMBER
12.6	Implementation of a new system – financial support	Establish EPR financial contracts and submission of data to TDA. Ensure financial instructions are adhered to in order to minimise costs and maximise benefit to the Trust	2016/17 and onwards	LIC 2 approved. LIC 3 in development.	DF	GREEN	GREEN	**GREEN**

REPORT TO TRUST BOARD Enclosure 9

Date of Meeting:	11th May 2016
Title of Report:	NEW Board Assurance Framework 2016/17
Presented by:	Laurie Wrench, Associate Director of Governance
Author of Report:	Laurie Wrench, Associate Director of Governance
Purpose / Intent of Report:	Assurance and information.
Executive Summary:	The Board Assurance Framework (BAF) for 2016/17 aligns the Trusts new strategic objectives to our quality priorities and key risks. The 2016/17 BAF provides a first glance at the key control and assurances to be introduced to ensure delivery of the seven strategic objectives. The level of risk appetite was determined at the Board of Directors Development session 27th April 2016.
Seen at SLT or **Exec** Meeting & date	SLT/EXEC: Date: Document Version number:
Committee Approval / Review	• Quality Committee • Finance and Performance Committee • Business Development Committee • Audit Committee
Relationship with: *Board Assurance Framework* *Strategic Objectives*	1. To provide the highest quality services ☒ 2. Create a learning culture to continually improve.☒ 3. Encourage, inspire and implement research at all levels.☒ 4. Maximise and use our resources intelligently and efficiently.☒ 5. Attract and inspire the best people to work here.☒ 6. Continually improve our partnership working. ☒ 7. To enhance service user and carer involvement.☒ **Comments:**
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	The BAF describes the risks associated with the delivery of the strategic objectives
Resource Implications: Funding source:	None
Equality & Diversity Implications:	None
Recommendations:	The Board receive the 2016/17 Board Assurance Framework for assurance and information purposes.

North Staffordshire Combined Healthcare NHS Trust

Board Assurance Framework (BAF) 2016/2017

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

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

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

Those key risks, mapped against our two strategic goals and 7 objectives are set out in the following pages. We have also categorised each objective against our quality priorities – SPAR.

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

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

Objective 1:	**To provide the highest quality services**
SPAR PRIORITY	
Exec owner:	Medical Director (MD) and Director of Nursing & Quality (DoN)
Assurance Committee:	Quality Committee

Risk appetite	Financial	3	Quality (Innovation)	3	Regulation	2	Reputation	3

RISK: *The Trust fails to improve patient safety, eliminate avoidable harm and deliver high quality services, resulting in less than optimal care, reputational harm, increased scrutiny and regulatory restrictions*	**Gross Risk (no mitigation)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/17)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	4	4	16	3	4	12	2	4	8

SPAR Reference	**CONTROLS**	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q1 RAG status**	**On Target RAG Status**	**End Year RAG Forecast**
	Improvement in CQC rating in September 2016	The Trust will achieve improvements in core service ratings	Quarter 2		CEO			
Recovery	Development of a Nursing Strategy	A Nursing Strategy is developed underpinned by the principles of recovery, the Trust values and	Quarter 3		DON			

		the six Cs						
Recovery	Strengthen governance management and clinical leadership	Development of an assessment and accreditation framework for inpatient wards to enhance the clinical leadership of ward managers which will include KPIs for: • Practice • Patient experience • Leadership • Clear professional and governance leadership across directorates	Quarter 4		DON			
		Develop a model for psychological therapies within Substance Misuse services	Quarter 2		MD			
Safe	Embedded safety culture and safe environments	The introduction of an inpatient safety matrix across all wards	Quarter 1		DON			
		The implementation of a patient safety campaign including targeted monthly assurance visits using peer review and Board to Team principles	Quarter 2		DON			

		Delivery of the safety culture CQUIN for 2016/17	Quarterly milestones to be achieved		DON			
		Develop and prioritise a plan for the reduction of ligature risks	Quarter 1		DO			
Safe	Ensure infection free environments	Strengthen infection prevention control surveillance within inpatient wards	Quarter 2		DON			
		Quarterly DIPC Report to the Board	Quarter 1		DON			
Safe	A reduction in harm	To maintain incident reporting levels above the national average	Quarter 4		DON			
Safe		Ensure 90% of eligible staff receive medicines optimisation training	90% of staff by Quarter 4		MD			
Safe		To reduce the number of medication errors from Quarter 3 by 10% from the 2015/16 baseline	5% decrease by Quarter 3		MD			
Safe		To reduce the number of medication omitted doses by 10% from the baseline by clinical teams	2.5% decrease by Quarter 1		MD			
Personalised		Consent to treatment to be recorded for	To be monitored		MD			

		100% in partnership with patients	Quarterly					
Personalised		Section 17 Leave forms to be completed for 100% in partnership with patients	To be monitored Quarterly		MD			
Recovery		90% of appropriate staff will receive training on the Mental Health Act and Mental Capacity Act	To be monitored Quarterly		MD			
Accessible		To increase the number of patients seen within 3 hours for a section 136 assessment by 50% by Quarter 4 Q4 baseline 43% Year end target 66%	12.5% increase by Quarter 1	Q1 target 50% Q2 target 55% Q3 target 60% Q4 target 66%	DO			
Safe Personalised Accessible Recovery	Delivery of CQUIN Programme	100% CQUIN milestones are achieved • Physical Health(S,R) • Communication with GPs (A) • Staff Well-being (P) • Safety Culture (S) • Green Light Toolkit (P) • Care Planning (SPAR)						

Accessible	Delivery of new national mental health access targets and ensure comprehensive access to all services	Early Intervention Team target of 50% patients having accepted a NICE approved package of care within 2 weeks	To be monitored Quarterly		DO			
		IAPT target of 75% patients having commenced treatment within 6 weeks of date of referral	To be monitored Quarterly		DO			
		IAPT target of 95% patients having commenced treatment within 18 weeks of date of referral	To be monitored Quarterly		DO			
		Achievement of waiting times initiatives - 92% patients are seen within 18 weeks	To be monitored Quarterly		DO			
Safe Personalised Accessible Recovery	Care Planning and Risk Assessments	100% patients to have a Care Plan and Risk Assessment	To be monitored Quarterly		DO			
		The Trust can evidence 100% patients have been involved in the development of their care plan	To be monitored Quarterly		DO			

Safe	Emergency Planning	Development of Emergency Planning Process and service level resilience plans (PARP) to be completed across services	Quarter 2		DO			

Objective 2:	**Encourage, inspire and implement research and innovation at all levels**
SPAR PRIORITY	
Exec owner:	Medical Director (MD)
Assurance Committee:	Quality

Risk appetite	Financial	2	Quality (Innovation)	2	Regulation	2	Reputation	3

***RISK**: The Trust fails to exploit its potential in research and innovation, losing credibility and reputation and under achieving in delivering evidence based care.*	**Gross Risk (no mitigation)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/17)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	4	4	16	3	4	12	2	4	8

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q1 RAG status**	**On Target RAG Status**	**End Year RAG Forecast**
	Strengthen integration of Mental Health with Primary Care services	Engage in all MCP adoption in North Staffs and Stoke	Quarter 4		DSD			
		Engage GP federation with Memorandum of Understanding (MOU)	Quarter 1		DSD			
		Portfolio of services to support primary care is	Quarter 1		DSD			

		developed and implemented						
		Deploy risk prevention research into MCP model	Quarter 3		DSD			
	Participate in the Staffordshire wide research strategy and West Midlands Academic Health Sciences Network.	To develop partnership agreement with Higher Education Institution in areas of mutual interest.	Quarter 4		MD			
	Increased research activity and profile	Increase the number of research partners by 50% from baseline by Quarter 4 (n=20)	12.5% increase by Quarter 1		MD			
		Increase the number of publications by 50% from baseline by Quarter 4 (n=8)	12.5% increase by Quarter 1		MD			
		Increase the number of staff / teams engaged in research by 50% from baseline by Quarter 4 (n=27)	12.5% increase by Quarter 1		MD			
		Increase the number of home grown research projects by 50% from baseline by Quarter 4 (n=14)	12.5% increase by Quarter 1		MD			
		Increase the number of returns for student satisfaction surveys by 50% from baseline by Quarter 4	12.5% increase by Quarter 1		MD			

	Increased productivity and efficiency	Using Meridian Productivity to redefine work practices to reduce administrative burden and maximise service user facing time for our clinicians. Develop the skill sets to apply the principles across all clinical services	Quarter 2		DSD			
	National Digital Exemplar	Deploy novel technologies and expand the use of digital technology to enhance quality and efficiency of service delivery • Access Programme • Autographer Programme	Quarter 4		DSD			

Objective 3:	**To create a learning culture to continually improve**
SPAR PRIORITY	
Exec owner:	Director of Leadership and Workforce (DLW)
Assurance Committee:	People and Culture Development

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

***RISK**: The Trust fails to support its workforce to continually learn and develop resulting in poor staff experience.*	**Gross Risk (no mitigation)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/17)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	3	4	12	2	4	8	2	4	8

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q1 RAG status**	**On Target RAG Status**	**End Year RAG Forecast**
	Appropriate values and behaviours demonstrated within our people	Values and Behaviour Framework is developed, approved and embedded. Assurance obtained via embedding the values in the following mechanisms:	Quarter 4		DLW			

		• Reach Awards • Values Based Recruitment • Induction • Appraisal/PDR • Training Courses • HR Policies and Procedures						
	Appropriate Leadership Development is in place to develop a learning organisation	Clinical Director and Clinical Leadership Development programmes are developed quarter 1 and assurance obtained via • Clinical Director's completion of programme (Q4) • All identified Senior Clinical future talent on a rolling leadership programme (Q4)	Quarter 4		DLW			
		A Leadership Competency Framework 360 review is undertaken for all Band 8a leaders and above	Quarter 4		DLW			

	Teams are supported effectively to learn and develop and to become high level performing teams	By embedding the Aston Team development programme and introducing WWL Team diagnostic tool to support highly performing teams.	Quarter 4		DLW			
		Increase by 20% the teams that have undertaken the ARTP review process. Show improvement in 80% of all of those teams	Quarter 4		DLW			
		The WWL model is launched within the Trust	Quarter 2		DLW			
		At least 10 teams are working with the WWL tool	Quarter 4		DLW			
	E-Learning - All but essential face to face training is delivered via e-learning	All but essential face to face mandatory training is delivered via e-learning.	Quarter 4		DLW			
	Staff have role clarity and are developed effectively within their role	Improved quality as assessed by re-audit of PDR's in 2016	Quarter 4		DLW			
		Implement Talent Management approach via PDR	Quarter 1		DLW			

		90% staff providing clinical services have Clinical Supervision at least every 2 months Compliance with clinical supervision target is 80% as of Quarter 1 and 90% at end Quarter 2	Quarter 2		DLW			
	Widening Participation	Develop and deliver a plan with partner Trusts as requested by HEEWM to A) Deliver 37 apprentices by 2017/18 B) A reciprocal process to carry out end of apprenticeship assessments. Q4.	Quarter 4		DLW			
		Achieve the following Apprentice trajectory Q1 2016 – 2 new in total Q2 2016 – 4 new in total Q3 2016 – 7 new in total Q4 2016 – 9 new in total Total = 22 for 2016	To be monitored quarterly					
	An organisation that is diverse and inclusive to support an open, welcoming, compassionate culture	Develop a strategy for Equality, Diversity and Inclusion to achieve strategic aims by 2020	Quarter 1		DLW			
		To progress the implementation of the EDS2 across the Trust	Quarter 4		DLW			

		over the period of 2016EDS2 compliant as assessed by commissioners						

Objective 4:	**Attract and inspire the best people to work here**								
SPAR PRIORITY									
Exec owner:	Director of Leadership and Workforce (DLW)								
Assurance Committee:	People and Culture Development								
Risk appetite	Financial	4	Quality (Innovation)	3	Regulation	2	Reputation	3	

***RISK**: The Trust fails to attract and retain talented people resulting in reduced quality and increased cost of services.*	**Gross Risk (no mitigation)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/17)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	3	5	15	2	5	10	1	5	5

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q1 RAG status**	**On Target RAG Status**	**End Year RAG Forecast**
	Recruitment and retention of talented staff	Recruitment and Retention Strategy and Plan is developed and implemented	Quarter 1		DLW			
		Develop transformational Workforce Plans to create roles that deliver outstanding services and attract staff	Quarter 3		DLW			
		Review what attracts talented individuals and refine	Quarter 1		DLW			

		recruitment and retention plan						
		Vacancies are reduced by half	Quarter 2		DLW			
	Improving Staff Engagement	Complete Wave 3 LIA and evaluate impact	Quarter 1		DLW			
		Hold further round of Big Conversations	Quarter 2		DLW			
		Launch LIA Wave 4	Quarter 3		DLW			
		Trust Engagement scores within the Staff Survey for 2016 continue to be improved (score of above 3.7).	Quarter 4		DLW			
	Effective marketing of the trust as a service provider and place to work	Review structure of the Communications function to deliver the strategy and plan	Quarter 1		DLW			
		A New Website is in place	Quarter 2		DLW			
		Develop an effective online presence and increase online traffic by 26k hits by Quarter 4 from 12.9k	26k hits by Quarter 4		DLW			
		Develop clear Trust branding and marketing approach through social media	Quarter 1		DLW			
		Raised awareness of the Trust and the services it provides within the local community with GPs and patients. Exercise is undertaken to	Quarter 3		DLW			

		ensure: • Website clear and utilised • Articles every week in local press and radio						
		Engage staff in two way communication - Increasing feedback from staff by 100% through various media. Twitter followership is increased from 442 to 900 The number traffic to our website is doubled from 650 to 1300	Quarter 4		DLW			

Objective 5:	**Maximise and use our resources intelligently and efficiently**
SPAR PRIORITY	
Exec owner:	Director of Finance (DF)
Assurance Committee:	Finance and Performance

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

***RISK**: The Trust fails to optimise its resources resulting in an inability to be a sustainable service.*	**Gross Risk (no mitigation)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/17)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	4	4	16	2	4	8	2	4	8

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q1 RAG status**	**On Target RAG Status**	**End Year RAG Forecast**
	Deliver the Financial Plan	Implementation of robust business decision making process	Quarter 1		DF			
		Delivery of CIP target	Quarter 4		DO			
		Development of robust CIP plans for 2017/18 QIA to take place during Quarter 4	Quarter 3 Quarter 4		DO MD and DON			

		Development and implementation of financial assurance model for all investments	Quarter 2		DF			
		Introduction of financial sustainability strategy	Quarter 2		DF			
	Focus on efficiency and productivity	Creation of a 'model hospital' in line with Lord Carter and national benchmarking data	Quarter 2		DF			
		Effective Trust wide efficiency programme reporting	Quarter 1		DF			
		Delivery of Trust wide CIP efficiency programme as per operational plan	To be monitored quarterly		DO			
		Attain below average reference costs	Quarter 3		DF			
		Review the Performance Team Function to support the delivery of Trust strategic goals	Quarter 2		DF			
		Seek best value for money in the PFI contract, identifying savings that could be realised. Review of negotiations with THL and Carillion re catering Costs	Quarter 1		DO			
		Development of Trust response and plan in respect of 7 day working	Quarter 1		DO			

		with Don/MD Agree 7 day Service Implementation plan						
	Deliver the Capital Plan	Completion of the Darwin Centre Redevelopment	Quarter 4		DO			
		Completion of A&T Telford Purchase	Quarter 1		DSD			
		Implement and ensure delivery of robust implementation plans for key estates schemes: 1. PICU (planning and commencement of work) 2. A&T Telford Redesign (subject to agreement) 3. Urgent Care Centre 4. Darwin	Quarter 1		DO			
	Progress is made with Digital Programme	Sign off by HSCIC for Lorenzo investment case including IPPMA	Quarter 1		DSD			
		Access innovation project is implemented	Quarter 1		DO			
		Combined app and website is launched	Quarter 2		DSD			
		Digital road map is produced	Quarter 1		DSD			
		North Staffs Design Authority is established	Quarter 3		DSD			
		EPR Project is completed by March 2017	Quarter 4		DSD			

		Develop plan for mobile technology for all clinical community staff	Quarter 4		DSD			
	Better use of the Estate	A review of the Estates function will be undertaken	Quarter 1		CEO			
		Estates rationalisation plan is developed. Plan approved by Board, with clear trajectories and milestones to reduce accommodation footprint linked to a mixed economy of freehold and leasehold properties.	Quarter 1		DO			
	Implementation of Manager self service	Deliver Business Case for enabling Financial Ledger and ESR to link	Quarter 1		DLW			
		Develop Business Case for ESR staff and manager Self Service	Quarter 2		DLW			
		Commence rollout of ESR staff and manager Self Service	Quarter 3		DLW			
		Complete rollout of ESR staff and manager Self Service	Quarter 4		DLW			

Objective 6:	**To continually improve our partnership working**
SPAR PRIORITY	 
Exec owner:	Director of Strategy and Development (DSD)
Assurance Committee:	Business Development

Risk appetite	Financial	3	Quality (Innovation)	4	Regulation	3	Reputation	4

***RISK**: The Trust fails to engage its partners resulting in fragmented care pathways.*	**Gross Risk (no mitigation)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/17)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	3	4	12	2	4	12	1	4	4

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q1 RAG status**	**On Target RAG Status**	**End Year RAG Forecast**
	Development of Trust plans demonstrating partnership working	Development of Five Year IBP in line with Staffordshire Transformation Plan "Together we're better"	Quarter 1		DSD			
		Framework for business planning for clinical and corporate directorates is implemented	Quarter 1		DSD			

		Approval of 2016/17 plan and Development of 2017/18, 1 year plan	Quarter 4		DSD			
	Robust partnerships are developed with the Third sector	Develop 5 Year Joint strategic intentions with Brighter Futures and Staffordshire Housing Association	Quarter 2		DSD			
		Develop 5 Year Joint strategic intentions with Changes	Quarter 2		DSD			
		Explore Prime provider model with commissioners	Quarter 4		DSD			
	Robust partnerships are developed with Social Care	Support delivery of joint Learning Disability model with Stoke Local Authority	Quarter 1		DSD			
		Explore opportunities for delivery of Staffs Social care	Quarter 2		DSD			
		Develop Joint digital road map with local authorities	Quarter 2		DSD			
		Integration of Learning Disability services and Social Care	Quarter 4		DO			
	Robust partnerships are developed with the Acute sector	Develop joint proposal for Emergency care centre	Quarter 1		DSD			
		Develop extension of Psychiatric liaison services	Quarter 3		DSD			

	Specialist Mental Health Services	Protect the specialist mental health services of the trust.	Quarter 4		DSD			
		Develop joint proposal for expansion of key services in line with population need	Quarter 4		DSD			
	Enhanced Primary and Community Care	Integrated Adult and NOAP community services into place based care model.	Quarter 4		MD			
		Work with partner organisations to deliver a model of place based care. Support the design of the governance and infrastructure arrangements for place based care across Northern Staffordshire	Quarter 4		DSD			

Objective 7:	**To enhance service user and carer involvement**
SPAR PRIORITY	
Exec owner:	Director of Nursing and Quality (DON)
Assurance Committee:	Quality Committee

Risk appetite	Financial	3	Quality (Innovation)	3	Regulation	2	Reputation	2

***RISK**: The Trust fails to listen and act upon service user and carer involvement resulting in an inability to deliver responsive services.*	**Gross Risk (no mitigation)**			**Residual Risk (with mitigation)**			**Target Risk (31/03/17)**		
	LIKELIHOOD	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**	**LIKELIHOOD**	**IMPACT**	**SCORE**
	3	4	12	2	4	8	2	4	8

	CONTROLS	**ASSURANCES**	**TIMESCALE**	**GAPS AND ACTIONS**	**Lead Director**	**End Q1 RAG status**	**On Target RAG Status**	**End Year RAG Forecast**
	Strengthened patient and carer engagement	A Carers strategy is developed supported by the establishment of a Patient Experience Group	Quarter 4	Strategy to be developed. The Patient Experience Group will oversee: • Friends and Family Test • Community Mental Health Survey • Patient engagement within Directorates • Triangle of Care • PALS • Complaints	DON			

		Further embedding of the Service User and Carer Council to demonstrate impact upon person centred delivery of care within Directorates	Quarter 4		DON			
		FFT response rate increased by 50% by quarter 4. Quarter 4 2016 baseline shows inpatient response rate is 23%	12.5% increase by Quarter 1		DON			
		Community Mental Health survey results improved in 20% of areas	Quarter 4		DON/DO			
		An increase in the number of service users employed by the Trust	Quarter 1		DLW			

REPORT TO TRUST BOARD Enclosure 10

Date of Meeting:	11th May 2016
Title of Report:	CQC Action Plan – At a Glance
Presented by:	Laurie Wrench, Associate Director of Governance
Author of Report:	Laurie Wrench, Associate Director of Governance
Purpose / Intent of Report:	Assurance and information.
Executive Summary:	This paper provides assurance against progress made against the core service action plans. This provides detail against the 'must' and 'should' do actions as described in each of the Core Service Reports
Seen at SLT or **Exec** Meeting & date	SLT/EXEC: SLT Date: 3rd May 2016 Document Version number:
Committee Approval / Review	• Quality Committee • Audit Committee
Relationship with: *Board Assurance Framework* *Strategic Objectives*	1. To provide the highest quality services ☒ 2. Create a learning culture to continually improve.☒ 3. Encourage, inspire and implement research at all levels.☒ 4. Maximise and use our resources intelligently and efficiently.☒ 5. Attract and inspire the best people to work here.☒ 6. Continually improve our partnership working. ☒ 7. To enhance service user and carer involvement.☒ **Comments:**
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	None
Resource Implications: Funding source:	None
Equality & Diversity Implications:	None
Recommendations:	To note the contents of the report and receive assurance as to progress being made

16 Weeks : 1 Hours to GOOD

CQC Improvement Monitoring Schedule – April 2016

Acute Inpatient - Clinical Director - Nasreen Fazal-Short / Operational lead – Natalie Larvin

MUST DO'S	DUE	RAG	Progress	Performance	What is required for completion / Assurance	Assurance	Expected assurance date
Seclusion facility		G	↑		mirrors required to add additional assurance Area is operational with staff presence.		30 April
POS Ligature risk		G	↑			✓	✓
SHOULD DO's	**DUE**	**RAG**	**Progress**	**Performance**	**What is required for completion / Assurance**	**Assurance**	
Mental Capacity Act Awareness	30/4	A	↔	84% staff trained	Improve training compliance per area. Targeted review of staff awareness		31st May
Medicines Management training.		G				✓	✓
Ligature risk (Window grills)		G				✓	✓
MHA / Informal Pt rights.		G				✓	✓
Infection control (COSHH Compliance)		G				✓	✓
Staff gender mix		G				✓	✓
Information to patients re CQC		G				✓	✓

Rehab Inpatient- Clinical Director - Nasreen Fazal-Short / Operational lead – Natalie Larvin

MUST DO's	DUE	RAG	Progress	Performance	What is required for completion / Assurance	Assurance	Expected assurance date
Accurate prescribing – T2 & T3 forms		G	↑			✓	✓
SHOULD DO's	**DUE**	**RAG**	**Progress**	**Performance**	**What is required for completion / Assurance**	**Assurance**	
Improve metabolic monitoring		G	↑			✓	✓
Improve alarm system	31/3	R	↔		Outside telephone line to be installed on 28Th April – work did not take place		30th April
Review mixed sex provision	31/5	G	↑		Door now installed and operational.	✓	✓
Clarity of referral and admission criteria		G	↑		Assurance obtained via pilot and expected to remain operational at end of pilot.	✓	✓
Compliance with Clinical risk training	31/3	A	↔	88%	Review of training matrix, team lead believes that 100% compliant.		
Robust risk management plans		G				✓	✓
Homely environments		G				✓	✓
Reduce absconding risk from garden		G				✓	✓
Improve physical health promotion		G				✓	✓
Staff gender mix on shift		G				✓	✓
Safe staffing levels		G				✓	✓
Risk assessment/ Management plans		G				✓	✓
Incident reporting & recording		G				✓	✓

Substance Misuse Clinical Director - Derrett Watts / Operational lead – Darren Bowyer

MUST DO's	DUE	RAG	Progress	Performance	What is required for completion / Assurance	Assurance	Expected assurance date
Risk assessment (Including risk formulation processes for IOU)	31/3	A	↔		Clinical risk training needs to be 90% Assurance re quality of risk assessments needs to be obtained.		31/6/16
Training and support for staff.	31/3	G	↑			✓	✓
SHOULD DO'S	**DUE**	**RAG**	**Progress**	**Performance**	**What is required for completion / Assurance**	**Assurance**	**Expected assurance date**
Clinical/managerial Supervision	31/3	A	↑	90%	Supervision reporting to be accurate. 6 weekly supervision to minimise risk of staff going overdue.		31/5/16
Safe staffing levels		G				✓	✓

LD Community - Clinical Director - Matt Johnson / Operational lead – Alastair Forrester

MUST DO's	DUE	RAG	Progress	Performance	What is required for completion / Assurance	Assurance	Expected assurance date
Care Planning	31/7	A	↑	29% Staff trained 86.7% Pts with CP 64% Quality assurance audit	Staff training improvement. Targeted improvements in Quality assurance audit		30/6/16
SHOULD DO's	**DUE**	**RAG**	**Progress**	**Performance**	**What is required for completion / Assurance**	**Assurance**	
Accurate CTO Documentation	31/5	R	↔		Service lead to confirm assurance		22/4/16
Patient engagement In service initiatives		G				✓	✓

LD Inpatient - Clinical Director - Matt Johnson / Operational lead – Alastair Forrester

MUST DO's	DUE	RAG	Progress	Performance	What is required for completion / Assurance	Assurance	Expected assurance date
Appropriate staffing levels		G				✓	✓
Ligature risk assessment & management		G				✓	✓
Mix sex accommodation arrangements.		G				✓	✓
Warning notices on store room containing oxygen.		G				✓	✓

Older Persons Community- Clinical Director - Darren Carr / Operational lead – Jane Munton- Davis

MUST DO'S	DUE	RAG	Progress	Performance	What is required for completion / Assurance	Assurance	Expected assurance date
Patient crisis contingency plans	30/5	A	↑	77% of patients with safety plan (↑9%)	Quality assurance audits need to demonstrate above 90%.		30/7/16
Risk assessments	30/4	G	↑	93% with Risk Assessment 75% compliance with QA audit.	Assurance required ensuring risk assessments are reviewed in line with trust policy.		30/6/16
Care plans	30/4	A	↑	76% compliance with QA audit	Quality assurance audits need to demonstrate above 90%. Data cleanse is expected to improve performance reporting.		30/7/16
Mental Capacity & consent, staff knowledge and understanding		G	↑	79% staff trained.	Chips performance reporting expected to be available by 30th April.		30/6/16
Patient awareness of complaints process		G				✓	✓
Consider implementing CPA.		G				✓	✓

Older persons Inpatients Clinical Director - Darren Carr / Operational lead – Jane Munton- Davis

SHOULD DO'S	DUE	RAG	Progress	Performance	What is required for completion / Assurance	Assurance	Expected assurance date
Improve access to psychology		G				✓	✓
Patient & carers copies of care plan		G				✓	✓
Dementia training	31/7	A	↔		Ward staff to complete level 2 dementia training throughout May & June.		30/6/16
Medication record keeping	30/4	A	↑		prescription card audit to demonstrate overall compliance of 100% of omitted doses signed for		30/6/16

16 Weeks : 1 Hours to GOOD

CQC Improvement Monitoring Schedule – April 2016

Community CAMHS - Clinical Director - Jo Barton / Operational lead - Kath Clark

MUST DO's	DUE	RAG	Progress	Performance	What is required for completion / Assurance	Assurance	Expected assurance date
Staffing levels		G	↔	15 posts in recruitment process.	15 posts out to advert, interview dates scheduled.		31/7/16 (dependent on suitable candidates)
Skilled and experienced staff		G	↔		As above		
Safeguarding training	31/3	A	↑	81% staff trained level 1 & 2	Level 3 e – training to be progressed and reported on in Mandatory matrix.		31/5/16
Clinical Outcome measures		G	↑			✓	✓
Waiting list to treatment gap	30/4	A	↑	88% (98) - 18 week	Data cleanse – expected to be reduced at next report due to additional work since Unannounced.		31/5/16
Pt feedback & theme analysis		G	↑			✓	✓
Suitable Buildings	30/7	A			Review of estates – 1 Year plan	✓	✓
Effective governance		G	↔		Assurance will be reviewed based on Unannounced visit report.		
SHOULD DO's	**DUE**	**RAG**	**Progress**	**Performance**	**What is required for completion / Assurance**	**Assurance**	
Clinical Supervision records in ASD		G	↑	ASD – 100% CAMHS 92%			
Robust appraisal		G	↔	92.96%	Outstanding staff dates to be confirmed and PDR completed.		31/5/16
Record of capacity and consent to treatment	31/3	A	↔	MHA -74% MCA – 74%	Need to be able to Performance report via CHIPS 7 training at 90%		31/5/16
Co-ordinated patient feedback		G				✓	✓
Duty worker system		G				✓	✓
Equipment calibration		G				✓	✓
Access to psychiatrist		G				✓	✓
Risk assessment		A	↓	QA audit 61% Training 68%	QA audit and training compliance to reach 90%		15/7/16
Care planning		A	↓	QA audit76% Training – 60%	QA audit and training compliance to reach 90%		15/7/16
Psychiatrist dedicated input		G				✓	✓
Single set of records		G				✓	✓
Risk assessment of patients waiting		G				✓	✓
Vulnerable adults referrals		G				✓	✓
Regular communication with young person's GP		G				✓	✓

CAMHS Inpatient - Clinical Director - Jo Barton / Operational lead - Kath Clark

MUST DO'S	DUE	RAG	Progress	Performance	What is required for completion / Assurance	Assurance	Expected assurance date
Mental Capacity act Awareness		A	↔	Darwin: 82% Dragon:100%	Compliance with training –all remaining staff are booked onto May sessions.		31/5/16
SHOULD DO'S	**DUE**	**RAG**	**Progress**	**Performance**	**What is required for completion / Assurance**	**Assurance**	**Expected assurance date**
Adequate staffing levels		G	↓	Supervision Compliance Darwin:59% Dragon:84%	Supervision compliance has dropped so the assurance has been removed.		31/5/16
Physical Health risk assessment		G				✓	✓
Risk assessment prior to admission		G				✓	✓
MDT involvement in record keeping		G				✓	✓
Being Open policy & incident recording.		G				✓	✓

CRISIS Services

Clinical Directors - Dennis Okolo - Access & Home Treatment/ Darren Carr – RAID / Nasreen Fazal – Short Place of safety
Operational Leads – Sam Mortimer – Access & Home treatment / Jane Munton Davis – RAID / Natalie Larvin Place of Safety

MUST DO'S	DUE	RAG	Progress	Performance	What is required for completion / Assurance	Assurance	Expected assurance date
Risk Assessment		R	↓	Training 84% Pts with 29% (↓16%)	Quality assurance audits to show improvement. Pts with risk assessment needs to improve		31st June
Lone working		G	↑	QA Audit -	Torches for staff SOP to be sent to all staff Audit to demonstrate compliance	✓	
Care Planning	30/4	R	↑	Pts with CP 27% (↑21%)	Access to report care plan on CHIPS Quality assurance audit to show improvements		31st June
Physical health Assessment		G	↑			✓	
Clinical Audit		R	↔		Access to adapt HT Audit and commence.		18th April
Confidentiality		A	↑			✓	
Equality & Diversity		G	↑			✓	
Monitoring effectiveness		G	↑			✓	
SHOULD DO'S	**DUE**	**RAG**	**Progress**	**Performance**	**What is required for completion / Assurance**	**Assurance**	
Clinical Outcomes	31/5	A	↑		RAID will implement plan..		30th April
Appraisal compliance		G	↑			✓	√
Discharge Plans		G	↔		HT to implement the same system as access		30th April
Patient feedback		G	↑			✓	
Right care / Right time.		G	↑	POS – 75% assessments seen within 3 hrs	Medics, AMPS, DSN's need to ensure that assessments are not delayed where there is no clinical need to delay - Justin monitoring.		31st May
Various Info for patients		G	↑		LIA group to distribute the interpreted leaflets		6th May
Medicines Management		G				✓	✓
Records Management		G				✓	✓
MDT meetings		G				✓	✓
Info for Patient to complain		G				✓	✓
Advocacy info for patients.		G				✓	✓
Carers assessment		G				✓	✓

Adult Community - Clinical Director – Dennis Okolo / Operational Lead – Sam Mortimer

MUST DO'S	DUE	RAG	Progress	Performance	What is required for completion / Assurance	Assurance	Expected assurance date
Risk assessments	30/4	A	↑	Pt with RA – 88% QA audit – 58% (↑15%) Staff trained 79%	Above 90% on assurance audits Pts with RA improving Staff training improvement		30th June
Care plans	30/4	A	↓	Pt with CP – 77% QA audit – 61% (↓5%) Staff trained 25%	Above 90% on assurance audits Pts with CP improvement Staff training improvement		30th June
Pt involvement Care plans		G	↔	As above	Above 90% on assurance audits		
Record of capacity and consent to care/ treatment		G	↔				
Appraisal Process & Compliance	31/3	R		PDR – 88.31%	Above 90% compliance		31/5/16
Caseloads & PIG Guidance		G				✓	✓
MHA rights & recording		R	↔		Review of all patients on CTO		29th April
Mandatory training compliance	30/4	A	↔	88% compliance.	Focus on mandatory training compliance and improve.		30th July
Clinical Supervision		R		82%	Compliance reporting to improve. Clear process for all staff.		31st May
Staff compliance with lone working policy.		A			Assurance needs to be obtained – Introduce risk assessment		31st May
Equipment for medication storage (fridge).		G				✓	✓

REPORT TO TRUST BOARD Enclosure 11

Date of Meeting:	11 May 2016
Title of Report:	Monthly Finance Reporting Suite – March 2016
Presented by:	Suzanne Robinson, Director of Finance
Author of Report:	Thomas Devonshire, Finance
Purpose / Intent of Report:	Performance Monitoring
Executive Summary:	The attached report contains the financial position to 31 March 2016. The Trust's financial performance is a retained surplus of £0.790m; and an adjusted financial performance surplus of £1.297m, giving a favourable variance of £0.396m against plan at an adjusted financial performance level. The year-to-date Cost Improvement Target of £2.658m was fully achieved. The cash balance as at 31 March 2016 was £7.903m. The net capital expenditure for the year is £0.680m, which is an undershoot of £0.572m against the revised Capital Resource Limit. The Financial Sustainability Risk Rating is reported as 3, in-line with plan.
Seen at SLT or **Exec** Meeting & date	SLT/EXEC: Date: N/A Document Version number: N/A
Committee Approval / Review	• Quality Committee • Finance and Performance Committee ✓ • Audit Committee • People and Culture Development Committee • Charitable Funds Committee • Business Development Committee
Relationship with: *Board Assurance Framework* *Strategic Objectives*	1. To provide the highest quality services 2. Create a learning culture to continually improve. 3. Encourage, inspire and implement research at all levels. 4. Maximise and use our resources intelligently and efficiently.✓ 5. Attract and inspire the best people to work here. 6. Continually improve our partnership working. 7. To enhance service user and carer involvement.

	Comments: N/A
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	N/A
Resource Implications: Funding source:	As above.
Equality & Diversity Implications:	N/A
Recommendations:	The Board is asked to: • note the financial performance reported to the NTDA of a retained surplus of £0.790m, subject to the outcome of the External Audit. • note the 'adjusted financial performance' of £1.296m surplus delivers the statutory duty for the year. • note the cash position of the Trust as at 31 March 2016 of £7.903m • note the capital expenditure position of an undershoot against the Trust's Capital Resource Limit, resulting in the delivery of the management responsibility against this target. • note the year to date Financial Sustainability Risk Rating of 3, in line with Plan.

Financial Overview

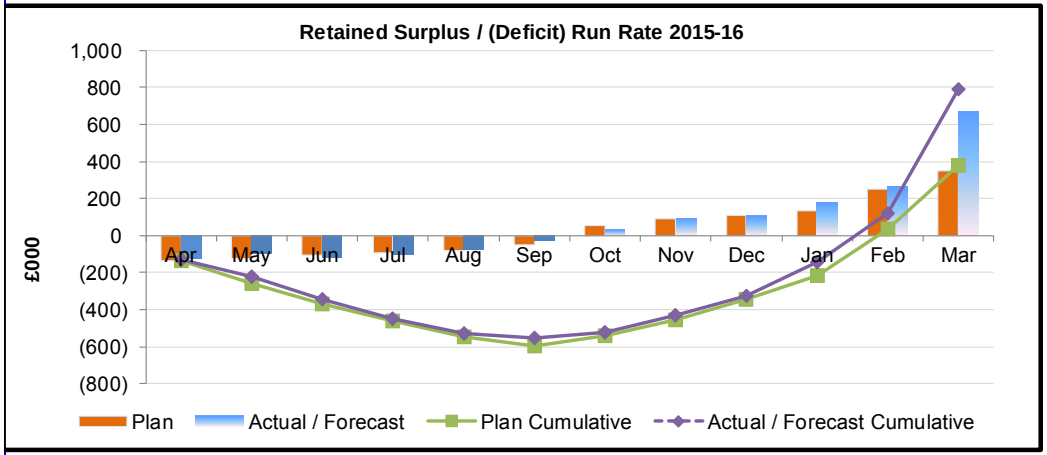
FINANCIAL OVERVIEW as at 31 March 2016

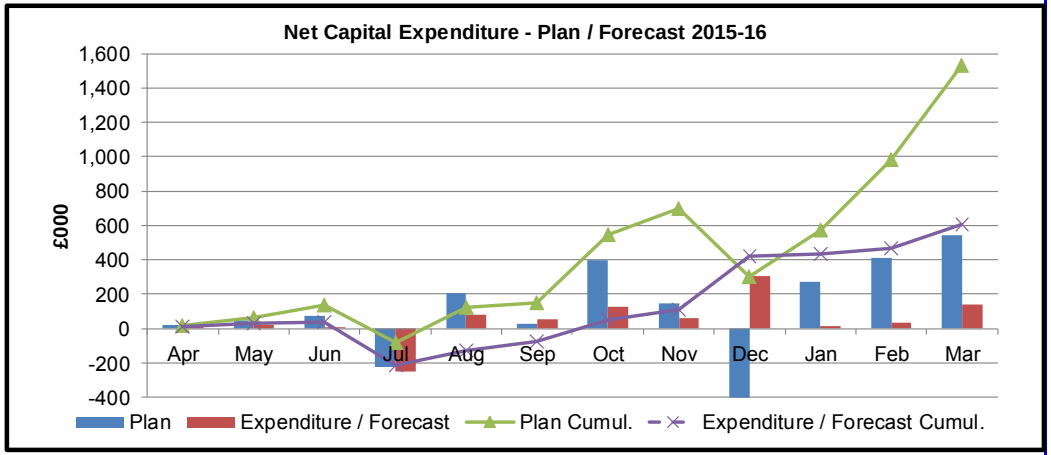
Income & Expenditure - Retained Surplus / (Deficit)

£000	Plan	Actual	Var	%	RAG
Adj Surplus	900	1,297	397	44	G
Retained Surplus	377	790	413	110	G

Net Capital Expenditure

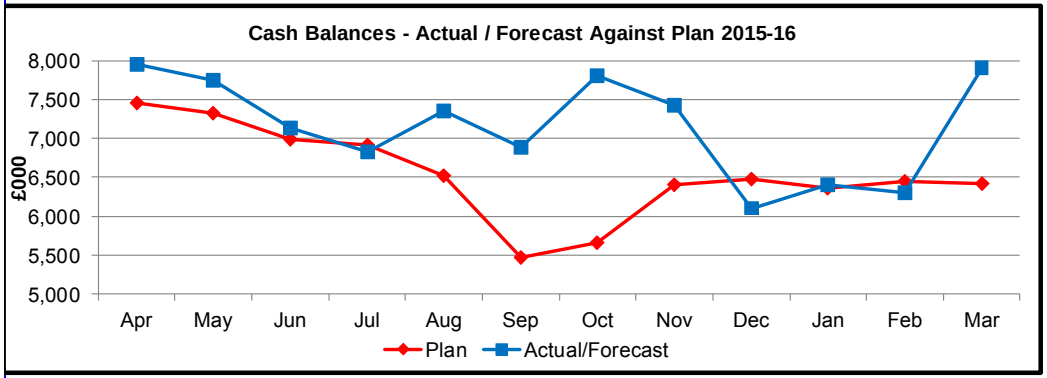
£000	Plan	Actual	Var	%	RAG
Net Capex	1,530	608	(922)	(60)	A
Gross Capex	2,300	930	(1,370)	(60)	A



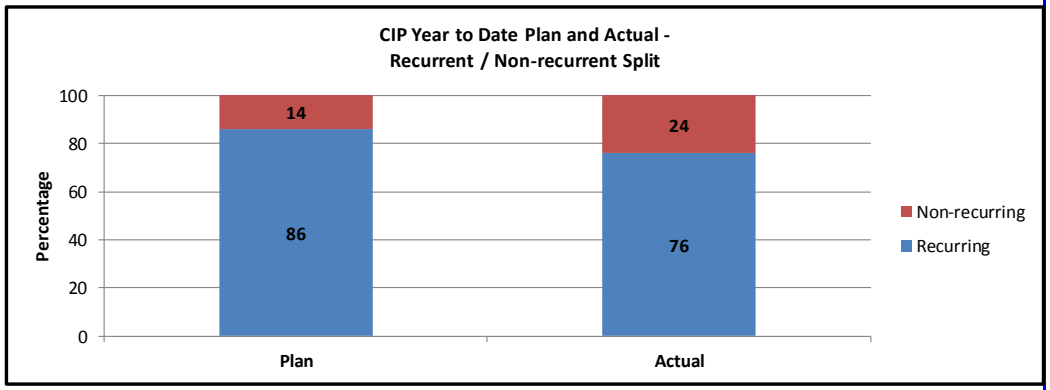


Cash Balances

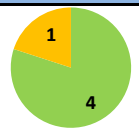
£m	Plan	Actual	Var	%	RAG
YTD	6.5	7.9	1.4	22	G



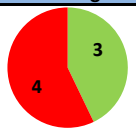
Cost Improvement Programme



Overall Performance Ratings YTD



Directorate YTD Against Budget



Financial Sustainability Risk Rating

	Plan	Act
Overall Risk Rating	3	3

1. Introduction

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

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

In late 2015 the TDA announced that NHS Trusts that were forecasting an undershoot against its 2015/16 Capital Resource Limit were to be given an opportunity to transfer this underspend from capital allocation into revenue positions. Any value agreed as part of this transfer by the TDA would be paid to the Trust as income to allow an increase its surplus (or reduce its deficit) by the same value.

Following a capital forecast review in December this Trust offered to transfer £0.350m. In January 2016 the Trust were informed that this transfer was to be transacted and the Trust consequently forecast a £1.250m adjusted financial performance surplus.

The Trust is pleased to report a year-end adjusted financial surplus of £1.297m against the forecast of £1.250m subject to the outcome of the external audit.

Table 1 below shows the increases to the forecast surplus position of the Trust due to the agreed improvement to the financial position and capital-to-revenue transfer agreed with the NTDA.

	Forecast		
Table 1: Revisions to Planned Surplus as Agreed with the TDA	**Retained Surplus / (Deficit)**	**IFRIC12 Expenditure**	**Adjusted Financial Performance Surplus / (Deficit)**
	£000s	**£000s**	**£000s**
Original Plan	227	523	750
Stretch Target (£150k)	377	523	900
Capital-to-Revenue Transfer (£350k)	727	523	1,250

2. Income & Expenditure (I&E) Performance

At the end of month 12, the Trust's budgeted plan was a retained surplus of £0.377m (£0.900m surplus at adjusted financial performance level). The reported retained position is a surplus of £0.790m (£1.297m surplus at adjusted financial performance level), giving a favourable variance of £0.396m against plan at adjusted financial performance level. The favourable variance is due to the Trust agreeing with the TDA to transfer £0.350m from capital to revenue; and a £47k improvement in the financial position. The IFRIC 12 adjustment was £27k higher than originally planned offset by fixed asset impairments of £43k.

Table 2 below shows the Trust's financial position in the Statement of Comprehensive Income (SOCI).

	Final Outturn		
Table 2: Statement of Comprehensive Income	**Budget £000s**	**Actual £000s**	**Variance £000s**
Income	78,106	78,588	481
Pay	(58,157)	(56,112)	2,045
Non-pay	(16,299)	(18,437)	(2,138)
EBITDA	**3,650**	**4,038**	**388**
Other Costs	(2,750)	(2,742)	8
Adjusted Financial Performance Surplus / (Deficit)	**900**	**1,297**	**396**
IFRIC12 Expenditure	(523)	(550)	(27)
Fixed Asset Impairment	0	43	43
Retained Surplus / (Deficit)	**377**	**790**	**413**

No. of Directorates YTD Variance Against Budgets

AMH Community (£0.055m), Substance Misuse (£0.355m) and LD (£0.595m) are all under-spent against their year-to-date budgets by £1.004m in total.

AMH Inpatient (£0.426m), CYP (£0.195m), NOAP (£0.149m) and Corporate (£0.330m) are over-spent against their year-to-date budgets by £1.100m in total.

3. Income

The Trust's total income for the financial year is £78.588m representing £0.481m favourable variance compared to budget.

Specialised Services is showing an adverse variance of £0.268m at month 12 due to an under-performance against the planned activity at the Darwin Centre. Staffordshire Public Health related activity is also under-performing by £0.109m.

The under-performance is offset by the significant over-performance relating to Out of Area and Non-contract Activity, which is showing a favourable variance of £0.847m at month 12. Within the OOA / NCAs income is the £0.350m as a consequence of the capital-to-revenue transfer.

Table 3 below shows the Trust's income by contract and other categories.

Table 3: Income	**Annual Budget £000s**	**Final Outturn**		
		Budget £000s	**Actual £000s**	**Variance £000s**
NHS Stoke-on-Trent CCG	31,543	31,543	31,298	(245)
NHS North Staffordshire CCG	24,151	24,151	24,424	273
Other CCGs	875	875	910	35
Specialised Services	3,015	3,015	2,747	(268)
Stoke-on-Trent CC s75	3,843	3,843	3,843	(0)
Staffordshire CC s75	1,112	1,112	1,112	0
Stoke-on-Trent Public Health	435	435	393	(42)
Staffordshire Public Health	706	706	597	(109)
ADS / One Recovery	2,888	2,888	2,881	(7)
OOA / NCAs	597	597	1,444	847
Total Clinical Income	**69,165**	**69,165**	**69,649**	**484**
Total Other Income	**8,941**	**8,941**	**8,938**	**(3)**
Total Income	**78,106**	**78,106**	**78,588**	**481**

4. Expenditure

Table 4 below shows the Trust's expenditure split between pay, non-pay and non-operating cost categories.

Table 4: Expenditure	Final Outturn		
	Plan £000s	Actual £000s	Variance £000s
Medical	(6,866)	(5,777)	1,090
Nursing	(26,977)	(25,526)	1,451
Other clinical	(13,660)	(12,345)	1,315
Non-clinical	(9,700)	(8,769)	931
Non-NHS	(954)	(3,696)	(2,742)
Total Pay	**(58,157)**	**(56,112)**	**2,045**
Drugs & clinical supplies	(2,024)	(2,174)	(150)
Establishment costs	(1,711)	(1,602)	110
Premises & IT costs	(2,186)	(3,418)	(1,232)
Private Finance Initiative	(3,865)	(3,983)	(118)
Other	(6,570)	(7,261)	(691)
Central Funds	57	0	(57)
Total Non-pay	**(16,299)**	**(18,437)**	**(2,138)**
Depreciation exc. IFRIC	(797)	(822)	(25)
Investment Revenue	12	(45)	(57)
Other Gains & (Losses)	0	42	42
LGPS	0	0	0
Finance Costs	(1,364)	(1,364)	0
Unwinding of Discounts	0	0	0
Dividends Payable on PDC	(601)	(553)	48
Total Non-op. Costs	**(2,750)**	**(2,742)**	**8**
Total Expenditure	**(77,206)**	**(77,291)**	**(85)**

Medical and Nursing underspends of £1.090m and £1.451m respectively are due to vacancies across a number of areas and are offset by agency spend of £1.191m and £1.157m respectively recorded within Non-NHS outturn of £3.696m.

Total vacancies, across the Trust, equating to £5.797m year-to-date is in-part offset by agency costs of £2.464m and bank of £1.530m.

An additional £0.450m was allocated to wards 1, 2 and 3 in response to Safer Staffing requirements earlier in the year.

The Premises over-spend of £1.232m includes additional IT costs of £0.4m, furniture for wards 2, 3, 6 and 7 of £0.1m, other equipment costs of £0.1m, £0.1m additional works at the Harplands (including £65k replacement of radiator covers), an upgrade to Marrow House of £0.1m and increased utilities costs and rates.

The overspend against Other is mostly due to additional professional fees and additional drug costs of £0.3m across AMH Community and CAMHS services.

The overspends against non-pay are offset by underspends within Pay areas.

5. Cost Improvement Programme

The in-year target for the year and reported to the NTDA is £2.658m and takes into account the requirement to deliver the revised surplus referred to above.

The Trust is pleased to report that it has achieved in full its CIP target of £2.658m.

Table 5 below shows the final CIP delivery for 2015/16.

Table 5: CIP Delivery	**Plan**	**Outturn**	**Variance**	**Recurrent**	**Non-recurrent**
	£m	**£m**	**£m**	**£m**	**£m**
Adult Inpatient	0.17	0.08	(0.09)	0.00	0.08
Adult Community	0.51	0.48	(0.04)	0.34	0.14
Substance Misuse	0.05	0.00	(0.05)	0.00	0.00
NOAP	0.55	0.56	0.01	0.56	0.00
Learning Disabilities	0.18	0.16	(0.01)	0.08	0.09
Children & Younger People	0.23	0.19	(0.04)	0.19	0.00
Corporate / Trust Wide	0.97	1.19	0.22	0.85	0.34
Total	**2.66**	**2.66**	**0.00**	**2.02**	**0.64**

6. Statement of Financial Position

Table 6 below shows the Statement Financial Position of the Trust as at 31 March 2016.

Table 6: SOFP	31/03/15 £000s	31/03/16 £000s
Non-Current Assets		
Property, Plant & Equipment	30,863	30,726
Intangible Assets	52	17
Trade and Other Receivables	0	568
Total Non-Current Assets	**30,915**	**31,311**
Current Assets		
Inventories	86	96
Trade and Other Receivables	3,017	3,803
Cash & Cash Equivalents	6,805	7,903
Total Current Assets	**9,908**	**11,802**
Non-current assets held for sale	2,520	2,198
Total Assets	**43,343**	**45,311**
Current Liabilities		
NHS Trade Payables	(864)	(1,963)
Non-NHS Trade Payables	(4,374)	(4,899)
Borrowings	(351)	(346)
Provisions for Liabilities and Charges	(1,682)	(1,298)
Total Current Liabilities	**(7,271)**	**(8,506)**
Net Current Assets / (Liabilities)	**5,157**	**5,494**
Total Assets less Current Liabilities	**36,072**	**36,805**
Total Non-Current Liabilities	**(14,154)**	**(13,030)**
Total Assets Employed	**21,918**	**23,775**
Financed by Taxpayers' Equity		
Public Dividend Capital	7,998	7,648
Retained Earnings	814	1,800
Revaluation Reserve	13,664	13,759
Other Reserves	(558)	568
Total Taxpayers' Equity	**21,918**	**23,775**

Property, plant and equipment and intangible assets balances have been revised in-line with the Trust's final capital outturn and due to the consequence of the £0.350m capital-to-revenue transfer agreement.

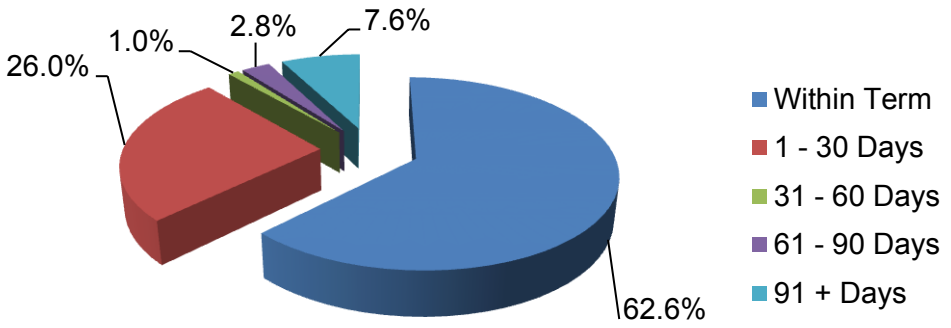
Debtors have decreased in month by £1.6m due to the receipt of outstanding monies from Local Authorities, various NHS organisations and the settlement of the Q3 ADS invoice, offset in-part by an increase in creditors of £0.4m. £2.735m of debtors relates to invoiced debt (see Table 6.1 for breakdown by age).

Of the £529k debt owed to the Trust overdue by 31 days or more:

- £286k has not been fully disputed and full payment is anticipated;
- Routine credit control processes have been activated for £17k;
- £10k has been escalated to management / solicitors.

Table 6.1	**Within Term** £000s	**1 - 30 Days** £000s	**31 - 60 Days** £000s	**61 - 90 Days** £000s	**91 +** £000s	**Total** £000s
NHS	633	592	27	73	183	**1,508**
LAs	327	105	0	0	0	**433**
Other	752	13	1	2	25	**794**
Total	**1,712**	**710**	**28**	**76**	**209**	**2,735**

Invoiced Debtors Age - 2015/16

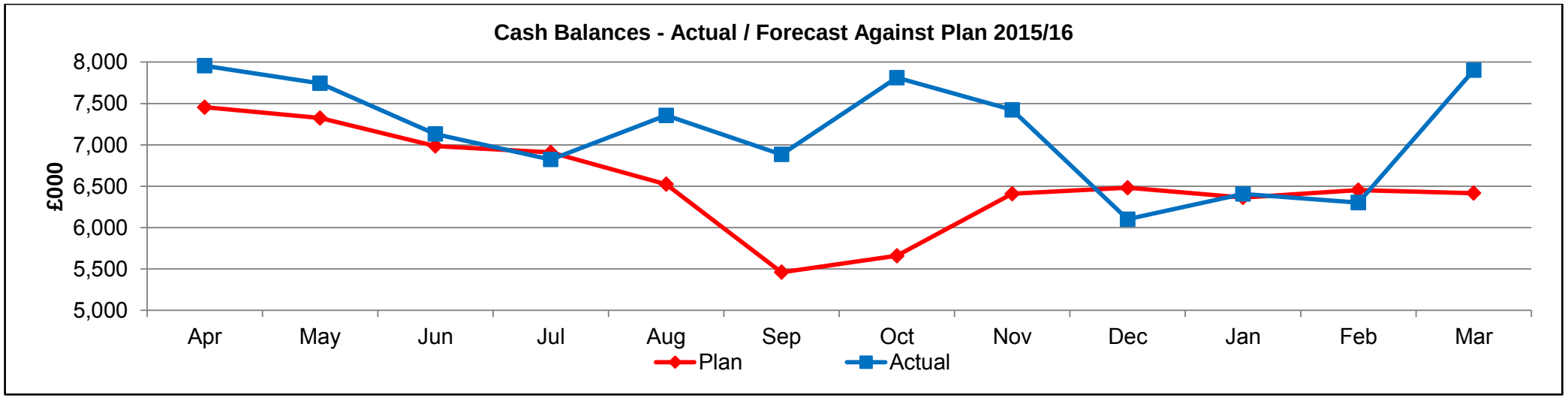


7. Cash Flow Statement

The Trust's cash position was £6.805m at 1 April 2015. The cash balance at 31 March 2016 has increased to £7.903m (£6.303m at month 11) due to a mix of the increase in operating surplus, increase in payables, decrease in receivables and the £350k PDC payment linked to the capital-to-revenue transfer. The purchase of the A&T and Telford Unit lease was not processed in month 12 as planned, but is due to be finalised in the early stages of 2016/17.

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

	Actual												Full Year
Table 7: Statement of Cash Flows	**Apr '15 £000s**	**May '15 £000s**	**Jun '15 £000s**	**Jul '15 £000s**	**Aug '15 £000s**	**Sep '15 £000s**	**Oct '15 £000s**	**Nov '15 £000s**	**Dec '15 £000s**	**Jan '16 £000s**	**Feb '16 £000s**	**Mar '16 £000s**	**£000s**
Net Inflow/(Outflow) from Operating Activities	1,190	(168)	(576)	(577)	643	(392)	1,085	(302)	(984)	351	288	1,677	**2,235**
Net Inflow/(Outflow) from Investing Activities	(10)	(16)	(8)	298	(81)	(51)	(128)	(57)	(307)	(16)	(12)	(48)	**(436)**
Net Inflow/(Outflow) from Financing Activities	(29)	(29)	(29)	(29)	(29)	(29)	(29)	(29)	(31)	(29)	(380)	(29)	**(701)**
Net Increase/(Decrease)	**1,151**	**(213)**	**(613)**	**(308)**	**533**	**(472)**	**928**	**(388)**	**(1,322)**	**306**	**(104)**	**1,600**	**1,098**
Opening Cash and Cash Equivalents	**6,805**	**7,956**	**7,743**	**7,130**	**6,822**	**7,355**	**6,883**	**7,811**	**7,423**	**6,101**	**6,407**	**6,303**	
Closing Cash and Cash Equivalents	**7,956**	**7,743**	**7,130**	**6,822**	**7,355**	**6,883**	**7,811**	**7,423**	**6,101**	**6,407**	**6,303**	**7,903**	



8. Capital Expenditure

The Trust's permitted capital expenditure agreed within the 2015/16 plan was £2.3m; this was the combination of the Trust's £1.53m Capital Resource Limit (CRL) and its predicted asset sales of £0.770m. This has changed as a consequence of the revised outturn position across schemes and the subsequent capital-to-revenue transfer detailed earlier in the report.

Table 8: Capital Expenditure	Original Scheme Value £000s	Revised Scheme Value £000s	Final Outturn £000s
Business Case Approved			
A&T and Telford Unit	600	500	27
Dragon Square Upgrade	250	500	533
Darwin Upgrade	0	680	48
Total Business Case Approved	**850**	**1,680**	**608**
Awaiting Business Case Approval			
Psychiatric Intensive Care Unit	400	0	48
Low Secure unit with rehabilitation	500	0	13
Total Awaiting Business Case Approval	**900**	**0**	**61**
Other			
Information Technology	100	100	100
Equipment	80	80	0
Other	270	270	161
Environmental Improvements	100	100	0
Total Other	**550**	**550**	**261**
Total Expenditure	**2,300**	**2,230**	**930**
Disposals			
Meadow View	(270)	(270)	(270)
Bucknall Hospital (Part)	(500)	(500)	(52)
Total Disposals	**(770)**	**(770)**	**(322)**
Net Expenditure	**1,530**	**1,460**	**608**

The capital expenditure for the year as at 31 March 2016 is £0.608m,made up of £0.930m of expenditure and £0.322m from the disposal of the former Learning Disability property Meadow View & part of Bucknall Hospital land disposal.

The purchase of the A&T and Telford Unit lease (forecast £0.500m at month 11) will now go ahead during the early stages of 2016/17.

The Trust's original plan predicted a further Bucknall Land related disposal receipt in December 2015, which will now be received in 2016/17 followed by further receipts in the following three financial years.

Table 8.1 below shows the Capital Resource Limit for the financial year.

Table 8.1: Capital Resource Limit	£000s
Initial CRL (per NTDA Plan submission)	1,530
Revisions to Plan:	
Capital to revenue transfer	(350)
Final CRL	**1,180**
Final Outturn 31/03/2016	**608**
(Over)/Under Shoot Against CRL	**572**

9. Financial Sustainability Risk Rating

The Trust's overall Financial Sustainability Risk Rating (FSRR) is calculated as a 3, in line with the planned rating for 2015/16. A rating of 1 indicates the most serious risk and 4 the least risk of financial failure. The FSRR is a new measure introduced during 2015/16, adding two further metrics to the Continuity of Services Risk Rating previously reported. Equal weighting of 25% is given to each of the four metrics.

Due to the Trust's cash balance the Liquidity Ratio metric is rated as 4. The Capacity Servicing Capacity metric is a lower rating of 2 due to the high capital service charges due to the Trust having a PFI scheme. The I&E margin is rated as 3 as the Trust is now making a cumulative surplus. The I&E Margin Variance shows a forecast rating of 4 due to the capital-to-revenue transfer of £350k. Table 9 below shows the separate metrics and the outputs in detail and Table 9.1 shows the relevant parameters.

Table 9: Financial Sustainability Risk Rating	**Forecast Plan £000s**	**Final Outturn £000s**
Liquidity Ratio (days)		
Working Capital Balance	2,203	3,200
Annual Operating Expenses	71,180	74,682
Liquidity Ratio Days	11.1	14.1
Liquidity Ratio Metric	**4**	**4**
Capital Servicing Capacity (times)		
Revenue Available for Debt Service	3,652	4,058
Annual Debt Service	2,276	2,681
Capital Servicing Capacity (times)	1.6	1.5
Capital Servicing Capacity metric	**2**	**2**
Continuity of Services Rating	**3**	**3**
I&E Margin		
Normalised Surplus/(Deficit)	377	705
Total Income	74,816	78,588
I&E Margin	0.5	0.9
I&E Margin rating	**3**	**3**
I&E Margin Variance from Plan		
I&E Margin Variance	(0.3)	0.4
I&E Margin Variance From Plan rating	**3**	**4**
Financial Sustainability Risk Rating	**3**	**3**

Table 9.1: Risk Assessment Framework Parameters				
Rating > > >	**4**	**3**	**2**	**1**
Liquidity Ratio (days)	0	-7	-14	<(14)
Capital Servicing Capacity (times)	2.5	1.75	1.25	<1.25
I&E Margin	1	0	-1	<=-1
I&E Margin Variance	0	-1	-2	<=-2

10. Better Payment Practice Code

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

At month 12 the Trust has slightly under-performed against this target for the number of invoices, having paid 94.6% of invoices in number (95.1% at month 11), but has paid 96.9% based on the value of invoices therefore achieving that target (97.4% at month 11).

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

Table 10: Better Payment Practice Code	**M11 Year-to-Date**			**M12 Final**		
	NHS	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**
Number of Invoices						
Total Paid	397	11,511	**11,908**	441	13,114	**13,555**
Total Paid within Target	380	10,939	**11,319**	418	12,405	**12,823**
% Number of Invoices Paid	95.7%	95.0%	**95.1%**	94.8%	94.6%	**94.6%**
% Target	95.0%	95.0%	**95.0%**	95.0%	95.0%	**95.0%**
RAG Rating	**0.7%**	**0.0%**	**0.1%**	**(0.2%)**	**(0.4%)**	**(0.4%)**
Value of Invoices						
Total Value Paid (£000s)	5,922	16,639	**22,561**	6,477	19,136	**25,613**
Total Value Paid within Target (£000s)	5,885	16,085	**21,971**	6,429	18,392	**24,821**
% Value of Invoices Paid	99.4%	96.7%	**97.4%**	99.3%	96.1%	**96.9%**
% Target	95.0%	95.0%	**95.0%**	95.0%	95.0%	**95.0%**
RAG Rating	**4.4%**	**1.7%**	**2.4%**	**4.3%**	**1.1%**	**1.9%**

11. Recommendations

The Board is asked to:

- note that the Trust has achieved an adjusted financial performance surplus of £1.297m;
- note the cash position of the Trust as at 31 March 2016 of £7.903m;
- note the net capital expenditure position as at 31 March 2016 is an underspend against plan of £0.572m; and
- note the final Financial Sustainability Risk Rating of 3.

REPORT TO Trust Board Enclosure 12

Date of Meeting:	11th May 2016
Title of Report:	Finance & Performance Committee Assurance Report to the Trust Board
Presented by:	Tony Gadsby
Author of Report:	Aaron Thomas, Deputy Director of Finance
Purpose / Intent of Report:	To provide information and assurance to the Trust Board of items arising in the Finance & Performance Committee
Executive Summary:	The report provides an overview of the key items discussed and reviewed during Aprils Finance & Performance Committee
Seen at SLT or **Exec** Meeting & date	SLT/EXEC: Finance & Performance Committee Date: 28th April 2016 Document Version number: N/a
Committee Approval / Review	• Quality Committee ☐ • Finance and Performance Committee ☒ • Audit Committee ☐ • People and Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐
Relationship with: *Board Assurance Framework* *Strategic Objectives*	1. To provide the highest quality services ☐ 2. Create a learning culture to continually improve. ☐ 3. Encourage, inspire and implement research at all levels. ☐ 4. Maximise and use our resources intelligently and efficiently. ☒ 5. Attract and inspire the best people to work here. ☒ 6. Continually improve our partnership working. ☐ 7. To enhance service user and carer involvement. ☐ **Comments:**
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	None identified
Resource Implications: Funding source:	N/a
Equality & Diversity Implications:	None identified
Recommendations:	The Committee is asked to note the content of this report

Assurance Report to the Trust Board – Thursday, 28 April 2016

Finance and Performance (F&P) Committee Report to the Trust Board – 11 May 2016

This paper details the issues discussed at the Finance and Performance Committee meeting on 28 April 2016. The meeting was quorate with minutes approved from the meeting on the 24th March 2016. Progress was reviewed and actions confirmed taken from previous meetings.

Finance Overview

The Committee received the financial update for month 12 (March 2016) 2015/16.

The income and expenditure final outturn position ended better than plan with a surplus position of £0.790m (£1.297m surplus at "adjusted financial performance" level) against a plan surplus of £0.727m, a favourable variance of £0.063m against plan.

The Trust's cash balance at the end of March was £7.9m against the plan balance of £6.4m. The higher balance being due to the delay in the lease purchase of the A&T and Telford Unit, as well as movements in working capital.

Capital Expenditure for the year as at 31 March 2016 is £0.608m (net of capital receipts) which ended behind plan. The target for 2015/16 was £1,180m, following the capital to revenue transfer made in December 2015.

It was noted that the Trust continued to report a Financial Sustainability Risk Rating of level 3 at March 2016. This level 3 rating is achieved primarily as a result of the Trusts healthy liquidity ratio.

Other Reports and Updates

The Committee received additional reports and verbal updates as follows:

- **Agency Staffing**
  A report was provided detailing current and projected agency expenditure with details of the 2016/17 £2,038k agency cap ceiling. The Trusts recruitment strategy will be key in filling vacancies and reducing agency spend in 2016/17.

- **Capital Plan Update**
  A report provided the 5 year capital plan, setting out the Trusts investments and affordability. Emphasis was placed on ensuring more robust processes were developed to ensure all Trust stakeholders were involved, with plans approved by the Business Development Committee and monitored financially by the Finance & Performance Committee. It was noted that NHS Improvement will continue to work locally with Trusts to make further capital to revenue transfers where feasible.

- **Performance Management Report**
  A report including TDA metrics, agreed targets, trends and a revised RAG rating was tabled. The report noted that, at month 12, there were 6 metric's rated as Red and 3 rated as Amber. The Committee were briefed on the issues within these areas.

- **Payments by Results**
  A report was provided updating the Committee on developments concerning the new payment mechanism covering mental health services. An initial assessment highlighted that a capitated payment mechanism is likely to be preferable to the Trust, as this allows better opportunities to re-allocate risk between provider and commissioner.

- **Patient Level Costing**
  A report detailing the relaunch of Patient Level Costing (PLICs) was provided; including the team's involvement in national currency development groups.

- **Estates Compliance & Moves Report**
  Reports were provided detailing the Estates Department activities for the year, covering Planned Preventative Maintenance (PPM) and Reactive Maintenance (RM), in line with Statutory Compliance. An update of the Estates Optimisation Plan was also presented highlighting estates moves for the coming year.

- **Tenders Briefing**
  An update was provided to the committee on current tender activity with the AMH-Community Co-operative working bid being successfully awarded to the Trust.

- **Cost Improvement Programme**
  A report on the CIP position for the Trust showed that the 2015/16 £2.658m target was fully achieved, although part non recurrently. The 2016/17 CIP target will be £2.6m with work required to develop and monitor CIPs in year.

- **Trust Risks**
  A schedule was provided which described the key risks appertaining to the Trust.

- **Capital Investment Group**
  The Committee received, for information, the minutes and report from the Trusts Capital Investment Group (CPU).

Recommendation

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

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

Aaron Thomas – Deputy Director of Finance

REPORT TO Trust Board

Enclosure 13

Date of Meeting:	11 May 2016
Title of Report:	Going Concern Declaration
Presented by:	Suzanne Robinson, Director of Finance and Performance
Author of Report:	Suzanne Robinson
Purpose / Intent of Report:	For decision/information
Executive Summary:	International Financial Reporting Standards (ITFS) require the Trust Board to assess and satisfy themselves that it is appropriate to prepare its financial statements on a going concern basis for at least 12 months from the date of the accounts. Going concern is a fundamental principle in the preparation of financial statements. Under the going concern assumption, the Trust is viewed as continuing in operation for the foreseeable future with no necessity of liquidation or ceasing trading. Accordingly, the Trust's assets and liabilities are recorded on the basis that the assets will be realised and liabilities discharged in the normal course of business. A key consideration of going concern is that the Trust has the cash resources to meet its obligations as they fall due in the foreseeable future. The Trust Board should consider the specific events, conditions or factors that individually or collectively, might cast significant doubt on the going concern assumption. Having considered the relevant conditions and performed an assessment of the above factors, it is concluded that no material uncertainties related to events or conditions that may cast significant doubt about the ability of the Trust to continue as a going concern have been identified by the directors The Trust Board is asked to endorse the conclusions reached and recommend to the Audit Committee that when considering the Annual Accounts for 2015-16 it is appropriate that the accounts were prepared on the going concern basis.
Seen at SLT or **Exec** Meeting & date	SLT/EXEC: Date: Document Version number:
Committee Approval / Review	• Quality Committee ☐ • Finance and Performance Committee ☐ • Audit Committee ☐ • People and Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐
Relationship with:	

Board Assurance Framework *Strategic Objectives*	1. To provide the highest quality services ☐ 2. Create a learning culture to continually improve.☐ 3. Encourage, inspire and implement research at all levels.☐ 4. Maximise and use our resources intelligently and efficiently.☐ 5. Attract and inspire the best people to work here.☐ 6. Continually improve our partnership working. ☐ 7. To enhance service user and carer involvement.☐ **Comments:**
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	See attached
Resource Implications: Funding source:	See attached
Equality & Diversity Implications:	-
Recommendations:	The Trust Board is asked to endorse the conclusions reached and recommend to the Audit Committee that when considering the Annual Accounts for 2015-16 it is appropriate for the accounts were prepared on the going concern basis.

Trust Board
11th May 2016
Going Concern Declaration

1. Introduction

International Financial Reporting Standards (IFRS) require the Trust Board to assess and satisfy themselves that it is appropriate to prepare its financial statements on a going concern basis for at least 12 months from the date of the accounts.

2. Going Concern

Going concern is a fundamental principle in the preparation of financial statements. Under the going concern assumption, the Trust is viewed as continuing in operation for the foreseeable future with no necessity of liquidation or ceasing trading.

Accordingly, the Trust's assets and liabilities are recorded on the basis that the assets will be realised and liabilities discharged in the normal course of business. A key consideration of going concern is that the Trust has the cash resources to meet its obligations as they fall due in the foreseeable future.

The Trust Board should consider the specific events, conditions or factors that individually or collectively, might cast significant doubt on the going concern assumption.

3. Conditional Assessment

The conditions assessed are set out in the table below;

Factors that might cast significant doubt on going concern Trust response and consideration	Trust response and consideration
Financial conditions	
Poor financial risk rating	The Trust reported a Continuity of Service Risk Rating (CoSRR) of 3. Looking ahead the Trust has prepared a 1 year budget and is projecting a CoSRR or Financial Sustainability Risk Rating of 3 in 2016-17.
Necessary borrowing / working capital facilities have not been agreed	The Trust does not require any external borrowing or working capital facility to support the 5 year capital programme
Existence of significant operating losses, historical and projected	The Trust is reporting a surplus of £1.297k at the year-end (including technical adjustments). The 1 Year operational plan submitted to NHSI assumed a surplus position.
Anticipated or actual loss of commissioner income	The Trust continues to work closely with North Staffordshire and Stoke CCGs and has secured additional investment in 2016-17 to support CQC actions plans and other transformation. The contract

	for 2016-17 was signed within the national deadline.
Cost Improvement Programme (CIP) with risk of non-achievement	The Trust is planning a CIP of £2.6m in 2016-17; as a percentage of operating expenditure stands at 3.3%. The Trust has an established review process for CIP including formalised monitoring through the Senior Leadership Team with oversight and scrutiny from the Finance & Performance Committee. Quality Committee receives oversight of all schemes from a Quality Impact Assessment (QIA) perspective. Of the £2.6m target, 99% has been identified and 58% has been through the QIA process. The Board receives updates as part of the Finance Board Report in addition to performance management via NHS Improvement on a monthly basis.
Major losses or cash flow problems which have arisen since the balance sheet date	None
Inability to repay PFI requirements	The Trust has sufficient cash balances and has historically generated surpluses to ensure the ability to maintain all payments in relation to the PFI. Over the coming years payments will start to reduce. The 5 year Integrated Business Plan (IBP) projects a maintained surplus position. This will be refreshed in June maintaining a balanced position.
Operational Conditions	
Appointment of Executive Directors and Non- Executive Directors (NEDs)	The Board has a full established Executive Director compliment with the in-year appointments of the Director Nursing and Quality, the Director of Strategy and Business Development and the Director of Finance & Performance. Following the retirement of the Chair, Ken Jarrold on 31st March, a new chairman, David Rogers (one of our existing NEDs), was appointed on the 1st April 2016 creating a subsequent vacancy. The Trust is continuing to deliver a succession plan for NEDs coming to the end of their term of office and by recruiting to any vacancies.
Loss of key staff without replacement and/or labour difficulties	The Trusts staff retention levels overall are good; however in common with other Trusts there are challenges in the short-medium term in recruiting additional registered nursing and medical staff; particular in CAMHS. The trust has launched a significant recruitment campaign to attract staff in the first quarter of the year. We are also developing stronger links with universities and offering flexible working options in relation to return to practise and incentive schemes.

	Areas of recruitment risk are monitored fortnightly by Senior Leadership and Executive team.
Poor oversight and escalation rating	The Trust achieved a level 4 (Standard Oversight) in Q3 and anticipates the same for Q4.
Failure to achieve Care Quality standards resulting in any restrictions on services provided	Following the comprehensive inspection in September 2015 where a rating of Requires Improvement was issued, the Trust has made significant progress. This was in part presented as part of the Quality Summit in March 2016 where there was notable support from commissioners, Healthwatch and the TDA (now NHSI). The trust has comprehensive action plans in place to support the achievement of at least a GOOD rating when reassessed in September 2016.
Fundamental changes in the market or technology to which the trust is unable to adapt adequately	The trust has a significant change programme for digital technology and is leading across the SLT footprint in this respect. We are always looking to ensure our systems are up to date and future-proofed. We have a modern data warehouse with highly capable technology development platforms (such as QlikView, Prodacapo) and is planning to implement a new electronic patient record system from Lorenzo in March 2017. All of these programmes contribute to our capability to respond rapidly to any changes in requirements.
Other conditions	
Serious non-compliance with regulatory or statutory requirements	The Trust has met all regulatory and statutory requirements.
Pending legal or regulatory proceedings against the trust that may, if successful, result in claims that are unlikely to be satisfied	As a member of the NHSLA's Clinical Negligence for Trusts and its Risk Pooling Scheme for Trusts, the Trust is bound by the NHSLA's Membership Rules. In essence, the Trust must co-operate with the NHSLA who indemnify the Trust against claims covered under each scheme. For the most part this is for clinical negligence and personal injury claims. We are aware of our limits of authority and action needed when dealing with claims. We also have a duty to conduct and report claims in accordance with the rules and reporting guidelines so as to ensure we are covered for all such liabilities.
Changes in legislation or government policy expected to adversely affect the trust	The Trust has prepared a 5 Year Integrated Business Plan (IBP) which will be refreshed in June 2016 with the aim of demonstrating the longer term financial viability and sustainability of the organisation. The plans were derived using NHS England's latest tariff and inflation assumptions, published as part of the planning round.

4. Conclusion

Having considered the relevant conditions and performed an assessment of the above factors, it is concluded that no material uncertainties related to events or conditions that may cast significant doubt about the ability of the Trust to continue as a going concern have been identified by the directors.

5. Recommendation

The Trust Board is asked to endorse the conclusions reached and recommend to the Audit Committee that when considering the Annual Accounts for 2015-16 it is appropriate that the accounts were prepared on the going concern basis.

REPORT TO TRUST BOARD

Enclosure 14

Date of Meeting:	11 May 2016
Title of Report:	Performance Report – Month 12 2015/16
Presented by:	Director of Finance
Author of Report:	Performance & Information Team
Purpose / Intent of Report:	Performance Monitoring
Executive Summary:	This report provides the Board with a summary of performance to the end of Month 12 (March 2016). Performance against the TDA metrics and key National Targets is included within the report. A range of metrics is in place to monitor performance, quality and outcomes. The indicators are those set by our commissioners and local trust targets and aligned to the relevant Trust objectives. At month 12 there are 6 metrics rated as Red and 3 rated as Amber; the attached exception report expands on these areas. Executive leads will provide a verbal update at the meeting, where appropriate.
Seen at SLT or **Exec** Meeting & date	SLT/EXEC: Date: Document Version number:
Committee Approval / Review	• Quality Committee ☐ • Finance and Performance Committee Y • Audit Committee ☐ • People and Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐
Relationship with: *Board Assurance Framework* *Strategic Objectives*	1. To provide the highest quality services Y 2. Create a learning culture to continually improve. ☐ 3. Encourage, inspire and implement research at all levels. ☐ 4. Maximise and use our resources intelligently and efficiently. ☐ 5. Attract and inspire the best people to work here. ☐ 6. Continually improve our partnership working. ☐ 7. To enhance service user and carer involvement. ☐ **Comments:**

	Focusing on quality and safety Consistently meeting standards Delivering our financial plan
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	All areas of underperformance are separately risk assessed and added to the risk register dependent on the outcome of the risk assessments.
Resource Implications: Funding source:	Not directly as a result of this report
Equality & Diversity Implications:	Not directly as a result of this report
Recommendations:	The Board is asked to Consider and discuss reported performance with particular emphasis on areas of underperformance. Confirm sufficient detail and assurance is provided.

North Staffordshire Combined Healthcare NHS
NHS Trust

PERFORMANCE MANAGEMENT REPORT TO TRUST BOARD

Date of meeting:	11th May 2016
Report title:	**Performance & Quality Management Framework** **Performance Report – Month 12** **2015/16**
Executive Lead:	Director of Finance & Performance
Prepared by:	Performance & Information Team
Presented by:	Director of Finance & Performance

1 Introduction to Performance Management Report

The report includes performance against TDA, Commissioner Contractual and local Trust metrics. Developing trends are highlighted and RAG rated accordingly. These are summarised in the Executive Summary

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

2 Executive Summary – Exception Reporting

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

In month 12 there are 6 metrics rated as Red and 3 as Amber.

	Month 12			
Metric Driver	**Red**	**Amber**	**Green**	**TOTAL**
Local indicators	**0**	**0**	**8**	**8**
National & Contractual Indicators	**6**	**3**	**49**	**58**

3 Exceptions - Month 12

Metric	Exec/Op Lead	Target	M12 Perf	YTD Perf	Trend	Commentary
18 WEEKS (1): Compliance with 18 week waits (**all referrals,** i.e. initial *and* subsequent internal referrals)	Dir of Ops Op Lead Head of Dir	**95%**	**AMBER** **91%**	**AMBER** **91%**	↘	**91% at M12 from 93% at M11** Month 12 breakdown; AMH Community = 95.5% from 94.5% at M11 Substance Misuse = 100% Learning Disabilities = 100% NOAP = 96.6% from 98.8% CYP = 84.5% from 86% at M11 Additional resource has been implemented until Children and Young People is achieving target. It is anticipated that improvements will be reflective by Quarter 1 2016/17.
18 WEEKS (2): Compliance with 18 week wait (**initial referrals only**)	Dir of Ops Op Lead Head of Dir	**95%**	**RED** **88%**	**RED** **88%**	↘	**88% at M12 from 91% at M11** Month 12 breakdown; AMH Community = 90% same as M11 Substance Misuse = 100% same as M11 Learning Disabilities = 97% from 100% at M11 NOAP = 95% from 98% at M11 CYP = 84% from 89% at M11

Metric	Exec/Op Lead	Target	M12 Perf	YTD Perf	Trend	Commentary
CPA: The proportion of those on Care Programme Approach(CPA) for at least 12 months Having formal review within 12 months	Dir of Ops Op Lead Head of Dir	**95%**	AMBER **94.2%**	AMBER **94.2%**	↔	**94.2% at M12 the same as M11** AMH Community = 94.2% Learning Disabilities = 96% NOAP = 92.9% This indicator has now been off track for the last 3 months. Patient level detail reports are being distributed to teams on a weekly basis. Team level rectification plans are in place. These are being followed up by HoD and Director of Ops.
RAID: A&E Emergency Portal referrals seen within 1 hour	Dir of Ops Op Lead D Carr	**95%**	RED **87%**	AMBER **90%**	↘	**87% at M12 from 91% at M11** A service review of patient referral process is to take place. The service has noted an increasing impact of patients from non-North Staffs CCGs above the original baseline activity. This is impacting of performance metrics. This issue to be raised at the SSIG.
RAID: All other referrals seen on same day or within 24 hours	Dir of Ops Op Lead D Carr	**95%***	RED **76%**	RED **89%**	↘	**76% at M12 from 95% at M11** Performance against target has reduced in month. This is due in part to additional demand and a change to recording systems that have temporarily reduced productivity.

						HoD reviewing performance and additional laptops have been purchased to support recording. Given the growth of Urgent Care activity at UHNM, the service has increasingly been picking up out of area activity. NSCHT is currently in discussion with commissioners via the RAID steering group to agree response targets, which will be updated as agreed.
TRAINING: % staff compliant with mandatory training	Workforce Dir Op Lead S Slater	**90%***	**AMBER 87.5%**	**AMBER 87.5%**	↗	**87.5% at M12 from 86.8% at M11** Month 12 breakdown; Corporate Services = 86.1% AMH Community = 87.2% AMH Inpatient = 86.19% CYP = 86.7% Learning Disabilities = 89.3% NOAP = 89.6% Substance Misuse = 86% Plans in development to increase the importance of mandatory training compliance.

Metric	Exec/Op Lead	Target	M12 Perf	YTD Perf	Trend	Commentary
Delayed Transfers of Care: MH Delayed Transfers of Care	Dir of Ops Op Lead	**7.5%**	**RED** **9.7%**	**RED** **9.7%**	↗	**9.7% from 8.2% at M11** Adult MH = Ward 1-6.7%, Ward 2-31.3%, Ward 3-7.7% NOAP = Ward 4-9.9%, Ward 5-9.7%, Ward 6-17.8%, Ward 7-20.9% Delays relating to the availability of social care packages are being discussed with commissioners to understand how this can be improved.
Nursing agency usage: Total spend against total nursing paybill (Qualified)	Workforce Dir Op Lead	**3%**	**RED** **5.15%**	**RED** **5.15%**	↔	**5.15% at M12 the same as at M11** The Trust is aware of areas contributing to current performance with targeted actions to address. (Namely future commissioning of Ward 4 and the permanent recruitment of vacancies within CAMHS and AMH Inpatient wards).

Metric	Exec/Op Lead	Target	M12 Perf	YTD Perf	Trend	Commentary
Complaints: Number of Complaints open beyond agreed timescale	Dir of Nursing	**0**	**RED** **2**	**RED** **2**	↗	**2 at M12 from 13 at M11** There was a small backlog of complaints which is being addressed as a matter of urgency; this will conclude by 30 April 2016.

4 Recommendations

- Trust Board is asked to note the contents of the report.

REPORT TO Trust Board

Enclosure 15

Date of Meeting:	11 May 2016
Title of Report:	Assurance Report from the Audit Committee
Presented by:	Tony Gadsby, Interim Chair/Non-Executive Director
Author of Report:	Laurie Wrench, Associate Director of Governance
Purpose / Intent of Report:	For assurance
Executive Summary:	To receive the assurance report from the meeting of the Audit Committee held on 28 April 2016
Seen at SLT or **Exec** Meeting & date	SLT/EXEC: Not applicable Date: Document Version number:
Committee Approval / Review	• Quality Committee ☐ • Finance and Performance Committee ☐ • Audit Committee ☐ • People and Culture Development Committee ☐ • Charitable Funds Committee ☐ • Business Development Committee ☐
Relationship with: *Board Assurance Framework* *Strategic Objectives*	1. To provide the highest quality services ☐ 2. Create a learning culture to continually improve. ☐ 3. Encourage, inspire and implement research at all levels. ☐ 4. Maximise and use our resources intelligently and efficiently. ☐ 5. Attract and inspire the best people to work here. ☐ 6. Continually improve our partnership working. ☐ 7. To enhance service user and carer involvement. ☐ **Comments:**
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	
Resource Implications: Funding source:	
Equality & Diversity Implications:	
Recommendations:	For assurance and information

Summary of the Audit Committee Meeting 28th April 2016
To Trust Board meeting 11th May 2016

1. Draft Annual Governance Statement

The committee received the draft Annual Governance Statement 2015/16. The AGS is a statement about the system of integrated governance, risk management and internal control across the whole of the Trust's activities. The draft has been prepared in accordance with the TDA guidance.

There are no significant control issues reported for the Trust in 2015/16 and the draft Head of Internal Audit Opinion is that adequate and effective assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives and that controls are generally being applied consistently.

The final version of the AGS will be submitted to the next meeting on 26 May 2016.

2. Draft Quality Account

The committee received the first draft of the Quality Account. As in previous years, the Trust is required to develop and publish a Quality Account by 30 June 2016, which if designed well will assure commissioners, patients and the public that Trust Boards are regularly scrutinising each and every one of their services.

Members were assured that the Quality Account project plan is on track. Plans are in place to engage with key stakeholders and the document will also be reviewed by External Auditors, Ernst and Young

3. Board Assurance Framework, Quarter 4 2015/16

The Board Assurance Framework for Q4 was presented. The BAF aligns the Trust Strategic objectives to the trust's quality priorities and key risks including the Board's level of risk appetite.

The Audit Committee received the BAF for assurance with closing down key objectives and to note the mitigations which still stand.

The committee chair noted that the BAF is an extremely beneficial source of reference.

4. Board Assurance Framework 2016/17

In addition to the Q4 BAF, the committee received the Board Assurance Framework in draft form for 2016/17. This provided a first glance at the key control and assurances to be introduced to ensure delivery of the seven strategic objectives which are all owned by an Executive lead and respective sub committees of the Board.

It was noted that the BAF will continually evolve. The Trust is taking into account the recommendations from the Internal Auditors - RSM for strengthening, monitoring progress and trajectories. It was noted that during the Board of Directors session held recently the Board focused on risk appetite and this will be reviewed on a quarterly basis.

5. **Risk Management Assurance Report**

The Risk Management Assurance Report provides information and assurance to the Audit Committee regarding the systems and processes used within the Trust to manage risk.

The Trust has strengthened team level risk registers and there has been positive feedback in terms of how teams are owning their risk registers. The Trust's Risk Manager provides ongoing support to Directorates and teams helping improve reporting.

The committee recognised the progress in this area and was happy to take assurance.

6. **CQC Quality Assurance Report and Action Plan**

The CQC Inspection and Quality Assurance Report was received which provides assurance as to the progress made for the CQC Comprehensive Inspection and wider quality assurance programme.

Since publication of the reports and ratings, the trust has maintained momentum with the required improvements and has systems in place to ensure that assurance against these improvements is robust. It was also noted that there has been good progress with the Section 29a Warning Notice for Community children and young people.

It was further noted that the Trust has a rolling programme for quality assurance with the peer review process taking place twice yearly.

7. Clinical Audit Programme 2016/17

The committee received the Clinical Audit Programme 2016/17 which has been developed in accordance with the Trust's Clinical Audit Policy.

8. Annual Report Project Plan

Members noted the key targets and actions as described in the project plan and assurance was given that the Trust is on track with the process.

9. LCFS Progress Report and Work Plan

The committee received the LCFS Progress Report and work plan for assurance.

Members noted the activities undertaken and it was noted that these all link into NHS Protect standards accordingly. The work plan provided a breakdown of the tasks and proposed timings for work to be undertaken also in line with NHS Protect standards.

10. Internal Audit Progress Report, Annual Report and Annual Plan – RSM

The Head of Internal Audit, RSM, presented the Internal Audit Progress Report which included the action plans in respect of the finalised reports since the last Audit Committee meeting. The Committee was informed that the Internal Audit Plan had been delivered and was included in the Draft Internal Audit Annual Report.

Since the last Audit Committee, RSM have finalised 8 reports as follows:

1. Data Quality – 18 week waiting times
2. Patient experience and patient engagement
3. Follow up management actions/recommendations
4. Quality of Performance Development Reviews
5. Team level risk registers
6. Board Assurance Framework review
7. Care plans
8. Identification, Delivery and Monitoring of the Cost Improvement Programme

The committee were presented with the Draft Annual Internal Audit Report 2015/16 which details the Internal Audit Opinion and sets out the basis on which this is founded. This can then be used to support the Trust's Annual Governance Statement.

The opinion

> *The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.*

The factors and findings which have informed the opinion were noted.

Members noted the contents of the Internal Audit Plan and also noted that it may be necessary to update the plan during the year, should different risks emerge or the risk profile change.

11. External Auditors - Ernest & Young Progress Report 2015/16

The committee considered the Ernst and Young External Audit Progress report. The report provided the Audit Committee with an update on external audit work undertaken and the impact on the trust's initial risk assessment set out in the audit plan presented at the meeting on 18 February 2016.

External audit have also conducted work to assess the Trust's Value for Money, based on the guidance issued by the National Audit Office.

The committee was informed that a review of the Trust Accounts will start next week.

12. Revised Internal Audit Protocol

The revised Internal Audit protocol was presented to the committee which was approved by the Executive Team. Internal Audit will continue to have regular contact with the Director of Finance and Performance and will notify of any slippage in reporting deadlines.

13. Unaudited Accounts Review

Mr Blaise, Deputy Director of Finance and Mr Thomas, Interim Deputy Director of Finance were in attendance for this item to present the unaudited accounts to the committee which demonstrated that yet again, the trust is ending the year in a strong financial position.

The committee gave formal thanks to Mr Blaise for all his support and dedication to the Finance Team who is retiring on 29 April 2016

14. **Review of the Business of other Board Committees**

The committee received the following summary business reports:

- *Quality Committee* meetings 16 February and 15 March 2016
- *Finance & Performance Committee* meetings 18 February and 24 March
- *People and Culture Development Committee* meetings 22 February and 21 March
- *Business Development Committee* meetings 4 March 2016

15. **Next meeting of the Audit Committee** – 26th May 2016, 1.00pm

On behalf of the Committee Interim Chair Mr Tony Gadsby
Laurie Wrench
Associate Director of Governance
4th May 2016

REPORT TO TRUST BOARD Enclosure 16

Date of Meeting:	11 May 2016
Title of Report:	Summary of the Business Development Committee meeting held on the 29 April 2016
Presented by:	Mr Patrick Sullivan, Interim Chair of Business Development Committee
Author of Report:	Thomas Thornber, Director of Strategy & Development
Purpose / Intent of Report:	For Decision/ Assurance
Executive Summary:	This report provides a high level summary of the key headlines from the Business Development Committee meeting held on the 29 April 2016 The full papers are available as required to Trust Board members
Seen at SLT or **Exec** Meeting & date	SLT/EXEC: Date: Document Version number:
Committee Approval / Review	• Business Development Committee ✓
Relationship with: *Board Assurance Framework* *Strategic Objectives*	1. To provide the highest quality services ☐ 2. Create a learning culture to continually improve. ☐ 3. Encourage, inspire and implement research at all levels. ☐ 4. Maximise and use our resources intelligently and efficiently. ☐ 5. Attract and inspire the best people to work here. ☐ 6. Continually improve our partnership working. ☐ 7. To enhance service user and carer involvement. ☐ **Comments:**
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	None
Resource Implications: Funding source:	None
Equality & Diversity Implications:	None
Recommendations:	To note the contents of the report

Summary OPEN from the Business Development Committee held on 29 April 2016

Terms of Reference
The Committee reviewed the Terms of Reference. S Robinson agreed to update the Terms of Reference to reflect the Investment Policy delegation responsibility and submit to the next meeting.

Estates Rationalisation
The Committee heard that the one year plan needed to be aligned with the capital plan on key moves. The five year plan will need to reflect the Pan Staffordshire estates proposals.

Mental Health A&E – S Robinson spoken to S Mortimer about taking this forward and what are the strategic implications for this. S Robinson stated that we need to be realistic about what we will be able to deliver in year. P Sullivan stated this needs careful planning.

Capital Plan
The Committee noted the report, approved the capital plan and supported the next steps and actions.

Board Assurance Framework – Q1 and Q4

D Hewitt informed the Committee that the LIC 3 paper for the EPR was reviewed at HSCIC Operational Development Group and it has been endorsed for going through to the Operational Development Board on the 5 May 2016.

5 Year Plan (Roadmap)
T Thornber presented the 5 year roadmap for the Trust and stated that the roadmap will shift as plans reflect the Pan Staffordshire direction of travel including the capital plan as they alter. It will be included in the 5 year plan submission to NHS Improvement.

Investment Policy
The Committee received an updated/ refreshed Investment Policy which now includes:

- The governance and delegation of authority to act for example, £250-£500k approval of delegated authority to this committee, instead of Finance & Performance Committee. This will provide assurance based on the decisions and approvals from this committee.
- Digital Programme Board will become a time limited committee with delegated authority for anything 'digital'.

D Hewitt agreed to update Digital by Choice Programme Delivery Board Terms of Reference to reflect this.

A Rogers clarified that a business case would not be required for a tender, it was agreed by the nature of tenders a business case would not be required and the Investment Policy reflected the process for tenders.

Discussion took place in relation where would all projects be managed once they turn into a project. It was agreed that a capital business case would have a lead, exec sponsor to drive this through and a project group who would manage this, by Directorate, who will report to Capital Investment Group and then report to this committee. It was also agreed that further clarity was needed on reporting of projects not only capital ones. **A meeting will be arranged to discuss this topic and an update provided at the next meeting.**

The Committee approved the Investment Policy.

Items received for information only:

1. Cycle of Business
2. Update on tender activity

REPORT TO Trust Board Enclosure 24

Date of Meeting:	11 May 2016
Title of Report:	Communications Strategy
Presented by:	Paul Draycott, Executive Director of Leadership and Workforce
Author of Report:	Caroline Thomsett, Interim Associate Director of Communications
Purpose / Intent of Report:	The report sets out the strategic direction for the communication, marketing and engagement activities for the Trust for 2016/17.
Executive Summary:	The strategy presents communications and engagement as a key priority for the organisation as part of its next stage of development. It sets out the Trust's brand positioning and the approach that need to be taken to raise the bar of communications and engagement across the organisation.
Seen at SLT or **Exec** Meeting & date	SLT/EXEC: SLT Date: 19 April 2016 Document Version number: 01
Committee Approval / Review	• Quality Committee • Finance and Performance Committee • Audit Committee • People and Culture Development Committee • Charitable Funds Committee • Business Development Committee
Relationship with: *Board Assurance Framework* *Strategic Objectives*	1. To provide the highest quality services 2. Create a learning culture to continually improve. 3. Encourage, inspire and implement research at all levels. 4. Maximise and use our resources intelligently and efficiently. 5. Attract and inspire the best people to work here. 6. Continually improve our partnership working. 7. To enhance service user and carer involvement. **Comments:** The strategy is aligned to all seven objectives.
Risk / Legal Implications: (Add Risk Register Ref [if applicable])	N/A
Resource Implications: Funding source:	There are resources implications, some of which will be cost neutral through, for example, the restructure of the directorate and others will be worked on and appropriate cases developed if/when required.
Equality & Diversity Implications:	N/A
Recommendations:	To discuss and approve the Communications Strategy.

Communications Strategy 2016/17

1. Purpose of document

This document sets out the strategic direction for the communication, marketing and engagement activities of North Staffordshire Combined Healthcare NHS Trust for 2016/17.

It is designed to sit as an integral part of the Trust's overall business plan and directly support the Trust's continued journey of improvement and delivery of its strategic aims.

The strategy presents communications and engagement as a key priority for the organisation as part of its next stage of development. It sets out the Trust's brand positioning and the approach that need to be taken to raise the bar of communications and engagement across the organisation.

The paper is also written against the background of the NHS Five Year Forward View, which set out a new and more engaged relationship with patients and communities, and the subsequent NHS Five Year Forward View for Mental Health which outlined priority areas for action and highlighted the need to optimise digital channels and, where appropriate, make services more readily available online.

2. Profile

The Trust is one of the main providers of mental health, social care and learning disability services in Staffordshire.

With 30 sites, it provides services in the home, community and hospital to around 470,000 people of all ages in Stoke on Trent and across North Staffordshire.

It also offers specialist inpatient and day patient care to children across the West Midlands who are suffering severe or complex mental health conditions (Tier 4 Child and Adolescent Mental Health Services, CAMHS) and substance misuse services to people throughout Staffordshire.

As well as a key partner with other NHS organisations, it works closely with the voluntary sector to support people with mental health problems.

Most inpatient services are based at Harplands Hospital in Stoke on Trent, which opened in 2001.

The Trust has a team of around 1400 staff and a turnover of £78m (2015/16).

3. National, regional and local context

National

In February 2016, the NHS committed to a major transformation of mental health care and investing over £1bn a year of additional funding to reach one million more people by 2020/1.

It followed the publication of the final report of the Mental Health Taskforce – the Five Year Forward View on Mental Health, which gave a frank assessment of the state of mental health care across the NHS. Its priority actions included 24/7 access to mental health care for people facing a crisis, an integrated mental and physical health approach and promoting good mental health/preventing poor mental health.

Investment in digital infrastructure was highlighted, including maximising digital channels to communicate key messages and raise awareness, make services available on line (where appropriate) and direct people to effective digital mental health products through websites and social media channels.

The paper followed the publication of the NHS Five Year Forward View published in October 2015, which set out a vision for future of the NHS. It's focus was on a radical upgrade in prevention and public health, giving patients greater control of their own care and breaking down the barriers in how care is provided between primary care and hospitals, physical and mental health and between health and social care. It also called for a new relationship with patients and communities. The NHS at its best, it stated, was 'of the people, by the people and for the people' and highlighted a 'need to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services'.

In December 2015, NHS England published Delivering the Forward View: NHS planning guidance 2016/17-2020/21 which called for local organisations to collaborate to produce sustainability and transformation plans on how they will accelerate the implementation of the Five Year Forward View.

Regional/local

The Trust is an integral part of the Pan Staffordshire Transformation programme – We're better together. Providers are now part of the Board steering group along with commissioners, with the Trust chief executive leading on mental health, organisational development (OD) and system leadership, and IT and technology. The organisation has contributed to the county's challenges with a new shared-care ward with University Hospitals of North Midlands NHS Trust (UHNM), Rapid, Assessment, Interface and Discharge (RAID) service across UHNM and local hospitals, and other services in partnership

Despite operating in a challenged health economy with high deprivation (the health of people in Stoke on Trent is generally worse than the England average with about 26% children living in poverty – Public Health England) and an ageing population, the Trust has a strong track record of financial balance and high quality cost effective services, achieving a surplus for 17 consecutive years.

Following an unsettling period of changing leadership, talks of potential merger, the Trust has now stabilised with a new executive team and is on a journey of improvement with strong ambitions.

The latest CQC inspection (September 2015, report March 2016), gave the trust an overall rating of 'requires improvement'. In the domain of 'caring', the trust services were rated as 'good'. Of the Trust's 11 'core' services, four achieved 'good', five 'requires improvement' and two 'inadequate'.

There were positive comments regarding the Trust's range of engagement initiatives including Listening in Action (LiA) and the new Service User and Carers Council. However, it also highlighted that the Trust scored below the national average for staff recommending the Trust as a place to work (57% 2015 National Staff Survey). Some staff they spoke to felt disengaged from improvements. Morale, the CQC, said was variable and staff turnover in the past months was almost 14%. While the Trust's mission and vision was on display and available, it felt there was an inconsistent level of awareness among front line staff with some senior clinicians unsure of the Trust's direction.

On 24/7 services, the Trust's community-based Access Team has been operating 24/7 for more than a year – providing crisis response and enabling access to all the Trust's services. An acute emergency centre for mental health is due to be built in 2017.

The Trust is heavily committed to its digital programme – Digital by Choice which is integrated into its Five Year Plan. Its outlined its ambitions to achieve a national reputation as a leader in the use of digital technology that enables the delivery of excellent care services, supports users of services to recover, allows staff and partners to work together easily and effectively and leads to innovation in the delivery of healthcare services. The programme is viewed as a key enabler for a channels shift in the delivery of care. It is due to implement a new electronic patient record (EPR) system in spring 2017.

4. Vision

The Trust's vision is:

To be an outstanding organisation providing safe, personalised, accessible and recovery-focussed support/services every time.

Its strategic aim is to develop enhanced and coordinated health and social care provision as an independent provider.

This will be achieved through seven key objectives:

1. Provide the highest quality services
2. Create a learning culture to continually improve
3. Encourage, inspire and implement research and innovation at all levels
4. Maximise and use our resources intelligently and efficiently
5. Attract and inspire the best people to work here
6. Continually improve our partnership working
7. Enhance service user and carer involvement

The Trust's four key quality priorities are 'SPAR':

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

For 2016/17 its ambitions include to:

- Be innovative and responsive in integrating physical health and mental health and develop a shared service with UHNM
- Expand the hours of the RAID service in partnership with UHNM
- Start building a new psychiatric intensive care unit (PICU)
- Finish improvements to CAMHS in the Darwin Centre to improve support for children, young people and their families
- Develop tier 3+ eating disorder service within CAMHS and expand central referral hub
- Work with commissioners to invest in the CAMHS community provision to enhance quality and access of services
- Work closely with primary care to strengthen the integration of services
- Make good progress in strengthening learning disability services to integrate with social care in 2016
- Work to develop a mental health emergency care centre to streamline the patient pathway
- Develop additional capacity in line with increased demand and need.

5. Current situation

In October 2015, the Trust Board decided to review existing communications and engagement activity and develop a robust new strategy that would meet the needs of the organisation, now and in the future.

Effective two-way communication is crucial to every successful healthcare organisation. When applied effectively, it can cement working relationships with internal and external stakeholders, augment a reputation for delivering high-quality care, and set the tone for an entire organisation.

Evidence also shows that good engagement improves quality of care and patient outcomes. Research by the Kings Fund in 2012 found that the more positive the experiences of staff within an NHS trust, the better the outcomes for that trust with links to patient satisfaction, patient mortality and infection rates. Engagement is also regarded as a key driver to ensure staff understand, feel motivated and are able to contribute to the direction of the Trust.

Reflecting detailed feedback from the Board and colleagues across the Trust, this strategy aims to strengthen the communications and engagement function, aligned to the Trust's strategic direction, while applying core communications principles and best practice from across the NHS.

(a) Method of analysis

An audit of existing communications activity was carried out in advance of the creation of this strategy. This included:

- Telephone interviews and workshop with members of the Trust Board
- Surveys with GPs (sample group recommended by the Trust)
- Interviews with CCGs (sample group recommended by the Trust)
- Survey and forum with staff
- Survey and forum with service users

Feedback from all participants is incorporated in the SWOT table on page 6.

(b) SWOT

Strengths	Weaknesses
• Good relationships with local media and respond well to media enquiries • Some well-received publications, including *Junction*, the GP newsletter and CEO blog • Positive local sentiment towards North Staffs Combined Health • Widespread awareness of the Combined brand • Established appropriate tone of voice based on openness and accuracy • Widely used and popular intranet • Effective communication between staff and managers	• Ineffective website • Communication is largely reactive • Inconsistent application of branding • Little evaluation of the impact of communications activity • Limited digital communications activity e.g. social media • Communication is largely one way, with infrequent opportunities for meaningful engagement • Insufficient focus on marketing and the promotion of specific services • Not enough is being done to build strong relationships with GPs • Existing communications activity is arguably too 'safe'
Opportunities	**Threats**
• Utilise tools that facilitate two-way communication to generate valuable feedback for stakeholders • Become an information leader for mental health • Build relationships with local GPs that facilitate service improvement • Utilise digital marketing tools to improve the quality of information for service users and reduce costs • Utilise workforce as a source of effective communications content e.g. blogs, videos, images etc • Build a strong visual identity for the Trust that is memorable • Use analytics tools to increase understanding of what works	• Failure to keep pace could see the Trust fall behind • If patients do not receive the information they need they may look elsewhere • If GPs and referrers do not receive the information they need they may refer elsewhere • There is limited capacity to implement required changes • The existing communications budget is insufficient to fund large projects e.g. a new website

Areas highlighted from the audit to be reviewed and improved were:

- Inconsistent application of the Trust brand, which has the potential to be a powerful communications tool
- Minimal proactive communications activity to promote the Trust and its services, resulting in a lack of awareness amongst local people
- An ineffective website that is difficult to navigate, does not provide the necessary information, and represents the brand poorly
- Limited engagement with GPs and referrers aside from the popular GP newsletter

- A basic online presence that does not embrace the potential of search marketing, social media or content marketing
- A focus on one-way rather than two-way communication, which prevents genuine engagement with stakeholders.

Key issues

Whilst the Trust has a number of strengths in terms of communication (e.g. good relationships with the local media and some effective communications tools in place), there are three key issues to address.

1) Better alignment of the communications and engagement activity to the Trust's overall strategic direction and objectives
2) The need to generate a step change in the quality of communications to match the Trust's ambitions of becoming an outstanding health and social care provider.
3) Communication points raised following the CQC inspection in September 2015 on awareness of the Trust's strategic direction and supporting the HR team on staff retention/attraction and improving the culture of the organisation.

To achieve these issues, there will need to be a review of the communications and engagement team structure.

6. Communication objectives

The communication and engagement objectives have been set to support the Trust to deliver its vision and ambitions for 2016/17. They also incorporate a range of improvements to make the necessary step change as outlined above.

Outstanding organisation with high quality services

1. Raise the quality of communication and engagement channels to match the Trust's ambitions set out in its vision and objectives – thereby raising its reputation, aiding staff retention and attracting the best staff.

2. Build and promote a strong profile of the Trust locally and nationally through a new distinctive design style within the NHS brand and compelling narrative to create greater awareness, confidence and relationship with stakeholders particularly people who need the Trust's services.

3. Improve the reputation of the organisation locally, regionally and nationally.

4. Support the Trust to become a national leader in digital technology and for all the stakeholders to understand the benefits and be engaged.

Partnership working and integrated care

5. Strengthen relationships with partners (particularly primary care) and collaborate on promotion of joint developments in integrated care.

Prevention agenda

6. Raise awareness of the Trust's services and how to improve wellbeing across online and offline channels with increasing use of digital media.

Internal communications

7. Involve and inform Trust staff in the vision and the direction of the organisation enabling them to contribute and understand how their roles support the success of the Trust and the impact on our patients.

8. Aim to raise the Trust's staff engagement score year on year by ensuring their views are heard, seeking their feedback, listening, empowering, and responding to make a difference to their working life.

Greater involvement with carers and users of our services

9. Ensure users of our services are involved in the design and development of external communications

Evaluation

10. Evaluate and measure communication performance.

7. Strategic positioning

The Trust positioning in recent years has been as 'a high quality, safe, health and social care provider which serves North Staffordshire and beyond'. This has been based more recently around the work on the Trust's four quality goals of safe, personalised, accessible and recovery-focussed.

With its future now more certain with a strong stable leadership team, its positioning is evolving to be more ambitious – focusing around innovation and working to become a centre of excellence in both integrated and specialist care. This will need to be more clearly defined in a core narrative and design/strapline to enable its population to understand its proposition (or offer) clearly. It will compliment the Trust's main NHS brand which remains one of the most powerful brands in the UK carrying over 95 per cent recognition among the general public.

In line with the Five Year Forward View, the Trust is also positioning itself as a strong partner for collaboration and breaking down the barriers between primary and secondary care, physical and mental health and between health and social care. This can be further strengthened through clearer branding and narrative around 'combined' and its philosophy of working with partners and with the people of North Staffordshire/West Midlands.

8. Audience

All of the audiences that are relevant to the Trust are shown below and Mendelow's power-interest matrix has been used to categorise each stakeholder according to their level of power and interest.

The matrix identifies high priority stakeholders (top right), which should be the focus for communications activity. Broad communication strategies for the remaining groups of stakeholders are also shown e.g. 'keep satisfied'.

High Power – Low Interest (Keep satisfied)	**High Power – High Interest (High priority stakeholders)**
• DH • Professional bodies and Royal Colleges • NHS Employers • Unions • Other regulators and inspectorates • MPs	• GPs • Clinical commissioning groups (CCGs) • People who use our services • Staff and volunteers • Staff side • Members • Service Users and Carers Council • Local authorities (health and wellbeing boards and overview and scrutiny committees) • NHS England, NHS Improvement • Volunteers • NHS partner trusts • Partner agencies • Pan-staffs clinical leads • CQC • Healthwatch and other patient groups
Low Power – Low Interest (Minimal effort)	**Low Power – High Interest (Keep informed)**
• MEPs	• Other voluntary sector organisations

9. Narrative and key messages

A compelling narrative and a series of key messages are essential for consistent communication of the organisation's direction and journey. These will change overtime.

The narrative needs to be worked up as part of this strategy – a number of current core messages are listed below, which will be reviewed on writing the new narrative.

- Our overriding aim is to improve the wellbeing and mental health of our community
- We are committed to providing safe, high quality health and social care services to North Staffordshire and beyond
- Quality is at the heart of everything we do – care must be safe, personalised, accessible and focused on the recovery of all who need our services.
- Our quality themes are driving our ambitions to be a centre of excellence for specialist and joined up care
- We've been through a process of healing, recovery and renewal and continue to be committed to our journey of improvement and to providing outstanding services.
- We are passionate about working together with our community and all of our partners – 'combined' we can support people to live longer happier, healthier lives.

10. Approach – how do we get there?

To achieve the communication objectives, the Trust will adopt a number of approaches.

1) We will develop a strong narrative – 'our story', based around our ambitions, vision, objectives and one/five year plans. This will be accompanied with a video designed with our staff and other key stakeholders, promoted to ensure everyone understands our direction and the role they play. The narrative will be compelling setting out our contribution to the future health and wellbeing of the community.

2) We will establish a strong memorable visual identity (sub brand to the NHS) with brand strategy, reflective of the Trust's goals and positioning, to connect with our community, create a sense of local identity, consistent and professional image and enhance people's relationship and confidence with the Trust in North Staffordshire and beyond.

3) We will plan and deliver proactive integrated communications activity to promote the Trust, its developments and success stories. This will include some core campaigns and impactful digital content to improve the community's wellbeing and awareness of the Trust's services. The focus will be on bringing the Trust to life with video content and stories from patients/people who've been supported through our services.

4) The Trust's social media channels will be reviewed and enhanced. We will encourage conversations and take part in national conversations on mental health and learning disabilities. Secure areas for conversations will be explored for people to share their experiences. We will keep all our stakeholders informed of our journey of improvement and innovation, sustaining and increasing their commitment to the Trust. This together with rolling key messages will be essential for the clear communication of the Trust's ongoing direction. Working relationships with key partners will be enhanced, with increased collaborative working and joint communication strategies to promote work across the local health economy on integration and better coordination of services.

5) An ambassadors' programme will be launched to harness the energy of staff individually and collectively to champion the Trust and the difference it is making to patients.

6) We will build recognition of our values through integrated communications and working with staff to ensure they become 'the way we do things around here' and colleagues are aware of the behaviours expected.

7) We will build and sustain new relationships with people using our services as partners, involving them in co-design, empowering them to self-manage through education and support and encouraging feedback through an increasing number of channels.

8) Perception of the Trust and success of the communications activity will be continually evaluated.

11. Communication channels

The communications environment has been rapidly changing over the last few years, with multiple platforms and an increase in the use of smart phones and tablets. Everyone is introducing conversations and new content in real time via social media.

The Trust needs to understand and adapt to the latest communication trends while at the same time recognising that some colleagues still rely on traditional channels.

According to the recent stakeholder audit, many staff were satisfied with the current level of communications with 46 per cent of the 186 respondents feeling the current level was just right. Many used social media in their personal lives and 30 respondents said they were prepared to work with the communications team on developing the next phase of the Trust's communications. The most useful form of communication channel, they said, was through managers and colleagues and then using the intranet.

Suggestions for improving communications included sharing more department information on the intranet, directorate bulletins, videos, fewer all user emails and more messages via text.

The channels that are currently used are listed below, these will be developed and improved.

Internal

- Intranet
- All staff emails
- Team brief/staff briefings
- Chief Executives blog
- Listening in Action (LiA) news
- Junction quarterly newsletter
- Dear Caroline
- Compliments corner
- Posters and fliers
- National staff survey

External

- Trust website
- Social media – Facebook/Twitter/YouTube
- Stakeholder newsletters (GP/key stakeholders/members)
- Corporate publications (e.g. annual report/quality account)
- Media releases

12. Budget

Some of the activities listed can be achieved within existing resources.

The new approaches will need additional capacity within the communications team to implement and raise the quality of communications across the organisation as well as additional funding for specific projects. These have been prioritised below.

- New visual identity to include rebranded templates
- New website
- Video content – 'our story video', patient stories (some as part of NHS Elect membership)
- Ambassadors programme
- Revision of the communications team structure
- Campaigns
- Enhance social media channels
- GP education programme
- Public/staff magazine
- Community outreach programme
- Communications bespoke training (part of NHS Elect membership)

There are resources implications, some of which will be cost neutral through, for example, the restructure of the directorate. Others will be worked on and appropriate cases developed if required.

13. Evaluation

The effectiveness of the strategy will be measured through feedback from annual staff and patient surveys, media monitoring and evaluation (number, sentiment reach etc), social media analytics and anecdotal feedback from stakeholders. Additional ways to measure success on engagement will be explored including surveys to assess GP opinion

14. Barriers to success

Barrier	Solution
Lack of capacity within the communications team	Reviewing the structure of the communications function and increase capacity, according to available funding. Outsourcing where appropriate, where possible. Utilising the wider workforce where possible. Employing apprentices, students, work experience to supplement existing team.
Skills gap within the communications team in certain specialist areas	Utilise NHS Elect membership for training and support Outsource where appropriate Partner with private sector e.g. for website.
Limited resources	Additional funds to be identified to support communications. Work with partners and sponsors where possible to minimise costs Utilise NHS Elect membership for training and support.
Cultural change required both within the communications team and across the organisation	Communications strategy and implementation plan to be agreed with the communications team. Expectations for creativity and innovation to be stressed. Staff-friendly version of communications plan to be shared with all staff to outline their potential contribution and create ownership.
Out of date technology	Additionals funds to be identified to support communications Work with partners and sponsors where possible to minimise costs.