Council of Governors Meeting

Wednesday 12\textsuperscript{th} March 2014
5.30pm for 6:15pm – 8.30pm

Shropshire Conference Centre
Mytton Oak Road
Shrewsbury
Shropshire
SY3 8XQ
## Council of Governors Meeting of South Staffordshire and Shropshire Healthcare NHS Foundation Trust

**Wednesday 12 March 2014**  
5.30pm – 8.30pm

Shropshire Conference Centre, Mytton Oak Road, Shrewsbury, SY3 8XQ

Members of the public are welcome to observe.

### Agenda

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<th>Time</th>
<th>Item</th>
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<tr>
<td>5.30pm</td>
<td>1. Refreshments</td>
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<tr>
<td>6.15pm</td>
<td>2. Welcome and Apologies</td>
<td>Steve Jones</td>
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<td>6.20pm</td>
<td>3. Minutes of the Council of Governors Meeting/Annual Members Meeting held on 17 December 2013 - to receive and approve the minutes</td>
<td>Steve Jones Enc 1</td>
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<td>6.25pm</td>
<td>4. Matters Arising</td>
<td>Steve Jones</td>
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<td>• Circulation of action plan – CQC Mental Health Survey 2013</td>
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### Items for Discussion or Consultation

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<th>Time</th>
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<tr>
<td>6.30pm</td>
<td>5. Chief Executive Report and Environmental Scan</td>
<td>Neil Carr Enc 2</td>
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<tr>
<td>6.45pm</td>
<td>6. Annual Plan</td>
<td>Steve Grange Enc 3</td>
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<td>7.00pm</td>
<td>7. Snapshots</td>
<td>Lesley Crawford Enc 4 Dr Jurai Darongkamas Enc 5</td>
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<td></td>
<td>• Mental Health Division – Strategic Plan</td>
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<td>• Personality Disorder Strategy</td>
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<td>7.45pm</td>
<td>8. Non-Executive Directors: Presentation: Marina McQuade</td>
<td>Steve Jones</td>
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<td>8.00pm</td>
<td>9. Governor Member Report on Activities, Events and Achievements</td>
<td>Tony Price Enc 6</td>
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<td>To note the range of activities undertaken by Governor Members since the last meeting and receive reports from sub committees for information</td>
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<td>- Non-Executive Director and Governor Engagement</td>
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<td>- Time to Talk Day</td>
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<td>- NHS Change</td>
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<td>- Essential Standards Reviews</td>
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<td>- Governor Handbook</td>
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<td>8.15pm</td>
<td>10. Report of the Nominations Committee To receive the report of the Nominations Committee</td>
<td>Liz Nicholson Enc 7</td>
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<td>8.25pm</td>
<td>11. Any Other Business: Please note: Any other business should be notified to the Chair at the commencement of the meeting. Acceptance of such items on the agenda will be at the discretion of the Chair.</td>
<td>Steve Jones</td>
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<td>8.30pm</td>
<td>12. Close and Date of Next Meeting: 18 June 2014 @ The Learning Centre, St Georges Hospital, Stafford, ST16 3SR</td>
<td>Steve Jones</td>
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Please note: Given sufficient notice, versions of the above papers can be made available in large print, easy read and audio or in other languages.

Declaration (Extract from Constitution)
An elected Governor may not vote at a meeting of the Council of Governors unless, before attending the meeting, they have made a declaration in the form specified by the Secretary of the particulars of their qualification to vote as a member of the Foundation Trust and that they are not prevented from being a member of the Council of Governors. An elected Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors, and every agenda for meetings of the Council of Governors will draw this to the attention of elected Governors.

Items in Closed Session
In accordance with the Council of Governor’s Standing Orders that representatives of the press and other members of the public be excluded from a closed session of the meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest (section (2) Public Bodies (Admission to Meetings Act 1960)
MINUTES OF THE COUNCIL OF GOVERNORS OF SOUTH STAFFORDSHIRE AND SHROPSHIRE HEALTHCARE NHS FOUNDATION TRUST HELD ON TUESDAY 17TH DECEMBER 2013 AT 6.15PM AT THE PARK INN HOTEL, TELFORD

57/13 PRESENT:
Ron Hilton Vice Chair (Non Executive Director)
Michael Allen Public/Service User/Carer Governor (South Staffs)
Karl Bailey Public/Service User Carer (Shropshire)
Ravi Bhakhri Public/Service User/Carer Governor (South Staffs)
Jackie Boyle Public/Service User/Carer Governor (Shropshire)
Mark Cardwell Staff Governor
Frances Carlin Public (South Staffs)
Peter Cross Public/Service User/Carer Governor (South Staffs)
Cllr Arnold England Partner
Jurai Darongkamas Staff Governor (Clinical Support)
Steve Riddle Public/Service User/Carer Governor (South Staffs)
Pauline Pearsall Public/Service User/Carer Governor (South Staffs)
Tony Price Partner/Deputy Chair and Lead Governor
Robin Harvey Public/Service User/Carer Governor (Shropshire)
Monica Hall Public/Service User/Carer Governor (North Staffordshire)
Bridie Oakes-Richards Partner
Enrique Mateu Public/Service User/Carer Governor (South Staffs)
Graham Riley Public/Service User/Carer Governor (Shropshire)
Janet Smith Public/Service User/Carer Governor (Regional/National)
Fran Virden Staff Governor (AHP)
Dave Gill Public/Service User/Carer Governor (Shropshire)
Mac Cock Partner
Lois Dale Public/Service User/Carer Governor (Shropshire)
Lilian Owens Partner

58/13 IN ATTENDANCE:
Neil Carr Chief Executive
Jane Landick Company Secretary
Sue Nixon Non Executive Director
Phoebe Wickens Membership Co-ordinator
Liz Nicholson Non Executive Director
Lesley Crawford Divisional Director (Mental Health)
Ron Hilton Vice Chair (Non Executive Director)
Steve Grange Director of Business Development
Thérèsa Moyes Director of Quality and Clinical Performance
Dr Ian Wilson Non Executive Director
Alison Bussey Director of Nursing/Chief Operating Officer
Jenny Smit Deputy Company Secretary/Membership Manager
Jayne Deaville Director of Finance and Performance
Marina McQuade Non Executive Director
60/13 WELCOME

Ron Hilton opened the meeting by welcoming all Governors, the evening’s speakers and all others present including members, staff, Executive and Non Executive Directors.

61/13 MINUTES

The minutes of the Council of Governors Meeting held on 11th September 2013 were agreed as a true and accurate record of the meeting.

62/13 MATTERS ARISING

The following matters arising were noted:

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<td>8</td>
<td>Consideration of the Quality Governance Framework by the Performance and Assurance Group (PAG)</td>
<td>Tony Price confirmed that was on the PAG forward agenda plan for 2014.</td>
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<td>10</td>
<td>Engagement Group dates for 2014</td>
<td>It was confirmed that these had been circulated.</td>
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The remaining matters arising were deferred pending the arrival of Steve Grange and Lesley Crawford.

63/13 WORKING GROUP ON HOLDING NON EXECUTIVE DIRECTORS TO ACCOUNT

Tony Price summarised the background to project which arose out of legislative changes and outlined the comprehensive process which had been discussed and agreed at the July and September 2013 Council of Governors meetings to ensure wide engagement with governors and executive directors. The resultant matrix of evidence and suggested additional actions were presented, with the first six points
representing the recommended priority actions based on the preferences expressed by governors through the survey questionnaire and feedback from the drop in sessions. Ron Hilton commented that the results of this work demonstrated that there was a lot already in place and that the additional actions identified could be implemented quickly and with high impact. It was noted that the working group intended to review progress after six months. In response to a comment from Lois Dale about the frequency of communicating non executive director activity, it was agreed that the proposed quarterly report format to each Council of Governors meeting gave a good overview of the range of NED activity. Liz Nicholson commented that it was important to note that some NEDs were also still in paid employment and that as such it was important to consider both the quality of their engagement with the Trust as well as the quantity and the value of they brought to the organisation from the other roles they held and this was noted. The Council of Governors received the report and noted the substantial assurance with respect to existing measures in place by which governors can hold non executive directors to account both individually and collectively. The priority areas for action were formally agreed as being the top six items on the matrix and it was agreed to review progress with a report at the June 2014 Council of Governors meeting.

64/13  RON HILTON: VICE CHAIR AND NON EXECUTIVE DIRECTOR

In accordance with the fifth priority for action as per minute reference 63/13, Ron Hilton gave an account of his role and priorities and made the following points:
- Non Executive Director at the Trust for four years
- Vice Chair and Senior Independent Director since the end of Roger Craven’s term of office earlier in 2013.
- Previous working life spent in local authorities, latterly as Chief Executive of Staffordshire County Council.
- Chair of the Human Resources, Organisational Development and Equalities Committee
- Particular interest and focus on empowering people, freeing them up from the system, growing the organization through its staff and the use of LEAN methodologies in achieving this. Also the promotion of role clarity including governor members and non executive directors.

65/13  ENVIRONMENTAL SCAN

Neil Carr briefed the Council of Governors on the following:
- Recent media reports and challenges to the organisation including the case of LF where an elderly patient was injured by another in-patient. Assurances were provided with respect to the timeliness of immediate actions taken to minimise risk and ensure ongoing communication with the family and lessons learned including the timeliness of the completion of serious incident investigations and the establishment of root causes.
- By contrast some positive media attention was noted in the shortlisting of the Trust’s MOD “app” for the prestigious Health Service Journal (HSJ) awards.
- An increasing Care Quality Commission (CQC) inspection focus nationally, with three visits specific to the CQC’s Mental Health Act (MHA) regulatory role having taken place recently within the Trust. Positive feedback was received.
during these visits on staff attitude and service user comments. Emerging themes for the CQC at present related to the usage of the Mental Capacity Act and the Deprivation of Liberty Safeguards (DOLS) specific to informal patients and those lacking capacity. Assurances were given with respect to local action being taken within the Trust to ensure compliance. Pauline Pearsall commented on an excellent training session on this subject provided by Capsticks to Trust staff, which she had attended earlier that day in her capacity as an MHA manager and this view was supported by two of the Non Executive Directors who had also attended.

- The in-patient estate upgrade programme was noted to be focusing on three phases: work to ensure a safe environment with a particular focus on ligature points and the reduction of risk; work to upgrade facilities which were currently functional but not considered to be highly valuing of service users and thirdly environments requiring significant upgrade or replacement to be fit for purpose. It was noted that confirmation of capital spend for 2014/15 required to be reported to Monitor early in the new year and that to this end a meeting had taken place earlier in the day to discuss the priorities and the process which would include consultation with service users and carers, relevant staff in Facilities and Estates and Finance, and with governor members.

- Progress with the implementation of RiO was noted and whilst not a smooth implementation process, through learning from the experiences of other NHS organisations, the project was on track. The national direction of travel towards a patient held record was noted as a future challenge to the NHS and the Trust. Neil Carr advised that Governors needed to be central to assuring the delivery of RiO and continued development of IT resource and capacity to be fit for the future.

- Post closing date, the response rate to the Staff Opinion Survey was noted to be 53% compared with 47% last year and against a top response rate nationally of 56%. The results were anticipated in the new year.

- Responding to a Non Executive Director challenge to reduce sickness absence, Neil Carr advised that it was pleasing to note that the Trust now had one of the lowest rates in the West Midlands, compared with one of the worst rates 12 months ago. The move to the current occupational health provider was highlighted as a significant factor in this achievement.

- With respect to the acquisition of Combined Healthcare, Neil Carr advised that the Trust Development Authority (TDA) had taken a view that greater harmonisation of views was required between commissioners and providers through the development of a business case. To this end the TDA had resolved not to sign off the process before March 2014 and no further progress was therefore likely before then.

In response to a question from Fran Virden about FISH, Neil Carr advised that the initiative originated from the Seattle fish market and represented an approach to enhanced customer care and valuing the customer experience which translated into a focus on values and attitude for staff engaging in the process. He advised that it had been implemented to great effect in the Facilities and Estates Department and commended Jon Meigh for implementing it.

In response to a question from Robin Harvey about who had been engaged in planning the in-patient estate project, Neil Carr advised that the initial meeting had
only taken place that day to establish the three phases and basic principles and that the next steps would include extensive stakeholder engagement including service users and clinicians. Sue Nixon advised that a ‘warm up’ session had already taken place to start to identify those willing and interested in being involved.

Peter Cross made reference to the serious incident on Baswich Ward and to the e-mail he had sent to Neil Carr commending the staff on the ward for their hard work and commitment in difficult circumstances. Neil Carr agreed that the care environment on this ward was a particularly challenging place to work and that the staff had been encouraged by Peter’s comments and support.

In response to a question from Ravi Bhakhri, Neil Carr advised that the information relating to the serious incident referred to above had been shared with governors within an hour of Neil Carr being informed that the story had been picked up by Midlands Today and that prior to this, he had not been aware that the family had wished to escalate the issue. Therèsa Moyes advised that the family had been involved in the serious incident investigation and had asked for two additional issues to be addressed, both of which were covered in the report.

66/13  CQC Community Mental Health Survey 2013

Therèsa Moyes summarised the process and findings of the report which contained both comparisons against the previous year’s survey and benchmark data including national averages and results for the best and other local Trusts. She advises that whilst a good response rate of 41% had been achieved, the Trust did not consider the results to be good enough. It was noted that the increasing usage of Meridian within the Trust enabled real time feedback on the current status of service user satisfaction to be routinely monitored. Lesley Crawford concurred with Therèsa Moyes’ view that the results were disappointing and outlined a number of approaches reflected in the action plan arising from the survey results which included a review of the strategic direction for mental health services and in particular with respect to community mental health teams and crisis resolution. She advised that a series of away days and stakeholder events were planned to explore the principles and values and to canvass suggestions on priorities such as response times, addressing what service users and carers want in terms of seven day access to services, access to talking therapies, throughput, recovery and co-production. She advised that work was also taking place surrounding care planning and risk assessment as linked projects. A challenge had also been made to team to achieve 30 responses per month to the Meridian surveys to monitor the impacts of service changes and improvement to service user satisfaction and qualitative feedback. In response to a comment from Lois Dale about mental health workers turning up at convenient times of day for service users, Lesley Crawford agreed that consideration of such issues often made a real difference. Jackie Boyle commented on the problematic wording of question 43, but also to the adverse impacts of accommodation issues on the mental health of individuals and the importance of addressing all the needs of service users in a holistic way. Lesley Crawford agreed that a multi-agency approach was essential and that the Trust continued to work with local authority colleagues to achieve this, but also agreed with Neil Carr that social care spending cuts were likely to make this more
difficult into the future, given the additional knock-on impacts to third sector provision. Lesley Crawford noted that the Trust was one of the worst performing Trusts with respect to length of stay as a direct consequence of the policy of not discharging service users until suitable accommodation had been identified. Monica Hall commented on the absence of questions relating to access to creative arts but noted that the questions were pre-set nationally and that it was not under the control of the Trust to add to or alter them. Robin Harvey referred to question 44 and the current anxieties of service users with respect to benefits and proposed changes. Lesley Crawford agreed that mental health workers should both have a basic knowledge of benefits and a range of expertise across the team but more importantly should be willing and able to support and signpost service users to access the information and advice they required with respect to both accommodation and employment. In response to a question from Robin Harvey with respect to the low scores for questions 38 and 40, Lesley Crawford advised that both areas were reflected as a key focus of the action plan. Thérèsa Moyes added that these issues were also the subject of discussion with commissioners to explore opportunities to address the holistic care needs of service users through shared care pathways. Neil Carr also referred to the work surrounding the report “The Abandoned Illness” relating to addressing the physical healthcare needs of service users and the selection of the Trust as a pilot site for this work and a further project around peer recovery. Lesley Crawford agreed to circulate details of the action plan outlined work completed to date and planned for 2014.

**Action:** Circulation of Action Plan (Membership Office)

**67/13  GOVERNOR MEMBER REPORT**

The minor amendments to the protocol on communication with Monitor and the Care Quality Commission were approved and the reports on events and activities attended by governors was noted. Tony Price thanked Steve Riddle for organizing the T-shirt competition and congratulated Fran Virden for designing the winning entry. Pauline Pearsall summarized the selection process to select the purchaser and developer of the Shelton site and added that she had valued the opportunity to be involved. She confirmed that it had been a robust process and that the decision was the right one in that the company selected had demonstrated sensitivity with respect to the needs of service users and carers of the Trust and to local residents.

Tony Price referred to the proposed action plan arising from the Council of Governors appraisal and self assessment which was agreed. He advised that the draft compact reflecting the shared and individual responsibilities of governors and the Trust, which had also been reflected in the work on holding Non Executive Directors to account, would be reviewed by the Steering Group in February prior to agreement and implementation. Fran Virden referred to a successful Allied Health Professional Best Practice Day in November 2013 at which Neil Carr had been welcomed as the keynote speaker. She advised that the Healthcare Professions Council Lead Officer had formally thanked Neil Carr for his contribution in his absence as he had had to leave following his presentation.

The summary report on the Governwell Governor Training event attended by Enrique Mateu and Fran Virden was noted. Fran Virden advised that three
examples of the practice in other Trusts was highlighted although one had been omitted from the report relating the minutes of Council of Governors meetings being taken by an official minute taker rather than the Company Secretary. Tony Price commented that the Governwell Training dates for 2014 had been circulated and encouraged Governors to take advantage of these training opportunities.

Tony Price summarized the Performance and Assurance Group (PAG) meeting held on 29th November 2013, which had continued the focus on the Trust response to the Francis recommendations. Discussion had also taken place on the Daily Mail article on death rates and Neil Carr’s prompt and clear response to this had been commended. Tony Price advised that at its February 2014 meeting, the PAG would be resurrecting the practice of setting the Chief Executive an objective for 2014. Tony Price concluded his report by wishing Steve Jones well during his current absence from work, thanking governors for their amazing contribution during 2013 and wishing everyone a good Christmas and new year.

68/13 MATTERS ARISING

a) Right Service, Right Place Update: Steve Grange advised that local project teams had been established and that at a meeting that day, a scoping exercise had been completed to agree assumptions and high level priorities. A steering group would be established in January 2014 involving governors already identified to be involved in this work. In response to a question from Jackie Boyle, Steve Grange clarified that whilst the two projects relating to the community and in-patient estates were separate, that they were linked and would be aligned to ensure economies of scale and co-ordination of the two projects.

b) Autism Update: Lesley Crawford summarised progress made in engaging with commissioners in Shropshire to identify and agreed gaps in services and the needs. This has resulted in a draft service model developed by Jane Hambleton being presented to commissioners and training community mental health team members to a basic level to enable them to work with services users with Autism.

c) Castle Lodge: Fran Virden advised that she had hoped to bring a service user to the meeting but that this had not been possible. Lesley Crawford advised that she would be happy to speak to this person at another time. Lesley Crawford advised that discussions had taken place with commissioners agreement reached that a wide range of stakeholder meetings involving service users and carers would be taking place across the whole pathway of mental health care from primary healthcare services to psychiatric intensive care, to determine whether the services of Castle Lodge were needed in the pathway. Recognising that the temporary closure was agreed for six months, these meeting would be set up to commence in January 2014 in order that a report was completed by March 2014 to comply with the original timescale. Councillor England expressed his thanks to Neil Carr and Lesley Crawford for their approach to meeting with key local authority colleagues and working to manage change effectively in partnership through a constructive engagement process.
a) **Community Development Workers (CDW):** Dave Gill asked how the decision was made to reduce the numbers of CDWs in Telford and Wrekin from 3 to 2. Lesley Crawford advised that six months ago, the CCG had asked for suggestions for quick savings in light of a significant funding shortfall but that despite the Trust not having put this forward as a proposal, the CCG had advised that this was something they wished to pursue. In response to a further comment from Dave Gill, Lesley Crawford agreed that opportunities should be explored to safeguard this important work including exploration of funding from the non statutory sector and collaborative approaches to partnership working across the wider remit of care pathways and integrated care, into the future. Lilian Owen commented that the CDWs attended forum meetings as did CCG representatives, but that this had not been raised or discussed and that an opportunity appeared to have been lost to discuss and address this at an early stage.

**70/13 DATE OF NEXT MEETING**

Wednesday 12 March 2014, Shropshire Conference Centre, Shrewsbury.

**71/13 NOMINATIONS COMMITTEE**

All those with the exception of Governor Members and the Deputy Company Secretary left the meeting.

Liz Nicholson summarised the report of the Nominations Committee and the process which had been followed to appoint Saxton Bampfylde to manage the recruitment and selection process and as part of this to engage stakeholders in expressing views on the attributes that would be required of the new Chair of the Trust. Tony Price advised that governors would be further involved in the selection process as part of the stakeholder groups who would be meeting with the shortlisted candidates. In response to a question from Graham Riley about how the governors for the stakeholder groups would be selected, Liz Nicholson advised that this had not been agreed, but would be addressed by the Nominations Committee. Peter Cross commented that he had met with Ann Bourne and that he was confident they would be able to deliver a strong field of candidates. Lois Dale recommended that the views of candidates with respect to rural communities should be covered as part of the stakeholder panels. In response to a question from Mac Cock about ensuring questions relating to carers needs were covered, Liz Nicholson advised that she would welcome any suggestions from governors on areas to be covered as would either Jane Landick or Tony Price. The Council of Governors received and noted the minutes of the Nominations Committee held on 29th October 2013 and 26th November 2013 and agreed the process to refine the role description and person specification to meet the needs of the Trust and attract candidates who represent a fit with the Trust values and aims. The Council of Governors also ratified the recommendation of the Nominations Committee with respect to the appointment of Saxton Bampfylde to conduct and support a robust
and transparent process to recruit a Chairman to replace Steve Jones from 1st July 2014 on behalf the Trust.
To:                  Council of Governors  
Date:                Wednesday 12th March 2014  
From:                Neil Carr, Chief Executive  
Subject:             Chief Executive Report and Environmental Scan

Executive Summary
The objectives of the report are to:-
• Scan the fast changing environment in which our NHS Foundation Trust operates
• Consider this from a range of perspectives
• Focus on new vital issues and encourage focused and strategic discussion
• Help stimulate all Council of Governors members to raise issues
• Encourage the Council of Governors to share intelligence, place action or seek assurance
• Ensure effective internal governance of issues discussed through sub committees

Recommendations
The Council of Governors is asked to:
• Receive and note the report
Chief Executive’s Report

February 2014

Neil Carr
Chief Executive
OVERVIEW OF THE REPORT

The objectives of the report are to:-
- Scan the fast changing environment in which our NHS Foundation Trust operates
- Focus on new vital issues and encourage focussed and strategic discussion
- Encourage the Council to share intelligence, place action or seek assurance
- Ensure effective internal governance of issues discussed through sub committees
- List policies for ratification by the Council and provide assurance of a robust consultation and approval process.

CONTENTS

1. Our strategy
2. New national guidance and reports
3. Our current priorities
4. Horizon scan
   - Quality
   - Staff, teams and culture
   - Partnerships
   - Commercial Development
   - Regulation
5. Key Opportunities / Risks
   - Strategic opportunities
   - Political issues of direct relevance
   - Area of particular success
6. Strategic Projects and key dates and events
1. OUR STRATEGY

“To be positively different through positive practice and positive partnerships”

INTENT

Provide demonstrable excellence in existing and new services through evidence based best practice that makes a positive difference

VALUES

1. People who use our services are at the centre of everything we do
2. We value our staff
3. Our partnerships are important to us

AIMS

1. Quality
   Provide high quality services built on best practice and evaluated through service user and carer feedback and clear progress and outcome measures

2. Staff, teams and culture:
   Development of teams and individuals who promote and deliver excellence across all of our services

3. Partnerships
   Review, create and strengthen strategic alliances in order to shape and influence existing and new service innovation

4. Business, growth and innovation
   To expand our current service portfolio in order to sustain services, establish new portfolios and remain competitive

5. Assurance
   To deliver all regulatory, financial, performance, quality standards and compliance indicators
2. NEW NATIONAL GUIDANCE, REPORTS

The following documents and reports are placed with Executive Leads for decisions on whether any actions are required for follow up or consideration by Board Sub Committees.

2.1 Guidance and Reports

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<tr>
<td>2.1.1</td>
<td>Royal College of Nursing (RCN) - The triangle of care - carers included: a guide to best practice for dementia care.</td>
<td>Guidance</td>
<td>Alison Bussey</td>
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<td>2.1.2</td>
<td>Foundation Trust Governors' Association (FTGA) - NHS finance - the fundamentals post 2012 reforms.</td>
<td>Briefing</td>
<td>Neil Carr</td>
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<td>2.1.3</td>
<td>Department of Health - Closing the gap: priorities for essential change in mental health.</td>
<td>Guidance</td>
<td>Alison Bussey</td>
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<td>2.1.4</td>
<td>Department of Health - Psychological wellbeing and work: improving service provision and outcomes.</td>
<td>Report</td>
<td>Alison Bussey</td>
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<td>2.1.5</td>
<td>NHS Clinical Commissioners - Taking the lead: how clinical commissioning groups are changing the face of the NHS.</td>
<td>Report</td>
<td>Thérèsa Moyes</td>
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<td>2.1.6</td>
<td>National Institute for Health and Care Excellence (NICE) - Autism quality standard.</td>
<td>Quality standard</td>
<td>Alison Bussey</td>
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England and this quality standard is designed to standardise and improve the care and management of autism. It covers autism in children, young people and adults, including both health and social care services.

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<td>2.1.7</td>
<td>Care Quality Commission (CQC) - <em>Monitoring the Mental Health Act in 2012/13</em>. This annual report into the use of the Mental Health Act provides an insight into the experiences of patients who received care under the act throughout 2012/13. It highlights five key areas which CQC will examine following the results of this report: community care; reporting on death; emergency and mental health crisis; involving people who use services; and investigating complaints relating to the use of the Mental Health Act.</td>
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<tr>
<td>2.1.8</td>
<td>NHS Confederation - <em>Mental health: the key facts and trends</em>. The factsheet gives an overview of the major trends and challenges facing mental health services today. Compiled from a wide range of sources, the factsheet sets out data in a range of areas relating to investment in services trends in morbidity; suicide and homicide rates; service activity; use of mental health legislation; mental health of children and young people; service user experience; inequalities experienced by people with mental health problems; and workforce and staff satisfaction.</td>
</tr>
<tr>
<td>2.1.9</td>
<td>Department of Health - <em>Preventing suicide in England: one year on first annual report on the cross-government outcomes strategy to save lives</em>. This report summarises the developments on the suicide prevention strategy for England at national level. It identifies key research studies and their findings, and is accompanied by a report of statistical information on suicides. It sets out the key initiatives that local areas can take to prevent suicides. It also highlights the importance of responsive and high quality care for people who self-harm.</td>
</tr>
<tr>
<td>2.1.10</td>
<td>NHS England - <em>Guidance published on safe compassionate care for frail older people</em> - Report offers practical guidance and evidence on the effects of an integrated pathway of care for frail older people. The document also suggests how a pathway can be commissioned effectively using levers and incentives across providers</td>
</tr>
<tr>
<td>2.1.11</td>
<td>NHS England - <em>Quality Accounts reporting arrangements for 2013/14</em> - NHS England has provided details of reporting requirements for Quality Accounts 2013/14. <a href="#">This letter</a> provides guidance on the information and indicators to be included, who Quality Accounts should be shared with, how organisations’ Quality Accounts should be published and how to access the indicator data. Quality Accounts are reports about the quality of services by an NHS healthcare provider, made available to the public.</td>
</tr>
</tbody>
</table>
### 2.2 Consultations

<table>
<thead>
<tr>
<th>No.</th>
<th>Document</th>
<th>Hyperlink</th>
<th>Closing Date</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2.1</td>
<td>Introducing fundamental standards - consultation on proposals to change CQC registration regulations. This consultation asks for views on changes to CQC registration requirements, in order to introduce fundamental standards of safety and quality for care.</td>
<td>Consultation</td>
<td>4 April 2014</td>
<td>Thérèsa Moyes</td>
</tr>
</tbody>
</table>
3. OUR CURRENT PRIORITIES

The priorities listed below are gathered from all of the Divisions and our collective corporate view. These represent what the organisation has as current in year priorities that support the development of the longer term strategy.

Strategic Aims – Our Care Commitment

Our key strategic aims include our commitment to;

- Provide care based on the holistic principles of recovery that recognises all aspects of recovery, including the physical care needs of those with mental health problems or learning disabilities
- Promote and achieve recovery, improving the health and well-being of our service users and carers at all times
- Allow service users to see how they can contribute their views and experience and how this influences service development
- Ensure our working culture is one where service users are respected, not judged and there is a belief in the capacity of change and wider social inclusion
- Ensure our organisational structure is based on evidenced workforce competencies, with innovative and flexible learning and development opportunities open to all staff, governors, members and volunteers
- Ensure services proactively work with commissioners and local stakeholders to ensure that we deliver in line with local priorities that are responsive to emerging agendas
- Promote a culture of learning where innovation and service development is encouraged, shared and where appropriate incorporated into service delivery
- Explore potential partnership and alliance opportunities to support service users in their journey to recovery
- Continue to operate within stringent regulatory and financial boundaries to ensure risk is actively and appropriately managed.

These aims will be delivered through a range of enabling actions and strategies including;

**Corporate**

- The deployment of a new clinical information system (Rio)
- The deployment of LEAN methodologies to enhance quality and empower the workforce
- The deployment of a Workforce Development Strategy including new ways of working and innovative ways to support training and education
- The deployment of a Medicines Optimisation Strategy
- The deployment of a central OD Strategy
- The establishment of an effective partnership with Primary care to deliver Dementia services across Staffordshire
- The deployment of the Estates Strategy including “Right Service, Right Place”

**Specialist Services Division**

- To enhance the range of forensic mental health and criminal justice provision, including greater working partnerships with Probation Trusts for prisoners with
personality disorders

• To continue to grow niche markets nationally such as IAPT services
• To support the development and the creation of harmonised Children’s Service provision across Shropshire, Telford & Wrekin, North and South Staffordshire, including the development of sustainable CAMHS T3, T3+ and T4 provision
• To support the development and the creation of harmonised Drug & Alcohol Service provision across Shropshire, Telford & Wrekin, North and South Staffordshire
• To support the development and the creation of harmonised Learning Disability services across Shropshire, Telford & Wrekin, North and South Staffordshire, including the development of Intensive Support Services

Mental Health Division

• To develop and enhance our local service offer including the development of a South Staffordshire & Shropshire IAPT service, enhanced PICU provision for Shropshire residents, and delivery of local substance misuse community services across Staffordshire
• To develop sophisticated partnerships with Primary Care to support integrated Dementia services across South Staffordshire
• To agree a revised Section 75 agreement in South Staffordshire, potentially including the Local Authority MH placement budget

Facilities and Estates Directorate

• To create an environment that contributes to holistic care and supports recovery
• To align accommodation to the requirements of clinical practice and organisational strategy, and to reflect value for money
• To continue to enable the Trust to meet its responsibilities as a good corporate citizen
• To continue to maintain and develop Shared Services Contracts

Colleagues will note that the above strategic aims reflect and resonate with the NHS Mandate. Our Strategy and aims are currently being reviewed in light of the mandate and its contents. These have been discussed with colleagues and will be reflected in our new strategy and Monitor Annual Plan.
### 4. HORIZON SCAN

**Performance on a page**

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monitor Compliance ratings</strong></td>
</tr>
<tr>
<td>Gov: GREEN</td>
</tr>
<tr>
<td>Finance: 5</td>
</tr>
<tr>
<td><strong>CQC compliance positions and rating</strong></td>
</tr>
<tr>
<td>Rating: GREEN</td>
</tr>
<tr>
<td><strong>Contract targets</strong></td>
</tr>
<tr>
<td>Performance against activity overall on target</td>
</tr>
<tr>
<td><strong>CIP position</strong></td>
</tr>
<tr>
<td>On target</td>
</tr>
<tr>
<td><strong>Membership</strong></td>
</tr>
<tr>
<td>The Trust has 15063 Members</td>
</tr>
<tr>
<td><strong>Sickness Absence rates</strong></td>
</tr>
<tr>
<td>On target: Steady reduction in sickness</td>
</tr>
</tbody>
</table>

![Risk ratings at a glance](image)
### Quality
- Refreshing our strategy and reflecting the NHS Mandate
- CQC inspection regime and focus on Quality
- Divisional business plans and plans for the future linked to our vision
- External and internal changes to inspection regimes
- Modernisation of inpatient and community estate
- Deployment of the VMPS system into clinical areas
- LEAN programme management and deployment of projects

### Staff, Teams and Culture
- Staff Opinion Survey – initial findings
- Leadership Development Programmes – reviewed and refreshed in line with senior leaders
- LEAN Training deployment - certified leader training and assessments
- Equality and diversity agenda, strategy and deployment
- Sickness absence performance
- NHS leadership schemes embedded and deployed locally
- Staff Compact - development and engagement programme (VMPS)

### Partnerships
- Development of integrated care models across a number of providers and sectors including the development of bespoke networks and prime contracting models.
- Lead provider model being explored locally to support CCGs and local commissioners
- Blue Light partnership formed with local prisons and local police and fire services.
- Partnership with Royal College of Psychiatrists on strategic developments
- Partnerships with local Universities on supporting local charities (Telford)
- Development of preferred providers for specific services

### Commercial Development
- Commercial profiling and new strategy in place and being deployed
- Tenders and competitive procurement (x15)
- Local Drug and Alcohol, IAPT and Autistic Spectrum Disorder provision and reviews
- Dementia pathway development and implementation including economic evaluation
- Learning Disabilities repatriation and prime contractor modelling
- Monitor role in acquisitions and competition processes including recent consultation
Strategic Opportunities

Future opportunities and large scale acquisitions including the establishment of prime contractor relationships to support economies of scale and higher quality standards

Development of network of providers for the delivery of
- Dementia
- Drug and Alcohol Services
- Learning Disabilities
- Special Skills Nursing
- CAMHS services including T2/3/3+/4
- Trauma based therapies
- Prison services
- IAPT provision
- Forensic services

Political issues of relevance

Mental Health Single point of access – national drivers

Mental Health Tariff deflator – challenges

Community services development of a national tariff and set of indicators

Monitor suspension of FT Pipeline

CCG Local pricing structure – national challenge

NHS England Alert System – development of a national system to alert about patient safety risks

Areas of particular success - Ministerial Visit

On 6 February we had the pleasure of hosting the Secretary of State for Health, Jeremy Hunt, to the Redwoods Centre. The visit was of around 2 ½ hours long and after being welcomed by the Deputy CEO Jayne Deaville and Director for Quality and Improvement Theresa Moyes, the SoS took the time to visit Laurel Ward to talk to service users and staff, whilst acting as a health care assistant. He also escorted a patient to the physiotherapy gym in the main Wenlock building and watched normal every day occupational therapy activities. At the same time his Private Secretary spent a happy hour as a domestic, washing up on Pine Ward, where his technique was described as satisfactory.

The visit concluded with a round table discussion with a mixture of staff, also attended by the local Shrewsbury and Atcham MP Daniel Kawczynski. The SoS was genuinely taken aback by the quality of the Redwoods environment and both he and the local MP were hugely impressed by the genuine care and enthusiasm of our staff. It was an informed and honest discussion of issues surrounding mental health provision and the SoS was keen to learn where he could best support frontline staff.

It was apt that the visit coincided with the national ‘time to talk campaign’ which was raising awareness of mental health issues. This was also recognized by the local MP in his weekly Shropshire newspaper column and on social media. Our staff were described as ‘outstanding’ and local mental health treatment as ‘first class’. The fact that the SoS visited the Redwoods Centre is recognition that our excellent services, working/caring environment and staff ability are positively on the national register.
• **The Official Opening of The Redwoods Centre**  
The planned date for the official opening of the Redwoods Centre is set for the 12\textsuperscript{th} March 2014.  
The day will be a significant celebration in the development of the new hospital and will showcase our approach to supporting modern Mental Health and Learning Disabilities services.

- **World Mental Health Day**  
The next World Mental Health Day will take place on 10 October 2014. Each year around World Mental Health Day the Mental Health Foundation try raise awareness about a particular aspect of mental health. This is prior notice of the day, something which the Trust fully supports. World Mental Health Day will focus on Living with Schizophrenia. Trust activity will be monitored and reported by the Service User and Carer Sub Committee.

- **Time to Talk Day**  
Thursday 6 February was the first ever Time to Talk Day: 24 hours in which people started conversations about mental health, raised awareness and shared the message that mental illness is nothing to be ashamed of, neither is talking about it.

  Sometimes it's the little things we do that make a big difference - like having a chat over a cuppa, sending a text or inviting someone out. And on Time to Talk Day we encouraged people to do just that. In fact, we hope to have sparked a million conversations.

  *The Trust and its partners supported “Time to Talk”. Governors joined Quest, Stafford FM and South Staffs Mental Health Network at Asda in Stafford where over 400 conversations were had! Inpatient areas all received literature and Time to Talk tea bags and the Songs for You event in Shropshire, with Arts for Health also supported the day.*

  **Time to Talk Day is over. What can I do now?**

  There is still a lot to do to spread the #TimetoTalk message. Are you online? Spread the message, there are lots of [images and links to share](#), tweet us about what you got up to on 6 February, and keep up to date on our latest advertising campaign.

  And celebrities are getting involved! Find out how you can [have a conversation to win a conversation](#) with Russell Kane, Ashley Roberts or Beverley Callard.
About Monitor

Monitor is the sector regulator for health services in England. Our job is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit.

We exercise a range of powers granted by Parliament which include setting and enforcing a framework of rules for providers and commissioners, implemented in part through licences we issue to NHS-funded providers.
Executive summary

Introduction

Rising health care demand, rising costs and flat real funding mean the NHS could face an estimated £30 billion financial shortfall by 2021\(^1\). We have worked with our national partners NHS England and the NHS Trust Development Authority to estimate the development of this unprecedented “affordability challenge” and understand how we can help the health care system to respond. Forthcoming changes to pensions and the planned pooling of some NHS spending with local authorities in 2015/16 through the Better Care Fund (previously known as the Integration Transformation Fund) are likely to bring the affordability challenge to an unprecedented peak in 2015/16.

Foundation trusts are already making enormous efforts to meet the affordability challenge, for example, through Quality, Innovation, Productivity and Prevention (QIPP) and Cost Improvement Programmes (CIPs). But our recent research\(^2\) makes it clear that foundation trusts will have to do more than just improve the productivity within existing service configurations at individual providers to meet future NHS efficiency requirements. To be confident of providing high quality care for patients on a sustainable basis, foundation trusts need to work with commissioners to transform the way they deliver services across the system (through measures identified at a national and a local level).

According to the findings of our research, delivering the right care in the right setting and developing new ways to deliver high quality care are the two main opportunities for transformational change available to foundation trusts. From this perspective, the Better Care Fund also represents an opportunity for local health economy (LHE) partners to work together on delivering this transformational change. Successfully meeting the affordability challenge will depend on excellent and co-ordinated strategic planning.

However, Monitor’s recent review of strategic planning at foundation trusts concludes that there are significant opportunities to improve strategic planning at the majority of foundation trusts\(^3\).

Monitor considers at a minimum, the following steps are required to develop a robust strategic plan:

\(^1\) see Monitor’s report Closing the NHS funding gap: how to get better value health care for patients available at http://www.monitor.gov.uk/closingthegap

\(^2\) see Monitor’s report Closing the NHS funding gap: how to get better value health care for patients available at http://www.monitor.gov.uk/closingthegap

\(^3\) see Meeting the needs of patients: Improving strategic planning in NHS foundation trusts, available at http://www.monitor-nhsft.gov.uk/information-nhs-foundation-trusts/planning-and-reporting-processes/annual-planning
• put in place a robust planning process and, in particular, ensure sufficient and appropriate engagement with the key stakeholders within the Local Health Economy (LHE);

• assess the risks to sustainability of high quality services in conjunction with LHE stakeholders by drawing on accurate inputs that have been analysed and presented correctly;

• assess the options available to address the identified sustainability risks in conjunction with LHE stakeholders and make choices on which option(s) are most appropriate;

• define a vision for sustainability and develop the key initiatives which underpin this, where appropriate in conjunction with LHE stakeholders; and

• set out a plan for delivery including financial projections which are internally consistent and based on credible assumptions.

While Monitor does not intend to be prescriptive about the content of individual foundation trust strategic plans, our review seeks to understand the work that foundation trusts have undertaken against each area above. We will also expect plans to outline how, when implemented, they result in the delivery of high quality care for patients on a sustainable basis.

Many of the resulting strategic initiatives, such as service redesign and cross cutting enablers, will need to be developed and implemented at an LHE level. In response, we are therefore calling for an iterative process of engagement by foundation trusts with their LHE partners. We consider this engagement to be central to the development of a robust strategic plan.

We recognise that meeting these expectations will take considerable board attention at foundation trusts. We also understand that day-to-day pressures make it hard for boards to treat strengthening strategic planning as a priority. However, improving planning is an essential first step towards transforming services, a goal that NHS foundation trusts have to achieve if they are to continue to provide high quality care to NHS patients for years to come. This is why supporting the sector to improve strategic planning is one of Monitor’s own strategic initiatives for 2014/15.

Key changes to the 2014/15 Annual Planning Review

As part of this initiative, we have upgraded Monitor’s annual planning review process to focus more closely on the strategic element of plans and to understand how foundation trusts intend to address the unique challenges in 2015/16 from both an operational and strategic point of view.

As set out with NHS England and the NHS Trust Development Authority in our joint letter on 4 November, we are making the following key changes:
Monitor will work with NHS England and the NHS Trust Development Authority to reconcile key commissioner and provider planning assumptions to highlight any LHEs where there are major planning divergences; and

Monitor will divide its annual plan review into two distinct phases, the first focused on operational planning, and the second focused exclusively on strategic planning.

**Phase 1 – Submission 4 April 2014 – Monitor review April to May 2014**

The first phase of the Monitor review will assess the strength of foundation trusts’ operational plans to address the two-year short-term challenge to 2015/16. During this phase, we will require two year supporting financial projections and we will seek to understand the degree to which foundation trusts have started planning for, and have already begun implementing, transformational initiatives.

**Phase 2 – Submission 30 June 2014 – Monitor review July to September 2014**

The second phase of the Monitor review will focus on the robustness of foundation trusts’ strategies to deliver high quality patient care on a sustainable basis. During this phase, we will ask foundation trusts to present five year financial projections and we will particularly focus on the degree to which each foundation trust has developed realistic transformational schemes and aligned its plans with those of other actors within the LHE.

**The outcome of our reviews**

Monitor will provide initial feedback to foundation trusts following the first phase review (May 2014) and final feedback will be provided on completion of the second phase review (October 2014).

Monitor is working closely with both NHS England and the NHS Trust Development Authority to ensure that foundation trust plans can deliver high quality sustainable services across LHEs, and that the actions of any organisation does not generate behaviours that work against patients’ interests.

Where we identify any significant weakness in planning, or we judge that a foundation trust is not adequately addressing risks to its stability or sustainability, we will take appropriate regulatory action. For the first time, this could include requiring a foundation trust to resubmit its plan.

**Purpose of this guidance**

This following guidance sets out more detail on each of the areas discussed above and other aspects of the 2014/15 planning round. We would like in particular to draw readers’ attention to Section 1, which sets out the planning assumptions for the
2014/15 planning round (including the expected tariff efficiency factor) and how we have reached them, and Section 7, which contains a self-assessment tool to help support strategic planning at foundation trusts. We strongly recommend foundation trusts to use the tool as part of its process to develop its 2014/15 plans.
Contents and document outline

This document is Monitor’s guidance on the 2014/15 planning round. This guidance covers Monitor’s expectations for foundation trusts and sets out details of our forthcoming Annual Planning Review (APR) process. The sections included in this guidance are outlined below.

**Section 1 – Planning assumptions** 7

This section aims to provide the sector with more certainty about the scale and make-up of the challenge facing the delivery of high quality, sustainable care for patients.

**Section 2 – Overview of the 2014/15 APR process** 14

This section describes the two phases of the APR process in 2014/15, the type of feedback Monitor intends to give.

**Section 3 – Practical guidance on APR 2014/15** 19

This section provides practical guidance on key submissions and matters which relate to both phases of the APR review.

**Section 4 – Operational plan guidance** 22

This section sets out the format of the operational plan and provides guidance on the areas that Monitor would typically expect the document to cover.

**Section 5 – Strategic plan guidance** 26

This section sets out the key elements of the strategic plan and provides guidance on the areas that Monitor would typically expect the strategic plan to cover.

**Section 6 – Other matters to consider** 30

This section contains a summary of a number of important other matters which foundation trusts should bear in mind when completing their plans.

**Section 7 – Self assessment tool** 33

This section contains a self-assessment tool that has been developed to support Boards and Executive teams at foundation trusts. The tool can be used to rapidly evaluate the robustness of the strategic planning at a foundation trust.
1 Planning assumptions

1.1 Section overview

This guidance aims to provide the sector with more certainty over the scale and nature of the challenge to delivering high quality care for patients on a sustainable basis. Understanding this challenge is critical to robust strategic planning.

1.2 Introduction

When developing plans, commissioners and providers must factor in assumptions about how fast costs, demand and commissioning budgets will rise. If the rate of growth in costs and demand is greater than budgets, then they must work out how they can respond while improving quality of care.

We have worked with our national partners the NHS Trust Development Authority and NHS England to develop assumptions on the rates of cost, demand and budget growth, which together we call the "affordability challenge". These assumptions show that the gap between budgets and projected pressures will rise to an unprecedented level over the next five years.

This means that even with continued tight control of pay and prices across the sector, delivering better patient care will require plans which:

- deliver greater gains in the efficiency of individual providers through redesign of individual patient services; and
- make a step change in the efficiency of the system as a whole by completely redesigning care pathways to transform care quality outside of hospitals.

We have also developed assumptions on this efficiency opportunity.

These planning assumptions presented in this section are intended for commissioners and providers to use when working together to develop credible strategic plans which consistently raise the quality of patient care over the next five years.

1.3 The Affordability Challenge

Every year, pressures on the NHS grow. As the population grows and ages, we have more frail elderly and a greater incidence of chronic disease requiring different patterns of care. Innovations in medicine continue to transform what it is possible for the NHS to provide beyond the expectations of previous generations. And the public rightly expects ever higher standards of safety, quality and access.

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4 Including acute, mental health, community and primary care providers.
In estimating the scale of the challenge, we have therefore considered the path of likely input cost inflation (pay and procurement), activity growth, known policy commitments, and the overall NHS budget settlement. For all these factors, the numbers reflect our views and those of our national partners, the NHS Trust Development Authority and NHS England.

Allowing for these pressures suggests that, even with extremely tight control of pay and prices from the centre, the “affordability challenge” for the NHS over the next five years will be unprecedented, as shown in Table 1 below. If input costs rise more quickly than shown in Table 1, or unfunded new policy commitments are made, the scale of the affordability challenge for local NHS organisations would increase still further.

Table 1: the total affordability challenge

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<tbody>
<tr>
<td>Affordability challenge for NHS as a % of current commissioning budgets</td>
<td>3.1%</td>
<td>6.6%</td>
<td>5.5%</td>
<td>4.7%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Assumption on input cost inflation</td>
<td>2.6%(^1)</td>
<td>2.9%</td>
<td>4.4%</td>
<td>3.4%</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

The total affordability challenge is greater in 2015/16 and 2016/17 than in other years. A key driver of this is the estimated cost of changes to pensions in 2015/16 and 2016/17, 0.7% and 1.4% of budget respectively. The assumed 0.7% pensions pressure for 2015-16 arises from the revaluation of public sector pension contributions and the assumed 1.4% pension pressure for 2016-17 arises from reforms to the state pension. These are predominately cost pressures for providers and assumed to be funded through tariff. The 1.4% in 2016-17 is however currently an estimate and in practice NHS England and Monitor will need to discuss with central government closer to the time the exact amount of funding pressure that will need to be met by the NHS and any funding arrangements to meet this pressure. The Better Care Fund will also impact on commissioner budgets in 2015/16, but this presents the NHS with an unprecedented opportunity to transform the quality of patient care outside of hospitals, preventing distressing and costly emergency hospital admissions and integrating care more closely around the needs of individual patients.

1.4 The efficiency opportunity

Over recent years, whilst productivity in the wider economy has struggled to recover from the shock of 2007/08, NHS productivity has continued to rise. This is a real achievement of which the NHS should be proud.

\(^1\) This is a blended uplift of acute and non-acute input cost inflation, including the average impact of the CNST uplift and pensions costs. These inflation assumptions may vary from other industry sources.
But to meet the affordability challenge shown in Table 1, the sector needs to know where to look for efficiency gains. To help the NHS to plan to redesign services for patients in response to this challenge, we have assessed the evidence of where those gains might lie and we want to have an open debate about the balance of opportunity between:

- redesigning and improving patient services in **individual providers** to improve quality and efficiency, through, for example, shorter lengths of stay;
- redesigning care pathways to transform how patient care is provided across the **system** and reduce unnecessary emergency admissions, improving quality and efficiency; and
- **further measures** which commissioners and providers can undertake in their local areas to improve quality and efficiency, such as reducing inappropriate variations in how care is provided or reducing interventions which have little if any benefit to patients.

### 1.4.1 Improving efficiency in individual providers

There is a large body of evidence which demonstrates the scope for significant transformation in service quality and efficiency by using proven methods to increase efficiency in individual providers. But we need to be realistic about the pace at which these gains can be realised across a system as large and complex as the NHS. Work by McKinsey for Monitor\(^2\) identified the potential scope for efficiency improvement if individual providers were able to “catch up” to existing good practice in the NHS. In addition to this, NHS providers continue to develop completely new and better ways of providing patient care. We therefore believe that there is a total opportunity for efficiency improvement in individual providers of approximately 2% per annum over the next five years. This is significantly more than the 0.4% to 1.4% underlying productivity improvement that external research\(^3\) suggests that the NHS has traditionally delivered. This is a big ask, so Monitor, the NHS Trust Development Authority and NHS England will provide all the support we can to help providers and commissioners in the forthcoming planning round.

### 1.4.2 Improved efficiency across the system

Better patient care provided in the community can prevent avoidable emergency hospital admissions. Better integration of care, prevention of unplanned admissions through better chronic disease management and moving care to more cost effective settings can all have a role to play in improving the quality of care whilst reducing costs to the system as a whole. None of these ideas are new – but the Better Care Fund provides commissioners and providers with the opportunity to plan for the transformational changes which many have wanted to make for years. Work by

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\(^2\) Improvement opportunities in the NHS: Quantification and Evidence Collection, February 2013.

\(^3\) The ONS (0.4%) and Centre for Health Economics, York (1.4%)
McKinsey for Monitor\(^5\) suggests significant savings could be delivered by redesigning services in this way. We believe the sector must do all that it can to deliver this over the next five years, so we have made the assumption that there is an opportunity for further savings of between 1\% and 2\% per year across the NHS.
1.4.3 Further measures to improve efficiency in individual health economies

Even adding together the opportunities for improving efficiency in individual providers and across the system that we have identified nationally, Table 2 shows that a significant affordability challenge is likely to remain in many local health economies.

Commissioners and providers have the local knowledge and expertise to develop strategic plans to tackle this remaining challenge, according to the circumstances of their local areas. In some cases, they may identify a greater opportunity to improve efficiency in local providers or across the local NHS than these broad national assumptions. In other cases, they may identify further opportunities such as reducing inappropriate variations in how care is provided or reducing interventions which result in little or no clinical benefits to patients.

Commissioners and providers will need to work together across all three of these opportunities to improve efficiency to meet the affordability challenge.

Table 2: Meeting the local affordability challenge

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<tbody>
<tr>
<td>Total affordability challenge</td>
<td>3.1%</td>
<td>6.6%</td>
<td>5.5%</td>
<td>4.7%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Provider efficiency</td>
<td>2.0%</td>
<td>2.5%</td>
<td>2.0%</td>
<td>2.0%</td>
<td>2.0%</td>
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<tr>
<td>System efficiency</td>
<td>1.0%</td>
<td>2.0%</td>
<td>1.0%</td>
<td>1.0%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Remaining challenge</td>
<td>0.1%</td>
<td>2.1%</td>
<td>2.5%</td>
<td>1.7%</td>
<td>1.6%</td>
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1.5 What does this mean for the efficiency assumptions in tariff?

As part of the annual National Tariff setting process, Monitor and NHS England agree an efficiency factor – which broadly equates to our estimate of the opportunity for efficiency improvement in individual providers. This year we have set it at 4%, which is higher than the 2% real efficiency gains we have assumed providers are likely to deliver in practice. This section explains the reason for this discrepancy.

Over the last three years, the tariff efficiency assumption has averaged 3.8%\(^8\). Falling margins in providers of around 0.4% p.a. suggest providers have managed to reduce costs by 3.4% p.a. at most. This broadly equates to the average delivered recurrent Cost Improvement Plan (CIP) saving of around 3.2%

However, there is a significant gap between reported CIPs of around 3.2% and external evidence that the underlying real productivity improvement across the system has traditionally only been around 0.4% to 1.4% p.a.\(^9\) Unless provider

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\(^8\) The efficiency factor was 3.5% in 2010/11 and 4% from 2011/12.

\(^9\) ONS and Centre for Health Economics, York
efficiency has improved very dramatically since that research was undertaken, closing the gap to balance the books is likely to have meant commissioners and providers have been moving money around the system in non-transparent or unpredictable ways. Not being able to predict income or expenditure with confidence makes it hard for either to plan.

The impact of these actions is sometimes referred to as “tariff leakage”. Whatever the source of this tariff leakage, it represents real money which has to be paid for from commissioner’s budgets since it is not real efficiency. Even if providers have been more successful at driving through efficiency improvements during the last few years, we believe that this tariff leakage could potentially represent around 1 to 2 percentage points of the 3.4% cost reduction although the exact figure is highly uncertain.

What we do know is that this reduces the confidence commissioners have in exactly what cost, quality and volume of patient care is being provided for local people within contracts. In the extreme, it raises the risk of providers being tempted to reduce the quality of patient care or not putting in place the right capacity to deal with winter pressures.

Moving money around might help balance the books, but it undermines planning for better patient care. Better planning is needed to deliver genuine change.

However, in the short term, as we develop a better understanding of the evidence and improve the transparency of commissioning and pricing, reducing tariff leakage may be difficult and we must account for this in the tariff efficiency factor. So until we succeed in bringing the rate of tariff leakage down nationally, or local commissioners and providers are successful in reducing it locally, providers and commissioners should plan for a tariff efficiency factor of 4% p.a. over the full five year period (as shown in Table 3). They should make sure that their response includes real efficiency improvement for individual providers of at least 2% p.a.

### Table 3: expected tariff efficiency factor

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider efficiency</td>
<td>2.0%</td>
<td>2.5%</td>
<td>2.0%</td>
<td>2.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Estimate of leakage</td>
<td>2.0%</td>
<td>2.0%</td>
<td>2.0%</td>
<td>2.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Tariff efficiency factor if leakage does not fall</td>
<td>4.0%</td>
<td>4.5%</td>
<td>4.0%</td>
<td>4.0%</td>
<td>4.0%</td>
</tr>
</tbody>
</table>

10 Which relates to increases in the price of services and is not volume related to services or drugs and devices either within or outside the scope of tariff.
To help support better planning, Monitor, the NHS Trust Development Authority and NHS England will seek to reduce tariff leakage over the next five years, by:

- identifying and estimating the scale of leakage activities;
- introducing new oversight of payment terms with greater expectations on transparency from both providers and commissioners; and
- exploring approaches to identify and take action against non-compliance with the pricing rules.

In line with our approach to devolve greater responsibility to local organisations, we think this will help commissioners and providers focus greater attention on how they achieve a real and lasting transformation in the quality of health care received by local people and less effort on moving money around the system to demonstrate cost reductions to the centre.

Over time, as tariff leakage falls, the efficiency assumption set annually in the National Tariff by Monitor and NHS England will fall in step to reflect more closely the opportunity for efficiency improvement in individual providers in the NHS. The speed and scale of this change will depend on how quickly the volume of tariff leakage in the system is reduced.

These efficiency assumptions challenge NHS commissioners and providers to work together to both:

- take advantage of the opportunities available to deliver a greater, though achievable, increase in real efficiency in how patient care is provided than has been achieved before; and
- make a step change in the quality of strategic planning by having more open and transparent dialogue on the changes in the quality, cost and volume of care which will be provided to local people.
2 Overview of the 2014/15 APR process

2.1 Section overview

This section provides a high level overview of the APR process in 2014/15, the type of feedback Monitor intends to give, and the plan documentation that we will ask foundations trusts to provide at the end of the process. Detailed requirements are described in the following sections.

2.2 Background

The APR process is designed to identify short term risks (quality, financial and operational) and longer term risks to the sustainability of high quality services. Monitor has previously required all foundation trusts to submit a three year annual plan in June which formed the basis of a short desktop review during June and July to determine Monitor’s regulatory approach for the year.

2.3 Key changes and rationale

Given the extent of the challenges outlined in our executive summary and Section 1, and the need for foundation trusts to improve planning, Monitor recognises that its plan review process also needs to be upgraded appropriately. Our main goals from the upgrade are to ensure that Monitor has greater visibility over the extent of the short and longer term challenges facing the sector, to ensure that there is robust planning across LHEs and that there are credible plans to deliver high quality services for patients on a sustainable basis.

This has led to the introduction of the following key changes which were set out in our joint letter dated 4 November 2013 (co-signed by NHS England, the NHS Trust Development Authority and the Local Government Authority):

1. Aligning assumptions and planning timetable with NHS England and the NHS Trust Development Authority, enabling better engagement and alignment across local health economies. This will include a reconciliation between provider and commissioner balances; and

2. Splitting the APR into two phases:
   a. Review of foundation trusts’ operational plans including a review of the supporting two year’s financial projections to 2015/16; and
   b. Review of foundation trusts’ strategic plans to ensure sustainability of high quality care for patients, including a review of the supporting five years of financial projections.
2.4 Monitor’s two phase review process

Monitor will seek to assess the quality of foundation trust plans through two distinct (but linked) review phases:

2.4.1 Two year operational and financial review: April – May 2014
Plan documents (two year plan narrative and supporting two year financial return) are required to be submitted to Monitor on 4 April 2014. These documents should set out how foundation trust boards intend to deliver high quality and cost-effective services for their patients over the next two years, with particular emphasis on the specific challenges posed in 2015/16.

Monitor will undertake a desktop review of plans during April and May 2014, which will seek to assess the level of short term financial, quality and operational risk to individual foundation trusts over the period 2014/15 - 2015/16 by considering:

- the strength of individual foundation trust’s understanding of the challenges being faced over the next two years;
- the Trust’s level of engagement with the key stakeholders within the LHE to assess the nature and scale of the challenge and plans to address the specific challenge faced in 2015/16;
- the congruence of commissioner and provider activity and revenue assumptions for 2014/15 and 2015/16 (please see 2.4.4);
- an assessment of the reasonableness of key assumptions in the plan, particularly in light of Monitor’s accuracy of planning findings and efficiency assumptions set out in Section 1;
- the level of planned capacity in key services compared to the likely demand over the period to 2015/16; and
- the nature and robustness of foundation trust initiatives to ensure that high quality services continue to be delivered over the next two years to 2015/16.

2.4.2 Five year strategic and sustainability review: July – September 2014
Plan documents (strategic plan and supporting five year financial return) are required to be submitted to Monitor by 30 June 2014. These documents taken together should set out how foundation trust boards intend to deliver appropriate, high quality and cost-effective services for their patients on a sustainable basis.

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\[11\] see *Meeting the needs of patients: Improving strategic planning in NHS foundation trusts*, available at [http://www.monitor.gov.uk/node/5492](http://www.monitor.gov.uk/node/5492)
Monitor will undertake a desktop review of plans during July - September 2014 to assess the level of risk to longer term sustainability of individual foundation trusts by considering:

- the outcome and trust response from the first phase of the review;
- the robustness of the strategic planning process;
- the trust’s understanding of its local health economy and any likely financial gap based on its current configuration;
- the congruence of commissioner and provider activity and revenue assumptions over the coming five years;
- the strategic options, which may include transformational change to the current configuration if necessary, that the foundation trust believes are available to ensure sustainability of high quality services for patients;
- the trust’s chosen schemes and initiatives that should secure the foundation trust’s long-term sustainability;
- the trust’s level of engagement and extent of alignment with the key stakeholders within the LHE to agree key initiatives; and
- the foundation trust board’s self-assessment of the trust’s longer term sustainability and the key points supporting its conclusions.

2.4.3 Financial returns
There is a single five year financial template which underpins both phases of the annual plan review. Monitor requires year one and two to be completed for the first submission (4 April 2014) and then the subsequent three years for the second submission (30 June 2014).

The operational plan will, because of the required submission date, be developed before a final year end financial position is known. Therefore foundation trusts should use a projected year end outturn for 2013/14 based on the most up-to date and relevant information available.

The financial information in the first two years can only be amended in the later June submission by exception where there is a material impact on the financial projections. Foundation trusts should contact their relationship manager at Monitor should they feel an amendment to the first two years is required, but the expectation is that this will be limited to exceptional circumstances only. While we cannot state all the reasons that may be accepted, these could include a material event or decision occurring after the first submission such as a transaction becoming likely or major service reconfiguration being agreed with commissioners.
Foundation trusts will be required to submit bridging analysis should any resubmission be made.

2.4.4 Reconciliation
Plans need to reflect local priorities for patients and we expect commissioners and providers to cooperate in planning and to be able to explain any differences in their plans.

It is expected that providers’ plans will be aligned with those of the wider local health economy. In order to test the alignment of key assumptions Monitor, NHS England, and the NHS Trust Development Authority will reconcile provider and commissioner income and activity plans for both the two and five year review phases.

The outputs of the reconciliation will be shared between the regional teams of Monitor, NHS England and NHS Trust Development Authority. Every step will be taken not to prejudice the position of any trust or commissioner and no information will be shared at individual organisation level without first contacting the appropriate party. However, where significant divergences are identified, this is likely to require further discussion with the parties involved.

2.4.5 Risk based approach
Monitor will take a risk based approach to both reviews.

2.5 Feedback
Monitor will provide feedback to foundation trusts setting out its assessment of individual plans after each phase of the review (initial feedback in May 2014 and final feedback in October 2014). Where necessary, we will take appropriate regulatory action, which could include but is not limited to:

- **Enhanced Scrutiny.** Where foundation trust plans demonstrate potential weakness or may be insufficient to address the nature of challenge facing the foundation trust, we may require additional assurance over whole or part of the plan. The type of required assurance will be bespoke but could well include a relationship visit to discuss the plan in more detail or a request for additional supporting information/explanation.

- **Re-submission.** Where foundation trust plans demonstrate significant weakness or are clearly insufficient to address the nature of challenge facing the foundation trust, we may require a resubmission of the plan and request external assurance over the robustness of any resubmission. Reasons for re-submission may include overly optimistic financial planning, plans that are significantly divergent with commissioner assumptions, material changes that become apparent after submission or apparent weakness in the trust’s approach to planning.
• **Investigation.** Where foundation trust plans are considered so weak, or highlight a level of unmitigated risk which could indicate a potential licence breach, Monitor may open an investigation under the Risk assessment framework. Reasons for opening an investigation might include a significant risk to any of financial stability, quality or significant longer term sustainability.

### 2.6 Publications

Monitor and foundation trusts have a duty of candour and transparency. Accordingly, Monitor intends to publish foundation trusts’ two year operational plans and strategic plans, whilst ensuring that commercially sensitive information is not made public.

Monitor intends to achieve this through publishing the following:

- the body of the two year operating plan excluding any commercially sensitive information, which foundation trusts should include in the annexes to their operating plan as in previous years; and

- a summarised version of the strategic plan.

Monitor will therefore require foundation trusts to prepare a separate summarised version of the strategic plan, which can be published at the end of the annual review process. This summary must be consistent with each foundation trust’s underlying detailed submission but is required to be a publishable separate document. While the format of which is a decision for each individual foundation trust this should cover as a minimum a summary of the market analysis and context, strategic options, plans and supporting initiatives and an overview of the financial projections.
3 Practical guidance on APR 2014/15

3.1 Section overview

This section sets out the key submissions required for the annual plan process and the matters which are pertinent for both phases of Monitor’s APR (engagement with the local health economy and the Better Care Fund).

Sections 4 and 5 respectively provide detailed guidance on both the operational plan and the strategic plan.

Section 6 concludes with a number of other matters which should be borne in mind when completing the annual plan submissions.

3.2 Key submissions

APR 2014/15 comprises two sets of submissions (one for each phase of the review). Both should be returned via the MARS portal (guidance on uploading your template can be found here):

1. On or before 4 April 2014 foundation trusts should submit the financial template with year one and two completed and an accompanying two year operational plan (see section 4); and

2. On or before 30 June 2014 foundation trusts should submit a completed five year financial template (with the final three years completed), an accompanying strategic plan (see section 5) and a publishable summary of the plan (see section 2.6).

The plan templates can be downloaded from the 2014/15 APR website and the financial template will be made available to foundation trusts on 7 January 2014 via the MARS portal (technical guidance on the financial template will also be made available on the 2014/15 APR website on this date).
Set out below is a summary of the two submissions:

<table>
<thead>
<tr>
<th></th>
<th>Operating and financial phase</th>
<th>Strategic and sustainability phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submission date</td>
<td>4 April 2014</td>
<td>30 June 2014</td>
</tr>
<tr>
<td>Financial information (2.4.3)</td>
<td>Two years</td>
<td>Five years</td>
</tr>
<tr>
<td>Monitor led reconciliation with commissioners (2.4.4)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

| Monitors key review objective | Understand risks to short term stability and resilience and the sufficiency of the trust response. | Understand the key risks to longer term sustainability and the sufficiency of the trust strategic response and underlying initiatives. |
| Monitor feedback (2.5)       | May 2014                       | October 2014                      |

3.3 Matters pertinent to both reviews

Both phases of Monitor’s review will seek to understand the extent to which foundation trusts have engaged with key stakeholders within the LHE to develop their plans. This will necessarily require a discussion about the challenges arising from the introduction of the Better Care Fund and foundation trusts’ responses to this.

3.3.1 Engagement with LHE

Monitor is working closely with both NHS England and the NHS Trust Development Authority to ensure plans lead to sustainability and are deliverable across local health economies.

We are therefore calling for an iterative process of engagement between foundation trusts and their LHE partners. While it is the responsibility of each foundation trust and its LHE partners to define its own process for engagement, Monitor and our partners consider this engagement to be central to the development of a robust strategic plan.

In doing so, providers and commissioners should be mindful of competition law. As a general rule, discussions between providers about their future plans are more likely to give rise to concerns than discussions between providers and commissioners. It is acceptable though for the relevant stakeholders in an area (including providers, commissioners, clinicians and others) to talk at a high level about desired outcomes.
and general transformational changes that may be needed to address health care economy challenges.

3.3.2 Better Care Fund

The Better Care Fund (formerly called the Integrated Transformation Fund) plan requires local areas to formulate a joint plan for integrated health and social care and to set out how their single pooled Better Care Fund budget will be implemented to facilitate closer working between health and social care services.

While joint plans for the Better Care Fund should be approved through the relevant local Health and Wellbeing Board and should be agreed between all local clinical commissioning groups (CCGs) and the Upper Tier Local Authority, health and social care providers should also be closely involved in developing the plan.

Both phases of Monitor’s annual plan review will seek to understand how individual foundation trusts are addressing the particular challenges posed by the Better Care Fund particularly in 2015/16.
4 Operational plan

4.1 Overview

The operational plan should set out how foundation trusts intend to deliver appropriate, high quality and cost-effective services for patients over the next two years in light of the particular challenges facing the sector e.g. the Better Care Fund.

Foundation trusts will need to develop operational plans that outline projected activity, pressures and performance over the next two years to 2015/16 that ensure that services to patients remain high quality and resilient.

4.2 Publication of the operational plan

Foundation trusts should be aware that, as part of Monitor’s duty of transparency, Monitor will publish the entire operational plan except for confidential annexes at the back.

4.3 Strategic and operational planning

Monitor recognises that, in a business as usual situation, a foundation trust would usually expect to develop its strategic plan and high level long term financial projections before translating this into a detailed short term operational plan.

In 2014/15 however, in order to align planning timetables across the system and to allow foundation trusts additional time to fully develop their strategic plans in response to the enclosed guidance, it has not been possible to order our reviews in this sequence.

The operational plan should, however, be linked to the broader strategy but does not need to set out the full evidence base and analysis that will support the strategic plan.

4.4 Format of operational plan commentaries

Monitor expects that a good two year operational plan should cover (but not necessarily be limited to) the following areas (in separate sections):

1. Executive summary

2. Operational plan

   a. The short term challenge
   
   b. Quality plans
   
   c. Operational requirements and capacity
   
   d. Productivity, efficiency and CIPs
e. Financial plan

3. Appendices

As a guide, we expect plans to be a maximum of 30 pages in length. Please note that this guidance is not prescriptive and foundation trusts should make their own judgement about the content of each section.

4.5 Executive summary

Monitor expects that the operational plan will include an executive summary outlining the key elements, including a summary of key financial data.

4.6 Operational plan

This section should set out how the foundation trust plans to deliver high quality services over the next two years in light of the key objectives within the foundation trust’s strategic plan. We would expect the trust to comment on the following sections:

4.6.1 The short term challenge
Foundation trusts should work with LHE partners to define the extent of the short term challenges within the LHE and should use this section to summarise the extent of the agreed likely two year challenge.

4.6.2 Quality plans
Foundation trusts should outline their quality plans to meet the short term challenges it faces (both internally and within the LHE) by considering the following:

- national and local commissioning priorities;
- the foundation trust’s quality goals, as defined by its quality strategy and quality account;
- an outline of existing quality concerns (CQC or other parties) and plans to address them;
- the key quality risks inherent in the plan and how these will be managed;
- an overview of how the board derives assurance on the quality of its services and safeguards patient safety (foundation trusts may find Monitor’s quality governance framework\footnote{Available at www.monitor.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-foundation-trusts/mandatory-} helpful for appraising quality arrangements);
- what the quality plans mean for the foundation trust’s workforce;

\footnote{Available at www.monitor.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-foundation-trusts/mandatory-}
• the foundation trust’s response to Francis, Berwick and Keogh;
• risks to delivery of key plans; and
• contingency that is built into the plan.

4.6.3 Operational requirements and capacity
Foundation trusts should outline their assessment of the activity and demand pressures and the inputs needed to address these over the next two years. This section should cover:

• an assessment of the inputs needed (such as physical capacity, workforce and beds) over the next two years, based on the trusts understanding of its expected activity levels; and
• an analysis of the key risks and how the trust will be able to adjust its inputs to match different levels of demand.

4.6.4 Productivity, efficiency and CIPs
Foundation trusts should define a robust programme of schemes which can improve or maintain quality whilst driving up productivity. Foundation trusts should therefore describe their CIP programme and make clear the difference and articulation between those CIPs which are incremental and efficiency driven (“traditional CIPs”) and those which are transformational in nature and involve new ways of working (“transformational CIPs”).

Monitor is particularly keen to understand the state of development of the transformational schemes being planned. Foundations trusts should therefore detail the nature of the planned transformation, the extent to which transformational schemes are already being implemented and the future schemes which are critical to the delivery of the strategic plan.

4.7 Supporting financial information
Two years of supporting financial projections are required to support the operational plan.

Foundation trusts should prepare the projections based on an assessment of the quality priorities, operating requirements and the productivity and efficiency initiatives in the plan and translate them into a financial projection from 2014/15 to 2015/16.

Foundations trusts should provide financial commentary on at least the following areas:

• income, and the extent of its alignment with commissioner intentions/plans;
• costs;
• capital plans;
• liquidity; and
• risk ratings.

Please note also that in 2014/15 we have introduced into the financial template the ability to model potential downside risks and mitigations to assist foundation trusts and Monitor to quantify the potential risks to plans and mitigations that could be used to offset these risks. We expect trusts to identify potential downside risks and mitigations as part of their planning activities and comment on their inclusion in the APR.

4.8 Appendices

Where foundation trusts have commercially sensitive or confidential matters that they do not want to include in the main published section of the operational plan, they may include them in the appendices.
5 Strategic plan

5.1 Overview

The strategic plan is expected to be a comprehensive summary of each foundation trust’s strategy, the analysis which underpins this and the plans to implement them. It should therefore, set out in detail an assessment of the future challenges facing the LHE and the foundation trust, the options available to address the identified challenges and ultimately its key service line strategic plans.

Monitor expects strategic plans to demonstrate the extent of each foundation trust’s ambition for patients. It should outline the practical ways in which key services will be transformed to lead to better quality care at a reduced cost and the investment that is required to support this transformation. It could also, for example, set out where key service lines are no longer sustainable and if the trust is proposing to take steps to divest or transfer services for the benefit of patients.

5.2 Publication of the strategic plan

Monitor recognises that the strategic plan is a confidential document and will necessarily contain commercially sensitive information. Monitor therefore does not intend to publish the strategic plan.

Notwithstanding this, Monitor has a duty of transparency and will require a summarised version of the plan to be submitted alongside the strategic plan which can be published.

While the format of which is a decision for each individual foundation trust this should cover as a minimum a summary of the market analysis and context, strategic options, plans and supporting initiatives and an overview of the financial projections.

5.3 Self assessment tool

In addition to the guidance included in this section, further information on the hallmarks of high quality strategic planning can be found in Section 7, where we have included a self-assessment tool to help support strategic planning at foundation trusts. We strongly recommend foundation trusts use this tool in their APR process for 2014/15.

5.4 Format of strategic plan

Monitor expects that a good strategic plan should cover the following areas:

1. Declaration of sustainability
2. Market analysis and context
3. Risk to sustainability and strategic options
4. Strategic Plans

As a guide we would expect strategic plans to be a maximum of 50 pages in length and the publishable summary to be a maximum of 20 pages.

Please note that this guidance is not meant to be prescriptive. Foundation trusts should make their own judgements about the content of each section.

5.5 Declaration on sustainability

Monitor requires all foundation trusts to declare whether or not the foundation trust’s strategic plans will ensure the sustainability of the foundation trust over the coming five years on a clinical, operational and financial basis.

In this section foundation trusts should summarise on a single page, the key evidence base and critical schemes upon which the foundation trust is relying to ensure the sustainability of high quality services.

5.6 Market analysis and context

Monitor expects strategic plans to be based on a detailed assessment of the wider LHE context. This requires foundation trusts need to engage with all key stakeholders within the LHE at each stage of the development of the strategic plan.

Foundation trusts should therefore set out their assessment of the material challenges facing the wider LHE and the analytical evidence base which underpins this assessment. This may include for example, a high level assessment of the affordability challenge facing the LHE over the coming years, or an assessment of the need for more activity to be provided in primary care.

Monitor would expect the analysis underpinning the market analysis and context section to include as a minimum:

- a healthcare needs assessment, based on demographic and healthcare trends;
- a capacity analysis, based on the sufficiency of estates, beds and staff to meet healthcare needs;
- a funding analysis, based on historic trends and likely commissioning intentions;
- a competitor analysis, based on an assessment of the trust’s key areas of strength and weakness relative to its key competitors;
- a SWOT analysis, to identify both the opportunities that can be exploited and the challenges that need to be addressed;
• forecasted activity and revenue in a ‘do nothing’ scenario and resulting financial gap across the LHE; and

• the extent of alignment of findings from these analyses with comparable intelligence from LHE partners.

An activity guide on the demand forecasting and competitor analysis is included in a recent report by PwC commissioned by Monitor\textsuperscript{13}, which foundation trusts may find useful.

5.7 Risk to sustainability and strategic options

After completing the outward facing market review, foundation trusts should consider the likely impact of the identified external challenges on each of its key service lines and the resulting sustainability risk.

This assessment should lead to a consideration of the range of strategic options available (e.g. grow, shrink, merge, collaborate or transform) to address the identified risk to sustainability.

Foundation trusts should set out the analysis supporting its view of the risk to sustainability across its key service lines and an assessment of which available strategic options are being rejected and why. In addition a summary of the key reasons for adopting the chosen strategic option(s) should be provided.

Monitor would expect the options analysis to include as a minimum:

• an assessment of the likely impact of chosen options on key service lines;

• an assessment of the likely impact of chosen options on the broader LHE; and

• an assessment of the LHE support required and alignment with the proposed options.

\textsuperscript{13} see Technical Annex to the Foundation Trust Strategic Planning Assessment Research Findings. It is recommended that this is read in conjunction with Foundation Trust Strategic Planning Assessment - Research Findings Report. Both documents are available at http://www.monitor-nhsft.gov.uk/information-nhs-foundation-trusts/planning-and-reporting-processes/annual-planning
5.8 Strategic Plans

Based on the analysis performed, foundation trusts should summarise its prioritised set of service line initiatives and outline the following:

- key milestones, resourcing requirements, dependencies and risk mitigations;
- communication plan for key stakeholders, including staff and the LHE; and
- the processes the foundation trust has in place to monitor performance against the strategic plan and how plans will be adapted and amended for unexpected future challenges.

An activity guide on initiative prioritisation is included in a recent report by PwC commissioned by Monitor\(^{14}\) which foundation trusts may find useful.

5.9 Supporting financial information

Five years of supporting financial projections are required to support the strategic plan. Years one and two of the financial return will already be fixed through the operating plan submission, review and feedback process completed during April and May 2014.

\(^{14}\) see Technical Annex to the Foundation Trust Strategic Planning Assessment Research Findings. It is recommended that this is read in conjunction with Foundation Trust Strategic Planning Assessment - Research Findings Report. Both documents are available at http://www.monitor-nhsft.gov.uk/information-nhs-foundation-trusts/planning-and-reporting-processes/annual-planning
6 Other matters to consider

6.1.1 Overview
The section sets out a number of other matters which should be considered when completing annual plans.

6.1.2 Capital planning and capital expenditure
Identifying the right capital expenditure to support strategic plans is one of the most important decisions a foundation trust will take. Monitor therefore expects foundation trusts to ensure that the right capital priorities are identified and supported by deliverable capital expenditure plans.

Historically however, foundation trusts have produced annual plans containing ambitious capital expenditure goals and then gone on to finish the year with a sizeable underspend. This culminated in an underspend of more than £840m against a plan of £2.5bn in 2012/13.

Unrealistic capital planning in foundation trusts affects the entire capital budget for the Department of Health (DH). It limits the availability of capital to other NHS bodies and also prevents the DH from making capital available to all NHS bodies, including foundation trusts, through centrally funded capital spending schemes.

It is therefore imperative that foundation trusts forecast their capital plans within the financial template as accurately as possible. This is particularly important in the two year APR phase, where capital plans and resulting cash flows are input on a quarterly basis.

In December 2013 Monitor will be requesting five year capital forecasts from all foundation trusts on behalf of the DH. These will need to be submitted in early January 2014.

These five year capital forecasts should form the basis of the APR financial template capital expenditure inputs for both the two year and five year submissions (albeit we acknowledge that differences may arise as plans are developed). Any significant variances between these two submissions will require explanation as part of the CapEx worksheet narrative for each scheme.

As usual, those foundation trusts subsequently triggering the Risk Assessment Framework (RAF) requirement for a reforecast will be expected to complete the capital expenditure reforecast template.

Foundation trusts should also outline their IT procurement plans as the national IT agreements, such as local service provider (LSP) contracts with BT and CSC, come to an end. The CSC LSP contract covering the North, Midlands and East ends in July 2016 (with a limited number of exceptions) and the BT LSP contract covering London and the South of England ends in October 2015.
6.1.3 Units of planning
When framing their strategic plans, foundation trusts should be aware that NHS England has asked for CCGs, in discussion with area teams, local government and providers to form a “unit of planning” for developing joint commissioner strategic plans. Each unit of planning should have the following characteristics:

- each CCG belongs to one unit only;
- the unit is locally agreed and has clear clinical ownership and leadership;
- it is based on existing health economies that reflect patient flows across Health and Wellbeing Board areas and local provider footprints;
- it has sufficient scale to deliver clinical improvements across the whole geography covered by the unit;
- it enables the pooling of resources to reduce the risk associated with large investments;
- it does not cut across existing locally agreed collaboration agreements; and
- engagement has been secured from local authorities.

It should be noted however that a provider may be part of more than one unit of planning.

6.1.4 Plan assurance
Foundation trust boards have a pivotal role in testing and assuring their plans within the context of their local health economies.

The table overleaf shows the lead responsibilities for plan production and assurance across local health economies.
<table>
<thead>
<tr>
<th>Strategic plan produced by</th>
<th>Engaged</th>
<th>Triangulation</th>
<th>Formal assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responsible for driving development, completing and submitting plan</strong></td>
<td>Contribute to plan development</td>
<td>Responsible for ensuring that their work triangulates with plan</td>
<td>Responsible for providing formal assurance of plan</td>
</tr>
</tbody>
</table>
| **Unit of Planning** | Patients  
CCG  
Provider  
HWB  
Local Authority  
NHS England Area Team | CCG  
Provider  
HWB  
Local Authority  
Area Team | NHS England Regional Team |
| **CCG** | Provider  
Local Authority (contracts with comm./SC providers) | Provider  
HWB  
Local Authority  
Unit of Planning | NHS England Area Team |
| **Provider** | CCG  
Local Authority (depending on provider type) | CCG  
HWB  
Local Authority  
NHS England Area Team  
Unit of Planning | Monitor  
NHS Trust Development Agency |
| **HWB (Better care fund)** | Local Authority  
NHS England Area Team  
PHE  
Monitor  
NHS Trust Development Agency | CCGs  
Provider  
Units of Planning | Ministers  
NHS England Area Team  
LGA |
| **Direct Commissioning (NHS England Area Team)** | NHS England Regional Team  
Provider | Provider | NHS England Regional Team |
7 Self assessment toolkit

7.1 Key elements of an effective strategic planning exercise

Independent research commissioned by Monitor has concluded that an effective strategic planning exercise (that identifies risks to sustainability and ensures that a provider organisation is doing all that it can to deliver high quality care for patients), requires the following three steps:

- **Step 1** – the provider must put in place strategic **planning processes** that ensures that an engaged board – and an executive team that can draw on sufficient skilled supporting resource – are undertaking necessary planning actions at the right times;

- **Step 2** - through that planning process, the provider must develop and refresh a strategic **plan with content** that is based on accurate and correctly-analysed inputs, which establishes an evidence-based sustainable vision and supporting initiatives to guide the organisation, and which explains how those initiatives will be delivered; and

- **Step 3** - ensure that the **delivery** of the initiatives is monitored, and that staff, patients and other stakeholders understand why transformation is necessary and what part they must play in delivering it.

The independent research report\(^{15}\) states that if a provider organisation is failing to complete any of these three steps, it is unlikely to be able to adapt to the challenging conditions facing the NHS. The report also states that a significant number of foundation trusts are at present failing to complete these steps, or completing them in a partial and unstructured way. This situation must change if the provider sector is to position itself to meet the future needs of patients sustainably, through transformational change where necessary.

Monitor has been and will continue to work with providers to identify gaps between current planning performance and the quality of planning needed. However, the primary responsibility for assessing the quality of planning being carried out by a provider, and for making any necessary improvements, lies with the board and executive team of that organisation.

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7.2 Evaluating the quality of provider strategic planning using an assessment tool

To support boards and executive teams in discharging that responsibility, an assessment tool has been developed that can be used to rapidly evaluate the quality of the strategic planning being undertaken. Using a series of structured questions, the assessment tool tests whether a provider is completing the three steps described above fully and rigorously. The tool identifies gaps in provider planning processes that the board and executive team can then fill, and it also identifies weaknesses in the plans produced by the provider that must be addressed.

The board and executive team at a provider can use the assessment tool in one of three ways. They can:

- work through an assessment using the tool collectively during a board session or meeting;
- empower an individual staff member or a group of staff to work through an assessment using the tool, and then have the board and executive team review and debate the findings; or
- identify a third party (eg, an expert from another provider organisation, or an advisory group) to work through an assessment using the tool, and then have the board and executive team review and debate the findings.

7.3 The assessment tool

To establish whether a provider is completing the three steps, the assessment tool requires the provider to discuss whether it can answer ‘yes’ to a set of key questions. If it cannot answer yes to some of the questions asked, or evidence cannot be found to support an answer, then it is unlikely that the provider is undertaking high-quality strategic planning. In that instance, the provider should seek to ensure that it is taking action to address the areas in which weaknesses have been identified.
The key questions are:

### Step 1: Evaluation of Planning Processes

To show that it has a strategic planning process in place that makes sure its board and executive team take the necessary planning actions at the right times, a provider must be able to answer “yes” to the following questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has the organisation put in place a structured strategic planning process to guarantee that the board and executive team regularly spend time discussing strategic issues?</td>
<td>Yes</td>
</tr>
<tr>
<td>2. Do the board and executive team have strategic planning backgrounds and skills?</td>
<td>Yes</td>
</tr>
<tr>
<td>3. Do the board and executive team have an identified, responsible and skilled supporting staff to draw on when they carry out strategic planning?</td>
<td>Yes</td>
</tr>
<tr>
<td>4. Do the board and executive team have regular strategy discussions with a range of local health economy stakeholders (e.g., commissioners and other providers) and understand their perspectives?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Step 2: Evaluation of Plan Content

To show that they have developed and refreshed a five to ten year strategic plan with content based on accurate and correctly analysed inputs, a provider must be able to answer “yes” to the following questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has the organisation quantified the risks to its clinical and financial sustainability and developed transformation plans by drawing on accurate inputs, including internal performance information and external market data, which it has analysed and presented correctly?</td>
<td>Yes</td>
</tr>
<tr>
<td>2. Can the board and executive team declare that their organisation will be financially and clinically sustainable according to current regulatory standards in one, three, five and ten years, if it keeps its current configuration and service profile?</td>
<td>Yes</td>
</tr>
<tr>
<td>3. Has the organisation identified a vision that establishes why and how the organisation should change or transform, if necessary, in order to deliver high-quality and efficient patient care and address any sustainability gap identified?</td>
<td>Yes</td>
</tr>
<tr>
<td>4. Is that vision supported by plans for initiatives that can be shown to address any sustainability gap identified?</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Step 3: evaluation of plan delivery

To show that they monitor delivery of their strategic initiatives, a provider must be able to answer "yes" to the following questions:

1. Does the organisation have detailed delivery plans for each of its strategic initiatives that lay out milestones, resource requirements, dependencies and risk mitigations?

2. Does the trust have skilled staff to draw on to implement those delivery plans?

3. Are trust staff, patients and other stakeholders able to explain the ambition and initiatives of the provider when asked, and do they know what they must do to deliver both?

4. Are strategic plans reviewed and updated yearly to keep them relevant?

7.4 Detailed hallmarks

To make sure all providers apply a consistent standard when they answer these questions, they should refer to the hallmarks of high-quality strategic planning set out below. Providers can use these hallmarks to work out whether they can answer "yes" to the questions above as follows:

- Providers that display most of the positive hallmarks relevant to each question are likely to display the required quality of strategic planning in that area and so be able to answer "yes" to that question;

- Providers that show only some of the hallmarks cannot answer "yes". They have further work to do before they reach the minimum quality of strategic planning in that area; and

- Providers that show few of or none of the hallmarks have serious deficiencies in the quality of their strategic planning and cannot answer "yes". They must make addressing those deficiencies a priority.

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### Step 1 – Questions and Hallmarks

#### 1. Has the organisation put in place a structured strategic planning process to guarantee that the board and executive team regularly spend time discussing strategic issues at the correct point in the trust calendar?

<table>
<thead>
<tr>
<th>Relevant hallmarks of high-quality strategic planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The board and the executive team are involved in planning, developing and drafting the 5-10 year strategic plan for the organisation and the annual updates required as part of Monitor’s APR process.</td>
</tr>
<tr>
<td>• The organisation has a planning calendar showing (a) the trust’s medium and long-term strategy development milestones (eg, dates for developing and refreshing five and ten-year strategic plans), (b) annual milestones (eg, dates for developing annual plan and refreshing strategic plan) and (c) regular milestones (eg, dates for strategic discussions at board and executive meetings, dates for engagement sessions with strategic partners).</td>
</tr>
<tr>
<td>• The board has a standing strategy and planning committee, and the executive team has a strategy and planning committee or other relevant forum.</td>
</tr>
<tr>
<td>• The board and relevant executive committees have regular slots at public and private meetings to discuss strategic issues and to monitor progress against the strategic plan.</td>
</tr>
<tr>
<td>• Board minutes show the extent of the strategic discussion held and also show that actions resulting from those discussions are taken within agreed time limits.</td>
</tr>
<tr>
<td>• The board and executive team hold strategic planning sessions of at least half a day and at least twice a year to identify medium- and long-term challenges to their plans and to discuss market developments.</td>
</tr>
<tr>
<td>• The organisation keeps a log of high priority and highly challenging risks to sustainability, which the board and relevant executive committees review regularly.</td>
</tr>
</tbody>
</table>
2. Do the board and executive team have strategic planning backgrounds and skills?

**Relevant hallmarks of high-quality strategic planning**

- The board includes at least two members with a background in strategy development, commercial development, business planning or organisational development in the public or private sector.

- The executive team includes a head of strategy or equivalent board-level member who has a background in strategy development in the public or private sector.

- The board and executive team always deploy qualitative and quantitative information (e.g., market profiling information, information on national and local commissioning plans) when discussing strategic options.

- The board and executive team include a review of their strategic planning performance in all board capability reviews and act on any development points that review identifies.

- The board and executive team engage quarterly with external experts (including analysts and commentators) to gather new insights and hear external challenges to their views.

3. Do the board and executive team have an identified, responsible and skilled supporting staff to draw on when they carry out strategic planning?

**Relevant hallmarks of high-quality strategic planning**

- In addition to board and executive capacity, there are at least two skilled fulltime equivalent (FTE) staff dedicated to strategic planning and commercial development (see Appendix B in Technical Annex to the Foundation Trust Strategic Planning Assessment Research Findings Report, for information on skill profiles).

- At least one of these two dedicated FTEs has a background in strategy development, commercial development or business planning.

- The supporting staff report directly to nominated board and executive directors, and meet at least monthly with service line leads and clinical leads to discuss strategic issues.
### Step 1

<table>
<thead>
<tr>
<th>Relevant hallmarks of high-quality strategic planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Board members and executives at various levels (eg, CEO, COO, service line leads) regularly meet their commissioning counterparts and other stakeholders to discuss health economy strategy in general and particular strategic issues.</td>
</tr>
<tr>
<td>• Board members and executives attend and contribute to local strategy discussion forums (eg, health economy-wide planning meetings, joint strategic needs assessment development meetings, ad hoc strategy forums).</td>
</tr>
<tr>
<td>• Provider representatives are involved in developing and reviewing commissioning strategies and the strategies of other partner organisations, and vice versa.</td>
</tr>
<tr>
<td>• Board members and executives can explain concisely the areas of congruence and areas of tension between the strategic intentions of their organisation and those of commissioners or other stakeholders (eg, Health and Wellbeing Boards, Overview and Scrutiny Committees).</td>
</tr>
<tr>
<td>• Feedback received from stakeholders demonstrates that they characterise their relationship with the provider as strong and productive, with an open discussion of views at all levels.</td>
</tr>
</tbody>
</table>

4. **Do the board and executive team have regular and frank strategy discussions with a range of LHE stakeholders (eg, commissioners and other providers) and understand their perspectives?**
## Step 2 – Questions and Hallmarks

### Step 2.1
Has the organisation quantified the risks to its clinical and financial sustainability and developed transformation plans by drawing on accurate inputs, including internal performance information and external market data, which it has analysed and presented correctly?

<table>
<thead>
<tr>
<th>Relevant hallmarks of high-quality strategic planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Strategy teams gather and analyse quantitative evidence related to key planning inputs and use supporting qualitative evidence.</td>
</tr>
<tr>
<td>• The provider draws on those inputs to generate and maintain three, five and ten-year forecast assumptions about the development of key business factors including funding levels, tariff, demographics and demand, competitor intentions, clinical standards and guidance, and commissioner intentions.</td>
</tr>
<tr>
<td>• The provider also gains insight into what local patients, carers and other stakeholders require of services. The provider should base this on regularly-updated survey and patient outreach work, and include information on patient preferences for how the organisation should transform and develop.</td>
</tr>
<tr>
<td>• Staff update those forecast assumptions both when new information is identified and on a rolling annual basis to ensure that they remain accurate.</td>
</tr>
<tr>
<td>• Staff test those forecast assumptions with reference to comparable benchmarks (e.g., assumptions made in other provider strategic plans, assumptions included in commissioning strategies). When they identify areas of difference, they analyse and understand causes.</td>
</tr>
<tr>
<td>• The provider also maintains its insight into its performance by gathering and analysing internal information such as service line reporting activity, profitability data and activity forecasts.</td>
</tr>
<tr>
<td>• Those forecast assumptions directly inform trust work on strategic planning and feed into long-term financial models, Monitor APR submissions, clinical and commercial strategies and long-term strategic plans.</td>
</tr>
</tbody>
</table>

### Step 2.2
Can the board and executive team declare that their organisation will be financially and clinically sustainable according to current regulatory standards in one, three, five and ten years, if it keeps its current configuration and service profile?

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### Relevant hallmarks of high-quality strategic planning

- The board and executive team review clinical and financial sustainability quarterly and determine whether they can declare that the provider will be sustainable in one, three, five and ten years (a) in its current configuration and (b) if they implement planned transformation and development plans and deliver modelled “base case” returns.

- They base their assessment of sustainability on current regulatory standards (e.g., Monitor risk assessment framework criteria).

- The organisation has one, three, five and ten year strategic plans that illustrate the predicted sustainability position at each of those points. The plans should include forecasts of financial factors (e.g., revenue, margin, surplus, cash flow, PFI obligations) and should also include forecasts of clinical viability (e.g., staffing shortages, minimum volume problems, excess activity etc).

### Step 2

3. **Has the organisation identified a vision that establishes why and how the organisation should change or transform, if necessary, to deliver high quality and efficient patient care and address any sustainability gap identified?**

### Relevant hallmarks of high-quality strategic planning

- The organisation has a vision that explains how, at a high level, it will address any sustainability gap it identifies. This vision should be a direct response to the organisation’s evidence-based sustainability assessment.

- If the vision, when implemented, will not completely close the sustainability gap, then the organisation should acknowledge and explain the remaining gap.

- The organisation demonstrates in its plan documents that it considers a broad range of options for becoming sustainable using quantitative and qualitative assessment criteria.

- The organisation demonstrates in its plan documents that its vision for becoming sustainable is compatible with local commissioners’ intentions and national policy developments, or states clearly why it feels it is appropriate for the organisation to choose an alternative direction.

- The vision explains how patients will benefit from the transformation proposed, including considerations of quality, safety, efficiency and access.
4. Is that vision supported by plans for initiatives that can be shown to address any sustainability gap identified?

Relevant hallmarks of high-quality strategic planning

- The transformational vision is supported by plans for initiatives that the organisation must undertake to achieve it (eg, service launches or closures, care model transformations, site and workforce developments, etc.)

- Those initiative plans include modelled forecasts of financial contribution or clinical impact over the plan period. Those forecasts must be evidence-based and cautious. They should model potential impact in line with Monitor standards of financial forecasting, clinical performance benchmarks and workforce benchmarks.

- The financial contribution and clinical impact of all the initiatives should be enough to close the sustainability gap. If they do not, the organisation should acknowledge and explain the gap.

Step 3 – Questions and Hallmarks

1. Does the trust have detailed delivery plans for each of its strategic initiatives that lay out milestones, resource requirements, dependencies and risk mitigations?

Relevant hallmarks of high-quality strategic planning

- For each initiative, the organisation has a detailed delivery plan including (a) a timeline for delivery with measurable milestones and metrics against which to assess progress, (b) an evaluation of resource and skills requirements and how those requirements will be met, (c) an identified responsible board-level sponsor, and (d) a risk log detailing potential delivery risks and mitigating actions.

- The organisation has mapped the dependencies between each initiative and all the other initiatives, so that potential knock-on risks are identified.

- For each initiative, the organisation has developed a stakeholder map to identify (a) the inputs required from key stakeholders both within and outside the organisation, and (b) the broader group of stakeholders who must be engaged with or informed to ensure successful delivery.

- The organisation reviews performance of their plan for each initiative and updates the resource requirements and risk log every month.
- Regular reports are presented to the board or relevant committees on initiative progress.

### 2. Does the trust have skilled staff to implement those delivery plans?

**Relevant hallmarks of high-quality strategic planning**

- The organisation reviews quarterly the total staffing requirements (FTE staffing levels and skills mix) to deliver each initiative individually, and all of the strategic initiatives supporting the vision collectively. The review should include both members of strategic planning teams and the clinical and service-level staff needed to deliver the initiatives.

- The organisation has a staffing capacity and skills development plan that it updates quarterly, based on those reviews of initiative staffing. The plan monitors whether there will be enough of the right resources and skills and shows how any shortages in either will be addressed.

### 3. Are trust staff, patients and other stakeholders able to explain the ambition and initiatives of the provider when asked, and do they know what they must do to deliver both?

**Relevant hallmarks of high-quality strategic planning**

- The ambition of the organisation has been communicated to staff in clearly-written documents and verbal briefings, and staff can explain the ambition when asked.

- Staff are briefed on their responsibilities for delivering the ambition and strategic initiatives, and can clearly explain those responsibilities when asked.

- Staff have incentives for delivering the initiatives, with achievement targets built into their objectives.

- LHE stakeholders, including commissioners, can explain the ambition of the organisation when asked.
4. Are strategic plans reviewed and updated yearly to keep them relevant?

<table>
<thead>
<tr>
<th>Relevant hallmarks of high-quality strategic planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The board and executive team review the strategic plans of the organisation once a year to ensure that they are still based on accurate and up-to-date inputs, and fully reflect developments in the trust’s internal performance and external environment.</td>
</tr>
</tbody>
</table>
Mental Health Strategic Delivery Plan 2014 - 2019
Discussion with CCG Leads
February 2014

Background

- Existing models of specialist mental health care delivery vary considerably.
- People who use our services continue to report gaps in provision and long waits.
- Have we got support in communities for people with mental health problems, i.e. have we got a clear integrated pathway of care?
- How do we demonstrate that we provide high quality and best value services?

Background

- Across adult mental health our teams differ markedly in terms of structure, staffing and practice – often based on increasingly irrelevant historical factors.
- Incremental changes have been made to services in response to local need and national and local priorities but fundamental whole system modernisation has never been achieved.
- Are we really a leading provider of mental health services?
Drivers
- National enquiries – Francis, Winterbourne etc
- Commissioning intentions and local priorities
- Professional guidance e.g. NICE, RCPsych
- True integration and partnership working
- Funding pressures and efficiency/CIP savings
- New CQC inspection regime
- Extended choice in Mental Health
- Care clusters and personal budgets
- Closing the Gap: Priorities for essential change in mental health – Department of Health Jan 2014

Ambition
- Move to a Recovery Model
- User at the centre of what we do/Co Production
- A new way of thinking
  “If you always do what you’ve always done then you’ll always get what you’ve always got”

What are we trying to do?
- Make our pathways work better for Service Users and Carers
- Make our pathways work better for external agencies, partners, GPs and commissioners
- Reduce bureaucracy and duplication
- Define, agree and improve quality and outcomes
- Increase capacity within existing resources
- Achieve CQUIN, QIPP and CIP targets
- Further modernise what we do
Benchmarking

- Some Community teams have twice as many referrals as others with the same population.
- Caseloads in one locality are 25% lower than another with the same population, but referrals are 15% higher.
- Length of stay on our wards varies considerably.
- Delayed transfers of care are increasing.

Acute Services

Why do we need to change

- Crisis Service – real concerns about how we work with AMHPS and the police force in response to mental health crisis.
- Access to support before the crisis occurs.
- Urgent and emergency access to crisis care.
- Two thirds of our admissions are out of hours – admission on Saturdays and Sundays account for half the weekly admission.

Acute Services

- Majority of discharges occur on a Monday.
- Higher proportion of formal admissions compared to other Trusts.
Acute services

- What do we want future models to incorporate?
  - Wherever possible avoid hospital admission and instead provide alternative care and support
  - Closer working with GP’s/Shropdoc for single point of access out of hours and expert triage
  - There should be no delays due to availability of professional
  - Clear purpose of admission
  - Medical assessment within 24 hours

Acute Services

- Formulation meeting within 72 hours
- Clear discharge planning from first day of admission
- Closer working between inpatient and community teams
- Need quick immediate Housing support/alternative to hospital
- Involvement of carers/family

Community services

- Why do we need to change?
  - Huge variations amongst CMHT – skill mix and working practices
  - Need to do better at identifying when to intervene with users, thus avoiding Crisis referral
  - Therapeutic interventions with defined outcome measures
  - Huge bureaucracy
  - Access, waiting times and services vary across the Trust and service developments have been piecemeal
Community Services

- What do we want future models to incorporate?
  - Single point of access – what does this really mean and does it work?
  - Face to face initial assessments with highly skilled MDT
  - Closer working with 3rd sector and local support groups
  - Time limited packages of care with defined outcomes and rapid access back into service
  - Greater use of peer recovery workers
  - Generic CMHT to be reshaped around Primary Care or around Care Clusters

Dementia services

- Why do we need to change?
  - Dementia a long term condition – is hospital admission (in an unfamiliar environment) the right place to be?
  - Inconsistent team structures and models of care
  - Staff working within the Community Teams operate a model consisting of large caseloads and routine reviews.
  - Two thirds of admissions are out of hours
  - No seven day week service
  - Much more carer involvement, understand the needs of carers and provide support to them.

Dementia Services

- What do we want future models to incorporate?
  - All-age Dementia service delivered by enhanced community teams
  - Home support accessible between the hours of 8am and 8pm and possibly during the weekend for the whole duration of the crisis period
  - Greater use of assistive technologies
  - Cognitive Stimulation Therapy
  - Ensuring that only patients with a dementia and who have challenging behaviour are admitted to inpatient services – for the shortest period of time
Dementia Service

- Patients’ and carers’ needs to be identified and met before a crisis develops, through enhanced community support
- Earlier discharge of patients through new and improved partnerships and increased community support.
- Patients to stay in their own home for longer and a reduction in patient moves/changes of environment at a vulnerable point in their illness
- Earlier Home package care
- Personal Budgets
- More alternative group day support – respite but stimulation

What have we done so far

• Established a clear internal project structure and governance arrangements to review and address present differences
• Set up work streams to look at Acute, Community and Dementia services
• Reviewed existing services and begun to think about what needs to change and why. Revision of skill mix in each team to ensure we are using the most expensive staff wisely and increase the numbers of peer recovery workers.
• Implementing plan to align management and team structures across all Community and Crisis services by September 2014

What have we done so far

• Developed a pilot scheme to evaluate the impact of increased home rehabilitation support for Dementia patients across Shropshire
• Held internal workshops for staff, service users and carers and key partners to explore current services and opportunities/options for future pathways
Next steps

• Discuss with commissioners, partners and external stakeholders how best to engage their views as we need to refine or change present models of service and ensure our work dovetails with theirs in relation to future care pathways
• Develop a joined-up approach for a consistent, effective, integrated and value for money service that meets CQUIN, QIPP and CIP requirements over the next 3 – 5 years
To: Council of Governors meeting

Date: 12th March 2014

From: Dr Jurai Darongkamas (Ms.)
Consultant Clinical Psychologist, Mental Health Division
Professional Lead for Mental Health Psychological Services, Trust
Lead for Personality Disorders, Staff Governor

Subject: Update the Trust Strategy for providing services to people who have symptoms consistent with a diagnosis of Personality Disorder(s) 2013 - 2018

Summary:

In September 2013, The Trust Board ratified the above strategy.

5 key priorities had been identified in the strategy as areas of focus:
The Strategy is being translated into practice; implementation is well underway.

**Main Report**

**Background**

Need for this strategy was highlighted by Neil Carr, to help improve services provided (quality issues, costs). A local stakeholders’ event was held in December 2012. Ideas were discussed at various meetings and the draft strategy was circulated widely for comment.

**What is “Personality Disorder”?**

The term is a diagnosis, i.e., using the medical model. It’s a controversial diagnosis to some; useful to others. The term covers a broad range of difficulties. A person may have this and other difficulties, such as depression. Please note symptoms may fall other alternative diagnoses, e.g., Post-Traumatic Stress Disorder (PTSD), Asperger’s. The role of trauma is recognised in many conditions including “PTSD, Complex PTSD, Borderline Personality disorder, Dissociative disorders, Bi polar, Psychosis, etc”
**DSM IV Definition of Personality Disorder**
An enduring pattern of inner experience and behaviour which deviates markedly from expectations of the individual’s culture. It’s pervasive and inflexible with onset in adolescence or early adulthood. It’s stable over time and leads to distress or impairment.

**International Classification of Mental & Behavioural Disorders (ICD-10, World Health Organisation 1992)** defines a personality disorder as:
‘a severe disturbance in the characterological condition & behavioural tendencies of the individual, usually involving several areas of the personality, & nearly always associated with considerable personal & social disruption’.

**Types of Personality Disorder**
There are three ‘clusters’ : A, B & C.
Cluster A - Odd/eccentric: paranoid, schizoid, schizotypal,
Cluster B - Dramatic/emotional/erratic: antisocial, borderline, histrionic, narcissistic
Cluster C - Anxious/fearful: avoidant, dependent, obsessive-compulsive.

In summary, people present to services with relational problems, and emotional management problems with severe, interrelated needs with high risks (to self/others) and often in crisis.

They are often subject to prejudice and/or discrimination. They have often been excluded from services on the grounds of untreatability; falling through gaps. They can be challenging for staff to offer appropriate care.

**Some important statistics**
- Lifetime risk of suicide with personality disorder is 11%
- % of people who commit suicide while an inpatient who have a personality disorder is 9%
- Lifetime risk of self-harm with personality disorder is 70%
- Over 40 % have co-morbid diagnosis
- Once admitted to psychiatric hospitals, people with personality disorder had an average stay of 70 days, with frequent re-admission
- 5-13% of general population
- 30-40% psychiatric outpatients
- 40-50% psychiatric inpatients
- 20-50% misuse substances
- 50-78% of prisoners have personality disorder
- 47-77% of people who complete suicides have personality disorder

**Progress to date**
Since the strategy was ratified, the following have been implemented:

A lead person and multidisciplinary group, including service user, has been identified to have oversight of developments. To date, the Trust steering group has met twice.

1. **Continue building positive attitudes and culture.**
This touches on other work in the Trust such as Values Based Recruitment and Recovery approaches (raised within the Strategy for this patient group).

All below have pledged their support to move this area forward:
- Dignity and Respect Group members,
- Community Engagement Group (building a multi agency group of interested parties), Ravi Bhakhri
- Time to Change Campaign, Jen Smit
- Lisa Gass (steering group member) agreed to be our media co-ordinator to work with communication dept. Postings have been placed on Trust intranet with plans to develop webpage to encourage clinicians to make information available, celebrate success, positive focus on this patient group.

Building positive attitudes is also occurring through training received (see below). For example, on the feedback form from one recent course attendee, s/he voluntarily commented that it was helpful to raise “awareness of own prejudices”.

2. **Training, supervision, peer support and reflective practice**

Implementing the Training Plan has been a main target. Alison Bussey and the training department have identified some additional monies to support staff training. This has enabled several courses to be set up for staff.

*Generic awareness training.*

A) The generic awareness training pack contents was designed and has been delivered to administration staff and receptionists; a half day training session took place on 3rd Dec 2013, facilitated by Dr Chris John and Lorna Abeysinghe. This was received positively with a participant spontaneously posting a comment on the Trust intranet. Future courses are in the pipeline.

B) The 3 day generic awareness package has been devised for clinicians and has been delivered.

*Training package*

Many drafts were circulated and comments received from many senior staff from all disciplines (too many to name here). Service User involvement was also obtained. Service Users reviewed and edited the training contents plus provided their story and perspective (including live during the training course).

Tailored slides for specific patient populations are being finalised (people with Learning Disabilities, child, forensic. For the latter area, this topic forms part of a broader package of psychologically informed training).

*Facilitators*

A Service User presented their perspective and story on the training days. Staff with expertise of client group and of teaching conducted the training (including clinical psychologists, psychiatrists).

*Contents*

Council of Governors Meeting – 12 March 2014
The course contents can be presented verbally at the meeting if required as it is confidential, market sensitive information (as other organisations are marketing such training. Reports of other training suggest our in-house training is more in-depth).

The training package appropriately covers many areas identified for further development; issues and approaches such as Recovery, collaborative working, service user involvement, clear contracting and co-producing agreed target problems thus helping with care planning, the move to Formulation driven services (looking behind the surface symptoms to consider probable cause and maintenance factors), improving multi-disciplinary working, providing truly holistic care, offering the range of bio psycho social – spiritual approaches.

Courses completed and on stream

The 5 day package has been delivered to S. Staffordshire in-patient and CRHT (Crisis Response Home Treatment) staff. The first course was held between 7 Jan – 4 Feb, the second course is currently running 11 Feb – 11 Mar, and a third course is planned for 18 Mar – 15 Apr.

Further 3 day courses are planned for 12 S. Staffordshire CMHTs and Shropshire and Telford Community Mental Health Teams (CMHTs), Early Intervention staff, Shropshire and Telford and Wrekin Crisis team staff, selected Learning Disabilities staff and selected CAMHS on:

- 27 Feb, 3, 4 March
- 12, 17, 18 March
- 19, 25, 26 March
- 24, 25 Mar, 3 April
- 24, 31 March, 1 Apr
- 2, 3, 8 April
- 2, 10, 11 April
- 6, 12, 13 May
- 30 April, 6, 7 May
- 2, 8, 9 May
- 13, 20, 21 May
- 14, 20, 21 May
- 15, 19, 20 May
- 16, 22, 23 May

Governors have already received an invitation to attend.

Number of staff members attended.

To date, approx. 85 staff members have attended across the first 3 courses.

Given the number of courses arranged so far, listed above (with more currently being organised), at least 500 staff will have participated in the training by summer.

Course Feedback- Summary of quantitative ratings from the 5 day (3 & 2 days) generic awareness training courses
The course:

• content was rated as very relevant across all the days with an average score of 5 (median 5, range 3-5),

• structure was rated as very well structured. Day 1 was given an average score of 5 and remained fairly high with an average score of 4 the other four days (median 5, range 3-5).

• used very appropriate methods to convey the material. Day 1 ratings yielded an average score of 5 (median 5, range 3-5). The average on Days 2 and 3 was 3 but picks up again to the maximum of 5 on days 4 and 5.

• provided very adequate materials. Day 1 materials handed out were given an average rating of 5, Days 2 and 3 averaged a rating of 4 and days 4 and 5 averaged 5 (overall median 5, range 3-5).

• gave positive ratings for the anticipated usefulness of the course content for the participant’s work. Day 1 averaged a rating of 5 (very useful). Days 2-4 received high ratings of 4 and day 5 received an average rating of 5 (overall median 5 (range 2-5, 2 from one person on day 1).

• resulted in a great deal of learning with an average rating of 5 for Day 1. Days 2-4 received high ratings of 4 and the last training day also received an average rating of 5 (overall median 5, range 3-5).

Very positive qualitative feedback received:

"Excellent, very knowledgeable presentation, Thank you"
“Very relevant to my role”
“Relating to practice; reflecting on self”
“Fascinating content and have hopes of it changing how we ‘do things' and have ‘done to’.”
“group work”, “group discussions”
“Mapping as a different approach to identifying and supporting clients.”
“Putting theory into practice (mapping).”

Suggestions included
“Everyone who works with this patient group should attend this training.”
“Brilliant training, every discipline should do including managers, medics, SHO’s, commissioners. More awareness required for trust to have ability to tailor.
“Doctors and higher bands to attend training.”
“Management (even the board of Directors should attend)- IMPERATIVE!”
“further training to aid more team members to attend, invaluable info being taught”
“It has highlighted the need for quality clinical supervision and support.”
“Would be good to be mandatory.” (N.B. aiming for status of “essential professional development” within Trust)

Overall evaluation plan for the generic awareness training:
A matrix of evaluation of the training was designed by a group of staff, (pre & post measures researched and designed, including patient experience – matrix itself available from the author on request, David Dobel-Ober, Lorna Abeysinghe, Jurai Darongkamas, Steve Hazeldine, Joanna Saddlington, S. Staffs. MH Psychologists, Tim Devanney, Cathy Riley.

A mini-audit of patient experience was conducted prior to the first training course for staff (designed by David Dobel-Ober, Lorna Abeysinghe, Jurai Darongkamas, Steve Hazeldine, Joanna Saddlington, S. Staffs. MH Psychologists, Tim Devanney, Rebecca Crawford, Terjinder Kaur, Cathy Riley).

Help with overseeing the analysis and reporting of this evaluation is now being sought.

*Psychological therapies.*

Two 2 day Introduction to Cognitive Analytic Therapy (CAT) workshops and one Introduction to Cognitive Behavioural Therapy (CBT) have been arranged.

CBT and CAT leads identified (N.B. Shropshire CAT lead retiring now).

Arrangements are in place to train up 5 (tbc) staff members to CAT Practitioner level (in discussion with Manchester) and to offer some CBT training to other staff also.

The provision of some ongoing supervision to embed learning is being arranged.

*Supervision.* The author contributed the ideas generated by attendees at the stakeholders’ event to the current draft of the Trust’s supervision policy which is currently out for consultation.

*Reflective practice* - “Schwartz Center Rounds® provide a monthly, one-hour session for staff from all disciplines to discuss difficult emotional and social issues arising from patient care. They have been positively evaluated.

Locally, monthly reflective groups can be embedded further as part of good practice, e.g., monthly Stafford CMHT staff support/Formulation group (positive feedback received), Cannock Mindfulness group for staff also led by Psychologist. This will help support and nurture the development and maintenance of compassionate care.

3. **Improving existing service offer (examples)**

Issues have been, and will be, on agenda and discussed at Senior Management Team and Divisional Management team.
The Trust steering group continues to prioritise the many other suggestions for improvements to the existing service offer as proposed in the strategy, operationalising and raising such ideas in appropriate fora for action. The aim being to improve support to staff and to improve services including driving forward the move towards Formulation driven services (work towards the latter is also via the training, supervision, reflective practice stream).

**DEFINITION.** Essential features of Psychological Formulation includes:

- summarise the service user’s core problems;
- suggest how the service user’s difficulties may relate to one another, by drawing on Psychological theories and principles;
- aim to explain, on the basis of psychological theory, the development and maintenance of the service user’s difficulties, at this time and in these situations;
- indicate a plan of intervention which is based in the psychological processes and principles already identified;
- are open to revision and re-formulation.

For example, the role of psychologists and other colleagues in helping with organisational work was outlined in a recently tabled paper for the Board (which was approved). Such work includes debriefing staff after a serious incident.

Another example of ideas in the strategy becoming implemented is of employing at least one person (to author’s knowledge) with experience of having a diagnosis of Personality Disorder. This has occurred.

4. **Developing closer Partnerships with a range of partners**

We continue to invite others to work together with us, e.g., contact made with person with role to set up multi-agency work, maintaining close links with CHORUS and SURF.

We continue to explore the possibility of developing a multi-agency strategy for this population.

Discussions have commenced with University colleagues in the W. Midlands about nurse training curricula (R. Salmon) and about research in this field (Professor E. Bradley, help of research department sought).

5. **UNMET NEED: Developing new services**

We are inviting others to work together with us, including seeking to meet and present to commissioners (& with Steve Grange, Director of Business and Strategic Development).

The group to work on developing new services have met once, so far, and will need to meet again to progress this work.
Capturing the numbers of patients who have such difficulties more accurately and reviewing out-of-area referrals will reveal the extent of needs unmet locally. We can plan to audit the number of service users in specific service areas (help of audit department is sought in addition to within the medication audit, designed with C. Riley).

The successful implementation of this strategy should

• raise quality,
• improve service accessibility for this patient group, through reducing stigma (meeting the Equality and Diversity agenda and reducing social exclusion),
• help meet NICE guidance and
• provide ongoing clinical supervision and reflective practice as part of good quality care and governance (please note the financial and resource implications).
To: Council of Governors  
Date: Wednesday 12 March 2014  
From: Tony Price, Lead Governor  
Subject: Governor Member Report on Activities, Events and Achievements

Non-Executive Director Activity

As agreed at Decembers Council of Governors meeting, please see appendix 1 for information regarding Non Executive Director activity (December 2013 and January 2014).

Governor Handbook

A new Governor handbook has been developed. This contains current key points for both new and existing Governors. This will be distributed to Governors electronically and will also be available on the Governor area of the website. Any changes or updates can then be made and the handbook will stay up to date.

Time to Change – Time to Talk

Thursday 6 February 2014 was the first ever Time to Talk Day: 24 hours in which people started conversations about mental health, raised awareness and shared the message that mental illness is nothing to be ashamed of, neither is talking about it.

The Trust and its partners supported “Time to Talk”. Governors joined Quest, Stafford FM and South Staffs Mental Health Network at Asda in Stafford where over 450 conversations were had! Inpatient areas all received literature and Time to Talk tea bags and the Songs for You event in Shropshire, with Arts for Health also supported the day.

On Thursday the 6th February, I was able to support the ‘Time to Talk’ event held at Asda Stafford.

If I am perfectly honest it was not hard work at all as ASDA had given the event prime spot adjacent to the main exit from the store and the community events coordinator, Dan Roberts, was an excellent host.
We were armed with a large variety of give aways, all carrying either, 'Time to Talk' or supportive organisations messages. We had been asked to attend for a short time during the planned event, between 10 and 2. Arriving at ten I thought we would be off to a slow start, however that was not the case, we were approached for information as we set up and that continued throughout the day, at some points we even had people waiting around for somebody to be free to speak to them.

I spoke with ex-service users, service users, carers, people who were related to service users. or ex-service users. Local business people, interested members of the public, armed services personnel. Even Trust employees.

I was honestly surprised how positive people were about the need to be more open about 'Mental Health' issues.

I was asked for membership forms, leaflets on how people could make contact about their or somebody they knew issues. We ran out of Teabags, Stress Balls, Badges, in fact everything.

Ray Crowther broadcast short interviews with all six of us in the group promoting the day, spoke about his time when he worked within our organisation, then he spoke to members of the public about the event, very professional. Ray had at one time been a member of our nursing staff.

The volume of contacts, pleasantly surprised all of us, I did at one point have to go to the membership office to get more supplies. Whilst we cannot be totally accurate we agreed that in the time we were in the store we made over 450 contacts.

We have not focused on events in any of the local supermarkets before, but this must now be considered due to the success of the event.

I had conversation with ASDA's General Store Manager, Grant Marshall, who stated that he would 'more than happy' to have the Trust and it's partners use ASDA Stafford as a facility to publicise the services of the Trust and it's partner organisations.

I would like to thank everybody involved in the days event I understand the event has had photos of it put on to various social media sites including Facebook and Twitter.

Pete Cross, Public/Service User/Carer Governor – South Staffordshire

**NHS Change Day – 3 March 2014**

NHS Change Day is a frontline led movement; the largest of its kind, with a shared purpose of improving health and care. Our mission is to inspire and mobilise people everywhere, staff, patients and the public to do something better together to improve care for people.

The first NHS Change Day, which took place last March, was unprecedented. It was a 'game changer' that provided the amazing grassroots momentum so many staff, patients and people working within the NHS needed. Anyone can get involved to pledge
something that will make a difference, no matter how big or small. A pledge could be part of your everyday routine or something extraordinary. It's simple, just think of something personal to you and make a pledge or join an existing one below. Every voice counts and every pledge matters. You can make a pledge until the 31st March.

Governors and Trust staff will be able to make their pledges at Georges Restaurant and at The Redwoods Centre between 12 and 1.30pm

Analysis of changes made following the Essential Standards Visits during 2013

1. Introduction

1.1 During the year 2013 there were 30 reviews including eight Community Mental Health Teams. 23 visits included governor members and two included a commissioner. At the end of the year there were three in-patient areas that had not been visited as part of the schedule but did have input from the Performance Development Team to complete the action plan following their visits at the end of 2012.

1.2 For the purpose of the analysis the actions have been allocated to one of two groups, namely direct patient benefit and indirect patient impact. Direct patient benefit being defined as an action that once addressed has an immediate impact on care delivery or safety and indirect patient impact which requires action outside of the care giving environment before the change or improvement makes a difference to care delivery.

2. Findings

2.1 In total the 30 reports made 270 suggestions for improvement. 103 of these represented direct patient benefit and 167 identified changes that impacted on staff or the organisation in the first instance and direct patient care delivery in the longer term. The average number of actions was 9 per visit and the range was 3 – 23. Some authors of the reports would individualise each recommendation and others would group them into one overall suggestion for improvement which accounts for the wide range found. The specific actions identified by the visiting team reflected their varied professional backgrounds and interests although the briefing note produced for each visit ensured there are some consistent themes being reviewed.

2.2 The first domain of the Essential Standards framework focuses on information and involvement and had 41 comments recorded against it. 30 of them, once action had been taken, had a direct impact on care delivery. The following represent some of the changes made in response to them:
- Norbury House have implemented a system to ensure they obtain service user experience feedback from service users without Section 17 leave by providing paper copies of the questionnaire used on the system and using admin staff to input the data into the Meridian system. They also use patient stories to inform care planning and service development
- Norton House started to use reports from the Meridian system to ensure timely feedback to service users
- Tamworth CMHT have developed a leaflet promoting Meridian, they are provided to all service users at their initial assessment and displayed in the waiting room and interview rooms
- Brockington now have community meeting minutes typed up and display them on notice boards ensuring service users have direct access to them
- A number of areas have introduced a weekly check of leaflet racks and notice boards to ensure they are up to date and replenished routinely
- Spruce have reviewed the pre-admission information they provide to service users, carers and staff to include details of what personal items are permitted on the unit
- Oak House ensure service users photographs are placed on bedroom doors on admission by including the photograph in admission packs
- Mental Health Act information specific to the individual has been made available to Elms House residents by including them in a folder in each room in addition to staff discussing their rights with them

2.3 There are three outcomes of the Essential Standards of Quality and Safety included in the domain around personalised care and treatment. This area consistently gets the most positive comments from visitors, however there were 39 areas for improvement identified (31 of these once completed have an immediate impact on direct patient care) and the following outline some examples of changes that have been made:

- Tier 4 have improved the links with Heartlands Hospital to enable quicker access to blood results for prescribers and service users
- Newport House, Pine, Birch routinely have housekeeping services at community meetings to discuss various issues around the provision of meals.
- Intentional round has been fully implemented in 2 areas following recommendations in the visit report
- Ellesmere House multi disciplinary team now care plan with service users for developmental and physical healthcare needs following issues identified by staff at the visit
- In the absence of a designated multi faith area Ashley House encourage service users to use their rooms for prayer time or the quiet area/room on the ward for service users without Section 17 leave
- Spruce have undertaken a review of activities available on the ward and included the views of service users and referrers as part of this
- Since the visit Oak, Redwoods have appointed a dedicated activity coordinator to provide activities and Milford House have increased and improved the availability of activities on the ward through the appointment of an OT assistant who works 2
evenings per week. These roles were in discussion before the visits, but were identified as a need by visitors in the absence of this knowledge
- Baswich have reviewed care planning to include mental health and behaviour plans of care for all service users.

2.4 The domain around safeguarding and safety contains the highest number of suggestions for improvement at 92. These actions are usually addressed by Facilities and Estates, as they are generally about the physical environment, before having a direct benefit to service users. Outcome 10 (safety and suitability of premises) had 43 actions and outcome 11 (safety, availability and suitability of equipment) had 19. The other 3 outcomes in this domain safeguarding, infection control and medicines management had fewer actions identified, there were 23 in total for this group. The Trust has a separate infection control audit programme.

2.5 These examples highlight some of the actions undertaken:

- Milford House have implemented a system that ensures the process of logging works request numbers in a folder is reviewed each week and unfinished jobs are chased up until completed.
- Newport House have also started to take this approach and escalate any prolonged issue to the directorate management team to pursue when necessary
- Working with Facilities and Estates colleagues Oak, Redwoods sourced alternative methods window screening to improve privacy and reduce ligature risks
- Brockington in discussion with Facilities and Estates purchased rubber corner protectors for bed heads to prevent injury and also replaced socket covers that had been broken
- Correct signage is now displayed on Kinver, Spruce, Elms House and Radford House
- Garden maintenance has improved on Newport, Ellesmere, Willow and Baswich by establishing or re-establishing gardening groups following visits where the lack of border maintenance has been identified. Facilities and Estates have also provided some input through raising of job numbers for grass cutting
- South Shropshire CMHT addressed issues with wheelchair access to the building with Facilities and Estates by providing a ramp
- Outstanding PAT testing at Burton CMHT was completed immediately following the visit and a weekly check implemented to ensure all PAT testing remains in date

2.6 Suitability of staffing had a total of 44 actions identified 31 of these were made around outcome 14 (supporting workers). Action undertaken in this domain does not generate immediate changes to care delivery however processes implemented develop and enable staff to provide improved care and treatment. The following illustrate actions taken by teams to address the concerns raised:
- Where mandatory training compliance was low teams worked with Learning and Development to arrange local provision of specific courses, this approach was taken by Yew, Spruce, East Wrekin CMHT and Pine
- On-line mandatory training was scheduled into the duty rosters on Willow and Burton CMHT
- Where appraisal compliance was low the following teams put in a process to address this ensuring all outstanding appraisals would be completed in a given timeframe. This was achieved by Baswich, East Wrekin CMHT and Laurel
- Supervision arrangements were improved on Milford House by ensuring staff supervision was included on duty rosters
- Norton House extended group supervision to include all disciplines and regular agency staff. This was also introduced by Ashley House
- All areas have implemented or are in the process of registers for clinical supervision for nursing staff. This provides a monitoring system for ward management teams and ensure staff comply with trust policy

2.7 53 suggestions for improvement were identified in the final domain around quality and management. 28 actions were made in relation to outcome 21 were concerned with recordkeeping and the management of the files e.g. entries written legibly, signed and dated, documents being filed correctly and stored safely. When these issues are found during a visit the details are given to staff to enable immediate correction or action. It is of note that member governors do not view records when visiting wards therefore it is Trust employees who identify the concerns. Outcome 16 (assessing and monitoring the quality of services) had 22 actions to address. The following examples indicate changes made to processes and systems as a result of some of the findings in this domain.

- Following the visits immediate action was taken to correct records on Oak House, Radford House, Lichfield DNLD CMHT, Tier 4, Pine, Milford House, Burton CMHT, East Wrekin CMHT and South Shropshire CMHT
- Health record audits have been established or re-established in South Shropshire CMHT, Milford House, Oak, and Radford House
- East Wrekin CMHT have included compliance with recordkeeping standards on clinical/management supervision checklists
- Norbury House ensured all staff were familiarised with the Rio system by scheduling on-line training in duty rotas
- Following a visit Ashley House identified more hardware was required for the introduction of Rio. It is now in place
- Team meetings have been re-established on Baswich and Norbury wards
- Processes for communicating information between team meetings have been implemented on Radford House, Baswich and Chebsey. These include the use of group e-mail and displaying of information such as audit results in staff rooms.

3. **Summary**

3.1 In summary changes made as a result of the Essential Standards visits undertaken during 2013 that had a direct impact on patient care were mainly found in the
domains relating to information and involvement and personalised care and treatment. These improvements were addressed by ward managers and team leaders following visits and were usually completed soon after the visit. Safeguarding and safety had the largest number of actions identified and around a third of these were of direct patient benefit once completed.

3.2 The actions highlighted in the domains around suitability of staffing and quality and management were less likely to be of direct patient benefit and required the implementation of a system or process before having an impact on the delivery of patient care.

Jill Wells, Assistant Clinical Performance Manager

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**GovernWell Training**

**Effective Listening and Questioning – 6 February 2014**

I would encourage Governors to attend training by the GovernWell organisation, as I found the materials and trainers to be of a very high standard. It was also very useful to meet Governors from around the country - the majority on the day in Birmingham had come from Norfolk! - and to hear different perspectives and experiences. This particular course was designed for newer governors but despite being a veteran of nearly 3 years(!) I found it incredibly helpful. Part of the time was spent exploring how we listen and what we can do to be a better listener. This largely involves self-awareness; being conscious of our own prejudices, preconceptions and internal dialogue can help to turn off the filters through which we tend to **hear** things, and make us able to actually **listen**.

The latter part of the day was spent in a variety of exercises developing our ability to ask more relevant and focussed questions, specifically at Council of Governors' meetings. The word that I have brought away with me is **ASSURANCE**: How can the NEDs assure me/the council that....? Are the NEDs assured that the data matches the narrative? There are various ideas which I may be able to feed in to the NED/Governor engagement plan when we have carried out our other agreed actions, but the main task that we can each carry out more effectively is **BEING PREPARED**. It’s obvious that we all need to read the papers for Council thoroughly, but not so easy to work out what we need to question and how to phrase those questions. There may be some technical issues (especially around the Annual Report) that we can clarify before the meeting, so that the precious time for challenge and debate at Council can be used for exactly that. In the longer term I believe it will be necessary to have some sort of pre-meeting to decide among ourselves what questions to ask. As you can see, there was lots of thought-provoking stuff!

I am looking forward to the Finance course in June and hope that other governors will be able to join me. The venue in Birmingham is lovely and very close to New Street Station. The food was fantastic too!
Veterans’ Mental Health
In January I had the privilege of spending a day shadowing Rob Heath, who is the Veterans’ Mental Health Lead Nurse for Staffordshire. Rob had kindly planned his appointments for the day to give me a flavour of the variety of work that he does. However, the best laid plans can go awry, and the inpatients that we were due to visit had chosen to go on leave that day! I accompanied Rob on a home visit in a very complicated situation and admired his emotional resilience and professionalism. I was also able to sit in on an appointment at the office and gain an insight into a completely different set of problems.
Governors are aware that the Veterans’ service exists to provide a layer of support and therapy which uses the language and understands the ethos of the Armed Forces. Service users are asked as part of their initial assessment whether they have a forces background and whether they would like to access the veterans’ support nurse. Rob has made good use of the introduction of the Rio system to ensure that the question of service history is asked. He receives a daily report of service users who have replied “yes”, and follows up the minority of this group who have requested veteran-specific support.
There are three issues which I would like to bring to governors’ attention:
1) I would like to be assured that professionals can use their discretion about whether to bring a computer and printer into a situation of therapeutic relationship. This topic arose from a lengthy conversation with Rob about the benefits of the Rio system coupled with my observation that he only took a paper diary to the home visit. Technology can get in the way of human interaction.
2) There is a huge variation in the level of veterans’ service available in different geographical areas of the Trust. Staffordshire has a 5-day post (which I believe to be the only one in the UK) whereas Shropshire has only a 1-day post, despite the population of veterans being estimated as similar in both counties. The data capture from Rio is already increasing the number of referrals to this service. I do not believe that this variation is acceptable, and that if the Trust wishes to hold itself up as an example of good practice then it must beware of hypocrisy. I request that an explanation is given to the Council of Governors.
3) Governors will remember the moving presentation given to the Council in April 2013 by Wayne Kirkham as National Veterans’ Lead. It is my understanding that Wayne’s role has now been moved out of SSSFT firmly into NHS England and that Wayne will no longer be based at St. George’s. I hope that Governors will join me in thanking Wayne for the hard work that he has put in to get the National Network off the ground and for making such a difference; and in wishing him all the best for the future.

Post Board Meeting Note:
Since writing this report the board has been informed that the Shropshire Veterans’ Lead has left her post, leaving Rob to cover the entire geographical patch. My question regarding equality of provision is therefore annulled. I ask instead what action is being taken to address the stretching of provision at the same time that referral numbers are increasing.

Jacki Boyle, Public Governor, Shropshire, Telford and Wrekin
Lead Governor Report

All Council meetings are important on a number of levels; they allow Governors to get together and see what activities they and the Trust have been undertaking since the last meeting, discuss key issues with each other, staff and Non Executive Directors (NED’s) and receive information on key risks and opportunities facing the Trust in the ever changing NHS world. This meeting is a particularly important one as we will be appointing a new Chair, possibly the most important decision that the Council has to make, based on the recommendations of the Nominations Committee which it is worth remembering has a Governor majority on it.

As ever, the Governor Report is full of the work of Governors, including notes and decisions of the various engagement groups and sub committees that Governors are involved as well as other important information. One area that I would particular like to mention is the programme of Governor’s shadowing NED’s. This is a key element of “holding to account” that we agreed at the last Council meeting. Three Governors have arranged to shadow NED’s so far and if you are interested in doing this yourself, please contact the Membership Office.

Most Governors will know Alan Snuggs who has worked as a consultant with the Trust generally and Governors specifically for a number of years. Alan has been instrumental in developing Governors individually and the Council collectively. Alan’s main work with the Trust has finished (although he may be back for special “guest” appearances!) and I would like to place on record both my personal and the Council’s thanks to him for his efforts over the years. I am especially grateful for his help and support to me as Lead Governor.

As everyone will know, the Mid Staffs Trust is to be disbanded and some of the services and staff moved to other hospitals, principally Cannock and Stoke on Trent. In some ways this brings to an end a number of years of issues and challenges for them but there will continue to be impacts on the wider health economy in Staffordshire. This will affect us and we need to be able to manage the risks but also be able to take advantage of any opportunities that may arise.

Governors should be aware of the We Are Human Conference being held on 1st April which will focus on how mental health and hate crime. If anyone is interested in attending, please contact the Membership Office. I particularly recommend the housing workshop (he says immodestly!)

Finally, as I always seem to say, I remain impressed and pleasantly surprised by all the work, effort and commitment that Governors show with their work with the Trust. Thanks to everyone for this.

**Summaries**

1.1 NED Activities (December 2013)
1.2 NED Activities (January 2014)
2.1 Trust Board (December 2013)
2.2 Trust Board (January 2014)
3.1 Trust Strategic Direction (January 2014)
4.1 Service User and Carer (December 2013)
5.1 Performance and Assurance (February 2014)
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<td>Sue Nixon</td>
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1 Note: the expected time commitment for Non Executive Directors and consequently their remuneration is based on four days per month, annualised over a 12 month period.
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<td>▪ Managers Appeal hearing</td>
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**Glossary of Abbreviations:**
- **BDISC**  Business Development and Investment Committee
- **HRODE**  Human Resources, Organisational Development and Equalities Committee
- **SUAC**  Service User and Carer Committee
- **F&P**  Finance and Performance Committee
- **QERC**  Quality, Effectiveness and Risk Committee
- **FTN**  Foundation Trust Network

In addition to the activities noted in the schedule NEDs spend at least 1-1.5 days per month reading and preparing for meetings.
### NED ACTIVITIES – JANUARY 2014

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<th>Name</th>
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- **FTN**: Foundation Trust Network
Council of Governors

Report to: Council of Governors
Date: 12 March 2014
Title: Board of Directors Meeting: 17 December 2013

Summary:
The full minutes of all board meetings and papers are available on the website at http://www.southstiffsandshropshealthcareft.nhs.uk/Partnership/Board-Meetings/Default/General-Information.aspx. They can also be obtained from the Membership Office.

Agenda Items
- Staff Story: Inclusions
- Questions from the floor
- Chief Executive Report and Environmental Scan
- Trust Assurance Report  
  - Quality and Clinical Performance  
  - Finance and Performance  
  - Business Development  
  - Human Resources, Organisational Development and Equalities
- Clinical System and Replacement Project Update
- Lived Experiences Influencing Service Improvement (Patient Stories) Pilot Evaluation
- Directors’ Declaration of Interests

Decisions taken
- The future approach to bringing Patient Stories to the Board was agreed to be based on the Manchester approach but not exclusively, to ensure other approaches and opportunities were pursued.
- The Care Cluster Policy was ratified.
- Amendments to the declaration of interest arrangements were agreed.

Recommendation
The Council of Governors is asked to note the report.
Report to: Council of Governors

Date: 12 March 2014

Title: Board of Directors Meeting: 17 December 2013

Summary:
The full minutes of all board meetings and papers are available on the website at http://www.southstaffsandsalphershealthcareft.nhs.uk/Partnership/Board-Meetings/Default/General-Information.aspx. They can also be obtained from the Membership Office.

Agenda Items

- Patient Story: Update on Patient Story from August 2012
- Questions from the floor
- Chief Executive Report and Environmental Scan
- Trust Assurance Report
  - Quality and Clinical Performance
  - Finance and Performance
  - Business Development
  - Human Resources, Organisational Development and Equalities
- Clinical System Project Update
- Approach to Future Monitoring of Safer Staffing
- Directors’ Declaration of Interests
- Use of Seal
- DOLS/Mental Capacity Act Assurance Report
- Francis Progress Report
- Medicines Optimisation Annual Report
- Post Project Evaluation: Shelton Hospital Redevelopment
- Risk Register and Assurance Plan
- Charitable Funds Annual Report

Decisions taken

- The policies listed at paragraph 11 were ratified by the Board.
- The Trust Management Team and the Senior Leadership Forum terms of reference were agreed.
- The planned approach to reviewing and reporting in-patient staffing levels was approved.
- The Register of Interests was confirmed as accurate and up to date.
- The uses of the Common Seal were approved.
- Assurance was confirmed relating to action taken and planned to improved compliance with DOLS/Mental Capacity Act.
- Recommendations for future work associated with the agreed priority areas with respect to the Francis Report were agreed.
- The Medicines Optimisation action plan was agreed.
- The management letter of representation relating to the Charitable Funds annual report and accounts for 2012/13 was agreed.
- Changes recommended to the Risk Register and Assurance Plan were agreed.
- The submission of the Charitable Funds annual report and accounts for 2012/13 to the Charities Commission was approved.

**Recommendation**
The Council of Governors is asked to note the report.
**Council of Governors Meeting**

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<td>Date:</td>
<td>12 March 2014</td>
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<tr>
<td>Title:</td>
<td>Strategic Direction Group – 20 January 2014</td>
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<tr>
<td>Report of:</td>
<td>Dave Gill, Chair of Strategic Direction Group</td>
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**Summary:**

The Trust Strategic Direction Group continues to provide Governor Members an opportunity for engagement and influence on the strategic direction of the Trust.

**Key Points**

- Professor Tony Elliott talked through the Trust’s Mental Health Division strategic plan.
- Steve Grange spoke about the Trust’s strategy and how this is being changed and would be brought back to this group.
- Steve Grange spoke about the LEAN training – all Executives have done and passed this training.
- Glen Francke spoke about Right Service, Right Place and specifically the inpatient side of the project.
- Steve Grange talked about the Trust’s Annual Plan.
- It was agreed that the next meeting would be a one item agenda looking at the Trust’s Annual Plan.

**Recommendation:**

The Council of Governors is asked to:

1. Receive and note the report for information
# Council of Governors Meeting – 14 March 2014

**Report to:** Council of Governors  
**Date:** 12 March 2014  
**Title:** Service User and Carer Involvement Committee Report on meeting of December 11th 2013  
**Report of:** Sue Nixon, Chair, Service User and Carer Involvement Committee

## Summary
The Service User and Carer Involvement Committee continues to receive reports and provide assurance to the Board against its work programme via a summary report submitted to the Board after each bi-monthly meeting. The Committee also reports to the Council of Governors. Full minutes are available from the Membership Office.

## Key Points

1. A new agenda item was introduced at the beginning of the meeting to address issues forwarded to the Chair in advance of the meeting. Choice for inpatients regarding the timing of hot meals on the wards in Shropshire was raised. A new nutrition group will be held monthly in the new year to address concerns and will feed back to the committee.

2. The Big Issue was about Focusing on Recovery. Trust lead for recovery, Rachel Lucas spoke about the principles of recovery: your health, your home, your life, for all, and we challenge ourselves. Also discussed was co-production between staff and service users/carers, and peer support workers. Responses from the committee members on the subject were recorded to contribute to a recovery event being held on December 18th.

3. We watched a short patient and carer experience film that had been made by the mental health trust in Manchester in collaboration with a production company. The committee was happy for this approach to go forward for Board approval, as they agreed our trust would benefit from recording patient stories in this way and using them in training. It was asked that alternative means of raising issues also continue to be supported.

4. The Open Space discussion was about the evaluation of this committee and the setting of its agenda. Questions such ‘how can we make sure the meetings work better and ‘what do we think is working well at the moment’ prompted many varied responses. A service user offered to go to the Board in February to help present the feedback.

5. Concerns about lack of support for people taking part in involvement were expressed. A feedback form is being designed to find out people’s experiences of involvement and where the gaps are in support.

## Recommendation:

The Council of Governors is asked to:

1. Receive and note the report for information
### Report to:
Council of Governors

<table>
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<th>Date:</th>
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<tr>
<td>Title:</td>
<td>Performance and Assurance Group – 18 February 2014</td>
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<tr>
<td>Report of:</td>
<td>Tony Price – Chair of Performance and Assurance Group</td>
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**Summary:**

The Performance and Assurance Group (PAG) considers the Trust’s Assurance Report, scrutinise performance and seek assurances on other key areas of the Trust’s operations. Full minutes are available from the Membership Office.

**Key Points**

- An update for RiO was agreed to be an agenda item for the next meeting.
  - Pete Kendal will be invited to present this item to the group at the next meeting.
- Sara Reeve spoke about the latest CQC visit.
  - Two areas of concern.
- Sharon Dennison gave an update on the Trust’s mandatory training.
  - In the last year overall compliance has risen by 5%.
- Jill Wells gave an update on the Essential Standard Review visits.
  - 30 areas covered in 2013.
- Tony Price spoke about the Chief Executives objective.

**Recommendation:**

The Council of Governors is asked to:

1. Receive and note the report for information