Derbyshire Healthcare
NHS Foundation Trust

Board of Directors

Conference Rooms A & B, First Floor, Centre for Research and Development, Kingsway Hospital
28 February 2018 13:00 - 28 February 2018 16:15

INDEX

Derbyshire Healthcare
NHS Foundation Trust

NOTICE OF PUBLIC BOARD MEETING – WEDNESDAY 28 FEBRUARY 2017
TO COMMENCE AT 1.00 PM IN CONFERENCE ROOMS A&B
FIRST FLOOR, CENTRE FOR RESEARCH & DEVELOPMENT, KINGSWAY HOSPITAL

	TIME	AGENDA	LED BY
1.	1:00	Chair's welcome, opening remarks, apologies for absence and Declarations of Interest Register	Caroline Maley
2.	1:05	Service Receiver Story	Carolyn Green
3.	1:30	Minutes of Board of Directors meeting held on 31 January 2017	Caroline Maley
4.	1:35	Matters arising – Actions Matrix	Caroline Maley
5.	1:40	Questions from governors or members of the public	Caroline Maley
6.	1:45	Chair's Update	Caroline Maley
7.	1:55	Chief Executive's Update including Director of Public Health annual report focus on health inequalities in the Derby population	Ifti Majid
OPERATIONAL PERFORMANCE, QUALITY AND STRATEGY			
8.	2:20	Integrated Performance and Activity Report	Mark Powell/Claire Wright/Amanda Rawlings/Carolyn Green
9.	2:40	Position Statement on Quality	Carolyn Green John Sykes
10.	2:50	Board Committee Assurance Summaries and Escalations: Safeguarding Committee 2 February, Quality Committee 8 February, Mental Health Act Committee 15 February 2018 *(minutes of these meetings are available upon request)*	Committee Chairs
3:00 B R E A K			
11.	3:15	Deep Dive – Joint Eating Disorders Service	Mark Powell
12.	3:35	Updated Constitution	Sam Harrison
13.	3:55	LGBT+ Commitments Update	Claire Wright
CLOSING MATTERS			
14.	4:05	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Meeting effectiveness	Caroline Maley
FOR INFORMATION			
2017/18 Board Forward Plan			-

Questions that are applicable to the agenda, and at the Chair's discretion, can be sent by email to the Board Secretary up to 48 hours prior to the meeting for a response provided by the Board at the meeting. Email: sue.turner2@derbyshcft.nhs.uk
The Trust Chair may, under the Foundation Trust's Constitution, request members of the public to withdraw for the Board to conduct its remaining business in confidence as special reasons apply or because of information which is likely to reveal the identities of an individual or commercial bodies.

The next meeting will be held at 1.00 pm on 28 March 2018
in Conference Rooms A & B, Centre for Research and Development, Kingsway, Derby DE22 3LZ
Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.
Participation in meetings is at the Chair's discretion

Declaration of Interests Register 2017-18

NAME	INTEREST DISCLOSED	TYPE
Margaret Gildea Non-Executive Director	• Director, Organisation Change Solutions Limited • Non-Executive Director, Derwent Living	(a, b)
Geoff Lewins Non-Executive Director	• Director, Woodhouse May Ltd • Director, Arkwright Society Ltd	(a, b)
Ifti Majid Chief Executive	• Board member, North East Midlands Leadership Academy Board • Kate Majid (spouse) Chief Executive of the Shaw Mind Foundation which is a UK/USA mental health charity	(a, d)
Caroline Maley Acting Trust Chair	• Director – C D Maley Ltd • Trustee – Vocaleyes Ltd.	(a) (a, d)
Mark Powell Chief Operating Officer	• Chair of Governors, Brookfield Primary School, Mickleover, Derby	(d)
Amanda Rawlings Director of People and Organisational Effectiveness (DHcFT)	• Director of People and Organisational Effectiveness, Derbyshire Community Healthcare Services (DCHS) • Co-optee Cross Keys Homes, Peterborough	(a, d)
Dr Julia Tabreham Deputy Trust Chair and Non-Executive Director	• Non-Executive Director, Parliamentary and Health Service Ombudsman • Director of Research and Ambassador Carers Federation • Leads the Parliamentary and Health Service Ombudsman's contribution to establishing NHS complaints advocacy support in Ireland • Elective member for CHETWYND, the Toton and Chilwell Neighbourhood Forum representing the community's interest in the HS2 high speed rail project. • Husband, Steve Tabreham of Steve Tabreham Inspection Services, also works for Lloyds Register	(a, d)
Dr John Sykes Medical Director	• Undertakes paid assessments of patients at the request of the local authorities under the Mental Health Act and Mental Capacity Act and acts likewise for solicitors representing patients. • Sits on the management side of the Trust's Local Negotiating Committee	(e)
Richard Wright Non-Executive Director	• Director, Sheffield Chamber of Commerce • Chair, The UTC Sheffield Multi Academy Trust • Member of Advisory Board of Sheffield National Centre for Sport and Exercise Medicine	(a, d)
Lynn Wilmott-Shepherd Interim Director of Strategic Development	• Director of Commissioning and Delivery, NHS Erewash Clinical Commissioning Group	(d)

All other members of the Trust Board have nil interests to declare.

(a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those dormant companies).
(b) Ownership or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
(c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
(d) A position of authority in a charity or voluntary organisation in the field of health and social care.
(e) Any connection with a voluntary or other organisation contracting for NHS services.

Derbyshire Healthcare
NHS Foundation Trust

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

Held in Conference Rooms A&B
Research and Development Centre, Kingsway, Derby DE22 3LZ

Wednesday 31 January 2018

MEETING HELD IN PUBLIC

Commenced: 1pm Closed: 4pm

PRESENT:	Caroline Maley	Trust Chair
	Dr Julia Tabreham	Deputy Trust Chair and Non-Executive Director
	Margaret Gildea	Senior Independent Director
	Geoff Lewins	Non-Executive Director
	Dr Anne Wright	Non-Executive Director
	Richard Wright	Non-Executive Director
	Ifti Majid	Chief Executive
	Claire Wright	Director of Finance & Deputy Chief Executive
	Dr John Sykes	Medical Director
	Carolyn Green	Director of Nursing & Patient Experience
	Mark Powell	Chief Operating Officer
	Amanda Rawlings	Director of People & Organisational Effectiveness
	Lynn Wilmott-Shepherd	Interim Director of Strategic Development
IN ATTENDANCE:	Anna Shaw	Deputy Director of Communications & Involvement
	Sue Turner	Board Secretary (minutes)
For item DHCFT 2018/002	Liz Harman	Integration Workforce Manager Ripplez CIC & Derby Integrated Family Health Service
For item DHCFT 2018/002	Danielle Nicholson	Derby City Health Visitor and Champion for the Family First Model
For item DHCFT 2018/002	Sue Earnshaw	Service Line Manager
For item DHCFT 2018/011	Dr Chinwe Obinwa	Consultant Forensic Psychiatrist
For item DHCFT 2018/011	Lisa Stone	Kingsway Campus Area Service Manager
For item DHCFT 2018/011	Rebecca Mace	Senior Nurse, Kedleston Low Secure Unit
For item DHCFT 2018/011	Linda Murrell	Lead Nurse, Kedleston Low Secure Unit
For item DHCFT 2018/012	Rachel Kempster	Risk and Assurance Manager
APOLOGIES:	Samantha Harrison	Director of Corporate Affairs & Trust Secretary
VISITORS:	John Morrissey Rosemary Farkas	Lead Governor and Public Governor, Amber Valley South
	Cllr Jim Perkins	Appointed Governor, Derbyshire County Council
	Martyn Bell	Trust Member, Amber Valley, South

DHCFT 2018/001	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST** Trust Chair, Caroline Maley, opened the meeting and welcomed everyone. Apologies were noted from Director of Corporate Affairs & Trust Secretary, Sam Harrison. The Register of Declarations of Interest was acknowledged and would be updated in respect of an additional interest declared by Deputy Trust Chair, Dr Julia Tabreham who informed the Board that she was now an elected member for CHETWYND, the Toton and

	Chilwell Neighbourhood Forum representing the community's interest in the HS2 high speed rail project. **ACTION: Declarations of Interest to be updated to reflect the Deputy Trust Chair's additional interest**
DHCFT 2018/002	**SERVICE USER STORY** Trust Service Line Manager for Children's Services, Sue Earnshaw, Liz Harman of Ripplez and Family Health Visitor, Danielle Nicholson presented the Family First Model to the Board which promotes the voice of parents. They also gave a family perspective of the Trust's Children's service and the Family Nurse and Health Visitor partnership model which works with young parents so that they can identify the specific support that they need relating to their own individual circumstances which works in partnership with Ripplez, a staff-led Community Interest Company (CIC). The Board heard how this initiative was especially set up to enable more vulnerable families to have access to a specialist parenting programme via the Family First Model who would not have been eligible for the original family nurse partnership service due to the limited age restrictions criteria. This new service is delivered using a caring approach and assists vulnerable people to prepare for parenthood depending on their needs aiding healthy pregnancies giving babies the best start in life and enables parents to become knowledgeable, sensitive parents. It also helps new and young fathers, and wider family support networks to gain a better understanding of how to care for babies and young children through the use of interactive tools. Danielle told the Board that feedback from families had helped develop the Family First Model as experts by experience and this had in turn enhanced her skills as a practitioner and has enabled a more therapeutic and interactive relationship to be developed with clients through her health visitor role. Chief Operating Officer, Mark Powell, was interested to know how men were approached to participate in the programme. Liz described how practitioners work to engage with fathers and they are now becoming more involved in the programme in the antenatal period. Practitioners also help fathers and grandfathers with literacy problems read to their young children and give them confidence to enjoy reading aloud to them. The success of this scheme has been seen through the ownership of the people it seeks to support. The integrated approach has brought about ownership from everyone involved. Caroline Maley commended Sue, Liz and Danielle for their passion as champions of the Family First Model and thanked them for giving the Board an insight into the innovative practices that have been developed through the partnership formed with Ripplez, family nurses and health visitors which she saw as a great example of continuous improvement that had been integrated into the Trust's children's service. **RESOLVED: The Board of Directors Board received and noted the innovative practices developed through the Family First Model**
DHCFT 2018/003	**MINUTES OF THE MEETING DATED 29 NOVEMBER 2017** The minutes of the previous meeting, held on 29 November were agreed and accepted as an accurate record subject to a correction to the Chief Executive's Report on page 5, under item DHCFT 20187/175 in the eighth paragraph to reflect that the letter written to the Secretary of State arose from a discussion that Toby Perkins MP for Chesterfield had with CCGs in general rather than the Derbyshire Clinical Commissioning Group (NDCCG).
DHCFT 2018/004	**ACTIONS MATRIX AND MATTERS ARISING** The Board agreed to close all completed actions. Updates were provided by members of

	the Board and were noted on the actions matrix. All completed 'green' actions were scrutinised to ensure that they were fully complete and actions that were not complete were challenged with Executive Director leads.
DHCFT 2018/005	**CHAIR'S VERBAL REPORT** Caroline Maley informed the Board that she would in future be providing a written report that will reflect on her activity within the Trust since the previous meeting. Recent meetings and visits to staff and services during December and January were briefly outlined. These included singing Christmas Carols with executive colleagues around the Kingsway site. Caroline extended her thanks to the League of Friends for providing Christmas gifts for inpatient service users and for their work in providing a little happiness at Christmas, which is a difficult time for people with Mental Health issues. Caroline made a point of visiting as many front line services as possible, so that her leadership is grounded on the reality of what staff face every day, and also to ensure she has a good understanding of the services provided by the Trust. Since November she has visited the Kedleston Unit, Morton Ward at the Hartington Unit and attended a COAT (Clinical and Operational Assurance Team) meeting for the Neighbourhoods. A meeting took place with Dr Paula Holt, an appointed Governor, who is also the Dean of the College of Health and Social Care at the University of Derby. They discussed a range of areas of interest around the training of students and the implication of our Trust strategy on the focus that they have in recruiting and teaching. Caroline was pleased to point out that there is a very good relationship with the University when it comes to placements, and it was good to hear that on the whole students are gaining good experience from their placements with the Trust. Likewise, Dr Gemma Stacey, an appointed Governor from the University of Nottingham, gave good feedback on the experience that their students are getting with us. Caroline visited the Kedleston Unit which is also the subject of the deep dive item at today's meeting, where she saw at first-hand how the investment in the building was making a difference to the team. At Morton Ward Caroline was able to sit in a service user review and was as always impressed by the compassion and care that our staff provide. She was hosted by a nurse, whose passion for the Trust and her job just shone through. This is the "DNA" that Caroline would love to see in all our staff. She was also pleased to be able to welcome a new starter who had had a placement with us, who then had to wait a year before a job was advertised by the Trust so that she could return to work within our organisation. It reinforced for Caroline the importance of the relationship with the universities and students who come to us for placements - they are the our workforce of the future and we should ensure that they have a great experience with us, that we invest in them whilst they are with us and that they return to the Trust at the end of their studies. Attending a COAT (Clinical Operations Assurance Team) meeting was important for Caroline to take part in given the prominence of these teams in the governance structure. She thought that there is more that needs to be done to enable these meetings to be smart, focussed and move with pace through what looked like a big agenda and a number of important areas. She hoped that in future these meetings would be more structured to focus on actions arising from clinical audits and responses to the staff survey to ensure that that the COAT team can mobilise what we are trying to achieve. Since the last Board meeting, Caroline has chaired a Council of Governors meeting on 24 January. She has also met with Lead Governor, John Morrissey, and attended half a day of a governors training day which followed up on the role of governors holding Non-Executive Directors to account, but most importantly starting to look at what engagement with the community could and should look like. This is an aspect of the role of a governor that needs more focus and drive and is one of Caroline's priorities for the governors in

	2018. There continues to be a turnover in elected governors and there are also a number of vacancies. Caroline was pleased to report that we have gained approval to change the constituency boundaries so that we have some bigger areas that could be covered by two governors rather than smaller areas where we cannot recruit. Caroline was pleased to welcome as new appointed governors, Roger Kerry for North Derbyshire Voluntary Action and Angela Kerry from Derbyshire mental Health Forum. Caroline also reflected on meetings which involved the Board. Two Board Developments sessions took place which proved helpful in ensuring the Board has a common view on some of the challenges and opportunities that are coming up via a presentation made by Jamie Foster of Hempsons on Accountable Care Systems. This provided the Board with a view across the country on the issues and learnings for the NHS and this also features in Ifti Majid's Chief Executive Report received at today's meeting. The second Board Development session included a review of the well-led review report from Deloitte and the actions that will follow as well as an opportunity for the Board to complete Information Governance mandatory training. Caroline also carried out an interim performance review with Chief Executive (CEO), Ifti Majid, to ensure that the objectives set in April last year are on track to be delivered and also to consider whether they are still appropriate. Non-Executive Director (NED), Barry Mellor, left the Trust at the end of December and Caroline carried out his appraisal which will be reported to the Council of Governors Nomination and Remuneration Committee at the beginning of March. Caroline continues to meet with NEDs on a quarterly one to one basis. She has recently met with Margaret Gildea and Geoff Lewins who joined the Board at the beginning of December. Together with Chief Executive, Ifti Majid, Caroline attended the Board meeting for Joined Up Care Derbyshire which is also covered in the CEO report, and the Derby City Health and Wellbeing Board. The Health and Wellbeing Board discussed the proposed Asylum Centre at Laverstoke Court and the implications for the health system with little if any funding. There are some implications for our Trust which are also referred to in the CEO report. The Board also received an annual report from the Director for Public Health which provided a telling and engaging report on the state of the health of the local population through the use of a story telling approach. Caroline was pleased to inform the Board that she has agreed with the CEO that the Director of Public Health will be invited to a Board Development session to discuss this report. Caroline and Ifti Majid also met with Fran Steel, Delivery and Improvement Director North Midlands from NHS Improvement (NHSI). She was pleased to report that there are no areas within the Trust which are cause for concern with NHSI. **ACTION: Director of Public Health to be invited to Board Development to discuss the public health annual report** **RESOLVED: The Board of Directors noted the activities of the Trust Chair throughout the months of December and January**
DHCFT 2018/006	**<u>CHIEF EXECUTIVE'S REPORT</u>** The Chief Executive's report provided the Board of Directors with an update on developments occurring within the local Derbyshire health and social care community. The report also updated the Board on feedback from external stakeholders such as

	commissioners and feedback from staff. The report was used to support strategic discussion on the delivery of the Trust strategy. Ifti Majid referred to the release of the annual NHS Workforce Race Equality Standard (WRES) data and was pleased to report that the low baseline we started at in 2015 has improved. The Trust has worked hard and improved its inclusion agenda and with the support from Assistant Director for Engagement & Inclusion, Harinder Dhaliwal, and other colleagues we have refocused and reinvigorated our BME focus on the areas that the WRES drives. Ifti was pleased to report that the reverse mentoring initiative is well underway to increase the Board's learning and understanding and this has also improved our recruitment and selection process. We also have a reinvigorated reverse commissioning project underway which will help us to understand the different commissioning aspects involved with our members. Ifti reflected on the day to day activity within the Joined Up Care Derbyshire (JUCD). He reported that the Derbyshire GPFV (General Practice Forward View) STP (Sustainability Transformation Plan (Joined Up Care Derbyshire)) Workforce plan has been accepted and the Trust was given an initial score of 48% and a rating of "partial assurance". This score represents a rating of "assured with conditions" as opposed to full assurance and this improved position is welcome. Since the last Board meeting on 29 November Ifti has visited a number of teams as part of the 'Ifti on the Road' initiative. He is delighted at how many colleagues have come along to these sessions to share thoughts, ideas and concerns. He assured the Board that all feedback from colleagues is being captured from these sessions and action is taking place to understand more about the issues raised. Issues have been raised about safety planning which is being responded to ensure we deliver this fully from a clinical front. He thought that Family First model described in today's Service Receiver Story was a very good example of responding to safety. Director of Nursing & Patient Experience, Carolyn Green, assured the Board that improvements to safety planning are being made in line with NICE guidelines and will be introduced very soon which will help us to adapt to the different components within our Trust. The Board heard how the trajectory of this piece of work will be monitored by the Quality Committee and will be fed back to the COAT team for appropriate delegation and will enable COAT to support local area teams. Julia Tabreham observed that as the Trust is driving towards system integration commissioning provision and felt that key enablers need to be in place. Ifti Majid agreed that this is one of the pillars underpinning the JUDC and there is a drive to share more information across the system. Discussion developed into understanding what protection there is within the drive for distribution of information for patients who do not want their information shared. The Board was assured that the security applied by the Trust's Caldicott Guardian protects the confidentiality of patient and service-user information and that Information Governance guidelines covering data protection requirements provide us with reassurance that we have a system in place that operates within this framework. NED, Richard Wright, observed that although new elements of the EU General Data Protection Regulation (GDPR) are uncertain at the moment and although these principles will be similar to the current Data Protection Act, the Board is aware of the Trust's requirements within GDPR and will operate within its contractual requirements. **RESOLVED: The Board of Directors noted and scrutinised the Chief Executive's update**
DHCFT 2018/007	**<u>INTEGRATED PERFORMANCE AND ACTIVITY REPORT (IPR)</u>** The IPR provided the Trust Board with an integrated overview of performance as at the end of December 2017 that focussed on workforce, finance, operational delivery and quality performance.

	The Trust continues to perform well against many of its key indicators, with maintenance or improvements continuing across many of the Trust's services. The issues identified in previous reports continue to be worked on through the plans to relieve ongoing pressures and have been discussed in detail at various Board Committees. The Board noted that the report now included data quality 'Kitemarks' added to a number of indicators. This is in line with best practice for performance reporting which provided the Board with assurance on the quality of the data being used to report Trust wide performance. Mark Powell drew attention to the changes to the operational standards in the Single Oversight Framework (SOF) and was pleased to report that the Trust is compliant against all SOF operational standards as shown in the dashboards contained in the report. Carolyn Green questioned the data concerning out of area placements and asked if this applied to this acute service or PICU (Psychiatric Intensive Care Unit) and whether this was measuring a day to day basis or the number of people. Mark Powell explained that this was a new addition to the dashboard and refers to out of area placements and the delivery of acute and PICU and covers bed days and showed the number of PICU placements in December. Although the Trust is not commissioned to provide a PICU service recording this data highlights the issue to the Clinical Commissioning Groups (CCGs) who do not report this data. The Board was informed that the dashboard would be changed next month to show the number of placements and bed days that fall within the Trust's responsibility as well as PICU so that the challenges that the data exposes can be highlighted. The Board noted that during December no patients were placed out of area and this is a vastly improved situation than five months' ago. Ifti Majid emphasised the importance of demonstrating to the CCG and NHSI that improvements we are making in our reporting are resulting in an improvement in adult placements out of area placements. Mark Powell updated the Board on the continued positive impact that the Red2Green programme is having on the efficient use of resource to reduce lengths of stay and out of area placements as well as our recruitment and retention plans. Progress has been made in recruitment to the Radbourne Unit and improvements have also been made to staffing at the Hartington Unit. Although staffing at this unit still remains an issue the People & Culture Committee is monitoring the recruitment plan on a regular basis to ensure the correct action is taken. The Neighbourhood review is on track for timelines and the Trust Management Team (TMT) has provided assurance to the Quality Committee that progress is being made in line with agreed timeframes. Director of Finance and Deputy CEO, Claire Wright, reflected on the Trust's changed forecast outturn which has been through significant scrutiny in order to assure the Board that the Trust will achieve its updated forecast. Our forecast has improved due to the significant reduction in the out of area cost pressure. We have been able to increase our forecast surplus to over achieve the control total by £636k which in turn will increase our STF (Sustainability Transformation Fund) bonus income by £636k. This will result in our surplus position being increased to £4.036m which is an overachievement of the control total of £1.3m and the additional cash will help us with our key priorities to put people first via our future years capital programme. Claire reported that although it will be challenging to deliver our control total for 2018/19 there is a lot of work taking place to make sure we progress the required cost improvement to achieve our planned control total. Carolyn Green welcomed the data quality kitemark system and was pleased to report that quality remains stable overall compared to the position we were at before the summer and that December showed a good monthly performance. Her main concern is that we main percentage levels on staffing in inpatient services. We must continue our focus on the restorative work taking place with supervision and appraisals which will work towards maintaining staffing levels. Director of People & Organisational Development, Amanda Rawlings drew the Board's

	attention to the high number of vacancies that are having an impact on the sickness levels. She was pleased to report that 49.15% flu vaccination rate is a substantial improvement in reaching the target of 50% in our sickness prevention rates. Attention was drawn to staffing levels on inpatient units. Ifti Majid observed that the report showed that staff turnover was low but staff vacancies remain high. Amanda Rawlings explained that this was due to internal movement within the organisation. So as to understand the core level of detail contained in this data the People & Culture Committee regularly reviews this performance data and focuses on hot spots. Chair of People & Culture Committee, Margaret Gildea, informed the Board that in order to understand this information better the Committee requested that hard data be provided on actuals rather than variables and percentages. This will enable the IPR dashboard to show a higher level of granularity to establish whether our recruitment work is effectively working and allow us to understand our level of retention. The People & Culture Committee will then be able to work on core areas from ward staffing reports and provide the Board with further assurance on staffing levels. **RESOLVED: The Board of Directors considered the Integrated Performance Report and obtained limited assurance on current performance across the areas presented.**
DHCFT 2018/008	**QUALITY POSITION STATEMENT AND MORTALITY REPORT DECEMBER 2017** Carolyn Green provided the Board of Directors with an update on the organisation's continuing work to improve the quality of services that are provided in line with the Trust Strategy, Quality Strategy and Framework and strategic objectives. This month's report included information on the care and treatment of children who are looked after children in Derby city and some individuals who are the responsibility of Derby city currently in foster or supported care outside of our county boundary. The report included detailed information on performance and an increasing trend in children on a child protection plan and increases in 'Looked After Children' (LAC). The report identifies Derby as a substantial outlier compared with other regions and this will impact upon our operational performance in 2018/2019. We will have to consider strategic decision making which will result in additional contracting discussions taking place with our lead in public health to establish mitigating solutions. The Mortality Report for December 2017 was appended to the Quality Position Statement. Medical Director, John Sykes's report updated the Board on the new national framework for NHS Trusts which requires the Trust to collect and publish specified information on deaths quarterly to include the total number of inpatient deaths and those deaths that the Trust has subjected to case record review. This report outlines the information required to be reported by the end of Quarter 3. The Board understood that completing this report required an extreme focus at a level never experienced by the Trust before which resulted from our well-led process. NED for Mortality and Learning from Deaths, Anne Wright, was pleased to note that we are managing to include the family in these detailed reviews but was concerned about the level of capacity involved in completing learning from deaths work. The Board acknowledged that the report identified death by ethnicity and revealed that white British is the highest recorded ethnic group, although nine patients refused to give their ethnic origin and the ethnicity of 103 were unknown. Julia Tabreham was concerned that other ethnic groups such as the Roma and traveller population were not included in the data. Carolyn Green confirmed that this was Derby City local authority performance data and she would feedback Julia's concern. Richard Wright, questioned how the actions captured in the action plan would be updated. John Sykes confirmed that a number of these actions had already been completed and would be reflected in a revised action plan that will be contained in the next quarterly report.

	The Board noted the ongoing work to improve the quality and safety of the Trust's services and the work undertaken to analyse and learn from deaths that the Trust has subjected to case record review. **RESOLVED: The Board of Directors received the Quality Position Statement and gained significant assurance on safety with the Trust**
DHCFT 2018/009	**<u>BOARD ASSURANCE SUMMARIES & ESCALATIONS</u>** Assurance summaries were received from meetings of the Audit & Risk Committee, Quality Committee and People & Culture Committee held in December and January. Committee Chairs summarised the escalations that had been raised and these were noted by the Board as follows: **Audit & Risk Committee:** Geoff Lewins, took up his position of Committee Chair at the January meeting and reported that he was impressed with the quality of information contained in reports received at the meeting. Some of the work carried out by the Committee was the oversight of risks held by other committees. The review of the Board Assurance Framework (BAF) provided significant assurance on the quality of this process and was also borne out by comments from internal auditors and the Deloitte Well Led framework report. Specific areas on conflicts of interest and general data protection were also covered at the meeting. In all areas there are good policies and frameworks in place and significant assurance was obtained on work taking place preparing for GDPR (General Data Protection) compliance. Accounting Policy updates for the year end accounts were approved. The Committee also gave its approval to procure audit services. **Quality Committee:** Committee Chair, Julia Tabreham fed back to the Board that the Committee was delighted that Ifti Majid attended the January meeting and that progress is being made across most areas. She had concerns about the amount of time it is taking to complete Serious Incident reports and the continued pressure felt by neighbourhood teams although the Committee was assured that the Executive Leadership Team is focussing on this. The highlight of the January meeting was receiving the Physical Healthcare Strategy. The Committee was impressed with the concept of using the personal story in the strategy of 'being bothered about Billy' that brought to life the impact that poor physical health has on people who use our services. The Committee was also pleased to see that the strategy was aligned to the Trust's new vision and values. When discussing the BAF risks assigned to Quality Committee the lack of headway taking place on the development of a community forensic team and the need to mitigate risks arising from the release of a high number of IPP (Imprisonment for Public Protection) prisoners into the county at a great pace was escalated to the Board and the lack of community forensic service will be reported to the Board in due course. **People and Culture Committee:** Committee Chair, Margaret Gildea, reported although the Staff Survey is not yet ready to share more widely early indications are starting to look positive that staff engagement is moving in the right direction and an in-depth review will be held at the next meeting of the Committee and will be reported to the Board in March. The People Plan for 2017 was signed off and progress has been made to continue actions into 2018 that will focus on workforce supply and staff engagement as well as education development and leadership retention. Workforce performance was not covered by Margaret Gildea as this had been discussed during the IPR item. **RESOLVED: The Board of Directors received and noted the Board Committee Assurance Summaries and Escalations**
DHCFT	**<u>DELOITTE WELL-LED FRAMEWORK REPORT</u>**

2018/010	This report presented the Executive Summary and recommendations of the final report of the Deloitte Review of the Trust's Governance Arrangements – Phase 3 which concludes the Trust's most recent well-led review. Ifti Majid was pleased to report that the report outlined clear progress has been made across the key areas followed up from Deloitte's Phase 2 review (resulting in an over-arching amber/green ratings throughout), and confirmed confidence from Deloitte that the Trust is on track to continue with current performance and make even further progress within a short timeframe. Amber/green is defined by Deloitte that the Trust is partially meeting their expectations in each domain but also that they are confident in our ability to deliver the top green performance (that meets or exceeds expectations) in the near future. Areas for improvement included the management of quality assessments and cost improvement programme. A framework will be set in place to enable continuous learning from these processes through the oversight of the Board Committees. The Board considered that the report was evidence of the significant progress that had been made over the last two years embedding good governance within the Trust. **RESOLVED: The Board of Directors:** **1) Received significant assurance from the Executive Summary of the Phase 3 Deloitte review of governance arrangements** **2) Accept the recommendations and note the oversight Board Committees assigned, with assurance on progress to be reported to the Board through their established assurance summary process**
DHCFT 2018/010	**<u>REGISTER OF TRUST SEALINGS 2017/18</u>** This report provides the Trust Board with an account of the authorised use of the Foundation Trust Seal during 2017-18. The Board noted the ten entries made to the Register of Trust Sealings for 2017/18 as shown in the report which provided a high level of oversight of where the Trust's seal is used. **RESOLVED: The Board of Directors noted the authorised use of the Foundation Trust Seal during 2017-18**
DHCFT 2018/011	**<u>DEEP DIVE – KEDLESTON UNIT</u>** Consultant Forensic Psychiatrist, Dr Chinwe Obinwa, Kingsway Campus Area Service Manager, Lisa Stone, Senior Nurse, Rebecca Mace and Lead Nurse, Linda Murrell, joined the meeting and presented a deep dive into the Kedleston Low Secure Unit. The service is based on the Kingsway site and cares for males over the age of eighteen and provides assessment, treatment and rehabilitation of patients with severe mental illness who have committed an offence or present a risk of aggression or violence to others. The Board noted that it was a year since the team presented their last deep dive which focussed on the improvements they were going to make. The team's biggest highlight was receiving the Quality Award for Innovation and Improvement and having their quality improvement rating increased by the CQC to "requires improvement" from "inadequate" and acknowledgement of the team's hard work in establishing a new recovery college for its service users. The Kedleston Unit has also become a teaching hub for all disciplines with students in psychiatry, occupational therapy and pharmacy students spending time within the service. The team was proud to announce that their teaching work is being showcased at the Forensic Conference 2018 where they hope to showcase their work. A significant improvement has been seen in staff satisfaction and it was thought that the Kedleston Unit Away Day invigorated staff and improved team morale. Although some staff have left the unit three members of staff have returned since leaving and recruitment

	is taking place to improve regular staffing. . Building refurbishment work is ongoing and the first phase is now complete. There was positive support from the patients while this work was being undertaken and patients were involved in deciding colour schemes. The Royal College of Nursing have acknowledged the improvements that have been made. The team was pleased to report that there had been no seclusion incidences for some time and the improved environment is thought to have helped with this. The start to this year is looking progressively encouraging. The team are continuing to increase stability within the unit and are concentrating on recruitment and retention of staff by ensuring they are valued and have adequate training and support. In terms of future planning the unit is recruiting to fill a clinical lead post. Linda Murrell talked about her experience transferring to the Kedleston Unit and the reservations she first had about working on a low secure forensic unit. She found this an interesting and rewarding experience which developed her learning and she has now applied for a permanent post with the team. Lisa Stone described how the team worked extremely hard on improving the culture within the team that that it has been a pleasure to see how the unit has developed. Staff all work well together which is an indication of good leadership style and has resulted in some staff members who left the unit returning to work within the team. Amanda Rawlings was inspired by the team's achievements and proposed using their stories describing the way staff have left and returned and developed their careers since joining the team to promote recruitment to the organisation. Ifti Majid reminded the team that the CQC had reported during their inspection that staff at the Kedleston Unit did not feel very connected to the Trust. Dr Chinwe Obinwa reported that due to the definite shift in the way the team works they now feel fully integrated within the Trust especially as expertise within the organisation has been brought into the service. This has made a significant improvement and has enabled the leadership team in the unit to work at expanding the forensic service. Caroline Maley congratulated the team on their achievements and suggested that an opening ceremony should take place to showcase the newly refurbished Kedleston Unit. The Board proposed that the team showcases the learning obtained over the last year and the good progress achieved that has been accomplished through a high standard of leadership. **RESOLVED: The Board of Directors received and considered and the presentation made by the Kedleston Unit Service Team**
DHCFT 2018/012	**<u>BOARD ASSURANCE FRAMEWORK UPDATE – FOURTH ISSUE</u>** This report presented by Claire Wright in the absence of Director of Corporate Affairs and Trust Secretary, Sam Harrison, detailed the fourth issue of the BAF for 2017/18 which met the Board's requirement to receive the BAF four times a year. There remain eleven risks identified on the BAF for 2017/18. The risk rating for three of the risks have been reduced since the BAF was last considered by the Board and no risks have increased: • 1d. *Risk of inadequate systems to ensure business continuity is maintained in the event of a major incident.* Reduced from a likelihood of 4 (likely) to 3 (possible) due to full compliance achieved with the EPRR Standards. The risk rating overall remains moderate • 3e. *Potential turnover of board members*. Reduced from a likelihood of 3 (possible) to 2 (unlikely) and a consequence of 4 (major) to 2 (minor) due to a

number of substantive Board appointments. This reduces the risk rating overall from moderate to low.

- 4a. *Failure to deliver financial plans.* Reduced from a likelihood of 4 (likely) to 2 (unlikely) due to confirmation received from commissioners that they will pay the 0.5% CQUIN risk reserve in full. This reduces the risk rating overall from extreme to moderate.

Risks 1d, 3e and 4a are now identified as 'tolerated risks' on the BAF, together with risk 3d There is a risk that the Trust does not operate inclusively and may be unable to deliver equity of outcomes for staff and service receivers which was identified as tolerated in the previous issue. These changes resulted in three risks remaining identified as extreme, four as high, three as moderate and one as low risk.

Risk and Assurance Manager, Rachel Kempster, confirmed that risks associated with the operational implementation of the electronic patient record will be developed by the Chief Operating Officer and will be included in the final issue of the BAF for 2017/18 to be received by the Board in March. She also updated the Board on discussions held at the Audit and Risk Committee in January that highlighted a risk for inclusion in the 2018/19 BAF in relation to the non-commissioning of services. This will be further discussed with the Board at the Board Development Session taking place on 14 February. The risk arising in relation to information governance compliance (in particular compliance with the new GDPR (General Data Protection) coming into force in May 2018 was also discussed and will be further considered as part of the cycle of review for the final issue of the BAF for 2017/18.

Rachel Kempster also informed the Board of improvements being made to good practice risk systems. A more automated system has been developed for policy notifications and this will enable more efficient timelines for policy revisions. In addition to this training on interrogation within the reporting of Serious Incidents is being set up along with e-learning sessions.

Attention was drawn to the KPMG audit of the BAF and Risk Register. Rachel Kempster was pleased to report that all actions arising from last year's audit have been completed and that the Board will be able to work on the headlines arising from this audit at Board Development in February. This session will also look at benchmarking the BAF against other organisations.

Claire Wright referred to the KMPG audit of the BAF and emphasised the importance of ensuring that the Board receives a high level of assurance when considering any recommendations that KPMG might make in respect of the BAF.

Geoff Lewins pointed out that although the rating of BAF risk 4a regarding the failure to deliver financial plans had been reduced to moderate for this year, this risk could be rated much higher next year and he questioned whether there was a better way to represent that aspect within this risk within the BAF. Claire Wright confirmed that a distinction is made between the ratings of this risk this year and clarified that the inherent risk represents next year's level of risk (being 5 by 5).

Caroline Maley thanked Rachel Kempster for her hard work managing risk management. This had enabled the Board to receive a high level of assurance that the work undertaken by the Board Committees assessing and mitigating BAF risks in order to achieve the Trust's strategic objectives is extremely robust.

John Sykes left the meeting at this point.

RESOLVED: The Board of Directors agreed and approved this fourth issue of the BAF for 2017/18 obtained significant assurance in the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives.

DHCFT 2018/013	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK** It was agreed that no further changes are required to be updated or included in the BAF as a result of today's discussions.
DHCFT 2018/014	**MEETING EFFECTIVENESS** The Board considered that appropriate items for discussion were included in today's agenda. It was noted that there was limited opportunity to heavily challenge reports as operational and performance scrutiny had taken place within the Board Committees. In addition to this some reports were covered at the meeting of the Council of Governors held on 24 January which might have had an impact on today's discussions. It was agreed that more thought should be given to offering strategic challenge and debate in future Board discussions.
DHCFT 2018/015	**REPORT FROM CONCIL OF GOVERNORS MEETING 28 NOVEMBER 2017** This report was received for information and was noted by the Board.
DHCFT 2018/016	**2017/18 BOARD FORWARD PLAN** The forward plan was noted by the Board and would be updated in line with today's discussions.

The next meeting of the Board to be held in Public Session will take place at 1pm on Wednesday, 28 February 2018.

The location will be Conference Rooms A&B
Research and Development Centre, Kingsway, Derby DE22 3LZ

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - FEBRUARY 2018			
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
1.11.17	DHCFT 2017/163	Governance Improvement Action Plan Six Month Update	Sam Harrison	Further review of the GIAP is to take place in March 2018 and is to be captured in the forward plan	28.3.2018	Agenda item for 28 March 2018 meeting	Yellow

Resolved	**GREEN**	0	0%
Action Ongoing/Update Required	**AMBER**	0	0%
Action Overdue	**RED**	0	0%
Agenda item for future meeting	**YELLOW**	1	100%
		1	100%

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors – 28 February 2018

Trust Chair's report to the Board of Directors

Purpose of Report

This report provides the Board with the Trust Chair's reflections on her activity with and for the Trust since the previous Board meeting on 31 January 2018.

Introduction

This is the first formal written report that I will be submitting to the Board. I have structured the report along the lines that I have used in the Board meetings to present the activities that I undertake, as previously reported verbally.

Our Trust and Staff

1. I have made a point of visiting as many front line services as possible, so that my leadership is grounded on the reality of what our staff face every day, and also to ensure that I have a good understanding of the services provided by the Trust.

2. I visited Audrey House on 1 February 2018. I was able to spend some time talking to Adrian Clowes, a Registered Nurse, about the unit, its transfer from the city to its current location, and some of the challenges that staff face. One of the service users came and talked to me in the corridor, and as always it reinforces for me the difficulties that mental health brings to patients, and the great work that our staff do to support service users on their journey.

3. I am delighted to welcome Stacey Rach to the Board meeting today, as she is shadowing me this afternoon. I met Stacey at the visit I undertook in January to the Morton Ward, which I reported on last month.

4. I will be spending time at Walton Hospital, Chesterfield on Wednesday 21 February, and will report back on this visit in my next Board report.

Council of Governors

5. I welcomed Christine Williamson as a returning Governor to the Trust, following the resignation of Amran Ashraf. Christine has been our membership Champion for a number of years and will continue to support our membership work as well as being a Governor. She is passionate about the Trust and what we do.

6. We continue to have some vacancies in the elected membership of our Governors, which we will continue to seek to fill. We need to be clear on the time commitment required and also the clarity over the role of a governor in a Foundation Trust. The changes in our constitution around the constituency boundaries, giving some bigger areas that could be covered by two governors rather than smaller areas where we cannot recruit, should help with managing the vacancies.

7. On 20 February I met with John Morrissey and Carole Riley, our Lead and Deputy Lead Governors. The purpose of these meetings is for me to share with them information relevant to their role of holding the Non-Executive Directors (NEDs) to account, and to learn from them some of the challenges and issues that are facing our Governors.

8. I met with Gillian Hough, chair of the Governance Committee. We covered a wide range of topics, including how we can use the Governance Committee to prepare for the Council of Governors and the holding of NEDs (Non-Executive Directors) to account. The Governance Committee meets on the 27 February 2018.

9. The next Council of Governors meeting will take place on 21 March 2018. Members of the public are welcome to attend this meeting.

Board of Directors

10. Our January Board Development meeting was focused on our strategic risks and a review of the Board Assurance Framework (BAF) for the new year ahead. Our internal auditors, KPMG, were involved in this working session, and we should see the revised BAF at the next Board Meeting.

11. Anne Wright has completed her first year as a Non-Executive Director, and I carried out her first appraisal, which will be reported to the Governors' Nomination and Remuneration Committee on 1 March 2018.

12. The Board Committee Chairs meet once a quarter and they met on 14 February. This gives them an opportunity to review how the governance structure is functioning, what roles NEDs have and whether there are any issues which can be shared across the various committees. I attend this meeting, as it is chaired by Deputy Chair, Julia Tabreham. At this meeting we rationalised the number of nominated Lead NED roles to just two: Freedom to Speak Up NED (Margaret Gildea) and Learning from Mortality NED (Anne Wright).

13. I attended the Mental Health Act Committee as a member of this Committee. It was good to see that the changes we have made to the structure of the Committee start to provide better assurance for the Board.

14. I continue to meet with Non-Executives on a one to one basis quarterly, and since the last report I have met with Julia Tabreham.

System Collaboration

15. The Joined Up Care Derbyshire meeting planned for 15 February was cancelled to allow a smaller group to plan and prepare for the NHSE/I stocktake meeting due to be held on 7 March 2018.

Regulators; NHS Providers and NHS Confederation

16. I have not had any activity to report under this heading this month.

17. Looking ahead to March, we have two meetings of note in the diary: NHS Confed Mental Health Network conference, and the NHS Providers Chiefs and

Chairs meeting.

Beyond our Boundaries

18. On 9 February I met with Pauline Latham MP in my office in the Ashbourne Centre. This follows an invitation from me in October 2017 to visit the Trust to learn more about our services, our priorities and challenges. It was a most useful meeting, and I believe that we have moved the relationship forward as a result of this encounter. The detail of our conversation has been relayed to the executive team, and there are a number of actions which we will take forward to continue our positive engagement with her.

Strategic Considerations	
1) We will deliver **quality** in everything we do providing safe, effective and service user centred care	X
2) We will develop strong, effective, credible and sustainable **partnerships** with key stakeholders to deliver care in the right place at the right time	X
3) We will develop our **people** to allow them to be innovative, empowered, engaged and motivated. We will retain and attract the best staff.	X
4) We will **transform** services to achieve long-term financial sustainability.	X

Assurances

- The Board can take assurance that the Trust level of engagement and Influence is high in the health and social care economy.
- Feedback from staff and other stakeholders is being reported into the Board.

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

None

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).

There are no adverse effects on people with protected characteristics (REGARDS).	x
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	

Actions to Mitigate/Minimise Identified Risks – not applicable

Recommendations

The Board of Directors is requested to consider the content of this report, and to ask for any clarification or further information.

Report presented by: **Caroline Maley**
Trust Chair

Report prepared by: **Caroline Maley**
Trust Chair

Chief Executive's Report to the Public Board of Directors

Purpose of Report:

This report provides the Board of Directors with feedback on changes within the national health and social care sector as well as providing an update on developments occurring within our local Derbyshire health and social care community. The report also updates the Board on feedback from external stakeholders such as our commissioners and feedback from our staff. The report should be used to support strategic discussion on the delivery of the Trust strategy.

National Context

1. Brexit has been continually in the media over the last few months and as we move towards the 29 March 2019 deadline and the move into a period of transition we must remain cognisant of the risks that could strategically and operationally impact on our Trust. The NHS Confederation in conjunction with the Cavendish Coalition have been monitoring potential impacts on our sector:

    - Workforce supply – information from NHS Digital suggests that 9.7% of staff working in general psychiatry are EU Nationals. In a time of shortage of workforce in many professions clarity is needed around the new 'settled status' scheme and if the UK will continue to honour the revised directive on Mutual Recognition of Professional Qualification, enabling member states to recognise each other's professional qualifications.
    - Employment law - A substantial proportion originates from the EU and provides important protections for health and social care staff. In particular, current rules on health and safety at work, information and consultation on collective redundancies and safeguarding employment rights in the event of transfers of undertakings (TUPE), are all aspects of employment practice which are covered by EU legislation. Clarity is needed post transition how these will become enshrined in UK law and if any changes are likely to be made at the same time.
    - There has long been underinvestment in mental health research. Research by MQ (mental health and quality of life charity) found that 85% of funding for mental health research in the UK is provided by just three funders: the Wellcome Trust; the National Institute for Health Research and the Medical Research Council. On average, the UK invests approximately £115m per year in mental health research – which constitutes 5.5% of total UK health research spend. The EU is the eighth largest global funder of mental health research and certainly to avoid ending access to those current underused pots of funding, we need assurance that access to those types of research opportunities can continue.
    - The UK is currently part of the EU's European Medicines Agency (EMA) network covering more than 500 million people. The EU accounts for 25% of all global pharmaceutical sales. On its own, the UK is thought to account for around 3%. Divergence from the EU medicines regulatory system may result in the UK becoming a second-tier market after the US, EU and Japan, meaning that patients would gain access to new medicines later.
    - Current cross border reciprocal healthcare arrangements provide a level of

reassurance to UK citizens including those who use our wide range of services that if they become ill whilst away services would be provided. Further clarity is needed on this as we move into the transition period.

The issues described above are longer term and more political in nature but we must remain sighted on them. I note that many of the areas mentioned are already covered in risks in our planned Board Assurance Framework for example workforce availability but by keeping an oversight through this strategic scan we can as a Board decide when risks materialise from potential to actual and need inclusion in our risk assurance processes.

2. NHS Improvement and NHS England have released a refresh of their NHS Operational Planning and Contracting Guidance 2017-19. It sets out detail of how the additional funding from the November 2017 budget will be allocated and the developments in national policy with regards to system level collaboration. The key points to note include:

    - The A&E performance recovery trajectory has been pushed back one year. Trusts will be expected to meet 90% by September 2018, and return to 95% by March 2019.
    - On the referral to treatment standard, the expectation is that the waiting list should not be any higher in March 2019 than in March 2018, alongside the expectation to halve the number of patients waiting 52 weeks in the same period.
    - The Sustainability and Transformation Fund is to become the Provider Sustainability Fund (PSF), with total funding of £2.45bn (up from £1.8bn currently). Access to 30% of the fund remains linked to A&E performance. A new £400m commissioner sustainability fund (CSF) will also be introduced to enable CCGs (Clinical Commissioning Groups) to return to in-year financial balance.
    - The eight shadow Accountable Care System sites and two devolved health and care systems are now to be known as Integrated Care Systems (ICS). ICSs are expected to prepare a single system operating plan and to work within a system control total.
    - The guidance states that there will be no additional winter funding in 2018/19. Systems are required to produce a winter demand and capacity plan with actions and proposed outcomes. Guidance on submitting these winter plans will be available by March 2018.
    - The two-year National Tariff Payment system is unchanged, with local systems encouraged to consider local payment reform in certain areas.

    I very much welcome the clarity in the guidance particularly in relation to services we deliver as part of our portfolio. The appendices to the plan along with the mental Health Delivery Plan 2018/19 set out clear expectations for Children's services and mental health services in particular with respect to expected funding increases and service developments.

    The guidance is clear that each CCG must meet the Mental Health Investment Standard (MHIS) by which their 2018/19 investment in mental health rises at a faster rate than their overall programme funding and that allocations are spent on the purposes for which they were originally intended and are not used to cross- subsidise other services or supplant existing spend.

Local Context

3. Each year the Directors of Public Health for the City and the County have a statutory duty to write and publish an annual report. *'How The Other Half Live'*, the report for Derby City, focuses on health inequalities in the Derby population through the fictional portrayal of two families - the Stanleys in Allestree and the Sahotas in Arboretum. The report discusses health issues and key statistics through a storytelling approach. It explores the families' various health trials and tribulations throughout the year, showing individual and family experiences and what they do to try and overcome their problems. A noticeable theme throughout the report is the widening gap in health inequalities between the two wards in Derby. There are a number of recommendations including:

    - Improved decision-making and commissioning: adopting a 'health in all policies' approach by all health and care partners. .
    - Better use of resources: shift more resource to help people to stay well rather than just treating them when they fall ill.
    - Adopt 'whole of society' approaches: all partners working in a seamless and co-ordinated way working to improve the health and wellbeing of the local population, in which we all have a role.
    - Becoming a Marmot city: through being a Marmot city, Coventry, has seen the life expectancy gap between their poorest and most affluent residents reduce as well as improvements in: education; health outcomes; life satisfaction and employment.
    - Strategic leadership by the Health and Wellbeing Board (HWB): ensuring that reducing inequalities is a priority for the city.

    I am delighted that Cate Edwynn who is the Director of Public Health for Derby City is attending our Board meeting to help us discuss the report contained in appendix 1.

Within our Trust

4. It is with pleasure I advise the Board that Graham Spencer who is a research nurse at our Trust and who has been instrumental in re-energising our Schwartz Rounds has been awarded the National Schwartz Shining Star Award. This is great recognition for both Graham and the Trust. Schwartz Rounds provide an opportunity for any member of staff, including students, to pause and reflect upon their work related experiences in a safe and supportive environment. They are a monthly compassionate meeting, attended in work time, and are designed to support employees with the emotional impact of work. The purpose of the rounds is to understand the challenges and rewards that are intrinsic to providing care, not to solve problems or to focus on the clinical aspects of patient care. Previous Rounds run by the Trust have been very popular and offered a comfortable space for staff to reflect on their roles. Evidence shows that staff who attend Schwartz Rounds feel less stressed and isolated, with increased insight and appreciation for each other's roles. They also help to reduce hierarchies between staff and to focus attention on relational aspects of care.

5. As part of celebrating the award of our second star for Triangle of Care I met with our local carers representatives this month to discuss some of the key issues important to them. A few of the issues they raised included:

    - Concerns around the lack of commissioner funding to support carer engagement

- Clear and timely communication to carers particularly about changes in care packages or treatment
- Variation in the way services embraced working with carers remains too great

These issues will form part of the revised care programme approach process and standards we are working to deliver and I am assured Wendy Slater and Lynn Dunham as our Carer links will ensure a good level of engagement.

6. The 5 and 6 February saw two firsts as part of our revised engagement approach. We launched our new Team Brief process which is a series of short messages with headline news, prepared by the executive team and including updates from the Board of Directors meeting which is then shared with senior leaders and cascaded down the organisation at team meetings. Feedback and questions from colleagues throughout the organisation are shared back to the executive team, who will respond the following month. Through this process we create a cycle of feedback that supports engagement and importantly involvement and inclusion. We have developed a range of mechanisms to ensure colleagues are able to feedback or ask questions in a way comfortable to them.

   We have also held the first of our new style leadership development sessions known as 'Team Derbyshire Healthcare – leaders'. Focussing on giving our leaders the opportunity to consider the broader skills and styles that will support the delivery of the revised Trust vision and objectives. The first session was all about supporting leaders to create a climate where the Trust values can be experienced and was led by an external leadership development coach.

7. The 13 February was our Equality Delivery System (EDS2) annual review. The main purpose of the EDS2 is to help our Trust (in discussion with local partners and people), review and improve our performance for people with protected characteristics (as per the Equality Act 2010). During the review we focus on four goals:

   1. Better health Outcomes
   2. Improved patient access and experience
   3. A representative and supported workforce
   4. Inclusive leadership and governance

   These goals contain eighteen outcomes, against which we assess and initially grade ourselves, using a range of evidence.

   The outcomes of this session will be reported to a future Board as part of our regular Equalities and Inclusion update.

8. Since our last Board meeting at the end of January I have met with or visited a number of teams including our Trust Administration Leads, Children's Universal Services at St Pauls and met some of the incredible children who are supported by our nursing team at Ivy House school. It was helpful in these meetings to hear about what was working well in particular praise for our leadership development programme and some specific work done with the administration leadership team at St Pauls. Also it was good to hear our newly implemented Team Brief being positively commented upon. I also heard about how when you deliver a more specialist service sometimes it can be hard to feel part of a bigger organisation particularly if you are located away from Trust buildings as well

Strategic considerations	
1) We will deliver **quality** in everything we do providing safe, effective and service user centred care	X
2) We will develop strong, effective, credible and sustainable **partnerships** with key stakeholders to deliver care in the right place at the right time	X
3) We will develop our **people** to allow them to be innovative, empowered, engaged and motivated. We will retain and attract the best staff.	X
4) We will **transform** services to achieve long-term financial sustainability.	X

Assurances

- Our strategic thinking includes national issues that are not immediately in the health or care sector but that could be of high impact.
- The Board can take assurance that Trust level of engagement and influence is high in the health and social care community
- Feedback from staff is being reported into the Board

Consultation

- The report has not been to any other group or committee though content has been discussed in various Executive meetings

Governance or Legal Issues

- This document presents a number of emerging reports that may become a legal or contractual requirement for the Trust, potentially impact on our regulatory licences

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).

There are no adverse effects on people with protected characteristics (REGARDS).	
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	x

Actions to Mitigate/Minimise Identified Risks – not applicable

This document is a mixture of a strategic scan of key policy changes nationally and locally that could have an impact on our Trust and the reporting of internal actions and feedback I have received relating to the strategy delivery.

Any implementation of national policy in our Trust would include a repeat Equality Impact Assessment even though this will have been completed nationally.

That said some of the reports both nationally and within the Derbyshire system have the potential to have an adverse impact on people with protected characteristics for example as yet is unclear how Brexit will impact people from protected groups.(REGARDS).

Internal Trust and wider system transformation schemes all need to involve an appropriate equality impact assessment in order to mitigate any risks that are identified in

actions being proposed

That equality impact assessment carried out will determine a response to the three aims of the general equality duty:

- identifying barriers and removing them before they create a problem,
- increasing the opportunities for positive outcomes for all groups, and
- using and making opportunities to bring different communities and groups together in positive ways.

The specific focus we have on assessing ourselves rigorously against the EDS2 key lines of enquiry supports us to understand more about areas for improvement and development.

Recommendations

The Board of Directors is requested to:

1) Scrutinise the report, noting the risks and actions being taken
2) Seek further assurance around any key issues raised.
3) Discuss the Derby City Director of Public Heaths Annual Report and consider any specific impacts for those who use our services.

Report presented by:	**Ifti Majid** **Chief Executive**
Report prepared by:	**Ifti Majid** **Chief Executive**

Derby City Council

How the other half live

The Director of Public Health's Annual Report 2017/18

CONTENTS

FIRST WORDS

Inequalities in health and wellbeing

Dr Cate Edwynn, Director of Public Health, Derby City Council

Arriving in Derby in December 2015, I was struck by the diversity and energy of the city and the varied communities and people that make up the local population. Thinking about this led me to ponder on the different health experience of both individuals and communities; and how much this is a product of cultural, economic and social differences. In light of this, I decided to focus on inequality as the main theme of this annual report, in recognition of all the differences that make us who we are, for good or ill, and which fundamentally affect our health and wellbeing, and life chances.

We live in an unequal society.

Whichever way we look in this country, we see people with poorer quality lives and poorer health and a widening gap between the have and have-nots. There is a clear link between disadvantage and health inequalities. On average poor people not only die earlier, but have poorer health throughout their lives.

"Fair society, healthy lives..."

more often known as the Marmot Review, has influenced thinking around inequality policy since 2010, especially amongst local authorities and health and wellbeing Boards and remains as relevant today, as then. One of the iconic charts within the review, referred to as the "Marmot Curve" demonstrates how life expectancy and disability free life expectancy (healthy life expectancy or living without disease) are related to differences in come deprivation across the country. The message is that poor health is not distributed randomly. There are causes. Reasons. The good news being that we can prevent this happening.

Yet are we?

And to answer that I want to turn to three recent pieces of information and analysis tells us.

Firstly, there is no doubt that the social gradient in life expectancy improved between 1999-2003 and 2006-10. Marmot's goal of "shifting the gradient" actually happened and that should be a source of inspiration to us all. A case of "can we do it?" "Yes, we can!"

Yet recent analysis of the rates and causes of death in England suggests these life expectancy increases may have begun to stall[1]. Since 2010, one-year increases in life expectancy are now occurring every 10 years for women, and six years for men; whereas between 2000 and 2009 women in England were on average living a year longer every five years, and men every three-and-a-half years. This means since 2010, the...

> "rate of increase in life expectancy has about halved.[2]"

Marmot has stated that the reasons for this slow-down are not clear, but notes that they have coincided with recent austerity programmes that have delivered deep cuts in health and social care spending in England. Prior to 2010, spending on the NHS and health services now provided by local authorities (public health services such as sexual health services) rose by around 3.8 per cent each year, but this has since fallen to 1.1 per cent a year.

A second piece of evidence was provided by another recent study showing a substantial rise in deaths for the whole of 2015 with a large spike in January 2015 (due to rise in over 75 old year deaths who rely heavily on a well-functioning health and social care system). This has worrying implications for health and wellbeing policy in the UK[3].

A further piece of this puzzle, lying deep in the Department of Health's annual report, is the assessment of how the Secretary of State is meeting his duties on health inequalities in England.

This includes a wider assessment, across 15 indicators from the Public Health and NHS outcomes framework. This shows that inequalities on all 15 indicators have widened[4].

Lastly, the Marmot Indicators 2015 have revealed that the percentage of households in England not achieving a 'minimum income for healthy living' has increased year on year, from 19.1% in 2008/09 to just under a quarter (24.4%) in 2012/13.

The persistence of low life expectancy in some areas or groups or the stagnation noted in life expectancy demonstrates we are not tackling health and social inequalities adequately and the economic impact on households may help us in understanding the increasing health inequality being seen. Health inequality is not self correcting, and the role of wider determinants, lifestyles and services need to be addressed together, rather than in isolation from - or even worse, in opposition to each other.

What causes inequalities?

Understanding the causes of health and social inequalities is useful when considering how to tackle this issue.

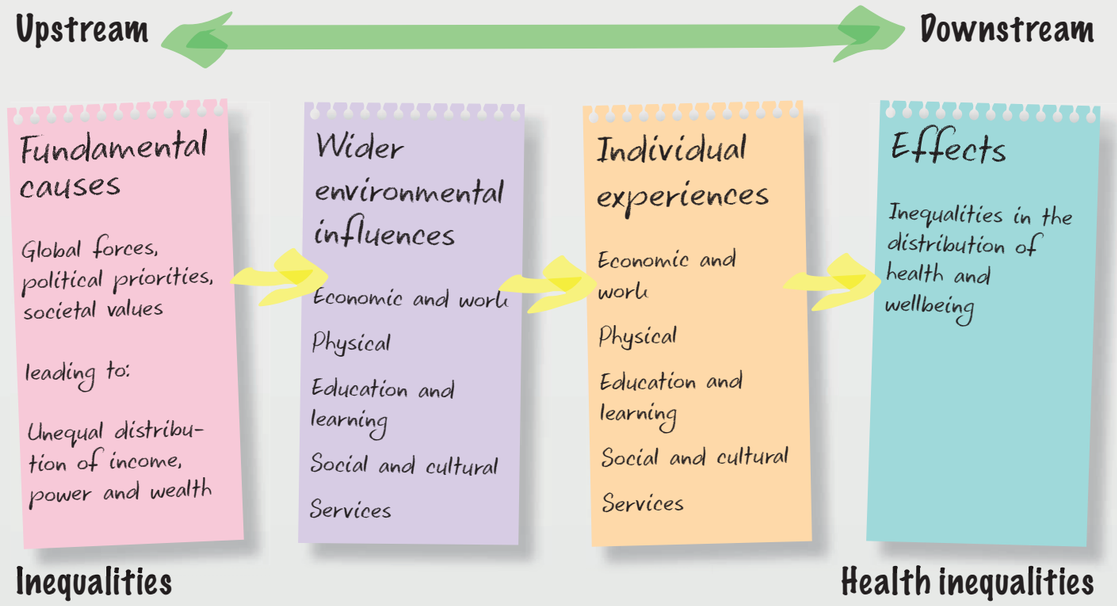
Some have tried to attribute the complex causes of health inequalities to misfortune or say it is self

> This must be countered and explained about how it is much complex than that.

inflicted due individual's own lifestyle. And we are told - incredibly in what is a wealthy nation— that there is not sufficient resources to meet such basic needs as improving our people's health.

Inequalities arise from where you live, your job, your parents wealth, the health and other services received (or not received). It is not just about behaviour, lifestyles, diet, physical exercise. The social and economic and environmental circumstances including the home, workplace and wider environment in which we are born, raised and work have a profound and sometimes lasting impact on our health and wellbeing.

One of the best ways to consider this problem I have found, is by considering the "theory of causation" as set out in the chart at the bottom of the page. From this we can see these occur as a consequence of a series of factors at a number of levels ranging from political priorities to the availability of local support and services.



[1] Michael Marmot, http://www.instituteofhealthequity.org/about-our-work/marmot-indicators-release-2017
[2] Michael Marmot, director of the Institute of Health Equity at University College London, who led the analysis
[3] Lucinda Hiam, Danny Dorling, Dominic Harrison, Martin McKee, Why has mortality in England and Wales been increasing? An iterative demographic analysis. Journal of the Royal Society of Medicine.
[4] DH Annual Report and Accounts, 2016-2017. https://gov.uk/government/publications/department-of-health-annual-report-and-accounts-2016-to-2017.

This suggests that any strategy to address health inequalities requires actions across all three levels of determinants: fundamental, wider environmental and individual.

This model suggests that there needs to be a greater focus on the fundamental causes of health inequalities and we must not be drawn into a mindset where we see lifestyle modification as the most important (or more worrying, only) way to tackle such inequality. inequalities requires actions across all three levels of determinants: fundamental, wider environmental and individual. Action to address the wider environmental causes, such as the availability of quality work, housing and education; and individual experiences, risks and lifestyles are important, but will alone not solve the problem. The fundamental - 'upstream' - causes of health inequalities such as lack of power and money also need to be addressed.

"Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities". Article 35 Health Care, EU Charter of Fundamental Rights

For example, fiscal and employment policies such as paying a living wage to all, or power redistribution through engaging people and communities in co-production to help design and shape the services they receive is important in formulating an asset based approach. A significant problem has been attention tends to be focused on what we decide to monitor (often because it's easier) rather than that of most critical factors. A case in point being uptake of health checks rather than income deprivation.

Human rights as a way of considering inequality

Another way of considering health inequalities is through the human rights perspective.

Firstly, this is important because the right to health is an inclusive right and includes not only the right to health services, but to a wide range of other factors that help us achieve the highest attainable standard of health, including decent housing, healthy food, healthy work and a clean environment. This leads us towards a more social model of health which as well as being broader and more inclusive, provides a greater range of possible options to improve health and wellbeing.

Secondly, the existence of health inequalities in the UK is a serious issue in terms of human rights, as it indicates that *the right to health is not enjoyed equally* across geographical communities or communities of interest[5]. The right to health can not only provide a solid framework to ensure that practice does not drift from well-intentioned policy, but also as a clear indicator demonstrating a worrying lack of basic human rights for certain communities or groups. This could provide a common thread to gain support for both the importance of "good" public services but also provide challenge to the system regarding how we provide all individuals with the opportunity to enjoy the highest possible standard of health[6].

Health inequalities are systematic and avoidable differences in health outcomes between social groups such that poorer and/or more disadvantaged people are more likely to have illness and disabilities and shorter lives than those who are more affluent (Judge, 2006)

Inequality, inequality, inequality - the theme of this year's report

This year, the report is concerned with the impact of inequality on individuals and families and how the conditions in **which we are born, live and die** can change our lives in profound ways. To do this, the report tells the story of inequality via the human currency of families we might know in Derby. They could be our neighbours or our friends. In this report, we catch a glimpse of ordinary people's lives, to help understand how life experiences impact on health and ill-health. This storytelling approach offers a way of hopefully turning "dry" statistics into the real experiences of people in order to explore and reflect on the existence of health inequalities in Derby and the rest of the UK.

Our story demonstrates that the right to health is not being enjoyed equally across the population in Derby.

Now, let's go meet the families...

[5] based on gender, age, ethnicity, sexuality and so on.
[6] The design of any health care system must be guided by the following key human rights standards:

- Universal Access: Access to health care must be universal, guaranteed for all on an equitable basis. Health care must be affordable and comprehensive for everyone, and physically accessible where and when needed.
- Availability: Adequate health care infrastructure (e.g. hospitals, community health facilities, trained health care professionals), goods (e.g. drugs, equipment), and services (e.g. primary care, mental health, stop smoking services) must be available in all geographical areas and to all communities.
- Acceptability and Dignity: Health care institutions and providers must respect dignity, provide culturally appropriate care, be responsive to needs based on gender, age, culture, language, and different ways of life and abilities. They must respect medical ethics and protect confidentiality.
- Quality: All health care must be medically appropriate and of good quality, guided by quality standards and control mechanisms, and provided in a timely, safe, and patient-centred manner.

MEET OUR FAMILIES

Allestree The Stanleys

The Stanley's live in the suburban area of Allestree, close to Allestree Park and Golf Course. Allestree is one of the most affluent areas of the city with people living on average five years longer than on average in the city. Dad, Mark, is employed by Rolls Royce, while mum, Laura, is a teacher at the local secondary Allestree Woodlands School. Their children, Martha aged 3 and Jake, aged 5, attend local nursery and primary schools respectively. Laura is expecting their third child in a few months.

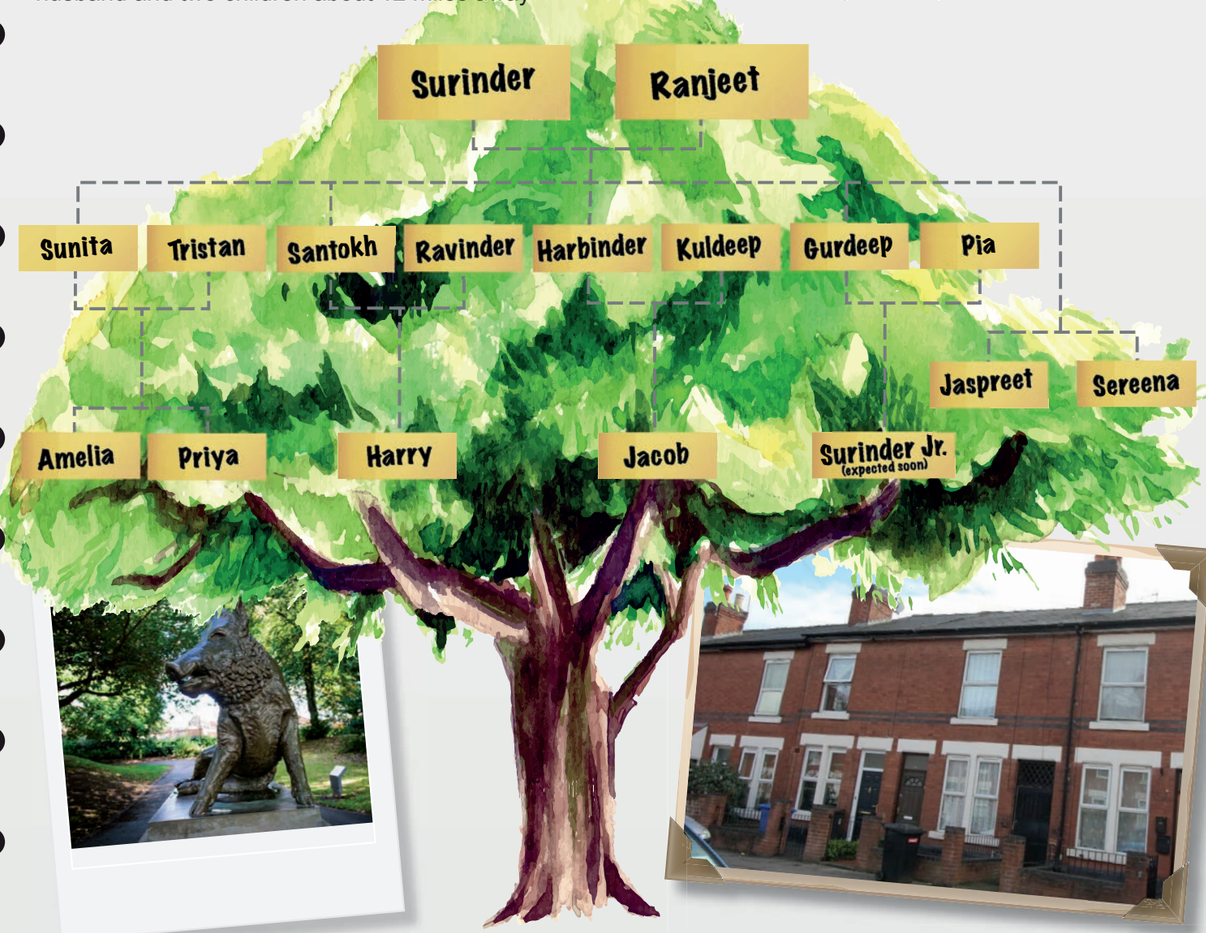
Their home was built just a few years ago, and Mark and Laura moved in as first time buyers. Mark and Laura are well educated and earn a decent household income, but because they are busy with work and their children, they rarely exercise. They also drink more than average, though otherwise live healthy lifestyles and are in good health. Laura's mum, Julie, lives in a nursing home in Aston ward in South Derbyshire, while Mark's dad, Norman, lives on his own in the Derwent area of the city.

Arboretum The Sahotas

The Sahota's are a large, extended family living in the diverse inner city area of Arboretum which has strong South Asian tradition. Arboretum is the most deprived area of the city where people live on average five years less. Their family unit comprises three generations – older parents, six children and four grandchildren. Surinder and Ranjeet are retired.

They live in two adjoining terraces, one of which is rented from a private landlord and occupied by two of their three sons. Their other son, Gurdeep, lives with his wife nearby.

One of their daughter's, Sunita, lives with her husband and two children about 12 miles away in Somercotes in the Amber Valley area of Derbyshire. Whilst some of their older children are working, Sereena, their youngest daughter, is studying for a degree at the University of Derby. Their eldest son, Santokh, was recently made redundant and is actively looking for a new job. Several family members smoke, and health in the area is poorer than might be expected.



STARTING WELL

"Giving every child the best start in life is crucial to reducing health inequalities across the life course" (Marmot 2010)

Children in Derby have a relatively poor start in life when compared to England as a whole, but there is considerable variation across the city with some areas achieving far better health and wellbeing than others. What happens during early childhood is important as it lays the foundations for how individuals will develop for the rest of their lives.

Both our families have women who are currently pregnant and also have young children at school. As the year progresses, it is clear that some early life events are experienced very differently for our two families.

3.1 Maternal health

The term maternal health refers to the time of pregnancy, childbirth and the first six weeks after birth in women. Infant health is typically associated with the first 12 months of a newborn's life. Experiences and behaviours in pregnancy will affect maternal and infant health outcomes.

3.1.1 Lifestyle

In Allestree, the Stanleys are expecting their third child. Laura is determined to live as healthy a lifestyle as she can. She does not smoke and has stopped drinking alcohol. She had got into the habit of having a glass of wine while cooking tea, but after reading about the harm drinking might cause to her unborn child she has stopped. In Arboretum, Surinder and Ranjeet's daughter-in-law, Pia, is expecting her first child. She lives with their son, Gurdeep, a short walk from the family home. They both try to eat a healthy diet and do not drink alcohol. They eat a varied diet of fresh fruit and vegetables but cook traditionally with Ghee, a clarified butter. Gurdeep smokes and is borderline diabetic.

Both mothers-to-be have been trying to give their babies the best start in life by taking supplements, such as folic acid, since conception. Likewise, both women are determined to breastfeed their babies. Laura knows what to expect from feeding her previous two children, but Pia has been feeling anxious about it and has been keen to speak with her Public Health Nurse.

Public Health Nursing

Derby's Public Health Nursing service includes the more traditional roles of Health Visitors, School Nurses and Family Nurses in an integrated children's Public Health System for 0-19 year olds and their families. The aim of this service is to improve health outcomes for the city's children and young people. Putting the needs of children and young people at the centre of our approach, Derby City Council in partnership with the NHS is focussing its efforts on early help, prevention and early intervention.

	Population aged 0-15 years (%)	Low birth weights (%)	Deliveries to teenage mothers (%)	Child Development at age 5 (%)	A&E attendances in under 5s (per 1,000)
Allestree	17	7	0	70	479
Arboretum	24	11	2	34	625

3.1.2 Access to services

All pregnant women are entitled to the same maternal healthcare under the NHS. The recently published National Maternity Review, Better Births: Improving outcomes of maternity services in England, has laid out a radical new approach to maternal care. The aim over the next five years is to introduce more personalised services, giving women greater control and more choice. It will be needs-based, and offers the following:

- ✔ Personalised care
- ✔ Continuity of carer
- ✔ Better postnatal and perinatal mental health care
- ✔ A payment system
- ✔ Safer care
- ✔ Multi-professional working
- ✔ Working across boundaries

Laura and Pia are both booked into the delivery suite of the Royal Derby Hospital. In the months before the big day they have been attending parenting classes to learn more about their pregnancies, what will happen during the delivery and what to expect in baby's first days, weeks and months of life. They have also had their first visit from their Public Health Nurse.

3.1.3 Smoking

Smoking during pregnancy puts mothers at higher risk of miscarriage as well as having low birth weight babies which, coupled with other poorer social and demographic outcomes, can negatively affect the cognitive development of children.
In Derby, the proportion of women who smoke through their pregnancy ranges from **1 in 3** in Derwent Ward, to almost no-one in Allestree, Mickleover and Littleover Wards. Though neither of our expectant mothers' smoke, dad-to-be Gurdeep does. He is starting to think that now would be a good time to stop as he knows that passive smoking has been linked to Sudden Infant Death Syndrome ('cot death'), but knows he will need help to quit.

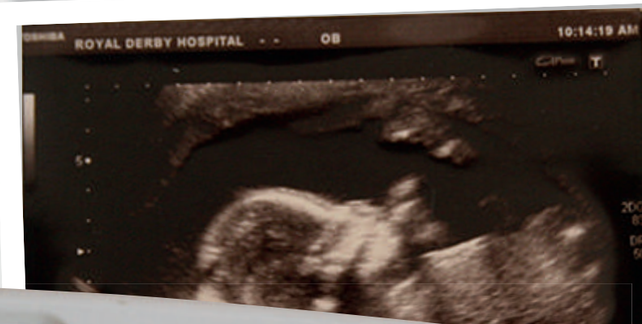
THURSDAY
Don't forget post-natal check-up at 9.45am -

3.1.4 Breastfeeding

The World Health Organisation (WHO) states that babies who are fed nothing but breast milk from birth through their first six months get the best start, and that exclusive breastfeeding provides babies with the perfect nutrition and everything they need for healthy growth and brain development.

Breastfeeding protects the health of baby and mother, and reduces the risk of illness. Laura knows all too well from her experiences with Martha, who she was unable to breastfeed, that she suffered far more infections in her early life, such as gastroenteritis and ear infections. Infants who are not breastfed are also more likely to become obese as they grow up, putting them at higher risk of developing Type 2 diabetes and other health problems. For the mother, breastfeeding is important as it is associated with a reduced risk of breast and ovarian cancers. Breastfeeding, however, is not always easy to start and sustain. Breastfeeding, however, is not always easy to start and sustain. This time around, Laura is determined to breastfeed the new baby and plans to access all the help she can in hospital to achieve this

In Derby, breastfeeding varies greatly by Ward. At birth, over 90% of mothers' breastfeed in Mickleover compared with 43% in Mackworth. At eight weeks, the proportion breastfeeding has fallen to **57%** in Mickleover and **24%** in Mackworth. Despite being neighbouring areas, these Wards highlight the early signs of health inequalities likely to be faced by our children as they grow up.



Baby Ruby, born
21 Jan 2017, 7lbs 1oz

3.1.5 Maternal mental health

Pia gave birth to a healthy baby boy, Surinder, and has been at home with him for a few weeks. Although she has adjusted to the new demands of a new baby in her life, she is not feeling as happy as she had expected to. In fact, she has been feeling sad and has a low mood. She has particularly missed the company of her parents and siblings who do not live in Derby. She lacks the energy to do anything other than meet Surinder's needs for food, sleep and clean nappies, and has recently been feeling guilty for being sad, unhappy and exhausted.

Pia's health visitor sees her at the 6-8 week post birth check-up appointment. Quickly, it is apparent to the health visitor that Pia is not her usual self so she listens to Pia talk about her recent feelings and asks her to complete a questionnaire. The health visitor picks up that these are some of the symptoms of postnatal depression. The health visitor recommends a self-help course which uses cognitive behavioural therapy and encourages Pia to open up to her husband, family and close friends. This results in Pia's husband encouraging her to get more rest, sleep and take time to herself away from the baby, as well as preparing her regular healthy nutritious meals.

Pia's sister comes to stay for a couple of weeks after a tearful phone call from her sister. This really helps Pia and in no time Surinder Jr is enrolled into a baby massage class where Pia can meet new parents. They also decide to take Surinder in the pushchair every day for a walk. This family support, the self-help course and regular appointments with a health visitor, work together to help Pia feel better and she begins to enjoy her time with Surinder.

Pia now understands that low mood isn't uncommon. Postnatal depression is thought to affect more than one in every 10 women in the year after child birth. It can also affect partners but this is far less common. It's best to seek help as soon as symptoms start and, just like Pia's experience, health visitors and GPs are there to support you to feel well again.

3.2 Child health outcomes

Just after Pia, Laura also gave birth to a healthy baby, a girl, Ruby. Children in Derby, however, have a relatively poor start in life when compared to England as a whole. Derby has a significantly:

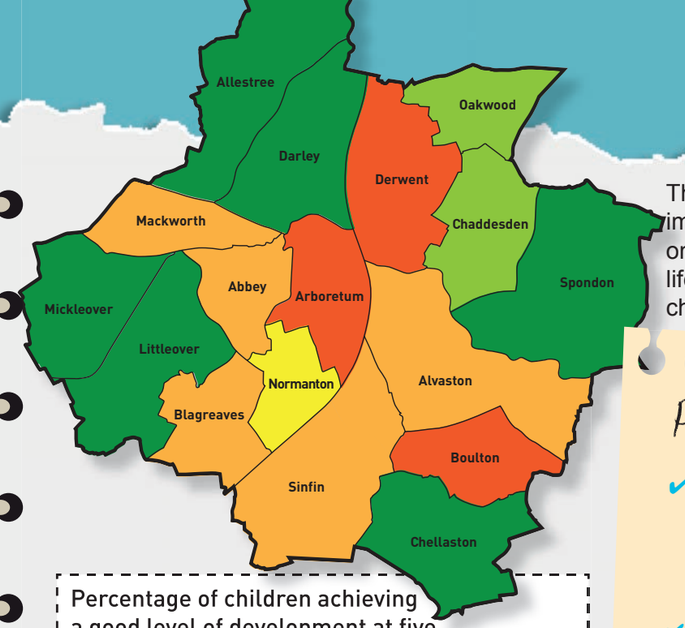
- ✔ High percentage of children living in poverty
- ✔ High rate of teenage pregnancies
- ✔ High proportion of mothers smoking at time of delivery
- ✔ High rate of low birth weight babies
- ✔ Low level of breastfeeding initiation
- ✔ Low level of children achieving a good level of development at the end of Reception school year.

Children do, however, have high levels of immunisation uptake across most childhood immunisations. This protects them from a range of diseases such as diphtheria, measles and meningitis.

3.3 Vaccinations and immunisations

From eight weeks old, children in the UK begin a routine immunisation schedule that protects them from infectious diseases including, diphtheria, tetanus, pertussis (whooping cough) and polio; rotavirus; measles, mumps and rubella (german measles). The full schedule can be accessed on Public Health England's website, and is available in the red book that parents receive for healthcare professionals to document all aspects of babies development.

"The two public health interventions that have the greatest impact on the world's health are clean water and vaccines" (WHO)



It is very important to be vaccinated in childhood as it does protect from many infectious and diseases. Although our mothers are aware of this, they are less aware that it provides benefits beyond the direct prevention of disease in childhood and the fact that not being immunised can impact on the entire life trajectory. For instance Ruby's economic future will be very different if she becomes blind as a consequence of measles infection in childhood. Vaccination also promotes health equity and protects those in the community who are not immunised. Doctors use the term "herd immunity" to describe the indirect protection provided when a large proportion of the population has been immunised. This is why nationally the target for all immunisations is 95%. So our parents are not only protecting their children from potentially life threatening illness but protecting other children who are yet to be immunised.

Pia's Home Safety Checklist

- ✔ Fix child locks on kitchen and bathroom cupboards so that cleaning products, laundry capsules and medicines are kept securely out of reach
- ✔ Keep a thermometer within reach of the bath and check bath temperature each time
- ✔ Check all blind cords are short, stored out of reach and will break under tension
- ✔ Store batteries in a child proof box and out of reach
- ✔ Install safety gates at the top and bottom of stairs to avoid serious falls
- ✔ Fit a fire guard
- ✔ Attach soft corner guards on furniture edges
- ✔ Put Surinder to sleep in a cot/moses basket next to the bed/sofa
- ✔ Keep plastic bags in one storage place, in a locked cupboard
- ✔ Only buy nappy sacks in roll form and store out of reach of Surinder

	Children with excess weight – Reception Year (%)	Children with excess weight - Year 6 (%)	Regular smoker, aged 15 years (%)	Young people's admissions for injury (per 10,000)	GCSE Achievement 5A*-C incl. English & Maths (%)
Allestree	16	25	7	116	73
Arboretum	19	40	5	154	32

3.4 Accidents and injuries

Since bringing baby Surinder home, Pia and Gurdeep have made an effort to create a safe home environment to prevent Surinder having avoidable accidents and injuries as he becomes more mobile. Pia's best friend went through the experience of their child having a severe accident in the home, which could have been avoided had she known how. Pia's best friend has shared her knowledge with friends and family and this has helped Pia to reduce risks around her home. Pia wrote a checklist of jobs to do around her home. She found a lot of useful safety tips on the RoSPA website www.rospa.com, which is a registered charity for accident prevention.

3.5 Dental health

Sunita works as a dental hygienist and specialises in child dental health and teaching children how to keep their teeth and gums healthy. When Sunita is not teaching about dental health, she sees children where she works with dental problems in the dentist practice. She knows all too well the damage to teeth and gums through infrequent teeth brushing, eating sugary foods, drinking sugary drinks like fizzy drinks and lots of fruit juice.

In Derby, 27.6% of five year olds have some degree of dental decay and 31% of children have one or more decayed, missing or filled teeth. Tooth extraction is the leading reason for hospital admission in children. Sunita has raised her two girls, Amelia and Priya, to look after their teeth by brushing their teeth twice a day, which Sunita supervises and checks, and the girls eat a diet that is low in sugar.

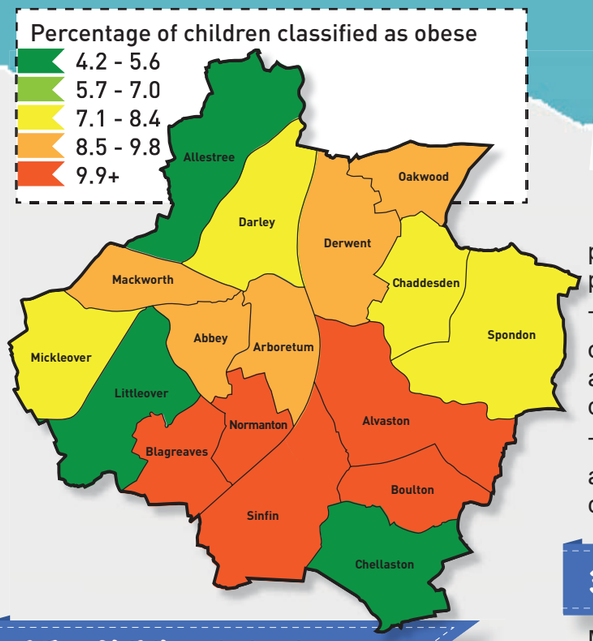
3.6 Primary school readiness

Both Harry Sahota and Jake Stanley are five years old and in reception class at their respective primary schools. The two boys have settled in well, love going to school and like to see their friends and play.

Harry and Jake have recently had their 'school readiness' assessed. This identifies if children in reception year have achieved the expected level of development for their age. It uses the Early Years Foundation Stage areas of learning: communication and language; physical development; personal, social and emotional development; literacy; mathematics. Both Harry and Jake were assessed to be 'school ready'. Their parents thought this was due to their boys attending nursery before starting school and going to preschool activities such as the free library story sessions. Both sets of parents encourage their children through activities such as listening to books being read to them, talking together and counting. Achieving school readiness before formal learning begins at school will help Harry and Jake keep pace with their peers and to have a positive learning experience.

Harry and Jake are fortunate to have achieved school readiness in reception class because only **1 in 2** boys in Derby are assessed as 'ready'. Overall, three-in-five Derby children achieve school readiness which means that in a class of 30 school children, on average only 18 will be ready to learn at school and 12 will not be. This shows that nearly half of the class would struggle with the expectations of age appropriate schooling and they may fall behind their more 'ready' peers.

On the other hand, their peers which are ready for school may be held back in their school learning because so many children are trying to catch up. Regardless of either outcome, it highlights the importance of families and care givers to help preschool children prepare for 'big school' to reduce any inequalities at this age that can negatively impact later on in life.



3.7 Childhood obesity

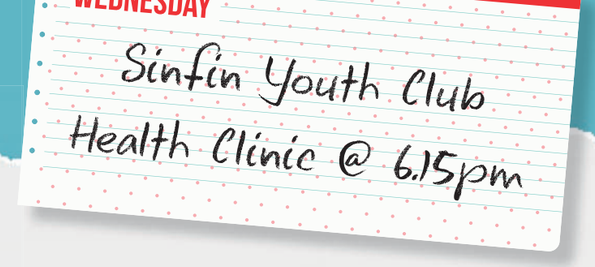
At the start of school, Jake and Harry's weight and height were recorded and their BMI was calculated. BMI is an abbreviation for Body Mass Index and is a measure of body fat in relation to height and weight. The BMI was then plotted onto the British 1990 growth reference chart according to children's age and sex.

Both parents have received the BMI results in the post. Jake's parents have received a letter informing them that their child is overweight, whereas Harry's BMI is in the healthy range. Jake's parents talk about ways to reduce tablet device and television screen time at home and ways that they all could become more physically active. In light of this Laura has decided to stop driving Jake to school and walk instead. It will also help lower air pollution which has been a concern of Laura's generally and particularly outside the school. In addition, the family have decided to stop buying sweets, biscuits and chocolate during their weekly supermarket food shop. Within three months of implementing a healthier lifestyle, Jake is a healthy weight for his age and height.

It's really important that Jake and Harry start primary school at a healthy weight and maintain the appropriate weight for their age and height as they grow up. As children progress through school, many children put on excess weight. In reception class, there are 21.9% of children that are overweight or obese in Derby. By the end of primary school, this rises to 34.3% - around ten pupils in each classroom of 29 children.

This is a concern because overweight and obese children are more likely to become obese adults and suffer from obesity-related illnesses, disabilities and premature deaths.

The map shows that children living in deprived areas are more likely to be obese compared to children in more affluent wards.



3.8 Mental health

Mental illness has been shown to have a similar effect on life expectancy to smoking. Nationally, mental health problems affect one-in-ten children and young people; a figure that rises to **1 in 5** for young adults, and one-in-four people in the general population. The cost of mental health problems to the economy in England have been estimated at over £100 billion, and treatment costs are expected to double in the next 20 years (Department of Health, 2014).

The cost of mental illness to the individual is significant. Mental illness impacts upon the wider health and wellbeing of the individual, with an increased harm to a person's physical health and the risk of premature death. Older childhood is a time where mental health issues could arise - eating disorders, negative body image and online bullying are just some examples of problems that are prevalent at this age. It is estimated that 6.6% of people aged 16+ years have eating disorders in Derby. Alongside NHS services, there are a number of specialist charities that support individuals and their families experiencing mental health illnesses.

Parents can help to give children the best start in life and to offer their children some degree of protection against mental health issues later on in adolescence and adulthood. For example, breastfeeding is a protective factor against mental health issues later in life. Although, wider issues like deprivation are known to have a negative impact on physical and mental health.

£21Bn is spent every year in England on alcohol related harm (Alcohol Concern, 2016).

3.9 Teenage risky behaviours

The transition from childhood to adulthood is a period where young people are given more independence and access to adult situations. Many teenagers engage in risky behaviours which have the potential to lead to long-term harm or even death in some cases.

Within our families, Ranjeet and Surinder's youngest children are now adults and their youngest daughter Sereena has started university. Because Ranjeet and Surinder are aware that adolescents and young adults take more risks than older people, they have worked with their schools to ensure Jaspreet and Sereena are aware of risks of drugs and smoking, importance of safe relationships, good school attendance, dangerous driving and avoiding youth crime. Ranjeet was furious when Sereena told her she had been texting when driving.

Some of their teenage friends have been involved in binge drinking and using drugs which had led to problems. Sereena told her mother recently that one of her friends had taken drugs at a party which had meant he had to go to A&E for treatment. Also, some of her friends who live in a shared house in Derby had the police turn up because of antisocial and nuisance behaviours. An old friend from school had just announced she had an unplanned pregnancy and so wouldn't be following Sereena to University.

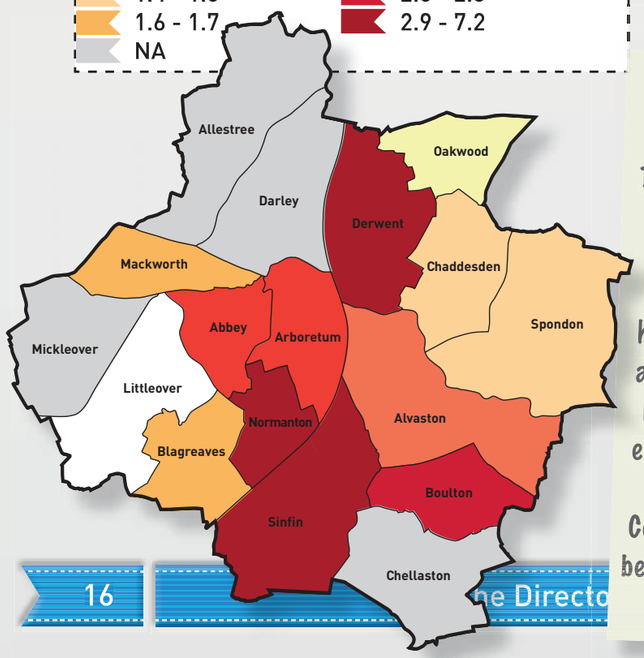
A survey of 15 year olds found that 7.7% were smokers and 4.78% of half school days were missed due to pupil absence. Both of these percentages are similar to the proportions in England.

With regards to sexual relationships for young people, in Derby the chlamydia detection rate is 1,653 per 100,000 people aged 15 to 24 years and there are 26.1 per 1,000 conceptions in females aged 15 to 17 years old. Chlamydia is a sexually transmitted infection (STI) that is easily cured yet preventable through safe sex (e.g. using condoms). Frequently, those infected have no symptoms but if left untreated the infection is problematic in the long-term as it can lead to inflammation and infertility. Young people should get tested for chlamydia each year or when they change sexual partner – it's free and confidential at sexual health clinics and GP surgeries.

There are more first time entrants to the youth justice system than the England average with a rate of 536 per 100,000 10-to-17 year olds receiving their first reprimand, warning or conviction. There are 138 per 10,000 hospital admissions due to injuries in young people aged 15 to 24 years. One in twenty 16-to-18 year olds are not in education, employment or training. In recent years there have been an increased number of apprenticeship opportunities for young people across a variety of sectors where people can combine a job with study to obtain on the job skills and qualifications in their chosen career-field.

Percentage of deliveries where the mother is aged under 18 years

- 0
- 0.1 - 1.1
- 1.2 - 1.3
- 1.4 - 1.5
- 1.6 - 1.7
- NA
- 1.8 - 1.9
- 2.0 - 2.1
- 2.2 - 2.4
- 2.5 - 2.8
- 2.9 - 7.2



Young people services

The SPACE @ Connexions provides a wide range of services for young people in Derby where staff offer information, advice, referral and support regarding issues such as: housing and homelessness; benefits; volunteering; drugs and alcohol; eating disorders; mental health; sexual health; stop smoking; education; training and employment; debt; travel; Chlamydia screening; pregnancy testing. Staff at The SPACE @ Connexions include nurses, and the services can be accessed through scheduled drop in clinics and appointments.

Youth clubs

Across Derby city there are a number of young people centres offering drop-in facilities, activities and youth clubs.

3.9.1 Access to services

Young people can go to Youth Clubs to participate in regular activities and social events specifically targeted to children and teenagers. There is also the specialised centre called The SPACE @ Connexions which is there for young people to seek advice, support and treatment for any issues that they are experiencing.

There is also a number of independent sports clubs and movements (e.g. Scouts, Guides, etc) which provide young people the opportunity to be physical active, develop a particular set of skills and self-confidence, as well as the chance to socialise outside of the school environment.

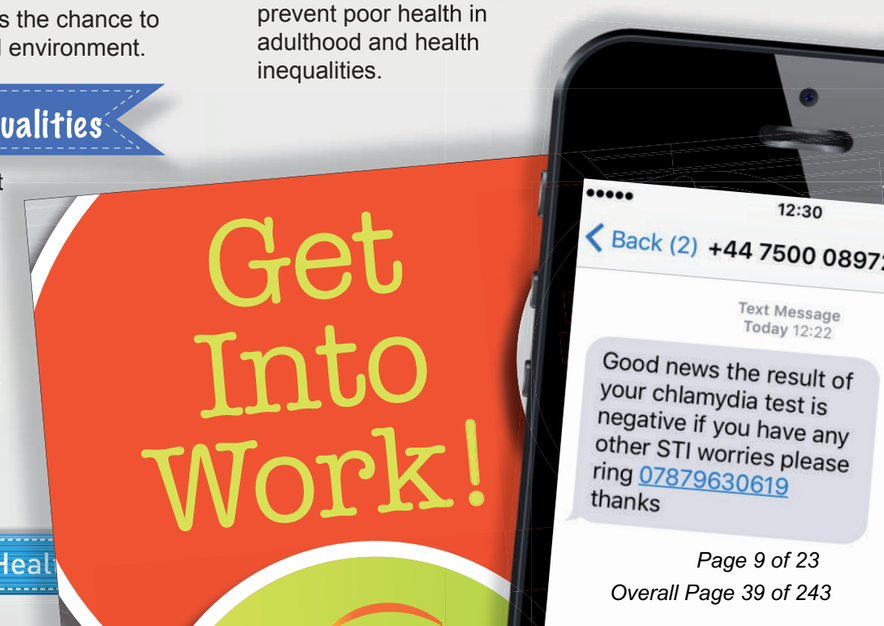
3.10 Starting well inequalities

This chapter shows that whilst there are a number of inequalities experienced across Derby City during the early years, school years and young adulthood, it is possible to reduce these inequalities. This can be done through individual, family and community choices and by taking advantage of the services available to help.

People in Derby can give their babies the best start in life by planning pregnancies and being in optimal health. This can be done by being a non-smoker, pausing alcohol consumption, taking pregnancy supplements, consuming a healthy diet, being physically active, opting to breastfeed, vaccinating against harmful diseases – all of which support babies start in life and reduce inequalities. Parents, caregivers and professionals can support nursery and primary school children to develop well.

This is the time where good dental, diet and physical activity behaviours are formed for adulthood. It is also important for a child's future that adults prepare children to be developmentally ready for school. Ensuring that all children have a good foundation in these areas will help to reduce inequalities and poor health later in life.

Teenagers need guidance to avoid taking part in risky behaviours and to protect their mental health and wellbeing.Experiencing negative behaviours at this age can cause long-term and irreversible harm, of which the consequences can continue into adulthood. Supporting the health and wellbeing of teenagers can help reduce and prevent poor health in adulthood and health inequalities.



LIVING WELL

4.1 Unhealthy behaviours

4.1.1 Lifestyles

England is in the grip of a rising wave of obesity: since the 1990s, the rate of obesity has significantly increased. Now one in three children are overweight or obese, with rates of obesity increasing as children age. 9.4% of children in Derby begin primary school obese and this rises to **23%** of children in Derby being obese when they leave aged 11. In Derby, two-thirds of adults are overweight or obese (Public Health England, 2016). These levels are concerning because being overweight and obese is associated with health problems such as diabetes type 2, heart disease, stroke, hypertension and some cancers. These conditions impact on people's ability to live well and are linked to premature death. Cases of overweight and obesity, are estimated to cost the NHS £4.2 billion each year.

Physical inactivity is associated with **1-in-6** deaths in the UK which is comparable to the harm from smoking (Public Health England, 2014). A third of UK adults do not manage 30 minutes of moderate physical activity a week and are classified as 'inactive'. It's not only adults who are not moving enough, nine-in-10 UK children aged between 2 and 4 years do not achieve the physical activity guidelines (HM Government, 2014). It's important to develop healthy lifestyle behaviours from a young age because poor lifestyles developed in childhood are challenging to reverse in adulthood. Good habits developed in childhood will provide positive health benefits in adult life.

Public Health England published the Eatwell Guide which outlines what constitutes a healthy and balanced diet. It includes fruit and vegetables (39%), starchy carbohydrates e.g. potatoes, rice (37%), proteins e.g. meat, pulses (12%), dairy and alternatives (8%), oils and spreads (1%), and occasional foods (3%). Therefore, three quarters of a healthy diet should encompass fruit, vegetables and starchy carbohydrates.

People living in the UK are advised to follow the 5-a-day campaign: being mindful of including five portions of fruit and vegetables in their diet each day. It is also advised that diets are low in sugar, salt and saturated fat. Following a healthy and balanced diet is known to reduce the chances of heart disease, stroke and bowel cancer cases.

In England, **3-in-10** working aged adults and four-in-10 older adults (65+ years) meet the 5-a-day dietary recommendation - similar to the England average. A large proportion of the local population could make improvements to their diet to include five portions of fruit and vegetables each day whilst at the same time avoiding foods containing excess sugar, salt and saturated fat.

Ultimately, to reverse the increasing trend in obesity, individuals, families and communities need to move more, eat less and consume a healthy, nutritious diet. The majority of the population would benefit from making improvements to their diet. More adults in Derby need to become physically active and strive towards regular physical activity at moderate level e.g. cycling to the shops and workplace. More pressingly, children require the opportunity and encouragement to be physically active each and every day. Physical activity across generations is recommended in order to avoid the associated diseases such as diabetes and specific cancers, and conditions such as hypertension and depression. This requires us as individuals, families and communities to make healthy choices but also for national and local governments to enable and support people to make these choices.

TUESDAY
Livewell appointment
2.45pm at Springwood Leisure Centre

Lifestyle Service

The Livewell Service is a healthy lifestyle service available for people registered to a doctor in Derby and who meet certain criteria. It has been successfully run for a few years now. Enrolled children and adults are supported by a designated Livewell advisor through health and wellbeing programmes specific to their needs to make positive changes to their lifestyle. The service is provided free of charge for up to 12 months. Programmes are varied and plans are personalised to the attending individual and family but commonly include stop smoking, weight reduction, physical activity and diet advice.

Did you know...

healthy eating need not be expensive! The NHS and the British Heart Foundation provides healthy eating ideas according to different budgets and gives ideas for ways to eat well for less.

	Obese adults (%)	Binge drinking adults (%)	Healthy eating adults (%)	Unemployment (%)	Population aged 25-64 years (%)
Allestree	20	18	36	0	46
Arboretum	23	13	28	4	53

Asian community. That being said, Surinder might have prevented his diagnosis if he had eaten a healthier diet, exercised more and maintained a healthy weight.

Ranjeet and Surinder spent the week busily preparing for the weekend family get together. They were having all the family and close friends over on Saturday to celebrate their 40th wedding anniversary and had prepared a feast for everyone. The meal and celebrations went well until Surinder tried to kick a football around with his grandchildren. He collapsed with chest pains and paramedics rushed him to hospital. Surinder had coronary heart disease and was told he needed to stay in hospital for coronary bypass surgery and recovery. His lifestyle of smoking, poor diet and lack of exercise had led to narrowed and clogged up arteries so his heart struggled to pump blood sufficiently around his body and supply oxygen to his heart.

The events at the wedding anniversary gave all of the members of the Sahota family a real shock and led them to reflect on their health. Ranjeet and her six children are determined to give their lifestyles an overhaul and Surinder also decides to change his lifestyle. Several family members begin attending a weight loss group together that promotes healthy eating and recipes for home cooked meals and exercise. The support of loved ones following the same healthy eating programme and the support from the local service Livewell, enables Ranjeet and her family to adopt positive behaviour changes.

Once the Sahotas had got to grips with their new diet and felt the improvements of eating well, the family began incorporating various physical activities into their weekly routine. Ranjeet and Surinder (with his recovering health) now walk to the shops, regularly taking their grandchildren to the local play park and have both signed up to a weekly yoga class. Their children have chosen more vigorous physical activities such as running, cycling to work, joining the gym and attending exercise classes. All six children and their respective partners are inspired to run together. To give themselves a target they sign up for the Derby 10k race and fun run.

Over the following three months, the exercise and healthy eating has meant that all family members have lost some weight and feel better in themselves. On average, each person has lost 12lbs, with some family members needing to lose more weight in order to obtain a healthy BMI score. The Livewell service has congratulated Ranjeet on lowering her blood pressure to a healthy range because it had been too high when she first registered with the service.

4.1.2 Alcohol and drugs

Over in Allestree, Laura and Mark have put the children to bed and while there is a bit of peace and quiet, they both sit down to a glass of wine. Laura was advised by her Public Health Nurse that she should not drink more than one or two units, more than once or twice a week – so this small glass of white is her limit for the next few days. After a long day at work and play with the children before bed, Mark however, sits down to his usual evening routine of two large glasses of red, followed by a whiskey night cap – the equivalent of seven units of alcohol. Though it might not feel like it, Mark has consumed half of a week's recommended units of alcohol.

The consequences of too much alcohol on a regular basis can be harmful not only to the individual, but to their families and the wider community. Unbeknown to Mark, his intake of alcohol has raised his blood pressure putting him at increased risk of stroke. Fortunately, he has received an invitation for a free NHS Health Check in the post.

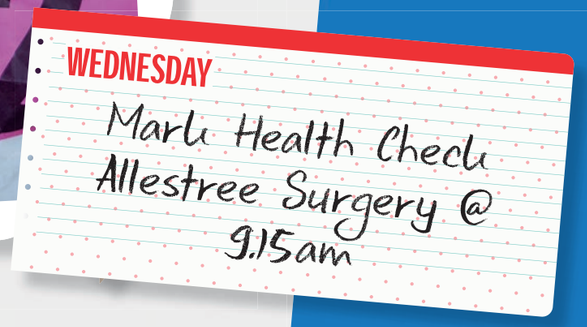
Substance Misuse Service

Derby has an integrated Drug and Alcohol Treatment Service. In April 2016 a newly integrated Family and Recovery Service providing support for families and those affected by someone else's drug/alcohol use, and recovery focused family interventions was established. The services continue to work in partnership with key agencies to facilitate access to and engagement with wider support services - such as housing, employment, leisure services, mutual aid and peer support groups. This is to help drug and alcohol clients to maintain recovery and improve wellbeing.

4.2 Prevention

4.2.1 NHS Health Checks

You take your car for an MOT after it reaches three years of age, so why not take yourself for one when you reach 40? The NHS Health Check is offered to adults aged 40 to 74 years of age.



You will be asked about your lifestyle and family medical history, and undertake some routine tests, such as having your blood pressure, weight and height measured. Your GP or other health professional can then use the results to determine your risk of developing conditions such as heart disease, stroke, kidney disease, type 2 diabetes and certain types of dementia. With help and advice, you can then consider ways of reducing your risk and enjoying a better quality of life, such as:

- Maintaining a healthy weight
- Being physically active
- Eating a healthy and balanced diet
- Stopping smoking
- Cutting down on alcohol.

At his appointment, Mark finds out that he has high blood pressure and that his risk of stroke has increased. High blood pressure is referred to as hypertension and puts the body under strain and this raises an individual's risk for potentially lethal conditions such as heart disease, heart attacks, strokes, aneurysms and vascular dementia. The good news is that in most cases, high blood pressure can be reduced through being a healthy weight, eating a healthy diet, being physically active, stopping smoking, getting enough sleep and reducing alcohol and caffeine intake.

Mark and his GP have a chat about his current lifestyle, and Mark explains that he does enjoy a drink each evening and struggles to find the time to exercise. Between them they come up with a personalised plan of action and series of health goals for Mark, the first is to cut down his alcohol intake. Mark decides to reduce his two glasses of wine a night to one glass and in addition decides to have three nights without alcohol during the week. This breaks Mark's daily habit of alcohol consumption at the point the children go to bed and gives his liver a break from processing alcohol.

The second goal is to increase his levels of physical activity. Mark is referred into the Livewell service where he speaks to an advisor about his

	Fertility rate per 1,000 female pop aged 15-44	Emergency hospital admissions for stroke (SAR)	Emergency hospital admissions for heart attack (SAR)	Incidence of prostate cancer (SIR)	Incidence of lung cancer (SIR)
Allestree	54	94	102	94	45
Arboretum	90	147	212	70	124

high blood pressure and lack of physical activity. He is encouraged to restart jogging, an activity he was fond of as a teenager.

Mark has begun going for a jog three mornings a week before the children have woken up. He has downloaded the NHS app 'Couch to 5k' and is currently on week 3. The podcasts take him through a five minute walking warm up and cycles of running and walking.

Mark's third goal is to address his diet. He has now started prioritising eating more healthy and has started eating breakfast at home and preparing a healthy packed lunch for work. This means that he is no longer hungry when he finishes work making him reach for quick-fix snacks or indulging in heavy and unhealthy dinners.

All of Mark's efforts result in the reduction of his blood pressure and he can now fit back into clothes he wore on honeymoon with Laura a few years ago!

At the same time, Gurdeep in Arboretum is being helped to stop smoking because he wants his newborn baby son Surinder to grow up in a smoke-free home and family. Gurdeep has recently adopted other healthy lifestyle changes since his father's ill health and surgery. Gurdeep now eats a diet that is low in saturated fat, sugar and salt, and is mindful to eat his 5-a-day. He is also active several times a week, including going to a local football club in his area for a kick around after work on Tuesdays. As Gurdeep is a smoker, he struggles to run a lot. Smoking has been the one part of his lifestyle that Gurdeep wants to change the most but has also been the most challenging. Gurdeep previously tried to quit smoking as a New Year Resolution and on specific milestones (e.g. when Pia found out she was expecting) but has been unable to manage it by himself.

There are lots of chemicals in cigarettes, one of which is nicotine. Nicotine is highly addictive and although many smokers may wish to quit smoking, it can be very difficult to stop. Gurdeep tried to stop smoking in the past by going 'cold turkey' but this is the least effective method of quitting smoking so it is not surprising that he began smoking again.

4.2.2 'Healthier Lives'

In order to live healthier lives, Mark and Laura think about what changes they can make to their diet. They adopt the habit of sitting down together each week to write a weekly meal plan for the family. The British Heart Foundation (BHF), as well as many other charities and organisations, provide advice on healthy eating on a budget and how to make the healthiest choices. In one example, the BHF provides a week's food shopping list and recipes for two adults at the cost of £21 each.

4.2.3 Sexual health

Taking care of your sexual health really matters!

Jaspreet and her fiancé Sam attended their local sexual health service together early in their relationship to rule out any sexually transmitted infections - although they felt well and had no symptoms they had both been in sexual relationships before dating one another. They also had no immediate plans for children so wanted to discuss contraception options.

Jaspreet and Sam were seen in a drop-in morning clinic, where they provided urine and swab samples and quickly learned that their results indicated a clean bill of health. The nurse provided the couple with condoms and Jaspreet booked in to have an IUD (intrauterine device) fitted, which is commonly called 'a coil'. The IUD is a T-shaped, long lasting, contraception device that is inserted into the womb and is highly effective at preventing pregnancy.

In the same week, Jaspreet also attended her GP Practice for a smear test. At 25 years old, she had recently received her first invitation for cervical screening. Jaspreet received her results through the post a few weeks after and found out that her results were normal.

Sexual Health Service

Derby's Integrated Sexual Health Service is based at London Road Community Hospital. It is open 8:30am to 8pm Monday to Friday and a short clinic is provided on Saturday 10am to 2pm for people to either attend by walk-ins or appointments. The service is free, confidential and provided by specialist sexual health professionals and includes sexually transmitted infections (STI) testing, treatment, contraception, advice, pregnancy testing and termination referrals.

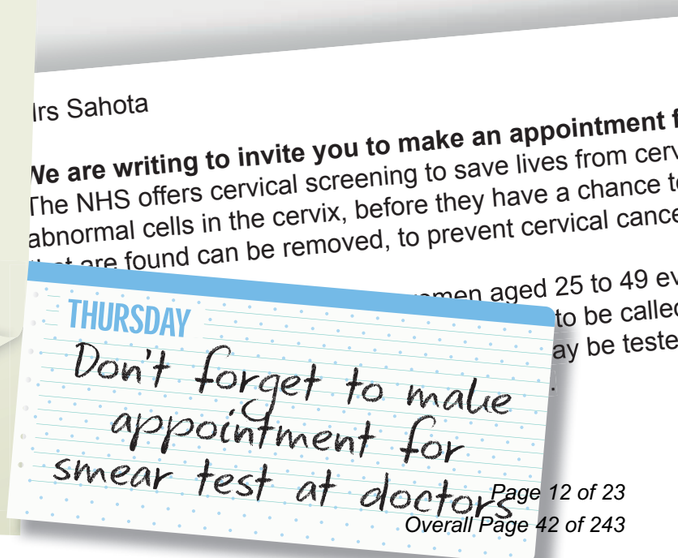
4.3 Screening

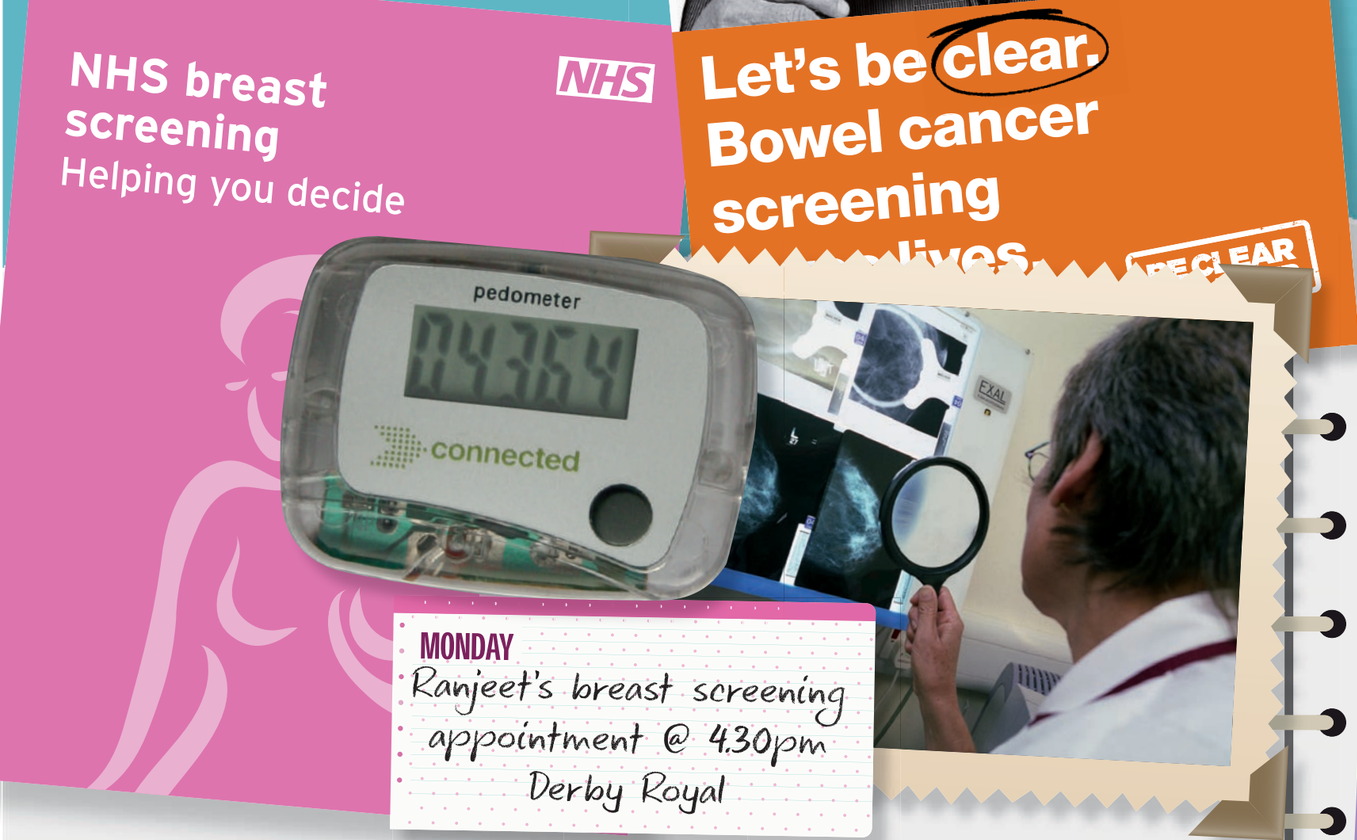
Screening is a way of identifying apparently healthy people who may have an increased risk of a particular condition. In England, there are 11 screening programmes including screening in pregnancy, types of cancer screening, diabetic eye screening, aortic aneurysm screening and newborn screening. Jaspreet's mum, Ranjeet, has received an invitation this year for NHS breast screening. This particular programme is offered to women between the ages of 50 and 70, once every three years.

In the UK, someone, somewhere, is diagnosed with cancer every couple of minutes. The rate of new cancers being diagnosed is increasing, but fortunately our treatment and survival rates are improving. Screening services enable the early detection of cancer so that an early diagnosis can be made and the treatments are more likely to be successful. Fortunately, 43% of cancers are preventable. One-third of cancers alone are caused by smoking, poor diet, harmful levels of alcohol consumption and obesity.

In the case of breast cancer, around 27% of cases are preventable. Excess weight and physical inactivity, certain occupational exposures and little/no breastfeeding are some of the lifestyle factors associated with this particular cancer.

Unfortunately, 23% of Derby's female population do not attend screening. However, Ranjeet attends as she did three years ago and her breast screening appointment is quick and pain free.





Over in Derwent, Mark's Dad Norman has received a bowel cancer home testing kit through the post. Norman hasn't done one of these home testing kits before but finds the instructions easy enough to follow so takes part in the screening. This is good news for Norman but there are many people aged 60-74 years old who do not participate in bowel screening in Derby. Of those who are eligible for bowel cancer screening, only **57%** are screened. Fortunately, Norman is given peace of mind two weeks later when he receives a normal test result through the post.

It's really encouraging that both Norman and Ranjeet have participated in screening because it is known that screening participation varies across Derby city with people from more deprived backgrounds being less likely to use this service and benefit from early disease detection. Equal participation in screening from all groups within the city will contribute to reducing health inequalities.

4.4 Access to services

Surinder is now managing his diabetes and heart disease through regularly attending GP practice appointments, screening, as well as using local services and speaking with his pharmacist for advice. Managing his long-term health problems in the community means that he is less likely to require emergency treatment through A&E attendance and will be preventing further ill health that would require long-stays in hospital.

The Sahota family's response to Surinder's ill health event is an example of how family networks are a protective factor to our health. It is a reminder that communities work at their best when people can manage their health, supported by local services as needed. This can also ensure that the NHS is able to use resources differently to function at its' best, providing hospital care to those most in need.

A&E attendance in England increased by 5.2% in 2016 compared to 2015 – this means that 3,216 more people arrived at A&E every day in 2016 (House of Commons, 2017).

Screening Services

A number of screening services are available to residents of Derby. Screening offers the opportunity to examine healthy individuals who may be at an increased risk of disease and detect any illnesses early on before symptoms present.

The **abdominal aortic aneurysm screening** programme is provided by the NHS to men aged 65 years and above. The aim of the service is to reduce aneurysm-related mortality. Men attending the screening have a stomach ultrasound scan and are informed of their results at the time of the test. At the moment, four in five Derby men eligible for abdominal aortic aneurysm screening use the service.

British Heart Foundation

Men and women aged between 60 and 74 years are invited to participate in the **bowel cancer screening** programme every couple of years. Identified individuals receive a home faecal occult blood sampling kit through the post to self-complete and return for laboratory testing. Any abnormal tests result in a follow invite for a colonoscopy. Currently, 58% of Derby people offered bowel cancer screening take part which shows that many more people could engage with this service in the future.

BOWEL CANCER UK

Women aged between 50 and 70 years old and registered with a Derby general practitioner (GP) are invited to attend **breast screening** every three years. Three in four women in Derby attend breast screening.

Cervical screening aims to detect abnormalities of the cervix through the laboratory examination of a sample of cervix cells. GP registered women aged 25 to 49 years old will receive an invitation every 3 years (women aged 50 to 64 years will receive an invite every 5 years), to attend cervical screening. 75% of women regularly attend cervical screening in Derby.

CANCER RESEARCH UK

All teenagers and adults with diabetes are eligible for **diabetic eye screening** because screening is able to pick up early eye changes and allow for preventions to be put in place to stop eye sight loss.

DIABETES UK
CARE. CONNECT. CAMPAIGN.

There are a few antenatal and newborn screening programmes. As part of antenatal care, pregnant women are offered **ultrasound scan** programme which is designed to detect conditions such as cleft lip, spina bifida, anencephaly, gastrochisis, etc. through ultra scans. There is a combined test which involves a blood sample and ultrsound scan. This **screening test is for the syndromes Down's, Edwards' and Patau's.** There is another blood test for these syndromes that can be conducted in later weeks. Pregnant women are offered a blood test to test for infectious diseases (hepatitis B, HIV, syphilis).

There is the **newborn and infant physical examination screening** programme for babies and this involves checks of the heart, hips, eyes, testes. Babies can have the newborn blood spot heel screening test which screens for nine rare but serious conditions. Babies are also eligible for the **newborn hearing screening** programme at 4 to 5 weeks old. The test aims to identify any incidences of moderate, severe and profound deafness and hearing impairment at the beginning of a child's life.

Yoga classes @ Derby Arena 12.15pm

4.5 Employment health & wellbeing

Almost all of our adults in both the Sahota and Stanley families work full-time, which means that they spend a lot of their waking hours at work. Working generally is good for your health and wellbeing and returning to work from unemployment results in significant health improvements and increases self esteem. In addition, there are many health benefits for those with on-going health conditions such as helping people recover from sickness and reducing the risk of long term incapacity. The individuals in our two families vary their approaches to work and how they support their own health.

Sunita knows that it is important to eat well in order to feel well. Therefore, she always takes a homemade lunch to work with her that contains salad or vegetables, some carbohydrates, protein and a piece of fruit. She stays hydrated, and avoids headaches, by drinking plenty of water during her work day.

Harbinder has a high pressured job in sales that involves long hours which got on top of him a few years back meaning that he had to take time out to focus on his mental health and wellbeing and received support from a mental health nurse. Now Harbinder practices mindfulness and goes to a yoga class two lunchtimes a week which relieves stress and helps him to practice a work-life balance.

Santokh experienced redundancy at the start of the year and in recent weeks has begun working in an office. His workplace supports and encourages employees to have a healthy lifestyle. Santokh is aware of his sedentary lifestyle at work; he travels to work by car and sits behind a desk for eight hours a day, so he has participated in his workplace health activities. Santokh gets himself outside at lunchtime to go for a walk and takes part in any workplace team health challenges such as the British Health Foundation Pedometer Challenge.

Santokh is feeling positive in his current workplace and secure in his permanent role. Previously he has, like many thousands of people in England, been part of the gig economy. The gig economy relates to short-term projects or freelance work, and can even be as short as work which provides single food deliveries and taxi journeys. Although different to zero-hour-contracts, the gig economy shares similarities of which the negatives include fewer employment rights, work security and company benefits, in addition to exclusion from paid sick and holiday leave. The lack of security can mean that people are in work one day and out of work the next, with devastating repercussions for individuals and families. As a result the gig economy can risk increasing inequalities for some people.

4.6 Reducing living well inequalities

Our two families have made significant improvements in their health and wellbeing during the last few months and their hard work and commitment has paid off. In particular, they have focused on increasing their physical activity, reducing alcohol intake, eating a healthy and balanced 5-a-day diet, losing excess weight, and stopping harmful habits such as smoking. They have also used services such as Livewell and screening programmes. Health conditions that were deteriorating or out of control are now well managed and warning signs of ill health have been heeded and addressed.

Even though the statistics show that various health conditions vary by different areas of the city, our families have put themselves in control of their health. They do not want to become an ill-health statistic so have taken it upon themselves to try to have a happy and healthy future and delay ill-health for as long as possible. Our families know that many chronic health diseases are preventable. Therefore, they recognise that their continued hard work at healthy living will pay off in their older years.

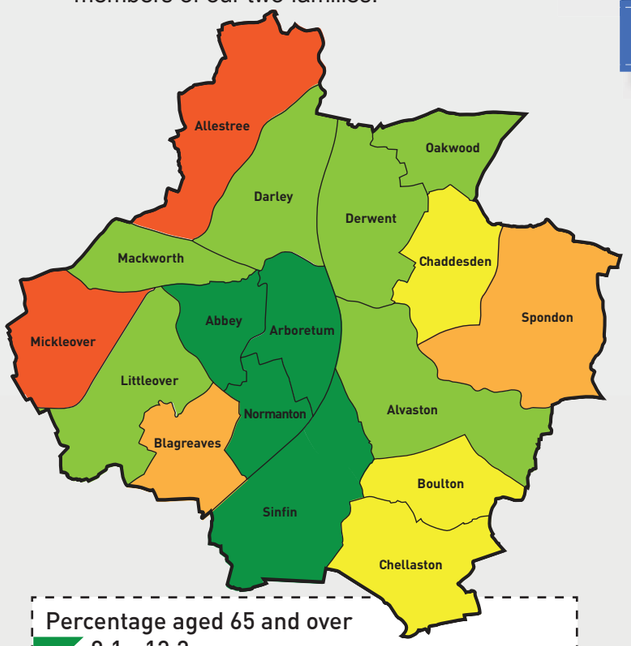
Our two families have achieved so much despite the changing service climate since the 2007-2008 global financial crash. Ten years on, many health improvement services have been closed, reduced or restructured in order to save public money and to provide better value for money. The services emerging in the wake of the financial crash are operating at a restricted level and this means that the public sector is finding it increasingly difficult to manage demand. This requires us all, individuals, communities, public and private sector, to take responsibility.

Carers provide unpaid care to family members or friends who cannot manage without support due to physical or mental illness, disability or addiction. Caring can be positive and rewarding but it can also negatively impact on various aspects of carer's lives – financially, health and wellbeing, availability to get out and about, working and learning. There is support available to carers which are signposted by Derby City Council.

AGEING WELL

The proportion of the population aged 65 and over is growing. People are living longer than ever before and the 'Baby Boomers' born after World War Two are reaching retirement age.

There are an estimated 40,806 people aged 65 years and over living in Derby. The majority of older people live outside of the city centre in wards such as Allestree, Mickleover and Spondon. This chapter focuses on the experiences of Julie, Norman, Surinder and Ranjeet - the older members of our two families.



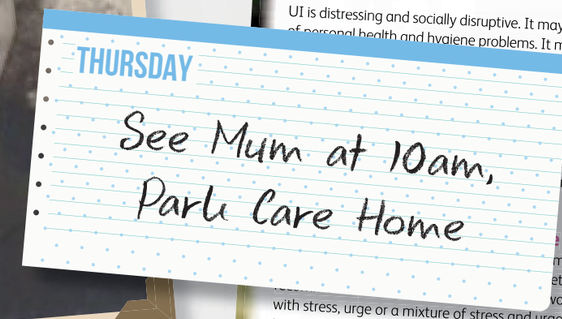
5.1 Long-term conditions

Laura regularly visits her mother Julie in the nursing home. Julie has been living in a nursing home since becoming a widow three years ago.

Julie has lived with chronic obstructive pulmonary disease (COPD) for a number of years which has limited her movement. In recent years she has relied upon oxygen therapy during the day. Her late husband John had managed their home, shopped and cooked, and assisted her around the house.

Julie became a heavy smoker from her early twenties, when smoking was popular and 'cool and sophisticated'. When two of her school friends died of lung cancer before retirement and their grandchildren were born, Julie vowed to stop smoking and successfully quit with the help of Stop Smoking Services. She thought she had been left with a lingering smokers cough that left her susceptible to frequent chest infections, but one day she was rushed to her doctor with breathlessness. Julie's GP suspected she had COPD and after another consultation and tests, diagnosed her with the condition.

	Male Life expectancy (years)	Female Life expectancy (years)	Deaths from all causes, under 75 yrs (SMR)	Deaths from heart disease, under 75 yrs (SMR)	Deaths from respiratory disease (SMR)
Allestree	83	88	66	62	67
Arboretum	73	79	176	211	167



COPD arises when the air sacs in the lungs are damaged or the airways are inflamed and narrowed. This causes the person to have breathing issues. The damage is permanent, but treatment can try to slow this down. The main cause of COPD is smoking.

Julie has adjusted to living in a nursing home and enjoys visits from Laura and Mark and the grandchildren. She hasn't seen Jake and Martha very much in the last year because they have had various coughs, colds, and infections. Laura has kept them away to avoid making her mum unwell. Today, all five of the Stanleys have visited. Julie adores cuddling baby Ruby and listening to Jake animatedly talk about what he has been doing at primary school and his new friends in class.

Laura notices that her mum is more often referring to Jake as "James" (which is Julie's son's name - James lives in Australia), and she has called Martha "Laura" several times that day. Julie has muddled up names before, so Laura does think too much of it. But as the family leave the care home, the manager has a quiet word with Laura. He tells her that her mum has had a few memory and communication problems which the care assistants felt were out of character. The manager asks if he can mention the specific instances to Julie's doctor when she visits to review her COPD condition and treatment next week.

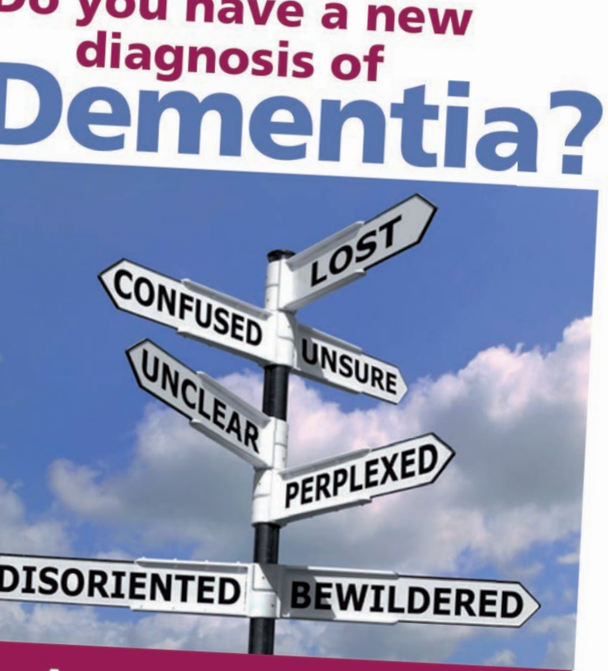
5.1.1 Incontinence

Although rarely spoken about, many people have long-term urinary and bowel control issues which

interfere with everyday life activities. In the UK, it is estimated that more than 3 million people aged 65 and over have urinary incontinence. Up until recently, Ranjeet has not talked to family and friends about the worsening trouble she has with bladder control and also has not sought help from health professionals.

After living in Derby all her adult life, Ranjeet has built up knowledge of local public toilet locations for when she is out and about, but finds herself feeling increasingly anxious at the thought of travelling to locations she is unfamiliar with. Her bladder control problems have started to control her life and this has made her feel unhappy. Ranjeet decides to mention the problem at her doctor's appointment, and is diagnosed with stress incontinence.

Ranjeet left her doctor's surgery feeling positive. She had found out that her condition is very common amongst women of her age, and that something can be done about it. In the first instance she was advised to try pelvic floor exercises to build strength in her muscles supporting her bladder. She was encouraged to keep a bladder diary, and informed that her current efforts towards losing weight may help her condition.



5.1.2 Multiple morbidities

Surinder, is managing his coronary heart disease and diabetes. Fortunately, his son Gurdeep has quit smoking, exercises regularly and has improved his diet significantly. Gurdeep is now no longer a borderline diabetic, and should have better health than his father Surinder when he is his age.

It is known that many physical and mental health conditions coexist resulting in multiple illnesses in individuals. Sadly, there is a poorer state of health in those with mental ill health. For instance, 39% of patients on the Severe Mental Illness (SMI) register are smokers, which is much higher than the national figure of **18%.** This will mean that a greater number of SMI patients will be at risk of smoking relating illnesses. This pattern is not only limited to people with SMI, it is also apparent for people with a diagnosis of mental illness. In relative terms, for example, the prevalence of epilepsy in the Derby City and Derbyshire population with a diagnosis of mental ill health is seven times greater than in the population without a mental illness.

5.2 Dementia

Dementia is a debilitating neurodegenerative syndrome that predominantly affects older people. Symptoms include deterioration in memory, reasoning and communication abilities, which impacts on a person's ability to conduct daily activities independently (Alzheimer's Society, 2007).

When Julie's doctor visited in the week, she didn't make any changes to the current COPD treatment. Before speaking with Julie, the care home manager had seen the doctor and mentioned her memory issues and comments received from the care staff. The doctor had a conversation with Julie about her memory, reasoning and communication abilities. Julie said she was aware that her recall was not as sharp as it had been whilst she worked as an office administrator. Through conversation and assessments the doctor established that Julie often lost her glasses and watch. She had difficulty remembering the daily routine of the nursing home and struggled to play board games with the other residents. The doctor concluded that Julie has the early symptoms of dementia. She offered reassurance about the condition and signposted her to the help that is available.

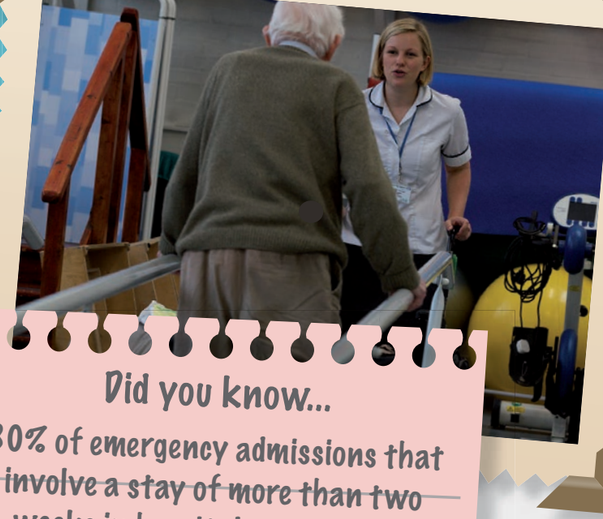
Julie is in her 80s, and at this age dementia is common in women, so she needn't feel alone with the condition. For instance, 20.2% of women aged 85-89 years old have late-onset dementia compared to 1.8% of women aged 65-69 years old (Alzheimer's Society, 2014). In Derby, **5.12%** of the population aged 65 and over have diagnosed dementia. This is higher than the England prevalence of **4.31%.**

5.3 Injuries in later life

Older people, particularly those with long-term health conditions, are at a greater risk of falls. These events can have serious consequences such as broken hips, a long stay in hospital and the possibility of long-term admission into care. Norman recently fell at home, but fortunately he had no serious injuries. Norman knows that he is lucky, especially after the experience of his neighbour Dorothy.

Home Care Reablement Services

In Derby, older adults who have been in hospital or risk a hospital admission could receive free assistance from the Home First Service provided by Derby City Council. The support can help individuals with personal care, mobility and meal preparation, and the aim of the service is to enable individuals to regain their confidence, independence and wellbeing.



Did you know...

80% of emergency admissions that involve a stay of more than two weeks in hospital are amongst patients aged 65 and over.

Last year, Norman's neighbour Dorothy fell at home when she got out of the bath and fractured her hip. Alone and in agony, she called out for help. Fortunately, her next door neighbour heard her and called an ambulance. Dorothy was admitted to hospital and underwent surgery; she was then transferred to a ward to begin a rehabilitation programme.

Dorothy spent several weeks recovering following surgery and concentrated on improving her mobility. She missed living at home and worried about her pets even though neighbours had kindly drawn up a rota to look after them.

Falls are a serious problem for older people. In Derby, there are 2,175 per 100,000 injuries due to falls in people aged 65 and over. Many falls occur in the home environment, and some can be prevented through exercise, physical activity, and environmental modifications (such as reducing potential fall hazards and the installation of aids such as hand rails). Dorothy and Norman have both benefitted from free help from the Home First Service. Norman also attended the falls clinic at the Specialist Assessment and Rehabilitation Centre (SpARC) in London Road Community Hospital to understand why he is unsteady on his feet.

5.4 Loneliness and isolation

Norman is determined to live independently in his own home and this desire was re-evaluated following his fall. Norman's family suspect that his difficulty in hearing and poor eye-sight contributed to his fall. They have encouraged him to buy a new pair of prescription glasses and to talk to the doctor about ways he might be able to improve his hearing.

Norman's fall earlier in the year knocked his confidence, and he became reluctant to leave the house. This led to him having a low mood, and little energy to make an effort at home with day to day activities. He felt lonely not seeing or speaking to people each day.

Loneliness and isolation is common and impacts upon a person's physical and mental health.

	Older people in deprivation (%)	Pensioners living alone (%)	Population whose ethnicity is not 'White UK' (%)	Fuel poverty (%)	General health - bad or very bad (%)
Allestree	6	30	7	7	4
Arboretum	52	39	67	20	8

A couple of months after the fall, Norman went into Derby to have an eye test to get new glasses. He also saw his doctor who believed he had noise-induced hearing loss from the years working as a welder with heavy machinery without wearing the workplace provided ear protectors. Norman tried using a discrete hearing aid, and used his new glasses. Although reluctant to take advice from family initially, Norman was now feeling much more positive, and was back out walking around the shops with a walking stick and seeing people he knew each day. His daily interactions with friends and locals improved his low mood and he no longer had those feelings of isolation.

Norman's brief experience of loneliness and isolation led him to consider ways he could prevent the situation reoccurring in the future. He has heard that his local Chaddesden Centre runs a Thursday lunch club and has contacted the centre to attend.

5.5 Social care

Norman has contacted the Derby City Council Adult Social Care department for local information about meals provided. He now experiences difficulty with preparing meals at home and recognises that he would eat a more balanced diet by having cooked meals delivered five days a week. Staff at Adult Social Care assist Norman with booking home delivered hot meals.

Norman found talking with Adult Social Care helpful, and this has opened up the idea of getting some home help. He organises a Talking Points appointment and meets with a social care worker in Derwent for a chat about his support options. Norman identifies that having someone work in his home would help him with laundry and to stay on top of the cleaning. He knows that his local social care worker will be able to help him with advice and information should he wish to hire a personal assistant.

5.6 Life expectancy

Life expectancy is generally into lower in Derby than the England average, with people in Derby having a life expectancy that is almost a year shorter than the national life expectancy of 79.3 years for males and 83.0 years for females.

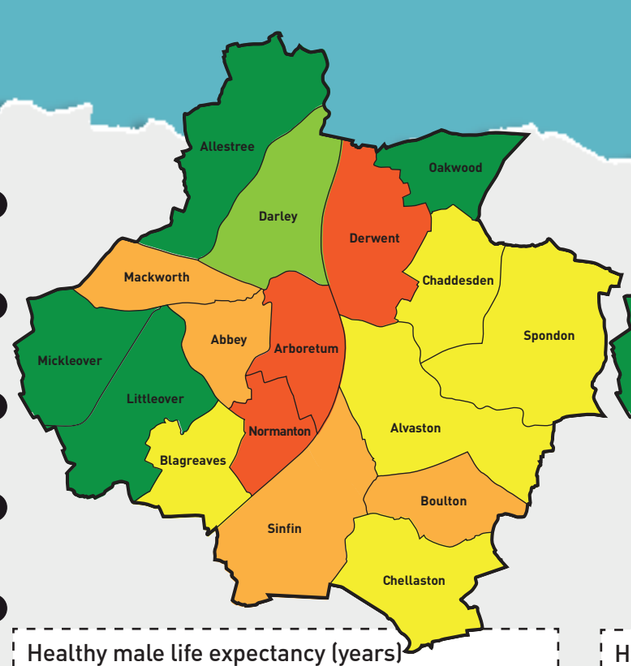
Healthy life expectancy is poor in Derby. This means that on average people in the city live for twenty years in poor health before death. Ranjeet and Surinder have spoken with their adult children about the importance of caring for their health in adulthood in order to live in good health in their twilight years.

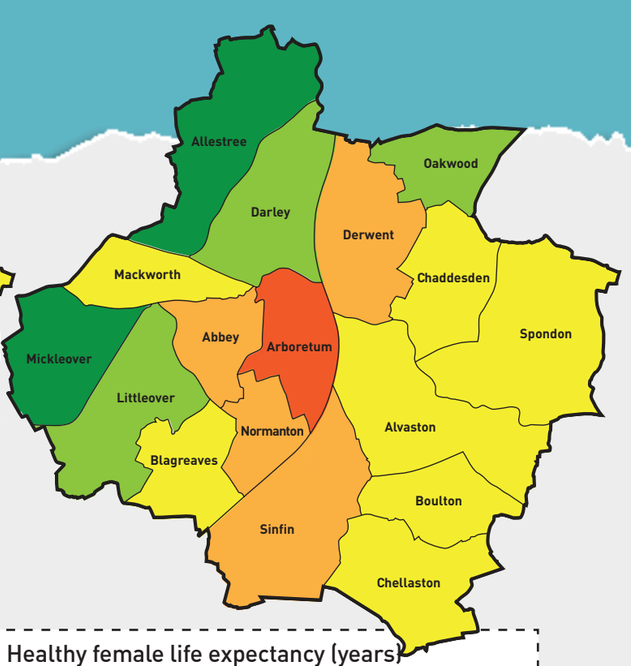
Day Services for Older People

In Derby, older adults who have been in hospital or risk a hospital admission could receive free assistance from the Home First Service provided by Derby City Council. The support can help individuals with personal care, mobility and meal preparation, and aim of the service is to enable individuals to regain their confidence, independence and wellbeing.

Day centre services

Social and therapeutic activities can be provided for older people at day centres. In Derby there is the Morleston Street Day Centre located in close proximity to Derby train station. The facilities include day care, transportation, meals, activities for the mind and body.





5.7 Environmental health

The built environment covers homes, schools, places of work, public recreation grounds, roads, etc. Since our physical and mental health is interlinked with the built environment, the importance of sustainable communities should not be under-estimated.

5.7.1 Healthy Housing Hub

There is a large and growing evidence base demonstrating the association between poor housing and poor health, particularly in vulnerable groups such as the elderly. Derby City Council's Healthy Housing Hub (HHH) works to reduce the risk of harm posed by poor housing, and works to prevent home accidents.

Mark's dad Norman lives on his own in Derwent Ward. He has a renewed determination for living independently in his own home despite his recent fall, and to support this his GP has suggested that he would benefit from a home visit from one of the HHH Project Officers. Upon visiting, the Officer assessed the risks in the property and agreed to not only install stair and grab rails, but also to repair the boiler, which was faulty.

"I'm really glad the Healthy Housing Team were able to help me. My self-confidence has had a real boost and I'm still living independently in my own home, exactly where I want to be."

A real service user

MONDAY

Meeting with Yaz from Adult Social Care at 10am

5.7.2 Local Area Coordination

Derby City Council first introduced Local Area Coordination (LAC) in 2012 in two of the city's Wards. The aim was to support residents in the local community to 'get a life, not a service', empowering individuals to find community-based support. LAC now have several staff spread across Derby, and the service has recently proved useful for Ranjeet. Ranjeet contacted LAC about the activities and groups occurring in her local community, and she began attending a weekly group where she enjoyed socialising with other women of a similar age.

5.8 Living spaces, living streets

5.8.1 Green spaces

Ranjeet and Surinder regularly go to their local Arboretum park so that their grandchildren can be outside and active – using the playground facilities and walking around. On the other side of Derby, mum Laura has started a weekly class called 'buggybabes', where parents do an hour of exercise in their local park, pushing their children in prams with other parents. Regular exercise in local parks is a great way to get outdoors in green spaces, which is good for the health of both the mind and body.

With that being said, only a small proportion of people use outdoor space for exercise or health reasons. Despite Derby having a lot of green space and parkland, it has been estimated that only 12% of the population visited the natural environment for health or exercise reasons over the previous seven days. This falls short of the estimated proportion of 18% nationally. Unfortunately, the health benefits of outdoor space utilisation are well evidenced but not practised by the majority of the population.

The Stanleys have made a family promise to go walking in the Peak District together once a month. The Peak District is one of ten National Parks in England, and these cover 10% of the English landscape. Like half of the population of England, the Stanleys' nearest National Park is within an hour's travel of their home. National Parks are free to access and open every day of the year, which makes this a fantastic local resource to the people of Derby to access for their emotional, physical and mental health.

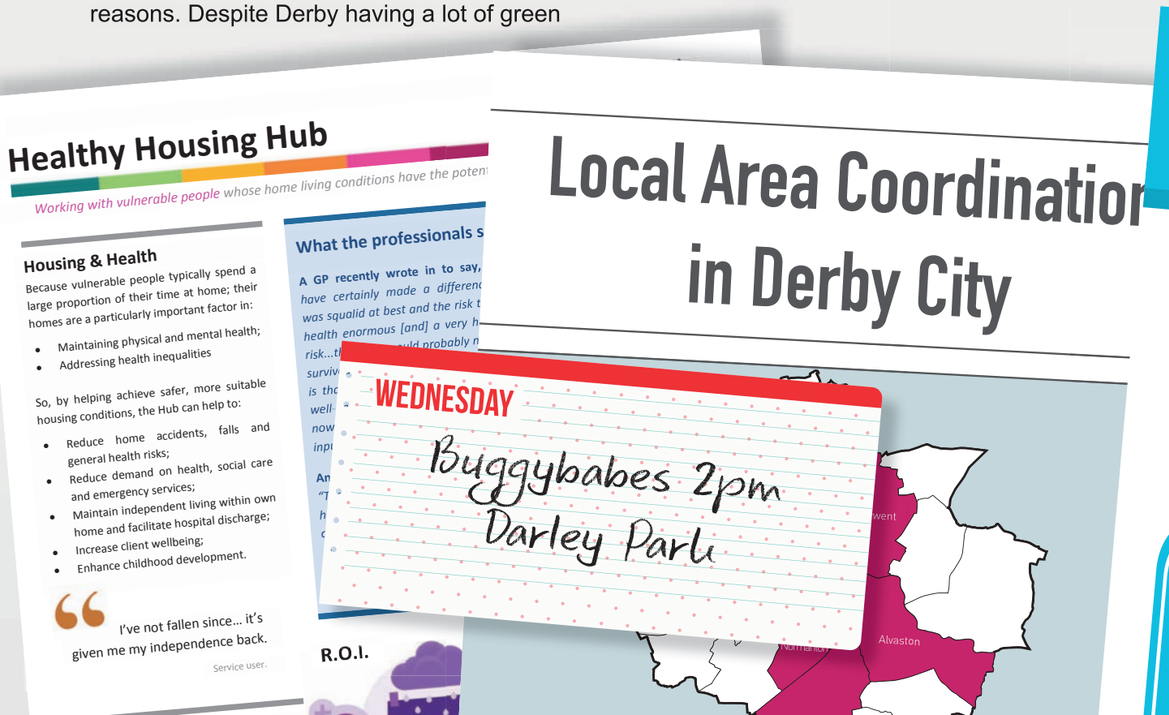
The NHS has the 10,000 steps challenge where the aim is to walk 10,000 steps a day. Surinder has a pedometer which he has been using since the day he left hospital. Initially, he only managed about 3,000 steps a day (roughly 30 minutes walking). Yet over the course of his recovery he has successfully built up to walking 10,000 steps a day, and his wife Ranjeet often joins him. When Surinder walks on his own he listens to downloaded podcasts and music to keep him entertained, and the time passes quickly.

5.9 Ageing well inequalities

The elders in our families have recently experienced a wide range of health conditions such as COPD from smoking, incontinence, dementia, heart disease, injuries from falls and low mood from loneliness.

Ranjeet, Surinder, Julie and Norman have experienced common health conditions related to older age and are now actively managing their conditions. They have addressed these conditions through accessing local services such as Livewell, GP advice, community care, Home First Service, the SpARC falls clinic, day centres, social care, Healthy Housing Hub, Local Area Coordination, NHS information and accessing charity advice.

"There are also many opportunities for those of us in this age group to continuously help ourselves, if we decide to. The choices we make every day will have an impact on how we age. Those of us who are Baby Boomers can embrace these opportunities to be healthier, and get 'fit' for our own futures. By doing so we can improve our chances of a comfortable and enjoyable older age."
Prof Dame Sally Davies, Annual Report of the Chief Medical Officer 2015

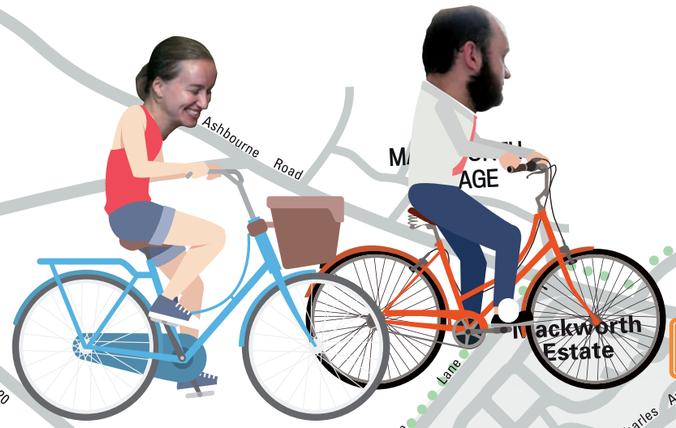


Talking Points

A face-to-face chat with social care

We offer a drop-in service with a social care worker who can chat with you about a variety of different support available for you.

Drop-in sessions at Village Community Medical Centre on the 1st and 3rd Tuesday of the month between



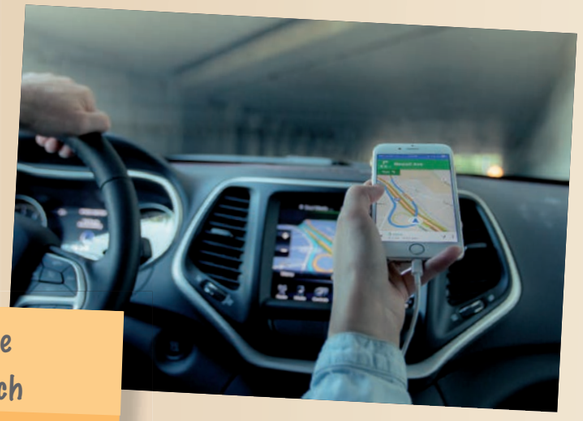
Norman has a fall

Marli has a NHS health check

Surinder has a heart attack

Gurdeep receives stop smoking support

Surinder attends retinopathy screening



The Social Mobility Commission published the 'State of the nation' fifth report (2017) which ranks all English local authorities by the social mobility prospects for people from disadvantaged backgrounds. The East Midlands is the lowest performing region for outcomes and Derby is the ninth worst (316th out of 324th) for social mobility in England. The 16 social mobility indicators cover the lifespan - early years, schools, youth, and working lives - of which Derby has a particularly low positioning for early years at rank 321 (fourth worst in England).

CONCLUSION

I hope you have enjoyed meeting the families and that the glimpse past the curtains of two Derby households has helped you see some of the common public health challenges they face, whether they live in an affluent suburb on the City fringe or within the more densely populated inner city area with older housing stock and less disposable income.

Both of our families have taken by the challenge and changed their lifestyles through personal motivation, family support, and by using community support and local services to help where necessary. Our families have stopped smoking; improved their diet, become more active, enjoyed our green spaces, reduced their alcohol consumption, lost weight, attended screening services, managed the challenge of chronic disease. They have done wonderfully! But let's remember they have taken care of themselves because they to a large extent lead happy, productive lives and want to continue to do so. There are others however, where another cigarette and a super-sized pizza with chips are perhaps the only things that make life bearable.

Both the Sahota's and Stanley's have friends and neighbours who do not live such lives. Who are unemployed, involved in the gig economy, who have scant resources. What both the Sahota's and Stanley's have is resilience bought about not by huge incomes in the Sahota's case, but by the social networks that protect them. And this reflects the choices they have made in our story.

I hope this story has given you insight into your lives and those around you and helped you consider what improvements you can make to your own health and wellbeing going forward. With the focus of this report being on our two families it has inevitably focused on their lifestyles and positive changes. It should be noted, however, that people's health is determined by a wide range of factors, particularly poverty and deprivation. To impact on health inequalities we cannot hold individuals responsible and must take action as a system to address these factors to provide a context and environment to support people to have good health and wellbeing.

Remember...
"The future depends on what you do today."
- Mahatma Gandhi

Here's to a healthy and happy future of the people of Derby!

LAST WORDS

Equally well..?

As I reflect on my years in the service of Public Health (and with the hope of many more despite my grave health problems currently); I am truly amazed at what has been achieved and dismayed at what has not. We can prevent and treat diseases formerly considered unpredictable death sentences. Yet many proven and simple strategies for preventing disease and disability sit on the shelves, gathering dust, while we do nothing. Sometimes, it appears our capability to prevent and treat disease seems to exceed our "collective" willingness to apply evidence based interventions.

Health inequalities seem to be a case in point. There is obvious evidence that we can turn things around. But the "evidence base" is only one part of the picture, there is also a requirement to "organise" action and draw others into the cause. Clearly, some actions rest nationally, especially on many of the root causes of ill health such as poverty. But there is much work we can do locally such as improving service access for disadvantaged groups.

So if we know we can improve them, why do we sometimes seem to lack the drive to do so? Perhaps because it requires a different way of working across the whole health and care system.

I think one of the key strategies needed to address this issue effectively, is to maintain an active focus on this and have clear priorities for action, because inequalities are persistent and stubborn and without this clear focus they can slip away from you. I think the other huge problem is that it requires a collective focus and a real drive to work together to address these priorities across health and care organisations, across public, not-for-profit and private sectors, across disciplines and professions because parts of the answer lie in different sectors. Simply stated, it means we need to all own the problem and have "shared" accountability. I think this must be led by Councils and Health and Wellbeing Boards (HWBBs), but we will not succeed unless it is shared in a meaningful way with the NHS via the STP or other vehicles for change.

Sadly without this, we will have huge difficulty in "closing the gap", between the "haves" and "have-nots" and health in the UK is neither equally distributed nor enjoyed.

Next Steps

I have spoken for the need for real collective action at local level to tackle health and social inequalities that seem almost endemic in our society. Leadership must rest with local government as their role in reducing avoidable health inequality between social groups is the most profound. Councils typically control the planning or delivery of such key social determinants as education, transport and spatial planning. But they cannot do this alone. My own view is that work should be progressed under the auspices of local HWBB by a taskforce. This taskforce would have responsibility for measuring and understanding the problem and would develop an Equity Action Plan, which would be need to be translated into our local STP.

Here are some of the areas we need to promote to reduce health inequalities.

Whole-of-society approaches to drive integrated action to reduce inequalities

We have spoken of the need for collective action and accountability at local level in tackling health and social inequalities. Evidence suggests that better integrated approaches would impact more effectively on health inequalities. It might be sensible that Derby Council employs Marmot as a platform to promote collective actions around health and wellbeing. Turning to vehicles for change outside the Council, it would be useful for Derby City Council to use its' influence within the local STP to ensure this becomes a cross-cutting theme across all of the current workstreams. This would integrate action more fully across the health and care system.

Within the STP, a number of us advocated the "industralising"[7] of prevention which not only frees up resources by limiting demand on more complex services but also may help in reducing health inequalities. However, to do this it is necessary for all STP workstreams, including prevention plans, demonstrate they are "as least as effective in groups with the worst health" so we do not "widen" the gap.

Health For All: Countering austerity[8] and other threats to health

Austerity and welfare reform in the UK have significantly affected local government funding and welfare support[9]. The result has been to hamper progress in reducing inequality and poverty by local councils[10]; led to poorer job prospects (particularly for younger people); decreased the number of households achieving a minimum income for healthy living; increased relative child poverty; and increased the levels of material deprivation. These factors impact negatively on health and wellbeing in the absence of strong social support systems and the most vulnerable groups have been unduly affected, so potentially increasing inequity.

> "Austerity is the central public health issue of our time. From A&E departments to mental health to child health, austerity hampers the ability of the NHS to respond to the needs of the British population... and austerity falls hardest on the poorest in society, the most vulnerable, the voiceless." Dr Yannis Gourtsoyannis, infectious disease registrar, University College, London Hospitals

Evidence and experience in other countries (such as Iceland, Sweden, Canada and Norway) suggests it is important to maintain public spending in key areas to improve health outcomes and reduce health inequalities namely social welfare and health and promotion of economic growth. This suggests a need to maintain spending in these areas despite reduced resources in the system as a whole. Although much of this action rests with national government, it also helps Derby City thinking in what might be their priorities beyond statutory duties. These areas include social protection systems (unemployment programmes, housing, income maintenance) which counter decreased welfare spending and public health services which includes lifestyle interventions but should reach into early help initiatives such as PAUSE.

To help our communities, it seems prudent to assess what we are currently doing and the likely impact on inequalities . A "health in all policies" approach to look at how current resources are used and impact on health and wellbeing outcomes and health inequalities might help decision makers in formulating policies and plans that do not widen health inequalities.

Good Places produce better health: putting people and places at the heart of health and wellbeing

The places in which we live are very important to us. There is a recognition that where we live, where we spend our time and who we live with, affects our health and wellbeing over and above our own individual circumstances.

Because of this, the interplay between place and person is vital to our wellbeing.

And by place, I mean the buildings, streets, public spaces and natural spaces that make up the physical environment of neighbourhoods.

And by person, I refer to the relationships, social contact and support networks surrounding us. We need to acknowledge that our "social" environment influences our health and recovery from illness as well as our likelihood of taking up and maintaining "unhealthy" behaviours.

[7] Cate Edwynn, Alison Wynn: Something we spoke about in our invited paper on "industrialising prevention" at PHE Conference in September 2016 which demonstrated the economic benefits of prevention within our local footprint.

[8] Austerity is defined as the process of reducing public spending principally through budgetary restrictions on departments and services.
[9] Local government budgets have decreased significantly between 2009-10 and 2014-15, with spending per person reduced by 23.4% on average. From: Innes D & Tetlow G (2015) Central cuts, local decision-making: changes in local government spending and revenues in England, 2009-10 to 2014-15. London: Institute for Fiscal Studies.
[10] Joseph Rowntree Foundation report (2015) noted that the ability of local councils in England and Scotland to influence health and well-being is limited as austerity is hitting councils in the poorest regions the hardest. From: Hastings A, Bailey N, Bramley G et al (2015) The cost of the cuts: the impact on local government and poorer communities. York: Joseph Rowntree Foundation.

"People who do not feel in control over their lives struggle because the system does things to them – it doesn't work with them and help them create 'wellness' for themselves ... when things happen that alienate people, they lose that sense of control and a whole range of biological, as well as psychological, things occur." Dr Harry Burns, Former CMO, Scotland

This people in places paradigm can either nurture us or contribute to our poor health. This depends upon how key factors come together. And this is an area dependent on our Councils. For we are speaking of how places are designed, how they evolve, how they are maintained on behalf of communities. But it is also about the strength of the social aspects of place and how engaged and involved communities are within the places they live in. Former Chief Medical Officer of Scotland, Harry Burns - who I confess is a hero of mine - compared mortality in Glasgow with that in Liverpool and Manchester - three cities with similar levels of poverty and inequality - and found Glasgow had higher premature mortality rates. The biggest relative excess in Glasgow was from drug overdose and poisonings, suicide, alcohol related causes and 'external' causes of death, all socially determined causes of early death.

These observations are not specific to Scotland. Studies elsewhere find clear relationships between turbulent early years and adult outcomes. The California Adverse Childhood Event study, for example, looked at nine types of childhood event and how they related to problems in adulthood such as alcoholism, drug abuse and domestic violence. None of these events were particularly damaging on their own, but the more of them an individual experienced, the more damaged their adult life was likely to be and the more likely they were to experience addiction, violence and mental health problems.

[11]Resilience is defined as the ability of a material to return to its original shape after being bent, stretched or compressed. In human terms it is about how people can cope with and recover from experiences that damage them which can include illness, stress, emotional trauma and social and cultural deprivation.

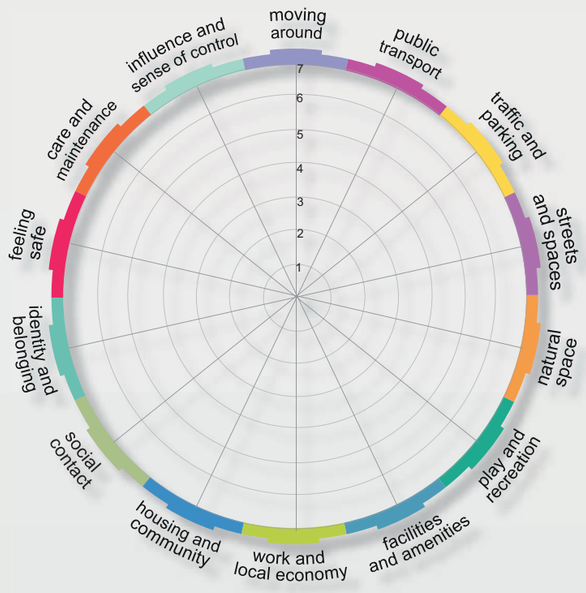
[12] It has just won a category at RTPI Awards for Planning Excellence which are the longest running and most high-profile awards in the industry.

Can we fix it? Yes, we can.

This type of damage can be tackled. This is the good news. Studies show that poorer communities and often very damaged individuals can take back control of their lives. The building of resilience[11] is key to this and something called social capital can be key to this. This suggests that when people trust and help one another, when one good turn deserves another and when a community feels like a community, not just a place where individuals live, people are enabled to be healthier, safer and happier, resilience is enhanced. Strangely both the fundamental causes and solutions to reducing health inequality lie both in places and communities in which we live.

So how do we tackle health destroying places? How do we improve them? And how do we decide which aspects are most important? One way is via an innovative Place Standard tool created by Architecture & Design, Scotland, which is designed for use in and with communities to increase the potential of both physical and social environments to support health and wellbeing and tackle inequalities.

This tool allows us to evaluate systematically what a "good place" means by thinking about the physical elements of a place (e.g. its buildings, spaces, and transport links) as well as the social aspects (e.g. whether people feel they have a say in decision making)[12]. A diagram to illustrate this model is located below.



Recommendations: addressing inequalities

This report has tried to consider health inequalities, and stressed the need to tackle the broad determinants of health, rather than drifting into lifestyle explanations. The recommendations set out below may help us impact more effectively.

1. Improved decision-making and commissioning - *decisions about services and provision should not increase health inequalities and should, ideally, reduce them. To help make sure that this happens, it is recommended that the Health and Wellbeing Board and its constituent members adopt a 'health in all policies' to reduce inequalities and limit disability.*

2. Better use of resources *- the majority of our local spend on health and wellbeing is used to treat and support people when they are unwell. We could get a lot more 'health' for our money. To do this, we have to make sure we only have in place treatment and services that are evidenced to be effective. We also need to shift more resource to helping people to stay as well as they can be in the first place.*

3. Adopt 'whole of society' approaches *- all partners working in a seamless and co-ordinated way working to improve the health and wellbeing of the local population, in which we all have a role. We know that health care services are only part of what contributes to our health and wellbeing. Our income, education, employment, housing, for example, significantly impacts on our health and wellbeing – for good or bad. We must, therefore, consider individual and population health and wellbeing in the round.*

4. Becoming a Marmot city: *through being a Marmot city, Coventry, has seen the life expectancy gap between their poorest and most affluent residents reduce as well as improvements in: education; health outcomes; life satisfaction and employment. It is recommended that we consider what is required to become a Marmot City. This would involve the council and its partners adopting the Marmot principles, from the Marmot Review, Fair Society, Healthy Lives which aim to reduce inequality and improve health outcomes for all.*

5. Strategic leadership by the Health and Wellbeing Board (HWB)*: ensuring that reducing inequalities is a priority for the city. The broad membership of the HWB puts it in a unique position to drive forward the recommendations described above. To ensure that we focus our effort to tackle the health inequalities that have been embedded in the city for many years, the HWB will need to hold to account its members and partnerships such as Joined Up Care Derbyshire in the delivery of these ambitions.*

Next year's report

The next DPH report, will take a more social model of health forward as well as focusing on various aspects of health inequalities and needs of vulnerable groups starting with the concept of "austerity and impact on health and wellbeing". The DPH report will take the form of a series of "bulletins" that will released over the period April 2018-March 2019 to be considered by Cabinet and Council in support of their thinking and decision making.

Acknowledgements

I am so very appreciative to Leila Whiteley for leading this work, Laura Barker and Carla Wilson for their design expertise, and Andrew Muirhead and Alison Wynn for their review and support. I would also like to thank everyone - in the Public Health Department and the wider Derby City Council - for their contributions to this new DPH annual report. However I am also incredibly grateful to the two Derby families who were generous enough to allow us to share their lives over the past year; at least within these pages. It is to those families we dedicate this report.

Thank you everyone for the hard work and for welcoming me back, Cate x

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Polish

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Prosimy o kontakt: 0800 0092117 **Tel. tekstowy:** 01332 640666

Punjabi

ਇਹ ਜਾਣਕਾਰੀ ਅਸੀਂ ਤੁਹਾਨੂੰ ਕਿਸੇ ਵੀ ਹੋਰ ਤਰੀਕੇ ਨਾਲ, ਕਿਸੇ ਵੀ ਹੋਰ ਰੂਪ ਜਾਂ ਬੋਲੀ ਵਿੱਚ ਦੇ ਜਿਹੜੀ ਇਸ ਤੱਕ ਪਹੁੰਚ ਕਰਨ ਵਿੱਚ ਤੁਹਾਡੀ ਸਹਾਇਤਾ ਕਰ ਸਕਦੀ ਹੋਵੇ। ਕਿਰਪਾ ਕਰਕੇ ਸਾਡੇ 0800 0092117 **ਮਿਨੀਕਮ** 01332 640666 **ਤੇ ਸੰਪਰਕ ਕਰੋ।**

Slovakian

Túto informáciu vám môžeme poskytnúť iným spôsobom, štýlom alebo v inom jazyku, ktorý vám pomôže k jej sprístupneniu. Skontaktujte nás prosím na tel.č: 0800 0092117 **Minicom** 01332 640666

Urdu

0800 0092117 یہ معلومات ہم آپ کو کسی دیگر ایسے طریقے، انداز اور زبان میں مہیا کر سکتے ہیں جو اس تک رسائی میں آپ کی مدد کرے۔ براہ کرم منی کام 01332 640666 پر ہم سے رابطہ کریں۔

Derby City Council

The Council House Corporation Street Derby DE1 2FS

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Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 28 February 2018

Integrated Performance Report Month 10

Purpose of Report

This paper provides Trust Board with an integrated overview of performance as at the end of January 2018. The focus of the report is on workforce, finance, operational delivery and quality performance.

Executive Summary

The Trust continues to perform well against many of its key indicators, with maintenance or improvements continuing across many of the Trust's services. These can be seen within the body of this report.
The issues identified in previous reports continue to be worked on through the plans that were previously referenced in the Integrated Performance Report.

1. Single Oversight Framework

The Trust is compliant against all Single Oversight Framework operational standards. This includes new standards relating to Out of Area Placements and Data Quality Maturity Index.

We continue to forecast a higher surplus than planned, overachieving the control total by £636k. Therefore the year end surplus position is forecast at £4.036m which is an overachievement of the Control Total of £1.3m (£636k additional surplus plus £636k additional STF 'bonus' income). This is in line with last month's forecast.

Within the NHSI financial metrics four out of five are relatively strong, but the agency metric continues to be challenging, both in terms of the ceiling and the medical staff cost reduction target.

The numbers reported in the attached finance report are consistent with the numbers reported in the monthly finance return sent to NHS Improvement on 23rd January 2018.

2. Areas of concern and / or under-performance

Slide 1 of the integrated performance report provides an overview of where the Trust is performing above and below the required standards that have been agreed by Board, with further detail provided in the body of the report.

Board members should note that deep dive assurance reports on the following will be provided to Board Committees during March.

- Outpatient Clinic cancellations (Finance and Performance)
- Delayed Transfers of Care (Finance and Performance)
- Recruitment, retention and sickness absence hot spot areas (People and Culture)

A number of the data quality Kite marks added in last month's report have been reviewed. Initially this exercise has been undertaken with all Single Oversight Framework (SOF) operational indicators. The others remain unchanged from last month.

Strategic Considerations	
1) We will deliver **quality** in everything we do providing safe, effective and service user centred care	X
2) We will develop strong, effective, credible and sustainable **partnerships** with key stakeholders to deliver care in the right place at the right time	X
3) We will develop our **people** to allow them to be innovative, empowered, engaged and motivated. We will retain and attract the best staff.	X
4) We will **transform** services to achieve long-term financial sustainability.	X

Assurances

This paper relates directly to the delivery of the Trust's strategy by summarising performance across the four key performance measurement areas.

This report should be considered in relation to the relevant risks in the Board Assurance Framework.

As an integrated performance report the content provides assurance across several BAF risks related to workforce, operational performance, quality performance, financial performance and regulatory compliance.

Consultation

This paper has not been considered elsewhere however; some content supporting the overview presented is regularly provided to, Finance and Performance Committee, People and Culture Committee and Quality Committee.

Governance or Legal Issues

Information supplied in this paper is consistent with the Trust's responsibility to deliver all parts of the Single Oversight Framework and the provision of regulatory compliance returns.

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people) (Public Sector Equality Duty & Equality Impact Risk Analysis)

There are no adverse effects on people with protected characteristics (REGARDS).	X
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or	

minimise those risks.	

Actions to Mitigate/Minimise Identified Risks

This report reflects performance related to our whole staff and service receiver population and therefore includes members of those populations with protected characteristics in the REGARDS groups.

Any specific impact on members of the REGARDS groups is described in the report itself.

Recommendations

The Board of Directors is requested to consider the content of the paper and consider;

1) The level of assurance obtained on current performance across the areas presented.
2) Determine whether further assurance is required and at which Committee this needs to be provided and by whom.

Report presented by:	**Mark Powell, Chief Operating Officer**
	Claire Wright, Director of Finance
	Amanda Rawlings, Director of People and Organisational Effectiveness
	Carolyn Green, Director of Nursing and Patient Experience
Report prepared by:	**Peter Charlton, General Manager, Information Management**
	Rachel Leyland, Deputy Director of Finance
	Liam Carrier, Workforce Systems & Information Manager
	Rachel Kempster, Risk and Assurance Manager
	Peter Henson, Performance Manager

Financial Perspective

Highlights
- Surplus ahead of plan year to date
- Forecast over achievement of control total
- Cash better than plan
- Delivery of Cost Improvement Programme

Challenges
- Containment of agency expenditure within ceiling set by NHSI
- Maintaining reduction in Out of Area costs
- High level of non-recurrent CIP

Operational Perspective

Highlights
- The target for outpatient letters sent within 10 working days has been addressed.
- All NHSI standards achieved
- Sustained Out of Area placements performance

Challenges
- PbR Clustering continues to be below our standard
- CPA Review in last 12 Months has fallen below the target
- Cancellations and DNAs in outpatients
    - The process of monitoring discharge emails sent in 2 working days is under review
        - 9 patients have had their discharge delayed this month.
        - Ward staffing

People Perspective

Highlights
- Compulsory training compliance remains high and is above 85%.
- Turnover remains low.

Challenges
- Monthly and annual sickness absence rates remain high.
- Budgeted Fte vacancies remain high, but are reducing.
- Appraisal compliance rates remain low, but are increasing.

Quality Perspective

Highlights:
- Flu vaccination is increasing
- Number of patients with a Safety Plan continues to increase
- Monthly increase but quarterly reduction in complaints opened for investigation
- Number of outstanding CQC actions continued to reduce

Challenges:
- Actions open following Serious Incidents
- CTO forms and MHA rights require work in some areas
- Up to date policies has improved but remains below target

FINANCIAL OVERVIEW – January 2018

Category	Sub-set	Metric	Period	Plan	Actual	Rating	Trend	Key Points
Governance	Finance Score	**Finance Score**	YTD	1	1	G	→	At the end of January the Finance Score is an overall '1' as per the plan. Forecast is a score of '2' which is slightly worse than the plan of '1'. This is mainly driven by the agency metric which is forecast at a '3' for the end of the financial year.
			Forecast	1	2	Y	→	
		Capital Service Cover	YTD	2	2	Y	→	
			Forecast	2	2	Y	→	
		Liquidity	YTD	1	1	G	→	
			Forecast	1	1	G	→	
		Income and Expenditure Margin	YTD	1	1	G	→	
			Forecast	1	1	G	→	
		Income and Expenditure variance to plan	YTD	1	1	G	→	
			Forecast	1	1	Y	→	
		Agency variance to ceiling	YTD	1	2	Y	→	
			Forecast	1	3	A	→	
	Single Oversight Framework	NHS I Segment	YTD		2	n/a	n/a	

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
I&E and profitability	Income and Expenditure	Control Total position £'000	In-Month	195	543	G	↑	At the end of January the surplus is ahead of plan by £1.9m. This is mainly due to non-recurrent income being received earlier in the year. Our forecast remains to over achieve the control total at the end of the financial year The normalised forecast takes out the non-recurrent income and expenditure. Without the non-recurrent income mentioned above we would have a small gap to the control total.
			YTD	2,542	4,490	G	↑	
			Forecast	2,765	4,037	G	→	
		Control Total position ex STF £'000	In-Month	102	451	G	↑	
			YTD	1,933	3,881	G	↑	
			Forecast	1,971	2,607	G	→	
		Normalised Income and Expenditure position £'000	In-Month	102	471	G	↑	
			YTD	1,933	3,194	G	↑	
			Forecast	1,971	1,959	R	→	

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Liquidity	Cash	Cash £m	YTD	13.330	18.795	G	↑	Cash is ahead of plan year to date due to non-recurrent income and additional STF income from 2016/17. Cash is forecast to be ahead of plan by £4.5m which is due to the current cash balance plus forecast cash receipts from future asset disposals. Capital expenditure is behind plan year to date but is forecast to achieve full spend.
			Forecast	12.193	16.681	G	→	
	Net Current Assets	Net Current Assets £m	YTD	8.571	9.501	G	↑	
			Forecast	8.345	7.797	R	→	
	Capex	Capital expenditure £m	YTD	2.574	1.993	R	↑	
			Forecast	3.338	3.338	G	→	

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Efficiency	CIP	CIP achievement £m	In-Month	0.321	0.375	G	↑	CIP is ahead of plan YTD and the forecast assumes an overachievement of £0.9m by the end of the financial year. A significant amount of CIP is non-recurrent in nature.
			YTD	3.208	4.051	G	↑	
			Forecast	3.850	4.778	G	↓	
			Recurrent	3.850	1.797	R	↑	

Key:

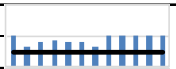
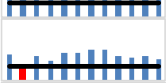
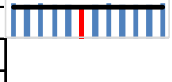
Period In-Month = Current Month
YTD = Year to Date
Forecast = Year end out-turn

Plan In-month or Year end Trust plan

Achieving plan
Not achieving plan

Trend comparing current month against previous month actual/YTD/Forecast

OPERATIONAL OVERVIEW – JANUARY 2018

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	DQ	Key Points
Performance Dashboard	NHSI	CPA 7 Day Follow-up (M)	Month	95.00%	100.00%	G	→			All NHS metrics are compliant. Out of Area Placements are now reported for PICU and Acute using two indicators, number of patients out of area in the month and average number of out of area patients per day during the month. For each metric we have indicated if it is monitored by NHS Quarterly (Q) or Monthly (M). Data Quality has been reviewed for all NHSi Indicators, those highlighted in yellow for Audit are as a result of being introduced since the last audit review. Those highlighted in yellow for validation do not have their compliant records reviewed by the teams prior to submission to the Board. Only exceptional records are reviewed.
			Quarter	95.00%	100.00%	G	→			
		Data Quality Maturity Index (DQMI) - MHSDS Data Score (Q)	Month	95.00%	96.46%	G	→			
			Quarter	95.00%	96.46%	G	→			
		IAPT RTT within 18 weeks (Q)	Month	95.00%	99.71%	G	→			
			Quarter	95.00%	99.71%	G	→			
		IAPT RTT within 6 weeks (Q)	Month	75.00%	92.56%	G	→			
			Quarter	75.00%	92.56%	G	→			
		Early Intervention in Psychosis RTT Within 14 Days - Complete (Q)	Month	50.00%	94.44%	G	↑			
			Quarter	50.00%	94.44%	G	↑			
		Early Intervention in Psychosis RTT Within 14 Days - Incomplete (Q)	Month	50.00%	71.43%	G	↓			
			Quarter	50.00%	71.43%	G	↓			
		Patients Open to Trust In Employment (M)	Month	N/A	9.88%		→			
			Quarter	N/A	9.88%		→			
		Patients Open to Trust In Settled Accommodation (M)	Month	N/A	60.58%		↓			
			Quarter	N/A	60.58%		↑			
		Under 16 Admissions To Adult Inpatient Facilities (M)	Month	0	0	G	→			
			Quarter	0	0	G	→			
		IAPT People Completing Treatment Who Move To Recovery (Q)	Month	50.00%	53.93%	G	↑			
			Quarter	50.00%	53.93%	G	→			
		Physical Health - Cardio-Metabolic - Inpatient (Q)	Month	N/A						
			Quarter	N/A						
		Physical Health - Cardio-Metabolic - EI (Q)	Month	N/A						
			Quarter	N/A						
		Physical Health - Cardio-Metabolic - on CPA (Community) (Q)	Month	N/A						
			Quarter	N/A						
		Out-of-Area Placements - No. patients (M)	Acute●	N/A	4		↑			
			PICU●	N/A	16		→			
		Out-of-Area Placements - Average placements per day (M)	Acute●	N/A	1.16		↑			
			PICU●	N/A	8.29		↓			

Key:

Period

Month Current Month

Quarter Current Quarter

Achieving target

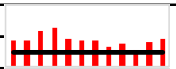
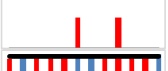
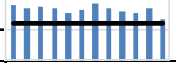
Not achieving target

↑ → ↓ Trend compared to previous month/quarter with tolerance of 1%

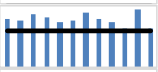
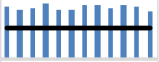
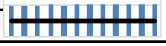
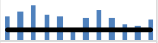
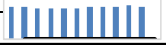
OPERATIONAL OVERVIEW – JANUARY 2018

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	DQ	Key Points
Performance Dashboard	Locally Agreed	CPA Settled Accommodation	Month	90.00%	95.57%	G	→			8 short of the target. The two teams which are particularly struggling to achieve target are Chesterfield Central and Bolsover & Clay Cross
			Quarter	90.00%	95.57%	G	→			
		CPA Employment Status	Month	90.00%	97.32%	G	→			
			Quarter	90.00%	97.32%	G	→			
		Patients Clustered not Breaching Today	Month	80.00%	75.82%	R	→			
			Quarter	80.00%	75.82%	R	→			
		Patients Clustered regardless of review dates	Month	96.00%	93.61%	R	→			
			Quarter	96.00%	93.61%	R	→			
		7 Day Follow-up - all inpatients	Month	95.00%	97.67%	G	→			
			Quarter	95.00%	97.67%	G	→			
		Ethnicity coding	Month	90.00%	91.35%	G	↓			
			Quarter	90.00%	91.35%	G	↓			
		NHS Number	Month	99.00%	100.00%	G	→			
			Quarter	99.00%	100.00%	G	→			
		CPA Review in last 12 Months (on CPA > 12 Months)	Month	95.00%	94.75%	R	↓			
			Quarter	95.00%	94.75%	R	↓			
		Clostridium Difficile Incidents	Month	7	0	G	→			
			Quarter	7	0	G	↓			
		18 Week RTT Greater Than 52 weeks	Month	0	0	G	→			
			Quarter	0	0	G	→			

OPERATIONAL OVERVIEW – JANUARY 2018

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	DQ	Key Points
Performance Dashboard	Schedule 6	Consultant Outpatient Trust Cancellations	Month	5.00%	8.79%	R	→			The most common reason was "consultant absent from work". Work is ongoing to address vacancies. A pilot was being undertaken in Derby City of telephoning patients to remind them of upcoming outpatient appointments.
			Quarter	5.00%	8.79%	R	↑			
		Consultant Outpatient DNAs	Month	15.00%	16.80%	R	→			
			Quarter	15.00%	16.80%	R	↑			
		Under 18 admissions to Adult inpatients	Month	0	0	G	→			
			Quarter	0	0	G	↓			
		Outpatient letters sent in 10 working days	Month	90.00%	92.73%	G	↑			
			Quarter	90.00%	92.73%	G	↑			
		Outpatient letters sent in 15 working days	Month	95.00%	97.64%	G	↑			
			Quarter	95.00%	97.64%	G	↑			
		Inpatient 28 day readmissions	Month	10.00%	7.30%	G	↓			
			Quarter	10.00%	7.30%	G	↓			
		MRSA - Blood stream infection	Month	0	0	G	→			
			Quarter	0	0	G	→			
		Mixed Sex accommodation breaches	Month	0	0	G	→			
			Quarter	0	0	G	→			
		Discharge Email Sent in 24 Hours	Month							Process under review
			Quarter							
		Delayed Transfers of Care	Month	0.80%	4.70%	R	→			9 Patients were delayed
			Quarter	0.80%	4.70%	R	↑			
		18 Week RTT Less Than 18 Weeks - Incomplete	Month	92.00%	92.78%	G	↓			
			Quarter	92.00%	92.78%	G	↓			

OPERATIONAL OVERVIEW – JANUARY 2018

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	DQ	Key Points
Performance Dashboard	Fixed Submitted Returns	18 weeks RTT greater than 52 weeks	Month	0	0	G	→			Compliant with Fixed Targets
			Quarter	0	0	G	→			
		18 Week RTT incomplete	Month	92.00%	92.39%	G	↓			
			Quarter	92.00%	92.39%	G	↓			
		Mixed Sex accommodation breaches	Month	0	0	G	→			
			Quarter	0	0	G	→			
		Completion of IAPT Data Outcomes	Month	90.00%	95.11%	G	↓			
			Quarter	90.00%	95.11%	G	↓			
		Ethnicity coding	Month	90.00%	91.73%	G	→			
			Quarter	90.00%	91.73%	G	→			
		NHS Number	Month	99.00%	100.00%	G	→			
			Quarter	99.00%	100.00%	G	→			
Other Dashboards	Health Visiting	% 10-14 Day Breastfeeding coverage	Month	98.00%	99.19%	G	→			Compliant with Targets.
			Quarter	98.00%	99.19%	G	→			
		% 6-8 Week Breastfeeding coverage	Month	98.00%	99.19%	G	↓			
			Quarter	98.00%	99.19%	G	→			
	IAPT	Recovery Rates	Month	50.00%	54.18%	G	↑			Compliant with Targets.
			Quarter	50.00%	54.18%	G	↑			
		Reliable Improvement Rates	Month	65.00%	68.01%	G	↑			
			Quarter	65.00%	68.01%	G	→			
	Safer Staffing	Inpatient Safer Staffing Fill Rates	Month	N/A	104.4%		→			Detailed ward level information shows specific variances
			Quarter	N/A	104.4%		→			

WORKFORCE OVERVIEW – January 2018

Category	Sub-set	Metric	Period	Plan	Actual	Variance		Trend	Key Points
Workforce Dashboard	NHSI Key Performance Indicator (KPI)	**Turnover** (annual)	**Jan-18**	10%	**10.14%**	↗	G	↑	Annual turnover remains within the Trust target parameters and is below the regional Mental Health & Learning Disability average of 11.99% (as at October 2017 latest available data). The monthly sickness absence rate is 0.86% higher than the previous month and compared to the same period last year (January 2017) it is 1.15% higher. The annual sickness absence rate is running at 5.30% (as at December 2017 latest available data). The regional average annual sickness absence rate for Mental Health & Learning Disability Trusts is 5.19% (as at September 2017 latest available data). Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounted for 21.35% of all sickness absence during January 2018, followed by cold / cough / flu at 20.87% and surgery at 8.94%. The Funded Fte vacancy rate has decreased by 0.91% to 5.03%. The number of employees who have received an appraisal within the last 12 months has increased by 1.82% to 78.60%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £733k. Compulsory training compliance has decreased by 0.48% to 85.93%.
			Dec-17		9.90%		G		
		Sickness Absence (monthly)	**Jan-18**	5.04%	**7.33%**	↗	R	↑	
			Dec-17		6.47%		R		
		Sickness Absence (annual)	**Dec-17**	5.04%	**5.30%**	↗	R	↓	
			Nov-17		5.28%		R		
		Vacancies (including funded fte flexibility / cover)	**Jan-18**		**5.03%**	↘		↓	
			Dec-17		5.94%				
		Appraisals (**all staff** - number of employees who have received an appraisal in the previous 12 months)	**Jan-18**	90%	**78.60%**	↗	R	↑	
			Dec-17		76.78%		R		
		Appraisals (**medical staff only** - number of employees who have received an appraisal in the previous 12 months)	**Jan-18**	90%	**72.89%**	↘	R	↓	
			Dec-17		77.36%		R		
		Agency Usage (£ year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Jan-18**	£0	**£0.733m**	↗	R	↑	
			Dec-17		£0.695m		R		
		Agency Usage (% year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Jan-18**	0%	**28.41%**	↘	R	↓	
			Dec-17		29.83%		R		
		Compulsory Training (staff in-date)	**Jan-18**	90%	**85.93%**	↘	A	↓	
			Dec-17		86.41%		A		

Key:

Period Current month and previous month

Plan Trust target

↗ Variance to previous month

Achieving target/within target parameters

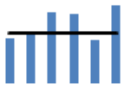
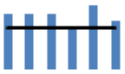
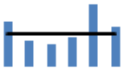
Approaching target/approaching target parameters

Not achieving target/outside target parameters

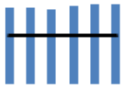
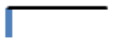
Trend based on previous 4 months

Turnover parameters (8% to 12%)

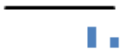
QUALITY OVERVIEW – JANUARY 2018

Sub-set	Metric	Period	Plan	Actual	Trend graph by month (rolling 6 months: Aug 17 - Jan 18)	Trend graph by quarter (last 3 qtrs: Apr – Dec 17)	Quality implications
Safe	No of incidents of moderate to catastrophic actual harm Plan: average last fin yr 2016/17 (month)	Month	29	46			Death unexpected - other incidents have increased from 13 in Dec 17 to 24 in Jan 18. There are no discernible patterns across other category of incidents
		Quarter	88	112			
	No of deaths of patients who have died within 12 months of their last contact with DHcFT Data as at 03/01/2018	No of deaths of patients	104	194			This is showing an increase due to data parameters now including deaths of people: open to IAPT services; whilst on waiting lists; and open to substance misuse services
		Quarter	312	339			
	No of serious incidents reported to the CCG	Month	5	6			Reducing trend influenced by peak reporting in May 17. Relative stability in reportable incidents since
		Quarter	16	20			
	No of episodes of patients held in seclusion	Month	10	13			The increasing number here is explained by the care of three patients , who had three or more separate episodes of seclusion in Dec 2017. Attempting to reduce the length of each seclusion spell may result in more episodes overall.
		Quarter	30	37			
	No of incidents involving patients held in seclusion	Month	16	24			
		Quarter	47	59			
	No of incidents involving physical restraint	Month	48	53			Physical restraint would ordinarily be part of a seclusion process
		Quarter	143	139			
	No of incidents involving prone restraint	Month	10	12			Prone restraint is usually at a time of enforced medication administration via an injection. We would often see an increase in this in line with increased use of seclusion in line with increased the number of incidents
		Quarter	29	33			
	No of incidents of physical assault - patient on patient	Month	12	15			As we move forward, this data will be reviewed in line with how any trend might be attributable to the same individual
		Quarter	37	39			
	No of incidents of physical assault - patient on staff	Month	19	27			
		Quarter	56	89			

QUALITY OVERVIEW – JANUARY 2018

Safe	No of falls on in-patient wards	Month	32	21			As we move forward, this data will be reviewed in line with how any trend might be attributable to the same individual
		Quarter	96	99			
	No of incidents of absconsion	Month	33	25			Lower incidents monthly and quarter
		Quarter	99	68			
	No of patients with a clinical risk plan (FACE or Safety Plan)	Month	100%	73.72%			This is showing an increase due to data parameters now including deaths of people: open to IAPT services; whilst on waiting lists; and open to substance misuse services
		Quarter	100%	73.09%			
	Of above, no of patients with a Safety Plan	Month	90%	57.38%			A piece of work currently underway with the Safety Planning Steering Group to audit the presence and quality of Safety Plans
		Quarter	90%	53.94%			
	% of staff compliant with combined Level 3 Safeguarding Children and Think Family training Compliance figure now only	Month	85%	NA			Consistently exceeds target
		Quarter	85%	NA			
	% of staff compliant with Level 3 Safeguarding Children training New indicator from Nov 17	Month	85%	75.79%			Perfomance will be reduced initially now that this figure does not count Think Family training.
		Quarter	85%	NA			
	% of staff compliant with Clinical Safety Planning eLearning	Month	95%	91.82%			This performance will be overseen and actioned as necessary by the Safety Planning Steering Group
		Quarter	95%	NA			
	% of CTRs (Care & Treatment Reviews) completed	Month	100%	Not available			The metric and data are currently under review and clarification
		Quarter	NA	NA			
	% of compliance with inpatients VTE assessment	Month	95%	94.69%			Increasing compliance in line with our work around physical healthcare
		Quarter	95%	NA			
	HCR20 assessment completed (Low Secure)	Month	100%	0%			The reporting of this will tend to be either 100% if we complete an HCR20 within the required timescale after someone has been admitted to Kedleston Unit, or 0% if we miss the timescale for that one person. The team are aware of requirements.
		Quarter	100%	NA			

QUALITY OVERVIEW – JANUARY 2018

Caring	No of complaints opened for investigation	Month	12	24			We have a monthly increase but a quarterly reduction. This trend will be monitored in Feedback Intelligence Group
		Quarter	37	40			
	No of concerns received	Month	35	29			Monitored in the Feedback Intelligence Group
		Quarter	104	107			
	No of compliments received	Month	100	91			Lower for the month but above for half year
		Quarter	300	305			
	No of investigations by the Parliamentary and Health Service Ombudsman	2016/17	NA	6			This is six for the previousl financial year, and one for the current year that has been on the dashboard before.
		2017/18	NA	1			
	% of complaints upheld (full or in part) by the Parliamentary and Health Service Ombudsman	2016/17	NA	1			5 no further action
		2017/18	NA	0			1 ongoing
	% of responded to (orange) complaint investigations completed within 40 working days, opened after 01/04/2017	Year	100%	30%			162 (orange) complaints as at 09/02/2018. 72 not responded within 40 working days. 31 resolved within 40 working days. 59 ongoing. The majority of those defined as overdue are still within the timescale negotiated with the complainant.
	% of responded to (red) complaints investigations completed within 60 working days, opened after 01/04/2017	Year	100%	25%			6 (red) complaints as at 09/02/2018. 3 not responded within 60 working days. 2 ongoing. The majority of those defined as overdue are still within the timescale negotiated with the complainant.
	No of incidents requiring Duty of Candour	Month	1	1			One incident in January 2017, a referral delay for a young person with an eating disorder. This is being investigated.
		Quarter	2	3			

QUALITY OVERVIEW – JANUARY 2018

Effective	% of in-patients with a recorded capacity assessment	Month	100%	94.69%			Ongoing work to both improve the quality and audit the evidence of this.
		Quarter	100%	95.37%			
	% of patients who have had their care plan reviewed and have been on CPA > 12months	Month	90%	94.68%			
		Quarter	90%	96.32%			
	No of seclusion forms not received by MHA Office	Month	0	0			Process now automated. Cross referenced with seclusion incidents reported on Datix. As of 09/02/2018: 5 seclusions reported on PARIS, not recorded as incidents on Datix. Head of Nursing escalating.
		Quarter	0	0			
	% of CTO rights forms received by MHA Office	Month	100%	83%			This has been lower performance since October 2017. This is not a global problem, so areas of lower performance will be specifically targetted for improvement work.
		Quarter	NA	NA			
	% of in patient older adults rights forms received by MHA Office	Month	100%	89%			Performance of less than 100% is only attributable to one ward. This ward will be targetted with a focus on quality improvement work
		Quarter	NA	NA			

QUALITY OVERVIEW – JANUARY 2018

Responsive	% of staff uptake of Flu Jabs	2017/18	45%	49.68%			Figure as at 07/02/2018. Performance as at 19th February is 50.2 %. Target for next year is 75%
		2016/17	45%	38.40%			
	% of policies in date	Month	95%	93.85%			This is being monitored and actioned as necessary.
		Quarter	NA	NA			

Well Led	% of staff who have received Clinical Supervision, within defined timescales	Month	100%	61.04%			All divisions have action plans around increasing the % of people receiving the target number of clinical and managerial supervision, but this remains a challenge.
		Quarter	100%	NA			
	% of staff who have received Management Supervision, within defined timescales	Month	100%	71.10%			
		Quarter	100%	NA			
	No of outstanding actions following serious incident investigations	Month	5	65			This is being monitored and actioned within the Serious Incident Group
		Quarter	0	NA			
	No of outstanding actions following complaint investigations	Month	5	26			Overall this is an improving picture
		Quarter	NA	NA			
	No of outstanding actions following CQC comprehensive review report (2016)	Month	0	14			We are working through the final remaining actions over the next few weeks with operational management colleagues.

Financial Section

Exceptions month 10

- **Over achievement of the control total**

  We continue to forecast a higher surplus than planned overachieving the control total by £636k. Therefore the yearend surplus position is forecast at £4.036m which is an overachievement of the Control Total of £1.3m (£636k additional surplus plus £636k additional STF 'bonus' income). This is in line with last month's forecast.

- **Capital Expenditure continues to be behind plan**

  Underspent by £581k YTD, which is a reduction on last month's YTD variance. The forecast remains to spend to plan by the end of the financial year. The capital schemes have been reprioritised in year for schemes that are due to complete in the last few months of the financial year. Therefore the current balance of £1.3m (40% of the plan) will be spent over the last two months of the financial year. The capital plan and forecast are monitored on a monthly basis by the Capital Action Team.

- **CIP performance – Non-Recurrent delivery**

  The total CIP forecast to be delivered is £4.8m which is an overachievement of £0.9m against the target of £3.8m. Of the forecast £4.8m, £3.1m is non-recurrent in nature. The non-recurrent nature of this year's delivery poses a significant risk to next year's financial performance.

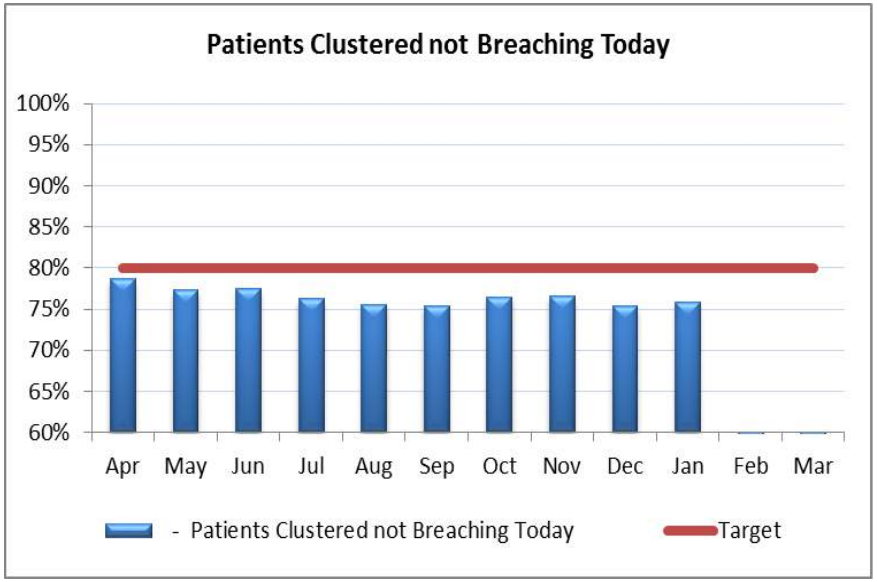
- **Agency expenditure**

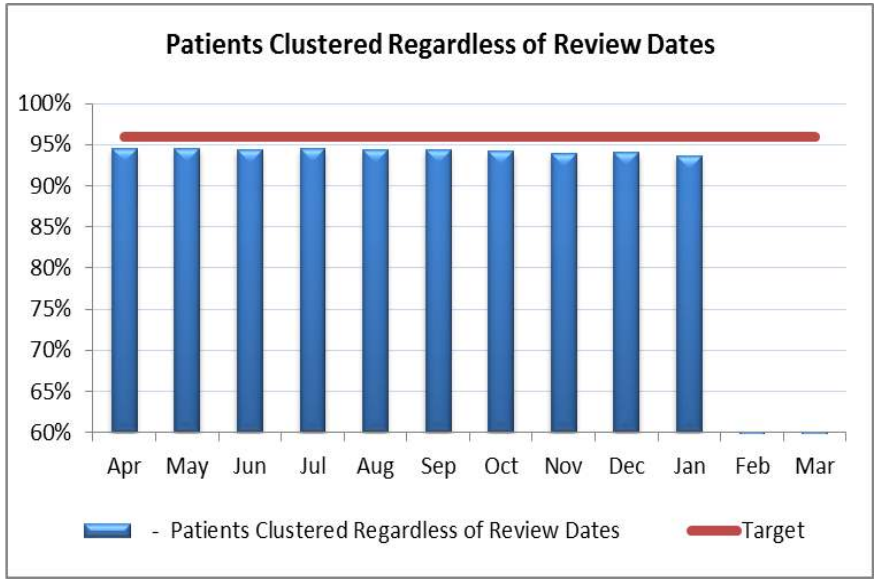
  YTD is above the ceiling by £609k (23%) which is generating a '2' on the agency metric. The agency expenditure is forecast to exceed the ceiling by £1.0m (33%) which is an improvement on last month's forecast. This is generating a '3' on the agency metric within the Finance Score.

  The forecast expenditure on medical agency is now below the medical agency target that was set by NHSI.

Operational Section

Patients Clustered not Breaching Today and Patients Clustered regardless of review dates

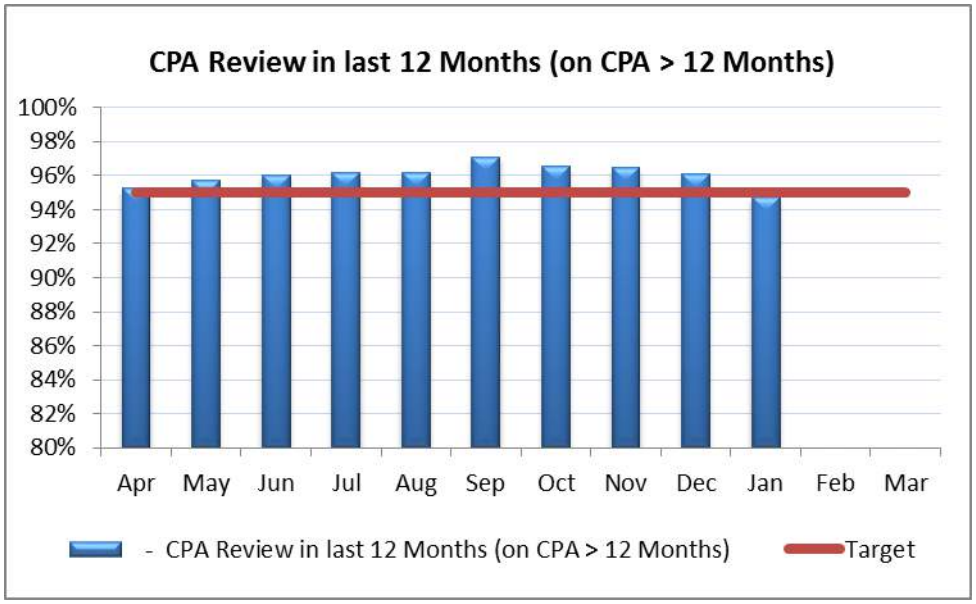




Finance and Performance Committee has requested further assurance regarding PbR clustering recording performance. This will be provided at the next meeting.

In addition, the Trust is seeking to understand the national context and policy on PbR Clustering as there have been suggestions at a number of recent conferences attended by Trust colleagues that it may not be an ongoing requirement for Trusts.

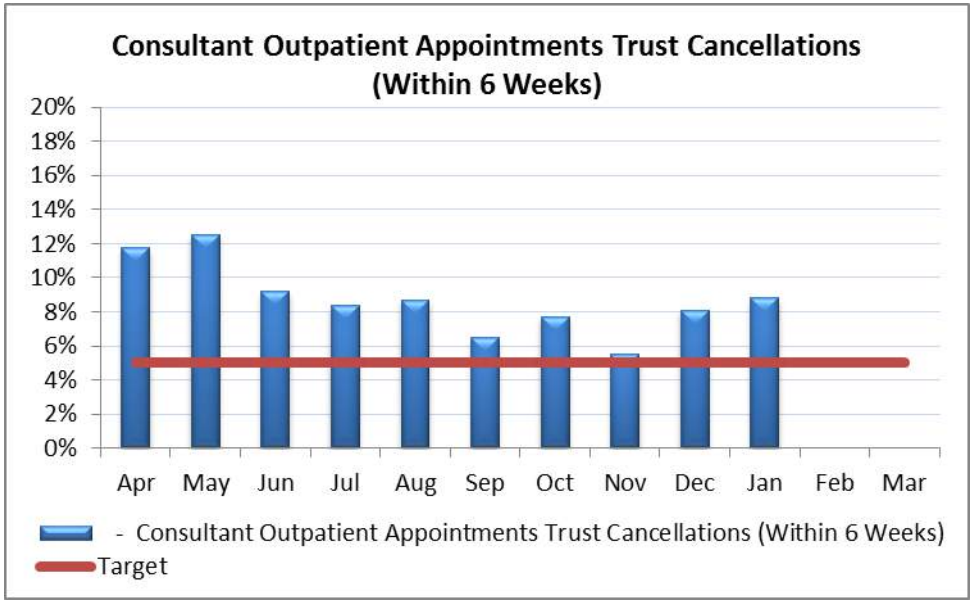
CPA Review in last 12 Months (on CPA > 12 Months)



The community teams have consistently found it challenging to complete the level of reviews required owing to individual clinicians carrying large caseloads. In January we were 8 short of the standard. The two teams which are particularly struggling to achieve target are Chesterfield Central and Bolsover & Clay Cross.

Further support is being provided to these areas to ensure that 12 month CPA reviews are completed.

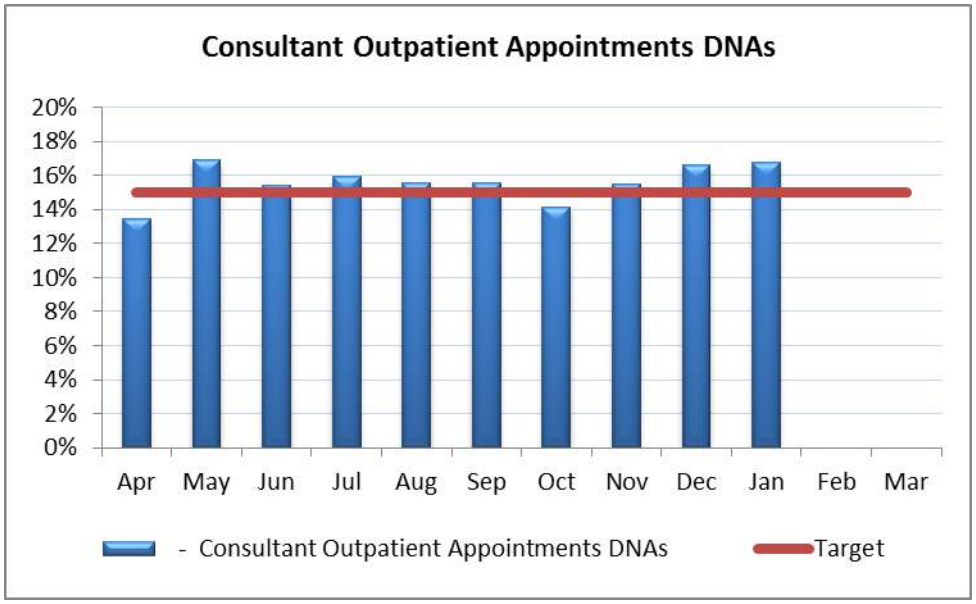
Consultant outpatient appointments Trust cancellations (within 6 weeks)



Reason	n	%
Clinician Absent From Work	142	43%
Moved - Staff Issue	41	13%
Moved - Trust Rescheduled	36	11%
Moved - Clinic Cancelled	33	10%
Moved - Location Issue	17	5%
Clinician On Annual Leave	16	5%
Clinician Must Attend Training	12	4%
Clinician Must Attend Meeting	10	3%
Clinician Must Attend Inquest	6	2%
Clinic Booked In Error	5	2%
No Consultant	3	1%
Jnr Dr Clinic No Consultant	3	1%
Must Attend Ward Round	1	0%
Paris System Issue	1	0%
Clinician Must Attend Tribunal	1	0%
Grand Total	**327**	**100%**

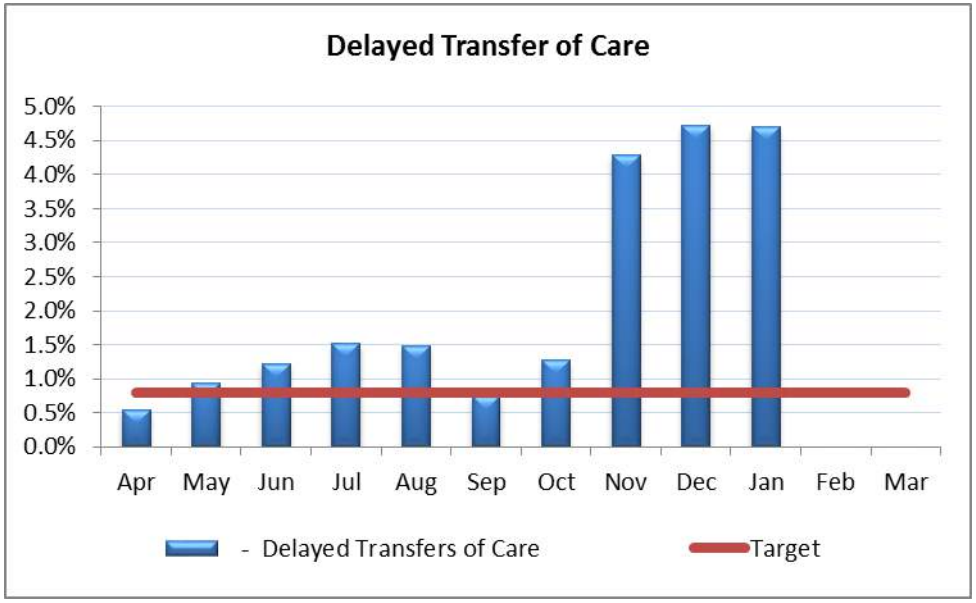
327 appointments were cancelled in January. The main reasons for cancellation were clinician absence from work and staffing issues. The level of cancellations would have been below the 5% threshold in January were it not for sickness absence.

Consultant Outpatient DNAs



A pilot is being undertaken in Derby City of telephoning patients to remind them of upcoming outpatient appointments. The impact of the pilot will be evaluated and if proven to be effective this practice will be rolled out across all outpatients. Early indication is that this approach is yet to have the desired impact. The outcome of the pilot will be reported in March 2018.

Delayed Transfers of Care



9 discharges were delayed in January, for the following reasons:

Current Ward	Delay Reason	Responsibility	Delay Start
Enhanced Care Ward	K2 - Housing - awaiting emergency accommodation from local authority	Health and Social Care	11/12/2017
RDH Ward 34 Adult Acute Inpatient	J2 - Housing - awaiting supported accommodation	Health and Social Care	30/10/2017
LRCH Ward 1 OP	D2 - awaiting nursing home placement or availability (waiting for bed in secure unit. Funding in place)	Social Care	15/12/2017
RDH Ward 33 Adult Acute Inpatient	E1 - awaiting care package in own home	Social Care	07/11/2017
RDH Ward 34 Adult Acute Inpatient	J2 - Housing - awaiting supported accommodation	Health and Social Care	30/10/2017
RDH Ward 34 Adult Acute Inpatient	C1 - awaiting further non-acute NHS care	Health and Social Care	30/10/2017
RDH Ward 36 Adult Acute Inpatient	C1 - awaiting further non-acute NHS care	Social Care	03/11/2017
RDH Ward 33 Adult Acute Inpatient	E1 - awaiting care package in own home	Social Care	07/11/2017
Hartington Unit Tansley Ward Adult	J2 - Housing - awaiting supported accommodation	Health and Social Care	30/10/2017

WARD STAFFING

Ward name	Occupancy % Rate	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
		Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
AUDREY HOUSE RESIDENTIAL REHABILITATION	70.00%	80.3%	135.5%	62.9%	0.0%	Yes	We currently have two band 5 RN out to advertisement.
CHILD BEARING INPATIENT	75.27%	64.1%	94.6%	100.0%	164.5%	Yes	Fill rate tolerances for registered nurses (day) have been broken due to cover needed for career break, sickness and 1.1 WTE vacancy. Care staff (night) is due to long term sickness absence, 0.8 WTE vacancy and high clinical activity/increased observations
CTC RESIDENTIAL REHABILITATION	70.13%	137.4%	105.9%	112.9%	154.8%	Yes	We continue to have 2 service users whom are nursed on level 2 observations due to their needs and level of risks, this is reviewed daily with MDT and in the MDM 4 weekly. Therefore we have been required to have extra staffing for these periods. Discharge plans are ongoing for both service users and we are working towards discharge in the near future – no dates yet set. We have also had significant levels of sickness on Cherry Tree Close during this month therefore have required bank staff to cover these shifts.
KEDLESTON LOW SECURE UNIT	40.00%	91.2%	59.7%	88.7%	80.6%	Yes	we have several areas in red due to only one ward being open at the moment. We are ensuring that we have 5 staff as a minimum however increasing the staffing to open the other side we are sometimes on 6. The other factor is sometimes with out reception staff our staff are then allocated into the front office of the ward.
KINGSWAY CUBLEY COURT - FEMALE	53.41%	82.1%	92.1%	48.4%	122.6%	Yes	
KINGSWAY CUBLEY COURT - MALE	88.53%	76.8%	127.4%	91.9%	182.8%	Yes	I can confirm that Cubley Court Male aim to ensure 2 qualified staff are rota'd to work every night, throughout January on occasions where this as not been possible we have had to back fill with unqualified staff to ensure safe staffing. There as been some sickness throughout January of both qualified and unqualified staff, mainly we are only able to cover with unqualified due to limited qualified available through the nurse bank. There also as been an increase in bed occupancy as well as the client group continues to become more complex meaning we require higher levels of observations which as resulted in increasing staffing levels to support the safety of the ward.

WARD STAFFING

Ward name	Occupancy % Rate	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
		Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP	85.30%	88.0%	92.8%	96.8%	124.2%	Yes	We have recently had staff sickness and this has been in the registered staff role. This has been reflected in the percentage
HARTINGTON UNIT - MORTON WARD ADULT	98.52%	112.0%	121.2%	61.3%	251.6%	Yes	We are still waiting for some Band 5 to start and we currently have one full time Band 5 acting into the vacant Band 6 role. In addition to that we have one full time Band 5 on long term sick leave – considering retirement on ill health. This is why we cannot always commit to 2 registered nurse on night duty. Recently we have had high levels of activity and observations and so have been working with 6 staff per day shift as opposed to 5.
HARTINGTON UNIT - PLEASLEY WARD ADULT	87.90%	103.8%	117.5%	54.8%	209.7%	Yes	The over safer staffing figures, in the day, is due to the ward requiring higher numbers of staff to support with the increased physical healthcare needs of the older adult population. The under safer staffing figures of Registered Nurses on nights is because we haven't always been able to cover the shifts with 2 Registered Nurses due to supporting cover of the Hartington Unit bleep holder role and also because of short sickness, the deficit has been covered with Care Staff.
HARTINGTON UNIT - TANSLEY WARD ADULT	96.91%	70.1%	144.5%	58.1%	187.1%	Yes	There were 6.6 wte vacant registered nurse posts on Tansley Ward in January. Two of the posts have been recruited into with one nurse starting supernumary on 28/01/18 and another nurse recruited and not due to qualify until September. A small number of these posts have been backfilled by contracted registered nurses offering to work additional hours on bank but the remainder have been covered by band 2 bank HCAs accounting for the poor skill mix evident in the report. In addition to the vacancies one part time (0.6 wte) registered nurse is on long term sickness absence and a further 1.0 wte nurse remains on special leave pending an HR process. There has been in addition a small amount of the usual winter short term absences. From 18/03/18 we will have filled another of our vacant 1.0 wte registered nurse posts when a registered nurse transfers from Ward 35 to work on Tansley Ward after moving to live locally and our OT post will be filled after the successful applicant qualifies in April. I am anticipating that the skill mix will be a gradually improving picture as the vacant posts are filled and staff already recruited commence. In appraisal I have not been made aware of any nurses who feel that they may be looking to move posts or have interests elsewhere so am hoping that retention will remain high this year.

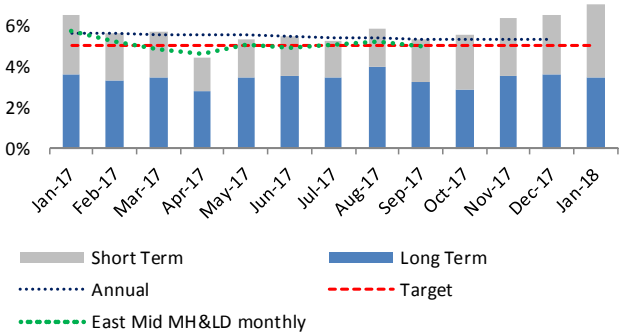
WARD STAFFING

Ward name	Occupancy % Rate	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
		Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
ENHANCED CARE WARD	93.23%	77.1%	136.0%	51.6%	240.3%	Yes	
RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT	104.35%	87.7%	142.0%	79.0%	267.7%	Yes	All inpatient wards at the Radbourne unit remain affected by low recruitment into Registered Nursing vacancies. The current staffing establishment for Ward 33 is unable to meet the full demands for RN cover on each shift. In order to maintain safety and stability within the clinical areas, we have over recruited into HCA posts, hence the higher than required fill rates for unregistered staff. The Trust and individual ward areas continue to proactively recruit into RN vacancies and staffing/ skill mix are reviewed on an ongoing basis at ward level, operational level and Trust level. In addition we are making all attempts to book regular bank/ agency staff who are familiar to our areas in order to provide a level of consistency. The Trust are currently looking to provide additional support into the unit, in order to allow senior and regular staff to work within clinical numbers on the wards where necessary.
RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT	100.48%	67.5%	133.9%	62.9%	267.7%	Yes	There continues to be a high number of registered nurse vacancies and despite efforts to recruit we are not able keep up with demand, subsequently there are a large number of RN shifts filled with unqualified staff.
RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT	100.16%	81.1%	129.9%	66.1%	145.2%	Yes	
RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT	103.55%	93.4%	124.8%	50.0%	248.4%	Yes	

Workforce Section

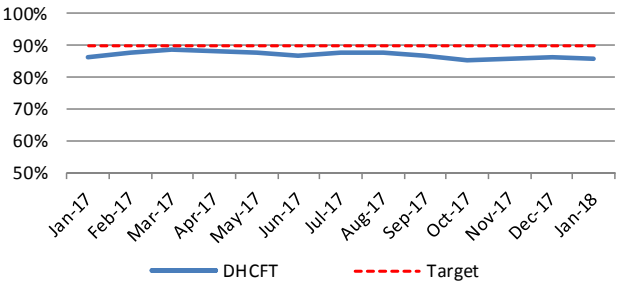
WORKFORCE DASHBOARD

Sickness Absence	Nov-17	Dec-17	Jan-18
(Monthly)	6.32%	6.47%	**7.33%**
(Annual)	5.28%	5.30%	**tbc**
			Target 5.04%



The monthly sickness absence rate is 0.86% higher than the previous month and compared to the same period last year (January 2017) it is 1.15% higher. The Trust annual sickness absence rate is running at 5.30% (as at December 2017 latest available data). Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounted for 21.35% of all sickness absence during January 2018, followed by cold / cough / flu at 20.87% and surgery at 8.94%. Compared to the previous month short term sickness absence has increased by 0.95% and long term sickness absence has decreased by 0.09%.

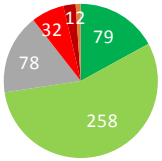
Compulsory Training	Nov-17	Dec-17	Jan-18
(Staff in-date)	85.62%	86.41%	**85.93%**
			Target 90%

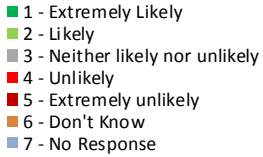


Compulsory training compliance continues to remain high running at 85.93%, a decrease of 0.48% compared to the previous month. Compared to the same period last year compliance rates are 0.28% lower.

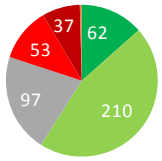
Staff FFT Q2 2017/18 (465 responses, 20.5% response rate) **& Staff Survey** 2016

How likely are you to recommend this organisation to friends and family if they needed care or treatment.





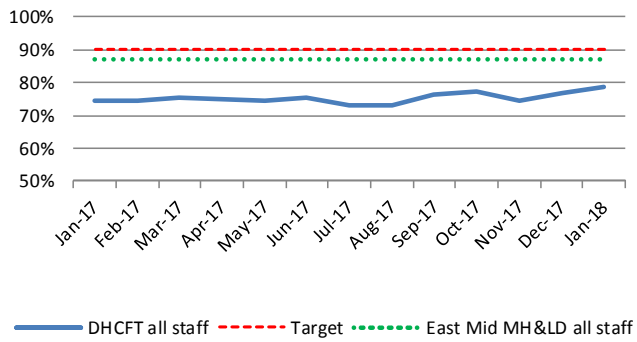
How likely are you to recommend this organisation to friends and family as a place to work.



	2016	National average 2016	2015	National average 2015
Overall staff engagement:	**3.69**	3.84	3.73	3.81

Appraisals (All staff)	Nov-17	Dec-17	Jan-18
	74.65%	76.78%	**78.60%**

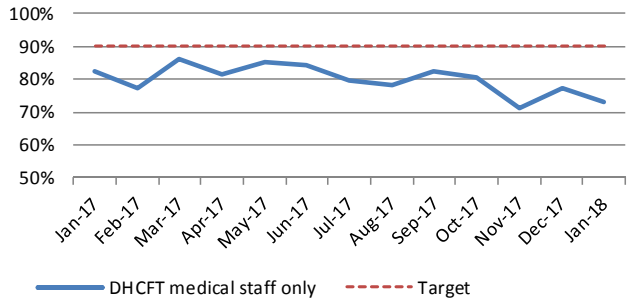
Target 90%



The number of employees who have received an appraisal within the last 12 months has increased by 1.82% during January 2018 to 78.60%. Compared to the same period last year, compliance rates are 4% higher. According to the 2016 staff survey results, the national average for Mental Health & Learning Disability Trusts is 88.79%. Local benchmarking data for a range of Trusts in the East Midlands shows an average completion rate of 85.40%.

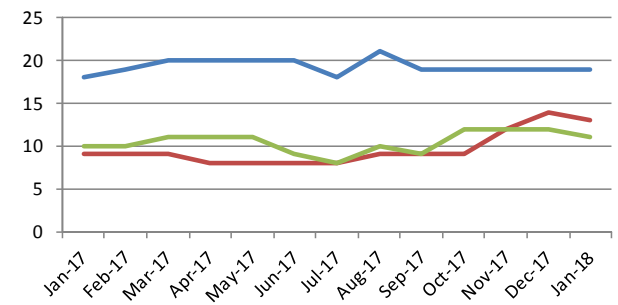
Appraisals (Medical staff only)	Nov-17	Dec-17	Jan-18
	71.15%	77.36%	**72.89%**

Target 90%



The number of Medical staff who have received an appraisal within the last 12 months has decreased by 4.47% to 72.89%. Compared to the same period last year, compliance rates are 9.52% lower. Junior Doctors on rotational training are excluded from the figures.

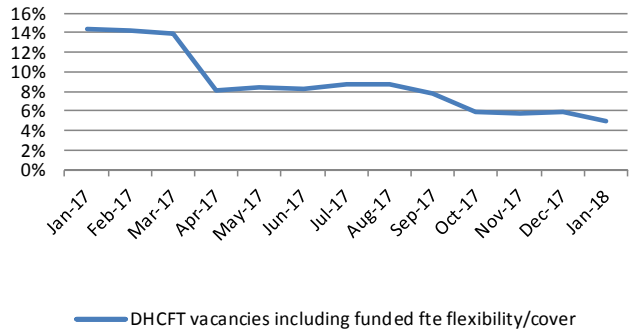
Disciplinaries/Dignity at Work/Grievances as at 31/01/2018



There are 19 Disciplinary cases, 2 new cases have been lodged and 2 cases have been resolved in the period. There are 13 Dignity at Work cases, 1 case has been resolved in the period. There are 11 Grievance cases lodged at the formal stage, 1 case has been resolved in the period.

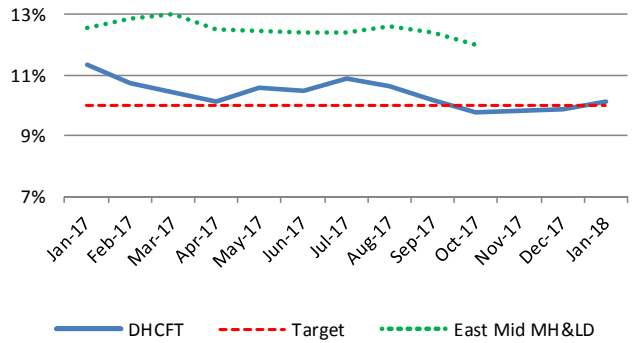
WORKFORCE DASHBOARD

Vacancy	Nov-17	Dec-17	Jan-18
(Funded full time equivalent) Including funded fte flexibility/cover	5.74%	5.94%	**5.03%** ↘



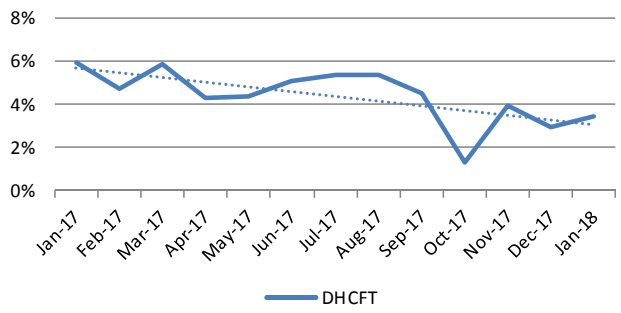
The Trust vacancy rate includes funded Fte surplus for flexibility including sickness and annual leave cover. Funded vacancy rates have decreased by 0.91% to 5.03% in January 2018. 2017/18 budget changes included a large reduction in Fte from 2016/17 investment not materialising and Cost Improvement Programmes. During the period February 2017 to January 2018, 251 employees have left the Trust and 337 employees have joined the Trust.

Turnover	Nov-17	Dec-17	Jan-18
(Annual)	9.85%	9.90%	**10.14%** ↗
			Target 10%



Annual turnover remains within Trust target parameters at 10.14% and remains below the average for East Midlands Mental Health & Learning Disability Trusts (11.99%). The average number of employees leaving over the last 12 months has increased from 20.67 to 20.91. During January 26 employees left the Trust which included 10 retirements.

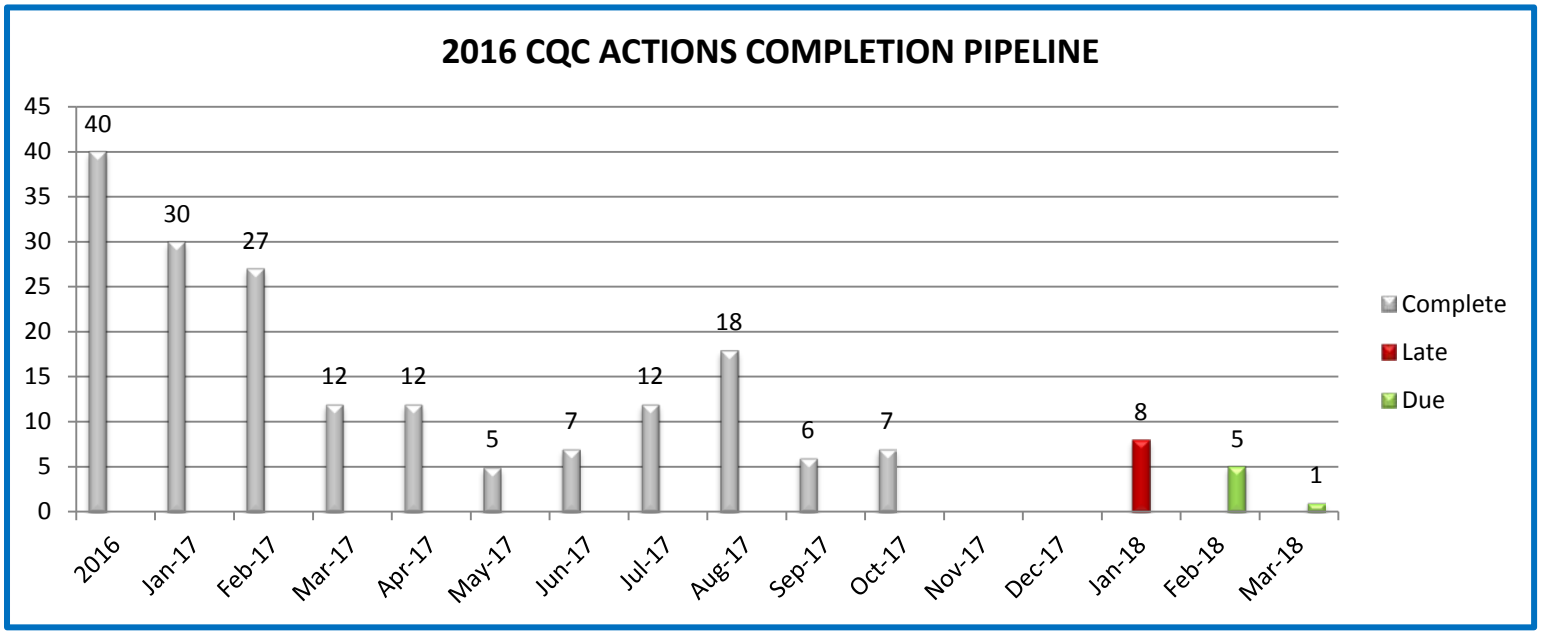
Agency Usage	Nov-17	Dec-17	Jan-18
(Spend)	3.90%	2.93%	**3.43%** ↗

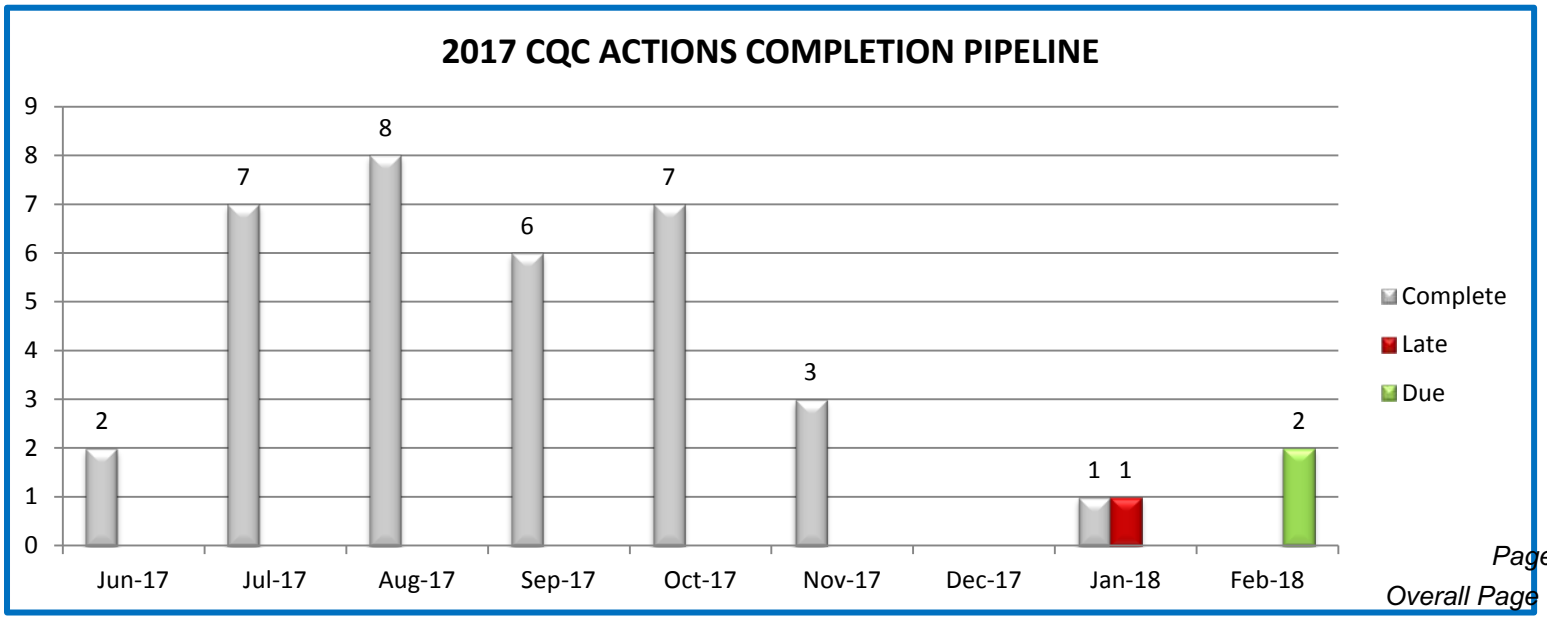


Total agency spend in January was 3.43% (3.96% including medical locums). Of total agency and locum spend for all staff groups, Qualified Nursing represented 0.73%, Medical 2.51% and other agency usage 0.19%. Agency Qualified Nursing spend against total Qualified Nursing spend in January was 1.98%. Agency Medical spend against total Medical spend in January was 14.13%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £733k.

Quality Section

CQC ACTIONS STATUS REPORT – FEBRUARY 2018





PROGRESS UPDATE

One of the 2016 actions has been signed off and evidence has been submitted to the CQC.

All outstanding actions have been reviewed by the CQC & Governance Coordinator and progress against the final requirements was mapped. The Deputy Director of Nursing & Quality Governance has reviewed all the evidence submitted on updated actions and has made recommendations to the Leads in order to meet any gaps. Target dates have been extended on two actions to allow for additional work to be completed and additional evidence to then be uploaded to the CQC Portal.

RISKS AND CONCERNS

There are 14 actions still outstanding from the 2016 CQC visits, eight of which are late. One of the 2017 actions is also late. Failure to meet agreed target dates for completion is a real concern. Detailed requirements for completion have been specified by the Deputy Director of Nursing & Quality Governance.

GOING FORWARD

The CQC and Governance Coordinator will review that status of outstanding actions again on 28.02.18 and provide an update to the March Quality Committee.

There will also be a final review meeting mid-February with the Deputy Director of Nursing & Quality Governance and the Leads to assess the progress of the last of the outstanding actions and to provide mutual support in meeting the completion date on them.

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 28 February 2018

Quality Position Statement

Purpose of Report

The purpose of this report is to provide the Board of Directors with an update on the Trust's continuing work to improve the quality of services it provides in line with the Trust Strategy, Quality Strategy and Framework and strategic objectives.

Executive Summary

This position statement sets out:

1. **Safety** – **National Quality Board have requested all NHS Trusts** to consider in their safer staffing reviews the newly published guidance. We have reviewed the guidance and our summary is contained within this report. We believe we exceed compliance in the methodology and detailed analysis will be provided to the Quality Committee. A heat map of compliance is provided to assure the Board.

    - **Safety – Progress on Mortality reviews**
      Progress on mortality reviews - An information sharing agreement has recently been achieved with NHS Digital so that the Trust should now receive the cause of death for all patients that have been in contact with us within the six months prior to their demise. This will enable us to enhance our data analysis to compare death rates and causes to the background population. Trends and variance will be identified which will enable interpretation and recommendations to be made.

      The individual case reviews have been piloted and a review tool developed. A recruitment process has begun for medical mortality reviewers.

      The serious incident review process has been streamlined and redefined with a strategic group to identify themes and trends from SI investigations and an operational group concentrating on fidelity of process around the individual reports.

    - **Safety - The publication of the National inquiry into Mental Health Homicides, suicides and wider learning.** The Inquiry has been published. The National Inquiry into Suicides and Homicides has been published and the lessons learned for this will be incorporated into our local initiatives which are described below.

      There was a cluster of mental health related homicides in the Trust in 2017. These coincided with the publication of the NHS England commissioned independent reports into two historical homicides. Since then NHS England has commissioned an independent report into a near-miss homicide following concerns raised by the Trust around prison releases and the lack of a dedicated community forensic team in Derbyshire. Commissioners have

recently confirmed that there will now be funding available to establish such a service.

The mainstay of homicide prevention in general services is the Care Programmes Approach (CPA) underpinned by capacity assessments, risk assessments and safety planning. Our approach to CPA has been revised to be fully compliant with the latest guidelines and implementation will be supported by training, compliance checks and audit.

Safety planning has been rolled out and is progressing with real time feedback and development from clinical staff to ensure longitudinal analysis of risk. The focus is now shifting to compliance checking and audit to continually improve clinical practice.

Data and a heat map on the incidences of mental health homicides to enable analysis of the risks in our county. A scorecard with the Trust's rate will be included in our Quality Account (2017-18).

2. **Responsiveness** - Decision making and mental capacity and our practice, has been reviewed this is monitored by our mental health legislation board committee, the Mental Health Act Committee. This quarter our clinical skills tutor and teams have been checking our compliance, to see if our improvements have been sustained. Unannounced spot checks have been undertaken and the report summarises that improvement have been made and on-going business as usual sustained improvement is required to maintain practice in these areas audited. There has been a significant improvement in the application of the Mental Capacity Act in inpatient units following extensive practice development and quality improvement measures. The focus is now shifting to the community. The Executive Lead is John Sykes.

3. **Well Led – Improving our knowledge base for our support staff - our standards**

   The ability of our Trust to embed sustained improvement is key to our future standards of quality and practice. The Director of Nursing has been undergoing testing of the essential standards without notice to confirm whether standards subject to an area of concern by our health regulator have been improved and have sustained improvement.

   The investment in training in our support workforce was raised as a concern specifically around uptake of the care certificate. A summary of the care certificate, compliance and trend. This improvement has been sustained for our workforce and in line with the Trust's values of putting people first (e.g. staff wellbeing, staff development or recruitment and retention).

4. **Well Led** – Our Care Quality Commission (CQC) Action Plan Performance to assure the public of our progress and commitment and that we now are off trajectory for our timeline for completion in January 2018. The evidence produced and performance in key operational and clinical areas of practice has not been to the required level and has not been achieved and has been further extended to the end of January and to April 2018 for some areas to ensure improved performance and re-audit to ensure adequacy and completeness. We

have had informal visits to the CAMHS and Adults Eating Disorders service on 13 February 2018. Our next informal visit is to our Substance Misuse service in February. We have not improved our position in February. The Executive Lead is Carolyn Green.

Strategic considerations	
1) We will deliver **quality** in everything we do providing safe, effective and service user centred care.	X
2) We will develop strong, effective, credible and sustainable **partnerships** with key stakeholders to deliver care in the right place at the right time.	X
3) We will develop our **people** to allow them to be innovative, empowered, engaged and motivated. We will retain and attract the best staff.	X
4) We will **transform** services to achieve long-term financial sustainability.	X

Strategic considerations

To give an insight into our quality management and focus our reporting to the key areas as key lines of enquiry and questioning by the Care Quality Commission as our Quality Regulator and to provide assurance level information on our services and their performance.

(Board) Assurances

Compliance with the key areas covered by the Care Quality Commission key lines of enquiry and emerging clinical strategy and how this will influence the quality team in developing practice.

Consultation

This paper has not been previously presented, but does reference information available to the Quality Leadership Teams and Quality Governance Structures.

Governance or Legal issues

- Evidence of our compliance with the Health and Social Care Act 2008 (Regulation activities) Regulations 2014 Part 3 and CQC (Registration) Regulations 2009 (Part 4).
- Children and Families Act 2014.
- The Care Act 2014.
- There are legal issues under the Regulatory Reform (Fire) Safety Order 2005, the Health & Safety at Work etc. Act 1974 and the Health & Social Care Act 2010 contained within this Report.

- Care Quality Commission Regulations this report provides assurance to:-
  - Outcome 4 (Regulation 9) Care and welfare of people who use services
  - Outcome 10 (Regulation 15) Safety and suitability of premises
  - Outcome 11 (Regulation 16) Safety, availability and suitability of equipment
  - Outcome 12 Regulation 210) Requirements relating to workers
  - Outcome 14 (Regulation 23) Supporting staff
  - Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
  - Children's Act (1989)
  - Adoption and Children Act (2002)
  - Children and Young Peoples Act (2008)
  - Children and Families Act (2014)

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation).

There are no adverse effects on people with protected characteristics (REGARDS).	
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations / inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	x

Actions to Mitigate/Minimise Identified Risks

Any impact or potential impact on equality is considered as a key part of all our quality work. Some of the examples are improving the equalities position for individuals and their families are fully in line with our duties and responsibly and due regard.

Individuals with mental health and learning disabilities are often adversely affected by economic disadvantage, due to the significant impact on life due to the period of illness.

Recommendations

The Board of Directors is requested to:

1) Receive this quality position statement.
2) Gain assurance, be advised on safety.
3) Review its content and seek clarity or challenge on any aspect of the report.

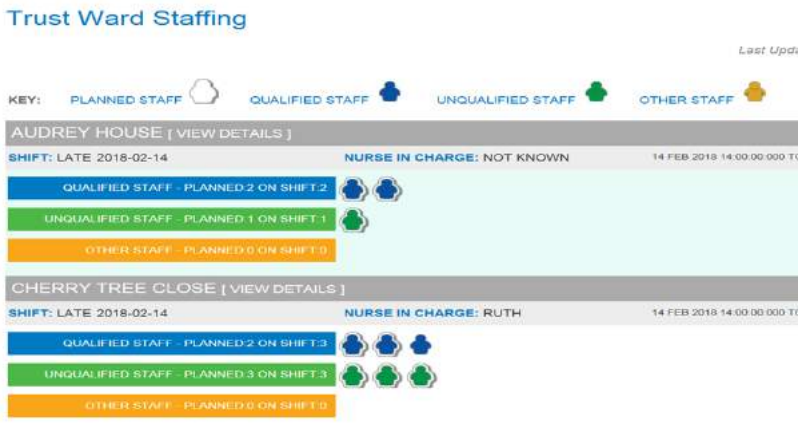
Report presented by: **Carolyn Green**
Director of Nursing & Patient Experience
John Sykes
Medical Director

Report prepared by: **Carolyn Green**

Quality Position Statement

1. Safety – Staffing

Safety –National Quality Board have requested all NHS Trusts to consider in their safer staffing reviews the newly published guidance as an improvement resource which was published in January 2018. We have reviewed the guidance and our summary is contained within this report. We believe we exceed compliance in the methodology and detailed analysis will be provided to the Quality Committee.



Every day, twenty fours a day we publish our current staffing and our fill rates. Our Trust is committed to openness, transparency and new ideas in an effective skill mix in our in-patient settings. The staffing review methodology makes a number of recommendations. The following highlight reports assesses the Trust compliance with the recommendation's in its operations.

Recommendation	Rating
RIGHT STAFF - The organisation has systems to monitor staffing requirements across all services (based on acuity and demand) and all these are measured and reviewed against actual team staffing levels.	Retrospectively not proactively. Staffing dashboard
There is an agreed process for escalating to the board significant issues that affect safe and sustainable staffing.	
Staffing reports take account of local contextual factors which affect safe delivery of services.	
The annually agreed uplift (headroom) percentage reflects organisational needs, is practical and is achieved.	To be reviewed in 2018
Clinical leaders and managers have allocated sufficient time to supervise and lead effectively.	Additional resources added to supplement teams
The annual review of safe sustainable staffing references benchmarking data available to the organisation (both internal and external).	

Recommendation	Rating
RIGHT SKILLS - Processes are in place to identify, analyse and implement evidence-based practice across services.	
Where new care models are developed, a clear plan exists for organisational development support to enable such change to take place safely and affordably and these plans are evaluated (see the national leadership framework for system leadership competencies (*Developing people – improving care*).	
An evidence-based approach in the organisation supports effective team working.	
Systems and processes are in place to promote staff wellbeing and prevent fatigue and burnout.	
The organisation has a clear strategy for staff retention, which clearly states learning and development opportunities for all staff groups, and plans for attracting, recruiting and retaining staff that are aligned with the workforce plan.	People strategy and projects- RETAIN
RIGHT PLACE AND TIME – Standard approaches across services identify and prevent unwarranted clinical variation in service provision.	
Technology is available to staff to allow them to undertake their duties safely, efficiently and effectively.	EPR with further improvements
Embedded quality improvement methods enable clinical teams to identify waste and make changes at service level to improve quality.	RED TO GREEN and other methods
Regular reviews of shift patterns and e-rostering support the efficient delivery of care and treatment.	Further work on e-rostering
Thresholds for the use of bank and agency staffing are set, monitored and responded to, with temporary staff recruited wherever possible from in-house staffing banks.	
Service models and staffing deployment reflect demand, including seasonal or other variation (across seven day services where appropriate).	
Expectations of clinical and managerial leaders	
RIGHT STAFF - Use professional judgement, local quality dashboard data and evidence-based workforce tools (see Appendix 2) when deploying staff.	
Ensure the team has plans to use the workforce flexibly to respond to temporary, unknown and unplanned variations in service need.	
Regularly review the quality metrics and budget statements with a line manager to understand how unplanned need impacts sustainable, safe, effective, caring, responsive and well-led care.	
Consider how the team reflects and responds to the diversity of the people who use its service.	
Consider the involvement/employment of people with lived experience as peer workers to support the professional workforce.	Emerging, some pilots
RIGHT SKILLS - Ensure the clinical team's skills can sustainably meet the needs of people who use services, by completing an annual team-level training needs analysis and evaluation.	Emerging

Recommendation	Rating
Develop the team using clear objectives and outcomes agreed by the multidisciplinary team (in line with the evidence base for effective team working).	Emerging
Support clinical staff to embed and evaluate quality improvements and innovations to improve service delivery.	RED to GREEN and other methods
Acknowledge and celebrate team members' achievements.	
Be aware of and respond to indicators of reduced staff resilience and increased stress.	
Ensure access to and uptake of supervision and reflective practice, and check that they are facilitated and monitored.	Some improvement of up-take in hotspot areas
Involve experts by experience in the selection of staff.	
RIGHT PLACE AND TIME - Review local systems and processes to ensure they are lean and responsive to the needs of people who use mental health services.	
Identify and prevent unwarranted variations in care and treatment, and implement plans to eliminate them.	Practice audits
When planning staffing and caseloads, consider (and plan to minimise) community teams' travel time.	
Review the use of technology to ensure it enables staff to work remotely, efficiently and safely.	Emerging
Ensure staff rosters are used in line with local and national procedural guidance.	Further work on eroster
Ensure bank and agency staff have the appropriate clinical skills to meet the needs of people who use mental health services.	
Ensure bank and agency staff receive an effective local induction.	
Identify over-dependence on bank and agency staffing, and reduce it.	
Ensure enhanced observations have the right checks and balances to ensure the resource being used is appropriate and efficiently and effectively deployed with minimum restriction for the service user.	

2. Our work toward meeting The National Requirements as outlined by the National Quality Board

The requirements were to publish our 'Learning from Deaths' policy, to publish our learning from deaths mortality report and include in our 2018-2019 Quality Account and review of our annual data.

We can confirm compliance with our policy in September. We can confirm compliance with our mortality report published on 31 December 2017 and the report is available in full on the Trust website and at the end of this report.

Progress on mortality reviews - An information sharing agreement has recently been achieved with NHS Digital so that the Trust should now receive the cause of death for all patients that have been in contact with us within the 6 months prior to their demise. This will enable us to enhance our data analysis to compare death rates and causes to the background population. Trends and variance will be identified which will enable interpretation and recommendations to be made.

The individual case reviews have been piloted and a review tool developed. A recruitment process has begun for medical mortality reviewers.

The serious incident review process has been streamlined and redefined with a strategic group to identify themes and trends from SI investigations and an operational group concentrating on fidelity of process around the individual reports. The Trust is undertaking mortality reviews and learning from this first cluster of mortality reviews will be published next month.

http://www.derbyshirehealthcareft.nhs.uk/about-us/publications

Actions: We will publish in our annual accounts in the Quality account the required data as specified by the national guidance and we have already included learning from mortality in our quality dashboard. This remains on trajectory for completion.

The Executive Lead for this work is Dr John Sykes and this will be monitored in the Quality Committee.

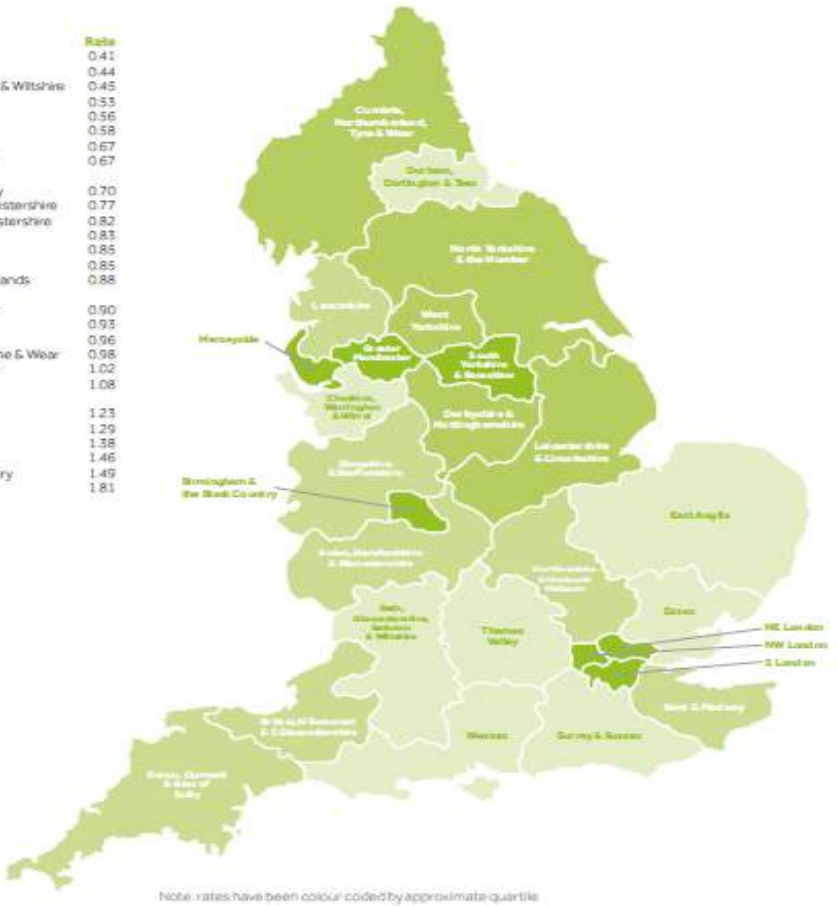
The publication of the National inquiry into Mental Health Homicides, suicides and wider learning. The National Inquiry into Suicides and Homicides has been published and the lessons learned for this will be incorporated into our local initiatives which are described below.

Variation in homicide convictions by area of residence (NHS England Area Teams)

104. Homicide conviction rates varied by area of residence (by NHS England Area Team) (average rate 2013-2015). The highest rate was in North East London at 1.81 per 100,000 population, and the lowest in Thames Valley at 0.41 per 100,000 (Figure 29).

Figure 29: Rates of homicide convictions per 100,000 population by NHS area of residence (average rate 2013-2015)

Area	Rate
Thames Valley	0.41
Surrey & Sussex	0.44
Bath, Gloucestershire, Swindon & Wiltshire	0.45
East Anglia	0.53
Essex	0.56
Wessex	0.58
Durham, Darlington & Tees	0.67
Cheshire, Warrington & Wirral	0.67
Devon, Cornwall & Isles of Scilly	0.70
Bristol, N Somerset & S Gloucestershire	0.77
Arden, Herefordshire & Worcestershire	0.82
Kent & Medway	0.83
Lancashire	0.85
Shropshire & Staffordshire	0.85
Hertfordshire & the South Midlands	0.88
North Yorkshire & the Humber	0.90
Greater Manchester	0.93
Leicestershire & Lincolnshire	0.96
Cumbria, Northumberland, Tyne & Wear	0.98
Derbyshire & Nottinghamshire	1.02
West Yorkshire	1.08
North West London	1.23
Merseyside	1.29
South London	1.38
South Yorkshire & Bassetlaw	1.46
Birmingham & the Black Country	1.49
North East London	1.81



Note: rates have been colour coded by approximate quartile

There was a cluster of mental health related homicides in the Trust in 2017. The details of these cases cannot be published in depth due to on-going police investigations and or court proceedings.

The national report, reports data through the year of conviction not the year of the offence or occurrence. Mental Health homicides are analysed over three year periods to see trends. The chart is a longer period to show the incidence over a longer period, due to the lower number of occurences.

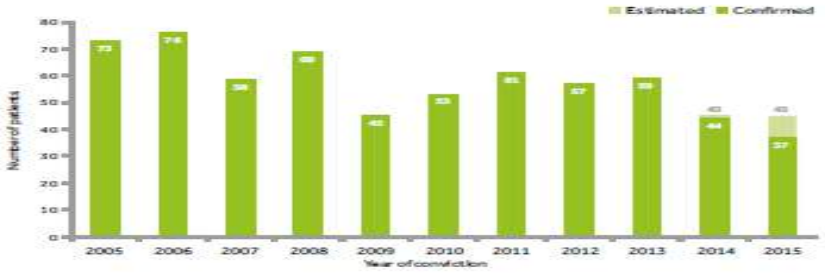


Figure 30: Number of patient homicides in England

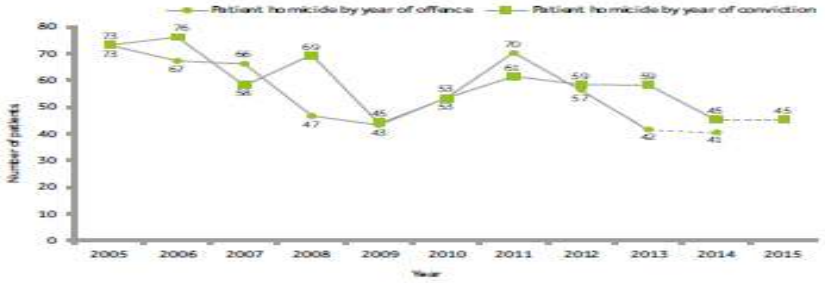


Figure 31: Number of patient homicides in England, by year of offence and year of conviction
Note: homicide numbers by year of offence for 2015 are not provided due to incomplete data

Social and clinical characteristics of homicide offenders

111. Table 2 shows the main social, clinical and offence features of patients convicted of homicide. These patients had high rates of social adversity, e.g. unemployment. Over half had a history of violence or self-harm and co-morbidities were common. Half of the patients were convicted of murder and the majority received a custodial sentence. There was a fall in homicides by those convicted of manslaughter (other including provocation, self-defence) over the report period.

112. The most common primary diagnosis was schizophrenia and other delusional disorders (Figure 32).

These coincided with the publication of the NHS England commissioned independent reports into two historical homicides from 2010 and 2013. Since then NHS England has commissioned an independent report into a near-miss homicide following concerns raised by the Trust around prison releases and the lack of a dedicated community forensic team in Derbyshire. Commissioners have recently confirmed that there will now be funding available to establish such a service.

The mainstay of homicide prevention in general services is the Care Programmes Approach underpinned by capacity assessments, risk assessments and safety planning. Our approach to CPA has been revised to be fully compliant with the latest guidelines and implementation will be supported by training, compliance checks and audit.

There has been a significant improvement in the application of the Mental Capacity Act in inpatient units following extensive practice development and quality improvement measures. The focus is now shifting to the community.

Safety planning has been rolled out and is progressing with real time feedback and development from clinical staff to ensure longitudinal analysis of risk. The focus is now shifting to compliance checking and audit to continually improve clinical practice. The risk profile of individuals is key to effective clinical

management and the six hundred and forty two mental health patient homicides are analysed to demonstrate risk history. It is evident that individual risk profiling is not a preventative strategy in homicides as a substantial level of individuals have a risk profile but would be statistically unlikely to go onto commit this level of crime. In addition just over thirty per cent of cases had no previous history of a forensic offence (Prison or Forensic service). However over a decade over eighty per cent of cases had co-morbid substance misuse and mental health conditions.

Table 2: Characteristics of patient homicide offenders in England (2005-2015)

	Number =641 Number	%
Demographic features:		
Age: median (range)	32 (13-83)	
Male	548	85
Not currently married	301 /375	80
Living alone	102 /338	30
Unemployed/on long-term sick	301 /366	82
Black and minority ethnic group	122	19
Homeless	26 /349	7
Behavioural features:		
History of self-harm	308	50
History of violence	332	53
Any previous convictions	469	77
History of alcohol misuse	455	73
History of drug misuse	489	78
Abnormal mental state at the time of offence	229	36
Offence variables:		
Age of victim: median (range)	43 (0-89)	
Male victim	438	68
Victim was a stranger	93	16
Sharp instrument used	345	56
Final Outcome:		
Murder	325	51
Manslaughter (diminished responsibility)	104	16
Manslaughter (other including provocation, self-defence)	196	31
Infanticide	4	1
Unfit to plead/not guilty by reason of insanity	12	2
Sentencing Outcome:		
Prison	468	73
Hospital order (with or without restriction)	153	24
Other non-custodial sentence	17	3

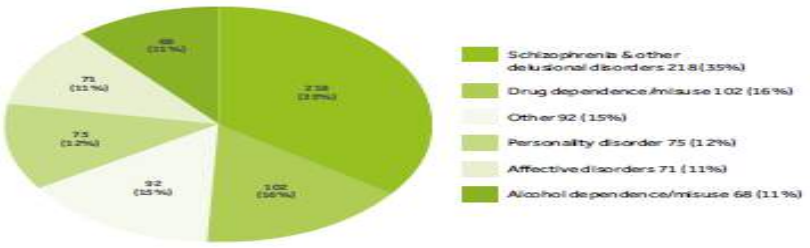


Figure 12: Patient homicide in England: primary psychiatric diagnosis

The above initiatives are supported by development of the electronic patient record and consideration is being given to the appointment of a Chief Clinical Information Officer (CCIO). In addition there has been specific work around aspects of the Mental Health Act with the forensic focus.

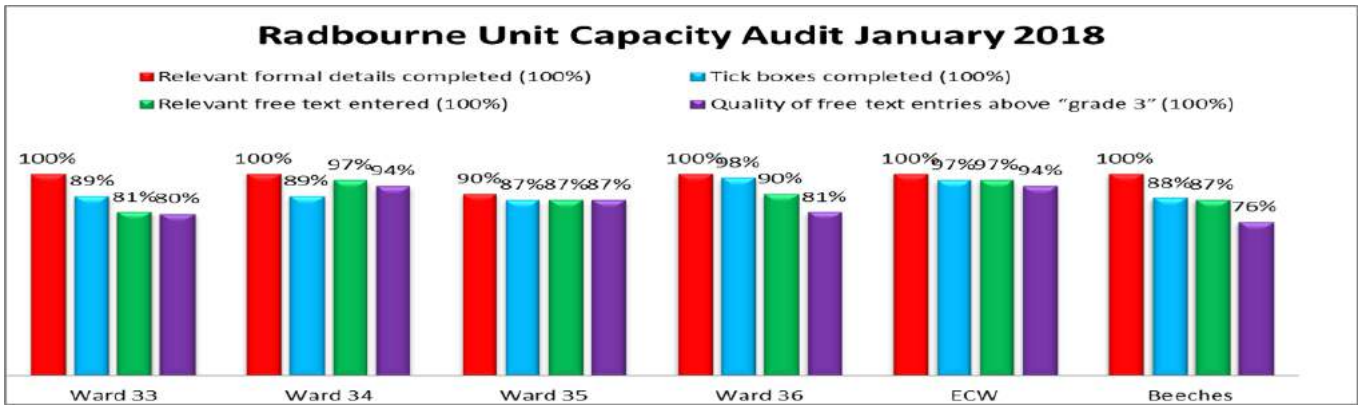
- All sections 37/41s have been audited and re-audited as part of a quality improvement cycle. This work has been presented to the Mental Health Act committee and its new Operational Group. A register of section 37/41s is held by the Mental Health Act office.
- Ongoing compliance checking with community treatment orders has seen an improvement in compliance and a re-audit is due in the next few months.

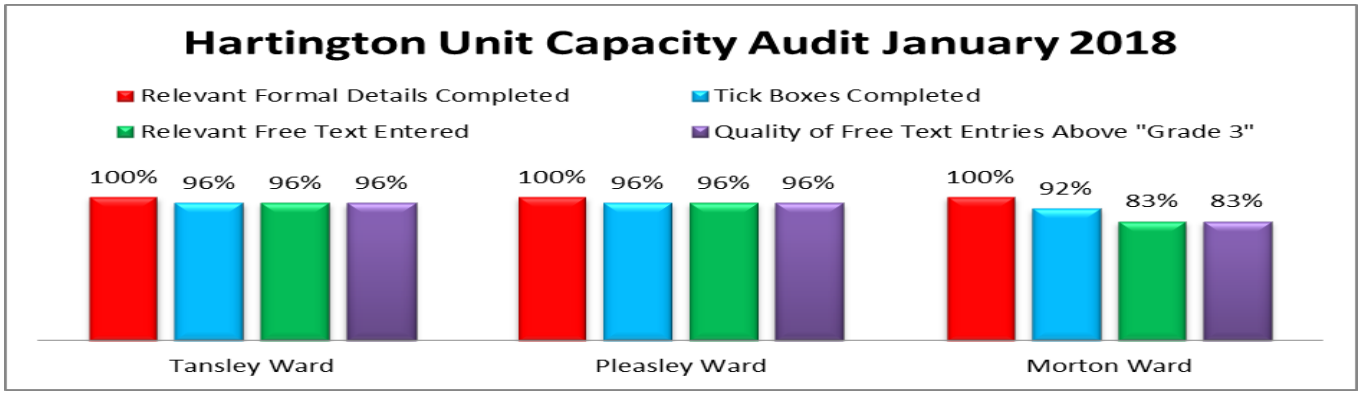
- Consultant caseload reviews have been conducted in those areas where homicides clustered and recommendations for a 'healthy caseload' approach is being made to the Trust Management Team and will inform the neighbourhood review and medical workforce review.
- In addition there has been a peer review of our overall processes and oversight commissioned from a forensic psychiatrist and Medical Director and a Nurse Consultant with extensive experience in Serious Incidents investigations.
- The outcome of the individual SI investigations are on trajectory for completion.

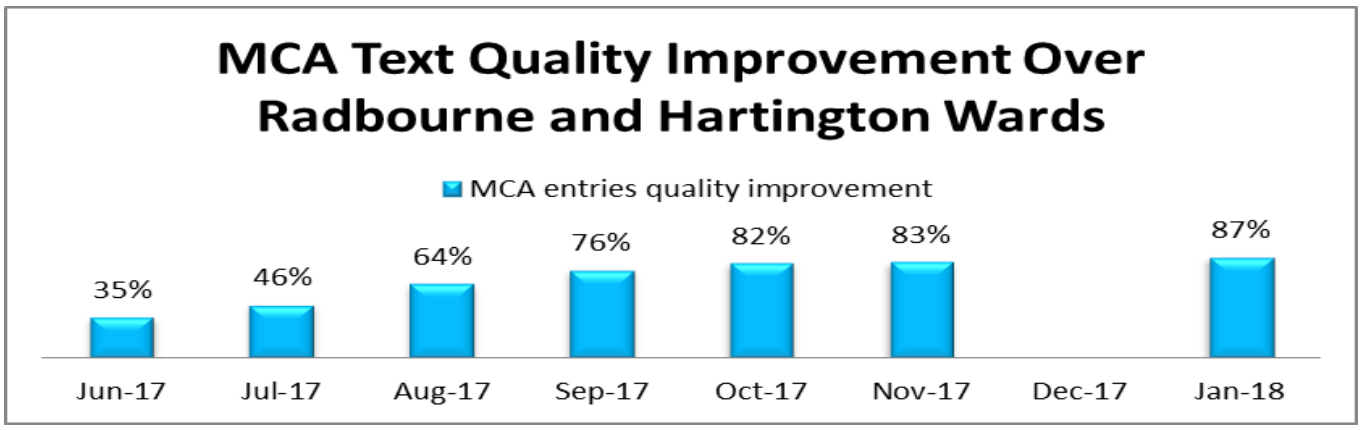
The Executive Lead for this work is Dr John Sykes and this will be monitored in the Quality Committee.

3. Responsiveness

Decision making and mental capacity. Are we learning and improving?







We can also confirm the following on the Kingsway site wards:

- Scores are comparable with those achieved during full audit of Sept/Oct 2017. Apart from one instance, scores on all measures were either maintained or improved on second and third reviews.

- All wards scored 100% for the QUALITY of their free text entries (i.e. on average each ward scored higher than 3-or-above, the score for quality which is deemed acceptable). Throughout the audit period the span of average quality scores ranged from 3.13 – 4-75 with a mean of 3.88.

- Of the staff groups completing the "Record of Capacity to Consent" EPR forms, junior medical staff scored within the lower ranges of the rating scale in the earlier spot checks. Since then it is to be noted that the standard of entries made by junior Doctors had improved. Consultants, Nurses, Psychologists and Physiotherapists continue to show high rates of compliance with all audit scores.

Action

- Continued support and training for all staff to maintain generally positive results led by clinical leads.

- Further encouragement to junior medical staff to promote better quality free text entries

The message to our teams from the clinical leads - Finally let me thank you all for your hard work in difficult times. The month on month improvements despite adversity are testament to your commitment, integrity and leadership as staff.

3. Well Led – Developing Our Workforce

A Care Certificate market stall is available for all new healthcare support workers where they can meet the Care Certificate Facilitator who will give them information on the Care Certificate Framework and the 15 Standards, and the Code of Conduct for Health and Social Care Support Workers.

Care Certificate Workshop

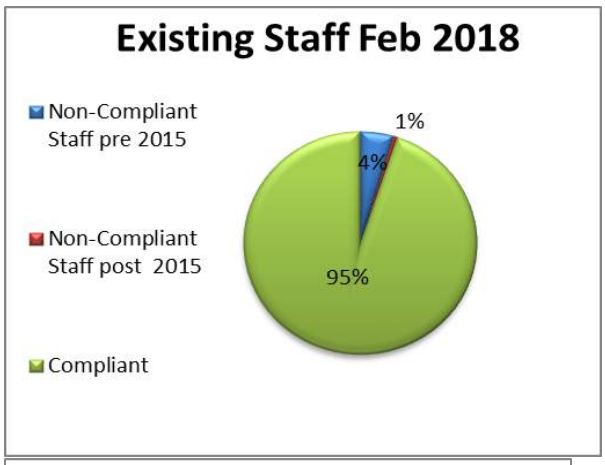
- The Care Certificate and how it can support staff in their career development, their role and in identifying knowledge gaps.
- Interactive activities including group discussions and videos.
- Covers 9 of the Care Certificate standards.
- Team participation using the Care Certificate game, which is an innovative practical learning tool endorsed by Health Education England.
- Share experiences of compassion, care, dignity and values in their day to day work and to help the Trust provide the best care possible to patients and carers.
- Identify compassionate behaviours that reflect the Code of Conduct for Healthcare Support Workers.
- Good and bad practice.
- Lessons learnt from the Francis Report
- Complete the e-learning so they are compliant (if they have previous care experience).

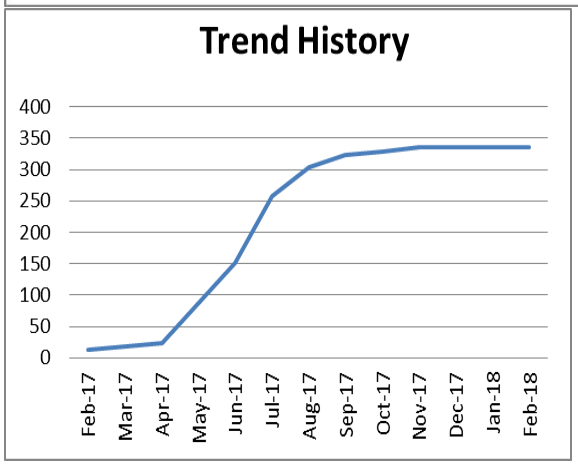
This includes group discussions about Understanding Your Role, Duty of Care and the following videos:

1. The launch of the Care Certificate.
2. Robert Francis - Lessons Learnt interview.
3. Dignity - The Tale of Two Wards film depicting good and bad practice in one hospital.

Strengthening the Compassionate Care Culture (SCCC) Workshop

This workshop is run from a service user's perspective and is for staff to share their experiences and stories of compassion, care, dignity and values in their day to day work and to help the Trust provide the best care possible to patients and carers. They will be able to identify compassionate behaviours that reflect the Code of Practice and Trust values. Six of the Care Certificate standards can be used as evidence by attending this workshop for those completing the 12 week Care Certificate programme.





Are staff completing this analysis and trend? Yes they are.

5. **Well Led - Care Quality Commission Comprehensive – Completing Our Action**

The performance this month has been disappointing. We continue to have 14 remaining actions on the 2016 comprehensive plan and 4 remaining action on the 2017 plan. Leaders have not been able to make the requisite improvements and provide additional evidence in both appraisal, supervision and in some training areas.

There has not been enough sustained improvement in copies of care plans being evidence in the clinical record. There remains further evidence required in community mental health settings in the full and quality standards of assessment mental capacity act and care planning.

The residual areas, although improved are inconsistent and sustained improvement is required before completion of care pathway level outstanding recommendation's. There has been limited movement in February 2018.

Action

We continue to make progress on our CQC action and improvement plan and we will continue to ensure that these recommendations and final actions are fully delivered. We look forward to meeting all of our essential standards and

providing maintenance of our compliance levels to refocus our attentions to continuous quality improvement, innovations and solution focused approach to our staff and community.

Report prepared by:	**John Sykes** **Medical Director and** **Carolyn Green** **Director of Nursing and Patient Experience**
Report presented by:	**John Sykes** **Medical Director and** **Carolyn Green** **Director of Nursing and Patient Experience**

Board Committee Summary Report to Trust Board
Safeguarding Committee - meeting held 2 February 2018

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Minutes and Actions matrix	Agreed and ratified Adjustments to minute in wording of safeguarding support.	Good assurance	Discussion regarding increases in thresholds Matters arising on impact of concerns re poverty. Challenge on public protection page development - positive support.	Minutes ratified	
Attendance Log	Good attendance.	Significant assurance	None		
Policy matrix	All policies in data on target	Significant assurance	None	None	
Terms of reference	Review and challenging on think family and family practice		NEDS and safeguarding training, Level 1,2,3. Level 3 training. Changes vulnerable to adults at risk	Workshops on learning 3, learning events and planning. Board development session on social media and a case scenario to be factored into Board Development programme	
Safeguarding effectiveness review	Attendance by Medical Director. Deputise on the spot. Lack of assurance on	Discussion	To be reviewed by Board Committee Chairs and attendance. ELT attendance and	CG to complete. AW to review Circulation first two weeks of April	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	attendance. Concern re attendance, and review.		director representation. Safeguarding children reference	 Mid April – circulation (17/18)	
Safeguarding children's reports	Audit – emerging and new communities. The impact of a new emerging community team and this service was disinvested by commissioners. Review of full report- AE17- not Trust report- was discussed for learning of young people with Autism. Gap- in service- Tier 4 forensic service. exploration of mitigation / risks. Discussion re children's dashboard / ethnicity and disability. To include trend-line Changes to Working together (2018) - summary. Changes to safeguarding partner's model and 12 month transition period. Sustained improvement in medical compliance – is	Discussion re the report Significant assurance on procedures Training– limited assurance Risks re school nursing Safeguarding outcomes – limited assurance due to significant population risks	Future and board session from Public Health Derby City and the referral centre. The health risks – access and adaptability of services/ for extended cultural services and direct need. Action to be reviewed, with Childrens services. Further discussions with children's commissioners for substantial need, on-going meetings Red rated risks in CQC on care co-ordination – delays due to extended capacity and demand Benchmarking – national is limited Population and reverse commissioning / overlay population. Sickness- of safeguarding trainer impacted on	Review of Safeguarding children – multi-agency strategy review to be shared with the community. New and emerging communities, clinical risks and plans.to be reviewed by the operational group. Assurance risks- must meet 85%/ TMT to monitor with education monitoring sub groups	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	maintained. Review of benchmarking – with East London and City annual report- no changes. Dashboard – to presented quartley		performance. Investment by Trust in training Risks – reduced training by safeguarding board. Some mitigation risks. Level 4 risks – improvement work- April meeting / scheduled. Risks re school nursing about risks- capacity and demand. Impacting upon safeguarding model. Careful management of the issues. Clinical risks of quality standards. A position paper on school nursing practice standards specifically around safeguarding and risks of next meeting.		
SEND	Key report on risks to legal requirements	Limited assurance	Risks and tensions re SEND EHCP plan Significant improvements in paediatric waiting times Legal compliance Level 1 and Level 2 compliance – convergings. For next time are we maintain our legal compliance.	For review of compliance of SEND through TMT	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Safeguarding Adult	Full report presented Carers and Quality improvement plan as new ideas and involvement. High activity- MASH Adult activity / higher than Children, Review of AC and AC male plans- actions remain on trajectory. Clinical review and development of CPA policy	Significant assurance- on procedures Limited assurance – PREVENT training off target	Significant risks in Domestic violence and in issues PREVENT activity remains high Safeguarding Adults – PREVENT- 85% PRVENT awareness – 75% must meet required level at 85% Monthly review and loss theft./ report on risks and issues. Learning from Bradbury- review of systems and process/ action plan in place.	TMT for PREVENT training to hit target. Letter re unify issues and dashboard/ PRVENT people being seen within 1/52 Non recent abuse strategy. Appointment of Dr Wendy Brown as a named Dr for Safeguarding adults	
Forward plan	Review of Safeguarding strategy Reviewing of strategy- new and emerging			Action – Carolyn Green draft forward plan	
Board Assurance Framework	Escalations from safeguarding committee Three issues to be added to risk register Capacity / Training/ Community forensic	Full assurance	Risk and mitigation and additions to Board assurance framework	Agreed	.

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Meeting effectiveness	Attendance from external participants/ observers Feedback on Key/ high level points. Discussion and presentation. Descriptors on numbers / add to assurance. Stay for your own section- only.	Continue work on assurance level	None	None	

Board Committee Summary Report to Trust Board
Quality Committee - meeting held 8 February 2018

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Minutes and Actions matrix	Agreed and ratified		Risks with some overdue actions that need further information updated. Update on new model of carers in quality improvement.		
Matters arising Actions Matrix	Matters arising- Audit feedback on observation Hate crime and racism – staff response				
Attendance Log	Agreed, in order				
Policy matrix	Agreed and assurance plan for forward planning		Agreed		
Summary of BAF risks for the Quality Committee	Update on escalation of risks associated with non-commissioned community forensic service. Staff violence. Positive and safe, 6 monthly review.	Progress on an integrated model Significant on process Limited assurance on the process.	Significant unmitigated risks continues. Risk mitigation plan, re: community forensic team, and commissioner investment - has been offered a proposal. CQC actions plan off trajectory and improvement	To include the BAF summary in next month's report. Discussion, on key areas and at Trust Board. Trajectory- April for investment. Quality impact assessment for CIP and QIPP disorder and June for completion of policy.	Request to Capital group to reconsider dormitories/ single sex, implications to ELT. BAF entry – Safety breach and Quality safety.

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Quality Dashboard: **- Internal analysis on interventions by ethnicity** **- Community waiting times (progress made over last 12 months)**	Improved performance CQC action plan Quality of response of complaints- addressed the complaint, not defensive. Responsiveness is improving	Significant assurance on model and monitoring Limited assurance specifically the CQC actions and outcomes. Change to the health service ombudsman completed.	CQC actions some residual issues Discussion re the risks and plans. TMT to focus on residual risks. Residual actions for 2018 not completed. Off trajectory for completion, expected timescale in April 2018 Hate crime and agreed actions were confirmed.	Agreed actions and recommendations.	
Embeddedness and Quality governance and improvement action plan	Evidence of improved effectiveness	Agreed as completed as green actions. Limited assurance	Agreed the COATS are functioning and not ineffective. Committee's current opinion is improving effectiveness	Agreed actions and recommendations.	
COAT- summary	Improved performance	Limited assurance as emerging.	Improving performance		
Suicide prevention strategy and group	Review of the strategy, against key priorities on trajectory. Good performance Training – 72% training compliance. Against a planned trajectory of 70%.	Significant assurance	None noted Positive impact.	Agreed To undertake an article for practice matters and or a CONNECT trust leaflet. To brief staff. Follow up paper on safety planning	
Serious incident reporting.	Review of information Contractual performance	Significant assurance Limited assurance	Develop bar chart and trend lines	Next meeting – full analysis and mortality	Please note the contractual notice has

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	notice- has been lifted in January Additional exploration of the alcohol rate in 8 weeks' time Additional exploration of homicide rate and assurance summary.		Risks and NRLS and full risk reporting for future information. Agreement for late report for next report	against CQC actions for the next quality committee	been lifted and completed. Well led recommendation
Health and Safety report	Improved performance on fire training. For investment. Foresight on the impact of Grenfell and sprinklers. Realigning with NHS protect/ fraud standards reviewed to include security and theft guidance Challenge on staff incidents of violence and convictions	Significant assurance on all three areas of reports. Significant 6 sanctions – fines and prison sentences. Have been achieved in the last quarter. Assurance received	Weighing up the risks and benefits of self-harm / ligature points versus a sprinkler model	Positive report	
Use of force and bill – impact on strategic intent	Foresight, on potential risks and watching briefing. Improvement work on admissions and staff relationships. Led by Heads of Nursing.	Future strategic changes in practice and policy Briefing on assurance	Future strategic risks, links to Mental Health Act, Buildings and estate. CCTV cameras in seclusion room and potential body cameras	Watching brief on implications for practice. This may mean that we need to continue Quality priorities of positive and safe.	
Quality committee – effectiveness - survey	SMART survey actions and members suggested for completion.	Can we request feedback on attendees?		Request feedback from Mark Broadhurst	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	Members or attendees.				
Any other business	None				
Items for escalation to Board or other Committees	No additional items				
Consideration of any items affecting the BAF	Changes to CQC standards on dormitories and single sex, for 1a risk.				
Forward Plan and draft agenda for February meeting	Review and plans, of Trust priorities. Agreed plan				
Meeting effectiveness (members only)	Timing and outcome Discussion re challenge at Board and Trust Effectiveness on issues Discussion re Trust strategy and decisions Review of Quality Committee				

Board Committee Summary Report to Trust Board
Mental Health Act Committee - meeting held 15 February 2018

Key items discussed

- Terms of Reference for Mental Health Act Committee (MHAC) and MHAC Operational Group
- MHA Manager's Report and associated actions
- Outcome of audits
  - Consent to inpatient treatment (S58)
  - Consent to community treatment/care plan
- Update on compliance re seclusion and rapid tranquillisation
- Training compliance and trajectory
- Ratification of S136 Policies – compliant with Police and Crime Bill

Assurance/lack of assurance obtained

- Terms of Reference require further work outside of meeting. Some confusion arose due to lack of version control – for discussion at ELT
- MHA Manager's Report:
  - No significant variance by ethnic grouping over a 12 month period is apparent. This is consistent with other REGARDS analysis based on 2 year data. The overall number of MHA assessments in Derby City has decreased over a 3 year period
  - Derby Council is in steady state over the same period
  - The number of S136 assessments has significantly decreased presumably as the result of police liaison/mental health triage
  - A small number of patients can account for a significant variance in the use of seclusion/rapid tranquillisation – Heads of Nursing are supporting/challenging/coaching
  - Significant assurance of CTO rights compliance
  - A discrepancy in the DoLS conversion rate proved to be spurious
  - Significant assurance re DoLS process from Trust but LAs overwhelmed with demand leaving Trust with liability
- Consent to treatment S58:
  - Significant assurance re patients covered – 100% on re-analysis of data
  - Limited assurance re quality of assessments – remedial action plan approved with re-audit
- Consent to treatment/care plans in community:
  - Limited assurance. Action plan in place
- Rapid tranquillisation:
  - Limited assurance. Confirmation required that electronic system to support rolling audit is in place
- Seclusion:
  - Limited assurance that least restrictive practices are being employed
  - This is due to poor quality of clinical records – both nursing and medical
  - Heads of nurses actively engaged in ensuring practice development and recording

- Training:
  - Significant assurance re MCA training compliance – ahead of trajectory
  - But limited assurance re newer MHA/DoLS training – trajectory required
  - Where practice development leads/medical leads have been regularly engaged with clinical teams there is a corresponding improvement in compliance and quality. The reverse is also true

Key risks identified

- CQC compliance may work on absolute terms so limited assurance is cold comfort. The solution is redeployment of practice development workers allied to focussed training but will inpatient improvement be retained as they refocus their efforts into community settings?

- The recurrent theme of CQC 2017 site inspections suggest limited ownership of the issues at team/unit level. The themes are:
  - S17 leave forms/process
  - Patient involvement in care plans
  - Recording of consent supported by capacity assessments for the above

Decisions made

- Action plans including re-audits noted and agreed
- To develop work plan of Operational group
- S136 Policies ratified
- BAF reviewed – still high risk due to absolute nature of compliance required despite significant progress in training and inpatient areas

Escalations to Board or other committee

None

Committee Chair: Anne Wright	**Executive Lead: John Sykes, Medical Director**

Derbyshire Adult Eating Disorders Service and South Derbyshire CAMHS Eating Disorders Service

Dr Joanna Miatt, Consultant Psychologist – Adult EDS

Elizabeth Banahan, Team Manager- CAMHS EDS

Adult EDS

- Developed 2007 , covering Derbyshire
- Team expanded 2010/11
- Eligibility criteria:- Mainly BMI 16.9 and below.
- MDT
- Offering a range of treatments
- Aim to improve the health and well being of clients with eating disorders
- 128 Clients currently in treatment approximately 10 wte clinical staff
- Current maximum waiting time less than 4 weeks

CAMHS EDS

- Developed 2016
- Eligibility criteria young people with an diagnosable eating disorder
- MDT
- Aim to reduce inpatient admissions and improve the health and well being of young people with eating disorders
- Offering a range of therapeutic treatments
- Caseload 72 (able to accept 75), 6.7wte clinical
- Meeting the access to waiting time standards (1 week for urgent cases 4 weeks for routine cases)

CQC Feedback

- Meets 5 Quality standards:-
  - Well led — Key performance indicators (padr's Supervision , waiting times etc.)
  - Caring — Good feedback from service users
  - Effective — NICE recommended treatments and innovative practice
  - Responsive — Clients seen locally (Adult)
Flexible working 8am-8pm(CAMHS)
Partnerships with First steps
Self referrals (CAMHS)
Individually tailored timely interventions
  - Safe — Physical health prioritised,
Capacity to consent considered,
Close partnership with Gastroenterologists

Highlights

- CAMHS –Reduction in inpatient admissions.
  High level of skills/training.
  Multi Family Therapy.
- Adult- Gastroenterology joint working
- Both Partnership working (first steps , paediatrics, specialist inpatient units)

  Transitions between the teams (link workers/ joint working)

  Ability to reflect and learn

Joint working

- Clinical Reference group for Eating Disorders
- RO-DBT
- Training
- Supervision
- Awareness raising
- MFT
- Transitions

Challenges

- Small size and Specialist nature (both teams)
- Access criteria (adult team)
- Moving on to other services (adult team)
- Outcome measures
- Clinical Accommodation
- Recruitment

Future developments

- Proposal for the commissioners around expanding the adult service
- Consolidation (CAMHS)
- Managing staff changes

Derbyshire Healthcare NHS Foundation Trust
Report to the Trust Board – 28 February 2018

Proposed Changes to the Trust's Constitution

Purpose of Report

Amendments to the Trust's constitution require the approval of both the Council of Governors and the Trust Board.

This paper requests the Trust Board to approve changes to the constitution, previously approved by the Council of Governors at its meeting on 24 January 2018.

Executive Summary

The Constitution is one of the most important documents within any foundation trust (FT) and all FTs are required to have one. The constitution is an organisation's governing document. It is a set of fundamental principles and processes according to which the foundation trust is governed and contains detailed information about how the trust will operate. It sets out, for example, the Trust's membership area, gives information on the various membership constituencies, and determines the size and composition of the Trust Board and Council of Governors (COG). It also prescribes the rules by which any election to the CoG is to be conducted. Having clear rules about how the organisation operates gives reassurance to patients and service users that the governance of the Trust is sound. All constitutions must comply with statutory requirements (those set out in legislation, such as the National Health Service Act 2006 and the Health and Social Care Act 2012) and therefore some of the content is consistent across all foundation trusts. Legislation also specifies a number of items that must appear within all FT constitutions. FTs are required, both in law and as part of their provider licence, to inform the regulator of the changes. A summary of the changes proposed are listed below. They are also attached illustrating the changes between the current text and proposed text:

- Public Constituency Changes
- Staff Constituency Change
- Partnership Organisations Change
- Composition of the Council of Governors Change – proposed changes to constituencies and composition were approved by Governance Committee on 6 December. The addition of two staff governors will not cause publicly elected governors to be outweighed in terms of representation
- Increasing quorum of the Council of Governors from 20% to one third, with a minimum of six – approved by Governance Committee on 6 December
- Decreasing the number of governors to terminate tenure of a governor from 75% to 70% - proposed by Lead Governor and agreed by Governance Committee on 3 July 2017
- Increasing the membership of the Governors Nominations & Remuneration Committee by one public and one staff governor (previously approved by Council of Governors on 18 July 2017 and introduced with immediate effect)

- Significant transactions
- Equality best practice – removing references to gender – in response to a request by governors
- Regulatory body changes - 'Monitor' will be amended to National Health Service Improvement (NHSI) unless specific to Acts or Publications

Strategic Considerations	
1) We will deliver **quality** in everything we do providing safe, effective and service user centred care	x
2) We will develop strong, effective, credible and sustainable **partnerships** with key stakeholders to deliver care in the right place at the right time	x
3) We will develop our **people** to allow them to be innovative, empowered, engaged and motivated. We will retain and attract the best staff.	x
4) We will **transform** services to achieve long-term financial sustainability.	x

Assurances

Changes will be made to the Constitution in line with guidance.

Consultation

Amendments have been reviewed by the Governance Committee and approved by the Council of Governors.

The final draft of the revised document must be submitted to both the Board and the Council of Governors for approval. There is no requirement for this to be done in any particular order – the only requirement is that both groups approve the document by majority vote. This means, provided the meetings are quorate, more than half of those present at each meeting must vote to approve the changes. It is not possible for the Board or Council to delegate responsibility for approval to a working group or committee; any changes must be approved by the Board and Council. If either the Board or the Council (or both) do not approve the changes, they do not take effect and the existing constitution remains in force.

Governance or Legal Issues

Changes are proposed in line with the Constitution:

39. Amendment of the Constitution

39.1 The Trust may make amendments of its Constitution only if:

39.1.1 more than half of the members of the Council of Governors voting approve the amendments, and

39.1.2 more than half of the members of the Board of Directors voting approve the amendments.

39.2 Amendments made under paragraph 39.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with Schedule 7 of the 2006 Act.

39.3 Where an amendment is made to the Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

39.3.1 at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

39.3.2 the Trust must give the Members an opportunity to vote on whether they approve the amendment.

39.4 If more than half of the Members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

39.5 Amendments by the Trust of its Constitution are to be notified to Monitor. For the avoidance of doubt, Monitor's functions do not include a power or duty to determine whether or not the Constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people).

There are no adverse effects on people with protected characteristics (REGARDS).	x
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential gaps/inequalities are outlined below, with the appropriate action to mitigate or minimise those risks.	

Actions to Mitigate/Minimise Identified Risks – not applicable

Recommendations

The Trust Board is requested to:

1. Consider and endorse the proposed changes to the Constitution, previously approved by the Council of Governors on 24 January 2018:
   - Public Constituency
   - Staff Constituency
   - Partnership Organisations
   - Composition of the Council of Governors
   - Quorum
   - Termination of Tenure

- Membership of Governors Nominations & Remuneration Committee
- Significant transactions
- Equality best practice
- Regulatory body changes.

2. Acknowledge that changing the termination of tenure voting will require a change to the Code of Conduct for the Council of Governors.

3. Note that once the Board has approved and endorsed the changes as agreed by the Council of Governors, the changes take immediate effect. The revised Constitution will be circulated to all directors and governors for information, and a copy sent to the regulator within 28 days of approval (this is the later of the two dates on which the Board and Council approved the changes). Copies on the Trust's website should also be updated.

4. Note that the changes to the composition of our Council of Governors (amendments to constituencies and an increase of staff governors) require presentation to the next Annual Members Meeting.

5. Note that the change to the powers of the Council of Governors related to quorum and termination of tenure require presentation to an Annual Members Meeting by a member of the Council of Governors where members will be given the opportunity to vote on whether they approve the amendment.

6. Please note that should governors and/or members not agree with the changes regarding composition and powers as presented at the Annual Members Meeting, the Trust will revert back to the previous version of the Constitution.

Report presented by:	**Sam Harrison, Director of Corporate Affairs & Trust Secretary**
Report prepared by:	**Sam Harrison, Director of Corporate Affairs & Trust Secretary** **Donna Cameron, Assistant Trust Secretary** **Denise Baxendale, Communications & Involvement Manager**

THE PUBLIC CONSTITUENCY

Annex 1 of the Constitution – The Public Constituency

Over the past six years the Trust has struggled to gain interest from prospective governors in some geographical constituencies. Experience from other trusts who have developed their Constitution more recently than ours, indicate that larger geographical areas can often attract more interest and lead to contested elections.

On 6 December the Governance Committee looked at a variety of options to consider how this could be achieved within our Derbyshire and surrounding area constituencies.

Discussion took place on the size of some of the proposed constituencies and the benefits and drawbacks of larger and smaller constituencies. Governors suggested an additional fourth option to those suggested for public constituencies and decided to vote on their preferred option for each constituency. It was agreed that the following configurations were preferred by the majority of governors:

Public Constituencies

Current Public Constituencies	**Public Governors**	**Proposed Public Constituencies**	**Public Governors**
Amber Valley North Amber Valley South	1 (vacant) 1	Amber Valley	2
Erewash North Erewash South	1 1	Erewash	2
Bolsover North East Derbyshire	1 1 (vacant)	Bolsover & North East Derbyshire	2
Chesterfield North Chesterfield South	1 1	Chesterfield	2
Derby City East	2	Derby City East	2
Derby City West	2	Derby City West	2
Derbyshire Dales High Peak	1 1	High Peak & Derbyshire Dales	2
North East Derbyshire	1 (vacant)	No change	1
South Derbyshire	1	No change	1
*Surrounding Areas	1	No change	1

Minimum number of members per constituency will be updated to reflect the new constituency; numbers will be combined.

***Surrounding Areas**

During the recent recruitment process for a Non-Executive Director it became apparent that there was clarification required with regard to the ‘Surrounding Areas’ constituency as outlined in the Trust’s Constitution. For example the Constitution includes counties that border with Derbyshire with the exception of Warwickshire and

West Yorkshire; and does not include the City Councils of Stoke on Trent, Nottingham, Leicester and Greater Manchester.

The Governance Committee on 6 December proposed that Surrounding Areas is extended to include all **regions,** including cities within them, that border Derbyshire including:

- East Midlands
- West Midlands
- Yorkshire and the Humber
- North West

STAFF CONSTITUENCY

Annex 2 of the Constitution – The Staff Constituency

Governors highlighted that they would like to review the staff membership constituency with a view to increasing the number of staff governors. This was reviewed at the Governance Committee on 6 December 2017 where it was proposed to increase the number of staff governors in order to provide additional capacity following feedback from existing staff governors and to split Nursing and Allied Professions constituencies. The proposed addition of two staff governors will not cause publicly elected governors to be outweighed in terms of representation which is a key element of the Constitution.

Current Staff Constituencies	**Staff Governors**	**Proposed Staff Constituencies**	**Staff Governors**
Medical and Dental	1	Medical and Dental	1
Nursing and Allied Professions	2	Nursing	2
Administration and Allied Support	1	Allied Professions	1
		Administration and Allied Support	2

PARTNERSHIP ORGANISATIONS

Annex 3 of the Constitution – Composition of the Council of Governors

The composition of the Council of Governors within the existing Constitution includes an appointed governor from Derbyshire Constabulary. Previous discussions on this subject have outlined that Derbyshire Constabulary no longer feel it is appropriate to identify an appointed governor and therefore it is appropriate to remove this post from the Constitution.

Please note there is no change to the Qualifying Local Authorities.

Current Partnership Organisations	Appointed Governor	Proposed Partnership Organisations	Appointed Governor
Southern Derbyshire Voluntary Sector Mental Health Forum	1	Derbyshire Mental Health Forum (formerly Southern Derbyshire Voluntary Sector Mental Health Forum)	1
North Derbyshire Voluntary Action	1	Derbyshire Voluntary Action	1
University of Nottingham	1	University of Nottingham	1
The University of Derby	1	The University of Derby	1
Derbyshire Constabulary	1		

Current Wording

2.4 The Trust shall nominate those organisations to be designated as Partnership Organisations for the purposes of this Constitution. The organisations so nominated as Partnership Organisations are:

2.4.1 Southern Derbyshire Voluntary Sector Mental Health Forum;
2.4.2 North Derbyshire Voluntary Action;
2.4.3 University of Nottingham;
2.4.4 The University of Derby; and
2.4.5 Derbyshire Constabulary.

Proposed Wording

2.4 The Trust shall nominate those organisations to be designated as Partnership Organisations for the purposes of this Constitution. The organisations so nominated as Partnership Organisations are:

2.4.1 Derbyshire Mental Health Forum;
2.4.2 Derbyshire Voluntary Action;
2.4.3 University of Nottingham; and
2.4.4 The University of Derby.

COMPOSITION OF THE COUNCIL OF GOVERNORS

Annex 3 of the Constitution – Composition of the council of Governors

Agreement to the proposed changes to constituencies and partnership organisations will culminate in a change to the composition of the Council of Governors. There is no proposal to change eligibility criteria or appointment process for composition. It is a requirement that the Council of Governors shall at all times be constituted so that more than half of the Council of Governors shall consist of Governors who are elected by members of the Trust other than those who are members of the Staff Constituency. The addition of two staff governors will not cause publicly elected governors to be outweighed in terms of representation.

Current Composition

	Electing/Appointing Body	Number of Governors	Total
1.	**Public Constituencies**		
	1.1 Derby City – East	2	
	1.2 Derby City – West	2	16
	1.3 Amber Valley – North	1	
	1.4 Amber Valley – South	1	
	1.5 Bolsover	1	
	1.6 Chesterfield – North	1	
	1.7 Chesterfield - South	1	
	1.8 Derbyshire Dales	1	
	1.9 Erewash – North	1	
	1.10 Erewash – South	1	
	1.11 High Peak	1	
	1.12 North East Derbyshire	1	
	1.3 South Derbyshire	1	
	1.14 Surrounding Areas	1	
2.	**Staff Constituency**		
	2.1 Medical and Dental Staff Class		
	2.2 Nursing and Allied Professions Staff Class	1	4
	2.3 Administration and Allied Support Staff Class	2	
		1	
3.	**Appointed Governors**		
	3.1 Derby City Council	1	
	3.2 Derbyshire County Council	1	7
	3.3 Southern Derbyshire Voluntary Sector Mental Health Forum	1	
	3.4 North Derbyshire Voluntary Action	1	
	3.5 Derbyshire Constabulary	1	
	3.6 The University of Nottingham	1	
	3.7 University of Derby	1	
	Total number of Governors		**27**

Proposed Composition

	Electing/Appointing Body	Number of Governors	Total
1.	**Public Constituencies**		
	1.1 Derby City – East	2	16
	1.2 Derby City – West	2	
	1.3 Amber Valley	2	
	1.4 Bolsover and North East Derbyshire	2	
	1.5 Chesterfield	2	
	1.6 High Peak and Derbyshire Dales	2	
	1.7 Erewash	2	
	1.8 South Derbyshire	1	
	1.9 Surrounding Areas	1	
2.	**Staff Constituency**		
	2.1 Medical and Dental Staff Class	1	6
	2.2 Nursing Staff Class	1	
	2.3 Allied Professions Staff Class	1	
	2.4 Administration and Allied Support Staff Class	1 2	
3.	**Appointed Governors**		
	3.1 Derby City Council	1	6
	3.2 Derbyshire County Council	1	
	3.3 Derbyshire Mental Health Forum	1	
	3.4 Derbyshire Voluntary Action	1	
	3.5 The University of Nottingham	1	
	3.6 University of Derby	1	
	Total number of Governors		**28**

QUORUM

Annex 6 of the Constitution - Standing Orders of the Council of Governors

At an Extraordinary Council of Governors Meeting, held on 5 October 2017, a public governor requested that the quorum for Council of Governors be considered and increased. The Governance Committee considered the matter at its meeting on 6 December 2017 and agreed with the proposed revision below.

Current Wording

3.26 Quorum – no business shall be transacted at a meeting of the Council of Governors unless at least 20% of the Council of Governors are present and that those present include at least one Staff Governor and Two Public Governors

Proposed Wording

3.26 Quorum - no business shall be transacted at meetings of the Council of Governors unless at least one third of the Council of Governors are present, with a minimum of six, a majority of whom must be Governors elected by the Public Constituencies, and one Staff Governor.

COUNCIL OF GOVERNORS: TERMINATION OF TENURE
Annex 5 – Additional Provisions – Council of Governors

At the Governance Committee on 3 July 2017, governors discussed the number of governors required to terminate the office of a governor for reasonable cause. It was agreed that the figure of three quarters, or 75%, be lowered to 70%. This would also require an update in the Governor Code of Conduct to reflect this change.

Current Wording

4.1.4 If the Council of Governors resolves to terminate his term of office for reasonable cause on the grounds that in the reasonable opinion of three quarters of the Governors present and voting at a meeting of the Council of Governors convened for that purpose that his continuing as a Governor would or would be likely to:

Proposed Wording

4.1.4 If the Council of Governors resolves to terminate his term of office for reasonable cause on the grounds that in the reasonable opinion of 70% of the Governors present and voting at a meeting of the Council of Governors convened for that purpose that his continuing as a Governor would or would be likely to:

MEMBERSHIP OF GOVERNORS NOMINATIONS & REMUNERATION COMMITTEE

Annex 5 (Additional Provisions – Council of Governors)

The Committee has struggled to achieve quoracy with the membership as outlined in the Constitution. Proposed changes to the Terms of Reference were approved by the Council of Governors, on 18 July 2017, to increase membership. Quorum will remain unchanged (three governors, two of whom must be public governors). This change will need to be reflected in the Constitution.

Current Wording

9.2 The Nominations Committee for Non-Executive Directors will comprise:

9.2.1 the Chairman (or, if the Chairman is not available, the Deputy Chairman or one of the other Non-Executive Directors who is not standing for appointment);

9.2.2 four Elected Governors including Public Governors and Staff Governors and *two* Appointed Governors;

9.2.3 no two Governors will be appointed from the same Public Constituency or Staff Class of the Staff Constituency,

9.2.4 not more than one may be a Local Authority Governor and not more than one may be a Governor appointed by the voluntary sector.

Proposed Wording

9.2 The Nominations Committee for Non-Executive Directors will comprise:

9.2.1 the Chairman (or, if the Chairman is not available, the Deputy Chairman or one of the other Non-Executive Directors who is not standing for appointment);

9.2.2 six Elected Governors including Public Governors and Staff Governors and two Appointed Governors;

9.2.3 no two Governors will be appointed from the same Public Constituency or Staff Class of the Staff Constituency,

9.2.4 not more than one may be a Local Authority Governor and not more than one may be a Governor appointed by the voluntary sector.

SIGNIFICANT TRANSACTIONS
Paragraph 39 – Trust Constitution
The constitution meets the requirement that it must include provision about significant transactions. A significant transaction requires the approval of the Council of Governors before the Trust is able to enter into it. It is up to the Trust how it wishes to define significant transactions, or indeed whether it wishes to specify any description at all. The only requirement is that the Trust's definition of a significant transaction is included in the constitution, otherwise the constitution must state that it contains no such description. The Trust would need to determine on a case-by-case basis whether a proposed transaction is significant.

The wording in the Trust's constitution regarding Significant Transactions was raised and discussed as part of the proposed merger discussions and it was felt appropriate to update our Constitution in this respect with a removal of the definition to 'future proof' the constitution to align with any future Monitor guidance.

Current Wording

39A Significant transactions

39A.1 The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors voting approve entering into the transaction.

39.6 "Significant transaction" means any transaction that meets one of the criteria set out in the table below:

Ratio	Description	Significant*
Assets	The gross assets* subject to the transaction, divided by the gross assets of the Trust	≥25%
Income	The income attributable to: • the assets; or • the contract associated with the transaction, divided by the income of the Trust.	≥ 25%
Capital	The gross capital* of the company or business being acquired/divested, divided by the total capital* of the Trust following completion, or the effects on the total capital of the Trust resulting from a transaction.	≥ 25%

Proposed Wording

39A Significant Transactions

39A.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

39.6 The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

39.7 "Significant transaction" means a transaction defined as significant by Monitor;

EQUALITY BEST PRACTICE

In response to a request from governors and in responding to advice on best practice within the Trust, It is now proposed to remove all references to gender from the Constitution, replacing words such as "he" with "they", and "Chairman with "Chair".

REGULATORY BODY CHANGES

NHS Improvement is the new name for the health and social care regulator which was created when Monitor and the NHS Trust Development Authority joined together in 2016.

All references to 'Monitor' will be amended to NHSI (Monitor) unless specific to Acts or Publications.

CONSTITUTION OF

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

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DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST CONSTITUTION

1. Name

The name of the foundation Trust is Derbyshire Healthcare NHS Foundation Trust (the "Trust").

2. Principal purpose

2.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

2.2 The Trust does not fulfil its principal purpose unless, in each Financial Year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

2.3 The Trust may provide goods and services for any purposes related to:

2.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and

2.3.2 the promotion and protection of public health.

2.4 The Trust may also carry on activities other than those mentioned in paragraph 2.3 above for the purpose of making additional income available in order better to carry on its principal purpose.

3. Powers

3.1 The powers of the Trust are set out in the 2006 Act, subject to any restrictions in its Licence.

3.2 The powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

3.3 Subject to the provisions of the Mental Health Act 2007, any of these powers may be delegated to a committee of Directors or to an Executive Director.

3.4 For the avoidance of doubt, the Trust shall, in performing its NHS functions (as defined in the Health Act 2009) have regard to the NHS Constitution.

4. Membership and constituencies

The Trust shall have Members, each of whom shall be a member of one of the following constituencies:

4.1 a Public Constituency; and

4.2 a Staff Constituency.

5. Application for Membership

5.1 An individual who is eligible to become a Member of the Trust may do so on application to the Trust, save as provided for in paragraph 8.1

5.2 Applications for Membership shall be dealt with by the Trust in accordance with the provisions of Annex 8.

6. Public Constituency

6.1 An individual who lives in an area specified in Annex 1 as an area for a Public

Constituency may become or continue as a Member of the Trust.

6.2 Those individuals who live in an area specified as an area for any Public Constituency are referred to collectively as the Public Constituency.

6.3 The minimum number of Members in each area for a Public Constituency is specified in Annex 1.

6.4 Further provisions relating to Membership of the Public Constituency are set out in Annex 8.

7. Staff Constituency

7.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a Member of the Trust provided:

7.1.1 they are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

7.1.2 they have been continuously employed by the Trust under a contract of employment for at least 12 months.

7.2 Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as Members of the Staff Constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.

7.3 Those individuals who are eligible for Membership of the Trust by reason of the previous provisions of this paragraph 7 are referred to collectively as the Staff Constituency.

7.4 The Staff Constituency shall be divided into 4 descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

7.5 The minimum number of Members in each class of the Staff Constituency is 100 in the Nursing Staff class and Allied Professions Staff class, 20 in the Medical and Dental Staff class and 50 in the Administration and Allied Support Staff class.

7.6 For the purposes of paragraph 7.1.2 and 7.2 of the Constitution, Chapter 1 of Part 14 of the Employment Rights Act 1996 shall apply for the purposes of determining whether an individual has been continuously employed by the Trust or has continuously exercised functions for the purposes of the Trust.

8. Automatic Membership by default and application for Membership – staff

8.1 An individual who is:

8.1.1 eligible to become a Member of the Staff Constituency, and

8.1.2 invited by the Trust to become a Member of the Staff Constituency and a member of the appropriate class within the Staff Constituency,

shall become a Member of the Trust as a Member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless they inform the Trust that they do not wish to do so.

8.2 An individual who is:

8.2.1 eligible to become a Member of the Staff Constituency by reason of paragraph 7.2, and

8.2.2 has made an application to become a Member of the Staff Constituency,

may become a Member of the Staff Constituency in accordance with this Constitution.

8.3 The process by which an individual may become a Member of the Staff Constituency by application or by being invited to become a Member of the Staff Constituency shall be in accordance with the provisions of Annex 8.

9. Restriction on Membership

9.1 An individual, who is a Member of a Constituency, or of a class within a Constituency, may not while membership of that Constituency or class continues, be a Member of any other Constituency or class.

9.2 An individual who satisfies the criteria for Membership of the Staff Constituency may not become or continue as a Member of any constituency other than the Staff Constituency.

9.3 An individual must be at least 16 years old to become a Member of the Trust.

9.4 Further provisions as to the circumstances in which an individual may not become or continue as a Member of the Trust are set out in Annex 8.

10. Council of Governors – composition

10.1 The Trust shall have a Council of Governors, which shall comprise both Elected and Appointed Governors.

10.2 The composition of the Council of Governors is specified in Annex 3.

10.3 The Members of the Council of Governors, other than the Appointed Governors, shall be chosen by election by their Constituency or, where there are classes within a Constituency, by their class within that Constituency.

10.4 The number of Governors to be elected by each Constituency is specified in Annex 3.

11. Council of Governors – election of Governors

11.1 Elections for the elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules.

11.2 The Model Election Rules as published from time to time by the Department of Health form part of this Constitution and are attached as Annex 4.

11.3 A subsequent variation of the Model Election Rules by the Department of Health shall not constitute a variation of the terms of this Constitution for the purposes of paragraph 39 of the Constitution.

11.4 An election, if contested, shall be by secret ballot.

12. Council of Governors – tenure

12.1 An Elected Governor may hold office for a period of up to 3 years.

12.2 An Elected Governor shall cease to hold office if they cease to be a Member of the Constituency or class by which they were elected.

12.3 An Elected Governor shall be eligible for re-election at the end of their term, subject to the provisions of paragraph 1.2 of Annex 5 (Additional Provisions – Council of Governors).

12.4 An Appointed Governor may hold office for a period of up to 3 years and shall be eligible for re-appointment at the end of that term, subject to the provisions of paragraph 1.2 of Annex 5.

12.5 An Appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him.

12.6 Further provisions relating to a Governor's tenure of office are set out in Annex 5.

13. Council of Governors – disqualification and removal

13.1 The following may not become or continue as a member of the Council of Governors:

13.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

13.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, their creditors and has not been discharged in respect of it;

13.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them.

13.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

13.3 Further provisions as to the circumstances in which an individual may not become or continue or may be removed as a member of the Council of Governors are set out in Annex 5.

13A Council of Governors – duties of Governors

13A.1 The general duties of the Council of Governors are:

13A.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors; and

13A.1.2 to represent the interests of the Members as a whole and the interests of the public.

13A.2 The Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as such.

14. Council of Governors – meetings of Governors

14.1 The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 21.1 below) or, in his absence, the Deputy Chair (appointed in accordance with the provisions of paragraph 23 below), shall preside at meetings of the Council of Governors.

14.2 Meetings of the Council of Governors shall be open to members of the public save that members of the public may be excluded from a meeting on the grounds more particularly provided for in Annex 5.

14.3 For the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Trust's or Directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting.

15. Council of Governors – standing orders

The standing orders for the practice and procedure of the Council of Governors are attached at Annex 6.

15A Council of Governors – referral to the panel

15A.1 In this Clause the Panel means a panel of persons appointed by NHSI (Monitor) to which a Governor may refer a question as to whether the Trust has failed or is failing:

15A.1 to act in accordance with its Constitution, or

15A.2 to act in accordance with the provisions made by or under Chapter 5 of the 2006 Act.

15A.2 A Governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

16. Council of Governors – conflicts of interest of Governors

16.1 If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered or is likely to be considered by the Council of Governors, the Governor shall disclose that interest to the members of the Council of Governors as soon as they become aware of it.

16.2 The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

17. Council of Governors – travel expenses

The Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust.

18. Council of Governors – further provisions

Further provisions with respect to the Council of Governors are set out in Annex 5.

19. Board of Directors – composition

19.1 The Trust is to have a Board of Directors, which is to comprise both Executive and Non-Executive Directors.

19.2 Subject to paragraph 19.8, the Board of Directors is to comprise:

19.2.1 a non-executive Chair

19.2.2 up to 6 other Non-Executive Directors (one of which may be nominated as the Senior Independent Director); and

19.2.3 up to 6 Executive Directors.

19.3 One of the Executive Directors shall be the Chief Executive.

19.4 The Chief Executive shall be the Accounting Officer.

19.5 One of the Executive Directors shall be the Finance Director.

19.6 One of the Executive Directors shall be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

19.7 One of the Executive Directors shall be a registered nurse or a registered midwife.

19.8 The Board of Directors shall at all times be constituted so that at least half the Board, excluding the Chair, shall comprise of Non-Executive Directors.

19.9 The Chair may appoint one of the Independent Non-Executive Directors as the Senior Independent Director in consultation with the Governors and the other Non- Executive Directors. The Chair shall normally, but not necessarily appoint the Deputy Chair to this position.

19A Board of Directors – general duty

19A.1 The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the Members as a whole and for the public.

20. Board of Directors – qualification for appointment as a Non-Executive Director

A person may be appointed as a Non-Executive Director only if –

20.1 they are a Member of the Public Constituency; and

20.2 they are not disqualified by virtue of paragraph 26 below.

21. Board of Directors – appointment and removal of Chair and other Non-Executive Directors

21.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair of the Trust and the other Non-Executive Directors.

21.2 The removal of the Chair or any other Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors.

22. Not Used

23. Board of Directors – appointment of Deputy Chair

23.1 The Council of Governors at a general meeting of the Council of Governors shall appoint one of the Non-Executive Directors as the Deputy Chair.

24. Board of Directors – appointment and removal of the Chief Executive and other Executive Directors

24.1 The Non-Executive Directors shall appoint or remove the Chief Executive.

24.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

24.3 Not used.

24.4 A committee consisting of the Chair, the Chief Executive and the other Non- Executive Directors shall appoint or remove the other Executive Directors.

25. Not Used

26. Board of Directors – disqualification

The following may not become or continue as a member of the Board of Directors:

26.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and who (in either case) has not been discharged;

26.2 a person who has made a composition or arrangement with, or granted a trust deed for, their creditors and who has not been discharged in respect of it;

26.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on the individual;

26.4 a person who falls within the further grounds for disqualification set out in Annex 8.

26A Board of Directors – meetings

26A.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

26A.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

27. Board of Directors – standing orders

27.1 The Board of Directors shall adopt standing orders from time to time for the practice and procedure of the Board of Directors and in particular for its procedure at meetings. These shall include setting a quorum for meetings, both of Executive and Non-Executive Directors.

28. Board of Directors – conflicts of interest of directors

28.1 The duties that a Director has by virtue of being a Director include in particular:

28.1.1 A duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

28.1.2 A duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

28.2 The duty referred to in sub-paragraph 28.1.1 is not infringed if:

28.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

28.2.2 the matter has been authorised in accordance with the Constitution.

28.3 The duty referred to in sub-paragraph 28.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

28.4 In sub-paragraph 28.1.2, "third party" means a person other than:

28.4.1 the Trust, or

28.4.2 a person acting on its behalf.

28.5 If a Director has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to the other Directors.

28.6 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

28.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

28.8 This paragraph does not require a declaration of an interest of which the Director is now aware or where the Director is not aware of the transaction or arrangement in question.

28.9 A Director need not declare an interest:

28.1.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

28.1.2 if, or to the extent that, the Directors are already aware of it;

28.1.3 if, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered:

(a) by a meeting of the Board of Directors;

(b by a committee of the Directors appointed for the purpose under the Constitution.

28.10 The Standing Orders of the Board of Directors shall make provision for the disclosure of interests and arrangements for the exclusion of a Director declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

29. Board of Directors – remuneration and terms of office

29.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors.

29.2 The Trust shall establish a committee of Non-Executive Directors to decide the remuneration and allowances and the other terms and conditions of office of the Chief Executive and other Executive Directors.

30. Registers

30.1 The Trust shall have:

30.1.1 a register of Members showing, in respect of each Member, the Constituency to which they belong and, where there are classes within it, the class to which he belongs;

30.1.2 a register of members of the Council of Governors;

30.1.3 a register of interests of Governors;

30.1.4 a register of Directors; and

30.1.5 a register of interests of the Directors.

30.2 The process of admission to and removal from the registers shall be as set out in Annex 8.

31. Registers – inspection and copies

31.1 The Trust shall make the registers specified in paragraph 30 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

31.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any Member of the Trust, if they so request.

31.3 So far as the registers are required to be made available:

31.3.1 they are to be available for inspection free of charge at all reasonable times; and

31.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

31.4 If the person requesting a copy or extract is not a Member of the Trust, the Trust may impose a reasonable charge for doing so.

32. Documents available for public inspection

32.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

32.1.1 a copy of the current Constitution;

32.1.2 a copy of the latest annual accounts and of any report of the auditor on them;

32.1.3 a copy of the latest annual report;

32.1.4 a copy of the latest information as to its forward planning; and

32.1.5 a copy of any notice given under Section 52 of the 2006 Act.

32.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

32.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act;

32.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act;

32.2.3 a copy of any information published under 65D (appointment of trust special administrator) of the 2006 Act;

32.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act;

32.2.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act;

32.2.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act;

32.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act;

32.2.8 a copy of any final report published under section 65I (administrator's final report);

32.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (acting following Secretary of State's rejection of final report) of the 2006 Act; and

32.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

32.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

32.4 If the person requesting a copy or extract is not a Member of the Trust, the Trust may impose a reasonable charge for doing so.

33. Auditor

33.1 The Trust shall have an auditor.

33.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

34. Audit committee

The Trust shall establish a committee of Non-Executive Directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

35. Accounts

35.1 The Trust shall keep proper accounts and proper records in relation to the accounts.

35.2 NHSI (Monitor) may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

35.3 The accounts are to be audited by the Trust's auditor.

35.4 The Trust shall prepare in respect of each Financial Year annual accounts in such form as NHSI (Monitor) may with the approval of the Secretary of State direct.

35.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

36. Annual report, forward plans and non-NHS work

36.1 The Trust shall prepare an Annual Report and send it to NHSI (Monitor).

36.2 The Trust shall give information as to its forward planning in respect of each Financial Year to NHSI (Monitor).

36.3 The document containing the information with respect to forward planning referred to at paragraphs 32.1.5 and 36.2 above shall be prepared by the Directors.

36.4 In preparing the document, the Directors shall have regard to the views of the Council of Governors.

36.5 Each forward plan must include information about:

36.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on; and

36.5.2 the income it expects to receive from doing so.

36.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 36.5.1 the Council of Governors must:

36.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions; and

36.6.2 notify the Directors of the Trust of its determination.

36.7 The Trust may only implement any proposal to increase by 5% or more the proportion of its total income in any Financial Year attributable to activities other than the provision of goods and services for the purposes of health service in England if more than half of the members of the Council of Governors voting approve its implementation.

37. Presentation of the annual accounts and Reports to the Governors and Members

37.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

37.1.1 the annual accounts;

37.1.2 any report of the auditor on them; and

37.1.3 the annual report.

37.2 The documents shall also be presented to the Members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

37.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of paragraph 37.1 with the Annual Members' Meeting.

38. Instruments

38.1 The Trust shall have a seal.

38.2 The seal shall not be affixed except under the authority of the Board of Directors.

39. Amendment of the Constitution

39.1 The Trust may make amendments of its Constitution only if:

39.1.1 more than half of the members of the Council of Governors voting approve the amendments, and

39.1.2 more than half of the members of the Board of Directors voting approve the amendments.

39.2 Amendments made under paragraph 39.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with Schedule 7 of the 2006 Act.

39.3 Where an amendment is made to the Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

39.3.1 at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

39.3.2 the Trust must give the Members an opportunity to vote on whether they approve the amendment.

39.4 If more than half of the Members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

39.5 Amendments by the Trust of its Constitution are to be notified to NHSI (Monitor). For the avoidance of doubt, NHSI's (Monitor's) functions do not include a power or duty to determine whether or not the Constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

39A Significant transactions

39A.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

39.6 The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

39.7 "Significant transaction" means a transaction defined as significant by Monitor.

40. Interpretation and definitions

40.1 Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this Constitution shall bear the same meaning as in the 2006 Act.

40.2 Not used.

40.3 References in this Constitution to legislation include all amendments, replacements or re-enactments made and references to paragraph numbers are references to paragraphs of this Constitution unless the context provides otherwise.

40.4 References to legislation include all regulations, statutory guidance or directions.

40.5 Headings are for ease of reference only and are not to affect interpretation.

40.6 If there is a conflict between the provisions of this Constitution and the provisions of any document referred to herein or the law then the provisions of this Constitution shall prevail unless the law requires otherwise.

40.7 All Annexes referred to in this Constitution form part of it.

40.8 References to paragraphs are to paragraphs in this Constitution save that where there is a reference to a paragraph in an Annex to this Constitution it shall be a reference to a paragraph in that Annex unless the contrary is expressly stated or the context otherwise so requires.

40.9 In this Constitution:

"Accounting Officer"	means the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act;
"the 2006 Act"	means the National Health Service Act 2006;
"the 2012 Act"	means the Health and Social Care Act 2012;
"Annual Members' Meeting"	means the annual meeting of all the Members as described in paragraph 3 of Annex 8;
"Appointed Governors"	means the Local Authority Governors and the Partnership Governors;
"Area of the Trust"	means the area consisting of all the areas specified in Annex 1 as an area for a Public Constituency;

"Board of Directors"	means the Board of Directors of the Trust as constituted in accordance with this Constitution and referred to in paragraph 19 and "Board" shall be construed accordingly;
"Chair"	means the Chair of the Trust appointed in accordance with paragraph 21 of this Constitution;
"Chief Executive"	means the Chief Executive (and Accounting Officer) of the Trust appointed in accordance with paragraph 24 of this Constitution;
"Constituencies"	means the Public Constituencies and, the Staff Constituency;
"Constitution"	means this Constitution of Derbyshire Healthcare NHS Foundation Trust;
"Council of Governors"	means the Council of Governors of the Trust as constituted in accordance with this Constitution;
"Deputy Chair"	means the Deputy Chair of the Trust;
"Director"	means a Director on the Board of Directors;
"Elected Governors"	means the Public Governors and Staff Governors;
"Election Scheme"	means the election scheme and rules set out in Annex 4 and which are to be used in connection with the election of the Elected Governors;
"Executive Director"	means an Executive Director of the Trust;
"Finance Director"	means the person who from time to time is appointed by the Trust to discharge the usual functions of its chief finance officer;
"Financial Year"	Means each successive period of twelve months beginning with 1st April;
"Governor"	means a Governor on the Council of Governors and being either an Elected Governor or an Appointed Governor;
"Licence"	means the licence granted to the Trust by Monitor pursuant to the 2012 Act;
"Local Authorities"	means those local authorities specified in Annex 3 which are local authorities for an area which includes the whole or part of the Area of the Trust;
"Local Authority Governor"	means a member of the Council of Governors appointed by a Local Authority in accordance with the provisions of this Constitution and as specified in Annex 3;
"Member"	means a Member of the Trust as determined in accordance with paragraph 5 and paragraph 8 of this Constitution;
"Membership"	means membership of the Trust through being a Member of one of its Constituencies;

"Members' Meetings"	means a meeting of the Members;
"Model Election Rules"	shall have the meaning given to them in paragraph 11. 2 of this Constitution;
"Monitor"	means the body corporate known as Monitor, as provided by Section 61 of the 2012 Act;
"NHS Constitution"	means: (a) the document entitled "The NHS Constitution" published by the Secretary of State on 21 January 2009; or (b) any revised version of that document published under sections 3 or 4 of the Health Act 2009;
"NHS Foundation Trust Code of Governance"	means the Code of Governance published by Monitor on the 10 March 2010 or such similar or further guidance as NHSI (Monitor) may publish from time to time;
"NHSI (Monitor)"	NHS Improvement is the body corporate previously known as Monitor, as provided by Section 61 of the 2012 Act.
"Nominated Lead Governor"	means the Governor nominated as the nominated lead Governor by the Council of Governors in accordance with Annex 5, Paragraph 10;
"Non-Executive Director"	means a Non-Executive Director of the Trust;
"Partnership Governor"	means a member of the Council of Governors appointed by a Partnership Organisation specified in Annex 3;
"Partnership Organisations"	means those organisations designated as partnership organisations for the purposes of this Constitution specified in Annex 3;
"Public Governor"	means a Member of the Council of Governors elected by the Members of a Public Constituency;
"Public Constituencies"	means a public constituency of the Trust as defined in Annex 1;
"Secretary"	means the secretary of the Trust or any other person appointed to perform the duties of the secretary of the Trust;
"Senior Independent Director"	means a Non-Executive Director nominated to the role of Senior Independent Director in accordance with the provisions of this Constitution;
"Staff Classes"	means the classes of the Staff Constituency as specified in Annex 2 (The Staff Constituency);
"Staff Constituency"	means that part of the Trust's Membership consisting of the staff of the Trust and other persons as more particularly provided for at paragraph 7 of this Constitution and which is divided into the staff classes as specified in Annex 2;

"Staff Governor"	means a member of the Council of Governors elected by a Staff Class;
"the Trust"	means Derbyshire Healthcare NHS Foundation Trust;
"University of Derby	Means the university of that name whose main campus is at Kedleston Road, Derby, DE22 1GB
"University of Nottingham"	means the university of that name whose main campus is at University Park, Nottingham, NG7 2RD;
"Voluntary Organisation"	means a body, other than a public or local authority, the activities of which are not carried on for profit.

ANNEX 1

The Public Constituency

1	2	3	4
Name of the Public Constituency	**Area of Public Constituency (as defined by electoral wards or Council areas)**	**Minimum number of Members**	**Number of Governors to be elected**
Derby City – East	**Alvaston** **Boulton** **Chaddesden** **Chellaston** **Derwent** **Oakwood** **Sinfin** **Spondon**	100	2
Derby City – West	**Abbey/Allestree** **Arboretum** **Blagreaves** **Darley** **Littleover** **Mackworth** **Normanton** **Mickleover**	100	2
Amber Valley	**Alfreton** **Belper Central** **Belper East** **Belper North** **Belper South** **Codnor and Waingrove** **Crich** **Duffield** **Heage and Ambergate** **Heanor and Loscoe** **Heanor West** **Ironville and Riddings** **Kilburn** **Langley Mill and Aldercar** **Ripley and Marehay** **Shipley Park** **Somercotes** **South West Parishes** **Swanwick** **Wingfield**	100	2

Bolsover and North East Derbyshire	**Bolsover District Council** **North East Derbyshire District Council**	60	2
Chesterfield	**Barrow Hill and New Wittington** **Brimington North** **Brimington South** **Brockwell** **Dunston** **Hasland** **Hollingwood and Indersal** **Holmesbrook** **Linacre** **Loundsley Green** **Lowgates and Woodthorpe** **Middlescroft and Poolsbrook** **Moor** **Old Whittington** **Rother** **St Helens** **St Leonards** **Walton West**	100	2
High Peak and Derbyshire Dales	**Derbyshire Dales District Council** **High Peak Borough Council**	100	2
Erewash	**Abbotsford** **Breaston** **Cotmanhay** **Derby Road East** **Derby Road West** **Draycott** **Hallam Fields** **Ilkeston Central** **Ilkeston North** **Kirk Hallam** **Little Eaton and Breadsall** **Little Hallam** **Long Eaton Central** **Nottingham Road** **Ockbrook and Borrowash** **Old Park** **Stanley** **Sandiacre North** **Sandiacre South** **Sawley** **West Hallam and Dale Abbey** **Wilsthorpe**	100	2

South Derbyshire	**South Derbyshire District Council**	50	1
Surrounding Areas	**All regions, including cities within them, that border Derbyshire, including:** **East Midlands** **West Midlands** **Yorkshire and the Humber** **North West**	25	1

ANNEX 2

The Staff Constituency

1	2	3	4
Classes within the Staff Constituency	**Individuals eligible for Membership of that Staff Class**	**Minimum number of Members in each Staff Class**	**Numbers of Governors to be Elected for each Staff Class**
Medical and Dental Staff Class	Those individuals defined in paragraph 1 below	20	1
Nursing Staff Class	Those individuals defined in paragraph 2 below	100	2
Allied Professions Staff Class	Those individuals defined in paragraph 3 below	100	1
Administration and Allied Support Staff Class	Those individuals defined in paragraph 4 below	50	2

1. Medical and Dental Staff Class

1.1 The Members of the Medical and Dental Staff Class are individuals who are Members of the Staff Constituency who:

1.1.1 are fully registered persons within the meaning of the consolidated Medical Act 1983 and the Dentists Act 1984 (as the case may be) and who are otherwise fully authorised and licensed to practice in England and Wales or who are otherwise designated by the Trust from time to time as eligible to be members of this Staff Class for the purposes of this paragraph having regard to the usual definitions applicable at that time for persons carrying on the professions of medical practitioner or dentist;

1.1.2 are employed by the Trust in that capacity at the end of their invitation or application under paragraph 8 of the Constitution to become a Member in accordance with the provisions of Annex 8 and at all times thereafter remain employed by the Trust in that capacity.

2. Nursing Staff Class

2.1 The Members of the Nursing Staff Class are individuals who:

2.1.1 are registered with the Nursing and Midwifery Council and who are otherwise fully authorised and licensed to practice in England and Wales or who are otherwise designated by the Trust from time to time as eligible to be members of this Staff Class for the purposes of this paragraph having regard to the usual definitions applicable at that time for persons carrying and the profession of registered nurse; or

2.1.2 are employed by the Trust in that capacity at the date of their invitation under paragraph 8 of the Constitution to become a member in accordance with the provisions of Annex 8 and at all times thereafter remain employed by the Trust in that capacity.

3. Allied Professional Staff

3.1 The Members of the Allied Professional Staff Class are individuals who:

3.1.1 whose regulating body falls within the remit of the Council for Healthcare Regulatory Excellence established by Section 25 of the NHS Reform and Health Care Professions Act 2002; and

3.1.2 who are employed by the Trust in that capacity at the date of their invitation under paragraph 8 of the Constitution to become a member in accordance with the provisions of Annex 8 and at all times thereafter remain employed by the Trust in that capacity.

4. Administration and Allied Support Staff

4.1 The Members of the Administration and Allied Support Staff Class are individuals who:

4.1.1 do not come within paragraphs 1, 2 or 3 above and who are designated by the Trust from time to time to time as eligible to be a Member of this Staff Class and who are not eligible to be members of another Staff Class for the purpose of this paragraph; and

4.1.2 who are employed or designated by the Trust at the date of their invitation and application under paragraph 8 of the Constitution to become a Member in accordance with the provisions of Annex 8 and at all times thereafter remain employed by the Trust in that capacity.

5. Minimum Numbers and Numbers of Governors

5.1 The minimum number of Members in each Staff Class shall be as set out in Column 3 of Table 1 to this Annex and the number of Governors to be elected by each such Staff Class is given the corresponding entry in Column 4 of that Table.

6. Continuous Employment

6.1 For the purposes of paragraphs 7.1 and 7.2 of the Constitution, Chapter 1 of Part 14 of the Employment Rights Act 1996 shall apply for the purposes of determining whether an individual has been continuously employed by the Trust or has continuously exercised functions for the purpose of the Trust.

7. Exercise of Functions

7.1 For the purpose of paragraph 7.2 of the Constitution it shall be for the Trust in its absolute discretion to determine whether an individual exercises functions for the purposes of the Trust and whether that individual has done so continuously for a period of at least 12 months.

ANNEX 3

Composition of the Council of Governors

1. Introduction

1.1 The Council of Governors shall comprise Governors who are:

1.1.1 elected by the respective Constituencies in accordance with the provisions of this Constitution; and

1.1.2 appointed in accordance with paragraph 2 below.

1.2 The Council of Governors shall at all times be constituted so that more than half the Council of Governors shall consist of Governors who are elected by Members of the Trust other than those who are Members of the Staff Constituency.

2. Bodies entitled to appoint a member of the Council of Governors

2.1 The following bodies in this paragraph 2 shall be entitled to appoint a Governor or Governors (as the case may be) to the Council of Governors as provided for in this paragraph 2.

2.2 Not used.

Qualifying Local Authorities

2.3 Derby City Council and Derbyshire County Council shall be entitled to appoint one Governor each in accordance with a process of appointment agreed by it with the Trust. The absence of any such agreed process of appointment shall not preclude the said local authority from appointing its Governors.

Partnership Organisations

2.4 The Trust shall nominate those organisations to be designated as Partnership Organisations for the purposes of this Constitution. The organisations so nominated as Partnership Organisations are:

2.4.1 Derbyshire Mental Health Forum;

2.4.2 Derbyshire Voluntary Action;

2.4.3 University of Nottingham; and

2.4.4 The University of Derby.

2.5 Each of the above organisations shall be entitled to appoint one Governor each in accordance with a process of appointment agreed by it with the Trust. The absence of any such agreed process of appointment shall not preclude that Partnership Organisation from appointing its Governor provided the appointment is duly made in accordance with its own internal processes.

Composition of the Council of Governors

Table 1

	Electing/Appointing Body)	Number of Governors	Total
1.	**Public Constituencies**		16
	1.1 Derby City - East	2	
	1.2 Derby City - West	2	
	1.3 Amber Valley	2	
	1.4 Bolsover and North East Derbyshire	2	
	1.5 Chesterfield	2	
	1.6 High Peak and Derbyshire Dales	2	
	1.7 Erewash	2	
	1.8 South Derbyshire	1	
	1.9 Surrounding Areas	1	
2.	**Staff Constituency**		6
	2.1 Medical and Dental Staff Class	1	
	2.2 Nursing Staff Class	2	
	2.3 Allied Professions Staff Class	1	
	2.4 Administration and Allied Support Staff Class	2	
3.	**Appointed Governors**		6
	3.1 Derby City Council	1	
	3.2 Derbyshire County Council	1	
	3.3 Derbyshire Mental Health Forum	1	
	3.4 Derbyshire Voluntary Action	1	
	3.5 University of Nottingham	1	
	3.5 University of Derby	1	
	Total number of Governors		**28**

4. **Further Provision**

Further provisions relating to the composition of the Council of Governors are at Annex 5.

ANNEX 4

The Model Election Rules

PART 1: INTERPRETATION

1. Interpretation

PART 2: TIMETABLE FOR ELECTION

2. Timetable
3. Computation of time

PART 3: RETURNING OFFICER

4. Returning officer
5. Staff
6. Expenditure
7. Duty ofco-operation

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election
9. Nomination ofcandidates
10. Candidate's particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination forms
15. Publication of statement of nominated candidates
16. Inspection of statement of nominated candidates and nomination forms
17. Withdrawal of candidates
18. Method of election

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot
20. The ballot paper
21. The declaration of identity (public and patient constituencies)

Action to be taken before the poll

22. List of eligible voters
23. Notice of poll
24. Issue of voting information by returning officer
25. Ballot paper envelope and covering envelope
26. E-voting systems

The poll

27. Eligibility to vote
28. Voting by persons who require assistance
29. Spoilt ballot papers and spoilt text message votes
30. Lost voting information
31. Issue of replacement voting information
32. ID declaration form for replacement ballot papers (public and patient constituencies)
33 Procedure for remote voting by internet
34. Procedure for remote voting by telephone
35. Procedure for remote voting by text message

Procedure for receipt of envelopes, internet votes, telephone vote and text message votes

PART 6: COUNTING THE VOTES

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

PART 8: DISPOSAL OF DOCUMENTS

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

PART 10: ELECTION EXPENSES AND PUBLICITY

Expenses

Publicity

PART 11: QUESTIONING ELECTIONS AND IRREGULARITIES

PART 12: MISCELLANEOUS

PART 1: INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution;

"*council of governors*" means the council of governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes

by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTIONS

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable

after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and
(b) the declared interests of each candidate standing, as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with

Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elec ted to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning

officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as "the telephone voting facility").

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as "the text message voting facility").

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone

voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(ii) the candidate or candidates for whom the voter has voted; and

(iii) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper

envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the "list of disqualified documents"); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list ofdisqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

[1] It should not be possible, technically, to make a declaration of identity electronically w ithout also submitting a vote.

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6: COUNTING THE VOTES

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark* " means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,
"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election, and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:

(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a firs t preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word "rejected" on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words "rejected in part" on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word "rejected" on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words "rejected in part" on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in

rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or
(b) at the value at which that vote was received by the candidate from whom it is now being transferred, whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been

transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47

(including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV49.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV49.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he or she has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he or she obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust, or

(ii) in any other case, to the Chair of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10, available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust, or

(ii) in any other case, to the Chair of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3, available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the Chair of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with "rejected in part",

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the Chair of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that NHSI (Monitor) has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the Chair of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before

the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to NHSI (Monitor) under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or

candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to NHSI (Monitor) for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to NHSI (Monitor) by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. NHSI (Monitor) will refer the application to the independent election arbitration panel appointed by NHSI (Monitor).

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 NHSI (Monitor) shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 5

Additional Provisions - Council of Governors

1. Council of Governors: Terms of Office

A Governor shall be:

1.1 elected or appointed for a term of up to three years;

1.2 shall be eligible for re-election or re-appointment at the end of that term but may not serve as a Governor for more than a total of 9 years;

1.3 shall cease to hold office if:

1.3.1 they cease to be a member of a Trust Constituency or, in the case of an Appointed Governor, if the body which appointed them withdraws its appointment at any time;

1.3.2 their term of office is terminated in accordance with paragraph 3 below and/or they are disqualified from or is otherwise ineligible to hold office as a Governor; or

1.3.3 they resign by notice in writing to the Trust.

2. Not used.

3. Council of Governors: Removal and Disqualification

3.1 A Governor shall not be eligible to become or continue in office as a Governor if:

3.1.1 they cease to be eligible to be a Member, save in the case of Appointed Governors;

3.1.2 in the case of an Appointed Governor, the appointing organisation withdraws its appointment of them;

3.1.3 any of the grounds contained in paragraph 13 of the Constitution apply to them;

3.1.4 they have within the preceding two years been lawfully dismissed otherwise than by reason of redundancy from any paid employment with a health service body;

3.1.5 they are a person whose term of office as the Chair or as a member or director of a health service body has been terminated on the grounds that their continuance in office is no longer in the best interests of the health service, for non-attendance at meetings or for non-disclosure of a pecuniary interest;

3.1.6 they have had their name removed by a direction under Section 154 of the 2006 Act from any list prepared under Part 4 of that Act and has not subsequently had their name included in such a list;

3.1.7 they have failed to make, or have falsely made, any declaration as required to be made under Section 60 of the 2006 Act;

3.1.8 NHSI (Monitor) has exercised its powers to remove them as a Governor of the Trust or has suspended them from office or has disqualified them from holding office as a Governor of the Trust for a specified period or NHSI (Monitor) has exercised any of those powers in relation to them on any other occasion whether in relation to the Trust or some other NHS Foundation Trust;

3.1.9 they have received a written warning from the Trust for verbal and/or physical abuse towards Trust staff and patients;

3.1.10 their term of office is terminated pursuant to paragraph 4 below;

3.1.11 the relevant organisation which they represent ceases to exist;

3.1.12 they are a Director of the Trust or a governor or director of another NHS foundation trust;

3.1.13 they are a vexatious or persistent litigant or complainant with regard to the Trust's affairs.

3.2 Where a person has been elected or appointed to be a Governor and becomes disqualified from that appointment they shall notify the Trust in writing of such disqualification as soon as practicable and in any event within 14 days of first becoming aware of those matters which rendered them disqualified.

3.3 If it comes to the notice of the Trust that a Governor is disqualified, the Trust shall immediately declare them disqualified and shall give them notice in writing to that effect as soon as practicable.

3.4 Upon the giving of notice under paragraphs 3.2 and 3.3 above, that person's tenure of office as a Governor shall thereupon be terminated and they shall cease to be a Council Governor and their name shall be removed from the Register of Governors.

4. Council of Governors: Termination of Tenure

4.1 A Governor's term of office shall be terminated:

4.1.1 by the Governor giving notice in writing to the Secretary of their resignation from office at any time during that term of office;

4.1.2 by the Trust if any grounds exist under paragraph 3 above;

4.1.3 by the Council of Governors if they have failed to attend three successive meetings of the Council of Governors unless the Council of Governors is satisfied;

(a) the absence was due to reasonable cause; and

(b) that the Governor will resume attendance at meetings of the Council of Governors within such period as it considers reasonable.

4.1.4 If the Council of Governors resolves to terminate their term of office for reasonable cause on the grounds that in the reasonable opinion of 70% of the Governors present and voting at a meeting of the Council of Governors convened for that purpose that their continuing as a Governor would or would be likely to:

(a) prejudice the ability of the Trust to fulfil its principal purpose or of its purposes under this Constitution or otherwise to discharge its duties and functions; or

(b) prejudice the Trust's work with other persons or body with whom it is engaged or may be engaged in the provision of goods and services; or

(c) adversely affect public confidence in the goods and services provided by the Trust; or

(d) otherwise brings the Trust into disrepute or is detrimental to the interest of the Trust; or

(e) it would not be in the best interests of the Trust for that person to continue in office as a Governor e.g.:

(i) they have failed or refused to undertake and/or satisfactorily complete any training which the Council of Governors has required them to undertake in their capacity as a Governor;

(ii) they have, in their conduct as a Governor failed to comply in a material way with the values and principles of the National Health Service or the Trust; or

(iii) they have committed a material breach of any code of conduct applicable to Governors of the Trust.

4.2 Upon a Governor resigning under paragraph 4.1.1 above or upon the Council of Governors resolving to terminate a Governor's tenure of office in accordance with the above provisions, that Governor shall cease to be a Governor and their name shall be forthwith removed from the Register of Governors.

4.3 Any decision of the Council of Governors' to terminate a Governor's tenure of office may be referred by the Governor to the dispute resolution procedure referred to in Annex 8, Paragraph 5.4 within 14 days of the date upon which notice in writing of the Council of Governor's decision is given to the Governor.

4.4 The Standing Orders adopted by the Council of Governors may contain provisions governing its procedure for termination under these provisions and for a Governor to appeal against the decision terminating their tenure of office.

4.5 A Governor who resigns or whose tenure of office is terminated under this paragraph 4 shall not be eligible to stand for re-election for a period of 3 years from the date of their resignation or removal from office or the date upon which any appeal against their removal from office is disposed of whichever is the later.

5. Council of Governors: Vacancies

5.1 Where a Governor's term of office terminates for whatever reason then:

5.1.1 in the case of an Appointed Governor, the Trust shall invite the relevant appointing body to appoint a new Governor as soon as practicable; and

5.1.2 in the case of an Elected Governor, elections for a new Governor shall take place as soon as practicable subject to the provisions of paragraphs 5.2 and 5.3 below.

5.2 Where an Elected Governor ceases for whatever reason to hold office within twelve months of his election:

5.2.1 the Trust shall offer the candidate who was ranked next highest in the last election for the Constituency (or class of Consistency as the case may be) which the vacancy has arisen the opportunity assume the vacant office of Governor for the unexpired balance of the former Governor's term of office;

5.2.2 if that candidate does not accept that invitation in a timely manner it shall be offered to that candidate who was next highest ranked in the last said election until the vacancy is filled; but if no other candidate stood for election or there are no remaining candidates who stood for election to that office or no candidate accepts the Trust's invitation in accordance with the above provisions within such time as the Trust may in its absolute discretion decide, the Trust shall hold an election for the vacancy as soon as reasonably practicable thereafter.

5.3 Subject to the provisions of paragraph 5.5, where an Elected Governor ceases for

whatever reason to hold office within the last twelve months of his term of office, the office shall remain vacant until the next scheduled election takes place.

5.4 The Returning Officer under the Election Scheme shall maintain a record of votes cast at each election under the Election Scheme for the purpose of paragraph 5.2 and the Returning Officer shall conduct and oversee the conducting of the process set out in paragraph 5.2 of this Annex 5.

5.5 Notwithstanding the above provisions of this paragraph 5, where the termination of a Governor's term of office causes the total number of Public Governors to be equal to or fewer than the other Governors of the Trust then an election for that vacant office shall be held as soon as reasonably practicable.

5.6 No defect in the election or appointment of a Governor nor any deficiency in the composition of the Council of Governors shall affect the validity of any act or decision of the Council of Governors.

6. Council of Governors: Role

6.1 The Council of Governors and each Governor shall act in the best interests of the Trust at all times and with proper regard to the provisions of the NHS Foundation Trust Code of Governance and Monitor's guidance "Your Statutory Duties: A Reference Guide for NHS Foundation Trust Governors".

6.2 Subject to the requirement specified in paragraph 6.1 above, each Governor shall exercise their own skill and judgement in his conduct of the Trust's affairs and shall in their stewardship of the Trust's affairs bring as appropriate the perspective of the Constituency or organisation by which they were elected or appointed, as the case may be.

6.3 Subject to the further provisions of this Constitution and without in any way derogating from them, the Council of Governors shall;

6.3.1 assist the Board of Directors in setting the strategic direction of the Trust and targets for the Trust's performance and in monitoring the Trust's performance in terms of achieving those strategic aims and targets which have been set; and

6.3.2 monitor the activities of the Trust with the view to ensuring that they are being conducted in a manner consistent with its Licence and the terms of this Constitution.

7. Council of Governors: Meetings

7.1 The Council of Governors shall hold not less than four general meetings each Financial Year.

7.2 All such meetings shall be open to the public unless the Council of Governors resolves that the public be excluded from the meeting, whether for the whole or part of the proceedings on the grounds that publicity would be prejudicial to the public interest or the interests of the Trust by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of the business to be transacted or the proceedings.

7.3 Not Used.

7.4 The Council of Governors may request the attendance of some or all of the members of the Board of Directors at its meetings and the Board of Directors may attend and may give such reports and information to the Council of Governors as the Board of Directors considers appropriate and subject always to the other provisions of this Constitution.

7.5 A meeting of the Council of Governors shall be quorate and quoracy shall require that there shall be present at the meeting not less than one third, with a minimum of six, of all Council of Governors, a majority of whom must be Governors elected by the Public Constituencies, and one Staff Governor.

7.6 No business shall be conducted at a meeting which is not quorate.

7.7 If a meeting is not quorate within 15 minutes of the time scheduled for its commencement it shall automatically stand adjourned for a period of 7 days and the Chair shall give or shall procure the giving of notice to all Governors of the date, time and place of that adjourned meeting.

7.8 The Council of Governor's Standing Orders as set out in Annex 6 of the Constitution provide for further details of the practice and procedure at Council of Governor's meetings (including general meetings).

8. Council of Governors: Declarations

8.1 A Member of a Public Constituency standing for election as Governor must make a declaration for the purposes of Section 60(2) of the 2006 Act in the form specified below stating the particulars of their qualification to vote as a Member and that they are not prevented from being a Member of the Council of Governors by virtue of any provisions of this Constitution. It is an offence to knowingly or recklessly make a statement or declaration which is false in material particular.

8.2 The specified form of declaration shall be set out on the Nomination Form referred to in the Model Election Rules at Annex 4 and shall state as follows:

"I, the above named candidate, consent to my nomination and agree to stand for election to the Council of Governors in the Constituency indicated in Section One of this form. I also declare that I am a member in that Constituency.

I, the above named candidate, hereby declare that I am not:

(a) a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

(b) a person who has made a composition or arrangement with, or granted a trust deed for, their creditors and has not been discharged in respect of it;

(c) a person who within the preceding 5 years has been convicted in the British Islands of any offence with a sentence of imprisonment (whether suspended or not) for a period of not less than 3 months (without the option of a fine) was imposed on the individual.

I confirm that to the best of my knowledge, the information provided on (or in connection with) this form is accurate".

8.3 A Governor elected to the Council of Governors by the Public Constituency or Staff Constituency may not for the purposes of Section 60(3) of the 2006 Act vote at a meeting of the Council of Governors unless within the period since their election, they have made a declaration in the form specified in paragraph 8.4 below stating which Constituency they are a Member of and is not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 to the 2006 Act or by virtue of any provisions of this constitution.

8.4 The specified form of declaration referred to in paragraph 8.3 above shall state as follows:

"I declare that I am a Member of the Public Constituency or Staff Constituency and am eligible to vote at a meeting of the Council of Governors, and that I am not debarred from voting by any of the provisions in paragraph 8 of Schedule 7 to the 2006 Act or by virtue of any provisions of this Constitution."

9. Council of Governors: Committees and Sub-Committees

9.1 A committee, chaired by the Chair, shall be established to assist the Council of Governors with the nomination and selection of the Non-Executive Directors (the "Nomination Committee for Non-Executive Directors"). In the case of the nomination and selection of the Chair the Nominated Committee for Non-Executive Director shall be chaired by the Deputy Chair.

9.2 The Nominations Committee for Non-Executive Directors will comprise:

9.2.1 the Chair (or, if the Chair is not available, the Deputy Chair or one of the other Non-Executive Directors who is not standing for appointment);

9.2.2 *six* Elected Governors including Public Governors and Staff Governors and *two* Appointed Governors;

9.2.3 no two Governors will be appointed from the same Public Constituency or Staff Class of the Staff Constituency,

9.2.4 not more than one may be a Local Authority Governor and not more than one may be a Governor appointed by the voluntary sector.

9.3 A committee may be established to assist the Council of Governors with the remuneration of the Chair and Non-Executive Directors (the "Remuneration Committee for Non-Executive Directors").

9.4 The functions of the Nominations Committee for Non-Executive Directors shall be as follows:

9.4.1 to determine the criteria and process for the selection of candidates for office as Chair or other Non-Executive Director of the Trust having first consulted with the Board of Directors and Governors as to those matters and having regard to such views as may be expressed by the Board of Directors and Council of Governors;

9.4.2 to assess and select for interview such candidates as are considered appropriate and in doing so the Nominations Committee for Non-Executive Directors shall be at liberty to seek advice and assistance from persons other than members of the Nominations Committee for Non-Executive Directors or of the Council of Governors;

9.4.3 to make recommendation to the Council of Governors as to potential candidates for appointment as Chair or other Non-Executive Director, as the case may be.

9.6 The Council of Governors shall resolve in general meeting to appoint such candidate or candidates (as the case may be) as it considers appropriate and in reaching its decision it shall have regard to the views of the Board of Directors and of the Nominations Committee for Non-Executive Directors as to the suitability of the available candidates and the remuneration and allowances and other terms and conditions of office.

10. Nominated Lead Governor

10.1 The Council of Governors shall nominate one of its Governors as the nominated lead Governor (the "**Nominated Lead Governor**").

10.2 The Nominated Lead Governor shall provide their contact details to NHSI (Monitor) and continue to update NHSI (Monitor) with their contact details as and when they change.

10.3 The role of the Nominated Lead Governor is to facilitate direct communication between NHSI (Monitor) and the Council of Governors in the limited circumstances where it may not be appropriate to communicate through the normal channels.

10.4 The Nominated Lead Governor shall take steps to understand NHSI (Monitor)'s role, the available guidance and the basis on which NHSI (Monitor) may take regulatory action.

10.4 In the event that an individual Governor wishes to make contact with NHSI (Monitor), this contact will be through the Nominated Lead Governor.

ANNEX 6

Standing Orders for the Practice and Procedure of the Council of Governors

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

Standing Orders

Council of Governors

FOREWORD

This document provides a regulatory and business framework for the conduct of the Council of Governors.

INTRODUCTION

Statutory Framework

Derbyshire Healthcare NHS Foundation Trust ("the Trust") is a Public Benefit Corporation.

The statutory functions conferred on the Trust are set out in the National Health Service Act 2006 and in the Trust's Licence issued by NHSI (Monitor).

As a Public Benefit Corporation the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable.

NHS Framework

Paragraph 15 of the Constitution, requires the Council of Governors to adopt its own Standing Orders for its practice and procedure.

1. INTERPRETATION

1.1 In these Standing Orders, the provisions relating to Interpretation in the Constitution shall apply and the words and expressions defined in the Constitution shall have the same meaning.

2. THE COUNCIL OF GOVERNORS

2.1 Roles and Responsibilities of Governors:

2.1.1 Appointment and removal of the Chair and Non-Executive Directors (Constitution Paragraph 21)

2.1.2 Approve the appointment (but not the removal) of the Chief Executive (Constitution Paragraph 24)

2.1.3 Appoint and remove the Auditor (Constitution Paragraph 33)

2.1.4 Receive the Annual Report & Accounts (Constitution Paragraph 37)

2.1.5 Ensure that the Trust operates in accordance with its Licence and will also act in a Trustee role for the welfare of the organisation as a vehicle for influencing change and developments.

2.1.6 Oversee and advise the Board of Directors regarding future Trust plans and priorities.

2.1.7 To hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and to represent the interests of the Members as a whole and the interests of the public, and monitor the performance of the Trust against the strategic direction and the targets with a view to satisfying itself that the Board of Directors is fulfilling its responsibilities in this regard. This will be achieved by regular briefings on the performance of the Trust and at its meetings, being able to consider and comment on that performance.

2.1.8 Ensure continued success of the organisation through overseeing of effective management, partnership working and maintenance of NHS values and principles.

2.1.9 Oversee the development of the Trust as an effective social enterprise through focus on the wider public interest and promoting social cohesion in ensuring that the Council of Governors reflects all the interests of the membership community.

2.1.10 To share local responsibility for the success of the Trust, in particular by building and sustaining a wide consensus to the vision for the Trust and by members representing the hospital to their respective communities and organisations and vice versa.

2.1.11 Instigate or be involved in review of a specific issue, or be involved in further development of a particular strategy through specific working groups.

2.1.12 To require one or more Directors to attend a meeting of the Council of Governors for the purpose of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Trust's or Directors' performance).

2.1.13 To approve the entering into of any significant transactions.

2.1.14 To determine issues in the forward plans regarding the proportion of the Trust's activities and income in relation to non-NHS income and

implementation of the same.

2.1.15 To exercise such other powers and to discharge such other duties as may be conferred on the Council of Governors under this Constitution.

2.2 **Composition of the Council of Governors** – The composition of the Council of Governors shall be as set out in Annex 3 of the Constitution.

2.3 **Appointment of the Chair and Non-Executive Directors** – The Chair and Non-Executive Directors are appointed by the Council of Governors in accordance with Paragraph 21 of the Constitution.

2.4 **Terms of Office of the Chair and Non-Executive Directors** – The provisions governing the period of tenure of office of the Chair and the Non-Executive Directors are contained in Paragraph 29 of the Constitution.

2.5 **Deputy-Chair -** The Deputy-Chair may preside at meetings of the Council of Governors in the following circumstances:

2.5.1 When there is a need for someone to have the authority to chair any meeting of the Council of Governors when the Chair is not present.

2.5.2 When the remuneration, allowance and other terms and conditions of the Chair are being considered.

2.5.3 When the appointment of the Chair is being considered, should the current Chair be a candidate for re-appointment.

2.5.4 On occasions when the Chair declares a pecuniary interest that prevents him from taking part in the consideration or discussion of a matter before the Council of Governors.

3. MEETINGS OF THE COUNCIL OF GOVERNORS

3.1 Calling Meetings

3.1.1 Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least fourteen days written notice of the date and place of every meeting of the Council of Governors to all Governors. Notice will also be published on the Foundation Trust's website, which will also be provided at least fourteen days before the meeting.

3.1.2 The Secretary shall ensure that within the meeting cycle of the Council of Governors, general meetings are called at appropriate times to consider matters as required by the 2006 Act and the Constitution.

3.2 **Admission of the Public** – The provisions for the admission of the public to meetings of the Council of Governors are detailed at Paragraph 14 and Annex 5 of the Constitution.

3.3 **Chair of Meetings** – The Chair of the Trust, or in their absence, the Deputy Chair, is to preside at meetings of the Council of Governors. If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy-Chair shall preside.

3.4 **Setting the Agenda –** The Council of Governors may determine that certain matters shall appear on every agenda for a meeting of the Council of Governors and shall be addressed prior to any other business being conducted.

3.5 **Agenda** – A Governor desiring a matter to be included on an agenda shall specify the question or issue to be included by request in writing to the Chair or Secretary at least three clear business days before Notice of the meeting is given. Requests

made less than three days before the Notice is given may be included on the agenda at the discretion of the Chair.

3.6 **Notices of Motion** – A Governor desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting to the Chair or Secretary, who shall insert in the agenda for the meeting all notices so received subject to the Notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without Notice on any business mentioned on the agenda in accordance with Standing Order 3.5, subject to the Chair's discretion.

3.7 **Withdrawal of Motion or Amendments** – A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.8 **Motion to Rescind a Resolution** – Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall be in writing, be in accordance with Standing Order 3.6 and shall bear the signature of the Governor who gives it and also the signature of four other Governors. When any such motion has been disposed of by the Council of Governors, it shall not be competent for any Governor other than the Chair to propose a motion to the same effect within six months; however the Chair may do so if considered appropriate.

3.9 **Motions** – The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

3.10 When a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move:

3.10.1 An amendment to the motion.

3.10.2 The adjournment of the discussion or the meeting.

3.10.3 That the meeting proceed to the next business.

3.10.4 That the motion be now put.

No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

3.11 **Chair's Ruling** – Statements of Governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

Save as permitted by law, at any meeting the person presiding shall be the final authority on the interpretation of Standing Orders (on which he should be advised by the Chief Executive).

3.12 **Voting** – Save as otherwise provided in the Constitution and/or the 2006 Act, if the Chair so determines or if a Governor requests, a question at a meeting shall be determined by a majority of the votes of the Governors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a casting vote.

3.13 All questions put to the vote shall, at the discretion of the person presiding, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request.

3.14 If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present

voted or abstained.

3.15 If a Governor so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

3.16 In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

3.17 **Minutes** – The Minutes of the proceedings of a matter shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

3.18 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.19 Minutes of meetings will be taken and circulated in accordance with Governors' wishes.

3.20 **Suspension of Standing Orders** – Except where this would contravene any statutory provision, the Licence or any provision of the Constitution, any one or more of the Standing Orders may be suspended at any meeting provided that at least two thirds – of the Council of Governors are present, including two Public Governors and one Staff Governor, and that a majority of those present vote in favour of suspension.

3.21 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

3.22 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Governors.

3.23 No formal business may be transacted while Standing Orders are suspended.

3.24 **Variation and Amendment of Standing Orders** – these Standing Orders shall be amended only in accordance with paragraph 39 of this Constitution.

3.25 **Record of Attendance** – the names of the Governors present at the meeting shall be recorded in the minutes.

3.26 **Quorum** – no business shall be transacted at a meeting of the Council of Governors unless at least one third of the Council of Governors are present, with a minimum of six, a majority of whom must be Governors elected by the Public Constituencies, and one staff governor.

3.27 A Governor who has declared a non-pecuniary interest in any matter may participate in the discussion and consideration of the matter but may not vote in respect of it: in these circumstances the Governor will count towards the quorum of the meeting. If a Governor has declared a pecuniary interest in any matter, the Governor must leave the meeting room, and will not count towards the quorum of the meeting, during the consideration, discussion and voting on the matter. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.28 Subject to Standing Orders in relation to interests, any Director or their nominated representatives shall have the right to attend meetings of the Council of Governors and, subject to the overall control of the Chair, to speak to any item under consideration.

4. COMMITTEES

4.1 Except as required by paragraph 9.2 of Annex 5, the Council of Governors shall

exercise its functions in general meeting and shall not delegate the exercise of any function or any power in relation to any function to a Committee.

5. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

5.1 **Declaration of Interests** – in accordance with Paragraph 16 of the Constitution, Governors are required to declare formally any direct or indirect pecuniary interest and any other interest which is relevant and material to the business of the Trust. The responsibility for declaring an interest is solely that of the Governor concerned.

5.2 A Governor must declare to the Secretary:

5.2.1 any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter concerning the Trust, and

5.2.2 any interests which are relevant and material to the business of the Trust.

5.3 Such a declaration shall be made by completing and signing a form, as prescribed by the Secretary from time to time setting out any interests required to be declared in accordance with the Constitution or these Standing Orders and delivering it to the Secretary within 28 days of a Governor's election or appointment or otherwise within seven days of becoming aware of the existence of a relevant or material interest. The Secretary shall amend the Register of Interests upon receipt of notification within three working days.

5.4 If a Governor is present at a meeting of the Council of Governors and has an interest of any sort in any matter which is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter and, if they have declared a pecuniary interest, they shall not take part in the consideration or discussion of the matter. The provisions of this Paragraph are subject to Paragraph 5.9.

5.5 "relevant and material" interests may include but may not be limited to the following:

5.5.1 directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);

5.5.2 ownership or part-ownership or directorships of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

5.5.3 majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS;

5.5.4 a position of authority in a charity or voluntary organisation in the field of health and social care;

5.5.5 any connection with a voluntary or other organisation contracting for or commissioning NHS services;

5.5.6 any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to, lenders or banks;

5.5.7 research funding/grants that may be received by an individual or their department;

5.5.8 interests in pooled funds that are under separate management.

5.6 Any travelling or other expenses or allowances payable to a Governor in accordance with this Constitution shall not be treated as a pecuniary interest.

5.7 Subject to any other provision of this Constitution, a Governor shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

5.7.1 the individual, or a nominee of the individual, is a director of a company or

other body not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

5.7.2 the individual is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

5.8 A Governor shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

5.8.1 of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body;

5.8.2 of an interest in any company body or person with which the individual is connected as mentioned in paragraphs 5.2, 5.5 and 5.7 which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

5.9 Where a Governor:

5.9.1 has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body; and

5.9.2 the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

5.9.3 if the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

the Governor shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to his duty to disclose his interest.

5.10 In the case of persons living together the interest of one partner or spouse shall, if known to the other, be deemed for the purposes of these Standing Orders to be also an interest of the other.

5.11 If Governors have any doubt about the relevance of an interest, this should be discussed with the Secretary.

5.12 **Register of Interests** - the Secretary shall record any declarations of interest made in a Register of Interests kept by him in accordance with paragraph 30 of the Constitution. Any interest declared at a meeting shall also be recorded in the minutes of the meeting.

5.13 The Register will be available for inspection by members of the public free of charge at all reasonable times. A person who requests it is to be provided with a copy or extract from the register. If the person requesting a copy or extract is not a member of the Trust then a reasonable charge may be made for doing so.

6. STANDARDS OF BUSINESS CONDUCT

6.1 **Policy –** in relation to their conduct as a Governor of the Trust, each Governor must

comply with the principles outlined in HSG(93)5, "Standards of Business Conduct for NHS staff" as amended. In particular, the Trust must be impartial and honest in the conduct of its business and its office holders and staff must remain beyond suspicion. Governors are expected to be impartial and honest in the conduct of official business.

6.2 **Interest of Governors in Contracts** – if it comes to the knowledge of a Governor that a contract in which he/she has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust he/she shall, at once, give notice in writing to the Secretary of the fact that he/she is interested therein. In the case of married persons or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

6.3 A Governor shall not solicit for any person any appointment in the Trust.

7. REMUNERATION

7.1 Governors are not to receive remuneration.

8. PAYMENT OF EXPENSES TO GOVERNORS

8.1 The Trust will pay travelling expenses to Governors at such rates as the Board of Directors decides for attendance at General Meetings of the Governors, or any other business authorised by the Secretary as being under the auspices of the Council of Governors.

8.2 Expenses will be authorised and reimbursed through the Secretary's office on receipt of a completed and signed expenses form provided by the Secretary.

8.3 A summary of expenses paid to Governors will be published in the Annual Report.

9. RESOLUTION OF DISPUTES

9.1 Dispute Resolution between Board of Directors and Council of Governors

9.1.1 The Council of Governors and the Board of Directors shall be committed to developing and maintaining a constructive and positive relationship. The aim at all times is to resolve any potential or actual differences of opinion quickly, through discussion and negotiation.

9.1.2 If the Chair cannot achieve resolution of a disagreement through informal efforts the Chair will follow the dispute resolution procedure described below. The aim is to resolve the matter at the first available opportunity and only to follow this procedure if initial action fails to achieve resolution:

(a) The Chair will call a joint meeting ("Resolution Meeting") of the members of the Council of Governors and Board of Directors, to take place as soon as possible, but no later than twenty clear days following the date of the request. The meeting must comprise two thirds of the membership of the Council of Governors and two thirds of the membership of the Board of Directors. The meeting will be held in private. The aim of the meeting will be to achieve resolution of the conflict. The Chair will have the right to appoint an independent facilitator to assist the process. Every reasonable effort must be made to reach agreement.

(b) If a Resolution Meeting of the members of the Council of Governors and Board of Directors fails to resolve a conflict, the Board of Directors will decide the disputed matter.

(c) If following the formal Resolution Meeting, and the decision of the Board of Directors, the Council of Governors considers that implementation of the decision will result in the Trust failing to comply with its Licence; the Council of Governors will notify NHSI (Monitor) of the specific issue of non-compliance.

9.1.3 The right to call a Resolution Meeting rests with following, in the sequence of escalation shown:

(a) the Chair;

(b) the Chief Executive;

(c) two thirds of the members of the Council of Governors;

(d) two thirds of the members of the Board of Directors.

10. MISCELLANEOUS

10.1 **Review of Standing Orders** – These Standing Orders shall be reviewed annually by the Council of Governors.

10.2 **Deputy-Chair** – In relation to any matter touching or concerning the Council of Governors or a Governor outside a meeting of the Council of Governors, which arises the Deputy-Chair may exercise such power as the Chair would have in those circumstances.

10.3 **Notice** – Any written notice required by these Standing Orders shall be deemed to have been given on the day the notice was sent to the recipient.

10.4 **Confidentiality** – A Governor shall not disclose any matter reported to the Council of Governors notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors shall resolve that it is confidential.

ANNEX 7

Not Used

ANNEX 8
Further Provisions

1. Eligibility for Membership

1.1 An individual shall not be eligible for Membership of the Trust if the individual:

1.1.1 is under 16 years of age at the date of their application or invitation to become a Member (as the case may be);

1.1.2 fails or ceases to fulfil the criteria for Membership of any of the constituencies;

1.1.3 has been placed on the registers of Schedule 1 offenders pursuant to the Sexual Offences Act 2003 (as amended) and/or the Children and Young Person's Acts 1933 to 1969 (as amended) and his or her conviction is not spent under the Rehabilitation of Offenders Act 1974;

1.1.4 has been involved as a perpetrator in a serious incident of violence or has used persistent abusive behaviour in the last five years at any of the Trust's facilities or against any of the Trust's staff members or patients, provided that the Trust may resolve acting in the absolute discretion and that their so doing is part of their medical or mental condition and should not in itself preclude him from being a Member of the Trust;

1.1.5 has been excluded from the Trust's premises or facilities from which services are provided;

1.1.6 does not agree to abide by the Trust principles; or

1.1.7 has been identified as a vexatious complainant.

1.2 It is the responsibility of Members to ensure their eligibility and not the Trust, but if the Trust is on notice that a Member may be disqualified from Membership, the Trust shall carry out all reasonable enquiries to establish if this is the case.

Public Constituency

1.3 For the purposes of determining whether an individual lives in an area specified as an area for Public Constituency, an individual shall be deemed to do so if;

1.3.1 the individual's name appears on the electoral roll at an address within the said area and the Trust has no reasonable cause to conclude that the individual is not living at that address; or

1.3.2 the Trust is otherwise satisfied that the individual lives in the said area.

1.4 An individual who is a Member of the Public Constituency shall cease to be eligible to continue as a Member if they ceases to live in the area of the Public Constituency of which they are a Member save as may otherwise be provided in this paragraph 1.

1.5 Where a Member of a Public Constituency ceases to live permanently in the area of the Public Constituency of which they are a Member they shall forthwith advise the Trust that they are no longer eligible to continue as a Member and the Trust shall forthwith remove the individual's name from the Register of Members unless the Trust is satisfied that the individual concerned lives in some other area of a Public Constituency of the Trust. Where the Trust is satisfied that such an individual continues to live in the area of a Public Constituency of the Trust it shall, if the individual so requests, thereafter treat that individual as a Member of that other Public Constituency and amend the Register of Members accordingly

provided the Trust has given that individual not less than 14 days' notice of its intention to do so.

1.6 Where a Member ceases to live temporarily in the area of the Public Constituency of which they are a Member, the Trust may permit that individual nonetheless to remain on the Register of Members for that Public Constituency if it is for good cause satisfied that the absence is of a temporary duration only and that the Member will either return to live in the area of that Public Constituency of which they are a Member or will live in some other part of the Area of the Trust in which case the provisions of paragraph 1.4 shall apply as appropriate.

Staff Constituency

1.7 A Member of a Staff Class will cease to be eligible to be a Member of that Staff Class if they no longer meet the eligibility requirements of paragraph 7 of the Constitution.

2. Application for Membership

2.1 An individual may become a Member by application to the Trust in accordance with this Constitution or, where so provided for in this Constitution, by being invited by the Trust to become a member of a Staff Class of the Staff Constituency in accordance with paragraph 8.1 of this Constitution.

2.2 Where an individual wishes to apply to become a Member of the Trust, the following procedure shall apply:

2.2.1 the Trust shall upon request supply the individual with a form of application for Membership in a form determined by the Trust;

2.2.2 upon receipt of the said form of application duly completed and signed by the applicant (or in the Trust's discretion signed on behalf of the applicant) the Trust shall as soon as is reasonably practicable and in any event within 28 working days of receipt of the duly completed form consider the same;

2.2.3 unless the applicant is ineligible for Membership or is disqualified from Membership, the Trust shall cause his name to be entered forthwith on the Trust's Register of Members and shall give notice in writing to the applicant of that fact;

2.2.4 upon the applicant's name being entered on the Trust's Register of Members the individual shall thereupon become a member;

2.2.5 the information to be included in the Trust's Register of Members shall include the following details relating to that Member:

2.2.5.1 full name and title;

2.2.5.2 date of birth;

2.2.5.3 full postal address;

2.2.5.4 home telephone number (if any);

2.2.5.5 email address (if any);

2.2.5.6 the Constituency and class of which they are a Member;

2.2.5.7 the date upon which they became a Member;

2.2.5.8 gender and ethnicity, and

2.2.5.9 affiliation to any health and social care group.

2.3 Where an individual is to be invited by the Trust to become a Member, the following procedure shall apply:

2.3.1 the Trust shall take all reasonable steps to satisfy itself that the individual is eligible to become a Member of the Staff Class of the Staff Constituency relevant to them before inviting the individual to become a Member of the Trust and that it has all the information needed to complete the Register of Members in accordance with paragraph 2.2.5 above;

2.3.2 the Trust having so satisfied itself, it shall thereupon invite that individual to become a Member pursuant to paragraph 8.1, of the Constitution;

2.3.3 unless the individual has within 28 days of the date upon which the Trust dispatches its invitation to them to become a Member advised the Trust that they do not wish to become a Member, the Trust shall thereupon enter that individual's name on the Register of Members and they shall thereupon become a Member provided that the Trust has been provided with the information, if any, requested pursuant to paragraph 2.3.2 to enable it to complete the relevant entry in the Register of Members.

2.4 No individual who is ineligible or disqualified from Membership shall be entered or remain on the Register of Members.

2.5 For the avoidance of doubt, an individual shall become a Member on the date upon which their name is entered on the Trust's Register of Members and shall cease to be a Member upon the date on which their name is removed from the Register of Members as provided for in this Constitution.

2.6 The Trust shall procure that the Register of Members and all other Registers to be maintained in accordance with this Constitution or in accordance with the 2006 Act are regularly reviewed and updated and that the Register of Members in particular is reviewed and updated as appropriate and no less often than every 28 days.

2.7 Where in the reasonable opinion of the Trust a Member is no longer eligible or is disqualified from Membership of the Trust it shall be entitled to remove the name of that individual from the Register of Members and that individual shall thereupon cease to be a Member provided always that this power shall not be exercised until the Trust has given not less than fourteen days written notice to the Member addressed to them at the address given in the Register of Members of its intention to remove them from the Register and that Member has not within that period notified the Trust of their wish to continue as Member and provided proof satisfactorily to the Trust of his continued eligibility.

3. Members Meetings

3.1 The Trust shall hold an annual Members' Meeting of its members (called the "Annual Members' Meeting") within eight months of the end of each Financial Year of the Trust. The Annual Members' Meeting shall be open to members of the public.

3.2 Any Members' Meetings other than the Annual Members' Meeting shall be called "Special Members' Meetings".

3.3 Not used.

3.4 All Members' Meetings are to be convened by order of the Board of Directors.

3.5 The Board of Directors may:

3.5.1 decide where a Members' Meeting is to be held and may also for the benefit of the Members arrange for the Annual Members' Meeting to be held in different venues each year;

3.5.2 make provision for a Members' Meeting to be held at different venues simultaneously or at different times. In making such provision the Board of Directors shall also fix an appropriate quorum for each venue provided that the aggregate of the quorum requirements shall be not less than the quorum set out in paragraph 3.26 of Annex 6 of this Constitution.

3.6 The Board of Directors shall present to the Members at the Annual Members' Meeting: -

3.6.1 a report on steps taken to secure that (taken as a whole) the actual membership is representative of those eligible for such membership;

3.6.2 the progress of the Membership strategy;

3.6.3 any proposed changes to the policy for the composition of the Council of Governors and of the Non-Executive Directors;

3.6.4 the results of the election and appointment of Governors;

3.6.5 the annual accounts, any report of the auditor on them and the annual report; and

3.6.6 any other reports or documentation it considers necessary or otherwise required by Monitor or the 2006 Act.

3.7 The Trust shall give notice of all Members' Meetings:

3.7.1 by notice in writing to all Members;

3.7.2 by notice prominently displayed at the Trust's main address and at all of the Trust's principal places of business;

3.7.3 by notice on the Trust's website;

3.7.4 to the Council of Governors and the Board of Directors, and to the Trust's auditors stating whether the meeting is an Annual or Special Members' Meeting giving the time, date and place of the meeting and indicating the business to be dealt with at the meeting at least 14 clear days before the date of the meeting.

3.8 The Chair or in their absence the Deputy Chair shall preside at all Members' Meetings of the Trust. If neither of the Chair or the Deputy Chair is present, the Governors present shall elect one of their number to be Chair and if there is only one Governor present and willing to act that person shall be Chair. If no Governor is willing to act as Chair or if no Governor is present within fifteen minutes after the time appointed for holding the meeting, the Members present and entitled to vote shall choose one of their number to be Chair.

3A. Voting at Governor Elections

3A.1 A Member may not for the purpose of Section 60(1) of the 2006 Act vote at an election for a Public Governor unless within the specified period they have made a declaration in the specified form stating the particulars of their gratification to vote as a Member of the Public Constituency for which an election is being held. It is an offence knowingly or recklessly to make such a declaration which is false in a

material particular.

4. Board of Directors: Disqualification

4.1 In addition to the grounds of disqualification set out in paragraph 26 of the Constitution, a person may also not be or continue as a Director of the Trust if:

4.1.1 in the case of a Non-Executive Director, they no longer satisfy the relevant requirements for appointment;

4.1.2 they are a person whose tenure of office as a Chair or as a member or director of a health service body has been terminated on the grounds that their appointment is not in the interests of public service, or for non-disclosure of a pecuniary interest;

4.1.3 they have within the preceding two years been dismissed, otherwise than by reason of redundancy, by the coming to an end of fixed term contract or through ill health, from any paid employment with a health service body;

4.1.4 information revealed by a Criminal Records Bureau check is such that it would be inappropriate for the individual to become or continue as a Director on the grounds that this would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute;

4.1.5 in the case of an Executive Director, the individual is no longer employed by the Trust.

5. Governors and Directors: Communication and Conflict

5.1 Summary

This paragraph 5 describes the processes intended to ensure a successful and constructive relationship between the Council of Governors and the Board of Directors. It emphasises the importance of informal and formal communication, and confirms the formal arrangements for communication within the Trust. It suggests an approach to informal communications, and sets out the formal arrangements for resolving conflicts between the Council of Governors and the Board of Directors.

5.2 Informal Communications

5.2.1 Informal and frequent communication between the Governors and the Directors is an essential feature of a positive and constructive relationship designed to benefit the Trust and the services it provides.

5.2.2 The Chair shall use his reasonable endeavours to encourage effective informal methods of communication including: -

5.2.2.1 participation of the Board of Directors in the induction, orientation and training of Governors;

5.2.2.2 development of special interest relationships between Non-Executive Directors and Governors;

5.2.2.3 discussions between Governors and the Chair and/or the Chief Executive and/or Directors through the office of the Chief Executive or their nominated officer;

5.2.2.4 involvement in membership recruitment and briefings at public events organised by the Trust.

5.3 Formal Communication

5.3.1 Some aspects of formal communication are defined by the constitutional roles and responsibilities of the Council of Governors and the Board of Directors respectively.

5.3.2 Formal communications initiated by the Council of Governors and intended for the Board of Directors will be conducted as follows: -

5.3.2.1 specific requests by the Council of Governors will be made through the Chair to the Board of Directors;

5.3.2.2 any Governor has the right to raise specific issues to be put to the Board of Directors at a duly constituted meeting of the Council of Governors through the Chair but if the Chair declines to raise any such issue the said Governor may nonetheless still raise it provided two thirds of the Governors present approve their request to do so. The Chair shall then raise the matter with the Board of Directors and provide the response to the Council of Governors;

5.3.2.3 joint meetings will take place between the Council of Governors and the Board of Directors as and when appropriate.

5.3.3 The Board of Directors may request the Chair to seek the views of the Council of Governors on such matters as the Board of Directors may from time to time determine.

5.3.4 Communications between the Council of Governors and the Board of Directors may occur with regard to, but shall not be limited to:-

5.3.4.1 the Board of Directors proposals for the Strategic Direction and the Annual Business Plan;

5.3.4.2 the Board of Directors' proposals for developments;

5.3.4.3 Trust performance;

5.3.4.4 involvement in service reviews and evaluation relating to the trust's services; and

5.3.4.5 proposed changes, plans and developments for the Trust other than may be covered by paragraph 5.3.2.2 above.

5.3.5 The Board of Directors shall also present to the Council of Governors the Annual Accounts, Annual Report and Auditors Report in accordance with the terms of this Constitution and of the 2006 Act.

5.3.6 The following formal methods of communication may also be used as appropriate with the consent of both the Council of Governors and the Board of Directors:-

5.3.6.1 attendance by the Board of Directors at a meeting of the Council of Governors;

5.3.6.2 provision of formal reports or presentations by executive directors to a meeting of the Council of Governors;

5.3.6.3 inclusion of appropriate minutes for information on the agenda of a meeting of the Council of Governors;

5.3.6.4 reporting the views of the Council of Governors to the Board of Directors though the Chair or Deputy Chair.

5.4 Other Disputes

5.4.1 Where an individual is held by the Trust to be ineligible and/or disqualified from Membership of the Trust and disputes the Trust's decision in this respect, the matter shall be referred to the Chief Executive (or such other officer of the Trust as the Chief Executive may nominate) as soon as reasonably practicable thereafter.

5.4.2 The Chief Executive (or his nominated representative) shall:

5.4.2.1 review the original decision having regard to any representations made by the individual concerned and such other material, if any, as the Chief Executive considers appropriate;

5.4.2.2 then either confirm the original decision or make some other decision as appropriate based on the evidence which he has considered; and

5.4.2.3 communicate their decision and the reasons for it in writing to the individual concerned as soon as reasonably practicable.

5.4.3 Where a Governor is declared ineligible or disqualified from office or their term of office as a Governor has been terminated (otherwise than as a consequence of their own resignation) and that person disputes the decision, they shall as soon as reasonably practicable be entitled to refer the matter to an independent assessor agreeable to both parties who will consider the evidence and conclude whether the proposed removal is reasonable or otherwise.

5.5 Not used.

5.6 Indemnity

Members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their Board functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust and the Trust shall have the power to purchase suitable insurance or make appropriate arrangements with the National Health Service Litigation Special Health Authority to cover such costs.

5.7 Validity of Actions

No defect or deficiency in the appointment or composition of the Council of Governors or the Board of Directors shall affect the validity of any action taken by them

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 28 February 2018

Trust Board LGBT+ update

Purpose of Report

February is LGBT+ history month and this paper provides an update to Trust Board on our LGBT+ commitments and priorities.

Executive Summary

Our LGBT+ commitments are:

- We want all our colleagues and service receivers to know we have zero tolerance to all kinds of homophobia, biphobia and transphobia: We will take a stand against all LGBT+ discrimination, victimisation or harassment.
- We commit to keep up to date with LGBT+ issues and support LGBT+ colleagues and service receivers. We want to know that we are not only meeting our statutory duties to our LGBT+ colleagues, patients and carers but that we are also providing the most inclusive experience we can for LGBT+ people.
- We will wear our rainbow heart on our sleeves to champion equality and openly promote inclusivity for LGBT+ colleagues and service receivers because we want people to feel confident to be themselves, knowing they will be accepted.

Initial LGBT+ Board champion priorities are:

- Being a specific named senior contact in order to hear directly from LGBT+ colleagues and service receivers
- To explore Derbyshire Healthcare 'accreditation' such as locally with Derbyshire LGBT+ and/or relevant Stonewall Diversity Champion or similar.
- To work with Derbyshire LGBT+ to achieve our commitments and objectives for the Derbyshire LGBT+ community (colleagues and service receivers)
- To improve recording rates for equalities indicators for both service receivers and colleagues so that we can see if we are reaching LGBT+ people effectively and so that we can also highlight any areas that may need additional support
- To review and action plan for staff survey feedback from our LGBT+ colleagues
- To support the creation of a vibrant LGBT+ network for colleagues to feel valued, to share their insight and to create improvements in our services and work environment.
- To encourage the use of more LGBT+ information to create a visible welcome in public areas in our services, review of website and promotion/participation in LGBT+ events.

Actions taken to date in line with commitments and priorities

- Engagement activity e.g. publicity and awareness e.g. through corporate induction, Connect and staff magazine, social media, Derbyshire LGBT+ role model conference, all staff emails interactions, meetings with LGBT+ colleagues, service users and others from inside and outside organisation.
- Analysis of complaints to see if any were LGB related (there were none).
- Corporate induction imagery updated for LGBT+ inclusive content and images
- Trust Board and Trust Management Team physically signed up to LGBT+

pledges, which has been publicised to all staff.
- Initial equalities data monitoring training co- delivered with Derbyshire LGBT+
- EDS2 (Equalities Delivery system) event held on 13/02/18 to consider how we are doing with regards to being a caring, good and fair employer for all REGARDS groups and valuing, harnessing and benefiting from the talents of our diverse workforce

Difference made
- Positive cultural impact through increased visibility, awareness, promotion and commitment to LGBT+ inclusion
- You-said-we-did specific LGBT+ decisions made e.g. the use of '+' not 'Q'
- Leadership connections have been made to discuss and share best practice e.g. in providing services for trans patients
- Autonomous decision-making has taken place e.g. LGBT+ inclusive environment decisions e.g. for gender neutral toilets in Hub at Hartington
- Confirmation of some key areas to address (e.g. low recording rates)

Next steps
- Analysis of staff survey by LGB responses (where possible)
- Equalities recording rates need to improve on Electronic Staff Record and on clinical systems (training provision) in order to inform help us know where we can make the most difference (information also needed to provide support for grading of how well we are doing for EDS2)
- Mini Conference (May) and LGBT+ Network set up (as soon as possible)
- Continuing/expanding engagement and making connections including key LGBT+ events across year and replacement of square rainbow stickers with rainbow heart stickers
- Application for appropriate Stonewall accreditation
- Support to LGBT+ role models and allies
- The creation of vibrant network will determine next key priorities

Strategic Considerations	
1) We will deliver **quality** in everything we do providing safe, effective and service user centred care	X
2) We will develop strong, effective, credible and sustainable **partnerships** with key stakeholders to deliver care in the right place at the right time	
3) We will develop our **people** to allow them to be innovative, empowered, engaged and motivated. We will retain and attract the best staff.	X
4) We will **transform** services to achieve long-term financial sustainability.	

Assurances

Through the Equalities Act 2010 we have statutory obligations around equality, diversity and inclusion.

Consultation

This paper has not been consulted on.

Governance or Legal Issues

There are no governance or legal issues other than those related to the Equality Act 2010 and Equality Delivery System.

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).

There are no adverse effects on people with protected characteristics (REGARDS).	x
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	

Actions to Mitigate/Minimise Identified Risks

There are no adverse impacts and indeed achieving our LGBT+ priorities will improve the experience and outcomes of LGBT+ colleagues, service receivers and carers.

Progress in this area also supports our Equality Delivery System (EDS2) work.

Recommendations

The Board of Directors is requested to:

1) Receive the update in line with their LGBT+ commitments
2) Take significant assurance from progress with activity for LGBT+ inclusion

Report prepared and presented by: **Claire Wright**
Deputy Chief Executive, Director of Finance and Board LGBT+ Champion

2017-18 Board Annual Forward Plan

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	26 Apr 17	24 May 17	28 Jun 17	26 Jul 17	27 Sep 17	1 Nov 17	29 Nov 17	27 Jan 18	28 Feb 18	28 Mar 18
		Deadline for papers	**18 Apr**	**15 May**	**19 Jun**	**17 Jul**	**18 Sep**	**23 Oct**	**20 Nov**	**22 Jan**	**19 Feb**	**19 Mar**
CM	Apologies given		X	X	X	X	X	X	X	X	X	X
SH	Declaration of Interests	FT Constitution	X	X	X	X	X	X	X	X	X	X
CM	Minutes/Matters arising/Action Matrix	FT Constitution	X	X	X	X	X	X	X	X	X	X
CG	Actions and learnings from patient stories.		X	X	X	X	X	X	X	X	X	X
CM	Board Forward Plan	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X
CM	Board review of effectiveness of the meeting	Statutory Outcome 3	X	X	X	X	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE												
CM	Chair's report	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X
IM	Chief Executive's report	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X
MP/ CW	NHSI Annual Plan *TBC awaiting NHSI guidance*	FT Constitution/NHSI Risk Assurance Framework (RAF)										
CW	NHSI Compliance Return (Public) (subject to change (incorporated into Integrated Performance Report)	NHSI Single Operating Framework		X	X				X	X		X
JS	Information Governance - annual report April interim report November	Strategic Outcome 1 Strategic Outcome 3 Information Gov toolkit	AR					IR				
AR	Staff Survey Results and Action Plan	Strategic Outcome 3 and 4										X
AR	Equality Delivery System2 (EDS2) & Workforce Race Equality Standard (WRES) Submission * (Jul & Sep 2017)	Strategic Outcome 3 and 4	AR		X *	X *	X Update		X Update			
AR	Pulse Check Results and Staff Survey Plan						X					
AR	Approval of Equality Delivery System2 (EDS2) 2017/18	Strategic Outcome 3 and 4					X					
SH	Review SOs, SFIs, SoD	FT Constitution Standing Orders					AR					
SH	Trust Sealings	FT Constitution Standing Orders	X							X		

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	26 Apr 17	24 May 17	28 Jun 17	26 Jul 17	27 Sep 17	1 Nov 17	29 Nov 17	27 Jan 18	28 Feb 18	28 Mar 18
SH	Annual Review of Register of Interests	FT Constitution Annual Reporting Manual	AR									
SH	Board Assurance Framework Update	Licence Condition FT4				X		X			X	
SH	Raising Concerns (whistleblowing)	Strategic Outcome 1 Public Interest Disclosure Act			X							
SH	Committee Assurance Summaries (following every meeting) - Audit & Risk Committee - Finance & Performance - Confidential - Mental Health Act Committee - Quality Committee - Safeguarding Committee - People & Culture Committee	Strategic Outcome 3	X	X	X	X	X	X	X	X	X	X
SH	Governance Improvement Action Plan	Licence Condition FT4	X	X	X	X	X	X				X
SH	Fit and Proper Person Declaration	Licence Condition FT4		X								X
MP	Emergency Planning Report (EPPR)								X			
SH	Board Effectiveness Survey			X			X					
SH	Report from Council of Governors Meeting (for information)		X	X		X	X	X		X	X	X
SH	Review of Policy for Engagement between the Board & COG											AR
SH	Board Development Programme											X
LWS	Business Plan 2017-18 Monitoring		X			X		X				X
LWS	Measuring the Trust Strategy			X								
OPERATIONAL PERFORMANCE												
CG, CW, AR, MP	Integrated performance and activity report to include Finance, Workforce, performance and Quality Dashboard	Licence Condition FT 4 Strategic outcome 1 Strategic Outcome 3	X	X	X	X	X	X	X	X	X	X

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	26 Apr 17	24 May 17	28 Jun 17	26 Jul 17	27 Sep 17	1 Nov 17	29 Nov 17	27 Jan 18	28 Feb 18	28 Mar 18
QUALITY GOVERNANCE												
CG	Position Statement on Quality (Incorporates Strategy and assurance aspects of Quality management) Quarterly publication of specicified information on death in Jan/Mar/Jun/Sep Includes Annual Review of Recovery Outcomes in November and Annual Looked After Children Report in December	Strategic Outcome 1 CQC and Monitor	X	X	X	X	X	X	X	X	X	x
CG/JS	Safeguarding Children & Adults at Risk Annual Report	Children Act Mental Health Standard Contract					AR					
CG	Control of Infection Report	Health Act Hygiene Code		AR								
JS	Re-validation of Doctors	Strategic Outcome 3			AR							
CG	Annual Review of Recovery Outcomes *							X				
CG	Annual Looked After Children Report *									X		

* Incorporated in Quality Position Statement