Derbyshire Healthcare NHS
NHS Foundation Trust

Meeting of the Board of Directors

27 April 2016

Trust Headquarters, Ashbourne Centre, Kingsway Site, Derby, DE22 3LZ
Tel: (01332) 623700 Fax: (01332) 331254
Acting Chief Executive: Ifti Majid Interim Chairman: Richard Gregory

Better together

NOTICE OF BOARD MEETING
WEDNESDAY 27 APRIL 2016
TO COMMENCE AT 1.00 PM IN THE CONFERENCE ROOMS A & B,
RESEARCH & DEVELOPMENT CENTRE, KINGSWAY, DERBY DE22 3LZ

	Time	AGENDA	Enc Ref	Discussion led by
1.	1:00	Chairman's Welcome and Opening Remarks	**-**	Richard Gregory
2.	1:05	Service Receiver Story – Mr Grundy's Group	**-**	Richard Gregory
3.	1:30	Apologies for Absence Declarations of Interest	**-**	Richard Gregory
4.	1:30	Minutes of Board of Directors meeting held on 30 March 2016	**A**	Richard Gregory
5.	1:35	Matters arising – Actions Matrix	**B**	Richard Gregory
6.	1:40	Chairman's Verbal Update	**-**	Richard Gregory
7.	1:50	Acting Chief Executive's Report	**C**	Ifti Majid
STRATEGY AND GOVERNANCE				
8.	2:00	Governance Improvement Action Plan and Delivery Framework	**D**	Mark Powell
9.	2:10	Monitor Compliance Return	**E**	Claire Wright
10.	2:20	Information Governance Update	**F**	Carolyn Gilby
11.	2:30	Staff Survey Results and Action Plan	**G**	Jayne Storey
12.	2:45	Annual Review of Register of Interests	**H**	Sam Harrison
3:00 B R E A K				
13.	3:15	Clinical Audit - Research and Development deep dive	**I**	John Sykes
14.	3:45	Board Committee Escalations: - Quality Committee ratified minutes of meeting held 10 March - People & Culture Committee – ratified minutes of meeting held 17 March - Audit Committee – draft minutes meeting held 16 March - Mental Health Act Committee – draft minutes meeting held 30 March - Quality Committee Assurance Summary of meeting held 14 April - Safeguarding Committee Assurance Summary of meeting held 15 April - People & Culture Committee Assurance Summary of meeting held 20 April	**J**	Committee Chairs
QUALITY GOVERNANCE				
15.	3:55	Position Statement on Quality	**K**	Carolyn Green
OPERATIONAL PERFORMANCE				
16.	4:05	Integrated Performance and Activity Report	**L**	Carolyn Gilby Claire Wright Jayne Storey
CLOSING MATTERS				
17.	3:40	Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework	**-**	Richard Gregory
18.	3:50	2016/17 Board Forward Plan	**M**	Sam Harrison

Questions that are applicable to the agenda, and at the Chairman's discretion, can be sent by email to the Board Secretary up to 48 hours prior to the meeting and a response will be provided by the Board at the meeting.
Email: sue.turner2@derbyshcft.nhs.uk

The Chairman 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 is to be held on 25 May 2016, at 1.00 pm 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 Chairman's discretion.

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Wednesday 30 March 2016

MEETING HELD IN PUBLIC

Commenced: 1pm Closed: 4.20pm

PRESENT:	Richard Gregory	Interim Chairman
	Jim Dixon	Deputy Chair and Non-Executive Director
	Caroline Maley	Senior Independent Director
	Maura Teager	Non-Executive Director
	Tony Smith	Non-Executive Director
	Ifti Majid	Acting Chief Executive
	Claire Wright	Executive Director of Finance
	Carolyn Green	Director of Nursing and Patient Experience
	Dr John Sykes	Executive Medical Director
	Carolyn Gilby	Acting Director of Operations
	Jayne Storey	Director of Workforce OD & Culture
	Jenna Davies	Interim Director of Corporate & Legal Affairs
IN ATTENDANCE:	Richard Eaton	Communications Manager
	Sue Turner	Board Secretary and Minute Taker
APOLOGIES:	Phil Harris	Non-Executive Director
	Mark Powell	Director of Business Development & Marketing
VISITORS:	John Morrissey	Lead Governor
	Carole Riley	Member of the Public
	Winston Samuels	Member of the Public

DHCFT 2016/034	**INTERIM CHAIRMAN'S WELCOME, OPENING REMARKS AND APOLOGIES** The Interim Chairman, Richard Gregory, opened the meeting by welcoming all present. Declarations of interest were declared by Maura Teager and Ifti Majid in respect of the Yates report provided in the agenda pack for information.
DHCFT 2016/035	**SERVICE RECEIVER STORY – EARLY INTERVENTION AND THE INTERNSHIP PROGRAMME** Richard Gregory and the Board welcomed service receiver Michael who was accompanied by Joanne Downing, Volunteer Manager Occupational Therapist and introduced by Bev Green, Release and Time to Care Lead and Divisional Nurse for the North Campus. Michael explained that he had been suffering from anxiety and depression and was referred by his GP to the Early Intervention Team. He is well now and has been involved in the Trust's internship scheme since October. Michael is particularly interested in IT

	and has worked well with the IT team. He has also worked as an administrator for ward managers recording training and qualifications and has carried out other administrative work. Michael described the support and guidance he has received from the internship team as very reassuring. Everyone he has worked with has been very welcoming and helpful. He was particularly impressed with the encouragement he received while working with Peter Charlton and the IT team and he found it extremely rewarding knowing the support he offered benefitted the IT team and other areas within the Trust. Michael also felt working within the internship programme gave him the confidence to learn to drive which has been very beneficial with his daily commute from Chesterfield. The internship scheme supports people and helps them get back into work. This is a new programme for the Trust and Joanne Downing is supporting Michael through his internship and looking at sourcing external areas for him to move into. She has also helped Michael with ideas for the future and he is hoping to progress to another placement in a technical role and is looking forward to getting back into full time work. Joanne Downing explained that the internship scheme works alongside the early intervention team and she would like to see the programme expanded as more work needs to be done in house to help and support other service receivers. She would also like to involve other organisations and businesses to help with this initiative. Richard Gregory agreed the internship programme could have more potential and suggested that organisations such as the Princes' Trust and Business in the Community could be approached for support. Occupational therapy intervention supports Michael and organises his work-based placements and provides him with contacts externally and internally. Each individual coming through the internship scheme has their skills mapped and these are matched with different functions. Michael has been impressed with the structure of the programme which has given him the opportunity to acquire new skills. The programme has also helped him integrate back into society and has given him the opportunity to enjoy mixing with people again and has given him a purpose in life. Essentially the most important thing about the internship scheme has been the people he has worked with who have helped him and made him feel confident to get back into work and he would now like to move onto something more challenging. Richard Gregory recommended to Michael that he should update his CV to mention that he presented his story very articulately and eloquently he would be happy to offer him further support and encouragement. The Board gave thanks to Michael for agreeing to tell his story and commended the way he presented his experience of the internship programme so articulately which allowed the Board to hear at first hand the service this new initiative provides. **RESOLVED: The Board of Directors expressed thanks to Michael for sharing his inspiring story and appreciated the opportunity to hear at first hand the services the Trust has to offer.**
DHCFT 2016/036	**MINUTES OF THE MEETING DATED 24 FEBRUARY 2016** The minutes of the meeting, dated 24 February were accepted and agreed.
DHCFT 2016/037	**MATTERS ARISING AND ACTIONS MATRIX** The Board agreed to close all completed actions. Updates were provided by members of the Board and were noted directly on the actions matrix. **DCHFT 2016/005 Industrial Action:** John Sykes, Medical Director, informed the Board of plans to provide bank holiday emergency cover for industrial action due to take place in early April. This cover had worked well on the previous occasions of industrial action and he was pleased to report that waiting times have been holding up well. A total walk

	out planned for the end of April is unprecedented and contingency plans will be discussed at the Executive Leadership Team as to how the Trust would continue to support junior doctors and improve the balance between staff morale/satisfaction and patient care.
DHCFT 2016/038	**CHAIRMAN'S VERBAL REPORT** Richard Gregory updated the Board on developments made in the last month. I. The Trust is looking to immediately recruit two Non-Executive Directors (NEDs) to replace Tony Smith and Phil Harris who has recently tendered his resignation and another to undertake a six month handover with Maura Teager before she retires in March 2017. A paper will be submitted to the Council of Governors Nominations Committee seeking their approval to appoint an agency to search for three high performing NEDs. The Nominations Committee would also receive details of the NEDs' new appraisal process and governors would be invited to forward comments into their forthcoming appraisals. II. Richard Gregory had recently met with Steve Lloyd of the Hardwick Clinical Commissioning Group and discussed holding a "Board to Board" meeting. This was seen as a positive intervention and Ifti Majid will work with Andy Gregory Chief Officer, Hardwick Clinical Commissioning Group, to take this initiative forward. III. Richard Gregory, Ifti Majid and Lead Governor, John Morrissey met local MP Pauline Latham to discuss her concerns regarding the ET and the improvement actions the Trust is undertaking. A programme of further meetings with MPs is being developed which the Lead Governor would be included in. IV. A regular programme of meetings has been scheduled between the Lead Governor and Richard Gregory to discuss subjects to be presented at Council of Governor meetings. Agenda items for these meetings would also be designed to enable governors to provide feedback on the Trust's services. V. Chief Constable of Derbyshire Police had written to Richard Gregory declining the invitation to be represented on the Council of Governors as they considered this would this would be a conflict of interest but stressed they wanted to work in partnership. **RESOLVED: The Board of Directors noted the Interim Chairman's verbal update.**
DHCFT 2016/039	**ACTING CHIEF EXECUTIVE'S REPORT** Ifti Majid's report provided 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 updated the Board on feedback from external stakeholders such as our commissioners and Trust staff. Ifti Majid drew attention to the Quarter 3 performance figures released by Monitor for the NHS which gave a perspective of the pressure the Trust was under to maintain its service levels. Ifti Majid explained that he had included a narrative of the visits made to service centres by Executive Directors is now a regular feature of Ifti Majid's report and provides visibility of themes emerging and resulting actions. These visits also provide staff with the opportunity to raise any concerns and are seen as a positive move forward.

	Slides setting out the draft governance arrangements for developing the Derbyshire Sustainability and Transformation Plan (STP) were contained in Ifti Majid's report and clearly showed the principles of the plan. He hoped that the Board was comfortable with the outline of the governance structure of this comprehensive governance system. Richard Gregory emphasised the need for governance to be kept up to date and requested that these STP Plan be provided to the Lead Governor and be included as a standing item on the Council of Governors' agenda. Ifti Majid to send this to John Morrissey so he can answer any questions he might have. Ifti Majid asked Executive Directors to devise boundaries for the STP Plan within the governance framework and proposed this be progressed within the Executive Leadership Team meetings. He also asked Jenna Davies to devise a process for delegated authority. **ACTION: Ifti Majid to forward the STP Plan to John Morrissey, Lead Governor.** **ACTION: Derbyshire Sustainability and Transformation Plan to be a standing item on the agenda for Council of Governor meetings.** **ACTION: Jenna Davies to devise a process for delegated authority with the governance framework for the STP plan.** **RESOLVED: The Board of Directors noted the contents of the Acting Chief Executive's report**
DHCFT 2016/040	**<u>POSITION STATEMENT ON QUALITY</u>** The Position Statement on Quality provided the Board with an update on the continuing work to improve the quality of services provided in line with the Trust's Strategy, Quality Strategy and Framework and strategic objectives. This paper outlined the Trust's position in terms of the quality of its service since the last Board meeting. Revised reporting of the risk register on the top 6 operational risks on the Trust wide risk register was discussed and it was agreed that these risks will be examined to ensure they are explicitly linked to the Board Assurance Framework. Attention was drawn to a letter the Trust had received from the police setting out the importance of the "National Initiative" of "Child Rescue Alerts" (CRA) and requested that Trust Boards agree to provide telephone numbers of the Trust's publically owned mobile telephone numbers to the National Crime Agency (NCA). The Board considered the information governance guidance involved and agreed to support this important initiative and proposed that the pro-forma issued to staff when they take possession of a Trust mobile phone includes a narrative setting out this agreement with the NCA. A communication outlining the CRA system will also be issued to all staff. **ACTION: Pro-forma issued to staff when they take possession of a Trust mobile phone will be adapted to include a narrative clearly setting out the agreement for National Crime Agency (NCA) to be provided with the mobile phone number for the purpose of child rescue alerts and a communication outlining this initiative will be issued to all staff.** **RESOLVED: The Board of Directors:** **1) Noted the Quality Position Statement Dashboard and trends.** **2) Scrutinised the current position**

DHCFT 2016/041	**INTEGRATED PERFORMANCE AND ACTIVITY REPORT** This paper provided the Trust Board with an integrated overview of performance as at the end of February 2016 with regard to workforce, finance and operational delivery and will evolve to also include Quality performance indicators. Discussions centred around the Workforce Dashboard of the report, especially regarding staff vacancies that are difficult to fill. Completion of staff appraisals was shown as a challenge and this would be followed up through the People and Culture Committee. The Workforce Dashboard was seen as providing the type of data that will drive focus and activity. Jayne Storey pointed out that Grievances/dignity at work benchmarking will be looked at as part of the development of the People Strategy and will be the subject of a report that will be produced for the Board at a future date. The dashboard showed that compulsory training is improving and it was noted that compliance with ILS training has been given recent attention at the Quality Committee. The report's balance between narrative and graph was seen to work well and the level of detail was seen as a positive improvement by Non-Executive Directors. It was thought that an improvement could be made if there was a page of narrative triangulating the common themes cross referenced from each section of the report to show parallels. The Board noted that the Quality Account dashboard will be phased into the report from April. Phase one will be received at the April Board meeting and phase two in June. **RESOLVED: The Board of Directors:** **1) Considered the content of the paper and was assured on the current performance across the areas presented.** **2) Considered the format of the report and discussed minor changes for subsequent iterations.**
DHCFT 2016/042	**MONITOR PLAN 2016/17** This paper set out the Trusts Final Operational Plan for submission to Monitor on the 11 April 2016. The plan forms part of the Annual Planning Review (APR) process set out by Monitor and was an updated version from drafts seen at previous meetings and also contained the publishable version required as part of the submission. This plan had also been discussed at the meeting of the Council of Governors on 15 March. The Board was asked to select the statement to be applied as part of the self-certification process of the submission and confirmed continuity of services condition 7 - Availability of Resources 1a as the preferred statement *"After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."* The Board discussed the Cost Improvement Programme (CIP) which is underpinned by a Quality Impact Assessment process and agreed the need for Chair's Action to sign off the final CIP plan. Richard Gregory confirmed that with the exception of CIP reporting, the Board was comfortable in approving the plan and agreed that Claire Wright would progress the Chair's Action for CIP and final sign off of the 2016/17 Operational Plan through the Executive Leadership Team. **RESOLVED: The Board of Directors:** **1. Reviewed the key changes made to the 2016/17 Operational Plan** **2. Sought assurance that the 2016/17 Operational Plan is aligned with the Trust's Strategy** **3. Discussed and agreed the Board's response to the declarations for sustainability and resilience** **4. Approved the content of the plan and delegated sign off of the final version of**

	the plan to the Executive Leadership Team (ELT) Meeting in order to take into account feedback on the draft plan from Monitor sent in the letter dated 24 March and any last minute alterations before the submission deadline of 11 April.
DHCFT 2016/043	**<u>BOARD ASSURANCE FRAMEWORK UPDATE</u>** The Board Assurance Framework (BAF) is a high level report which enables the Board of Directors to demonstrate how it has identified and met its assurance needs, focused on the delivery of its objectives, and subsequent principal risks. The BAF provides a central basis to support the Board's disclosure requirements with regard to the Annual Governance Statement (AGS), which the Chief Executive signs on behalf of the Board of Directors, as part of the statutory accounts and annual report. This report included the first formal presentation of the Board Assurance Framework to the Board for 2016/17 and the final presentation of the Board Assurance Framework for 2015/16 and was duly approved. During 2015/16 the BAF was presented and considered by the Audit Committee and Board three times during the year. For 2016/17 the Board agreed for the Audit Committee and Board to receive the BAF four times during the year, in line with Monitor's governance guidance. The Board also agreed that for 2016/17 all high level risks contained within the BAF would be scrutinised in detail by the Audit Committee. This would ensure that the Audit Committee has complete oversight of assurance of high level risks contained in the BAF. It was noted that the Governance Improvement Action Plan will cover the scheme of delegation governing the risks associated with the Board's sub-committees and the forward plan for each committee will be adapted by the executive leads to accommodate any delegation of associated BAF risks. **ACTION: Scheme of delegation governing risks will be captured in the Board sub-committee forward plans by the executive lead for each committee.** **ACTION: Board Forward Plan to reflect BAF updates received by the Board four times a year (March, July, October, January and March 2017).** **RESOLVED: The Board of Directors:** **1) Approved the first issue of the BAF for 2016/17 and the final issue of the BAF for 2015/16.** **2) Agreed for the Audit Committee and Board to receive updates on the 2016/17 BAF four times a year in March 2016, July 2016, October 2016, January 2017 and March 2017.**
DHCFT 2016/044	**<u>GOVERNANCE IMPROVEMENT ACTION PLAN AND DELIVERY FRAMEWORK</u>** This paper set out the arrangements by which the Trust's Board will be assured that the Governance Improvement Action Plan (GIAP) is systematically implemented, delivering the agreed key outcomes so that it is able to demonstrate to all key stakeholders that the required governance improvements have been made. The paper also describes how the Governance and Delivery Framework will operate, identifying key roles and responsibilities and the requirement being placed on the governance structure that currently exists within the Trust. The GIAP was submitted to Monitor on 17 March and the Board noted that no feedback had yet been received on its contents.

	Assurance mechanisms have been put in place to ensure delivery of GIAP. In addition, a full time Governance Improvement Programme Manager will be assigned to enable actions to be completed on time to the expected standard and will report to a responsible director who will work on behalf of the Board to provide oversight, leadership, transparency, reporting and programme delivery arrangements, as well as holding to account those who are required to deliver the key tasks set out within the GIAP. **RESOLVED: The Board of Directors approved the Governance Improvement Action Plan.**
DHCFT 2016/045	**STRATEGY UPDATE** The Board of Directors has committed to developing a new Trust Strategy. This report provided the Board of Directors with a brief update on progress to date, through the prioritise element of the Monitor toolkit. It also provided an update on stakeholder engagement and next steps. Board members were assured that the agreed timeline for strategy development continues to be met, although the timeframe for delivery remains challenging. It was noted that a composite draft strategy was shared with the Council of Governors on 15 March. The final strategy would be presented to the Council of Governors at their next meeting on 1 June and to the Board on 25 June for joint approval of the strategy. **ACTION: Approval of the draft Trust Strategy to be an agenda item for the June Board meeting.** **RESOLVED: The Board of Directors noted the content of the Strategy Development Update.**
DHCFT 2016/046	**BOARD DEVELOPMENT PROGRAMME** The Board Development Programme was tabled at the meeting which supported the recommendations contained in the Deloitte report and the Yates investigation report and has been discussed within the Executive Leadership Team. It was understood that as the year progresses the programme will be aligned with how the organisation is moving forward in the delivery of the Governance Improvement Action Plan (GIAP). The Board approved the first draft of the Board Development Programme and agreed that Non-Executive Director Chairs of the Board Committees and Board Members would forward any further comments or additions they wish to be made to Jenna Davies outside of the meeting. **RESOLVED: The Board of Directors approved the first version of the Board Development Programme.**
DHCFT 2016/047	**BOARD COMMITTEE ESCALATIONS** Committee chairs escalated to the Board matters of interest and note from recent meetings: I. **Quality Committee:** The Chair of the Quality Committee, Maura Teager, escalated to the Board the effect of patients being admitted having taken NPS substances (legal highs) and the impact this was having on bed management, patient and staff safety. She also raised the matter that the JNCC (Joint Negotiating Consultative Committee) had been unable to agree changes to the Induction Policy and this issue had been escalated to the People and Culture Committee. In addition, Maura Teager commended the development of the Dementia Strategy and the services of the dementia team.

The high level of apologies received at the March meeting was a matter for concern, although the committee remained quorate. The impact of providing a high secure service for a patient and the effect this had on staff and the environment was discussed at the meeting and Maura Teager recommended that the Board extend their thanks to the front line team who cared for this patient under very exceptional circumstances. The complexity of using paper and electronic records in care planning was escalated to the Board as an area of concern as a shared understanding of this operational risk is required. Carolyn Gilby wished to assure Maura Teager that the EPR (Electronic Patient Record) Board were aware of this issue and processes were being worked through to improve the system. Information sharing by the police was raised with the Board as an issue as the police are reluctant to release forensic history of individuals being cared for by the Trust. It was agreed that John Sykes, Medical Director, will work with the Trust's Health and Safety Manager and draft a letter to the police in order to expose the problem and high level discussions would be held with the police in order to improve the sharing of information.

II. **Audit Committee:** Caroline Maley, Chair of the Audit Committee reported that a very positive meeting of the committee was held on 16 March. The committee had its first sight of the draft annual report, draft annual governance statement and external audit plan and a long discussion took place around the external audit value for money report. Caroline Maley was pleased to inform the Board that the annual counter fraud report contained no issues to be concerned about and she commended the way the counter fraud organisation controls fraud. Clinical audit progress was seen as a concern by both the Audit Committee and Quality Committee and it was recommended that a deep dive on the capacity of the clinical audit team takes place at the Quality Committee.

III. **People & Culture Committee:** The People & Culture Committee held its first meeting in February when the terms of reference and governance and people issues were addressed. The second meeting was held on 17 March and was chaired by Maura Teager in the absence of the Interim Chair, Richard Gregory when compliance with mandatory training was discussed. Sickness and absence levels were seen as exceptionally high as are the high level of staff vacancies and further high level scrutiny of both these matters will take place at the April meeting. The committee recognised that a number of actions in terms of culture and staff engagement and HR policies are contained in the GIAP which will be addressed at each meeting. The effects on staff who nursed a patient in high secure seclusion was also discussed at the meeting (this was also discussed at March meeting of the Quality Committee (see above).

IV. **Finance & Performance Committee:** Jim Dixon, Chair of the Finance & Performance Committee explained that this meeting had only taken place the day before and he highlighted key issues relating to the Trust's budget. He gave praise to all managers and staff for getting to the end of the financial year in such a positive position and he was assured the Trust would reach the end of the year extremely close to target. He was also confident there is a good financial plan in place for 2016/17 although he drew attention to the need to strengthen the content and planning of the Cost Improvement Programme which will have to be aligned with the quite stringent requirements Monitor have introduced for costs of agency staff and will be a challenge for the Trust to meet. It was noted that retrospective reporting of Monitor compliance will be required once the scheduling of Board meetings moves to the beginning of the month later in the year.

V. **Mental Health Act Committee:** This committee had only met this morning and was chaired by Richard Gregory. Three policies were approved by the committee, the Consent to Treatment Policy, Section 17 Leave Policy and

	Procedure and the Mental Health Act 1983 Procedure for Managers Hearings Policy and Procedures. A further meeting of the committee will take place towards the end of April to ensure further policy profiles are up to date Richard Gregory gave thanks to Non-Executive Director, Tony Smith, for his significant contribution to the Trust and for his service as Chair of the Mental Health Act Committee. The Board wished him and his family well as Tony Smith has resigned from the Trust in order to spend more time with his family. **RESOLVED: The Board of Directors noted the contents of the ratified minutes of the Quality Committee and People and Culture Committee and the verbal updates on escalations from the Finance & Performance Committee and Mental Health Act Committee.**
DHCFT 2016/048	**BOARD FORWARD PLAN** The forward plan provided the Board with assurance that the regulatory and legislative business has been considered by Board at the appropriate time. The 2016/17 forward plan has been reviewed to ensure that any business coming forward to the Board is in line with the scheme of delegation and also considers regulatory and legislative items. The 2016/17 forward plan has also been developed in consultation with the Executive Leadership Team (ELT) who have identified business which requires Board consideration. The Board forward plan does not preclude the Board from considering any other strategic issues it wishes or to vary the forward plan to fulfil its functions and maintain a focus on strategy, Performance and Culture. **RESOLVED: The Board of Directors approved the forward plan for 2016/17**
DHCFT 2016/049	**BOARD PERFORMANCE AND CONTENT OF MEETING** The Board considered good engagement with processes was undertaken at today's meeting. At the last meeting it was agreed that questions from the public applicable to the agenda and at the Interim Chairman's discretion could be received up to 48 hours in advance of each meeting in order to receive a response from the Board. **ACTION: Director of Corporate and Affairs and Trust Secretary will ensure that the notification of all Board Meetings will carry an instruction that questions applicable to agenda and at the Interim Chairman's discretion can be received by the public 48 hours prior to the meeting for a response from the Board.**

The next meeting of the Board held in Public Session will take place at 1pm on Wednesday, 27 April 2016.

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

BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - APRIL 2016						
Date	**Minute Ref**	**Action**	**Lead**	**Status of Action**	**Current Position**	**Enc B**
27.1.2016	DHCFT 2016/005	Acting Chief Executive's Report - Industrial Action	John Sykes	John Sykes as Medical Director will oversee communication to all staff and patients and will be available to answer external enquiries. He will liaise with neighbouring Medical Directors and CCGs in efforts to improve overall system resilience and will escalate risks as necessary to ELT for action and if necessary direct action by the Acting Chief Executive.	Further industrial action has been announced for 9 March, 11 March, 6 April 8 April, 26 April and 28 April. Cover has gone well so far on previous occasions. Waiting times have been holding up well despite industrial action. Risks will be mitigated fairly across all provider units. Total walk out at the end of the month is unprecedented and will be discussed at ELT. Ifti Majid received a petition in support of junior doctors and he is more concerned about how we continue to support our doctors as a Trust and make sure we know the real link between staff morale and patient care. Richard Gregory and Ifti Majid will meet with junior doctors with John Sykes and other members of the Board to look at ways of finding mitigations.	Amber
27.1.2016	DHCFT 2016/011	Remuneration Committee Terms of Reference	Jenna Davies	Jenna Davies to amend the Remuneration Committee's Terms of Reference and submit to April meeting of the committee.	Amended Remuneration Committee's Terms of Reference on agenda for April Remuneration Committee meeting.	Green
30.3.2016	DHCFT 2016/039	Acting CEO Report	Ifti Majid	Ifti Majid to forward the STP Plan to John Morrissey, Lead Governor	STP Plan forwarded to Lead Governor. ACTION COMPLETE	Green
30.3.2016	DHCFT 2016/039	Acting CEO Report	Ifti Majid Sue Turner	Derbyshire Sustainability and Transformation Plan to be a standing item on the agenda for Council of Governor meetings	Action transferred to COG action matrix and item is on agenda for next meeting in June. ACTION COMPLETE	Green
30.3.2016	DHCFT 2016/039	Acting CEO Report	Sam Harrison	Jenna Davies to devise a process for delegated authority with the governance framework for the STP plan	Awaiting update from CCG on progress of the governance framework with the STP plan.	Amber
30.3.2016	DHCFT 2016/040	Position Statement on Quality	Jayne Storey	Pro-forma issued to staff when they take possession of a Trust mobile phone will be adapted to include a narrative clearly setting out the agreement for National Crime Agency (NCA) to be provided with the mobile phone number for the purpose of child rescue alerts and a communication outlining this initiative will be issued to all staff	Communication sent to all staff via CONNECT. ACTION COMPLETE	Green
30.3.2016	DHCFT 2016/043	Board Assurance Framework Update	Claire Wright Sam Harrison Carolyn Green John Sykes	Delegation of governing risks will be captured in the Board sub-committee forward plans by the executive lead for each committee	Committee forward plans will reflect BAF risks delegated to each committee.	Amber
30.3.2016	DHCFT 2016/043	Board Assurance Framework Update	Sue Turner	Board Forward Plan to reflect BAF updates received by the Board four times a year (March, July, October, January and March 2017)	Now reflected in the forward plan. ACTION COMPLETE	Green
30.3.2016	DHCFT 2016/045	Strategy Update	Mark Powell Sue Turner	Approval of the Trust Strategy to be an agenda item for the June Board meeting	Agenda item for June meeting.	Yellow

30.3.2016	DHCFT 2016/049	Board Performance	Sam Harrison Sue Turner	Director of Corporate and Affairs and Trust Secretary will ensure that the notification of all Board Meetings will carry an instruction that questions applicable to agenda and at the Interim Chairman's discretion can be received by the public 48 hours prior to the meeting for a response from the Board.	Agenda and Trust website now state that questions applicable to agenda and at the Interim Chairman's discretion can be received by the public 48 hours prior to the meeting for a response from the Board. ACTION COMPLETE	Green

Key	**Agenda item for future meeting**	**YELLOW**
	Action Ongoing/Update Required	**ORANGE**
	Resolved	**GREEN**
	Action Overdue	**RED**

Public Session
Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 27 April 2016

Acting Chief Executive's Report

1. Introduction

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 our staff. The report should be used to support strategic discussion on the delivery of the Trust strategy.

2. National Context

2.1 Information released by NHS Providers evidences that demand and operational performance of our Trust remains in line with similar Trusts nationally. Mental Health demand has remained relatively static over the last year. Nationally about 910,000 people in contact with mental health services. A very slight reducing trend for people with a learning disability in contact with services at around 54,000 and a small general increase in children's services open episodes.

In terms of other NHSI mental health performance trends our Trust continues to perform well for example our crisis gatekeeping figure exceed the national average of 97%

Financially the provider sector continues to struggle with some 76% of provider Trusts in deficit at end of Q3 with an anticipated deficit of £1.8billion. Trusts are reporting the key reasons for this position include

- Move towards 7 day services
- National policy and contract changes e.g. IAPT
- Changes to national insurance contributions
- Increased complexity and demand

The national provider picture should be used to provide context for the Trusts performance detailed in the integrated performance report later in the agenda.

2.2 On 13 April I was fortunate to spend the morning with international healthcare students at the Cohehre International Conference where I was presenting on the mental health system in the UK. Feedback from other countries showed that they have very similar challenges around depravation of liberty, stigma, capacity and person centered care. Our regulatory system was a great topic of discussion along with the NHS funding system and the expectation on providers to deliver year on year efficiencies.

Derbyshire Health and Social Care Community

2.3 Transformation plans associated with both the 21st Century work and the Joined up Care Programme in the South of the County have importantly included the need to support the increase in ***social capital/community resilience***. In addition this forms a core work stream of the developing sustainability and transformation plan for Derbyshire. As the Executive lead I wanted to update our Board on progress to date.

A community resilience strategy has been developed and approved by the Derbyshire Health and Wellbeing Board with 13 recommendations. In addition partner organisations agreed a number of key principles:

- **Social capital is about everyone.** Individuals, community groups, the voluntary sector and public sector all have an equally important contribution to make.
- **There are different types of social capital** – bonding, bridging and linking - which can produce different outcomes.
- **Social capital can exist at different levels** – individual, community, society.
- **Investment in social capital is one component of a resilient community** – alongside human, physical and economic capital.
- Building social capital can **help support health and wellbeing outcomes** in a number of ways, including behaviour change, mutual support and self-help as well as increasing community involvement in the design of services.
- **Building trust is important** and this must be between different types of people and between people and public services.

Appendix 1 gives Board members more detail around the recommendations and the 10 year vision for social capital within Derbyshire.

2.4 The Derbyshire health and social care community has now completed the first 'short' submission of our Sustainability and Transformation Plan. The submission can be seen at appendix 2 and contains information about the governance of the plan development discussed by our Board last month as well as early indications concerning:

- Health and wellbeing gap
- Quality gap
- Financial gap

Board members will note the submission is 'organisation agnostic' and talks in cross Derbyshire terms.

Next steps in the plan development are for 12 work streams to meet to outline mitigations against the three gap areas above:

- Prevention/Self Care
- Urgent Care Network
- Planned
- Acute Care

- Maternity
- Mental Health
- Cancer Learning
- Disabilities
- End of Life Children's Specialist
- Community
- Specialist Social Care
- Community Resilience

In addition a group is meeting to review the plans for locality services known as 'Place' as well as groups that will review infrastructure across Derbyshire such as workforce, estates and IM&T. Staff from our Trust will be involved as required in these groups with the Trust taking a leadership role around Mental Health, Community Resilience, Procurement and IM&T.

The full document is due to be submitted at the end of June and the Board will have full sight of this prior to then.

2.5 The North Derbyshire Community Hubs proposal was scrutinised by NHS England at the checkpoint meeting on 7 April 2016. NHSE have fully assured the business case on five of the eight checks, with partial assurance on the three others. The partial assurance will require further evidence but we are confident that we will be able to provide this and gain full assurance. However NHSE have advised that purdah will apply and that the consultation will therefore need to be put back until after the EU referendum vote. A revised timetable for consultation is being developed but it is likely to be July, August and September.

Inside Our Trust

2.6 Listen, Learn, Lead.

The latest round of visits to teams can be seen detailed in the Listen, Learn Lead matrix in appendix 3.

Key themes that have emerged this month include concerns around the neighbourhood transformation programme in some case leading to reduced economies of scale. Recruitment of band 5 nurses and a great suggestion from a staff member on Cherry Tree Close to try to encourage new starter student nurses to join our bank. Concerns around career progression in specialist areas such as substance misuse. The continued uncertainty about Melbourne house and Tissington was also a feature of a number of visits this month.

Where staff discussed the aftermath of the ET and media coverage the most common sense continues to be anger at perceived money paid out to ex staff members along with comments about why the Trust was not more assertively defending itself.

2.7 CEO/Chair Engagement Sessions

Matlock 8 April

This session fell on the last day of half term and perhaps not surprisingly was not well attended. Middle managers spoke of the pressure of trying to implement the neighbourhoods which had been an easier transition in some areas than others, in particular Chesterfield was proving challenging due to the more complex moves required. They also spoke of the need to align medical staff as closely to the neighbourhood as possible to improve communication and efficiency. The impact of the ET was discussed however more pressing they felt was the need to move forward.

A senior consultant spoke about the issues of morale for the junior doctors and the risk around filling rotas in the future and that we may not actually see the full impact for several years when gaps in senior staff may emerge.

Richard Gregory was also able to meet with the Chair of Medical Staff Committee and the Local Negotiating Committee to discuss the investigations following the ET, their independence and findings.

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

Equality Delivery System

There are no issues raised in this paper that would have a negative impact on any regards groups

Consultation

This paper has not been considered by other committees or groups.

Recommendation

The Board of Directors are requested:

1) To note and discuss the paper using its content to inform strategic discussion.
2) Agree the STP governance process

Report Prepared by: **Ifti Majid**
Acting Chief Executive

Name of footprint and no:
(12) Derbyshire

Region:
Midlands and East

Nominated lead of the footprint including organisation/function:
Gary Thompson - Chief Officer, Southern Derbyshire CCG

Contact details (email and phone):
Gary.Thompson@southernderbyshireccg.nhs.uk
01332 888 177

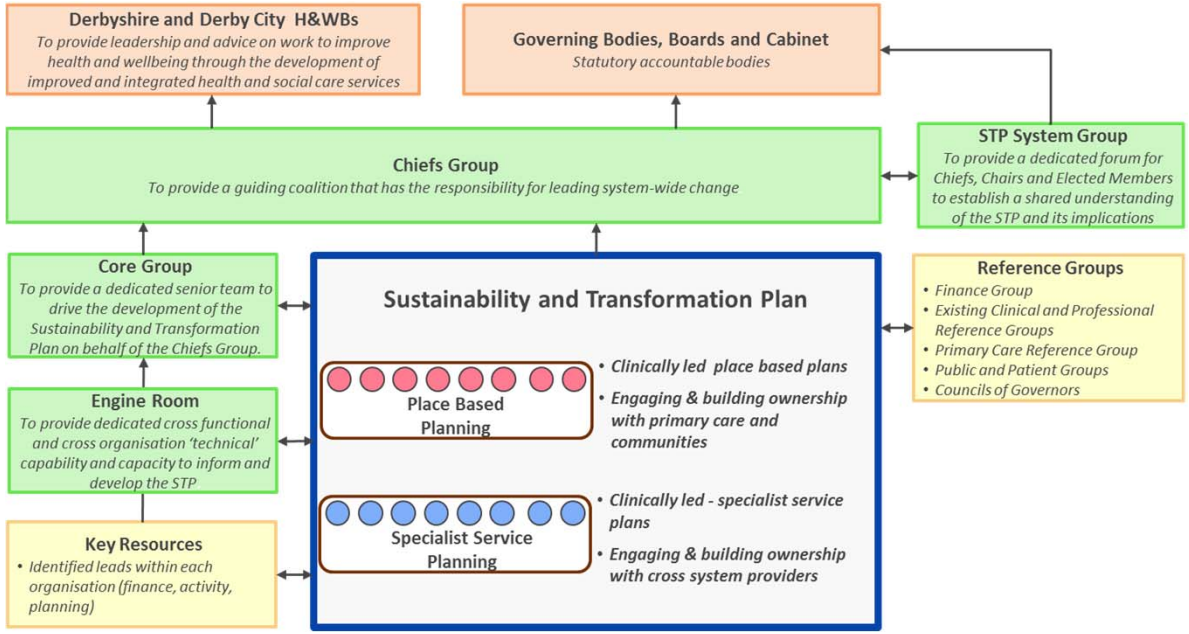
Organisations within footprints:
- ***Erewash CCG***
- ***Hardwick CCG***
- ***North Derbyshire CCG***
- ***Southern Derbyshire CCG***
- ***Chesterfield Royal Hospital NHS Foundation Trust***
- ***Derby Teaching Hospitals NHS Foundation Trust***
- ***Derbyshire Healthcare NHS Foundation Trust***
- ***Derbyshire Community Health Services NHS Foundation Trust***
- ***Derbyshire Health United Limited***
- ***East Midlands Ambulance Service NHS Trust***
- ***Derby City Council***
- ***Derbyshire County Council***
- ***Burton Hospitals NHS Foundation Trust – Associate Member***

Section 1: Leadership, governance & engagement (1 of 2)

Across Derbyshire we have established cross system leadership and a programme support team to develop the STP...

Collaborative leadership and decision-making

- Derbyshire and Derby City have a strong history of working collaboratively across both health and social care. Whilst there have recently been two units of planning in the North and South of the county, both have been working to System Plans directed by Health and Wellbeing priorities to deliver 'joined up care' through place based services. The Derbyshire STP, covering the whole Derbyshire footprint, is consequently building on a strong shared foundation.
- Leaders from across the footprint are now working together including:
  (i) meeting fortnightly as a 'Chiefs Group' chaired by the STP SRO Gary Thompson, which brings together the Accountable Officers and Chief Executives from the Derbyshire NHS organisations, Clinical Leaders from Commissioners and Providers, the Derbyshire County Council Director of Adult Social Care, and the Derby City Council Director of People;
  (ii) meeting three times before the end of June as a System Group including Chiefs, Chairs, Directors of Social Care and Elected Members, established with the purpose of building a shared understanding of the STP and its implications which will need to be taken through existing statutory bodies.
- In addition, a programme team ('Engine Room') has been established to manage and support the necessary planning including planners, finance leads, public health and information analysts from each of the organisations.
- The figure below represents the governance arrangements that have been agreed through all Boards, Governing Bodies and Health and Wellbeing Boards, which importantly includes a set of principles to help direct system behaviours. These arrangements apply learning from the two existing transformation programmes in the county.



Section 1: Leadership, governance & engagement (2 of 2)

Our STP development processes builds on existing arrangements and relationships to ensure effective engagement with clinicians, professionals, our local authorities and other stakeholders…

Engaging clinicians and professional (health and social care)

- We will build upon the extensive primary, secondary and community care clinical involvement and engagement we have already established through our existing transformation programmes (21C and Joined Up Care). Where necessary, through the STP process, we will quickly realign existing transformation workstreams to our identified gaps and plans, ensuring we continue to capitalise on our excellent clinical and professional leaders and experts within both commissioners and providers.
- In particular, we recognise the importance of strong clinical and professional involvement in the development of our place based plans. Over the past 18 months, the 'Community Hubs' work in the North and more recently the development of our Vanguard MCP in Erewash provide important learning we will use.
- There is a long-standing and collaborative Derbyshire Communications & Engagement network, which includes all partner organisations, that has planned and engaged jointly on initiatives including transformation and winter. We will continue to use this as a key engagement mechanism through the development and implementation of our STP.
- There is a strong track record of collaborative internal engagement on joint programmes across Derbyshire and staff report positive engagement in recent NHS Staff Surveys.

Local government involvement

- All NHS organisations are represented on and actively involved with the Health and Wellbeing Boards together with representatives from the wider voluntary and community sectors, HealthWatch, and CCG GP clinical leaders.
- Local government representatives are part of, and lead a number of joint transformation and planning groups at both strategic and operational level involving professionals both clinical and non clinical from health and social care from across Derbyshire and Derby City.
- The previous slide outlines the STP Governance structure, and local authority colleagues are actively involved in each of the groups.
- We have an active and positive relationship with Health Overview and Scrutiny Committees who regularly advise on service configuration and developments.
- Through our transformation work to date we have developed strong links with District and Borough Councils. We will continue to build on these through the STP process to build resilient communities and link into wider determinants of health like housing quality.

An inclusive process

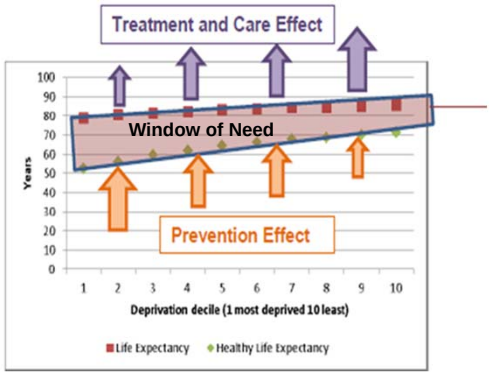
- Our STP will build on a set of principles that were developed and agreed on a Derbyshire wide basis through wide scale public engagement. These already form the foundation of the current transformation programmes.
- We are using public health insight to tailor place based approaches to meet local need. This insight will be refined through the STP process to enable focused and specific outcomes to be defined with each of our communities. By focussing on outcomes we will enable and support communities to co-create the future provision of health and care services.
- Existing community support work, including local area coordinators and Voluntary and Community Sector (VCS) activity, is providing the basis to engage with places.
- We will use 'real' examples to articulate our STP priorities so local communities can visualise and shape how the health and care offer can address the specific challenges for their population, with a commitment to consult early in the life of the STP where proposals require material change to services.
- Importantly, as we develop the STP, we will consider further how we will achieve the necessary targeted step change to better empower places to take responsibility for their health, care and community.

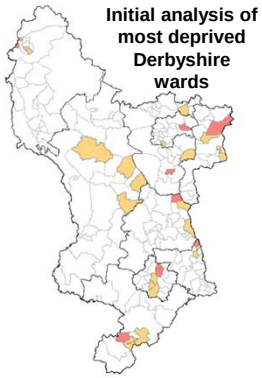
Section 2a: Improving the health of people in your area

Fundamentally we know that across Derbyshire people are living longer in ill health and that significant inequalities exist …

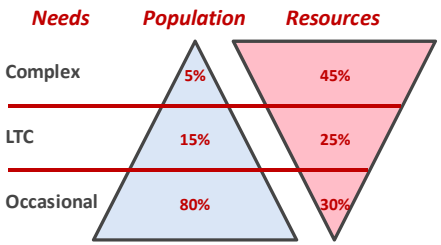
People are living longer in ill health (with ongoing care needs)

- More people in Derbyshire are living longer in poor health due to a combination of increasing life expectancy and decreasing healthy life expectancy. Therefore the period in people's lives when they require health and social care support is steadily rising (the 'window of need').
- We also know there are marked inequalities in healthy life expectancy. People who live in the more deprived communities in the footprint or are part of certain groups such as those with severe and enduring mental health or learning disabilities spend more of their lives in ill health.





- Deprived communities have greatest exposure to a range of factors that impact adversely on the health of individuals, families and communities, including fuel poverty, poor housing, higher unemployment and low paid jobs, lower educational attainment and poorer access to services.
- These wider determinants of health underpin lifestyle risk factors such as smoking, physical inactivity and poor diet, which are most prevalent in these communities.
- Because people are living longer with ongoing needs, and given the way health and care services are currently organised consumption of resources occurs in a wholly disproportionate manner.
- Within a population or given locality, around five percent of the population consume around 45% of the health resource. These are patients with complex chronic conditions. A further 15% have at least one long term condition (e.g. diabetes) and this group consume a further 25% of the health care resources. In total this means 20% of the population consume 70% of the care budget. Much of the care received and contributing to this cost could be avoided by interventions 'upstream' that would improve quality of life and independence.



Coronary heart disease and amenable cancers contribute disproportionally to the overall potential years of life lost

- Our assessment of Potential Years of Life Lost (PYLL) from causes amenable to healthcare has identified that two groups, coronary heart disease and amenable cancers, contribute disproportionally to the overall potential years of life lost across Derbyshire. And, we know that our one year cancer survival rate is below the ambition for 2020.
- For the Derbyshire footprint these areas provide the greatest opportunity to save years of life by tackling the conditions, and their causes, that are preventable and amenable to health care.

A greater focus on the emotional health and wellbeing of children and young people is required

- There is increasing local and national evidence that getting emotional health and wellbeing right in early years is key. 75% of adult mental health problems, excluding dementia, develop by the age of 18. However, we know a treatment gap exists where only 25% of those with a diagnosable condition access the support they need.
- Early intervention and prevention in childhood can avoid expensive and longer term interventions in adulthood.

Section 2b: Improving care and quality of services (1 of 2)

Whilst we have made significant progress with beginning to 'join up care', overall it is still fair to say that…

The lack of joined up care…

Services are not integrated effectively:

- Fundamentally, our health and care services have been set up to help sick people get well, often in a hospital setting (reactive episodic care).
- These services are often characterised by organisation and role boundaries, not a system that is centred on people and communities.
- Individuals and teams do not work in an integrated way and are often conflicted and constrained by organisational priorities.
- Our services are struggling to meet the increasing demand for ongoing complex care (social, physical and mental) the way they are currently delivered.
- People with such needs often experience care that: (i) does not support their independence and control; (ii) is fragmented and difficult to navigate; (iii) results in a poor quality of life for both the patients and their carers.

Care is not proactive:

- We do not routinely and systematically identify and support people with complex ongoing needs.
- Mechanisms for information sharing, care planning and care co-ordination are generally ineffective.
- There are occasions where harm could be prevented for vulnerable people (e.g. pressure ulcer and falls)

Results in…

And…

Our system being overly reliant on bed based care…

Frail elderly patients decompensate:

- Following an illness or injury elderly patients sometimes spend far too long in bed based care (acute and community) causing physical, psychological, cognitive and social deconditioning resulting in lost independence.
- In our system, 6,700 patients aged over 65 stayed >14 days once admitted to hospital, occupying c.500 acute beds (38% of all adult NEL care beds). In addition, >95% inpatient community hospital care supports people >65 years.

Patients are not supported to be independent:

- Adults of working age requiring admission for mental ill health stay in hospital longer than the England average, leading to bed occupancy of 100% and some receiving treatment outside of Derbyshire.
- Derbyshire is an outlier for numbers of people admitted to care homes, key drivers are short term stays leading to long term stays and over prescribing of care home use on discharge from hospital.
- Too many people with dementia are hospitalised which can have negative impacts on both physical and mental health, making a return home difficult.
- Current services for people with Learning Disabilities are fragmented, inequitable, overly reliant on bed based care and offer poor value for money.

Doesn't always provide care in the right settings

Delayed transfers:

- Reported DTOC performance is in line with the standard; however local experience highlights flow and discharge issues within the system.

Avoidable admissions:

- Avoidable admission activity is classified on the basis of whether a patients condition could have been managed in primary care: 8,500 (8%) of our NEL admissions are linked to chronic ambulatory care sensitive conditions; 12,800 (12%) are linked to acute conditions.

End of life care in acute hospitals:

- Within Derbyshire, 48% of deaths occur in hospital

A health and care system that is not integrated effectively and proactive enough is at the heart of our care and quality gap

Section 2b: Improving care and quality of services (2 of 2)

We also have significant improvements to make in Primary Care and Urgent and Emergency Care as well as ongoing improvements in a number of other areas…

Area	Access	Unwarranted Variation	Sustainability
1. Primary Care	• Demand continues to steadily rise and general access to services under significant pressure • Latest GP patient surveys highlight 15-25% patients waited a week or more for appointment (England av. = 18%) • Access issue are being compounded by the push for extended hours and seven day working	• Patients in affluent areas receive more referrals, test and prescriptions than those in the deprived • Variation across primary care in terms of cancer screening and early diagnosis, and flu vaccination uptake • Variation in chronic disease management (e.g. diabetes), means the impact of established disease on quality of life, independence and life expectancy is not minimised	• Increasing pressure on General Practice due to (i) increased demand; (ii) increased complexity of patient needs; (iii) inability to attract / retain clinical workforce; (iv) ageing workforce (retirements); (v) financial uncertainty and tie-in to estate; (vi) lack of structure, infrastructure, culture that supports operating at scale • Of 119 General Practices, of the 48 rated, 2 are 'inadequate', 5 'require improvement'; Increasing number of practices facing sustainability issues
2. Urgent and Emergency Care Network	• Uncoordinated points of delivery, inequitable access, limited integration with General Practice and confusing due to inconsistent service provision • Does not currently provide consistent care 7 days a week • 4 hour wait A&E performance averaged for 15/16 was 93% at CRHFT and DHFT	• Ambulance response time standards not met 36% of the time; 44% of ambulance arrivals do not result in admission to an acute provider; conveyance from ambulance to ED is consistently higher than rest of E. Midlands (8%) • The Keogh Review recognised an increased risk of mortality when admitted on a Saturday (11%) Sunday (16%), across the East Midlands	• A&E activity at acute providers has increased c.7% in past year, consistent performance is a challenge
3. Other areas	• Meeting RTTs, except: Ophthalmology, Oral Surgery, General Surgery, Urology, T&O and Plastics; however elective activity rising • Access to cancer treatment within Derbyshire is currently better than the standard for 2 week waits; 31day and 62day performance is variable • Long waits for IAPT treatment being addressed, performance better than target • Above target for dementia diagnosis standard. However increasing prevalence requires continual improvement to access • Shortage of mental health care coordinator capacity drives waiting lists for ongoing care	• MSK elective/day is a Commissioning for Value priority. Long wait in Orthotics leading to unwarranted surgery. • Commissioning for Value identified as an outlier in Gastro Intestinal NELs • Variable access to IAPT treatment • Home care and Reablement capacity, particularly in rural geography • Quality and capacity of nursing care and Dementia skills across community and residential provision	• CQC: RDH 'good'; CRH 'requires improvement' – key themes: levels of registered nurse at night; patient flow; monitoring of deteriorating patients on wards and HDU; specific improvements required in paediatric care; difficulties in recruiting nursing and medical staff • Registered Mental Health Nurses – difficult to recruit to band 5s, national shortage leading to use of temporary staff • Early intervention and prevention service capacity is a growing challenge due to general and specific funding gaps

- Overall, there are consistent whole system challenges related to retaining, developing and attracting our workforce e.g. East Midlands account for 9% of population and receives 7% of junior doctor training posts; Derbyshire is under doctored and under nursed for its equivalent in primary and community care
- Moreover, our teams work on the basis of traditional roles and organisation boundaries.
- And, generally we are not using information technology effectively to transform how we support and care for people.

Section 2c: Improving productivity and closing the local financial gap (1 of 2)

Following an initial assessment we have identified a number of issues that are driving our forecast health and social care financial gap over the next five years…

Service

- Demand growing quicker than resources (driven by demographics, patient expectation, medical advances)
- A system focussed on treatment rather than prevention, underpinned by a heavily bed based model.
- People with established LTCs not sufficiently engaged in self-care
- Services not joined up and inhibited by organisational / sector boundaries
- Services not maximising the value of the local community offer
- Care not being delivered in the most appropriate settings
- Different care delivery models in different areas e.g. falls pathway

Productivity

- Duplication of services
- Unwarranted variation in clinical care
- Repeated testing and diagnosis
- Delays in patient care
- Service capacity not aligned to demand
- Duplication of management and back office functions

Infrastructure

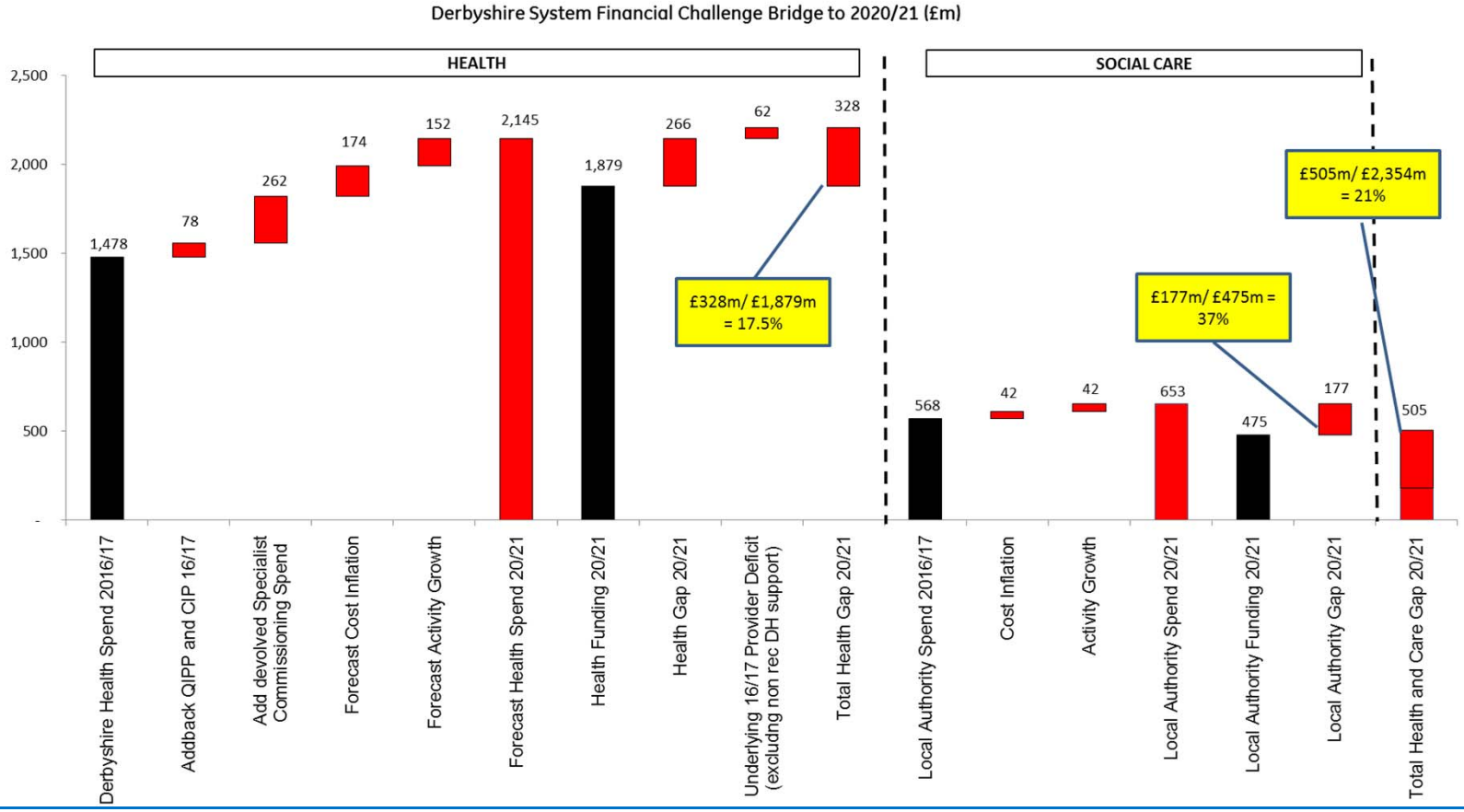
- ‘Bleeding’ of existing staff
- Over reliance on premium cost bank, agency, locum
- Below average training placements
- Shortages in key professions requires a different response, including doctors and nurses in primary and community services
- Underutilisation of estate
- Disparate information systems that don’t talk
- Clinical information not shared within and across organisations
- Lack of investment in system infrastructure

Finance and contracting

- Cost inflation in future years
- Underlying structural financing issues (PFI)
- Perverse incentives and payment mechanisms
- Regulator focus upon organisational performance rather than system
- Local Authority funding cuts
- NHS allocation growth not matching demand
- Capital controls
- Cash Shortfall

Section 2c: Improving productivity and closing the local financial gap (2 of 2)

Considering the impact of the driving factors gives a forecast financial gap of £505m by 2020/21…



Planning assumptions:

- Health: funding growth to 2020/21 as published; activity growth based on demographic change and local forecasts; cost inflation based on national guidance.
- Social Care: 3% activity and cost inflation growth for Adult Social Care and Children services; 2% activity and cost inflation growth for Public Health; funding assumed to continue to be reduced.

Consequently:

- Total health gap = £328m (17.5% of forecast funding)
- Social care gap = £177m (37% of forecast funding)
- **Overall challenge = £505m (c. 21% of forecast funding)**
- **Equivalent of c.4% per annum for 5 years**

Section 3: Your emerging priorities (1 of 2)

To tackle the health & wellbeing, care & quality and financial gaps we have identified for the Derbyshire footprint we plan to move to a place based care system which is effectively joined up with specialist services…

Vision Aims for Derbyshire footprint

We have defined a set of aims for the Derbyshire health and care system:

Fundamentally, we want the Derbyshire health and care system to keep people:

- **Safe & healthy** – *free from crisis and exacerbation.*
- **At home** – *out of social and health care beds.*
- **Independent** – *managing with minimum support.*

... which will be founded on building strong, vibrant communities (places).

Whilst maintaining financial balance

Levers for addressing the gaps

We will apply three 'levers' to address the gaps and challenges we face to delivering these aims:

Sustainability and Transformation Plan

1. Prevention

2. Care Quality

3. Efficiency

Future Derbyshire health and care system

20 places across Derbyshire

Place Based

Joined up with

Specialist Services

Inter footprint services

'Management'

To do this we have to make a transformational shift from institutional to community care:

- Delivering proactive, preventative health and well-being services in an increasingly resource constrained context.
- Developing integrated primary/community and social care delivery models within **place, that are responsible for whole population budgets**
- Ensuring our hospitals and specialist providers deliver the **specialist care** only they can, **focussing on sustainable access, quality and cost (not income).**
- Developing optimised clinical networks, clinical support functions, management and back-office across Derbyshire organisations and those with patient flows in surrounding footprints.
- Ensuring we capitalise on key system enablers including workforce, technology and assets & estates.

Section 3: Your emerging priorities (2 of 2)

To shape our STP planning we have identified a set of interventions against our 3 'levers' together with an initial hypotheses for the necessary scale of impact from them i.e. what it will take to close the gaps…

1. Prevention		2. Care Quality		3. Efficiency		TOTAL
1. 1º and 2º Prevention	3.0%	3. Unwarranted variation:	3.0%	5. Technical Efficiency:	5.0%	21%
2. Proactive care	5.0%	4. Right care setting:	5.0%			
£m (net)	*£193m*	*£m (net)*	*£193m*	*£m (net)*	*£119m*	*£505m*

Prevention – by doing what…

1. ***Improve the impact of primary and secondary prevention:***
   - Getting upstream to address the determinants of health (thereby preventing the onset of disease), aligned to local health inequalities and prevalence.
   - Supporting the 'promoters of wellbeing' in line with HWB strategies and priorities e.g. community & personal resilience, social capital, healthy communities, and emotional wellbeing
   - Detecting asymptomatic disease to intervene to slow or stop progression, including screening and case finding
2. ***Better meet the needs of people who require complex ongoing care - tertiary prevention:***
   - Providing person centred proactive planning and support to meet 'whole person' needs (mental, physical and social care). Specific areas of focus are chronic disease management, emotional mental health, and frailty - supporting people to feel competent about self-care *'getting out of peoples lives*'

Care Quality – by doing what…

3. ***Eliminate unwarranted variation:***
   - Increasing early diagnosis and intervention to ensure better outcomes and avoid unwarranted and more costly care - focussing on cancer, CHD, diabetes, mental health and MSK
   - Ensuring that primary care provides consistent, informed and equitable access to diagnostics and treatments (including drugs, specialist (acute) care)
4. ***Ensure that the 'right care is provided in the right setting by the right people':***
   - People are directed to the right care / right setting; access is consistent and aligned to needs (7 day)
   - Service capacity is aligned to needs (and is informed by shared patient information), especially for primary care and urgent care
   - Services are of a consistent high quality
   - Patients 'flow' effectively through their care pathway – and are supported to return to '*safely living independently at home*'

Efficiency – by doing what…

5. ***Ensure that it is provided efficiently through improved care pathways and delivery models:***
   - Streamlined care pathways with reduced duplication and hand-offs, and aligned clinical governance processes
   - Reduced duplication of service provision within Derbyshire where possible and networking of services with other footprints
   - Aligned and optimised clinical support services with a specific focus of diagnostics and pathology
   - Aligned and optimised 'back office' services (finance, HR, IM&T, facilities management)
   - Optimised procurement of equipment and medicines across all providers
   - Optimised management and Boards functions (commissioners and providers)
   - Reduced reliance on agency/locum staffing
   - Estates rationalisation
   - Effective use of technology

Section 4: Support you would like

1. Areas where you would like **regional or national support** as you develop your plans:
   - Flexibility and pragmatism to managing the sometimes competing and contradicting priorities of regulators and National policy.
   - Transformation/transitional funding for the system
   - National funding to address the structural deficit created by the local PFI hospital
   - Ongoing transformation funding for Erewash Vanguard beyond 2016/17.
   - Release of local 1% non – recurrent transformation resource in each year of the plan to enable change
   - Politically contentious changes and consultations

2. **National barriers** or actions you think need to be taken in support of your STP:
   - Removal of restrictions on capital controls for capital funding to enable investment in new care delivery models
   - Relaxation of national / contractual targets that do not add value and increase cost

3. Areas where you could share **good practice** or where you would like to access expertise or best practice from other footprints:

   We can offer:
   - Learning from MCP Vanguard in Erewash;

   We would like to receive:
   - Transformation 'hypotheses' developed elsewhere;
   - Case studies of what is working well;
   - National co-ordination of specific enabling workstreams to avoid duplication e.g. contracting / risk sharing

4. Any other **key risks** that may affect your ability to develop and/or implement a good STP:
   - Lack of change capacity and capability during transition period.
   - Pace of change, especially for politically contentious changes and consultations.

Social Capital work stream update

Ifti Majid, Acting Chief Executive
Derbyshire Healthcare

Project scope and key tasks

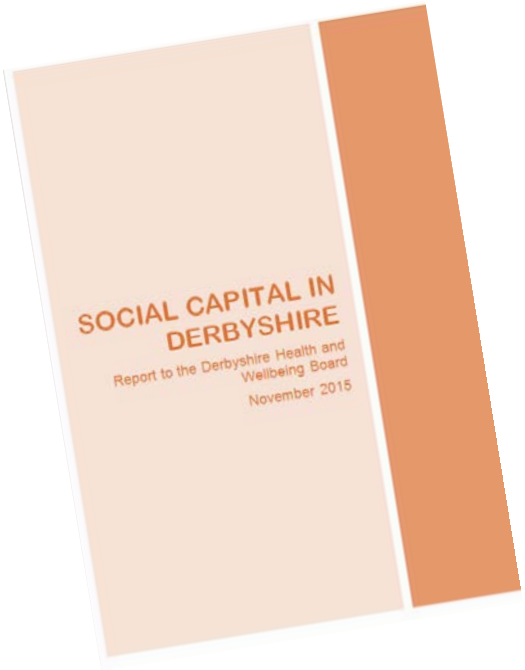
To develop a collective approach to the development of social capital in order to achieve better health outcomes in Derbyshire. The project will identify what is effective, at what location and how this can be fostered elsewhere in a sustainable way.

- Establish a HWB social capital task and finish group with membership from key organisations;
- Produce report on Social Capital definition;
- Develop principles for commissioning of services
- Develop methodology for mapping social capital activity through the exploration of the customer segmentation model and citizen panel;
- Develop agreed measures for social capital in Derbyshire;

Definition and principles

Definition:

Social capital is about the relationships, networks and trust which help people to support each other, build confidence, and create the opportunities to bring about change in their lives and communities



- **Social capital is about everyone.** Individuals, community groups, the voluntary sector and public sector all have an equally important contribution to make.
- **There are different types of social capital** – bonding, bridging and linking - which can produce different outcomes.
- **Social capital can exist at different levels** – individual, community, society.
- **Investment in social capital is one component of a resilient community** – alongside human, physical and economic capital.
- Building social capital can **help support health and wellbeing outcomes** in a number of ways, including behaviour change, mutual support and self-help as well as increasing community involvement in the design of services.
- **Building trust is important** and this must be between different types of people and between people and public services.

Recommendations - Community

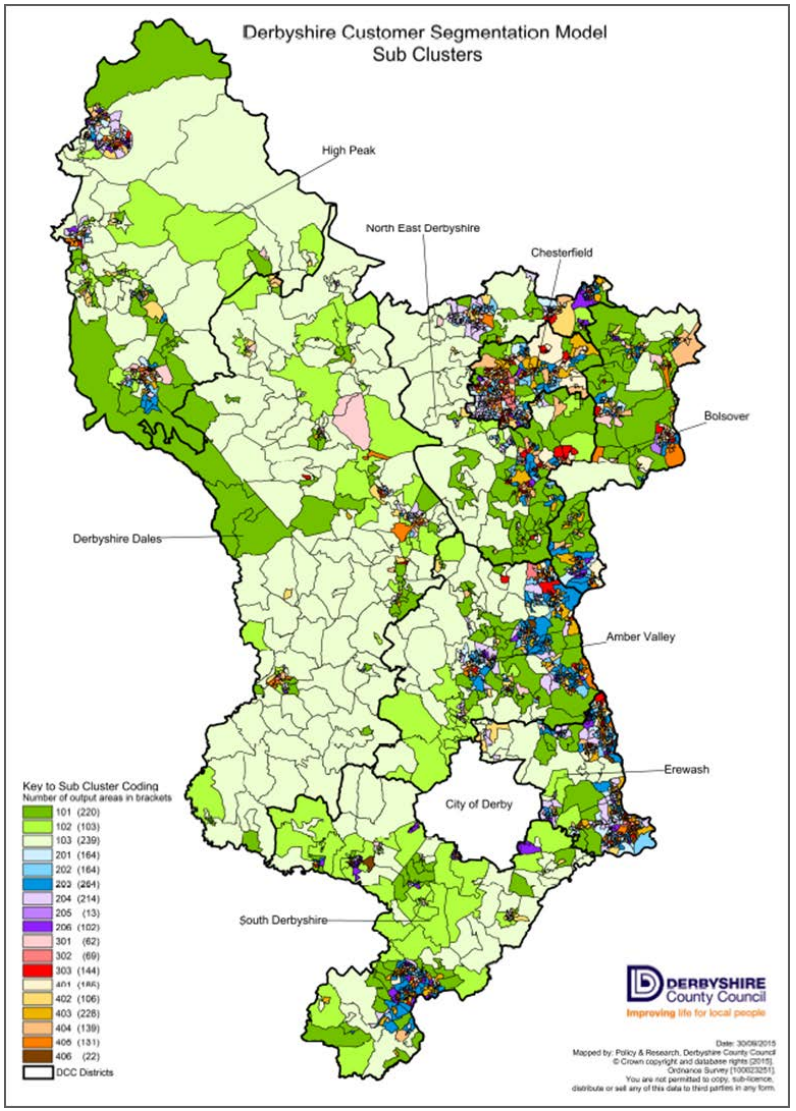
- **Social Prescribing** - Continue to provide, promote and grow mechanisms that direct people to community based services and social interaction activities
- **Community led transport -** Explore creating new community led transport services which provide access to social and economic activities and opportunities for Derbyshire residents
- **Access to information – communities -** Find creative ways of informing communities and connecting residents to encourage interaction, communication and disseminating information
- **Access to information – workforce -** Create networks between HWB partners in order to share information, best practice and create new ways for community knowledge to be used
- **Sharing assets -** Free up public sector assets & resources for greater community use
- **Sharing economy -**Build opportunities for people to engage in and access the potential offered by the sharing economy

Recommendations - Organisations

- **Co-production -** Promote collaborative approaches to community challenges, ensuring new approaches are feasible and desirable, unlocking new resources, new solutions and community assets
- **Trusted workforce -** HWB members commit to being a local, progressive employer, reflecting the communities they serve
- **Social Value -** HWB members should adopt the principles of social value and develop frameworks to ensure social value is achieved in commissioning and procurement activity
- **Staff volunteering** - Individual members of staff, no matter what their organisational role, should be encouraged to volunteer to help build social capital and stronger networks into and within their local community

Recommendations - Data

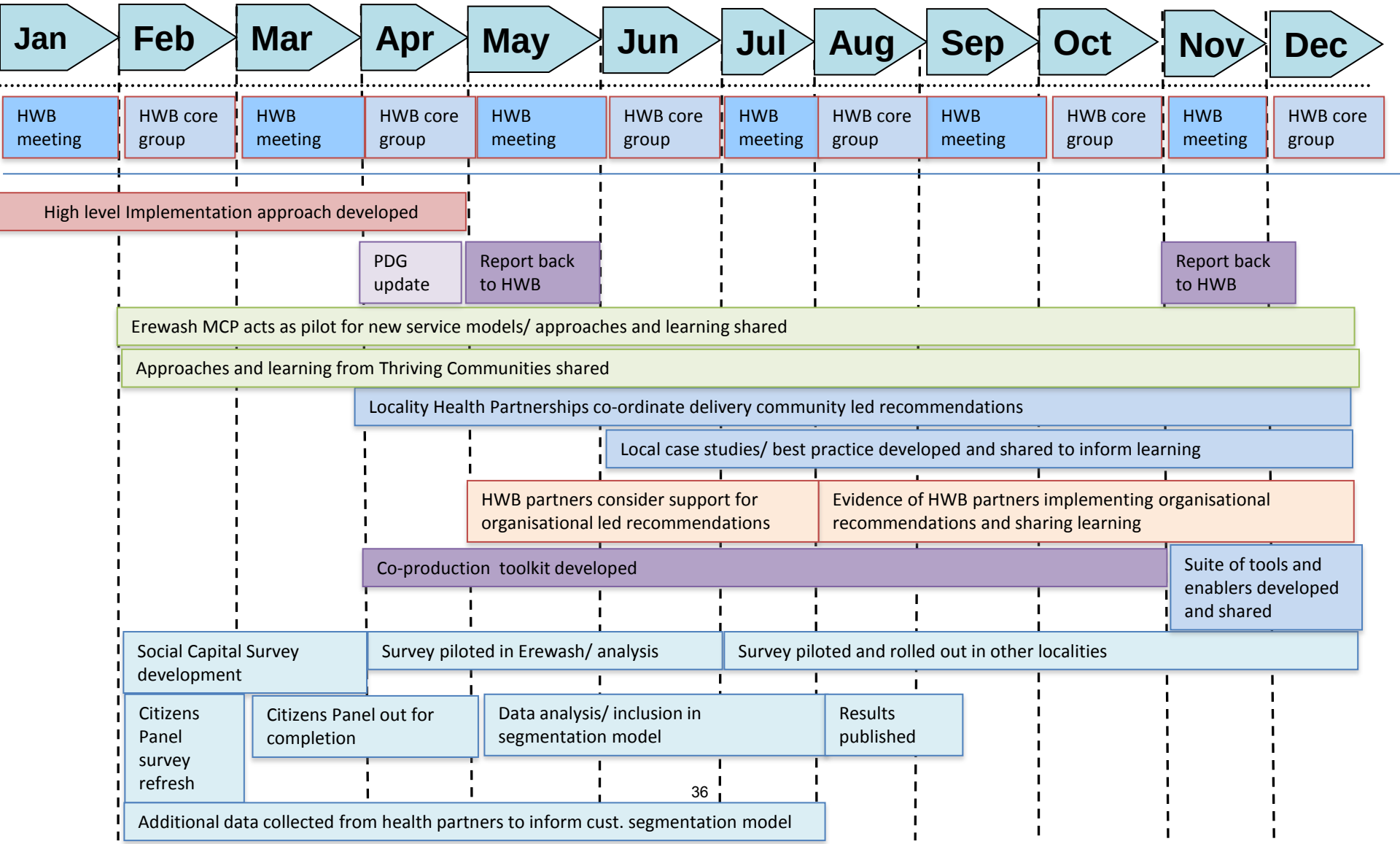
- **Recommendation 11: Customer segmentation model** - HWB partners should collaborate on the sharing of data to better understand the communities they serve
- **Recommendation 12: Social capital survey -** Develop a social capital survey which can be distributed by all HWB partners in order to accurately assess and understand social capital in Derbyshire
- **Recommendation 13: Qualitative data -** Recognise the value of qualitative data and customer insight in decision making and service development



Social Capital measures

- Residents trust people who live on their street to a large extent.
- Residents trust people living in the local area to a large extent.
- Residents state that trust in their neighbourhood has improved in the last 12 months.
- Residents state that trust in their neighbourhood has got worse in the last 12 months.
- Residents have been involved in decisions affecting their community in the last 12 months.
- Individuals who have provided unpaid help to a group, club or organisation at least once a month in the past year.

Timeline


Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
HWB meeting
HWB core group
HWB meeting
HWB core group
HWB meeting
HWB core group
HWB meeting
HWB core group
HWB meeting
HWB core group
HWB meeting
HWB core group
High level Implementation approach developed
PDG update
Report back to HWB
Report back to HWB
Erewash MCP acts as pilot for new service models/ approaches and learning shared
Approaches and learning from Thriving Communities shared
Locality Health Partnerships co-ordinate delivery community led recommendations
Local case studies/ best practice developed and shared to inform learning
HWB partners consider support for organisational led recommendations
Evidence of HWB partners implementing organisational recommendations and sharing learning
Co-production toolkit developed
Suite of tools and enablers developed and shared
Social Capital Survey development
Survey piloted in Erewash/ analysis
Survey piloted and rolled out in other localities
Citizens Panel survey refresh
Citizens Panel out for completion
Data analysis/ inclusion in segmentation model
Results published
Additional data collected from health partners to inform cust. segmentation model

Social Capital: 10 year vision

Social capital is about the relationships, networks and trust which help people to support each other, build confidence, and create the opportunities to bring about change in their lives and communities. Over the next ten years health and wellbeing partners in Derbyshire want to develop social capital further in our communities.

Where are we now? Derbyshire is a vibrant place with many communities who have strong bonds, high levels of trust and a community spirit which supports people when they need help. Building social capital can help improve health and wellbeing outcomes through behaviour change, mutual support and self-help as well as increasing community involvement in the design of services.
A report has been published which details recommendations about how to build social capital further and achieve the following:

Services:

Services are co-designed by the users or communities who access them, connecting people to peer support and local voluntary networks. Organisations operate in a joined up way, with strong and constructive relationships in place within and between organisations. Knowledge and information is effectively shared and as people tell their story once there is improved confidence and trust in services. A strong culture of collaboration is embedded across the public sector and silo working is a term of the past. Local public assets are fully utilised for social benefit and shared with local communities.

Connectivity:

The use of technology is maximised to enable individuals to link with and develop community networks through online spaces. Information is shared quickly by organisations and services supporting individuals and specific support is provided to those who are digitally excluded to ensure they are online. Individuals can easily find out practical advice about their health or lifestyle concerns. Locally led transport solutions are sustainable and affordable, providing a range of options for individuals to access different places and locations to support their wellbeing.

Individuals and communities:

People are empowered to see solutions for their own health and lifestyle issues. Individuals and communities understand their own and collective skills, knowledge and resources and utilise it to their full potential. Strong relationships, online platforms and activity such as time swaps, result in a broad range of informal support networks and those with long-term health conditions or those who are recovering from a health problem are appropriately supported by a mix of community and public sector resources.

Workforce:

Organisations reflect the communities they serve, with staff employed from a broad range of backgrounds, including those who are experts by experience.
Young people from a range of backgrounds, such as carer leavers, are employed by organisations and they are encouraged to develop themselves further through in work qualifications and training. Employees volunteer across a range of projects and are supported by their employer to do so.

In 10 years' time…

The health and wellbeing of Derbyshire residents will have improved as:

- Healthy norms of behaviour have spread and increased.
- Socially cohesive communities share assets, trust others, provide a sense of belonging and support networks both prevent and limit the effects of ill health.
- Individuals are engaged in issues affecting their health and wellbeing exerting influence and shaping decisions.

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Appendix 3

Listen Learn and Lead Action Tracker

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
11/04/2016	Cherry Tree Close	Ifti Majid	Staff asked specific questions around the money linked to HM and ST. Felt moment had passed but welcomed opportunity to discuss. Staff felt indignant that Trust isn't defending itself to negative press. Staff feel communication has improved and they feel able to raise concerns. Asked questions about Governor training and induction and plans to improve. Raised issue about the absence policy and how it promoted presenteeism. Concerned about speed of recruitment and if possibility of asking student nurses to sign on our bank within their first few weeks of commencing in training.	1. Inclusion of staff/consultation with staff at CTC to pick up any ideas about developing new absence policy. 2.Look into signing up student nurses in introductory week onto bank	1. Jayne Storey 2.Carolyn Green	Email reply from Ifti Majid with respect to actions and way to take forward.

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
08/04/2016	Young Person's Substance Misuse Service	Jayne Storey	Passionate team - open dialogue – welcomed discussion. Angry recent media re: money paid due to senior managers - compared cost impact v junior doctors fighting for pay rise. Perception of leaving with good reference and pay off. AGM – Public face of the Trust, how do we justify the spend on buffet – wrong perception. Transparency of HR procedures – equitable for all – don't see adverts for secondments – just see people seconded into posts. No recognised training / professional qualifications for substance misuse team – just about to have first training in 3 years, no career progression as roles require qualifications not equivalent experience. Have raised with their Line Manager – as part of the training plan, but don't get feedback. Asked the question – How do we retain staff on the basis of the above?	1.Clear communications about this year's AGM and consideration about any hospitality. 2.Need to ensure that clarity is given in JDs around use of equivalent experience as universally acceptable substitute for formal training. 3.More communications around staff packages to support recruitment and retention	1. Sam Harrison (Anna Shaw) 2.Jayne Storey 3.Jayne Storey	

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
04/04/2016	Occupational Therapy Team, Radbourne Unit	Ifti Majid	Very brief reference made to embarrassment around ET but staff specifically wanted to focus on Melbourne House and the security of their roles. Discussed the process with commissioners that was in place and expectations around letter of clarification that was expected. Talked about the confusion about letter sent in November that could be read as promising them a job on the Hub. Discussed significant improvements in care due to increased staff numbers in Unit.	1. Alert staff on Hub as soon as letter received from commissioners. 2. Independent review of letter sent in November		
04/04/2016	Chesterfield CMHT and North East CMHT Older Adult Team, Hartington Unit	Ifti Majid	Staff explained that the media coverage, and therefore the amount of discussion within staff groups less in North. Questions around financial affordability of the total cost of the ET and also staff wanted an understanding of why ST had left rather than process completed. Staff wanted to talk about the Neighbourhoods and the impact this was having on their ability to safely work with patients particularly around CAS/triage. Requesting support to pull CAS back to Hartington Unit due to economies of scale.	1. Ensure agreement to recentralise CAS given on temporary basis	1. Ifti Majid	1. Action completed by Julia Lowes in email sent 4/4/16. Email sent by IM after a couple of weeks to understand current position

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
30/03/2016	Workforce & Organisational Development Team	Carolyn Green	Detailed discussion around the outcome of the investigations, the way that had been handled and the method of communications or lack of with the team. Discussed historical culture in the team and previous leadership under past HR Director. Need to consider how the team supported going forward to cope with past issues as well as moving forward. Team keen to move towards a consultancy, assurance function rather than at current where high expectation on delivery due to lack of management training.	1. Jayne Storey to attend regular team meetings 2. Short term support to discuss CQC visit expectations	1. Jayne Storey 2. Carolyn Green	Carolyn Green has emailed the team to thank them for the visit and propose the agreed actions

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
23/03/2016	Learning Disability Team & Occupational Therapy Team	Ifti Majid	Team keen to hear summary of events and details around the outcome of the investigations. Team had specifically looked at well led review outcome from CQC to see what they needed to change as a result. Discussed perception around financial impact to the Trust due to the amount of money as well as reputational impact. Team would be supportive of more assertive response in the media. Discussed the issues the team had with accessing timely HR support. Team wondered about ability to access 360 appraisal process. Discussed the teams disappointment that the showcase had not been attended by commissioners.	1. Regular Director visits to the team meeting 2. Information about 360 degree appraisal system to be sent to the team	1. Ifti Majid 2. Jayne Storey	IM sent email to Team leader following visit.

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
21/03/2016	South Derbyshire Mental Health Team for Older People, Dale Bank View, Swadlincote	Carolyn Green	The team found it helpful to talk about the ET and their experiences when having issues raised by the community. It was a very difficult period and should a major event happen again, more directive advice would be appreciated. It was raised that although the ET aspect was important, and important to discuss. key issues to the team were the neighbourhood model, release of vacancies to recruit to and the impact on team capacity, access to an all age crisis response service, exploring inter team related challenges. Having capacity to meet demand and having access to more psychology or psychological therapy time to meet the needs of individuals in their care.	To feedback to the executive team on this visit, to consider the impact on capacity and demand in contracts negotiation and going forward. For the executive to consider feedback on solutions to issues raised	Carolyn Green	20-Apr-16
17/03/2016	Information Management, Technology & Records	Ifti Majid	The team took the opportunity to bust some rumours around the ET, particularly around the cost and impact on clinical services. General sense of being very busy, competing demands and how IT was often seen as key to innovation therefore demand high. Capacity seen as a problem as well as lack of clarity of who was who in Trust middle management.	Need to receive clarity about the recent changes in operational management	1. Carolyn Gilby	

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
16/03/2016	Amber Valley CTLD, Rivermead	Carolyn Gilby	Team had questions about the recent press coverage and the amounts of money that had been lost to the organisation. There was concern regarding reputation and embarrassment regarding this. There was an expectation of better behaviour from Directors and disappointment as they set the tone for the organisation. In terms of moving forward they wanted to be forward focused and wanted the current acting CEO to be the new CEO as he was being open, honest and communicating well with the organisation.	The openness and good communication from the CEO to continue	1.Ifti Majid	
15/03/2016	IAPT Team, Ilkeston	Ifti Majid	New contract issues, capacity, covering whole of county and differences north/south. Multiple assessments and patient experience due to bouncing from service to service. Team interested in engaging in more detail with Directors around some of unique problems team face.	Specific Director visit to be arranged to team meeting	1.Ifti Majid	Meeting aranged

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
15/03/2016	Estates Team	Claire Wright	The estates team talked about what impacts on staff morale and team relationships and what we need to learn from. They also asked questions about the exits of the ex-chair and CEO and investigations. Also wanted to know more about the “Fit and Proper” Test. Also discussed equality of access to training across staff groups. Discussed wanting to resolve more issues at team level rather than escalating.	Further visit needs arranging to finish off discussion	1.Claire Wright	Date diaried
11/03/2016	Neurodevelopment Team	Mark Powell	The team wanted to understand more about Trust finances and future financial position which we discussed in some detail. The team were very keen to explore how they could develop wider Partnerships to support the development of their service. They wanted to understand if the outcome of the ET would affect them in delivering their service to which I said it shouldn’t. They were happy with this and didn’t wish to talk about the ET anymore. We also discussed Trust Values and the team were very clear that they should not be changed, are very good and are used by them each and every day.	No specific actions arising	N/A	Email sent to Team thanking them for visit

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
29/02/2016	Campus Care North, Hartington Campus	John Sykes	John Sykes visited the new neighbourhood teams in Chesterfield and spoke to service managers. Also visited wards at the Hartington Unit and spoke to ward nurses and individual CPNs. Carried out a separate meeting with general managers and met with individual consultants but was unavailable for the Trust Medical Advisory Committee in April. Good overall support of the Board and the process we are following regarding the GIAP. Staff often asked how we were coping with the stresses given the level of external scrutiny and challenge from others. They also thought the Board needed to learn the lessons from what has happened and articulate these. "How are things going to be different?" There is considerable angst about the money that has been spent on this issue and the remedial processes. Generally there is no desire to prolong the process and spend any more money. The BMA are involved following receipt of a letter from Helen and Peter Marks. The chairs of the Medical Staff Committee and Local Negotiation Committee have asked for confirmation of: • Was the overarching investigation properly commissioned with sufficient Terms of Reference? • Are disciplinary and other processes being followed properly now? They have met with chairman, Richard Gregory, on these matters. Transition to the new neighbourhoods has been tricky. We have had all of the anticipated teething problems and none of the potential advantages as yet. John Sykes co-location geographically is not possible and this is proving a major problem		John Sykes	

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
26/02/2016	Southern Derbyshire Crisis and Home Treatment Team	Mark Powell	The team would like to change their name from Crisis and Home Treatment to something akin to Assessment and Home Treatment.There was a request for some guidance on what could be said to patients who asked questions about the recent Employment Tribunal and media attention. Discussed the impact on the image and the perception of those who are doing a very good job for the Trust at this time and what actions the Board was taking to improve the Trust's reputation. The team were concerned about the number of patients with a PD who were presenting to the service and there was a concern about Melbourne House not accepting admissions. An issue was raised about staff from Melbourne House and then deployment to the Hub.	Was the overarching investigation properly commissioned with sufficient Terms of Reference?	1.Caroly Gilby 2.Mark Powell 3.Mark Powell	Summary of visit and agreed actions sent to Team

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
23/02/2016	North Derbyshire Drug Service	Ifti Majid	Some discussion on negative publicity linked to ET and impact of cost on services however main areas of discussion from the Team lined to the upcoming tender, the lack of capacity in services and some of the good practice associated with court work and primary care liaison. Senior management visibility was commented upon - not Directors but upper middle management. Some concerns around the need to ensure managers from other sectors trained if going to manage our staff in partnership.	Are disciplinary and other processes being followed properly now?	N/A	

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
23/02/2016	Bolsover Recovery Team	Ifti Majid	Significant discussion around reputation and financial cost of ET. Impact on social media and staff embarrassment. Trust culture of starting things but not finishing e.g. releasing time to care. Concern about the impact of neighbourhoods, will it give benefits expected. Some posts have been held too long linked to neighbourhoods. Problems with getting staff onto bank, even staff who just finished at Trust need to jump through hoops e.g. numeracy tests. Communication improved of late and staff do feel Directors keen to engage. Discussed and showed me the environmental problems in patient areas e.g. waiting room.	They have met with chairman, Richard Gregory, on these matters.	1.Ifti Majid 2.Ifti Majid	Feedback to Team within two weeks and to Board - extract from Board paper.....'*You will recall when I visited Bolsover CMHT they had issues with the quality of the environment in the waiting room, my thanks to the estates team for quickly going up to Bolsover and redecorating the room, I understand the environment is much improved. Additionally the team asked for support around some specialist admin advice, thanks to Julie Scattergood admin lead who contacted the team the following week'.*
16/02/2016	Radbourne Unit	Mark Powell	Spoke specifically with a couple of people, key messages from them was about focussing on patients and delivering services and need to move forward rather than focus on past.	No specific Actions	N/A	
15/02/2016	Radbourne Unit Acute Wards and Perinatal Service	Carolyn Gilby	Unit very busy, acuity on the unit, senior staff feeling regarding ET and ‘pay out’ in particular embarrassment and anger.	No specific Actions	N/A	

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 27 April 2016

Governance Improvement Action Plan – Full Report

Purpose of Report

As described in the GIAP Governance and Delivery framework, the Board has overall responsibility for ensuring that the GIAP is delivered.

Therefore, the purpose of this paper is as follows;

1. To provide Board members with an update on progress of all tasks within the GIAP, including the identification of tasks that are off track

2. To receive assurances on delivery and risk mitigation through the updated GIAP, from Board Committees and lead Directors

3. To enable Board members to constructively challenge each other to establish whether sufficient evidence has been provided for completed actions

4. To decide whether tasks and recommendations can be closed and archived

Executive Summary

The GIAP governance and delivery framework sets out a robust accountability process that includes lead Directors and Board/Board Committees.

The month of April has been the first cycle of this accountability process, culminating in this report. The full GIAP accompanying this report provides Board members with an up to date position of the totality of the plan.

It is worth noting the following;

- The main focus of attention during the last 4 weeks has been on tasks with a delivery deadline up to, and including the end of May. There is a need to look to the future over the course of the next month.

- Owing to the timing of meetings in April only Quality Committee and People and Culture Committee have met to discuss and receive assurance on the tasks that they have oversight for on behalf of the Board. Board members will see the outcome of these meetings presented in the 'comments on progress' and in the updated RAG ratings sections in the GIAP.

- Remuneration Committee and Audit Committee meet on the day of Board and the following day respectively.

At the time of writing this report, weekly one to one meetings have been held with each lead Director to discuss their tasks/actions, for assurance to be sought by the Responsible Director on task delivery and to agree associated evidence. This process continues to evolve to ensure that it is a meaningful approach and places focus on delivery 'and' supports the foundation for sustainable change.

Key Tasks – Currently 'Off Track' or 'Some Issues'

The following section sets out the key tasks that are off track / some issues and will be the main focus for Board member discussion and assurance.

- *HR 2 - Ensure external resources for the newly appointed Director of Workforce, OD and Culture are obtained in order to drive the transformation of HR and related functions through a combination of coaching, buddying, and mentoring support.*

- *PC4 – Prioritise the development of the People Strategy and ensure the agenda and focus of the newly formed People and Culture Committee is clearly aligned the Trust's overall strategy.*

- *Corporate Governance – all or parts of CG 1, 2, 4, 7 & 9*

Key Tasks – Recommended for Board assurance RAG rating blue (closure / archive)

The following section sets out the key tasks that are rated as completed with a recommendation from the Responsible Director to Trust Board that these are Board rated blue for closure and archive.

- *HR1 – The HR and OD departments should be under the management of one Executive Director*

- *PC6 – Expand the current Chair and CEO reports to provide a greater depth of information regarding key priorities for stakeholder engagement, feedback provided and any barriers to progress*

- *CG12 – Reintroduce short summary reports from committee chairs to the Board to supplement minutes. These should identify key risks, successes and decisions made / escalated from the meeting*

- *M2 – The Governance Improvement Action Plan will be updated to reflect material matters arising from the HR investigation*

- *M4 – The Trust will implement Programme management and Governance arrangements to ensure the delivery of the Governance Action Plan*

- *M6 - The Licensee will, by 18th March 2016 or such other date as agreed with Monitor, develop and submit to Monitor a timetable for making permanent appointments to all director roles which are currently vacant and/or filled on an*

interim basis. It will, by a date to be agreed with Monitor, revise that timetable in response to any comments made on it by Monitor.

Feedback from NHSI on the GIAP

NHSI has in their letter dated 20th April to the Trust, stated that they are supportive of the approach the Trust is taking to the development and implementation of the GIAP to address the undertakings.

They note that it is important that the Board is confident in its ability to effectively monitor and assure the delivery of the plan and that it focuses its review and challenge at the right level. NHSI has suggested that within future iterations of the GIAP there is a portfolio of proposed key outcomes, and associated metrics, evidence and risks that the Board will focus on.

Strategic considerations

- Delivery of the GIAP links directly to Monitor enforcement action and associated license undertakings

Assurances

- This paper should be considered in relation to key risks contained in the Board Assurance Framework

Consultation

- This report has not been discussed at any other meeting

Governance or Legal issues

- This paper links directly to Monitor enforcement action and associated license undertakings

Recommendations

The Board of Directors is asked to;

1. Review the content of this paper, full GIAP (attached) and seek assurance where required

2. Discuss the recommendations rated as 'off track' or 'some issues' and seek assurance on the mitigation provided from the Responsible Director, Individual Directors or Committee Chairs

3. Discuss and approve the recommendations put forward as 'complete' for closure

Report prepared and presented by: **Mark Powell**
Director Business Development and Marketing

Governance Improvement Action Plan

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
	CORE 1- REUNIFICATION OF THE HR AND ASSOCIATED FUNCTIONS											
HR1	The HR and OD departments should be under the management of one Executive Director	1) Recruitment of Director of Workforce, OD and culture	14th December 2015	**Completed**	None Required	Acting Chief Executive	Rem Com	18th January 2016	1) Role agreed at Remuneration Committee 2) Organisational change process completed 3) Communication with individuals and organisation	1) Director of Workforce, OD and Culture is in post	1) Refreshed Organisational structure communicated	Complete
		2) Job Description approved at Rem Com	21st December 2015	**Completed**		Acting Chief Executive	Rem Com					
		3) Inform staff effected by the change	11th January 2016	**Completed**		Acting Chief Executive	Rem Com					
		4) Formal recruitment to the post	4th January 2016	**Completed**		Acting Chief Executive	Rem Com					
		5) Communicate the change to affected departments	18th January 2016	**Completed**		Director of Workforce, OD and Culture	Rem Com					
		6) Communicate the change to the organisation	18th January 2016	**Completed**		Acting Chief Executive	Rem Com					
HR2	Ensure external resources for the newly appointed Director of Workforce, OD and Culture are obtained in order to drive the transformation of HR and related functions through a combination of coaching, buddying, and mentoring support.	1) Develop and agree a plan which identifies additional resources to ensure successful delivery of HR, Workforce and OD GIAP actions	18th March 2016	**Some Issues**	A resource plan will identify costs	Director of Workforce, OD and Culture	People and Culture Committee	30th April 2016	1) A plan setting out resource requirements to deliver the GIAP was agreed by ELT 2) Internal process for approval/adverts in progress 3) CV's received from agencies with interviews planned for mid to late April 4) An exception report was presented to People and Culture Committee on 20.4.16 by the Director of Workforce explaining the delay in the delivery of the agreed resource plan. The report set out the timeframes for recruitment of the agreed posts, with assurances given that all posts except 1 would be in place by the end of April. The Committee were assured that progress was being made, but were not fully assured, hence the rating of 'some issues' 5) Members of P&CC also reviewed the assurance provided for the resource plan itself and challenged whether the plan included enough resource to deliver the totality of the actions within GIAP. The Committee was not assured about the level of resource that had been agreed and requested that ELT reviewed the plan. It was agreed that 'some issues' was the correct rating for this.	1) External resource in place fulfilling GIAP tasks	1) Demonstrable delivery of the GIAP tasks	
		2) Deliver the Resource Plan	31st March 2016	**Some Issues**		Director of Workforce, OD and Culture	People and Culture Committee					
HR3	Undertake an exercise to update the model for HR. Utilising the model as a guide, expertise and best practice across the LHE, and beyond. As a priority the Trust should focus on establishing clear foundations, utilising key building blocks to create sustainability in the long term.	1) In consultation with team develop and deliver the new model for HR	30th June 2016	**On Track**	External support may be required on both the developmental and delivery stages	Director of Workforce, OD and Culture	People and Culture Committee	30th October 2016		1) Revised HR model in place 2) Positive HR Effectiveness KPI's	1) Improvement of HR KPIs	

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
HR4	Define a new structure for HR and its related functions with a priority on operational efficiency and strategic impact taking into account the refreshed People Strategy and revised model for HR and related functions.	1) Develop and implement a new structure for HR and its related functions with a priority on operational efficiency and strategic impact	30th June 2016	**On Track**	External support may be required on both the developmental and delivery stages	Director of Workforce, OD and Culture	People and Culture Committee	31st October 2016		1) New HR structure in place and working effectively	1) Improvement of HR KPIs 2) Demonstrable delivery of the GIAP tasks	
HR5	As part of the development of the People strategy and developing the model for HR, the function should define how it measures and evaluates the impact of HR, particularly around securing organisational development. A clear set of metrics demonstrating the impact of the function should be a focus on the newly created People and Culture committee.	1) Develop a suite of metrics to measure impact of interventions at an organisation and service line level	30th June 2016	**On Track**	None Required	Director of Workforce, OD and Culture	People and Culture Committee	31st July 2016	1) Progress against this action has been delayed due to annual leave and sickness. 2) Functional HR metrics presented at People and Culture Committee on the 20.4.16 for Committee discussion. Feedback was provided by the Committee and the metrics were agreed. The Committee noted that the timeframe for delivery had not been met, but was assured by the proposed metrics and agreed that this was now back ono track. It was agreed that the metrics will be included within the HR model proposal due by the end of June 2016 and used to monitor effectiveness	1) Agreed set of metrics 2) Evidence of metrics used with Governance structures	1) Integrated performance report includes a set of HR metrics	
		2) Develop an internal suite of metrics to measure functional effectiveness	31st March 2016	**On Track**		Director of Workforce, OD and Culture	People and Culture Committee					
	CORE 2- PEOPLE AND CULTURE											
PC1	The Trust should adopt an Organisational Development and Workforce Committee	1) Terms of Reference Developed	29th January 2016	**Completed**	None Required	Director of Workforce, OD and Culture	People and Culture Committee	27th January 2016	1) TOR for P&CC agreed in February 2) TOR of P&CC sub committees were presented in March but not approved. Revised TOR will be re-presented for approval by P&CC committee in April 3. Revised TOR for the sub groups were approved at P&CC 20.04.16	1) People and Culture committee in place and working effectively 2) People and Culture committee agenda reflective of the priorities set out within the People Strategy	1) Well led External review provides positive assurance on the effectiveness of the Committee	
		2) Terms of Reference approved by Board	29th January 2016	**Completed**								
		3) First Committee meeting	17th February 2016	**Completed**								
PC2	Develop and undertake a clear programme of work around culture, utilising the expertise of other NHS Trusts in the LHE, and where necessary beyond, to inform the programme of activities.	1) Develop a programme of work against the delivery of the people strategy	30th June 2016	**On Track**	Resources required to be identified within People plan.	Director of Workforce, OD and Culture	People and Culture Committee	31st March 2017	1) People Strategy on the agenda for the people committee in April. 2) An externally facilitated Board development session was held on the 13th April 2016 at which the Board discussed the values 3) The People strategy framework was presented to People and Culture Committee on the 20.4.16	1)Monthly pulse checks 2) Annual staff survey 3) Evidence of attendance on Leadership Development courses 4) Evidence of health and well being events	1) Evidence of improvement against an agreed trajectory using the staff survey, Cultural Barometer and informal and formal feedback	
		2) Develop a clear plan which outlines an on-going focus on pulse surveys to enable targeted activity	31st July 2016	**On Track**		Director of Workforce, OD and Culture						
		3) Based on Pulse Checks develop a focused coaching within teams	31st August 2016	**On Track**		Director of Workforce, OD and Culture						
		4) Implement events focused on staff health and well-being	30th June 2016	**On Track**		Director of Workforce, OD and Culture						
		5) Ensure there is an agreed approach to extensively share good practice and innovation	30th June 2016	**On Track**		Director of Workforce, OD and Culture						

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
		6) Develop and implement a leadership development programme	31st July 2016	On Track		Director of Workforce, OD and Culture						
PC3	Supplement the current mechanisms to engage with staff through the inclusion of more informal activities across both clinical and corporate areas. Develop clearer reporting of information and trends from these activities in order to triangulate with other information, for example, through the CEO report and Quality Position Statement.	1) Develop a comprehensive internal Comms plan, which clearly articulates engagement approaches both formal and informal	31st May 2016	On Track	Comms resource may be required	Director of Corporate Affairs	People and Culture Committee	27th June 2016	1) CEO Report to Board has been enhanced to include more detailed information about stakeholder engagement and it now includes a detailed section called listen, learn, lead. This summarises feedback from staff and provides evidence of where action has been taken in response to this feedback.	1) Evidence the delivery of the internal Comms plan	1) Improvement of staff survey 2) Improvement of pulse check metrics	
		2) Develop a clear system to record feedback received from staff	31st May 2016	On Track		Director of Corporate Affairs	People and Culture Committee					
PC4	Prioritise the development of the People Strategy and ensure the agenda and focus of the newly formed People and Culture Committee is clearly aligned the Trust's overall strategy.	1) Refresh People Strategy including reporting metrics	29th April 2016	Off Track	Identified within the resource plan	Director of Workforce, OD and Culture	People and Culture Committee	31st July 2016	1) People Strategy to be presented to P&CC in April. 2) A draft People Strategy framework and plan was presented to People and Culture Committee on the 20.4.16. The Committee acknowledged progress and discussed the draft documents, agreeing that the content was good, but that the People Plan (implementation) was not complete. The Committee was therefore not assured and agreed that a completed People Plan was required at its March meeting for approval.	1) People Strategy and supporting plan in place	1) Well led External review provides positive assurance on the effectiveness of the Committee	
		2) Ensure the people Strategy places greater emphasis at divisional and service lines to support our leaders to deliver the strategic objectives	29th April 2016	Off Track		Director of Workforce, OD and Culture	People and Culture Committee					
PC5	Undertake an exercise to refresh the Trust values. As part of this exercise engage with staff to ensure that values are meaningful and expected behaviours are clear. Prelaunch revised values across the Trust.	1) HR and OD to undertake a review of the Trust values	31st May 2016	On Track	Investment in external consultants to support culture change programme	Director of Workforce, OD and Culture	People and Culture Committee	31st August 2016	1) An externally facilitated Board development session on Trust values took place on the 13th April 2016, and was discussed by ELT on the 18th April 2016. A further discussion is planned for Board in April to agree next steps	1) Trust Values identified within Trust Strategy 2) Visibility and understanding of Trust Values	1) Staff Survey	
		2) Set a programme of engagement with staff to consultant on the refresh of the values	31st May 2016	On Track		Director of Workforce, OD and Culture	People and Culture Committee					
		3) Ensure a comprehensive Comms plan in place to ensure values are visible across the Trust; and	30th June 2016	On Track		Director of Workforce, OD and Culture	People and Culture Committee					
		4) HR and OD to undertake a refresh of the behavioural framework	31st July 2016	On Track		Director of Workforce, OD and Culture	People and Culture Committee					
PC6	Expand the current Chair and CEO reports to provide a greater depth of information regarding key priorities for stakeholder engagement, feedback provided and any barriers to progress.	1) Chairman and CEO reports to include information about stakeholder engagement and feedback from commissioners	31st March 2016	Completed	None Required	Acting Chief Executive	Board of Directors	30th April 2016	1) CEO report to Board has been enhanced to include more detailed information about stakeholder engagement and it now includes a detailed section called listen, learn, lead. This summarises feedback from staff and provides evidence of where action has been taken in response to this feedback	1) Regular reports received by BoD and CoG	1) Evidence of reports discussed at BoD and CoG	Complete
		2) Chairman to provide updates to Board from Council of Governors	31st March 2016	Completed		Acting Chief Executive	Board of Directors	30th April 2016				
	CORE 3 CLINICAL GOVERNANCE											
CG1	Refresh the role of Quality Leadership Teams to increase their effectiveness as core quality governance forums.	1) Agree and implement a QLT forward plan process to ensure all required papers are received at each meeting	30th April 2016	Completed	Resource required to support time out days for QLT and	Director of Nursing	Quality Committee	13th October	1) April Quality Committee received a paper outlining the process on this action and also included Model Quality Leadership team - forward plan, a template issue log and a template agenda for the QLT meetings. The Committee were assured by the proposed	1) Evidence of implementation of QLT forward plan 2) Evidence of QLT's owning and overseeing delivery of Trust quality priorities 3) Evidence of BM attendance at QLT's	1) Achievement of the quality framework	
		2) Develop and implement a standard escalation template to be used by QLT's	30th April 2016	Completed		Director of Nursing	Quality Committee					

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
CG1		3) Review frequency of clinical reference groups so that QLTs are enabled to undertake their work as defined by TOR	30th April 2016	Completed	days for QLT and CRG leadership teams	Director of Nursing	Quality Committee	2016	programme of work.			
		4) For a 6 month period DoN and MD to attend QLTs to provide coaching and oversight of meeting effectiveness.	30th September 2016	On Track		Director of Nursing	Quality Committee					
CG2	The Trust would benefit from a robust and thorough policy review programme.	1) Undertake a review of Trust policies in order to; a)Revise the number of policies; b) update to ensure for plain English; c) ensure consistency and clarity in how policies are presented , e.g. managers guide, policy or procedure.	31st December 2016	On Track	Resource will be required to increase capacity within the risk management function	Director of Nursing	Audit Committee	31st January 2017	1) Extra resource to support this action was approved by ELT 2) A member of staff has been seconded to the role for 6 months in order to review policies	1) Evidence that the Trust has reduced the number of policies 2) Evidence of policies being reviewed within date	1) Audit of policy compliance	
CG3	Increase the effectiveness of the Quality Committee by ensuring clear alignment of the committee with the quality strategy and associated objectives, and ensuring a clear focus on seeking assurance.	1) Board Development to focus on NED challenge of overdue actions and reports (see RR2)	31st March 2016	Completed	Resource identified in Board Development RR2	Director of Corporate Affairs	Board of Directors	30th November 2016	1) Board Development programme agreed at March Board meeting. This includes a session in June on holding to account	1) TOR agreed 2) Evidence of agenda reflecting Quality Strategy and Quality Goals 3) Quality Governance Group implemented 4) Evidence of actions agreed	1)Achievement of the quality framework 2)Annual report	
		2) As part of the review of all Committee TOR ensure there is clarity of Quality Committee TOR and work plans in relation to the Audit Committee and People and Culture Committee	31st May 2016	On Track		Director of Corporate Affairs	Audit Committee					
		3) Introduce a Quality Governance Group that will report to Quality Committee	31st July 2016	On Track		Director of Nursing	Quality Committee					
		4) Ensure that Quality Committee agenda is structured so that it focuses on topics to deliver quality strategy and goals.	30th June 2016	On Track		Director of Nursing	Quality Committee					
	CORE 4; CORPORATE GOVERNANCE											
CG1	The Trust should consider how its governance arrangements could better match its strategy and plans.	1) Develop and approve a Corporate Governance Framework which supports the delivery of the Trust strategy ensuring that the Board of Directors and Board Committee agendas adequately reflect the strategic objectives of the Trust	31st May 2016	Some Issues	None Required	Director of Corporate Affairs	Board of Directors	30th June 2016	1) The key tasks associated with the development of the Corporate Governance Framework identified in the GIAP have been reviewed by the new Director of Corporate Affairs. There is a concern about the timeframes for delivery. This is being raised as a significant issue to Trust Board ahead of the 31st May delivery date. In order to successfully deliver and embed these key recommendations, an extended timeframe will need to be agreed. A plan will be presented to May's Board meeting setting out how all or parts of CG1, 2, 4, 7, and 9 will be delivered along with clear timeframes	1) Corporate Governance framework agreed by Board 2) Board and Committee agendas reflective of strategic objectives 3) Board and Committee papers link to the Trust's strategic objectives	1) Well led External review provides positive assurance on the effectiveness of the Corporate Governance Framework	

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
CG2	The Governance Framework should be updated to give greater clarity regarding roles of key individuals and governance forums, including: all EDs, the SID and Vice Chair, PCOG, QLTs and the Safeguarding Committee.	1) Develop and approve a Corporate Governance Framework	31st May 2016	Some Issues	None required	Director of Corporate Affairs	Board of Directors	30th June 2016	See CG1	1) Accountability Framework approved by Board of Directors 2) A full suite of ToRs in place with clear responsibilities for compliance monitoring and systems governance	1) Internal Audit on effectiveness of accountability framework	
CG3	The Board and its committees need to have a greater focus on capturing, recording and holding to account for agreed actions.	1) Board Development programme to be updated to include a session on holding to account which will include holding to account for agreed actions.	15th June 2016	Completed	External Support needed in order to facilitate Board Development session	Director of Corporate Affairs	Audit Committee	27th June 2016	1) Board Development programme agreed at March Board meeting. This includes a session in June on holding to account	1) Board Development Session undertaken 2) Revised action log process embedded 3) 6 month review of Action Matrix implementation undertaken 4) Reduced number of outstanding actions across Board of Directors and Board Committees	1) Well led External review provides positive assurance on the effectiveness of Board Development	
		2) Ensure a fit for purpose action log process is in place ensuring that the Board and Board committee action trackers are revised so that all actions captured have a clear close date, 'current position' and 'status of action'; and that RAG ratings are more clearly utilised to demonstrate progress	31st May 2016	On Track		Director of Corporate Affairs	Audit Committee					
CG4	Review the operation of all committees seeking to minimise duplication, revising membership, ensuring a focus on capturing and tracking actions, and increasing contribution to the debate. -a review of forward plans against ToR to ensure clarity of purpose; -minimise duplication of papers; -committee chairs should also meet quarterly to ensure effective co-working; -ensure robust attendance of all key EDs at committee meetings; -ensure a consistent focus on summarising debate and capturing actions. (feedback on this should be sought in annual effectiveness reviews); -review appropriateness of membership and provide a focus on members and attendees contributing equitably and effectively; and	1) Undertake a comprehensive review of the Board Committee structures including TOR	31st May 2016	Some Issues	None Required	Director of Corporate Affairs	Audit Committee	27th June 2016	1) ED attendance at Committees reviewed at ELT and will be reflected in revised TOR 2) See CG1	1) Robust governance committee structure fully established 2) Annual cycle of meetings available 3) Full suite of ToRs in standardised template 4) Further Well Led Self Assessment to be completed 5) Chair of Committees meeting on a regular basis 6) Attendance at meeting reported as part of the minutes	1) Well led External review provides positive assurance on the effectiveness of Committees	
		2) Arrange for Committee Chairs to meet on a quarterly basis	31st March 2016	Completed		Director of Corporate Affairs	Audit Committee					
		3) Review ED attendance at Committees	27th January 2016	Completed		Director of Corporate Affairs	Audit Committee					
		4) Review the minutes of the Board and Board Committees and consider the use of action notes as a more effect way of recording debate and actions	30th April 2016	On Track		Director of Corporate Affairs	Audit Committee					

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
	-timely submission of papers and consistent use over cover sheets	5) Embed a process for the yearly review of the effectiveness of Board Committee against TOR	30th June 2016	On Track		Director of Corporate Affairs	Audit Committee					
CG5	Undertake a review of the Finance and Performance Committee outlined below -a review of forward plans against ToR to ensure clarity of purpose; -minimise duplication of papers; -committee chairs should also meet quarterly to ensure effective co-working; -ensure robust attendance of all key EDs at committee meetings; -ensure a consistent focus on summarising debate and capturing actions. (feedback on this should be sought in annual effectiveness reviews); -review appropriateness of membership and provide a focus on members and attendees contributing equitably and effectively; and -timely submission of papers and consistent use over cover sheets	1)Undertake a comprehensive review of the Committee aligned to the TOR of the Committee	31st May 2016	On Track	None Required	Director of Corporate Affairs	Audit Committee	27th June 2016	1) Updated TOR were approved at the Committee meeting on the 28th March 2) The TOR were updated to reflect the well led findings, Trust Board forward plan updates, creation of People and Culture committee and general refresh 3) As part of the Committees annual report on its work the committee has also reviewed its effectiveness.	1) Forward plan approved 2) Review of TOR undertaken and updated TOR approved by Board 3) F&P Annual report reported to Audit Committee	1) Well led External review provides positive assurance on the effectiveness of Committees	
		2) Finance and Performance Forward Plan approved by F&P	31st May 2016	Completed		Director of Corporate Affairs	Audit Committee					
		3) Embed a process for the yearly review of the effectiveness of Board Committee against TOR	31st May 2016	On Track		Director of Corporate Affairs	Audit Committee					
CG6	The Audit Committee should reaffirm its role in seeking assurance over systems, controls and processes and not matters of operational or managerial detail.	1) Ensure processes are in place for Audit Committee to undertake a review of its effectiveness	30th April 2016	On Track	None Required	Director of Corporate Affairs	Audit Committee	30th April 2016	1) Committee Terms of Reference have been reviewed in line with Best Practice	1) Updated TOR updated and Approved by Committee and Board 2) Audit Committee Annual Report reported to Board	1) Well led External review provides positive assurance on the effectiveness of Committees	
		2) Review reporting and monitoring process to ensure Audit Committee is receiving required assurance on systems, controls and processes	30th April 2016	On Track		Director of Corporate Affairs	Audit Committee					
		3) Review Audit committee TOR in line with best practice from across the NHS	30th April 2016	On Track		Director of Corporate Affairs	Audit Committee					
CG7	In light of the changing governance and accountability structures (such as neighbourhoods, campuses and QLTs), an accountability framework should be designed to fully engage staff in how these changes will affect ways of working, performance management structures and desired behaviours moving forward.	1) Aligned to the Corporate Governance Framework develop and approve an organisational accountability framework	30th June 2016	Some Issues	None Required	Director of Corporate Affairs	Audit Committee	July 27th 2016	See CG1	1) Accountability Framework approved by Board 2) Accountability Framework communicated to staff 3) Session on the Accountability framework delivered at spotlight on leaders	1) Well led External review provides positive assurance on the effectiveness of Committees	
		2) Develop and fully engage senior staff in an accountability framework which should define: •the values, behaviours and culture to be role modelled by senior management; •roles and responsibility of key divisional leaders, including delegated authorities and duties; •expectations of performance; and •mechanisms to be used for holding to account both by EDs and within divisions.	30th June 2016	Some Issues		Director of Corporate Affairs	Audit Committee					

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
CG8	The Board needs to introduce an integrated performance report which encompasses key operational, quality, workforce and finance metrics	1) The Trust will revise the integrated performance report which will include: •key operational metrics; •a workforce dashboard; •the Quality Dashboard, updated to show the refreshed Quality Priorities; •a finance dashboard; and •a summary of performance of groups to highlight any underlying themes.	31st May 2016	**On Track**	None Required	Director of Operations	Board of Directors	31st May 2016	1) New Integrated Performance Report presented to Board in March 2) Quality Metrics required to complete the report by the end of May	1) Integrated performance report format approved at Board	1) Evidence of links between the Integrated Performance report and Board Assurance Framework	

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
CG9	Formalise the role of PCOG as a key forum in the Trust's governance structure	1) As part of the Governance Framework review the Trust will formalise the role of PCOG	31st May 2016	Some Issues	None Required	Director of Operations	Audit Committee	29th June 2016	1) See CG1 for task 1 2) Actions matrix has been introduced with further development required 3) Escalation to ELT being provided by Director of Operations	1) PCOG TOR reviewed and approved 2) ED attendance reviewed and formally recorded	1) Well led External review provides positive assurance on the effectiveness of Committees	
		2) Increasing ED attendance at PCOG	31st May 2016	On Track		Director of Operations	Audit Committee					
		3) Improving the quality of minutes and action trackers and the timeliness of papers to this forum.	31st May 2016	On Track		Director of Operations	Audit Committee					
		4) Clarifying the role of PCOG in light of the move to neighbourhoods and campuses	31st July 2016	On Track		Director of Operations	Audit Committee					
CG10	Further improve the function of the ELT by improving the timeliness of papers and quality of debate.	1) Ensure ELT agenda focuses on agreed key priorities and items appropriately escalated through the Governance Structures. Agenda and papers will be circulated on a Thursday	31st March 2016	Completed	None Required	Acting Chief Executive	Board of Directors	30th April 2016	1) ELT agenda completed and sent out on a Thursday 2) Revised agenda reflects the focus on agreed key priorities and principles.	1) Weekly ELT agenda and minutes reflects key priorities and appropriately escalated items	1) Well led External review provides positive assurance on the effectiveness of ELT	
CG11	The Board needs to address the quality of debate and dialogue, focussing on increasing contributions across all BMs, displaying greater leadership and vision, ensuring an appropriate balance between strategic and operational debate, and pushing for increased momentum around key issues.	1) Ensure a Board development programme which is linked to the Trust Strategy	31st March 2016	Completed	None Required	Director of Corporate Affairs	Board of Directors	31st March 2017	1) Board development programme approved at the Board meeting in March 2) 360 degree appraisals have commenced for 2016. The Council of Governors Noms and Rems Committee agreed the paper work and framework, but have agreed given the current environment that Governors will not comment on the NED appraisals this year, as they will hold the NEDs to account through their task and finish group 3) Board forward plan was approved at the meeting in March which includes a balance of operational and strategic items 4) The agenda will continue to be reviewed by the Director of Corporate Affairs as well as ELT to ensure the plan remains balanced	1) Board Development programme approved by Board 2) 360 Appraisals of all Board Members Completed 3) Skill Mix review of the Board completed and reported to Board	1) Well led External review provides positive assurance on the effectiveness of the Board	
		2) Ensure all Board Members have completed 360 appraisals which focus on development	31st March 2017	On Track		Director of Workforce, OD and Culture	Rem Com					
		3) Ensure that there is the appropriate balance of strategic and operational items on the Board Agenda	30th September 2016	Completed		Director of Corporate Affairs	Board of Directors					
CG12	Reintroduce short summary reports from committee chairs to the Board to supplement minutes. These should identify key risks, successes and decisions made / escalated from the meeting.	1) Reintroduce short summary reports from committee chairs to the Board which identify key risks, successes and decisions made / escalated from the meeting.	30th April 2016	Completed	None Required	Director of Corporate Affairs	Audit Committee	31st May 2016	1) Summary reports will be presented at the Board meeting in April	1) Summary reports are issued to Board 2) Clear articulation in the Board minutes of items escalated to Board from Committees 3) Minutes of Board Committees showing not only escalated items but also showing that the committee receives feedback from the Board	1) Well led External review provides positive assurance on the effectiveness of the Committees	Complete
	The Board should re-establish the Board Assurance Framework as one for all risks including risks which it is involved in and when that risk has an element of confidentiality how it is handled. It should write and implement a plan for BoD development which includes these objectives.	Develop and Agree BAF 16/17	31st March 2016	Completed		Director of Corporate Affairs			1) Board has agreed 16/17 BAF at march Board meeting 2) Board has agreed timetable for BAF deep dives	1) 16/17 BAF approved by Board 2) Each Board committee undertaking deep dives of BAF risks 3) Board Development Session on	1) Well led External review provides positive assurance on the effectiveness of the Board Assurance Framework	

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
CG13		Schedule BAF Deep dive reviews for Board Committees	31st March 2016	Completed	None Required	Director of Corporate Affairs	Audit Committee	31st March 2016		the BAF completed		
CORE 5- COUNCIL OF GOVERNORS												
CG1	The relationship between the BoD and the CoG is poor. Both parties should adopt a conciliatory approach rather than continuing with the antagonism which inflicts the current relationship.	1) The Board and Council of governors will co-write a policy on how the Board and council of governors will work in partnership	30th June 2016	On Track	None Required	Director of Corporate Affairs	Board of Directors & Council of Governors	Board and CoG meeting date	1) Council of Governors have approved a new meeting structure which include a more robust and effective Nomination and Remuneration Committee 2) Council of Governors have approved an expanded lead Governor job description and appointed to it 3) Code of Conduct to be reviewed at 12th April meeting	1) Partnership Policy approved by both CoG and Board of Directors 2) Code of Conduct approved by CoG 3) All Governors sign up to Code of Conduct 4) Council of Governors approval of Lead Governors Job Description 7) Council of Governors to agree, Council of Governors Governance Framework 8) Council of Governors to agree revised Constitution	1) Well led External review provides evidence of effective working relationships	
		2) The Trust will expand the role of lead governor to ensure greater collaborative working with the Chairman and SID	29th January 2016	Completed		Director of Corporate Affairs	Board of Directors & Council of Governors					
		3) Development and implement a process for the assessment of the effectiveness of Council of Governors	30th September 2016	On Track		Director of Corporate Affairs	Board of Directors & Council of Governors					
		4) Council of Governors to review and embed a new governance structure which will focus on more joined up working between CoG and the BoD	29th January 2016	Completed		Director of Corporate Affairs	Board of Directors & Council of Governors					
		5) Implement a Code of Conduct for all Governors	30th June 2016	On Track		Director of Corporate Affairs	Board of Directors & Council of Governors					
CG2	**Deloitte 12** - Formal training should be required for all current members of the CoG and to future members as they join. This training should include the role of the Governors, the context of organisational governance and the personal conduct expected of Governors. **CQC 3** - The trust should ensure that all board members and the council of governors undertake a robust development plan	1) Develop a new induction programme for the Council of Governors and roll out its delivery	31st May 2016	On Track	Requirement for external governance training	Director of Corporate Affairs	Council of Governors	31st March 2017	1) A new induction programme has been developed and will be used to induct all new Governors in May 2) A new development programme has been developed and will be discussed at the Governance Committee of Council of Governors on the 12th April 2016 3) The CoG Governance Committee on the 12th April 2016, discussed and approved the Governor Development programme and the first session is due to take place on the 22nd April 2016 focusing on Trust Strategy and GIAP	1) CoG development plan in place 2) Governors attending development sessions with positive feedback 3) Governor Induction process in place with positive feedback	1) 100% of new Governors inducted 2) Evidence of Governors accessing rolling programme of training	
		2) Develop a CoG development plan for 2016/17 to include Governwell and other external training	30th April 2016	On Track		Director of Corporate Affairs	Council of Governors					
		3) Ensure that a schedule of the plans are made available to all Board members and members of the Council of governors and the plan is delivered	31st March 2016	Completed		Director of Corporate Affairs	Council of Governors					
CG3	Prioritise the recruitment to the Council of Governors, ensuring that the role of the governor and vacancies are publicised.	1) Chairman will engage stakeholders to ensure representation on the Council of Governors	31st May 2016	On Track	Electoral reform services will manage the Governor Elections	Director of Corporate Affairs	Council of Governors	27th June 2016	1) The Chairman has written to all stakeholders to ensure they have identified someone in the organisation to represent them. The local police constabulary has written to decline representation. This will be discussed at the Governance Committee of CoG 2) Following the nomination process in Feb/March 16 we now have six new governors who were elected unopposed These are: Bolsover Chesterfield North Derby City East Derby City East Erewash North Surrounding Areas This leaves us with the following:	1) Contested Governor Elections	1) Minimal vacant Council of Governors seats 2) Vacant stakeholder governor seats filled	

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
		2) Hold Governor elections	31st May 2016	On Track		Director of Corporate Affairs	Council of Governors	27th June 2016	Upcoming elections (close on Tuesday 3 May): High Peak (two candidates) Nursing and Allied Professions – staff (three candidates) Remaining vacancies: Amber Valley North Chesterfield South Voluntary sector (appointed) x 2 Derbyshire Constabulary (opted out)			
	CORE 6- ROLE AND RESPONSIBILITIES OF BOARD MEMBERS											
RR1	Implement proposals to improve succession planning at Board level, including ensuring that Governors are adequately engaged in this process. Alongside this, develop processes for succession planning for Senior Leader positions	1) Develop and approve Board level, key divisional and corporate leaders succession plan	30th September 2016	On Track	None Required	Director of Workforce, OD and Culture	Rem Com	31st March 2017		1) Evidence of a succession plan that includes nominating successors at contingency, immediate and planned levels, from ED level to head of service	1) Evidence of succession plan being enacted when the need arises	
		2) Implement and embed succession plan	31st March 2017	On Track		Director of Workforce, OD and Culture	Rem Com					
RR2	**Deloitte 5** - Agree a programme of Board development work which includes a mix of internal and externally facilitated sessions, is clearly aligned to the combined governance action plan. the Board development plan should consider: •more detailed consideration of the governance action plan; •a focus on Board challenge, including assurance, reassurance and the role of the corporate director; •facilitated 360 feedback; •Board cohesion and dynamics; •use of external speakers to add insight and prompt debate; •joint sessions governors ; and •engagement from senior Trust leaders. **CQC 3** - The trust should ensure that all board members and the council of governors undertake a robust development plan (Link to CG2)	1) Develop a Board Development plan for 2016/17	31st March 2016	Completed	External resource will be required to facilitate Board Effectiveness sessions	Director of Corporate Affairs	Board of Directors	31st March 2017	1) Board Development programme agreed at March Board meeting 2) An externally facilitated Board development session focusing on the Trust's values took place on the 13th April 2016, with a further discussion planned for Board in April	1) Evidence of delivery of Board Development plan 3) Full attendance of all Board Members 4) No cancelled Board Development Session	1) Well led External review provides evidence of effective board challenge	
		2) Implement Board Development programme which will include Board effectiveness sessions to address team dynamics and agreed ways of working including •clarity of purpose and vision; •effective challenge and leadership; and •individual coaching.	31st March 2017	On Track		Director of Corporate Affairs	Board of Directors					
RR3	**Deloitte 6** - Complete the full process of 360 feedback for all BMs and utilise the outcome to set clear objectives in relation to portfolio areas (for EDs) as well as in relation to the role of the corporate director and contribution to the Board. **CQC 8** - The trust should introduce and effectively monitor 360 degree feedback all senior managers and directors.	1) Develop a 360 feedback process for BM's with forms and expectations on what and how to feedback	30th June 2016	On Track	Support required from external organisations	Director of Workforce, OD and Culture	Rem Com	31st March 2017		1) Evidence of 360 feedback taking place 2) Evidence of 360 feedback influencing BM objectives and development	1) Improvement in Board Effectiveness 2) Development plan for each BM be more tailored	
		2) Implement 360 degree feedback for all BM's	30th September 2016	On Track		Director of Workforce, OD and Culture	Rem Com					
		3) Integrate 360 feedback into BM's appraisal objectives and personal development goals	31st March 2017	On Track		Director of Workforce, OD and Culture	Rem Com					
		4) Implement 360 degree feedback for all senior managers	31st March 2017	On Track		Director of Workforce, OD and Culture	Rem Com					

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
		5) Integrate 360 feedback into senior manager appraisal objectives and personal development goals	30th September 2017	On Track		Director of Workforce, OD and Culture	Rem Com					
RR4	Implement a programme of Executive Team development which focuses on team dynamics, effective challenge and leadership and is supported by individual coaching where necessary.	1) Develop and agree Executive Team development programme which will include; team dynamics and agreed ways of working; •clarity of purpose and vision; •effective challenge and leadership; and •individual coaching.	31st May 2016	On Track	Support required from external organisations	Acting Chief Executive	Rem Com	31st March 2017	1) A paper setting out an ELT development programme will be presented the Remuneration Committee on 27.04.16 for consideration and approval	1) Evidence of Executive Coaching 2) Evidence of positive feedback through 360	1) Positive assurance received from external consultancy on the Improvement of Exec Effectiveness 2) Tailored development plan for each Director	
		2) Implement development programme and monitor effectiveness through 360 feedback	31st March 2017	On Track		Acting Chief Executive	Rem Com					
RR5	The trust should ensure that training passports for directors reflect development required for their corporate roles.	1) Training requirement for all ED's and NEDS are agreed by CEO and Chair, with passports updated accordingly	30th June 2016	On Track	Resource may be required for individual development	Acting Chief Executive / Chairman	Rem Com	26th October 2016	1) An assurance paper will be presented to the Remuneration Committee in October	1) All Directors 100% Compliance with their training requirements	2) As assured by positive well led external review that the Board are competent and effective	
		2) Developmental training requirements are discussed and agreed with Board members in their Appraisals	31st May 2016	On Track		Acting Chief Executive / Chairman	Rem Com					
		3) Provide BM and NED training update reports to Rem Com to demonstrate completion in line with mandatory and CPD requirements	30th September 2016	On Track		Acting Chief Executive / Chairman	Rem Com					
CORE 7- HR AND OD												
WOD1	**DR34**- Define and agree a process to regularly monitor the consistent application of HR policies and procedures for the full range of Employee Relations cases. **CQC 1** - The trust must ensure HR policies and procedures are followed and monitored for all staff	1) To undertake a review of HR policies and procedures to ensure all are in date and are compliant with expected HR practice	30th September 2016	On Track	Additional senior HR capacity is required to lead on this work. HR Resource plan to identify this is needed	Director of Workforce, OD and Culture	People and Culture Committee	January 17 committee		1) HR Policies signed off through JNCC 2) Suite of training agreed and tracking of compliance and impact evident 3) Positive Internal audit assurance	1) Improvement in the following areas of the staff survey 1.1) KF 14 Staff satisfaction with resourcing and support 1.2) KF 23 Percentage of staff experiencing physical violence from staff in last 12 months 1.3) KF 26 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months 1.4) KF 27 Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse	
		2) Develop an internal compliance monitoring process for HR policies and procedures including case management and tracking. This will be monitored by Trust Board and integrated into its performance reporting	31st July 2016	On Track		Director of Workforce, OD and Culture	People and Culture Committee					
		3) A training programme on HR policies and process is designed, available and accessible	31st December 2016	On Track		Director of Workforce, OD and Culture	People and Culture Committee					
		4) HR function to Audit compliance against two selected HR policies	30th June 2016	On Track		Director of Workforce, OD and Culture	People and Culture Committee					
		5) Internal Audit review of control process and assurance to demonstrate sustained improvement in compliance levels	quarter 4 16/17	On Track		Director of Corporate Affairs	Audit Committee					
	The trust should ensure that recruitment processes for all staff are transparent, open & adhere to relevant trust policies	1) Review and ensure that Trust recruitment and acting up policies are fit for purpose	30th June 2016	On Track		Director of Workforce, OD and Culture	People and Culture Committee			1) Approved Recruitment Policy 2) No Policy breaches	1) Positive audit Assurance on recruitment processes 2) Improvement in the following areas of the staff survey 2.1) KF 15 Percentage of staff	

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
WOD2		2) Agree a plan and deliver recruitment training to all appointing officers	31st March 2017	On Track	Additional senior HR capacity is required to lead on this work. HR Resource plan to identify this is needed	Director of Workforce, OD and Culture	People and Culture Committee	31st July 2016			satisfied with the opportunities for flexible working patterns 2.2) KF 21 Percentage of staff believing the organisation provides equal opportunities for career progression or promotion 3) positive outcome from external assurance visits	
		3) Deliver a peer audit of recruitment policies compliance to demonstrate improvement	31st December 2016	On Track		Director of Workforce, OD and Culture	People and Culture Committee					
WOD3	Address the relationship issues identified within the function, and alongside this agree a development programme for HR and its related functions that starts by building relationships at a senior level before seeking to develop an effective and efficient function.	1) Develop and implement a HR and related function Development programme, which includes building good working relationships	31st May 2016	On Track	External resource and support required	Director of Workforce, OD and Culture	People and Culture Committee	31st March 2017		1) Evidence of backlog of cases being addressed 2) Evidence of positive assurance from Internal Audit 3) Evidence of use of case tracking system	1) Effective operational HR team 2) Compliance Management training	
		2) Implement Development Programme	31st May 2016	On Track		Director of Workforce, OD and Culture	People and Culture Committee					
WOD4	As part of its review programme, the Trust may wish to consider a mandatory programme for line managers in order to embed the revised policies and procedures.	1) A training programme on HR policies and process is designed, available and accessible	31st December 2016	On Track	Additional capacity to develop core management training is required	Director of Workforce, OD and Culture	People and Culture Committee	31st January 2017		1) 90% of Managers trained before 31st December	1) There is a rolling pro active mandatory training programme which is regular reviewed by the people Committee	
WOD5	Consider a range of development interventions for the operational HR team to ensure employment law risks are mitigated.	1) As part of the wider HR development programme (WOD 3) deliver specific interventions on employment law	31st September 2016	On Track	Specialist HR Employment law specialist request	Director of Workforce, OD and Culture	People and Culture Committee	19th October 2016		1) Evidence of CPD within HR team 2) Reduction in investigation timeframes	1) Evidence of use of enhanced training with HR team	
WOD6	Consider mechanisms to regularly seek feedback from the HR function on the extent to which the candour, openness, honesty, transparency and challenge to poor performance are the norm, e.g. through monthly pulse checks	1) Introduce a monthly pulse check for the HR team	31st May 2016	On Track	None required	Director of Workforce, OD and Culture	People and Culture Committee	17th July 2017		1) Evidence of positive feedback and improvement	1) Effective operational HR team	
		2) Integrated Team meeting implement	30th June 2016	On Track		Director of Workforce, OD and Culture	People and Culture Committee					
WOD7	The trust should monitor the adherence to the grievance, disciplinary, whistle-blowing policies and the current backlog of cases concluded.	1) Implement a proactive system which monitors adherence to the grievance, disciplinary, whistle-blowing policies, including a robust case tracking system.	31st May 2016	On Track	Resource Plan	Director of Workforce, OD and Culture	People and Culture Committee	19th October 2016	1) the Director of Workforce has provided assurances that there is a proactive system which monitors adherence to the grievance, disciplinary, whistle-blowing policies, including a robust case tracking system is already in place. An internal audit is due which will review the case tracker.		1) Effective operational HR team 2) Compliance Management training	
		2) Internal audit compliance against named policies and the defined timescales against cases identified on the tracker.	30th September 2016	On Track		Director of Workforce, OD and Culture	Audit Committee					
		3) Ensure the backlog of cases made known to the CQC at the time of the inspection are concluded.	30th June 2016	On Track		Director of Workforce, OD and Culture	People and Culture Committee					
WOD8	The trust should continue to make improvements in staff engagement and communication	1) Develop a clear staff engagement plan that takes account of listen, learn and lead, wider open staff forums and enhances existing good practice	30th June 2016	On Track	1) Resource may be required for Pulse Check	Director of Workforce, OD and Culture	Board of Directors	31st March 2017		1) Evidence of published engagement plan 2) Evidence of improved engagement via pulse check	1) Improvement in the following areas of the staff survey 1.1) KF 4 Staff motivation at work 1.2) KF 5 Recognition and value of staff by managers and the organisation 1.3) KF 8 Staff satisfaction with level of responsibility and involvement 1.4) KF 6 Percentage of staff reporting good communication between senior management and staff	
		2) Publish and implement agreed engagement plan	31st December 2016	On Track		Director of Workforce, OD and Culture	People and Culture Committee					

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
		3) Monitor delivery of the plan at P&C Committee using feedback mechanisms such as pulse checks and staff survey.	31st March 2017	On Track		Director of Workforce, OD and Culture	People and Culture Committee					
	CORE 8- WHISTLEBLOWING											
W1	As part of the Trusts Well Led Self assessment we identified the need to take further action around the recommendations from the Francis report relating to whistleblowing in order that staff, patients and stakeholders feel confident to raise concerns	1) Freedom to speak up action plan will be refreshed and approved	31st March 2016	Completed		Director of Workforce, OD and Culture	People and Culture Committee	31st March 2017	1) Action plan agreed in Feb 2016 by ELT 2) National Whistleblowing Policy published 1st April 2016 3) Revised action plan and National Policy to be presented to April P&CC 4) At the P&CC on 20.04.16 Committee members were assured that a policy and plan were in place and acknowledged the requirement to update this following a national policy being released. It was agreed that an updated plan would be brought to May's P&CC.	1) Refreshed Whistleblowing policy and process approved by Board 2) Freedom to Speak up action plan delivered 3) Comms plan associated with Whistleblowing approved by the People and Culture 4) Compliance of training	Positive feedback from Staff Survey and pulse check	
		2)Freedom to Speak up action plan will be delivered and monitored through the People and Culture Committee	31st March 2017	On Track		Director of Workforce, OD and Culture	People and Culture Committee					
	CORE 9- FIT AND PROPER PERSON TEST											
FF1	The trust must ensure that a fit and proper person review is undertaken for all directors in light of the findings of the employment tribunal.	1) Develop fit and proper persons policy and have it ratified by Board of Directors	24th February 2016	Completed	None required	Director of Corporate Affairs	Board of Directors	29th June 2016	1) Fit and Proper Persons Policy approved by Board in February, with further amendments agreed in March 2) Board forward plan now includes an annual review of the Fit and Proper Persons Policy and its implementation 3) The Trust Board received and approved the Fit and Proper Persons Test Policy at its meeting on 30 March 2016. As part of this agenda item, all Board Members completed a self declaration to confirm that they do not fit within the definition of an 'unfit person' and that there are no other grounds under which they would be ineligible to continue in post. This declaration was completed by all Board members including voting and non voting directors and those holding interim director positions. The Director of Corporate Affairs reported to the People and Culture Committee on 20 April on GIAP item FF1 (5) that a process has been established to develop and implement a proactive process for monitoring the filing system for all Directors to ensure consistency and ease of access to evidence as detailed in policy. The Director of	1) Evidence of full compliance with fit and proper persons requirement as identified by Monitor licence conditions, CQC registration requirements and Trust constitution	1) Board Assurance via the Chair	
		2) Ensure that HR maintain the Fit and Proper Persons tracker	30th April 2016	On Track		Director of Workforce, OD and Culture	Board of Directors					
		3) Develop and implement a proactive process for monitoring the filing system for all Directors to ensure consistency and ease of access to evidence detailed in policy	30th April 2016	On Track		Director of Corporate Affairs	People and Culture Committee					
		4) Ensure that all current Directors comply with all aspects of the policy and that evidence is available in revised file structures	31st May 2016	On Track		Director of Corporate Affairs	Board of Directors					
		5) The Trust will ensure that a process in place to review the fit and proper requirement on an annual basis	31st March 2016	Completed		Director of Corporate Affairs	Board of Directors					

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
		6) Formal confirmation to Board by Chair of full compliance with fit and proper persons requirements	30th April 2016	On Track		Chairman	Board of Directors		[illegible] Corporate Affairs is working closing with the HR team to ensure all required checks are carried out and evidenced within the files. To date there are some outstanding areas of evidence which would be required to give assurance to the chairman to make a formal declaration of confirmation to the Board full compliance with Fit and Proper Persons Requirements. It should be reiterated that all required policies and self-declarations are in place. It should be noted that GIAP ref FF1 (3), which has a key task date of 31 May, relates to ensuring that all current Directors comply with all aspects of the policy and that evidence is available in revised file structures. The Trust is on track to meet this key task.			
CORE 10- CQC												
CQC1	The trust should ensure that the outcome of this focussed inspection impacts directly upon the organisational strategy	1) The CQC targeted report is used as a key guide in Trust strategy development days	30th June 2016	On Track	None Required	Director of Business Development	Board of Directors	30th June 2016		1) There is a clear reference made to the outcome of the focused inspection within the Trust strategy	1) The Trust Strategy addresses the findings of the CQC report	
CQC2	The trust should continue to proactively recruit staff to fill operational vacancies.	1) Develop and agree a proactive operational recruitment plan, including in reach to the local University and wider health community	30th April 2016	On Track	None Required	Director of Operations	People and Culture	January 2017 (People Committee)	1) P&CC received an operational recruitment plan paper from the Director of Operations at its meeting on the 20.04.16. The Committee were assured that the actions identified in the plan were the right ones, but requested a clear improvement trajectory and sought further assurance by the end of the week that there was enough capacity within the Trust to be able to deliver the plan. It was agreed that confirmation of this would be circulated to all Committee members by cop Friday 22nd April. This remains 'on track' pending confirmation of capacity to deliver the plan.	1) Reduction in the number of operational vacancies as per the operational recruitment plan	1) Reducing the number of operational vacancies	
		2) Implement the recruitment plan and monitor effectiveness against an agreed vacancy rate trajectory	31st December 2016	On Track		Director of Operations	People and Culture					
		3) Develop and implement an internal communications plan which supports pro-active recruitment	31st May 2016	On Track		Director of Operations	People and Culture					
	CORE 11- MONITOR ENFORCEMENT UNDERTAKINGS											
	The Trust will deliver a Governance Improvement Action Plan (GIAP) to address the findings and recommendations from the Employment Tribunal Investigation, Deloitte report, and the CQC focused inspection DR13; Further iterations of the governance action plan should include a greater depth of detail, including summary of progress and clearer insight into priority actions required. the action plan should include: •priority ratings for each action;	1) Governance Improvement Action plan approved by Board of Directors	30th March 2016	Completed	Programme Manager to be appointed PMO admin support appointed responsible Director identified	Responsible Director	Board of Directors		1) GIAP and Governance and delivery Framework agreed by Board in March 2) GIAP delivery framework implemented during April, with updates made to the plan accordingly	1) Governance Improvement Action Plan in line with recommendations agreed by Board 2) Governance Improvement Action Plan assured by an external auditor 3) Monitor approval of the action plan	1) Enforcement notice removed	
		2) GIAP and Governance and Delivery Framework sent to Monitor	18th March 2016	Completed		Responsible Director	Board of Directors					

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
M1	•key tasks required for each recommendation / action area; •associated risks with non-implementation; •outline of any key resources required; •completion of KPIs and success measures; •comments on progress comments; and •links to demonstrable outcomes	3) Governance and Delivery Framework developed and approved	30th March 2016	Completed		Responsible Director	Board of Directors	31st March 2017				
		4) Governance Action plan delivered	31st March 2017	On Track		Responsible Director	Board of Directors					
M2	The Governance Improvement Action Plan will be updated to reflect material matters arising from the HR investigation	1) The HR Investigation report relating to the overall HR function will be reviewed for lessons learnt and incorporated into the Action Plan	18th March 2016	Completed	None Required	Director of Corporate Affairs	Board of Directors	30th March 2016	1) HR Investigation report reviewed and there are no material issues that are not already included in the GIAP	1) Governance Improvement Action Plan agreed by Board 2) Governance Improvement Action Plan assured by an external auditor 3) Monitor approval of the action plan 4) Governance Action plan delivered	1) Enforcement notice removed	Complete
		2) Action Plan approved by Board of Directors	30th March 2016	Completed		Director of Corporate Affairs	Board of Directors					
M3	The Trust will undertake to gain external assurance that the Governance improvement action plan has been implemented in full or that it can be implemented in full	1) The Trust will gain external assurance that the Governance improvement action plan has been implemented	31st March 2017	On Track	External Assurance from professional service consultancy e.g. Deloitte resource will be required	Acting Chief Executive	Board of Directors	31st March 2017		1) External assurance process undertaken in a timely manner	1) External positive assurance report	
M4	The Trust will implement Programme management and Governance arrangements to ensure the delivery of the Governance Action Plan	1) Governance and Delivery Framework developed and approved	30th March 2016	Completed	A programme Management resource is required	Responsible Director	Board of Directors	30th March 2016	1) Governance and Delivery Framework agreed 2) Programme Manager recruited for 6 months starting April	1) Programme manager appointed 2) Governance and Delivery Framework approved	1) Evidence of the Governance delivery framework delivered and adhered to	Complete
		2) A programme manager will be appointed to support Responsible Director to hold Directors to account for the delivery of the programme	30th March 2016	Completed		Responsible Director	Board of Directors					
M5	The Trust will provide regular reports to Monitor	1) The Trust will report on a monthly basis on the delivery of the action plan	31st March 2017	On Track	None Required	Acting Chief Executive	Board of Directors	31st March 2017		1) Positive Formal correspondence with monitor on the delivery of the plan 2) Positive and credible relationship with Monitor	1) Enforcement notice removed	
M6	The Licensee will, by 18th March 2016 or such other date as agreed with Monitor, develop and submit to Monitor a timetable for making permanent appointments to all director roles which are currently vacant and/or filled on an interim basis. It will, by a date to be agreed with Monitor, revise that timetable in response to any comments made on it by Monitor.	1) Develop a timetable for making permanent appointments to all director roles which are currently vacant and/or filled on an interim basis	18th March 2016	Completed	None Required	Acting Chief Executive	Board of Directors	18th March 2016	1) Rem Comma have seen and agreed the timetable for recruitment of all Board level posts	1) Agreed recruitment timetable	1) All interim/acting roles appointed to	Complete

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 27 April 2016

Governance Improvement Action Plan
Board Tasks Oversight Report

Purpose of Report

The purpose of this paper is to set out the arrangements by which the Trust's Board will be assured that the GIAP is systematically implemented, delivering the agreed key outcomes so that it is able to demonstrate to all key stakeholders that the required improvements have been made.

The paper also briefly explains the role of the Board with respect to its oversight of GIAP actions and provides an overview of the actions that Board is responsible for seeking assurance on delivery.

Executive Summary

This section provides an initial overview to the Board of all the GIAP key tasks that it will be responsible for seeking assurance on delivery.

The Board has oversight of 34 Actions; these risks are currently rated as

Action Rag Rating	
Completed	19
On track	13
Some Issues	2
Off Track	0

Each month the Board will receive a report that sets out the following;

- Progress to date against relevant actions, including exception narrative if timeframes have not been met. Board members may wish to request further information.
- Evidence / assurance of delivery either through specific papers and/or information provided by task owners or via this report
- Future risks to delivery and associated mitigation
- Recommendations to close / archive tasks from task owners and the Responsible Director regarding delivery and embedded change

The Board will need to assimilate the information provided. This will require Board members to be fully aware of all the key tasks and recommendations.

It will be the role of the Board to determine whether it agrees with recommendations that are proposed where key task owners believe key tasks have been completed and/or embedded.

Board members will need to seek their own assurance and subsequently make collective decisions about completion of actions.

There are a number of tasks that should be delivered by the end of April. Board members should assure themselves that these are on track and be clear about the evidence that is required to demonstrate delivery and embedded change.

Strategic considerations

- Delivery of the GIAP links directly to NHSI enforcement action and associated license undertakings.

Assurances

- This paper should be considered in relation to key risks contained in the Board Assurance Framework.

Consultation

- This report hasn't been discussed at any other meeting.

Governance or Legal issues

- This paper links directly to Monitor enforcement action and associated license undertakings.

Recommendations

The Committee is asked to receive this report and seek assurance on the actions it has oversight for.

Report prepared and presented by: **Mark Powell**
Director of Business Development and Marketing

Governance Improvement Action Plan

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress	outline of any key	Owner	Responsible	Issue/	comments on progress	KPIs and success measures;	Evidence of demonstrable	Board
PC6	Expand the current Chair and CEO reports to provide a greater depth of information regarding key priorities for stakeholder engagement, feedback provided and any barriers to progress.	1) Chairman and CEO reports to include information about stakeholder engagement and feedback from commissioners	31st March 2016	Completed	None Required	Acting Chief Executive	Board of Directors	30th April 2016	1) CEO report to Board has been enhanced to include more detailed information about stakeholder engagement and it now includes a detailed section called listen, learn, lead. This summarises feedback from staff and provides evidence of where action has been taken in response to this feedback	1) Regular reports received by BoD and CoG	1) Evidence of reports discussed at BoD and CoG	Complete
		2) Chairman to provide updates to Board from Council of Governors	31st March 2016	Completed		Acting Chief Executive	Board of Directors	30th April 2016				
CG3	Increase the effectiveness of the Quality Committee by ensuring clear alignment of the committee with the quality strategy and associated objectives, and ensuring a clear focus on seeking assurance.	1) Board Development to focus on NED challenge of overdue actions and reports (see RR2)	31st March 2016	Completed	Resource identified in Board Development RR2	Director of Corporate Affairs	Board of Directors	30th November 2016	1) Board Development programme agreed at March Board meeting. This includes a session in June on holding to account	1) TOR agreed 2) Evidence of agenda reflecting Quality Strategy and Quality Goals 3) Quality Governance Group	1)Achievement of the quality framework 2)Annual report	
CG1	The Trust should consider how its governance arrangements could better match its strategy and plans.	1) Develop and approve a Corporate Governance Framework which supports the delivery of the Trust strategy ensuring that the Board of Directors and Board Committee agendas adequately reflect the strategic objectives of the Trust	31st May 2016	Some Issues	None Required	Director of Corporate Affairs	Board of Directors	30th June 2016	1) The key tasks associated with the development of the Corporate Governance Framework identified in the GIAP have been reviewed by the new Director of Corporate Affairs. There is a concern about the timeframes for delivery. This is being raised as a significant issue to Trust Board ahead of the 31st May delivery date. In order to successfully deliver and embed these key recommendations, an extended timeframe will need to be agreed. A plan will be presented to May's Board meeting setting out how all or parts of CG1, 2, 4, 7, and 9 will be delivered along with clear timeframes	1) Corporate Governance framework agreed by Board 2) Board and Committee agendas reflective of strategic objectives 3) Board and Committee papers link to the Trust's strategic objectives	1) Well led External review provides positive assurance on the effectiveness of the Corporate Governance Framework	
CG2	The Governance Framework should be updated to give greater clarity regarding roles of key individuals and governance forums, including: all EDs, the SID and Vice Chair, PCOG, QLTs and the Safeguarding Committee.	1) Develop and approve a Corporate Governance Framework	31st May 2016	Some Issues	None required	Director of Corporate Affairs	Board of Directors	30th June 2016	See CG1	1) Accountability Framework approved by Board of Directors 2) A full suite of ToRs in place with clear responsibilities for compliance monitoring and systems governance	1) Internal Audit on effectiveness of accountability framework	

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress	outline of any key	Owner	Responses	Issue/	comments on progress	KPIs and success measures;	Evidence of demonstrable	Board A
CG8	The Board needs to introduce an integrated performance report which encompasses key operational, quality, workforce and finance metrics	1) The Trust will revise the integrated performance report which will include: •key operational metrics; •a workforce dashboard; •the Quality Dashboard, updated to show the refreshed Quality Priorities; •a finance dashboard; and •a summary of performance of groups to highlight any underlying themes.	31st May 2016	**On Track**	None Required	Director of Operations	Board of Directors	31st May 2016	1) New Integrated Performance Report presented to Board in March 2) Quality Metrics required to complete the report by the end of May	1) Integrated performance report format approved at Board	1) Evidence of links between the Integrated Performance report and Board Assurance Framework	

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress	outline of any key	Owner	Responsible	Issue/	comments on progress	KPIs and success measures;	Evidence of demonstrable	Board
CG10	Further improve the function of the ELT by improving the timeliness of papers and quality of debate.	1) Ensure ELT agenda focuses on agreed key priorities and items appropriately escalated through the Governance Structures. Agenda and papers will be circulated on a Thursday	31st March 2016	Completed	None Required	Acting Chief Executive	Board of Directors	30th April 2016	1) ELT agenda completed and sent out on a Thursday 2) Revised agenda reflects the focus on agreed key priorities and principles.	1) Weekly ELT agenda and minutes reflects key priorities and appropriately escalated items	1) Well led External review provides positive assurance on the effectiveness of ELT	
CG11	The Board needs to address the quality of debate and dialogue, focussing on increasing contributions across all BMs, displaying greater leadership and vision, ensuring an appropriate balance between strategic and operational debate, and pushing for increased momentum around key issues.	1) Ensure a Board development programme which is linked to the Trust Strategy	31st March 2016	Completed	None Required	Director of Corporate Affairs	Board of Directors	31st March 2017	1) Board development programme approved at the Board meeting in March 2) 360 degree appraisals have commenced for 2016. The Council of Governors Noms and Rems Committee agreed the paper work and framework, but have agreed given the current environment that Governors will not comment on the NED appraisals this year, as they will hold the NEDs to account through their task and finish group	1) Board Development programme approved by Board 2) 360 Appraisals of all Board Members Completed 3) Skill Mix review of the Board completed and reported to Board	1) Well led External review provides positive assurance on the effectiveness of the Board	
		3) Ensure that there is the appropriate balance of strategic and operational items on the Board Agenda	30th September 2016	Completed		Director of Corporate Affairs	Board of Directors					
CG1	The relationship between the BoD and the CoG is poor. Both parties should adopt a conciliatory approach rather than continuing with the antagonism which inflicts the current relationship.	1) The Board and Council of governors will co-write a policy on how the Board and council of governors will work in partnership	30th June 2016	On Track	None Required	Director of Corporate Affairs	Board of Directors & Council of Governors	Board and CoG meeting date	1) Council of Governors have approved a new meeting structure which include a more robust and effective Nomination and Remuneration Committee 2) Council of Governors have approved an expanded lead Governor job description and appointed to it 3) Code of Conduct to be reviewed at 12th April meeting	1) Partnership Policy approved by both CoG and Board of Directors 2) Code of Conduct approved by CoG 3) All Governors sign up to Code of Conduct 4) Council of Governors approval of Lead Governors Job Description 7) Council of Governors to agree, Council of Governors Governance Framework 8) Council of Governors to agree revised Constitution	1) Well led External review provides evidence of effective working relationships	
		2) The Trust will expand the role of lead governor to ensure greater collaborative working with the Chairman and SID	29th January 2016	Completed		Director of Corporate Affairs	Board of Directors & Council of Governors					
		3) Development and implement a process for the assessment of the effectiveness of Council of Governors	30th September 2016	On Track		Director of Corporate Affairs	Board of Directors & Council of Governors					
		4) Council of Governors to review and embed a new governance structure which will focus on more joined up working between CoG and the BoD	29th January 2016	Completed		Director of Corporate Affairs	Board of Directors & Council of Governors					
		5) Implement a Code of Conduct for all Governors	30th June 2016	On Track		Director of Corporate Affairs	Board of Directors & Council of Governors					
RR2	**Deloitte 5** - Agree a programme of Board development work which includes a mix of internal and externally facilitated sessions, is clearly aligned to the combined governance action plan. the Board development plan should consider: •more detailed consideration of the governance action plan; •a focus on Board challenge, including assurance, reassurance and the role of the corporate director; •facilitated 360 feedback; •Board cohesion and dynamics; •use of external speakers to add insight and prompt debate; •joint sessions governors ; and •engagement from senior Trust leaders. **CQC 3** - The trust should ensure that all board members and the council of governors undertake a robust development plan (Link to CG2)	1) Develop a Board Development plan for 2016/17	31st March 2016	Completed	External resource will be required to facilitate Board Effectiveness sessions	Director of Corporate Affairs	Board of Directors	31st March 2017	1) Board Development programme agreed at March Board meeting 2) An externally facilitated Board development session focusing on the Trust's values took place on the 13th April 2016, with a further discussion planned for Board in April	1) Evidence of delivery of Board Development plan 3) Full attendance of all Board Members 4) No cancelled Board Development Session	1) Well led External review provides evidence of effective board challenge	
		2) Implement Board Development programme which will include Board effectiveness sessions to address team dynamics and agreed ways of working including •clarity of purpose and vision; •effective challenge and leadership; and •individual coaching.	31st March 2017	On Track		Director of Corporate Affairs	Board of Directors					
WOD8	The trust should continue to make improvements in staff engagement and communication	1) Develop a clear staff engagement plan that takes account of listen, learn and lead, wider open staff forums and enhances existing good practice	30th June 2016	On Track	1) Resource may be required for Pulse Check	Director of Workforce, OD and Culture	Board of Directors	31st March 2017		1) Evidence of published engagement plan 2) Evidence of improved engagement via pulse check	1) Improvement in the following areas of the staff survey 1.1) KF 4 Staff motivation at work 1.2) KF 5 Recognition and value of staff by managers and the organisation	

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress	outline of any key	Owner	Responds	Issue/	comments on progress	KPIs and success measures;	Evidence of demonstrable	Board A
FF1	The trust must ensure that a fit and proper person review is undertaken for all directors in light of the findings of the employment tribunal.	1) Develop fit and proper persons policy and have it ratified by Board of Directors	24th February 2016	Completed	None required	Director of Corporate Affairs	Board of Directors	29th June 2016	1) Fit and Proper Persons Policy approved by Board in February, with further amendments agreed in March 2) Board forward plan now includes an annual review of the Fit and Proper Persons Policy and its implementation 3) The Trust Board received and approved the Fit and Proper Persons Test Policy at its meeting on 30 March 2016. As part of this agenda item, all Board Members completed a self declaration to confirm that they do not fit within the definition of an 'unfit person' and that there are no other grounds under which they would be ineligible to continue in post. This declaration was completed by all Board members including voting and non voting directors and those holding interim director positions. The Director of Corporate Affairs reported to the People and Culture Committee on 20 April on GIAP item FF1 (5) that a process has been established to develop and implement a proactive process for monitoring the filing system for all Directors to ensure consistency and ease of access to evidence as detailed in policy. The Director of Corporate Affairs is working closing with the HR team to ensure all required checks are carried out and evidenced within the files. To date there are some outstanding areas of evidence which would be required to give assurance to the chairman to make a formal declaration of confirmation to the Board full compliance with Fit and Proper Persons Requirements. It should be reiterated that all required policies and self-declarations are in place. It should be noted that GIAP ref FF1 (3), which has a key task date of 31 May, relates to ensuring that all	1) Evidence of full compliance with fit and proper persons requirement as identified by Monitor licence conditions, CQC registration requirements and Trust constitution	1) Board Assurance via the Chair	
		2) Ensure that HR maintain the Fit and Proper Persons tracker	30th April 2016	On Track		Director of Workforce, OD and Culture	Board of Directors					
		4) Ensure that all current Directors comply with all aspects of the policy and that evidence is available in revised file structures	31st May 2016	On Track		Director of Corporate Affairs	Board of Directors					
		5) The Trust will ensure that a process in place to review the fit and proper requirement on an annual basis	31st March 2016	Completed		Director of Corporate Affairs	Board of Directors					
		6) Formal confirmation to Board by Chair of full compliance with fit and proper persons requirements	30th April 2016	On Track		Chairman	Board of Directors					
CQC1	The trust should ensure that the outcome of this focussed inspection impacts directly upon the organisational strategy	1) The CQC targeted report is used as a key guide in Trust strategy development days	30th June 2016	On Track	None Required	Director of Business Development	Board of Directors	30th June 2016		1) There is a clear reference made to the outcome of the focused inspection within the Trust strategy	1) The Trust Strategy addresses the findings of the CQC report	
	The Trust will deliver a Governance Improvement Action Plan (GIAP) to address the findings and recommendations from the Employment Tribunal Investigation, Deloitte report, and the CQC focused inspection DR13; Further iterations of the governance action plan should include a greater depth of detail, including summary of progress and clearer insight into priority actions required. the action plan should include: •priority ratings for each action;	1) Governance Improvement Action plan approved by Board of Directors	30th March 2016	Completed	Programme Manager to be appointed PMO admin support appointed responsible Director identified	Responsible Director	Board of Directors		1) GIAP and Governance and delivery Framework agreed by Board in March 2) GIAP delivery framework implemented during April, with updates made to the plan accordingly	1) Governance Improvement Action Plan in line with recommendations agreed by Board 2) Governance Improvement Action Plan assured by an external auditor 3) Monitor approval of the action plan	1) Enforcement notice removed	
		2) GIAP and Governance and Delivery Framework sent to Monitor	18th March 2016	Completed		Responsible Director	Board of Directors					

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress	outline of any key	Owner	Responds	Issue/	comments on progress	KPIs and success measures;	Evidence of demonstrable	Board A
M1	•key tasks required for each recommendation / action area; •associated risks with non-implementation; •outline of any key resources required; •completion of KPIs and success measures; •comments on progress comments; and •links to demonstrable outcomes	3) Governance and Delivery Framework developed and approved	30th March 2016	Completed		Responsible Director	Board of Directors	31st March 2017				
		4) Governance Action plan delivered	31st March 2017	On Track		Responsible Director	Board of Directors					
M2	The Governance Improvement Action Plan will be updated to reflect material matters arising from the HR investigation	1) The HR Investigation report relating to the overall HR function will be reviewed for lessons learnt and incorporated into the Action Plan	18th March 2016	Completed	None Required	Director of Corporate Affairs	Board of Directors	30th March 2016	1) HR Investigation report reviewed and there are no material issues that are not already included in the GIAP	1) Governance Improvement Action Plan agreed by Board 2) Governance Improvement Action Plan assured by an external auditor 3) Monitor approval of the action plan 4) Governance Action plan delivered	1) Enforcement notice removed	Complete
		2) Action Plan approved by Board of Directors	30th March 2016	Completed		Director of Corporate Affairs	Board of Directors					
M3	The Trust will undertake to gain external assurance that the Governance improvement action plan has been implemented in full or that it can be implemented in full	1) The Trust will gain external assurance that the Governance improvement action plan has been implemented	31st March 2017	On Track	External Assurance from professional service consultancy e.g. Deloitte resource will be required	Acting Chief Executive	Board of Directors	31st March 2017		1) External assurance process undertaken in a timely manner	1) External positive assurance report	
M4	The Trust will implement Programme management and Governance arrangements to ensure the delivery of the Governance Action Plan	1) Governance and Delivery Framework developed and approved	30th March 2016	Completed	A programme Management resource is required	Responsible Director	Board of Directors	30th March 2016	1) Governance and Delivery Framework agreed 2) Programme Manager recruited for 6 months starting April	1) Programme manager appointed 2) Governance and Delivery Framework approved	1) Evidence of the Governance delivery framework delivered and adhered to	Complete
		2) A programme manager will be appointed to support Responsible Director to hold Directors to account for the delivery of the programme	30th March 2016	Completed		Responsible Director	Board of Directors					
M5	The Trust will provide regular reports to Monitor	1) The Trust will report on a monthly basis on the delivery of the action plan	31st March 2017	On Track	None Required	Acting Chief Executive	Board of Directors	31st March 2017		1) Positive Formal correspondence with monitor on the delivery of the plan 2) Positive and credible relationship with Monitor	1) Enforcement notice removed	
M6	The Licensee will, by 18th March 2016 or such other date as agreed with Monitor, develop and submit to Monitor a timetable for making permanent appointments to all director roles which are currently vacant and/or filled on an interim basis. It will, by a date to be agreed with Monitor, revise that timetable in response to any comments made on it by Monitor.	1) Develop a timetable for making permanent appointments to all director roles which are currently vacant and/or filled on an interim basis	18th March 2016	Completed	None Required	Acting Chief Executive	Board of Directors	18th March 2016	1) Rem Comma have seen and agreed the timetable for recruitment of all Board level posts	1) Agreed recruitment timetable	1) All interim/acting roles appointed to	Complete

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors 27th April 2016

Quarterly Compliance Return – Quarter 4 2015/16

Purpose of Report

To summarise for Trust Board the key elements of the Quarter 4 compliance return for approval. The full return has been scrutinised by the Audit Committee prior to Trust Board.

Executive Summary

Information contained in the quarter 4 compliance return is consistent with the information reported in the Integrated Performance Report and key areas are summarised below.

1. Achievement of Plan

There is an overachievement against planned surplus at the end of the financial year as forecast, which is discussed in the public Integrated Performance Report, finance section.

2. Financial Sustainability Risk Rating (FSRR)

Board will wish to note that the reported FSRR for Q4 is an overall rating of 2 in the quarter, which has been driven by the, as expected, deficit in the quarter.
The year-to-date FSRR is a rating of 4 which is better than the plan and is as per the forecast.
It is this year-to-date FSRR of 4, that we are monitored on by NHSI.

Content on financial performance in the quarterly return is consistent with the information contained in the Finance section of the Integrated Performance Report.

As the in-quarter FSRR is only 2, additional detailed information is provided in this report to help assure the board of the regulatory impact thereof.

3. Cost Improvement Programme

CIP is slightly behind plan in the quarter due to the phasing of some schemes, however is achieved in full at the end of the financial year. The split of recurrent and non-recurrent CIP is reported in the Finance section of the Integrated Board report. To confirm there are no revenue generation schemes.

4. Capital Expenditure

Capital expenditure ended the financial year behind plan by £300k due to the re-prioritisation of clinical schemes in year as reported in the Finance section of the Integrated Performance Report. This is as per forecast.

5. Targets and Indicators

All targets and indicators are fully achieved in quarter 4 and there are no exceptions to note. This information is consistent with the Operational section of the Integrated Performance Report.

6. Elections

There have been 6 Public Governor elections results reported in this quarter's return for Bolsover, Chesterfield North, Derby City East (x2) Erewash North and Surrounding Areas. These were elected unopposed.

7. Organisation Health Indicators

In this quarter it has been reported that there are 5 voting Executive posts on the Board of which two are interim appointments.

8. Checks and Validations

Any checks and validations have been explained in the return.

Strategic considerations

This report is linked to the strategic five year plan previously submitted to Monitor in June 2014 which was updated for 2015/16 financial planning in May 2015.

Board Assurances

This report should be considered in relation to the following risks contained in the Board Assurance Framework 2015/16:

- 2c There is a risk that the Trust will be unable to maintain its regulatory compliance due to identified gaps in its governance systems and processes.
- 3a Risks to delivery of 15/16 financial plan. If not delivered, this could result in regulatory action due to breach of Provider Licence with Monitor.

Consultation

The content of the quarter 4 template has been sent to members of the Audit Committee for review and scrutinised in the usual quarterly call between Finance and Audit Committee members on Friday 22nd April.

Governance or Legal Issues

This report supports the requirement of the Monitor Risk Assessment Framework for the Board of Directors to make the in-year governance statement and to review and approve the submission of the Quarterly in year monitoring return to Monitor.

This return is required to be submitted to Monitor in accordance with their Risk Assessment Framework 2015/16 by noon 29th April 2016.

Financial sustainability risk also relates to the Provider Licence conditions, in particular condition Continuity of Services CoS3 and Foundation Trust condition FT4. Relevant consideration of the regulatory conditions is considered in this paper.

Equality Delivery System

This report has no impact on REGARDS groups.

Recommendations

The Board of Directors are requested:

1) To discuss the governance statement and agree that the interim Chairman and acting Chief Executive, on behalf of the Board of Directors, are able to sign the governance statement to confirm:

a) For finance, that:

- The board anticipates that the trust will continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months.
- The Board anticipates that the trust's capital expenditure for the remainder of the financial year will not materially differ from the amended forecast in this financial return.

b) For governance, that:

The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.

Otherwise

The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework Table 3) which have not already been reported.

c) Consolidated subsidiaries:

'*Number of subsidiaries included in the finances of this return. This template should not include the results of your NHS charitable funds.'*

There are **zero** subsidiaries included in the finances of this return and only the finances of Derbyshire Healthcare NHS Foundation Trust are included.

2) **To approve the Q4 return** to be otherwise appropriately signed and returned to Monitor by noon 29th April 2016.

Report presented by: **Claire Wright, Executive Director of Finance**
Report prepared by: **Claire Wright, Executive Director of Finance**
Rachel Leyland, Deputy Director of Finance

Supporting information

In order to support the Board in:

a) understanding in detail the regulatory impact of ratings of FSRR of 4 for the year-to-date and FSRR of 2 for Q4

b) making the declaration "*The board anticipates that the trust will continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months*", and

c) making the declaration that "*The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework Table 3) which have not already been reported*".

The following additional information is provided for reference, scrutiny and assurance.

1. The regulatory requirements for financial performance and reporting (using extracts from the Risk Assessment Framework RAF)

Monitor assesses the degree of financial risk of the provider and whether this reflects a potential breach of the Continuity of Services CoS licence conditions or the NHS foundation trust governance condition (Condition FT4).

For ease of reference these conditions are summarised below (extracted from the RAF):

Table 4: Requirements of the continuity of services licence conditions

CRS providers are required to…	**…resulting in**
Be financially viable	no financial concerns as per Monitor's risk rating (**Condition CoS3**)
Co-operate with Monitor	in cases of financial concern, licensees must co-operate with Monitor, including providing information to commissioners and allowing parties identified by Monitor to enter premises (**Condition CoS6**)
Provide assurance on commitment and capability to provide CRS	assurance from ultimate controller* (**Condition CoS4**) assurance on ability to provide CRS (**Condition CoS7**): o annual availability of resources statement highlighting any factors affecting the capability to deliver CRS o working capital statement o in-year exception reporting
Maintain CRS provision	approval of Monitor and commissioners required to change CRS (**Condition CoS1**) retain assets required to provide CRS (**Condition CoS1**)

*not relevant to FTs

The relevant provisions of Condition FT4 are:

- foundation trusts must establish and effectively implement systems and processes to ensure compliance with the duty to operate economically, efficiently and effectively (see Condition FT4 paragraph 5(a); Appendix H of RAF)

- foundation trusts must establish and effectively implement systems and processes for effective financial decision-making, management and control (see Condition FT4 paragraph 5(d); Appendix H of RAF).

2. For ease of reference: how the FSRR rating is calculated (from RAF)

Table 5: Calculating the financial sustainability risk rating for NHS foundation trusts

	Financial criteria	Weight (%)	Metric	Rating categories**			
				1*	2***	3	4
Continuity of services	Balance sheet sustainability	25	Capital service capacity (times)	<1.25x	1.25 - 1.75x	1.75-2.5x	>2.5x
	Liquidity	25	Liquidity (days)	<(14) days	(14)-(7) days	(7)-0 days	>0 days
Financial efficiency	Underlying performance	25	I&E margin (%)	≤(1)%	(1)– 0%	0-1%	>1%
	Variance from plan	25	Variance in I&E margin as a % of income	≤(2)%	(2)-(1)%	(1)-0%	≥0%

*Scoring a 1 on any metric will cap the weighted rating to 2, potentially leading to investigation.
**Scores are rounded to the nearest number, ie if the trust scores 3.6 overall, this will be rounded to 4; if the trust scores 3.4, this will be rounded to 3.
***A 2* rating may be awarded to a trust where there is little likelihood of deterioration in its financial position.

3. How NHSI monitors the financial sustainability risk (extracts from RAF)

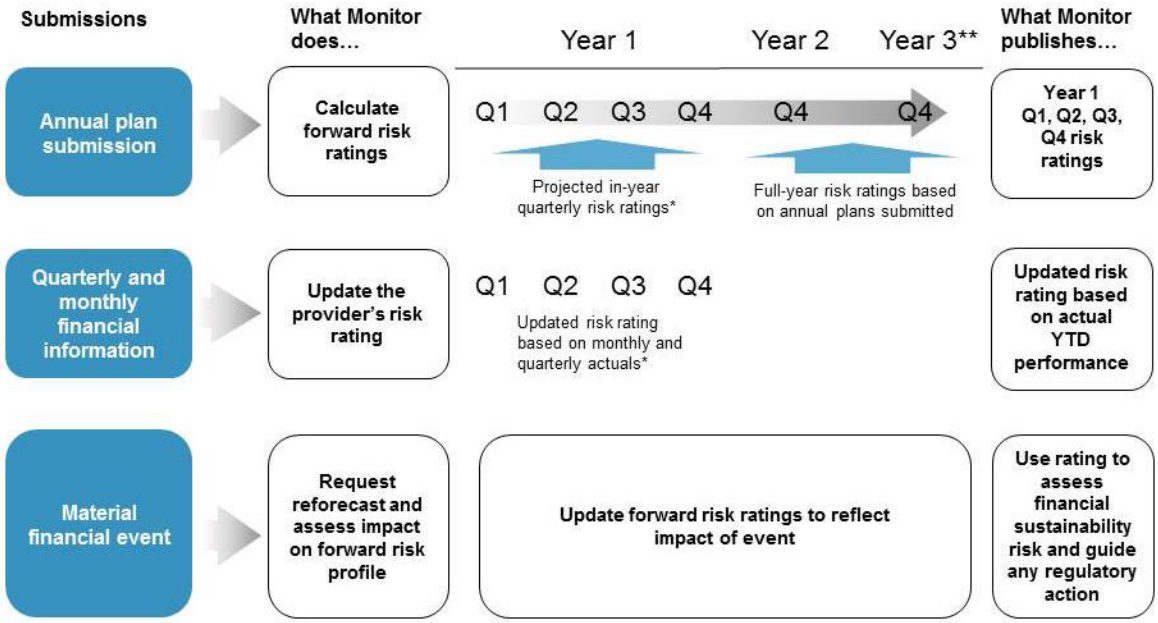
Figure 4 below shows how we [NHSI] monitor and assess financial risk both regularly and by exception. We:

- use **operational plans** to calculate the financial sustainability risk rating quarterly over the coming 12 months and for the next one to two years following that

- on a **quarterly and monthly** basis, compare the risk rating against quarterly and monthly financial performance information

- assess the impact of **ad hoc or 'exceptional'** financial events with material potential impact on the CRS provider's financial prospects.

Figure 4: Process of monitoring the financial sustainability risk rating



*Calculated on year-to-date (YTD) information.
**Potentially up to Year 5.

In-year submissions

What Monitor [NHSI] does with this information

- Monitor uses financial submissions, quarterly and monthly to calculate each provider's year-to-date financial sustainability risk rating.

- Each quarter, we publish the financial sustainability risk rating calculated from year-to-date submissions.

- Where the quarterly rating is 1 or 2, reflecting a potential breach of the licence, we consider whether closer monitoring, requesting further information or other action under the licence is necessary to establish whether the provider complies with the CoS or governance licence conditions and, if not, whether regulatory action is appropriate.

So, bearing this in mind would an exception report required to NHSI?

2.4. Exception reports (extracts from RAF)

We [NHSI] expect NHS foundation trusts to notify us in writing of any incidents, events or reports that may reasonably be regarded as raising potential concerns over compliance with their licence. This expectation applies to all licence conditions, not just the conditions that are the focus of the RAF.

We also require NHS foundation trusts to inform us of events that could have an impact on the operation of their business. We may then assess their impact on the trust's compliance with the licence. Examples of such events are:

- undertaking a major acquisition, investment or divestment
- losing a significant contract
- a significant change in capital structure
- a material deterioration in financial performance
- an immediate need to spend significant sums to meet regulatory requirements (eg increased costs as a result of a requirement from CQC).

Table 3: Examples of where an exception report is required [this table is referenced in the board declaration above]

Continuity of services	• unplanned significant reductions in income or significant increases in costs • discussions with external auditors which may lead to a qualified audit report • future transactions potentially affecting the financial sustainability risk rating • risk of a failure to maintain registration with CQC for CRS • loss of accreditation of a CRS • proposals to vary CRS provision or dispose of assets, including: • cessation or suspension of CRS • variation in asset protection processes • proposed disposals of CRS-related assets
Financial governance	• requirements for additional working capital facilities • failure to comply with the statutory reporting guidance • adverse report from internal auditors • significant third-party investigations or reports that suggest potential material issues with governance • CQC inspections and their outcomes • performance penalties to commissioners
Governance	• third-party investigations or reports that could suggest material issues with financial, operational, clinical service quality or other aspects of the trust's activities that could indicate material issues with governance • CQC responsive or planned inspections and the outcomes/findings • changes in chair, senior independent director or executive director • any never events* • any patient suicide, homicide or absconsion (mental health trusts only) • non-compliance with safety and security directions and outcomes of safety and security audits (providers of high security mental health services only) • other serious incidents or patient safety issues that may impact compliance with the licence (eg serious incidents, complaints)

Other risks	• enforcement notices or other sanctions from other bodies implying potential or actual significant breach of a licence condition • patient group concerns • concerns from whistleblowers or complaints • any significant reputation issues, eg any adverse national press attention

We don't trigger any of these financial reasons for exception reporting (see conclusions)
For the avoidance of doubt, we have reported exceptions to Monitor for other non-financial reasons during the year.

4. Additional supporting commentary for the drivers of the Q4 risk rating:

The full FSRR worksheet from the Q4 Compliance return is shown on the final page of this report.

The in-quarter FSRR of 2 is driven by the individual component metrics as follows:

- Capital Service Cover has been a 3 at the end of quarters 1, 2 and 3 due to the increased revenue available for capital cover and remains a 3 at the end of the financial year (ytd). However the metric reduced to a 2 in the individual quarter for two main reasons
    - o PDC increased slightly but also
    - o the main driver was lower available revenue in the quarter. The average quarterly revenue available was £2.5m and the net revenue available in quarter 4 was £715k less. This is mainly due to the net revenue available being reduced by the additional costs in the last quarter.

- The Liquidity metric was a 3 at the end of the first quarter but improved to a 4 for the reminder of the year. The in-quarter metric remained at a 4. The additional costs that went through in the last quarter were not all cash related, so have not impacted on this metric as much as the others.

- Income and Expenditure Margin has been a 4 at the end of each of the first three quarters and remained at a 4 at the end of the financial year (ytd). However the in-quarter metric was a 2 which is solely driven by the in-quarter deficit of £200k.

- Income and Expenditure Margin Variance to plan has been at a 4 at the end of quarters 1, 2 and 3 and remains at a 4 (ytd) at the end of quarter 4 due to the Income and Expenditure Margin being better than plan on a cumulative basis throughout the year. However the in-quarter metric has just tipped into a 1 due to the Income and Expenditure Margin being in a negative position compared to a positive plan.

- A '1 rating trigger' has been triggered in the quarter and therefore caps the overall quarter's FSRR at a 2. Of note in the "small print" so to speak the trigger

ignores the Income and Expenditure margin variance to plan figures, so the rating remains at a 2 in the actual quarter anyway, on a mathematical average of (2+2+4+1)/4 = 2.25 which rounds down to 2.

5. Conclusions

The in-quarter performance does not equate to a "material deterioration in financial performance". We expected a final quarter deficit and forecast for it within our forecast achievement of plan.

We have achieved our overall year end outturn surplus as planned.

We have expected, forecast and reported the significant change between year-to-date and year-to-go financial performance during the year with Board, Finance and Performance Committee and Monitor/NHSI. There is not therefore an exception to report in that sense.

The year-to-date rating is a 4 and it is that rating of 4 that will be published and we will be monitored on.

However, we will need to be able to assure NHSI and ourselves that reporting a FSRR of 2 in-quarter does not indicate a trend that will continue through to the future. To support us in this assertion we can refer to several key considerations:

1. At last Trust Board we deliberated the CoS 7 availability of resources condition declaration which accompanies the operational plan submission, and we confirmed that "*After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate*".

2. A "going concern" paper to accompany the draft annual accounts will be presented to April Audit Committee for scrutiny that further supports this level of confidence in our general financial sustainability.

3. We have concluded contract negotiations so there are no outstanding material uncertainties regarding income.

4. Some significant additional costs were incurred, mostly in the latter part of 15/16, that were non-recurrent i.e. will not continue into 16/17, or not at the same level. (These have included for example; significant additional consultancy and legal costs, the costs of absence cover at board level, new year-end provisions, exit payments, "Fresh" mattresses/signage)

5. The main issue to resolve or mitigate successfully for 16/17 financial plan achievement is the Cost Improvement Plan gap. We have debated this at Finance and Performance and Board, but it remains the most significant financial challenge that we need to overcome. This may require us to utilise

contingency reserves if additional mitigations that are being personally overseen by the Director of Finance don't take the required effect.

6. The net CIP gap after mitigation should not prevent us being able to maintain a risk rating of 3. Although we do have limited headroom in quarter 1 as previously reported, so this cannot be guaranteed. Very close scrutiny will be essential to maintain oversight of compliance with controls and to take speedy remedial action if necessary.

7. We will monitor compliance with expected due process in financial management at all levels in the organisation, including compliance with Trust Standing Financial Instructions (SFIs).

8. Systems and control processes in the finance function are strong. We have a strong track record of financial management. The governance machinery, in our SFIs is sound. Because of the limited planning headroom and the current CIP gap, finance teams have already implemented additional oversight measures in the form of early forecasting and rolling 12 month forecasts. These new forecasts will highlight any additional key areas for scrutiny and oversight.

9. In summary, the Board may wish to be assured by the facts that we have good financial governance machinery in place, that we measure financial performance effectively and that we have good systems and processes for reporting actual and expected performance. The key to success will be to take swift and effective remedial action if performance drifts

   Board may wish to debate this further or refer for further scrutiny to Finance and Performance Committee.

Financial Sustainability Risk Ratings (updated from August 2015 RAF) for Derbyshire Healthcare NHS Foundation Trust

			Plan For Current YTD ending 29-Feb-16	Actual For Current YTD ending 29-Feb-16	Plan For YTD ending 30-Jun-15	Actual For YTD ending 30-Jun-15	Plan For Quarter ending 30-Sep-15	Actual For Quarter ending 30-Sep-15	Plan For YTD ending 30-Sep-15	Actual For YTD ending 30-Sep-15	Plan For Quarter ending 31-Dec-15	Actual For Quarter ending 31-Dec-15	Plan For YTD ending 31-Dec-15	Actual For YTD ending 31-Dec-15	Plan For Quarter ending 31-Mar-16	Actual For Quarter ending 31-Mar-16	Plan For YTD ending 31-Mar-16	Actual For YTD ending 31-Mar-16
Capital Service Cover																		
Capital service																		
PDC dividend expense	£m	(-ve)	(1.300)	(1.594)	(0.325)	(0.325)	(0.325)	(0.324)	(0.650)	(0.649)	(0.325)	(0.456)	(0.975)	(1.105)	(0.325)	(0.489)	(1.300)	(1.594)
Interest Expense on Overdrafts and Working Capital Facilities	£m	(-ve)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Interest Expense on Bridging loans	£m	(-ve)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Interest Expense on Non-commercial borrowings	£m	(-ve)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Interest Expense on Commercial borrowings	£m	(-ve)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Interest Expense on Finance leases (non-PFI)	£m	(-ve)	(0.208)	(0.230)	(0.052)	(0.058)	(0.052)	(0.058)	(0.104)	(0.116)	(0.052)	(0.057)	(0.156)	(0.173)	(0.052)	(0.057)	(0.208)	(0.230)
Interest Expense on PFI leases & liabilities	£m	(-ve)	(1.462)	(1.417)	(0.365)	(0.353)	(0.365)	(0.356)	(0.731)	(0.709)	(0.365)	(0.356)	(1.096)	(1.065)	(0.366)	(0.352)	(1.462)	(1.417)
Other Finance Costs	£m	(-ve)	(0.049)	(0.038)	(0.049)	(0.038)	-	-	(0.049)	(0.038)	-	-	(0.049)	(0.038)	-	-	(0.049)	(0.038)
Non-Operating PFI costs (e.g. contingent rent)	£m	(-ve)	(0.526)	(0.484)	(0.132)	(0.120)	(0.132)	(0.122)	(0.263)	(0.242)	(0.132)	(0.122)	(0.395)	(0.364)	(0.132)	(0.120)	(0.526)	(0.484)
Public Dividend Capital repaid	£m	(-ve)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Repayment of bridging loans	£m	(-ve)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Repayment of non-commercial loans	£m	(-ve)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Repayment of commercial loans	£m	(-ve)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Capital element of finance lease rental payments - On-balance sheet PFI	£m	(-ve)	(0.866)	(0.864)	(0.217)	(0.215)	(0.217)	(0.217)	(0.433)	(0.432)	(0.217)	(0.217)	(0.650)	(0.649)	(0.217)	(0.215)	(0.866)	(0.864)
Capital element of finance lease rental payments - other	£m	(-ve)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Capital Service, total	£m	(-ve)	**(4.411)**	**(4.627)**	**(1.140)**	**(1.109)**	**(1.091)**	**(1.077)**	**(2.230)**	**(2.186)**	**(1.091)**	**(1.208)**	**(3.321)**	**(3.394)**	**(1.091)**	**(1.233)**	**(4.411)**	**(4.627)**
Revenue Available for Capital Service	£m	(+/-ve)	8.204	9.209	1.838	2.244	1.960	2.776	3.799	5.021	2.207	2.423	6.006	7.444	2.198	1.766	8.204	9.209
Capital Service Cover metric	0.0x		1.86	1.99	1.61	2.02	1.80	2.58	1.70	2.30	2.02	2.01	1.81	2.19	2.02	1.43	1.86	1.99
Capital Service Cover rating	Score		3	3	2	3	3	4	2	3	3	3	3	3	3	2	3	3
	Check		OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK
Liquidity																		
Working capital balance (for use in FSRR rating calculation)	£m	(+/-ve)	1.370	0.500	1.032	(0.107)	1.414	1.172	1.414	1.172	1.410	1.399	1.410	1.399	1.370	0.500	1.370	0.500
Operating Expenses within EBITDA, Total	£m	(-ve)	(123.982)	(121.772)	(31.082)	(30.174)	(31.178)	(29.702)	(62.259)	(59.876)	(30.920)	(30.200)	(93.179)	(90.076)	(30.803)	(31.697)	(123.982)	(121.772)
Liquidity metric	Days		3.6	1.4	3.0	(0.3)	4.1	3.6	4.1	3.5	4.1	4.2	4.1	4.2	4.0	1.4	4.0	1.5
Liquidity rating	Score		4	4	4	3	4	4	4	4	4	4	4	4	4	4	4	4
I&E Margin																		
Normalised Surplus/(Deficit)																		
Surplus (Deficit) after Tax	£m	(+/-ve)	0.970	1.123	0.065	0.480	0.236	1.030	0.302	1.510	0.383	0.531	0.685	2.041	0.286	(0.918)	0.970	1.123
Profit/(loss) from discontinued Operations, Net of Tax	£m	(+/-ve)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Gain/(loss) on asset disposals	£m	(+/-ve)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Gains on transfers by absorption	£m	(+ve)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Losses on transfers by absorption	£m	(-ve)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Impairment (Losses) / Reversals net, total	£m	(+/-ve)	(0.300)	(0.712)	-	-	-	-	-	-	(0.100)	-	(0.100)	-	(0.200)	(0.712)	(0.300)	(0.712)
Restructuring Costs	£m	(-ve)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Normalised Surplus/(Deficit)	£m	(+/-ve)	**1.270**	**1.835**	**0.065**	**0.480**	**0.236**	**1.030**	**0.302**	**1.510**	**0.483**	**0.531**	**0.785**	**2.041**	**0.486**	**(0.206)**	**1.270**	**1.835**
Adjusted Total Income for FSRR	£m	(+ve)	132.187	130.982	32.920	32.418	33.138	32.478	66.058	64.896	33.127	32.623	99.185	97.519	33.002	33.462	132.187	130.982
I&E Margin	%		0.96%	1.40%	0.20%	1.48%	0.71%	3.17%	0.46%	2.33%	1.46%	1.63%	0.79%	2.09%	1.47%	-0.62%	0.96%	1.40%
I&E Margin rating	Score		3	4	3	4	3	4	3	4	4	4	3	4	4	2	3	4
I&E Margin Variance From Plan																		
I&E Margin	%		0.96%	1.40%	0.20%	1.48%	0.71%	3.17%	0.46%	2.33%	1.46%	1.63%	0.79%	2.09%	1.47%	-0.62%	0.96%	1.40%
I&E Margin Variance From Plan	%		-0.11%	0.44%	-0.11%	1.28%	-0.11%	2.46%	-0.11%	1.87%	-0.11%	0.17%	-0.11%	1.30%	-0.11%	-2.09%	-0.11%	0.44%
I&E Margin Variance From Plan rating	Score		3	4	3	4	3	4	3	4	3	4	3	4	3	1	3	4
Financial Sustainability Risk Rating																		
Capital Service Capacity rating	Score		3	3	2	3	3	4	2	3	3	3	3	3	3	2	3	3
Liquidity rating	Score		4	4	4	3	4	4	4	4	4	4	4	4	4	4	4	4
I&E Margin rating	Score		3	4			3	4	3	4	4	4	3	4	4	2	3	4
I&E Margin Variance rating	Score		3	4			3	4	3	4	3	4	3	4	3	1	3	4
Financial Sustainability Risk Rating before overrides	Score		3	4			3	4	3	4	4	4	3	4	4	2	3	4
1 Rating Trigger for FSRR	Text		No Trigger	No Trigger			No Trigger	No Trigger	No Trigger	No Trigger	No Trigger	No Trigger	No Trigger	No Trigger	No Trigger	Trigger	No Trigger	No Trigger
Financial Sustainability Risk Rating after 1 rating override	Score		3	4			3	4	3	4	4	4	3	4	4	2	3	4
Overall Financial Sustainability Risk Rating	Score		3	4			3	4	3	4	4	4	3	4	4	2	3	4
Continuity of Service Risk Rating	Score				3	3												

Derbyshire Healthcare NHS Foundation Trust
Report to Public Board April 2016

Information Governance- Quarter 4 report

This report provides our performance update on our Quarter 4 progress towards meeting the requirements of the 2015-16 Version 13 Information Governance Toolkit as well as the work of the Information Governance Committee and Information Governance breach monitoring.

Executive Summary

- The IG Toolkit was submitted on 31st March 2016 at 97% and satisfactory. This keeps DHCFT at the forefront of our category as the draft highest scoring Mental Health and Community Trust. This is an improvement from the 96% score for the previous year.
- The IGC continues to progress the agreed work programme
- There have been no new reportable incidents this quarter

Strategic considerations

- To maintain high level of organisational performance

(Board) Assurances

- Full assurance on our IGT V 13 Toolkit submission
- Full that we continue to progress the IG agenda
- Full assure that IG breaches are monitored and responded to appropriately including any actions required

Consultation

- This report will be presented at the Information Governance Committee in April

Governance or Legal issues

- Compliance with the IG Toolkit forms an important pillar of assurance around data protection (The Data Protection Act), Freedom of Information, confidentiality and information security

Equality Delivery System

- A high level of compliance in the IG Toolkit supports improved practice around data collection that enables analysis of activity supporting improving outcomes for all REGARDS Groups

Recommendations

The Board of Directors is requested to:

- To acknowledge the successful completion of the IG Toolkit
- To acknowledge the progress made with the IG work plan

Report presented by: **Carolyn Gilby**
Acting Director of Operations
Report prepared by: **Alex Rose**
Records Manager

INFORMATION GOVERNANCE Q4 (Jan- March 2016) Report

INTRODUCTION

This report provides information on our Version 13 Information Governance Toolkit submission demonstrating we have met all the requirements for 2015-16 at level 2 or above. We have surpassed our target of 96% and Satisfactory and remain top in our category.

BACKGROUND

The annual cycle of Information Governance (IG) implementation starts with the publication of the IG Toolkit which enables organisations to self- assess baseline compliance and develop plans to achieve improvements in-year, prior to the final annual return submitted at year end.

V13 of the toolkit requires the 3-stage reporting process requiring organisation's to carry out the following stages:

- Baseline assessment on 31st July 2015.
- Performance update on 31st October 2015. This was submitted showing 62% attainment and Not Satisfactory.
- Final submission by 31 March 2016. The Annual Return to be submitted on line as in previous years with our IG Statement of Compliance (IGSOC). We have achieved 97% and Satisfactory

To be considered "satisfactory" a Trust must obtain level 2 for all IG criteria. We have obtained level 3 for 41/45 criteria. This includes the requirement for Trust Board involvement at the "highest level" in reviewing specified IG policies and the IG Management framework.

FINAL SUBMISSION STATUS

Assessment	Stage	Overall Score	Self-assessed Grade	Reviewed Grade	Reason for Change of Grade
Version (2015-2016)	Baseline	62%	Not Satisfactory	n/a	n/a
	Performance Update	62%	Not Satisfactory	n/a	n/a
	Published	97%	Satisfactory	n/a	n/a

PROGRESS OF THE 2015-16 IG WORK PROGRAMME

The following planned priorities were agreed for 2015-16: these have all been achieved

- To complete the IG Toolkit so that all relevant (45) standards were achieved at a minimum level 2 or above producing a score of 96% compliance. This will produce an overall rating of “Satisfactory” allowing us to submit our annual IGSOC. It should be noted that one Information Governance requirement (13-112) states that all staff (95%) are fully trained in IG awareness. Our final submission was at 96.3% compliance. This is a significant undertaking for the Trust especially given the increase in staff with the acquisition of new services. We continue to address the issues we have capturing new starters, manual updating from face to face training and unavailable staff.
- To continue to review and update policy in line with National Guidance.
- To continue to promote IG awareness.

INFORMATION GOVERNANCE COMMITTEE

The IGC has met three times this quarter. The IGC has reviewed and ratified a number of IG and IT policies to ensure that they incorporate any legal changes or guidance provided by the ICO. The focus has been to ensure that relevant policies support the shift from paper to an electronic Full Single Patient record. The IG policy dashboard for year-end shows us at 97% with 1 policy out of date (Freedom of Information). The IGC has ratified a number of new applications and Information Sharing Agreements.

INFORMATION GOVERNANCE BREACHES

During this quarter we have had no new level 2 reportable SIRIS. The table below shows this quarter’s incidents broken down by outcome with 3 major and no catastrophic breaches. We continue to get a number of incidents reported which have originated outside the Trust which the Information Standards Lead liaises on. We also continue to liaise with Patient Experience as required.

	Insignificant	Minor	Moderate	Major	Total
Breach of Confidentiality - Verbal	0	1	2	0	3
Breach of Confidentiality - via Social Networking Sites	0	2	0	0	2
Electronic Record - Incorrect address or other personal details	1	3	0	1	5
Electronic Record - Other electronic breach	4	0	2	0	6
Electronic Record - Unauthorised access to clinical record Actual or Potential)	2	1	0	0	3
Electronic Record - Unsafe e-mailing of confidential information	1	0	0	0	1
Paper Record - Breaches related to faxing	1	1	0	0	2
Paper Record - Incorrect address or other personal details	2	4	1	0	7
Paper Record - Misfiled document(s)	1	3	2	0	6
Paper Record - Missing/Lost document(s)	1	1	0	1	3
Paper Record - Missing/Lost record(s)	0	3	1	1	5
Paper Record - Other paper record breach	2	4	2	0	8

	Insignificant	Minor	Moderate	Major	Total
Paper Record - Unauthorised access to clinical record (Actual or Potential)	0	0	1	0	1
Paper Record - Unsafe disposal of confidential waste	1	1	0	0	2
Total	**16**	**24**	**11**	**3**	**54**

RISKS

The main risks remain:

- IG Breaches which are SIRI reportable to the ICO at Level 2

Year End Benchmark Position

Derbyshire Healthcare's attainment level of 97% and Satisfactory maintains our position as the one of the highest achieving Trusts within the Mental Health, Community and Acute categories. The league table below is an interim report until the formal result publication of the V13 Toolkit results across all organisations. This will confirm the final Trust ranking.

Alex Rose
Records Manager

Assessment Version 13 (2015-2016)

Organisation Name	Org Code	score	Self Assessed Grade	Reviewed Grade	Org Type
Derbyshire Healthcare NHS Foundation Trust	RXM	97%	Satisfactory	n/a	Mental Health
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	RTF	95%	Satisfactory	n/a	Acute
LEICESTERSHIRE PARTNERSHIP NHS TRUST	RT5	94%	Satisfactory	n/a	Mental Health
LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	RP7	94%	Not Satisfactory	n/a	Mental Health
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	RXA	94%	Satisfactory	n/a	Mental Health
SOUTH STAFFORDSHIRE AND SHROPSHIRE HEALTHCARE NHS FOUNDATION TRUST	RRE	93%	Not Satisfactory	Satisfactory With Improvement Plan	Mental Health
EAST MIDLANDS AMBULANCE SERVICE NHS TRUST	RX9	93%	Satisfactory	n/a	Ambulance
SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	RX2	91%	Satisfactory	n/a	Mental Health
GATESHEAD HEALTH NHS FOUNDATION TRUST	RR7	91%	Satisfactory	n/a	Acute
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST	RV5	89%	Satisfactory	n/a	Mental Health
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	RP1	88%	Satisfactory	n/a	Mental Health
UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRU	RJE	87%	Satisfactory	n/a	Acute
DERBY HOSPITALS NHS FOUNDATION TRUST	RTG	86%	Satisfactory	n/a	Acute
TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST	RNK	83%	Not Satisfactory	n/a	Mental Health
BURTON HOSPITALS NHS FOUNDATION TRUST	RJF	82%	Satisfactory	n/a	Acute
HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	RWR	81%	Satisfactory	n/a	Mental Health
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	RXT	79%	Satisfactory	n/a	Mental Health
NHS Erewash CCG	03X	79%	Satisfactory	n/a	CCG
Nottinghamshire Healthcare NHS Foundation Trust	RHA	78%	Satisfactory	n/a	Mental

Organisation Name	Org Code	score	Self Assessed Grade	Reviewed Grade	Org Type
					Health
Worcestershire Health and Care NHS Trust	R1A	78%	Satisfactory	n/a	Mental Health
Nottingham City Care Partnership	NR3	77%	Satisfactory	n/a	Community
Staffordshire & Stoke on Trent Partnership NHS Trust	R1E	77%	Not Satisfactory	Satisfactory With Improvement Plan	Community
Virgin Care Services Ltd	NDA	76%	Satisfactory	n/a	Community
NHS Southern Derbyshire CCG	04R	74%	Satisfactory	n/a	CCG
Derbyshire Community Health Services NHS Trust (East Midlands)	RY8	73%	Satisfactory	n/a	Community
NHS North Derbyshire CCG	04J	73%	Satisfactory	n/a	CCG
NHS Hardwick CCG	03Y	73%	Satisfactory	n/a	CCG
NHS Tameside and Glossop CCG	01Y	72%	Satisfactory	n/a	CCG
PENNINE CARE NHS FOUNDATION TRUST	RT2	70%	Satisfactory	n/a	Mental Health
Birmingham Community Healthcare NHS Trust	RYW	69%	Satisfactory	n/a	Community
Sheffield Health & Social Care NHS Foundation Trust	TAH	67%	Satisfactory	n/a	Mental Health
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	RFS	67%	Satisfactory	n/a	Acute
Rotherham Doncaster and South Humber NHS Foundation Trust	RXE	66%	Satisfactory	n/a	Mental Health
Shropshire Community Health NHS Trust	R1D	66%	Satisfactory	n/a	Community

Grade key

Not Satisfactory	Not evidenced Attainment Level 2 or above on all requirements (Version 8 or after)
Satisfactory with Improvement Plan	Not evidenced Attainment Level 2 or above on all requirements but improvement actions provided (Version 8 or after)
Satisfactory	Evidenced Attainment Level 2 or above on all requirements (Version 8 or after)

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board April 2016

Annual Staff Survey Action Plan 2016

Purpose of Report

To agree the action plan following the annual NHS National staff survey results in February 2016

Executive Summary

Our response rate was 41% in the 2015 survey one key area to address is the increase of participation. This will be realised by a number of factors – a shift in the current culture, acceptance by staff that the survey is managed via an external agency and individuals are not identifiable internally, and finally that we act on feedback. Our approach to internal communication, involvement and engagement with our staff will be critical to deliver the desired participation and improve overall response rates. Our relationship with staff side to create true partnership will also assist in building improved relations across the Trust.

There is an ambitious agenda to address the significant challenges that we are facing over the next 12 months –a number of areas are identified within the governance improvement action plan – key strategic enablers will be the refreshed Trust strategy as well as the supporting People Strategy and People Plan. There is no one factor that will improve our staff survey results, but ensuring clarity at every level, reviewing and improving our systems, processes and behaviours inevitably will have a positive effect.

Our overall results in 2015 when ranked, compared with all combined MH/LD and community trusts identified:
4 KF above (better than) average
5 KF above (worse than) average
10 KF Average
13 KF below (worse than) average

We would be aiming to improve our ratings in all areas, without specific targets, but the attached action plan identifies the key areas of focus, and where central corporate action is needed, this will be further developed by introducing a service level action plan. It is anticipated that the service level actions will be refined at the next Spotlight in Leaders event and through team briefings in the interim.

Next Steps
Proactive work will be undertaken to explore the results further and analyse by service line with the service line managers and specific occupational groups. This detail will be shared with the Engagement Group and escalated to the People and Culture Committee as appropriate. Progress on actions will be on the People and Culture Committee forward plan.

Strategic considerations

'We Focus on Our People' is a core value for our Trust. The annual staff survey is one indicator of how our staff feel in their day to day working environment – our future strategy and activities will be informed by the results of the annual survey.

Board Assurances
The action plan will be delivered through the Engagement Group and a quarterly update at the People and Culture Committee.

Consultation
This paper has not been previously submitted to the People and Culture Committee - due to timings it will be presented at the next JNCC

Governance or Legal issues The annual staff survey will support the governance improvement action plan

Equality Delivery System
Further analysis will be undertaken of the results to ascertain any impact and be explicit of future action required

Recommendations
The Board is requested to:

- Receive the staff survey action plan

- Monitoring will be through the People and Culture Committee on a quarterly basis

Report presented by: **Jayne Storey, Director of Workforce, OD and Culture**

Report prepared by: **Jayne Storey, Director of Workforce, OD and Culture**

Staff Survey Action Plan - WE DELIVER EXCELLENCE

Area of Focus	Corporate Action	Timescale 2016	Success Criteria
WE PUT PATIENTS AT THE CENTRE OF EVERYTHING WE DO			
Improve staff perception of the Trust as a high quality employer and service provider	Increase staff understanding of the quality of care that their colleagues provide by: • Use of quality measures and improvements • Focus on Quality as part of the 'cultural change programme' • Use the data from quarterly Staff Family and Friends test (SFFT) • Improvements in internal communications • Listen, Learn, Lead sessions • Actively pursue and promote internal and external awards and recognition • Review of employee life cycle with focus on training and development	May - Sept	Staff would recommend the Trust as a place to work or care for a friend of family member 2015 Score 3.55 Appraisal compliance • Through PC&C metrics • Effectiveness of appraisals Communications Audit
Improve the fairness and effectiveness of procedures for reporting errors, near misses and incidents	• Review of current procedures • Communication of errors/near misses and incidents in an anonymous way (where appropriate) to support 'the learning organisation' • Review Datix training	May – Sept	Improving the 2015 Trust Score 3.64
Improving staff agreeing that their role makes a difference to patients / service users	• Ensure Organisation alignment by: o Launch of new Trust strategy - link with individual appraisal and objectives to become the 'norm' o Revised appraisal process o Training & Development programmes o All leaders to receive training in 'coaching for performance'	May – Sept	Organisation and Service line pulse checks Improving the 2015 Trust score 87%
WE INVOLVE OUR PEOPLE IN DECISIONS			
Improving the effective use of patient / service user feedback	• The re-design on 'My Care' patient leaflet • Effective communication on 'how to raise concerns'	June	Improving the Trust score 2015 3.37

Area of Focus	Corporate Action	Timescale 2016	Success Criteria
	• Patient experience with external agencies / safeguarding • Podcast to launch • Ensure Patient / Service User in the re-development		
Staff ability to contribute towards improvements at work	Cultural change programme to promote: - Inclusivity - Decision making made at a local level - Lean methodology introduced	May – Sept	Improving the Trust score 2015 73% Number of teams engaged in lean work and evidence of impact
Acting on concerns raised by patients / service users and staff	Cross reference 'Freedom to Speak Up' action plan - launch campaign Ensure visible communications –'you said – we did – impact Positively recognising those who raise concerns		Improving the Trust Score 69% Audit against the number of concerns raised and actions as a result
Staff confidence & security in reporting unsafe clinical practice	Develop and launch Freedom to Speak Up action plan Listen, learn, lead - 2-way feedback Training /facilitation/open sessions to share learnings Develop and launch cultural change programme Advertise and engage (voluntary) named leads for raising clinical practice concerns	May – Sept	Pulse checks Improving Trust Score 2015 3.56%
WE FOCUS ON OUR PEOPLE			
Improving communications between senior managers and staff	Ensure that managers are communicating effectively through: - Review of communication channels - Corporate messages to be disseminated via a range of sources such as team briefing packs on specific topics, screensaver, intranet - Management training – effective communication / effectiveness of supervision - Listen, learn and lead sessions - 2-way feedback	May – Sept	Improving Trust Score 2015 27% Internal audit of communication mechanisms – measure number of team meetings - Listen, Lead and Learn events
HEALTH AND WELL-BEING			
Reducing the % of staff/colleagues	Re-establish Mindful, health and wellbeing group	May – Sept	Decrease in the Trust Score 2015 Experiencing 67%

Area of Focus	Corporate Action	Timescale 2016	Success Criteria
reporting most recent experience of violence Reporting/experiencing recent experience of harassment, bullying or abuse	Introduce 'Cultural change programme' – refresh and launch Trust values Develop and launch 'Freedom to Speak Up action plan		Increase in Reporting – 2015 Trust score 57% Decrease in Experiencing - 2015 Trust score 22% Exit data / ER data
Reducing the % of staff suffering from work related stress	Develop and launch the mindful, health and well-being strategy Management development Workforce planning Review of EAP provision – internal and external Review of Schwartz rounds	May –Sept	Reduction of staff reporting work related stress Monthly work related stress metrics to mindful, health and well-being group identifying Quarterly review of workforce plan v actual via the Workforce group 2015 Trust Score 41%
Reducing the % of staff working extra hours	Workforce planning Ensuring E-rostering is utilised across Trust Training for managers Lean working Review recruitment process to streamline and reduce time from vacancy to appoint Proactive recruitment	May – Sept	2015 Trust score – 67%
Feeling pressure in last 3 months to attend work unwell	Review Health and attendance policy Workforce planning Training for managers EAP provision / Schwartz rounds	May – Sept	Decrease in the 2015 Trust score 64% HR attendance metrics
TRAINING AND DEVELOPMENT			
Quality of appraisals Appraisal compliance	Refresh of the policy / process / forms Training of managers Introduce core elements of management training into Leaders passport as mandatory	May – Sept	2015 Trust score Quality - 2.89 Compliance – 83% Management mandatory training compliance

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors - 27 April 2016

Corporate Governance
Register of Directors' Interests 2015-16

Purpose of Report

This report provides the Trust Board with an account of directors' interests during 2015-16.

Executive Summary

- It is a requirement that the Chairman, Board members and Board-level Directors who regularly attend the Board and current members, should declare any conflict of interest that may arise in the course of conducting NHS Business.

- The Chairman and Board members should declare any business interest, position of authority in a charity or voluntary body in the field of health and social care, and any connection with a voluntary or other body contracting for NHS services. These should be formally recorded in the minutes of the Board, and entered into a register, which is available to the public.

- Directorship and other significant interests held by NHS Board members should be declared on appointment and kept up to date.

Board Assurances

Directors are asked to disclose to the meeting any changes to the Register of Directors' Interests during the course of the year.

When reviewing their disclosures, each Board member has personally reaffirmed in writing their agreement to comply with the NHS Codes of Conduct and Accountability, and the Seven Principles of Public Life (Nolan), and to state whether there is any relevant audit information of which the Trust's Auditors are unaware.

Governance or Legal issues

The disclosure and statements referenced within this report are subject to the NHS Code of Conduct and Accountability and Licence Conditions of the Foundation Trust.

Equality Delivery System

This report has a neutral impact on REGARDS groups

Recommendations

The Board of Directors are requested to:

1) Approve and record the declarations of interest as disclosed. These will be recorded in the Register of Interests which is accessible to the public at the Trust Head Office and will be listed in the Trust's annual report and accounts for 2015-16.
2) Record that all directors have signed as to compliance with the NHS Codes of Conduct and Accountability and Nolan principles; no relevant audit matters have been declared.

Report presented by: **Samantha Harrison**
Director of Corporate Affairs and Trust Secretary

Report prepared by: **Sue Turner**
Board Secretary

Declaration of Interests Register 2015-16

NAME	INTEREST DISCLOSED	TYPE
Jenna Davies	Nil	-
Jim Dixon	Director – Winster Village Shop Association Director – Jim Dixon Associates Director - UK Countryside Tours Limited Patron – Accessible Derbyshire	(a) (a) (a) (d)
Carolyn Gilby	Nil	-
Graham Gillham	Nil	-
Carolyn Green	Nil	-
Richard Gregory	Director - Clydesdale Bank Plc (including Yorkshire Bank) Director – CYBG Plc (holding company of Clydesdale) NHS Providers Trainer/Facilitator for Board/Governor Development Member of Governwell, NHS Providers	(a) (a) (e) (e)
Phil Harris	Director – Phormative Ltd	(a, b, c)
Samantha Harrison		
Ifti Majid	Nil	-
Caroline Maley	Director – C D Maley Ltd Trustee – Vocaleyes Ltd.	(a) (a, d)
Mark Powell	Nil	-
Tony Smith	Panel Member (Assessor) – Judicial Appointments Commission (from 26 March 2010 to 31 March 2017)	(d)
Jayne Storey	Nil	-
John Sykes	Independent Deprivation of Liberty mental Health Assessor undertaking assessments on BGHS patients at the request of Derbyshire County Council via my medical secretary	(b)
Maura Teager	Non-Executive Director – Ripplez social enterprise and NHS provider of the Family Nurse Partnership	(a)
Mark Todd	Chair of Trustees – Motor Neurone Disease Association	(d)
Steve Trenchard	Nil	-
Claire Wright	Nil	-

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 share holdings 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
Report to Board of Directors 27 April 2016

Clinical Audit Deep Dive

Purpose of Report

The purpose of the report is to provide the Board a 'deep dive' into the current Clinical Audit processes and performance and outcomes

Executive Summary

- This is an unscheduled report to the Trust Board of Directors requested at short notice following the Audit Committees intention to escalate to the Board the need for a deep dive into systems and process of clinical audit that the Audit Committee has a lack of assurance on (AUD 2016/032).

- Supporting information is provided for this deep dive but where gaps in information are identified by the Board these will be followed up through subsequent reports as needed.

- Following the PwC review of Clinical Audit findings of medium risk, reports on progress have been maintained through the Quality Committee and Audit Committee during the year.

- The follow up review which was undertaken by PwC in March 2016 confirmed implementation of all agreed actions (five out of five) from prior year audits.

- The current position at the end of March 2016 and as reported to the Quality Committee in April 2016 is an improving one with respect to clinical audit performance and team capacity.

- The governance structures in place for managing clinical audit includes the Research and Development Governance Committee which has encountered difficulties in recruiting and maintaining attendance by members and continues to be under review to achieve improvement.

- Clinical Audit systems and processes are driven by the Clinical Audit Framework which is based on national guidance and compares well to those of other organisations.

- The level of dedicated resources available to support the current Trust Clinical Audit Programme and related activities is however challenging and reflects to some extent the delays observed in Clinical Audit completion timescales. This is evidenced by comparative clinical audit infrastructure in some other organisations and is supported by the March 2016 PwC follow up review.

- Never the less our Clinical Audit activity continues to contribute to the Trust's strategic objectives and quality priorities enabling services to provide evidence of effectiveness. Some positive assurances are provided through Clinical Audit.

- Future development is planned for Clinical Audit process and outcomes. The proposal for this has now been agreed. This is intended to be measured and improved using Healthcare Quality Improvement Partnership (HQIP) and Good Governance Institute guidance using their maturity matrix.

Strategic considerations

- Delivery of strategic outcome on people receiving best quality of care

Assurances

- This report provides information relating to progress in delivering the current 2015-16 Clinical Audit Programme and related activity.
- This report also provides information on future plans for development using the Clinical Audit Maturity Matrix.
- The report provides partial assurance on Clinical Audit processes and outcomes

Consultation

The last Clinical Audit update was reported to the Quality Committee on 14th April 2016.

Governance or Legal issues

Potential impact on Commissioner Contract and Care Quality Commission Regulations

Equality Delivery System

Actions being taken do not affect REGARDS groups adversely and likely to have positive impact as individual projects are completed.

Recommendations

The Committee is requested to:

1) Note the content of the report.

2) Request any further information required not provided in this report.

Report presented by: **John Sykes, Executive Medical Director**
Report prepared by: **Rubina Reza, Research & Clinical Audit Manager**

Clinical Audit Deep Dive

This is an unscheduled report to the Trust Board of Directors requested at short notice following the Audit Committees intention to escalate to the Board the need for a deep dive into systems and process of clinical audit that the Audit Committee has a lack of assurance on (AUD 2016/032).

In September 2014 aspects of the Clinical Audit function was reviewed by PwC and the final report was issued on 28 October 2014. An overall report classification of Medium Risk (15 points) was assigned with 5 medium risk findings (and 3 advisory findings which did not have a risk impact).

The PwC report on clinical audit was reviewed and actions taken to implement controls to mitigate risks identified. Actions taken in response to the PwC report were agreed by the R&D Governance Committee on 6 November 2014 and reported to the Quality Committee on the 13 November 2014.

Monitoring reports on Clinical Audit progress has been maintained to both the Quality Committee and Audit Committee throughout the year following the PwC review:

- Quality Committee 14th April 2016 – report on clinical audit update and R&D Governance Committee attendance
- Audit Committee 16 March 2016 - For information only Research & Development Centre Update incorporating Clinical Audit
- Quality Committee 11 February 2015 - Research & Development Centre Update incorporating Clinical Audit (report submitted to Trust Board of Directors 27 January 2016 as scheduled in Board forward plan but informed report had been put forward to Quality Committee instead)
- Quality Committee 10 December 2015 – report on Clinical Audit trajectory for improvement
- Audit Committee 15 December 2015 – report on Clinical Audit update
- Quality Committee 12 November 2015 – report on Clinical Audit update and future development plans
- Audit Committee 21 July 2015 – report on Clinical Audit update
- Quality Committee 9 July 2015 – report on Clinical Audit update
- Board of Directors 25 June 2015 - Research & Development Centre Update incorporating Clinical Audit
- Audit Committee 18 March 2015 – report on Clinical Audit Update
- Quality Committee 12 March 2015 - Minutes of Research and Development Governance Group

- Quality Committee 12 February 2015 – report on Clinical Audit update
- Board of Directors 28 Jan 2015 – report on Research only
- Audit Committee 23 January 2015 – report on Clinical Audit update and response to PwC report
- Quality Committee 13 November 2014 – report on Clinical Audit update and response to PwC report
- Audit Committee 9 October 2014 – report on Clinical Audit update

The follow up review which was undertaken by PwC in March 2016 confirmed implementation of all agreed actions (five out of five) from prior year audits.

Current status

- In December 2015, a trajectory for improvement was presented to the Quality Committee estimating an increase in the number of completed (signed off) clinical audit projects by the end of March 2016.

- The plan for improvement was put forward as the new Clinical Audit & Research Co-ordinator had commenced in post in December and it was anticipated the increased capacity as a result, even with the period of learning and induction required initially, would enable us to progress at a faster pace.

- Tables 1a and 1b below demonstrates that as estimated the number of projects signed off has doubled from 16 signed off projects reported in December 2015 to 32 at the end of March 2016.

- There are now 5 open projects over 12 months on the programme (compared to 13 reported in December) that need to be supported through to the sign off stage (numbers highlighted in red text in tables 1a and 1b)

- However there are also 11 open projects currently which are not delayed (more than 6 months but less than12 months) which also need proactive managed to ensure that these are signed off and do not become delayed.

- There remains the potential risk that if reports are not received in time or action plans are not signed off as expected, these projects may go on to become delayed. However, systems and processes are in place to minimise these risks.

- The outcome of Clinical Audit projects whether delayed or not is to contribute to improvements in practice through a continuous practice improvement approach.

- Although following the PwC review, monitoring has become focused on the numbers of delayed projects, it should be noted that the vast majority of projects complete to an improvement action plan. Implementation of actions will lead to improvements in practice and contribute to the quality of care delivered. To date only one (out of the 32 completed projects) did not result in an action plan being agreed to improve practice and this project (Patient Transfer to Recovery Ward) was actually completed in <6 months.

Table 1a Project Progress Stage - Actuals at 31/03/2016

Time since project approved	Complete – signed off	Awaiting sign off	*Action plan Production	Data Collection / write up	Suspended	Total
Dark Red: >18 months	13	4		1		18
Red: >12 months <18 months	9	1	1	3		14
Amber: >6 months <12 months	6	4	2	5		17
Green: <6 months	4	2	2	21		29
Projects not confirmed					5	5
Total	**32**	**11**	**5**	**30**	**5**	**83**

Table 1b Project Progress Stage - Actuals at 30/11/2015

Time since project approved	Complete – signed off	Awaiting sign off	*Action plan Production	Data Collection / write up	Suspended	Total
Dark Red: >18 months	5	3	5	1		14
Red: >12 months <18 months	5	1	3	4		13
Amber: >6 months <12 months	3	5	5	4		17
Green: <6 months	3	0	3	13		19
Projects not confirmed					5	5
Total	**16**	**9**	**16**	**22**	**5**	**68**

(The Clinical Audit Framework acknowledges that some projects may take up to 18 months to complete through to sign off so we would next expect project delays over 12 months to be a 'never event' but we would like these to be the exceptions.)

- Over this same period we have continued to review and support new Clinical Audit project plans thus the total number of projects on the programme has continued to increase from 68 in December to 83 at the end of March 2016.

- Clinical Audit action plans have also continued to be monitored for completion and the increased numbers of action plans which have been signed off to date are also reflected in the increased numbers of actions logged for follow up – at the end of March 2016 there were 305 actions compared to 222 in December 2015 (tables 2a and 2b).

- Once an action plan for improvement has been signed off, actions are monitored for completion.

- The table below shows the status of actions arising from Clinical Audit Action Plans at the end of March 2016

Table 2a Action Progress Stage - Actuals at 31/03/2016

Action Status @ 31/03/2016	No. of actions	%	
Complete	218	71%	
Action over-due	34	11%	
Action - on hold	6	2%	
Action not yet due	47	15%	Includes 9 with revised timescales
Total	**305**		

- The table below shows the status of actions arising from Clinical Audit Action Plans reported at the end of November 2015 for comparison

Table 2b Action Progress Stage - Actuals at 30/11/2015

Action Status @ 30/11/2015	No. of actions	%	
Complete	151	68%	
Action over-due	27	12%	
Action - on hold	6	3%	
Action not yet due	38	17%	Includes 15 with revised timescales
Total	**222**		

- In order to further improve timely completion of actions, it is planned that reports will be shared with General Managers to facilitate action completion for their divisions. This change is scheduled to be implemented once the staff list is available this month for the new campus, neighbourhood, Children's and Central Services structures so that reports can be filtered by divisions.

- The process of signing off action plans continues to add considerable time to the project cycle. This is particularly evident when action plans are not signed off first time round and are required to go back to the committee. Where possible, committee chairs are requested to sign off action plans subject to requested amendments being made and circulated by email rather than brought back for further discussion at subsequent meetings.

- We have experienced some delay in projects being signed off through the D&T Committee as these occur every other month and agendas are busy. Similarly Mental Health Act Committee meetings held quarterly also delayed sign off of some action plans.

- The role of the Quality Leadership Teams (QLTs) have started to become established in the review of clinical audit reports and action plans and the support from QLTs has significantly contributed to the progress and the large numbers of projects which have been reviewed and signed off through the QLTs have received strong scrutiny and challenge.

- The R&D Governance Committee has discussed the need for action plan sign off by a committee and agreed that the importance of sign off through committees and the challenge and scrutiny of action plans received as well as the assurance provided for any risks being adequately addressed through action plans, outweighs the need for speed of sign off.

- The performance in 2015-16 is reflective of reduced capacity with the Clinical Audit & Research Co-ordinator post vacancy being covered by the Research and Clinical Audit Manager over April 2015 to November 2015 (8 months). The vacancy was filled from December 2015 increasing our capacity in the last four months of the financial year.

Clinical Audit Governance Structures

- The Trust Clinical Audit activities are overseen by the Research & Development (R&D) Governance Committee (since June 2014) and reports to the Quality Committee.

- The Terms of Reference, membership and attendance at the R&D Governance Committee has been under on-going review in an effort to improve attendance at the meetings.

- Attendance at the R&D Governance Committee has not improved and requests for new members have not been completely successful to date.

For example the Consultant Nurse identified to join the committee withdrew before attending any meetings due to other commitments. We have not been able to secure representatives from Psychology or a nomination of a deputy for Pharmacy. The invitation to the interim Head of Education has also not been successful.

- Further expressions of interest will be sought by advertising for new members as this may attract staff interested in Research and Clinical Audit. Members external to the Trust such as Universities has also been suggested as possible new members.

- The frequency of meetings are planned to be reduced to alternate months. This will be possible as a new virtual process of review and approval for new projects via email has been established and is working well.

- At the next face to face meeting attendance via Skype is planned to be tested.

- The Table below shows attendance at R&D Governance Committee in 2015/16 - there were 11 meetings in the year as one meeting was cancelled due to the HEEM quality visit taking place at the same time.

Core Members	Attendance^	%
Medical Director – Chair	6 out of 11	55%
Consultant Psychiatrist - Deputy Chair	6 out of 11	55%
Research & Clinical Audit Manager	11 out of 11	100%
Consultant Psychiatrist Older Peoples	1 out of 11	9%
Consultant Psychiatrist Adults	3 out of 11	27%
Chief Pharmacist	0 out of 11	0%
Derbyshire Voice*	5 out of 6	83%
Vishnu Gopal, Consultant Psychiatrist (medical education)	1 out of 4	25%

*New service user representatives to be identified

^The number of attendances varies by members dependent on when they joined in the year

Clinical Audit Resources

The Trust has a devolved model of Clinical Audit but there are no dedicated resources within the divisions for undertaking clinical audits. The central Clinical Audit Team is made up of a 0.6 WTE band 6 Clinical Audit Co-ordinator role supported by a 0.4 WTE band 4 assistant role. This level of resource to support the large number of Clinical Audit projects is a challenge.

A visit was made to a Mental Health and Community Trust, outside of our region. The 2014/15 Quality Account for this organisation states the reports of 54 local clinical audits were reviewed by the provider in 2014/15. Of these reports, 38 had action plans for quality improvement, and the remainder had action plans in development. The website

for the organisations states it employs around 4,000 staff. This organisation employs 3 full time band 6 posts and 2 band 4 support posts all dedicated to Clinical Audit. In addition this organisation does not monitor action plans for completion.

In July it was reported that another regional Mental Health and Community Trust's infrastructure includes 10 dedicated clinical audit staff. The organisation employs approximately 6,000 staff and reported 86 local audits reviewed (not necessarily completed) in the Quality Account for 2013-14.

It is apparent that the level of resources available to Clinical Audit in the Trust is inadequate for the level of demand. It will be important to manage expectations according to our capacity in order to protect our staff from the risks of work related stress.

Clinical Audit Systems and Processes - Key Controls

The DHCFT Clinical Audit Framework guides clinical audit activity and is based on national guidance.

Clinical Audit process awareness is raised through Trust induction processes and is available on our clinical audit connect intranet pages,

All new projects are required to complete project plan templates which are reviewed and approved by the R&D Governance Committee prior to registration onto the clinical audit programme.

Report and action plan templates are available and provided to project leads at the time the project is approved.

Once registered on the clinical audit programme projects are reviewed and updated regularly for news received from project leads.

All completed reports received are required to include improvement action plans where gaps in practice are identified.

Reports are reviewed and action plans proposed, consulted as widely as possible and negotiated with action leads prior to putting forward to a relevant Trust committee as the final check to assess the adequacy of the action plan in addressing risks arising from any shortfalls in compliance

Clinical Audit project plans are not regarded as complete until an action plan for improvement has been signed off.

Approved action plans are registered on our clinical audit actions log and action leads reminded of their actions and confirmation of completion.

Clinical Audit Systems and Processes - Assurances

The Trusts Programme of Clinical Audit contributes significantly to quality improvements, including care that is joined up and easy to access. Clinical Audit provides internal assurance on controls as part of the Trust Board Assurance Framework.

Clinical audits also identify gaps in assurance where practice falls below standards and through improvement action plans contributes to increasing effective controls and gaining assurance through re-audits.

An example of this can be demonstrated by the Second Re-audit of Consent to Treatment (Section 58) which was included in the quality position statement to the Trust Board in March 2016 as contributing towards the evidence of effective services.

As the conduct of clinical audit is a key requirement for medical trainees and so the practice of quality assessment and improvement has become well established in a large section of the workforce.

There is a core universal element to clinical audit processes which most clinicians and trainees will experience as similarities with slight local differences irrespective of which NHS Trust they may be working for.

As a tool for quality improvement it is used by different professions to review and improve their practice. Many clinical audits are multi-disciplinary reviews and areas for investigation are identified from within clinical teams supporting decision making close to the point of care delivery. This approach contributes to the strategic outcome that care is delivered by empowered and compassionate teams.

Many of the clinical audit projects on the programme are also in response to Trust identified quality priorities or other priorities identified either as a national or commissioner priority or local priority identified from a serious incident requiring investigation or serious case reviews.

Health Education East Midlands (HEEM) gives significant importance to the support structures available for Clinical Audit for medical trainees. Organisations educational funds have been threatened where sufficient support has not been provided. The HEEM quality management visit which took place on 1st and 2nd October 2015 did not identify any areas for improvement in Clinical Audit and Research contributions to the quality of multi-professional education and training.

The East Midlands Clinical Audit Support Network (EMCASnet) is a group of clinical audit, effectiveness and improvement professionals who work within organisations providing or commissioning NHS services within the East Midlands region. From our

membership on this group our Clinical Audit systems and processes and our performance and outcomes do not appear to be inferior to other organisations in the region.

The Clinical Audit Framework requires that action plans for improvement are agreed and implemented dependent on the findings of the Clinical Audit. This ensures that quality improvements are achieved. The impact of Clinical Audit is reported annually in the Trust Quality Account. http://www.nhs.uk/services/trusts/overview/defaultview.aspx?id=2673

The public awareness and access to information on our efforts to review and improve quality of care systematically through clinical audit can help contribute to the public confidence in our healthcare and developments.

Table 3: Year on Year Project Completion (Sign off) status

	2012-13	2013-14	2014-15	2015-16
Total Projects on Programme	54	84	90	83
Total Signed off Projects	22*	18*	27*	36*

*As reported or submitted for Trust Quality Accounts.

The rate of completion of clinical audit projects which have been reported by PwC in their review of clinical audit is an inaccurate measure of performance as not all projects in a financial year is expected to be completed in that financial. For this reason our reporting has changed to indicate numbers of projects which are taking longer than 18 months to complete.

Quality requirements of the NHS standard contract to our commissioners include requirements for clinical audit which are fulfilled.

Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Monitoring	Monthly or annual application of consequence	Applicable Service Specific-Action
3.2 NATIONAL CLINICAL AUDITS Provider actively engages with a range of clinical audit programme, both nationally and local and that changes in practice is evidenced	a) Programme of audit is available to the CCG at the end of Q1 b) Provider is able to evidence changes in clinical or other practice based on audit outcomes	a) Q1 – programme provided to Commissioners b) Change in practice evidenced annually via Quality Account or Clinical Audit Committee report (end of Q4)	General Conditions 9 Contract Management	Q1 & Q4	Annual	

Future Plans – Clinical Audit Maturity Matrix

This clinical audit development idea was originally proposed by Tony Smith, Non-Executive Director and discussed further with John Sykes, Medical Director, and was taken to the Quality Committee in November 2015. For information the following was proposed:

Clinical Audit Maturity Matrix – a proposal for improvement

What is being proposed?

It is proposed to establish a baseline position for our clinical audit function in order to develop an action plan towards excellence using HQUIP and Good Governance Institute guides for NHS boards and partners which places clinical audit within the broader context of quality improvement.

Plans for development will be based on views of clinical audit, using the published Clinical Audit Maturity Matrix, at different organisational levels as well as a wide range of other stake-holders to obtain a 360 degree-like development plan for Clinical Audit.

The Clinical Audit Maturity Matrix illustrates how to progress from an organisation's current progress level in 10 key aspects of clinical audit to where they aim to be in 12 months' time.

http://www.hqip.org.uk/assets/QID-Education-training-online-learning/FINAL-CA-matrix.pdf

It places clinical audit within the broader context of quality improvement, and provides guidance to those commissioning, delivering, and scrutinising clinical audit as part of the wider quality improvement strategy.

How will this be achieved?

Two rows have been added to each element of the clinical audit maturity matrix to assess level of attainment and plan progress to the next level (see page x).

This adapted maturity matrix assessment tool will be provided both electronically and in paper format for completion by groups and individuals.

The Trust's Clinical Audit Framework will be available as supporting information for current practice.

Completed assessments and actions will be collated to compile the overall plan for development.

Who will be involved?

Key individuals will be asked to complete the maturity matrix assessment tool although collective responses can be completed

The R&D Governance Committee has agreed to dedicate some time to self-assess collectively as a group.

Other proposed groups with some responsibility for the delivery of quality improvements to be asked to complete the assessment include:

- Quality Committee
- Audit Committee
- QLTs and/or CRGs

An on-line version will also be made available to enable anyone wishing to influence the development plan.

When will this be done?

Estimated Timescale	Action
January/February 2016	The R&D Governance Committee will complete a self-assessment before the end of financial year. This will enable any specific issues identified by the group to inform the roll-out and process of completion for other groups.
March/April 2016	Chairs of other relevant groups and committees will be contacted providing instructions/options and to agree the best approach for them including timescales required for completion.
March/April 2016	The assessment tool will be opened up for wider input.
April/May 2016	Analysis of returns and an overall development plan will be agreed by the R&D Governance Committee
May/June 2016	Quality Committee will be asked to ratify the proposed development plan

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE QUALITY COMMITTEE

Held in Meeting Room 1, Albany House, Kingsway, Derby DE22 3LZ

Thursday, 10 March 2016

PRESENT:	Maura Teager	Chair and Non-Executive Director
	Phil Harris	Non-Executive Director
	Dr John Sykes	Executive Medical Director
	Emma Flanders	Lead Professional for Patient Safety
	Rachel Kempster	Risk & Assurance Manager
	Sangeeta Bassi	Chief Pharmacist
	Hayley Darn	Nurse Consultant
	Dave Hurn	Service Line Manager for Substance Misuse
	Carrina Gaunt	Health & Safety Manager
For item QC/2016/048	Tracy Shaw	Training Manager
IN ATTENDANCE:	Sue Turner	Board Secretary and Minute Taker
APOLOGIES:	Carolyn Green	Director of Nursing and Patient Experience
	Carolyn Gilby	Acting Director of Operations
	Jenna Davies	Interim Director of Corporate & Legal Affairs
	Clare Grainger	Head of Quality & Performance
	Sarah Butt	Assistant Director of Clinical Practice and Nursing
	Jayne Storey	Director of Workforce & OD
	Petrina Brown	Consultant Clinical Psychologist
	Wendy Brown	Clinical Director
	Richard Morrow	Head of Nursing Radbourne Campus and Children's and CAMHS
	Rubina Reza	Research & Clinical Audit Manager
	Catherine Ingram	Chief Executive, Derbyshire Voice
	Pam Dawson	Carer Forum

QC/2016/039	**WELCOME AND APOLOGIES** The chair, Maura Teager, opened the meeting and welcomed everyone. The high number of apologies received at today's meeting was noted and Maura Teager would escalate this concern to the Board. Quoracy was confirmed in line with the Terms of Reference. As the committee's executive lead, Carolyn Green was absent at a Coroner's Inquest, Haley Darn agreed to act as her deputy.
QC/2016/040	**MINUTES OF THE MEETING DATED 11 FEBRUARY 2016** The minutes of the meeting, dated 11 February 2016 were accepted and agreed.
QC/2016/041	**ACTIONS MATRIX** The committee agreed to close all completed actions. Updates were provided by members of the committee and were noted directly on the actions matrix. Due to the fact that the February meeting of the Mental Health Act Committee had been cancelled, actions due to be transferred to that committee would continue to be tracked on the action matrix by the Quality Committee. **POLICY ACTIONS MATRIX**

	This is an addition to the matrix for the committee to action. Rachel Kempster highlighted the eight policies that were overdue and pointed out that the following policies have been submitted for ratification at today's meeting. • Complaints 4Cs policy • Advance Decisions and Statements Policy • Consent to Examination and Treatment Policy and Procedures • Supervision Policy and Procedure • Seclusion and Long Term Segregation – Psychiatric Emergency Policy and Procedure The Junior Doctor's Handover Policy has been signed off John Sykes. Violence and Aggression Prevention and Management Policy and Procedures has been redrafted by Carolyn Green and will be submitted to the committee's April meeting for ratification. The Engagement Improvement Framework would be transferred to the People & Culture Committee for ratification. It was agreed that Rachel Kempster will amend the Policy on Policies to show that all Board committees have ratification rights. Rachel Kempster informed the committee she is discussing the approach of other trusts to the review and ratification of policies and these results will be included in the next policy governance update in May. **RESOLVED: The Quality Committee noted the progression of the work that had taken place to review and update outstanding policies.**
QC/2016/042	**SERIOUS INCIDENT REPORT** Emma Flanders, Lead professional for Patient Safety, provided the Quality Committee with information relating to all Serious Incidents (SIs) occurring during February 2016. The committee noted there has been an increase of one incident externally reported in February, compared to January. There has been a decrease in the number of both catastrophic and major incidents occurring in February. There are no specific patterns or issues arising within the analysis of the major/catastrophic incidents reported in February. There are currently 15 overdue actions from SIRI investigations. Duty of Candour – this has been reported on, both in the feedback from the individual investigations in section 4 and in section 7, the extract from the Contractual Duty of Candour report to commissioners. Section 7 illustrates there have been no breaches in discharging our statutory Duty of Candour reported to commissioners at the end of December 2015. The following themes have emerged from the investigations concluded in December as documented in section 4: Improvement issues identified include: • Care planning/risk history • Communication (third party/families/within teams) • Patient engagement • Training

	These themes will be communicated to staff in the 'Practice Matters Bulletin' and to the Quality Leadership Teams. The committee discussed the impact of providing a high secure service for a patient released from prison in Nottingham. An analysis of the recorded increase in violence and aggression will be completed by Emma Flanders and Richard Morrow to take into account the impact on staff and other patients and to identify any learning opportunities. In addition to this, the increased costs, mainly relating to staffing resources, has been discussed and agreed with the Commissioners. The patient has now been transferred to Rampton Secure Hospital. Maura Teager recognised on behalf of the committee, the difficulties that clinical, domestic and estates staff experienced in caring for this patient and will inform the Trust Board. Maura Teager suggested that staff affected by this case should be given time to reflect on their experience and provide their perspective, at some stage, to the Trust Board as part of the Patient/Staff story on the impact on individuals and the team. Hayley Darn offered to discuss this with Carole Gilligan the Ward Manager. The committee was pleased to note that a number of overdue actions have now been completed and that Emma Flanders is waiting for further evidence before formally closing these actions. The three high priority actions relate to one incident on Cubley Court, male and progress of these actions has been taken up with the Ward General Manager. The committee discussed the higher rate of incidents and recognised that violence and crime is often linked to substance misuse. Lengthy discussion took place around the analysis on homicides from January 2007 to December 2015, none were recorded in 2009 and 2012 and 12 recorded during the period between 2013 and 2015. One of these was a double homicide, not a Trust incident. Recommendations in the main relate to care-planning, communication with external agencies, documentation, health and safety, medicines management and "Think Family". A revised version of the terms of reference for the Mortality Group was reviewed and agreed by the Committee, subject to minor amendments. The amended version would be issued to Maura Teager and Phil Harris by Emma Flanders for final sign off. The terms of reference for the Serious Incident Group was also reviewed and agreed in principle by the committee and would be forwarded to Maura Teager and Phil Harris by Emma Flanders for formal sign off. The complications arising from electronic and paper systems in care planning was discussed and it was recognised that an effective system is required to be implemented by IT so that care planning can be assured between the two systems. It was agreed that Dave Hurn would brief Peter Charlton on the concerns of the Committee regarding the PARIS system and ask for a position paper setting out the requirements and timeline for a single patient care system or a functional workaround to be submitted to the next meeting of the committee. This issue would also be escalated to the Board to brief the Board for monitoring of this issue in line with learning from the AC female serious incident. IODEM is the independent contractor commissioned by NHS England to undertake the independent homicide investigation learning from this 2013 incident and review the Trusts monitoring and learning form this incident. The committee also discussed the need for improved information sharing with the police regarding patients who are a danger to the public and the difficulties incurred because the police consider forensic history confidential information. It was agreed that a summary of recent history be produced by John Sykes/Emma Flanders for escalation to the Board.

	Phil Harris suggested approaching the Police Crime and Commissioning Authority to resolve this issue. **ACTION: Mortality Group terms of reference and Serious Incident Group terms of reference to be forwarded to Maura Teager and Phil Harris for sign off.** **ACTION: Summary of difficulties incurred due to protected forensic information to be produced by John Sykes and Emma Flanders.** **ACTION: Hayley Darn to discuss with Carole Gilligan the possibility of staff reporting on the effects of their experience of caring for the high disturbed patient in the 136 Suite and Enhanced Care Ward.** **ACTION: Peter Charlton to provide a short position paper to the April meeting setting out the requirements and timeline for a single patient care system** **RESOLVED: The Quality Committee evaluated the report and accepted the level of assurance in the processes involved of emergent and current issues under a monitoring brief by the SIRI Group.**
QC/2016/043	**SUBSTANCE MISUSE CONCERNS** David Hurn provided a verbal update on the issues raised by the CQC regarding breaches in the safety of the healthcare provided to people who are addicted to alcohol and/or opiates. David Hurn informed the committee that he had produced a comprehensive analysis of Trust's current position in relation to Substance Misuse for each of the six issues raised by the CQC. He highlighted the main points of his analysis and informed the committee that the Trust's policies and guidelines are very clear as to the processes that should be followed and are also in line with NICE guidelines. Maura Teager requested that David Hurn's detailed CQC Substance Misuse Update be circulated to the committee. The committee was assured that the evidence contained in David Hurn's analysis found that the Trust is compliant in the safety of healthcare provided to people addicted to substances across the city and the county. **ACTION: CQC Substance Misuse Update to be circulated to the committee as an addendum to the minutes for March.** **RESOLVED: The Quality Committee noted the Trust's level of compliance within substance misuse healthcare protocols**
QC/2016/044	**TERMS OF REFERENCE FOR DRUGS AND THERAPEUTICS COMMITTEE AND MEDICINES SAFETY COMMITTEE** The Drugs and Therapeutics Committee terms of reference and the terms of reference for the Medicines Safety Committee explained the main challenges for both committees. Representation and attendance from specific groups including operational management is a problem and this matter has been escalated to TOMM (Trust Operational Management Meeting). It was agreed that capacity and representation of attendance at these committees should be discussed further with Carolyn Green and Carolyn Gilby and feedback provided to the Quality Committee.

	The Committee requested that the templates for both terms of reference be consistent in line with the corporate format and alignment to key objectives should be clarified for the accountability of both committees The Committee agreed that the Annual Report to the QC in May will include elements from the Drugs and Therapeutics Committee; the Medicines Safety Group and the Medicines Management Action Plan with confirmation on assurance; any gaps in assurance and mitigation plans. **RESOLVED: The Quality Committee reviewed the Terms of Reference and confirmed they should be amended and included as part of the Annual Report to be received in May.**
QC/2016/045	**<u>CONTROLLED DRUGS – GOVERNANCE SYSTEMS REVIEW</u>** The Chief Pharmacist's report provided the committee with information regarding governance systems relating to the Management of Controlled Drugs and highlighted any gaps / actions required. Following the results of an investigation at a West Midlands hospital Trust relating to the management of Controlled Drugs (CD), a review undertaken by the Trust's Chief Pharmacist, highlights within this report current practice / gaps / actions required relating to governance systems in place at DHCFT. Key areas of concern identified in the West Midlands Report included: • Board visibility in relation to Controlled Drug (CD) related issues and reports • Trust CD Accountable Office status and training • Trust Medicines code and training • Effectiveness of Medicines Related Committees – Drugs & Therapeutics Committee and Medicines Safety Committee (Operational Management and Medical representation and regular attendance) • Trust-Wide Shared learning of CD-related incidents • CD Trust audit work • Staff ability to challenge non-compliance with Trust Policies and Procedures / the organisation not addressing concerns • Links with external bodies – Local Intelligence Network (regional) The committee noted that the Trust's Controlled Drugs Accountable Officer is now in place. The committee considered this report as a position statement against the findings of the investigation into the management of controlled drugs arising from a national alert. Limited assurance was obtained on the findings of the report, although the committee recognised that an action plan is in place. The disconnect between controlled drugs and medicines management and drugs and therapeutics was recognised by the committee and needs to be rectified. Recommendations contained in the report indicated issues the committee will consider and how this is reported through the committee structure. It was agreed that the report and work plan will be submitted to Medicines Safety Committee. It was pointed out that the responsibility and accountability between Medicine Safety Committee and Drugs and Therapeutics Committee should be made more explicit in the terms of reference. It was agreed it will be the Quality Committee's responsibility to provide a level of assurance to the Board. The committee discussed the challenges contained in the report and confirmed that amendments made to the Terms of Reference will be received by the committee as

	part of the Annual Report due to be received in May as per previous item. **ACTION: Forward plan to show the Annual Report on Medicine Management received by the committee in May.** **RESOLVED: The Quality Committee discussed and considered the actions recommended in the report – gaps in assurance noted**
QC/2016/046	**PHYSICAL CARE COMMITTEE UPDATE** Hayley Darn's report updated the Quality Committee on recent work and progress made by the members of the Physical Care Committee and associated work streams. The report covered the following aspects of development: • Progress with NICE guidelines appraisal • Resuscitation Training update • Policies and guidelines reviewed • Clinical standards and practice development • CQUIN • Safety thermometer and harm free care The Quality Committee was aware that the Physical Care Committee has expressed concern regarding overview reports of resuscitation training and this has been escalated to the Board of ILS training. It was acknowledged that an audit of ILS training had been carried out and discrepancies had been addressed at the Urgent and Planning Care QLT in February and an early warning screening system for physical care training is being undertaken. Hayley Darn hoped this action would provide the Quality Committee with sufficient assurance in progress. However, Maura Teager acknowledged this would depend on the success of the training programme going forward. She recognised this as a gap in assurance and asked that these concerns be addressed at QLT and recommendations for improvement be brought back to the Quality Committee. The gap in assurance around the Derbyshire Early Warning System, (DEWs) vis a vis the National Early Warning System (NEWS) incorporated into ILS training and the proposed change to the national system was debated by the committee. Maura Teager sought advice from John Sykes, Medical Director, who requested that a report on the differentials with each of these EWS be urgently reconsidered by the Physical Care Committee and that a paper be prepared that will compare the Trust's guidelines with national guidelines and include associated risks and recommendations for the next meeting in April. The committee was pleased to note that the Physical Care policies are up to date and Rachel Kempster requested that Hayley Darn be aware of policies that are coming up for review. The committee was pleased to note the significant progress made with the recruitment of registered dieticians as part of the skill mix review for key clinical services. Maura Teager thanked Hayley Darn for her report. She recognised that the main focus was in adults and older people and she looked forward to the focus increasing on learning disabilities, children and young people. **ACTION: Report on early warning system for ILS training and work plan be received at the next meeting in April.** **RESOLVED: The Quality Committee:**

	1) Scrutinised and considered the contents of the report and progress made **2) Recommended that concerns regarding resuscitation training be addressed at QLT and recommendations for improvement be brought back to this Committee**
QC/2016/047	**HEALTH AND SAFETY HALF YEAR REPORT** Carrina Gaunt's report provided the members of the Quality Committee with a half yearly Health and Safety Report. The report outlined the activities and achievements in Fire, Health and Safety, Moving and Handling and Security Management for April 2015 to September 2015. The committee acknowledged this report should have been received in October and accepted Carrina Gaunt's verbal report on the status of current progress. The committee noted delivery of health and safety training and fire risks assessments was on track and there were no significant findings in fire risk assessment this year due to work carried out in 2014/15 which brought the Trust in line with regulations. It was recognised there are legislative and people elements that define how the Health and Safety Report is written and it was agreed that Carolyn Green and John Sykes will determine whether this report is to be considered by the Quality Committee or People & Culture Committee in the future. Discussion took place on why the report stated the Trust is working towards maintaining compliance with regulations. The committee agreed that the organisation should establish its level of compliance and state that compliance is in place. The committee discussed the phased move to CRIB 7 higher resistance foam mattresses in time for the Trust becoming smoke free on 9 March and the complex issues this has caused regarding the balance between the requirements for higher fire resistance and comfort for patients. **ACTION: Forward plan to be adjusted to show correct timeline of Health & Safety reporting.** **RESOLVED: The Quality Committee noted the progress reported in Health and Safety aspects within the Trust.**
QC/2016/048	**UPDATE ON RESUSCITATION TRAINING** Tracy Shaw informed the committee that compliance in ILS Training is currently 59% and additional external training will take place until the end of June in order to improve compliance. It was noted that staff who had not received ILS training had been targeted via email to book onto ILS courses. However, despite the tremendous effort to target people who have never had ILS training and the provision of extra training sessions, levels of compliance are still running below target. Maura Teager asked that Tracy Shaw provide a post meeting note that will show how many people were targeted and the results this produced. John Sykes pointed out had attended the training and he considered it was of a particularly high standard. The committee discussed whether there was a correlation between staffing levels and DNAs and accepted that some DNAs are due to clinical priorities. John Sykes was concerned that DNAs are higher than other courses and proposed to raise this issue at ELT. Tracy Shaw informed the committee she was concerned she had an overspend on the budget for training due to the requirements of the Trust to comply with the accredited level of training.

	RESOLVED: The Quality Committee received limited assurance on progress made with ILS training
QC/2016/049	**POLICIES FOR RATIFICATION** **Complaints 4Cs policy:** It was noted that the main changes to the policy were around the time frames that were added to complete complaints and investigations. The committed ratified the policy was ratified in principle in line with the small amendments noted. It was agreed that Anne Reilly would amend the policy and submit a revised version Phil Harris and Maura Teager for sign off. **Advance Decisions and Statements Policy:** Amendments were clearly highlighted in the policy. Rachel Kempster would address point 9.4 with Alex Rose and check the numbering formation. Definitions regarding power of attorney / enduring power of attorney would be clarified further in the policy and the front sheet updated. The committee agreed to ratify the policy in principle in line with the small amendments noted. A revised version would be sent to John Sykes, Maura Teager and Phil Harris for sign off. **Consent to Examination and Treatment Policy and Procedures:** The committee requested that the Gillick Competence Guide be removed and replaced with Fraser Guidelines and the policy be cross referenced with Mental Capacity Act. It was agreed that the policy will be amended and brought back to the April meeting for ratification with the changes highlighted and explanation of why changes are required. **Supervision Policy and Procedure:** The committee noted this policy had been re-written and was difficult to ratify without the author being present. Supervision is something we will be scrutinised heavily on during the upcoming CQC inspections. The committee needed to be confident that the policy covers all professional disciplines. Maura Teager felt the paragraph on safeguarding seems weak and the minimum standards of recording felt low. The policy was approved with recommendations to be considered to the safeguarding paragraph. **Seclusion and Long Term Segregation – Psychiatric Emergency Policy and Procedure:** The committee was pleased to see that changes to this policy arose from Serious Untoward Incidents and agreed to the policy being ratified. The committee considered the review of policies challenging due to the absence of authors. **RESOLVED: The Quality Committee agreed that in future, all policies received for ratification are to be presented by their author.**
QC/2016/050	**FORWARD PLAN** The forward plan would be updated in line with today's discussions and presented for reference at the next meeting of the committee. **RESOLVED: The Quality Committee received the Forward Plan for 2016/17.**
QC/2016/052	**ITEMS INCLUDED FOR INFORMATION** The following items were received and noted by the committee: • Specialist Services Quality Leadership Team draft minutes • Urgent and Planned Care Quality Leadership Team minutes

	• Quality Assurance Group Report • Patient and Carer Experience Committee Terms of Reference
QC/2016/053	**ITEMS ESCALATED TO THE BOARD OR OTHER COMMITTEES** • High number of apologies at today's meeting. • Impact of providing 'high secure' services on patient, staff and environment for an extended period of time. • The complexity and complications arising from the mix of electronic and paper systems in care planning raised in the SI report. • Improved information sharing with the police regarding patients who are a danger to the public and the difficulties incurred due to protected forensic information and history held by the police.
QC/2016/055	**EFFECTIVENESS OF THE MEETIING** Extended but relevant discussion led to an over run of the meeting. Large number of apologies meant that a number of items were deferred to future meetings.

Date and Time of next meeting: The next meeting of the Quality Committee will take place on:
Thursday, 14 April 2016 at 2.15 pm
Venue: Meeting Room 1 – Albany House, Kingsway, Derby

Appendix 1

Quality Committee CQC Substance Misuse Update

The following issues were raised by the CQC after they reported that *'seven of the first 16 inspections we have completed using this new approach, we have found problems with the safety of the healthcare provided to people who are addicted to alcohol and/or opiates'*.

Following a review of policies and procedures and clinical records where assisted withdrawal/community detoxification has been undertaken. The view of the Substance Misuse operational and clinical team is that both Derby Drug and Alcohol Service and Derbyshire Substance Misuse Service are compliant with the issues raised by the CQC. Below is the current DHcFT position in relation to Substance Misuse for each of the six issues raised by the CQC:

Providers with no written protocols in place in respect of assisted alcohol or opiate withdrawal.

DHcFT Substance Misuse Services have up-to-date policies and procedures relating to managing opiate or alcohol withdrawal within both community and inpatient (mental health) settings. These polices are compliant with the following relevant NICE and national guidance:

- Department of Health. Drug Misuse and Dependence-Guidelines on Clinical Management. London (2007).
- Royal College of General Practitioners (RCGP) Guidance for the use of methadone for the treatment of opioid dependence in primary care (July 2005).
- British Association of Psychopharmacology (BAP). Evidence based guidelines for the pharmacological management of substance misuse, addiction and co-morbidity: recommendations from BAP. Journal of Psychopharmacology 18(3) 2004.
- National Institute for Health and Clinical Excellence (NICE). Methadone and Buprenorphine for the Management of Opioid Dependence. Technology appraisal 114. November 2007
- National Treatment Agency for Substance Misuse (NTA). Drug misuse treatments and reductions in crime: Findings from the National Treatment Outcome Research Study (NTORS). Research Briefing 8; June 2005.
- Hidden harm: responding to the needs of children of problem drug users. A report by the Advisory Council for the Misuse of Drugs. London: HMSO, 2003.
- Reducing Drug Related Deaths: A report by the Advisory Council for the Misuse of Drugs. London: HMSO, 2000.

All the Substance Misuse policies have been reviewed, updated and signed off by both the Drug and Alcohol Advisory Group (internal substance misuse CRG) and the Drugs and Therapeutics Committee. These policies and procedures include:

Alcohol Detoxification Community (ADC) Guidelines for Specialist Substance Misuse Services

Staff who are not trained and competent to provide safe care to people who are undergoing assisted withdrawal.

The Substance Misuse services provided across Derby and Derbyshire are delivered in conjunction with partner organisations Phoenix Futures (Derby and Derbyshire) and Aquarius (Derby). However community detoxification for opiates or alcohol is only undertaken by DHcFT qualified and trained staff with experience in delivering these interventions and who are familiar with the relevant policies and procedures. This would meant that if a service user was under Aquarius or Phoenix Futures for their key working and psycho-social interventions they would receive their assisted withdrawal (community detoxification) from a DHcFT qualified practitioner.

There is no specific training available for staff in relation to community detoxification or assisted withdrawal. However all practitioner would be expected to shadow an experienced practitioner completing a community detox until they felt competent and competence was agreed by the prescriber. All interventions involving community pharmacological reduction plans would include discussion in supervision by both prescriber and clinical staff, review of criteria and plan for intervention discussed at MDM and a specific care plan in place to address physical and psychosocial issues.

There is no rapid detoxification undertaken and all community detoxification is undertaken following:

- Alcohol Detoxification Community (ADC) Guidelines for Specialist Substance Misuse Services
- Lofexidine Prescribing Guidelines
- Guidelines for Prescribing in Substance Misuse Services for Opioid dependence - Methadone oral solution, Buprenorphine sublingual tablets, Symptomatic detoxification and relapse prevention medication

Units where staff have failed to create an adequate care plan that addresses the potential risks for people undergoing assisted withdrawal.

Prior to community detoxification all proposed detoxes should be discussed via MDM with consultant in-put to identify any potential risks for clinical staff to discuss with service user. In-line DHcFT policies and guidance above all service users due to undertake a community detoxification will have a formal pre-detox medical review with the designated prescriber. There is evidence, in all cases, that care plans and risk assessments prior to commencement of an assisted withdrawal programme have been undertaken at that risks have been clearly documented in the medical record, alongside any risks related to physical/mental health history and any previous drug or alcohol detoxes.

Residential Inpatient Detoxification is an option available for service users where contra-indications for detox are identified and these are clearly identified in the community alcohol detox policy.

Units where staff do not make an adequate physical health assessment before a person starts assisted withdrawal and/or fail to carry out regular physical health checks to identify withdrawal symptoms.

The DHcFT Alcohol Detoxification Community (ADC) Guidelines for Specialist Substance Misuse Services states that:

All interventions for people who misuse alcohol should be delivered by appropriately trained and competent staff. Pharmacological intervention should be administered by specialist and competent staff. Staff should consider using competence frameworks.

1. *In-depth drinking history taking particular account of the patient's recent drinking pattern (see assessment sheet Appendix 1).*
2. *Does the patient experience symptoms of withdrawal? Previous experience of withdrawal. Seizures, DTs*

3. *Laboratory investigations, FBC, U&E, LFT & Clotting Screen within 4 weeks prior to assessment. Any concerns will require further discussion with the doctor/Consultant/prescriber.*
4. *Concomitant drug intake.*
5. *All patients being prescribed methadone should be discussed with Consultant Specialist prior to agreement to offer home detoxification. Those on 100mls+ a day should have an ECG.*
6. *Chlordiazepoxide should be prescribed 'on top' of any benzodiazepines the patient is already taking.*
7. *Co-existing medical/psychiatric disorders- discuss with doctor/Consultant/prescriber.*

In addition during any detoxification process within the community the following steps are taken to ensure monitoring and safety of the service user:

- *Medication is routinely dispensed in daily doses during clinicians visits*
- *All clients will be breathalysed routinely during detox.*
- *Patient/carer to be given information leaflet (appendix3) at commencement of programme. This also contains contact details.*
- *Clinical Institute Withdrawal Assessment (CIWA) (see appendix 2) is administered on each visit so symptoms of withdrawal can be monitored objectively. The clinician will be able for client contact during working hours and further arrangements made for out of hours with the client being contacted at least daily for 3-4 days.*
- *Any concerns with regard to deterioration in a patient's physical condition should be discussed with the Consultant/doctor/prescriber or be referred directly to A&E dependent on severity.*
- *The consequences of recommencement of drinking during the detox process should be considered on an individual basis. Normally this would lead to suspension of the detox.*
- *Copies of prescription sheet and CIWA to be left with the patient should this be required for use by out of hours services in the event of an emergency.*

Doctors who have prescribed medication for patients by telephone or by email when it is doubtful that the doctor has adequate knowledge of the patient's health.

All DHcFT prescribers must comply with the Medicines Code and there must be a written request for all prescribing in line with the DHcFT Guidelines for Prescribing in Substance Misuse Services for Opioid dependence - Methadone oral solution, Buprenorphine sublingual tablets, Symptomatic detoxification and relapse prevention medication.

Therefore this requires face-to-face assessment for initiation of all prescribing by the prescriber. This assessment is documented on the prescribing template on SystmOne and includes both physical and mental health issues as well as risk and drug/alcohol use.

Only exception for an initial face-to-face assessment for prescribing occurs with prison releases or hospital discharge where script continuation is required to support safety and transfer from another prescriber external to DHcFT. These requests would be confirmed in writing (letter/fax/email) by the prescribing organisation (hospital, prison healthcare/CARAT

team etc.) and included in the clinical record. Individuals transferred on prescribed medication are then booked for face-to-face review with a prescriber within 4 weeks of transfer.

Poor medicines management. This includes procedures for ordering, receipt, storage, administration and disposal of controlled drugs that are not in accordance with the Misuse of Drugs Act 1971 and its associated regulations.

None of DHcFT's Substance Misuse Services have controlled drugs on the premises. Therefore there are no compliance issues with ordering, receipt, storage, administration and disposal of controlled drugs.

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE PEOPLE & CULTURE COMMITTEE

Held in Meeting Room 2, Albany House, Kingsway, Derby DE22 3LZ

Thursday, 17 March 2016

PRESENT:	Maura Teager	Delegated Chair and Non-Executive Director
	Phil Harris	Non-Executive Director
	Jenna Davies	Interim Director of Corporate Affairs
	Dr John Sykes	Executive Medical Director
	Carolyn Gilby	Acting Director of Operations
IN ATTENDANCE:	Michele Tuttle	Personal Assistant & Minute Taker
	Rose Boulton	Principal Workforce & OD Manager
	Lee Fretwell	Staff Side Chair
	Richard Eaton	Communications Manager
APOLOGIES:	Richard Gregory	Chairman
	Jayne Storey	Director of Workforce, OD & Culture
	Liam Carrier	Workforce Systems & Information Manager
	Anna Shaw	Deputy Director of Communications
	Tracy Shaw	Training Manager
	Sue Turner	Board Secretary

P&C/2016/011	**WELCOME AND APOLOGIES** In Richard Gregory's absence the delegated chair, Maura Teager, opened the meeting and welcomed everyone. Maura Teager commented that, at the inaugural meeting, it had been agreed to invite Robert Quick to become a member of the Committee to represent Trust Governors. **ACTION: Ensure Robert Quick is invited to join the Committee**
P&C/2016/012	**MINUTES OF THE PREVIOUS MEETING, ACTION MATRIX AND MATTERS ARISING** Minutes of the meeting held on 17 February 2016 were approved. **Matters Arising:** **QC/2015/180** – Support for Employees – Rose Boulton confirmed that a list of all activity relating to employee support is reported through the Health & Safety Committee and into the Quality Committee. Staff element and metrics will be reported to the People & Culture Committee. **ACTION: Employee Support Metrics to be reported in People & Culture Committee** **Think Family** – An update report from Tracy Shaw was circulated prior to the meeting which showed training compliance was low. Maura Teager commented that it was important to note where training was not being completed. Carolyn Gilby pointed out there are sufficient places on courses for people to attend but they often

	don't turn up. This then means a high level of non-compliance at year end. Phil Harris raised concerns about the Safeguarding Children's Trainer whose two-year contract is due to expire in September 2016 and asked if this resource is the only one of its kind within the Trust. Carolyn Gilby agreed to establish the position of the Safeguarding Children's Trainer and report back to the next meeting. **ACTION: Tracy Shaw to provide update on training compliance post-meeting. Carolyn Gilby to ascertain situation with regard to Safeguarding Children's training.**
P&C/2016/013	**MINDFUL HEALTH & WELLBEING BOARD TERMS OF REFERENCE** Rose Boulton presented the terms of reference and informed the meeting that this was an existing group. However, the group had come into difficulty since May 2015 when a planned meeting was cancelled as Staff Side were unable to attend. Following discussion with Lee Fretwell, Staff Side Chair, it has now been agreed that a member of Staff Side does not need to be present for the group to be quorate. The terms of reference were discussed in detail and amendments agreed. Carolyn Gilby suggested that Tim Slater should join the group from an operational perspective and Rose Boulton agreed to contact him in this regard. The Trust's Health and Wellbeing Strategy would be updated by Rose Boulton and submitted to the committee at the June meeting. This would be reflected in the forward plan. **ACTION: Mindful Health & Wellbeing Board Terms of Reference to be updated in line with Trust standard and presented to the next meeting of the committee. The Health & Wellbeing Strategy to be updated and submitted to the committee in June and this would be reflected in the forward plan.**
P&C/2016/014	**ENGAGEMENT GROUP TERMS OF REFERENCE** The committee reviewed the Engagement Group Terms of Reference and agreed that the Engagement Group should retain its core memberships but should operate a 'surgery/drop-in approach' for staff to attend and that meetings should rotate across the Trust allowing as much visibility as possible. **ACTION: Updated Terms of Reference to be submitted to the next meeting**
P&C/2016/015	**HR METRICS** The Workforce KPI Dashboard was discussed by members of the Committee. John Sykes pointed out that he felt the Medical Staff Appraisal statistic was inaccurate. Medics are supervised by HEEM within their process. John Sykes will obtain statistics from HEEM. Rose Boulton agreed to establish doctors who took part in the appraisal process. It was noted that whilst staff turnover had remained at a steady level, the level of vacancies had increased. Carolyn Gilby commented that she had never known this figure to be so high. It was noted that the number of qualified nurses employed by the Trust is high in comparison to other Trusts. Carolyn Gilby attached a caveat to this commenting that many nurses are newly qualified and this, in itself, presents a risk to the Trust.

	Whilst the committee was happy with the format of this report, it was agreed that additional narrative would be useful to give more meaning to the statistics. Rose Boulton agreed to discuss this with Liam Carrier. Sickness and absence rates are exceptionally high and it was understood that more analysis was required in order to establish what the issues are. **AGREED: That a Deep Dive into Sickness and Absence take place at the next meeting.**
	Lee Fretwell joined the meeting at 2.45pm and introductions were made. Maura Teager brought him up to date with the discussion about sickness and absence.
P&C/2016/016	**FREEDOM TO SPEAK UP ACTION PLAN** Jenna Davies informed the meeting that the Action Plan had been updated by ELT and aligned to the GIAP. Actions have arisen out of the Staff Survey and the recent CQC inspection. Jenna Davies also informed the meeting that the NHS is looking to have one process in place across the organisation in terms of Whistleblowing and Freedom to Speak Up. The consultation ended in December and the Trust has been informed that the new process will be released imminently. The Whistleblowing Policy is legally compliant and issues are reported into the Audit Committee on a regular basis. Principle 11 – Maura Teager questioned whether there are two roles for Non-Executive Directors within this principle or just one. Jenna Davies informed Maura that within the new policy there is just one NED role, that of Speak Up Guardian. Principle 9 – The question was raised as to whether or not the Trust has sufficient mediators who are trained and accessible. It was confirmed that Julieann Trembling is trained and based at Kingsway and an external source is also used. Other people have been trained but their training is out of date and mediator training should be reviewed. John Sykes informed the committee that the GMC had provided training to the Medical Advisory Committee about raising concerns and wondered if other groups might be interested in such training. Lee Fretwell said that he would like to see open surgeries for staff wishing to raise concerns. John Sykes suggested that he and Jayne Storey discuss how this type of training would fit in with current training plans. Maura Teager asked if there were any particular areas of concern currently. Lee Fretwell responded saying that there are a lot of issues at the Radbourne Unit. Staffing levels are causing concerns as are stress and safety. Julieann Trembling is visiting the unit regularly to talk to staff on both ECW and Ward 35. Carolyn Gilby updated the Committee on the effects felt by staff who cared for a patient on ECW (Enhanced Care Ward) for a period of three weeks. This patient has since transferred to Rampton High Security but caring for this patient has understandably had an impact on staff and on the unit. Maura Teager informed the Committee that a letter is being sent to all the staff on ECW commending them for their exceptional work in caring for this patient. Maura Teager has also suggested through the Quality Committee that the team from ECW carry out a “ward to board” story in the fullness of time. John Sykes commented that it is more difficult to assess stress levels across

	community teams. The Committee considered it would be helpful to look at the caseload numbers of staff who are absent with work related stress from the community teams. Carolyn Gilby agreed to advise the Committee at the next meeting on the average caseload of the community teams and the best practice guidance regarding case load size and she would benchmark this against similar organisations. Principle 6 – A question was raised as to whether Swartz rounds were taking place as it was thought they had not been carried out recently due to capacity issues. However it was noted that this process is still a valid mechanism and it was agreed to discuss this issue at the next meeting of the committee. **ACTION: Average caseload of the community teams and the best practice guidance regarding case load size benchmarked against similar organisations to be provided by Carolyn Gilby at the April meeting.** **RESOLVED: The People & Culture Committee received and noted the information contained within the report**
P&C/2016/017	**BAF RISK** Risk 4a – this risk is the one of a fundamental loss of confidence by staff in the leadership of the organisation. Jenna Davies informed the committee that the BAF was currently in draft form and would be approved by the Board at the end of March. Work is ongoing around gaps in control. In the meantime, members of the committee could feed back comments to Jayne Storey for inclusion in the final version. Richard Eaton informed the committee that staff want to be assured that their concerns are not only listened to but actioned as well. Jenna Davies commented that Ifti Majid is communicating with staff through planned and advertised site visits to enable staff to feel more empowered. **RESOLVED: The People & Culture Committee received and noted the information within the report.**
P&C/2016/018	**2015 STAFF SURVEY** Jenna Davies presented the report which had already been discussed at the last meeting of the Council of Governors when concerns were raised about sickness levels, freedom to speak up and appraisal rates. When Maura Teager asked how the Trust compared with other organisations within the NHS she was informed that the Trust was well balanced with other mental health organisations. It was understood that it is difficult getting people to undertake the survey as staff do not believe it is a truly anonymous process. Phil Harris asked if uptake would improve if it could be completed online. It was, however, noted that it would be difficult for the survey to be anonymous if it was completed online. Carolyn Gilby commented that staff feel completing the survey is a waste of time as they don't believe it makes a difference. It was noted that the Engagement Group is to look into the results in more detail and agreed that a timeline against actions would be submitted to the next meeting of the committee. **RESOLVED: The People & Culture Committee received and noted the information within the report.**
P&C/2016/019	**OPERATIONAL UPDATE**

	Carolyn Gilby provided the committee with a verbal operational update and drew attention to the following issues: • The incident with the patient in ECW had caused significant issues and had a negative impact on staff. • Unusually, there were no female beds available in Acute or Dementia nationally at the moment. This has caused issues in the North of the region. • Staffing is a concern. The numbers of preceptors going forward is an issue. There is a need to look at the retirement profile of the workforce and feed this into the workforce plan. Lorraine Statham would liaise with the Royal Derby with regard to the work they carrying out around workforce planning, if appropriate. Carolyn Gilby also reported that MAS was going live across the Neighbourhoods over the forthcoming weekend. **RESOLVED: The People & Culture Committee received the report.**
P&C/2016/020	**GOVERNANCE IMPROVEMENT ACTION PLAN** Jenna Davies provided the committee with a verbal update on the Governance Improvement Action Plan (GIAP). The committee understood a large number of these actions in terms of culture and staff engagement, HR policies will fall to the People & Culture Committee to be addressed. An Action Plan and Delivery Framework is being reported to the Trust Board at the end of this month and once approved, it will then be available to staff. A progress report against actions will be a regular agenda item for the committee. **RESOLVED: The People & Culture Committee received and noted the Governance Improvement Action Plan.**
P&C/2016/021	**FORWARD PLAN** The forward plan would be updated in line with today's discussions and presented for reference at the next meeting of the committee.
P&C/2016/022	**ITEMS ESCALATED TO THE BOARD** The following items are to be escalated to the Trust Board meeting: - • 2015 Staff Survey • Ward to Board • Workforce Profile/Retirement
P&C/2016/023	**EFFECTIVENESS OF THE MEETING** Members of the committee felt that in order to provide more meaning behind reports, it is important for authors to be present at the meeting.
Date and Time of next meeting: The next meeting of the People & Culture Committee will take place on: **Wednesday, 20 March 2016 at 2.00 pm** ***Venue: Meeting Room 2 – Albany House, Kingsway, Derby***	

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MINUTES OF THE AUDIT COMMITTEE HELD ON WEDNESDAY, 16 MARCH, 2016 AT10.30 AM HELD IN MEETING ROOM 1, ALBANY HOUSE, KINGSWAY, DERBY DE22 3LZ

PRESENT:	Caroline Maley	Chair/Senior Independent Director
	Phil Harris	Non-Executive Director
	Tony Smith	Non-Executive Director
IN ATTENDANCE:	Ifti Majid	Acting Chief Executive
	Claire Wright	Executive Director of Finance
	Jenna Davies	Interim Director Corporate and Legal Affairs
	Alison Breadon	PricewaterhouseCoopers
	Mark Stocks	Engagement Lead Grant Thornton
	Joan Barnett	Engagement Manager Grant Thornton
	Rachel Kempster	Risk and Assurance Manager
	Sam Harrison	Director Corporate and Affairs and Trust Secretary
For items AUD 2016/02 & 028	Matthew Evans	Local Counter Fraud Specialist
	Sue Turner	Board Secretary and Minute Taker

WELCOME AND APOLOGIES

The Chair, Caroline Maley opened the meeting and welcomed everyone present.

AUD 2016/015	**MINUTES OF THE AUDIT COMMITTEE MEETING DATED 20 JANUARY 2016** The minutes of the meeting held on 20 January were accepted and approved as an accurate record of the meeting.
AUD 2016/016	**ACTION MATRIX** All updates provided by members of the committee were noted directly to the matrix.
AUD 2016/017	**GOVERNANCE IMPROVEMENT PLAN** The Governance Improvement Action Plan (GIAP) was circulated to members of the committee at the meeting. Jenna Davies informed the committee that oversight for the delivery of the GIAP programme is the responsibility of the Board, but there are a number of actions which are the responsibility of Audit Committee. Jenna Davies informed the Committee of the Governance arrangements which support the delivery of the GIAP. The GIAP will be submitted to the Board for formal approval at the end of March. Ifti Majid informed the Committee that Mark Powell will be the responsible Director for the delivery of the GIAP and will hold directors to account for their actions. Ifti Majid also noted that a Programme Manager will be appointed to support Mark Powell in holding Director leads to account for their actions. Caroline Maley highlighted action CG6 *"The Audit Committee should reaffirm its role in*

	seeking assurance over systems, controls and processes and not matters of operational or managerial detail". The committee discussed the recommendation and asked that clarity is obtained from Board on the ownership of risk within the Committee structures. .It was agreed that this action to decide what will work best for this organisation would rest with Sam Harrison when she takes up her role as Director of Corporate Affairs and Trust Secretary. **RESOLVED: The Audit Committee received the Governance Improvement Action Plan.**
AUD 2016/018	**<u>BOARD ASSURANCE FRAMEWORK</u>** This report included the first issue of the BAF for 2016/17 and the final issue of the BAF for 2015/16. The committee noted that deep dives on BAF risks were undertaken by the named responsible committee for eight of the nine risks during 2015/16. The final risk (delivery of the Commercial Strategy) remains for consideration by the Finance and Performance Committee in March 2016. However, Claire Wright pointed out that it had been agreed that the deep dive of this risk would now be closed off when the Commercial Strategy update is received by the committee at the May meeting. Caroline Maley made the point that as risk 3b Commercial Strategy is not complete and asked that evidence is provided with every action to be closed/superseded or taken across into the 2016/17 version of the BAF. Rachel Kempster informed the committee that identification of the principle risks for 2016/17 against the Trust's strategic objectives was undertaken during a Board Development Session held on 10 February when Board members identified a total of six risks along with the director responsible for each. Meetings have since taken place with individual directors and each risk has been populated with risk controls, assurances, gaps and mitigation and has been identified by a current risk rating identified. The draft BAF for 2016/17 was then reviewed and agreed by the Executive Leadership Team on 7 March. The 2016/17 BAF identifies five risks graded as high and one currently graded as moderate and reflects the current situation. A summary of these risks identified for 2016/17 was set out in the report and the committee noted that all risks have been allocated a responsible committee and actions identified. A proposed timetable of risk deep dives is being put in place and will be included in the report received by the Board on 30 March. Tony Smith highlighted the need to perform an analysis between 2015/16 and 2016/17in order to properly close off 2015/16 BAF risks. Rachel Kempster assured the committee this process would be carried out with individual directors and the narrative contained in the BAF covering report submitted to the Board in March will indicate that this exercise has taken place. **RESOLVED: The Audit Committee:** **1) Agreed this first issue of the BAF for 2016/17 and the final issue of the BAF for 2015/16.** **2) Agreed for this report to be updated following discussion at the Audit Committee and then shared with the Board in March 2016** **3) Agreed for the Audit Committee and Board to start to receive updates on the 2016/17 BAF four times a year: Audit Committee: March 2016, July 2016, October 2016, Jan 2016 and again in March 2017. Board: in March 2016.**

AUD 2016/019	**INTERNAL AND EXTERNAL AUDIT PROGRESS REPORT** This report identified progress of actions resulting from internal and external audit reports. A review of actions is undertaken on a regular basis to ensure the actions identified are completed in a timely manner and if overdue, the risks associated with the delay in completion are identified. Caroline Maley drew attention to the dates that have slipped for 2015/16 Off Payroll Procedures. Claire Wright clarified 31 March would be deliverable and assured her that revised systems and process were in place. Claire Wright also pointed out that 2015/16 HR Processes – Recruitment dates would be reviewed against dates contained in the Governance Improvement Action Plan and all these dates will be checked to ensure timeframes are deliverable. Caroline Maley queried whether 2014/15 actions shown on the schedule should be included in the narrative report that will be submitted to the committee at the next meeting. The committee reviewed the progress report and agreed the report would be submitted to the Audit Committee twice a year in March and October and this would be reflected in the forward plan. **RESOLVED: The Audit Committee received the Internal and External Audit Progress Report and agreed to do so twice a year in March and October.**
AUD 2016/020	**DRAFT ANNUAL REPORT AND AUDITED ANNUAL REPORT** Anna Shaw provided the committee with a first draft of the Annual Report. The committee recognised this first draft was incomplete and that some information will not be available until the end of March. Amendments and corrections were noted by Anna Shaw and it was agreed that a full draft will be brought to the Audit Committee on 28 April 2016 for further review. **ACTION: Full draft Annual Report to be received by the committee at the next meeting on 28 April.** **RESOLVED: The Audit Committee received the Draft Annual Report and Audited Annual Report, with thanks to Anna Shaw and all involved for the hard work done to get this into good shape in advance of the year end.**
AUD 2016/021	**DRAFT ANNUAL GOVERNANCE STATEMENT** The draft Annual Governance Statement was reviewed by the committee and minor amendments and corrections were noted by Rachel Kempster. The committee considered the draft Annual Governance Statement. Jenna Davies noted that a lot of work had been completed on the Annual Governance Statement to ensure it was balanced in terms of corporate and clinical governance. Rachel Kempster explained that major risks have been included at year-end which is different to the way this has been done before and identified gaps in controls have been taken from the Deloitte and CQC findings which mirror the risks contained in the BAF.

	ACTION: Revised draft Annual Governance Statement to be received by the committee at the next meeting on 28 April. **RESOLVED: The Audit Committee reviewed the Draft Annual Governance Statement with thanks for the hard work done to get this into good shape in advance of the year end.**
AUD 2016/022	**REVIEW OF ASSURANCES FROM OTHER COMMITTEES** The Board Committee Assurance Summary was reviewed by the committee. Lack of assurance with training was observed and would be addressed through the People and Culture Committee. Gaps in assurance and the escalation of gaps was observed with other committees and it was noted these gaps represented risks and are not reflected as operational risks in the BAF. It was recognised that this report was an interim step in providing the Audit Committee with assurance of the effectiveness of each committee. It was agreed that Sam Harrison, Director of Corporate Affairs and Trust Secretary would develop this process further when she takes up her appointment in April. **RESOLVED: The Audit Committee discussed and noted the Board Committee Assurance Summary.**
AUD 2016/023	**EXCEPTION REPORTING** The committee was assured there were no exceptions to report on Losses and Compensations, Hospitality and Sponsorship or Debtors and Creditors.
AUD 2016/024	**INTERNAL AUDIT** **Internal Audit Progress Report:** This report provided an update on internal audit progress and activity since the last meeting of the committee and focussed on the final status of each audit undertaken in the 2015/16 audit plan. Appendix 2 provided a good update on sectors and publications. Alison Breadon indicated that the likely internal audit opinion which the committee will receive in April is: Governance, risk management and control in relation to business critical areas is generally satisfactory. However, there are some areas of weakness and non-compliance in the framework of governance, risk management and control which potentially put the achievement of objectives at risk. The committee accepted that some improvements are required in those areas to enhance the adequacy and effectiveness of the framework of governance, risk management and control. **Internal Audit Risk Assessment and Plan 2016/17:** The plan set out the Trust's risk assessment and internal audit plan for the period up to 30 November 2016 and was linked through to the BAF risks as at March 2016. The Audit Committee approved the draft plan and indicative timeline and declared that any further changes will be authorised through the committee. It was agreed that a tighter narrative on the corporate objectives and risks would be included in the next report and key financial systems for 2016/17 would also be included. **Mental Capacity Act Action Plan:** PwC's review of the action plan had been conducted

	in relation to the planned review of capacity and consent forms. The committee understood the new forms need to be implemented and embedded into practice within the Trust before their effectiveness can be evaluated and that a review of the new forms would be undertaken with the Medical Director and Clinical or Internal Audit during 2016/17. Tony Smith confirmed this was contained within the Mental Health Act Committee's work programme and would be addressed at the next meeting of the committee on 30 March. **Information Governance:** The committee noted this report showed the Trust had retained its IG status as low risk which was the same classification which took place in 2012/13 review and considered this to be a good piece of work. **Data Quality – Waiting Times:** This report tested the accuracy of indicators for data between 1 April and 31 December 2015. **Transformation – Phase Two:** The committee agreed the findings of the report showed this work had moved on positively. **Follow up of recommendations:** This report looked at recommendations due and showed good progress had been made. **RESOLVED: The Audit Committee agreed the PwC reports showed a respectable completion of the Internal Audit 2015/16.**
AUD 2016/025	**EXTERNAL AUDIT** The External Audit report provided the committee with an update on progress in delivering external audit responsibilities. The report included emerging national issues, developments and also confirmed progress against the plan which was on track. The committee noted that a report on benchmarking would be submitted to the next meeting on 26 April. It was noted that the Key Performance Indicators; and Annual Report Benchmarked reviews would be distributed to the committee on behalf of Joan Barnett outside of the meeting. Mark Stocks ran through the value for money audit plan and guidance and confirmed that they will review the Trust as the audited body to confirm that it had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes. The results of the Value for Money Audit and key messages arising will be reported in the External Audit Findings Report. They are required to report by exception where they are not satisfied that NHS bodies have proper arrangements in place to secure value for money. The committee noted that on site audit work and the work plan had been discussed and agreed with Claire Wright and the finance team and meetings are being held with Trust staff to produce the Annual Report. **RESOLVED: The Audit Committee received good evidence of External Audit progress.**
AUD 2016/026	**CLINICAL AUDIT** This report was originally reviewed by the Quality Committee and provided an update on the activity of the Trust's Research & Development Centre rather than clinical audit. Tony Smith informed the Audit Committee that the Quality Committee received partial assurance

	on the activity undertaken as part of the Trust's R&D Strategy and contribution to the Trust's strategic outcomes and priorities. Discussions took place on the lack of dedicated resources within the divisions for undertaking clinical audits and that the level of resources in the Trust is low compared to the volume of projects managed and outcomes achieved with other Trusts. It was noted that as additional resources are unlikely to be available, the clinical audit maturity matrix will define and identify objectives of clinical audit and decisions to be made in the future. The committee had reservations around the capacity of clinical audit team to deliver the clinical audit and agreed to escalate this matter to the Board. The committee also agreed the focus area for the Audit Committee should be the processes and systems of clinical audit and not the programme of assurance on clinical audit. **RESOLVED: The Audit Committee did not obtain assurance from the activity contained in the report and was not assured that research and development is making a positive impact on delivery of the Trust's strategic outcomes and the areas of further development proposed.**
AUD 2016/027	**<u>COUNTER FRAUD REPORT</u>** This report was prepared to provide the committee with assurance regarding the Trust's Counter Fraud, bribery and corruption arrangements and 360 Assurance Counter Fraud Service's performance. This draft annual report detailed the activities undertaken and showed that proactive and reactive work had been undertaken during 2015/16 in accordance with the approved annual work plan and the Trust has maintained compliance with the NHS Protect requirements throughout the course of the year. Reporting lines in relation to counter fraud, bribery and corruption work at the Trust were detailed, as well as compliance with the 2015/16 provider standards, as self-assessed and submitted to NHS Protect in May 2016. The committee noted the good practice and progress made in the investigations and the use of first case management system. Timelines were made clear in the report and it was noted that the final report will be received by the committee in May. **ACTION: Final Counter Fraud Annual Report to be received by the Committee in May.** **RESOLVED: The Audit Committee** **1) Received assurance that the Trust's counter fraud, bribery and corruption arrangements are embedded.** **2) Received assurance that there is a strong anti-fraud, bribery and corruption culture within the Trust and that Counter Fraud service delivered by 360 Assurance (as positively commented upon by NHS Protect in their inspections) is efficient and effective.**
AUD 2016/028	**<u>2016/17 FRAUD, BRIBERY AND CORRUPTION RISK ASSESSMENT AND WORK PLAN</u>** The Operational Work Plan 2016/17 has been approved by the Executive Director of Finance and set out the arrangements for counter fraud, bribery and corruption developed within the resources determined to be available by the Trust. It was noted that an apportioned plan is provided for the period 1 April 2016 to 30 November 2016 since the current extension to contract with 360 Assurance for the provision of Counter Fraud

	services is due to expire. It was pointed out that the risk assessment and work plan includes the 44 days which has been taken as pro rata in accordance with the tasks and objectives as agreed with Claire Wright as follows: Strategic Governance - 13 days Inform & Involve – 12 days Prevent & Deter – 17 days Hold to Account – 2 days **RESOLVED: The Audit Committee agreed the Fraud, Bribery and Corruption Risk Assessment and Operational Work Plan 2016/17.**
AUD 2016/029	**AUDIT COMMITTEE SELF ASSESSMENT** Alison Breadon provided the committee with a verbal summary of the self-assessment discussion held with the Chair prior to the meeting taking place. Alison Breadon explained that Caroline Maley was asked as Chair of the Committee to answer questions around Audit Committee effectiveness and her answers were compared with other Audit Committee Chairs. The members of the committee and the executive were also asked to complete an effectiveness questionnaire out of which several actions have been agreed. Areas discussed were the relationship between Audit Committee and Council of Governors and the interpretation of the "governing body" in the questionnaires, where it has been interpreted both as the Board and as the Council of Governors. A number of actions were agreed going forward on how to liaise with the Council of Governors which included potential representation by Council at May Audit Committee meeting to discuss the annual report. Discussions would also take place with governors on the progress of each Board committee and its workload and priorities for last 12 months, once the annual reports have been received from the other committees. Discussion with governors would also take place around the involvement of sub-committees and the right representation of individuals on the sub-committees to achieve more detailed and open discussions. Caroline Maley pointed out that an outstanding action remained from last year and involved the approval of a policy for external audit to approve other work. Mark Stocks informed the committee that Grant Thornton have recently reviewed such a policy will forward an anonymised version to Claire Wright to enable her to put in place a policy which the Audit Committee would approve. **ACTION: Claire Wright to receive an anonymised version of a policy on external audit to approve other work from Grant Thornton and put in place a policy which the Audit Committee would approve.** **RESOLVED: The Audit Committee noted the verbal summary of the committee's self-assessment undertaken by the Chair.**
AUD 2016/030	**RE-PROCUREMENT OF INTERNAL AUDIT AND COUNTER FRAUD SERVICES** The current Internal Audit Services contract and Local Counter Fraud, Corruption and Bribery Services contract are due to expire at the end of November 2016, and this report contained recommendations on the way forward in re-procuring these services.

	The committee discussed the options related to the tender process. It was agreed that a risk based audit approach will be taken for re-procuring these services and Claire Wright will inform the committee of the timeline for this process outside of the meeting. **ACTION: Claire Wright to provide the timeline for the off-framework process for re-procurement.** **RESOLVED: The Audit Committee:** **1) Discussed the options related to the tender process for Internal Audit and Local Counter Fraud, Corruption and Bribery service provisions.** **2) Agreed the recommendation contained in the report for re-procurement; which is to re-procure suppliers off-framework using a mini competition as opposed to full open tender.**
AUD 2016/031	**REVIEW OF FORWARD PLAN** The Chair requested that the committee had a single point of support for formulating the forward plan and it was agreed that Jenna Davies will provide a new version of the forward plan at the next meeting in April. **ACTION: Jenna Davies to formulate the forward plan for 2016/17 for submission at the next meeting in April.**
AUD 2016/032	**MATTERS TO BE ESCALATED TO THE BOARD** The Quality Committee and Audit Committee are not assured that research and development is making a positive impact on the delivery of the Trust's strategic outcomes and the areas of further development proposed. The Audit Committee will escalate to the Board the need for a deep dive into systems and process of clinical audit that the Audit Committee has a lack of assurance on.
AUD 2016/034	**CLOSURE OF THE MEETING** This was Tony Smith's last attendance at the Audit Committee and the Chair thanked him for his service over the years. Until a replacement Non-Executive Director is appointed, Jim Dixon has been asked to attend Audit Committee meetings in the interim although he is unable to attend the May meeting. The Chair thanked all those present for their attention and attendance and closed the meeting at 1:10pm. **Date of next meeting:** Thursday, 28 April at 10:30am. Venue: Meeting Room 1 – Albany House, Kingsway, Derby DE22 3LZ.

MINUTES OF THE EXTRAORDINARY INTERIM MEETING OF MENTAL HEALTH ACT COMMITTEE MEETING HELD ON WEDNESDAY, 30 MARCH 2016 CONFERENCE ROOMS A&B, RESEARCH & DEVELOPMENT CENTRE, KINGSWAY, DERBY

PRESENT:	Richard Gregory	Chair
	Maura Teager	Non-Executive Director
	Dr John Sykes	Medical Director
	Jenna Davies	Interim Director of Corporate and Legal Affairs
IN ATTENDANCE:	Sue Turner	Board Secretary and Minute Taker

MHA 2016/001	**OPENING REMARKS** Due to the resignation of the previous Chair, Tony Smith, the meeting was chaired by the Trust's Interim Chairman, Richard Gregory. This extraordinary and interim meeting was held to replace the cancelled meeting of 28 February and was attended by the Committee's Executive Directors and Non-Executive Directors only. The purpose of the meeting was to progress outstanding actions and discuss the way forward of the Committee.
MHA 2016/002	**MINUTES FOM THE MEETING HELD ON 27 NOVEMBER 2015** The minutes of the meeting held on 27 November were agreed and accepted.
MHA 2015/003	**MATTERS ARISING FROM THE ACTIONS MATRIX AND THE MINUTES** The Committee agreed to close all completed actions and updates were provided by members of the Committee and were noted directly to the matrix.
MHA 2015/004	**MENTAL HEALTH ACT COMMITTEE REPORT** Christine Henson's report provided the Committee with a quarterly admissions update covering the period 1 October to 31 December 2015. It was noted that the appropriate use of Section 5(2) and the increase of informal admissions was discussed at the previous meeting. Feedback obtained from Griff Jones suggests the Trust is not an outlier and John Sykes agreed to ask Griff Jones to provide further detail at the next meeting. Concern was raised regarding the current lack of routine exception reporting for patients who are secluded and it was agreed that John Sykes will improve and formalise the process for exception reporting. John Sykes would also ask Christine Henson to include a narrative in the next report that will explain why an informal patient was held in seclusion. **ACTION: John Sykes to ask Griff Jones to provide update section 5(2)s at the next meeting.** **ACTION: Christine Henson to provide narrative covering exceptions in future reports.** **ACTION: John Sykes to formalise a process for exception reporting with Christine Henson re seclusion. Narrative to explain reason why informal patient was held in seclusion to be included in next report.**

	RESOLVED: The Mental Health Act Committee received and noted the Mental Health Act Committee Report 1 October to 31 December 2015.
MHA 2015/005	**APPROVED CLINICIAN STATUS OF DOCTORS** PwC recently carried out an audit on the Approved Clinician Status of Doctors and their report to the Audit Committee recommended that the Trust enhanced its system for scrutiny. This matter was transferred to Mental Health Act Committee to ensure all doctors carry the required approval and that this information is recorded on the register for approved clinicians. John Sykes explained the process currently in place for scrutiny of Section 12 approved doctors which he considered to be satisfactory. In addition, the Mental Health Act Office believe there is already an adequate procedure in place and do not have the capacity to carry out further scrutiny. The process is linked into the PARIS system and is also combined with a check carried out by HR. The Committee agreed John Sykes would discuss the fail safe systems held in place by the Mental Health Act Office with PwC. He would also ask PwC for clarification on the red status of additional management actions shown in their report. **ACTION: John Sykes will discuss the Trust's fail safe scrutiny of Section 12 approved doctors with PwC. He would also check the "red status" of additional management actions contained in their report.** **RESOLVED: The Mental Health Act Committee noted the process for scrutinising the approved status of Section 12 doctors.**
MHA 2015/006	**POSITIVE AND SAFE STRATEGY** This report provided the Mental Health Act Committee with a position statement of progress of the reducing restrictive interventions action plan. The action plan is in response to the national drivers and The Mental Health Act (1983) Revised Code of Practice (2015). This report was received by the Quality Committee in February and submitted to the Mental Health Act Committee due to issues regarding non-compliance around care planning. The Committee scrutinised the action plan developed in response to the strategy and agreed this will be monitored by the Quality Committee. The Committee noted that the Seclusion Policy has recently been updated in line with the revised Code of Conduct and would be aligned to the Quality Committee for review and ratification rather than the Mental Health Act Committee. It was noted that the Conveyance Policy is due to be ratified but has been delayed because of complications with people who are cared for out of area and the need for an out of hours ambulance service. The Committee agreed that John Sykes would obtain clarification on the status of this policy and arrange for the policy to be reviewed at the next meeting. **ACTION: Status of Conveyance Policy to be clarified and reviewed at next meeting. Seclusion Policy to be aligned to the Quality Committee for review and ratification.** **RESOLVED: The Mental Health Act Committee considered and scrutinised the contents of the Positive and Safe Strategy and action plan.**
MHA 2015/007	**CONSENT TO TREATMENT POLICY** The Consent to Treatment Policy was ratified by the Committee. However, it was agreed

	that the recent ruling on young person age limits would be checked and clarified in the policy by Jenna Davies. The Committee requested that all policies carry an expanded narrative explaining the reason for policy being produced. **ACTION: Recent ruling on young person age limits to be checked and clarified in the policy by Jenna Davies.** **ACTION: All policies to include an expanded narrative to explain the reason for the policy being produced.** **RESOLVED: The Mental Health Act Committee ratified the Consent to Treatment Policy.**
MHA 2015/008	**SECTION 17 LEAVE POLICY AND PROCEDURE** The Section 17 Leave Policy and Procedure was ratified by the Committee on the understanding that it would be amended to show John Sykes as the sponsor. **ACTION: Policy to be amended to show John Sykes as the sponsor.** **RESOLVED: The Mental Health Act Committee ratified the Section 17 Leave Policy and Procedure**
MHA 2015/009	**MHA 1983 PROCEDURE FOR MANAGERS HEARINGS POLICY AND PROCEDURE** The Mental Health Act 1983 Procedure for Managers Hearings Policy and Procedure was reviewed and ratified by the Committee as it was due for renewal, subject to the policy being amended to show John Sykes as the sponsor. **ACTION: Policy to be amended to show John Sykes as the sponsor.** **RESOLVED: The Mental Health Act Committee ratified the Mental Health Act 1983 Procedure for Managers Hearings Policy and Procedure**
MHA 2015/010	**FORWARD PLAN** The Chair asked that forward plan be populated with additional items by John Sykes and that CQC Action Plans would be included as an agenda item for the next meeting. **ACTION: Forward Plan to be reviewed and updated by John Sykes. CQC Action plans will be an agenda item for the next meeting.** **RESOLVED: The Mental Health Act Committee reviewed the Forward Plan.**
MHA 2015/011	**ISSUES ESCALATED TO BOARD, AUDIT COMMITTEE OR OTHER BOARD COMMITTEES** No issues were escalated.
MHA 2015/012	**MEETING EFFECTIVENESS** The Committee made progress on closing actions and the ratification of policies and agreed that a further interim meeting would be scheduled to take place held at the end of April.

DATE OF NEXT MEETING

Friday, 3 June, 2016 at 10.00am, Meeting Room 1, Albany House, Kingsway site.

If you are unable to attend, please advise your apologies to Sue Turner, Board Secretary, extension 31203, for recording in the minutes.

Board Committee Summary Report to Trust Board
Quality Committee - meeting held on 14 April 2016

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Serious Incident Report	Information relating to SI's during March 16. 2 less incidents reported during 15/16, compared to 14/15. 3 externally reported incidents in March 16.	No actions resulting from SI's now overdue for completion. Review of community suicides from 2011, results show no significant changes and findings in line with national trends.	None identified.	Audit of actions welcomed, requested to be repeated in 6 months and reported to QC.	None
Section 28 Report	Number of inquests and level of Trust involvement during 15/16. Included projections for 16/17.	Low number of Regulation 28 reports in comparison in other Trusts, from Coroners provides some independent verification that the Trust is learning from deaths. Support provided well by line managers and legal staff.	Capacity, particularly of consultants and CPN's to both prepare for and attend inquests. Also on corporate staff to support process.	Report supported.	Positive report. Capacity issues.
Governance Improvement Action Plan	Arrangements by which GIAP is implemented and delivered. Role of QC with respect to actions for which is has oversight.	QC to ensure and be assured that actions for which they have oversight are completed within required timescales.	None currently identified. Reported as 'on track' for all 6 actions identified.	Evidence presented and signed as reflecting required actions. Quality Governance Group TOR planned for May 16 QC. QLT forward plan process to be implemented by 30/04/2016.	None at this stage.
Risk Escalation Report	Summary of current high level strategic and operational risks.	Assurance received of the process for reviewing and updating high level risks	5 of 6 strategic risks currently graded as high. Lack of community	Provide report to QC every 2 months.	Risk escalation through Board and Board Committees already in

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
			paediatricians has moved from a high to an extreme risk.		place.
Clinical Audit and Research and Development Governance	Update on the status of clinical audit projects and engagement with R&D Governance Committee.	Increased level of assurance on completion of audits and strengthened by the engagement with QLT's.	Attendance R&D Governance Committee remains adequate. RR to ask for interested individuals and also University contacts.	Report supported.	Positive progress with the completion and signing off of clinical audit projects.
Staff Friends and Family Test	Results of most recent Family and Friends test	Limited assurance on the impact of staff morale on the quality of clinical care.	Significant reduction in staff morale and confidence in being able to deliver safe services.	Work with People and Culture Committee to ensure effective workplan to address issues, specifically around management training support. Communication plan led by ELT.	Significant concerns regarding feedback comments from staff and level of distress being raised.
Update Report on Chesterfield Central Neighbourhood Team	Verbal - Follow up report detailing audit of case notes at St Marys Gate	Care plans, risk assessment and family and carers information well completed.	None identified. Reassurance that case notes standards being adhered to. However concerns that doctors still recording in paper records.	Skill mix review to be undertaken. Further assurance paper to be received May 16.	Concern that doctors not recording on EPR.
Quality Account	Presentation of first draft of Quality Report for 2015/16.	Assurance received that report accurately reflects papers and discussion undertaken by QC throughout 15/16 and in quality position statement reporting to Board.	Risk and challenges detailed in report	Request to add further detail on safer staffing and our mitigations. Action required to increase the uptake of flu vaccination.	Report to Board June 16. Consider incentivising uptake of flu vaccine

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Managing Frailty	Overview of content and objectives in relation to new e-learning to support the identification of 'frailty' as a clinical syndrome.	Positive assurance to support new neighbourhood model	None	Communications to promote update of training. To be added to ESR training directory.	None
Interim Policy Governance Report	Summary of overall position in relation to review and update of policies. Request amendment to policy to allow controlled extension to review date of some policies.	Positive assurance on timeliness of review of policies, up from 58% Mar 14, to 94% Mar16. Agreed to process for allowing controlled extensions to review dates.	Remaining gaps in control of review and update of policies	Agreed for amendment to policy on policy documents	Positive assurance on timeliness of review of policies, up from 58% Mar 14, to 94% Mar16.
NICE Guidelines Report	Update on progress to improve systems and processes for monitoring effectiveness of NICE guideline implementation	Steady progress. Move toward information held on a single Connect page being progressed.	Still considerable work to be undertaken to complete gap analysis of all relevant NICE guidelines	Continued support of approach.	Considerable work still to be completed. Projected timescale of at least 6 – 9 months to achieve.
Single Patient Care System	Verbal – Plans to allow access between systems, rather than developing a single EPR for the Trust.	Looking at allowing clinicians access to be able to see information on other systems through integrated systems. In effect a 'looking glass' into other systems.	At least a 6 month lead in to develop the technical and cross organisational solution.	Approach supported. Formal report to be received by QC May 16.	None.
Improvements to Data Quality in Intelligence Monitoring	Verbal – Identifies: employment rates for people with mental health conditions; death rates for detained patients are	Recruiting AHP lead to support employment. Suicide strategy and safety	Still level 4 (low risk)	QC supported accuracy of intelligent monitoring report data and actions taken against indicators that have increased.	None

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
	showing as 'moderate'.	plans to impact			
Annual Infection Control Report	Summarises infection control activity during 15/16.	Performance across the range of infection control standards remain consistent.	Flu vaccine uptake.	Raise issue of flu vaccine uptake with People and Culture Committee.	Report to go to Board. Consider incentivising uptake of flu vaccine
Violence and Aggression Prevention and Management Policy and Procedure	Policy has been reviewed in line with national and local requirements and best practice. Considerable rewrite.	For early consideration by QC prior to ratification next month.	NA	Planning to ratify May 2016	None
CQUIN Agreements	Received for information	Meets requirement to be reviewed throughout the year	Flu vaccine uptake	To be scheduled on the forward plan	None
Nicotine Management Policy	For formal approval	Agreed	None	Approved	None

Board Committee Summary Report to Trust Board
Safeguarding Committee - meeting held on 15 April 2016

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
The Voice of Those With Lived Experience	How it feels to be a victim of abuse and what helps Advice on the trust what to do? Patient experience of our services	The voice of the community on the Trust clinical service.	Developing our staff knowledge on their assessments?	Carolyn Green to meet with Derbyshire Rose and look at PODCASTS to talk about asking the abuse questions and education on the dark net.	None
SAFEGUARDING ADULTS					
Safeguarding Adults Strategy	Received and ratified	Assured	Appointment of the named Safeguarding Doctor.	Agreed	None
Update Report on Safeguarding Adults Training Report and RAP	Received and ratified	Assurance received	Continued uptake of PREVENT and CHANNEL training. Review of Bank training in this area and confirmation of adequacy.	Information received	None
Update on Bullying and Harassment Training	Not provided due to apologies	Not received			None
Goddard Enquiry	A verbal	Partial assurance, awaiting action based upon a gap	Effective management of	Agreed for gap analysis report	Escalation

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Presentation	presentation	analysis next time,	independent enquiry	in August	
Aston Hall Update	CG provided a update report	Information received and assurance on active support and intervention Appointment of a clinical psychologist	The significant impact on the wellbeing of staff receiving calls and emotional impact of significant abuse	Information received.	None
SAFEGUARDING CHILDREN					
Safeguarding Children Strategy Update	Strategy discussed and reviewed	Accepted	None	Ratified and agreed	None
Safeguarding Children Work Plan	Work plan received and accepted	An agreed work plan was ratified subject to additional measures of success and adopting committee level method of RAG rating	Measurable outcomes and process criteria	To make revisions on measures and update on all exceptions	None
Safeguarding Children Audit Plan 2016/17	Audit plan received and accepted	Accepted and agreed	Ensuring the R&D governance meeting occurs to ratify. John Sykes	Ratified and agreed	None
CAMHS Service Development Presentation	Was presented, the impact on children and young people. The CAMHS RISE was presented to the Midlands Cabinet visit	Accepted and agreed Very positive immediate impact. Positive implementation of self-harm effective	None	Information received	None
Safeguarding Children Referrals	Verbal report given on clinical	Gap in assurance on newly agreed protocol	Staff not filling in referral forms, and copying them to assure that the quality of	Risk agreed, to meet the protocols	None

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
	performance. Copies of referrals from the local authority	Audit to mitigate.	referrals are high and no gaps.		
Safeguarding Children Training Update	Report received and accepted	Full Assurance on Level 1 and Level 2 training. Additional Level 3 training.	Bank staff. Review of Bank training in this area and confirmation of adequacy.	For CCG Designated nurse to review adequacy.	None
Marker of Good Practice	Verbal report	Assured on progress	None	Information received	None
CQC Safeguarding Children Action Plans	Report received and accepted Verbal report on Derby City community waiting list.	Limited assurance on 1 recommendation	The capacity of community teams to allocate a care co-ordinator to patients	Escalate to Board Addition to BAF of this key risk. Add to DATIX as risk	Significant risks, escalate current risks
Serious Case Reviews	KN15 update. ADS15 update ADS14	Report progress and early management of recommendations Escalation of the court case and findings. Limited trust involvement.	The ability to proactively and clinically manage safeguarding incidents.		None Escalate to confidential Board
Assessment of child sexual abuse in the family	Deferred to the next meeting				None

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
network					
Personal Relationships Policy	Not presented for next period				None
Managing Safeguarding Allegations Against Staff Policy & Procedure	Not presented for next period				None
Forward Plan **Meeting dates 2016/17**	Agreed and ratified				None
Any Other Business	None				None
Meeting Effectiveness	Revisit report front sheets, specific focus and ensuring board assurance. Constructive challenge. Absence of some key attendees.				None

Board Committee Summary Report to Trust Board
People & Culture Committee - meeting held on 20 April 2016

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Governance Improvement Action Plan	Key areas from the GIAP appropriate to the PC&C The two 'red' actions and challenged the 'completed' (blue) actions Expectations on the Committee on the GIAP actions 39 specific actions from GIAP for oversight of the PC&C	Overall progress recognised Resource Plan - some issues / amber with a narrative to support Lack of assurance on numbers of resources / or length of time for contracts Positive assurance on HR effectiveness metrics	Timing of completion of the People Strategy (GIAP) v Trust strategy Internal functional metrics ahead of model for HR (recognised to be refined by June) 6-month contracts may be insufficient to enable the plan to be delivered	Review resource plan to ensure impact in 2 months Resource plan to be re-visited at next ELT including length of term (1 years) GIAP to go back to PC&C quarterly back to the PC&C – go through line by line – June Develop metrics in line with HR model	
PC4 People Strategy Approach and Supporting People Plan	Discussed and agreed approach to strategy and approach to the people plan Discussion on values and whether they should be refreshed / start again	Assurance on progress People plan off-track for end of April, recognised progress People Strategy – June	Credibility of existing Values Capacity to deliver plan	People plan to be completed and on forward plan for May Survey monkey approach on 'values' And application of values Podcast - share the dilemma should we review values / not - bottom up approach – honesty about context Create an On-line mechanism to support staff surgeries	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
				Share / involve with as many teams – governors re. strategy / plan	
W1 Freedom to Speak Up Policy and Action Plan	Discussion re existing plan and the need to revise in light of national policy	Positive assurance on there is a policy in place whilst review takes place	None	SH/JSt to update plan in light of national policy and share action plan asap – for forward plan	
FF1 Fit & Proper Internal Process	Check list confirmed To be managed by HR To be signed off by RH	Positive assurance	Delay in DBS returns	SH to complete for RG sign off - 31 May	None
CQC 2 Operational Recruitment Plan	Options presented to improve recruitment processes (possible bursary options - apprentices)	Assured on 'ideas' Partial assurance on impact	Job evaluation process – back log identified DBS – speed of processing HR capacity	Accept proposals to take forward Prioritise Recruitment Policy to review Positive communication re. actions to be taken and positive impact for staff To be agreed at TOMM - appropriate minute to be circulated to PC&C JSt to discuss with HR team Impact on recruitment team – re resources needed to implement operational plan	None

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
HR 2 & 5 Exception Reports	See GIAP above				None
2015 Staff Survey Action Plan and Timeline	Staff survey – communication – ensure that owned by all Consideration of how do we drive participation	Positive assurance on plan in progress	Patient focussed actions to be completed with the assistance of Nursing Directorate	Staff survey action plan to be completed for Annual report / public board Engagement Group to focus on participation/completion of actions / next year's approach Demonstrate partnership with staff side	None
HR Metrics	Recognised the refined metrics	Positive assurance	None	Develop further to triangulate with other data available	None
Operational Update					None
Research & Development Strategy Update	Offer of management training in compassion - train the trainer R&D offered research into leadership styles / behaviours		Does it complement the core management training needs	Jst to meet with PG to understand more how the 'compassionate model could complement the leadership development offering	None
Workforce Plan	Approach to the workforce plan - timeline and activities	Positive assurance on project plan	Risk to future workforce through the impact of tenders Retirements	Consider tenders and impact within the planning	None

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Updated Engagement Group ToR	Discussed revised TOR	Positive assurance	Nil	Incorporate minor amends – invite governor to join the group Clarity on attendees	None
Updated Mindful, Health and Wellbeing Group ToR	Discussed revised TOR	Positive assurance	Nil	First meeting to be scheduled and held within 4 weeks Clarity on attendees	None
Education, Training and Development Group ToR	Discussed revised TOR	Positive assurance	Nil	First meeting to be scheduled and held within 4 weeks Clarity on attendees	None
Sickness and Absence Deep Dive	Paper and data submitted – c/f to next agenda				None
Reinstating Schwartz Rounds	Value v resources to maintain			Task the Mindful, health and well-being group to re-visit and integrate into health and wellbeing strategy and plan if viable option	None
Any Other Business	Recognised the need to add an addendum onto the existing appraisal policy re. nurse validation until policy is reviewed and revalidation process integrated			Add appendix onto existing policy - share with JNCC/Policy group	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Forward Plan	Captured within minutes				
Items Escalated to the Board or other Committees	Nil				
Identified Risks	Resources / capacity Length of time resources are contracted for				
Meeting Effectiveness	Recognised busy agenda - but important one Good healthy debate				

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 27 April 2016

Quality Position Statement

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

Executive Summary

This position statement sets out:

Work we are doing to improve safety in our environments with the introduction of new training between our organisation and the police.

Our Safeguarding Adults & Families in our Trust 2016 to 2019 Strategy.

An update on our preparation work for our planned inspection which will take place in June by the Care Quality Commission.

Our commissioning for quality and innovation agreements 2016/17.

Strategic considerations

The wider work with the police in providing this joint training.
The commissioning for quality and innovation agreements as part of our monies to secure within our contract agreements.
Our preparation work for our planned inspection in June.

(Board) Assurances

Assurance from our work to improve safety through improvements in training and our work throughout the year on infection control.

Assurance from the strategy that underpins all our work on safeguarding provides.

Assurance that we are involving and informing our staff on what to expect during our planned inspection week.

Consultation

This paper has not been previously presented.

Governance or Legal issues

Evidence of our compliance with the Health and Social Care Act 2008 (Regulation activities) regulations 2014 Part 3 and Care Quality Commission (Registration) Regulations 2009 (Part 4)

Equality Delivery System
Any impacts or potential impacts on equality have been considered as part of all our quality work.

Recommendations

The Board of Directors is requested to:

1) Receive this quality position statement and note that the infection control annual report will be presented in May in line with the code of practice requirements.
2) Note the safeguarding adults and families in our trust strategy provided for information.

Report prepared by: **Clare Grainger**
Head of Quality and Performance

Report presented by: **Carolyn Green**
Executive Director of Nursing and Patient Experience

QUALITY POSITION STATEMENT
APRIL 2016

1. SAFE SERVICES

1.1 Infection Control

At the meeting of the Quality Committee on 14th April 2016 the annual infection control report was presented. The Code of Practice: Prevention and Control of Healthcare Associated Infections (2010) provides the framework for the standards we are required to achieve, and this report details the actions and on-going work which underpins the achievement of this. The Chief Executive holds the responsibility for overall standards; however the Trust is required to designate a Director lead for Infection Prevention & Control (DIPC), Carolyn Green - Executive Director of Nursing & Patient Experience. Some of the key achievements of 2015/16 include:

- Continued investment in the capital programme has seen sustained improvement in the care environment in a number of locations, through a dedicated capital expenditure allocation for Infection Control.
- The Infection Control team have been involved in the planning of the new of the seclusion suite at Radbourne Unit.
- Continued delivery of a training programme for those clinical and support staff who are identified as requiring the training.
- Surveillance of healthcare associated infections (HCAI alert organisms) have seen no cases of MRSA bacteraemia between April 2015 – March 2016 (0 reported in 2014/15) and 0 cases of *Clostridium difficile* in the same time period (0 in 2014/15).
- Cleaning scores, measured against the national standards of cleanliness, have continued to meet the nationally defined 'excellent' standard in clinical areas across the year.

What we are doing

The programme of work is devised and delivered by the Infection Control Committee, which forms a key component of the Governance structure, along with reporting via Quality Leadership teams (QLT) as required. .

The Code requires the annual report to be presented to the Trust board and in line with the board forward plan this will be completed in May 2016.

1.2 Safeguarding Adults & Families in our Trust and the Safeguarding children Strategy 2016 to 2019

These strategies set out the direction of travel for our Trust and our proposed way forward on many issues under a collective heading of the 'Safeguarding Adults and Families' agenda. The strategies were reviewed and ratified at Board level

committee and are presented to the Trust Board as part of this position statement attached at appendix 1 as a clinical enabling strategies to support the Trust Board in discharging its statutory duties to Safeguard and in line with required regulations.

1.3 Joint training with the police in Derbyshire

Our Physical Care Management (Resuscitation) Officer has written to the Police in Derbyshire to invite them to attend a joint training programme the letter is set out below:

We have always included in our training the importance of effective handover of patients between our two services and how this can be improved. We utilise the services of the Derbyshire Constabulary quite extensively especially in the use of the 136 suite. We are now looking to step this particular part of training up in the interest of patient safety. We feel that there is a lot that we can learn from each other in relation to what the expectations are from both parties. We are also looking at the possibility of putting together a national conference around physical health care in mental health settings which would include the role of the police in the 136 suite and believe that Derbyshire Constabulary would be a very useful contributor at this event.

We are in the process of setting up a training programme which is multi-disciplinary and involves the handover and receipt of patients to/from the police either by phone and/or in person when a constable attends. To this end we would be very grateful if you would be able to attend one of these sessions to provide us with feedback and critique that would improve the safe handover of patients. We feel that going forward that the training programme could be very useful for constables to attend (it's a one day session, but we may look to provide it over a half day) as part of their training programme around mental health.

2 Caring Services

2.1 Your Care Leaflet

We have recently finalised a 'Your care' leaflet. This leaflet aims to help service receivers to have a better experience by providing them with information about what to expect whilst in our care. The leaflet is currently being printed and will be cascaded across the organisation. We will be supporting staff to put this into practice and talk to them about working this way and training them this way. The booklet includes information about:

- Involvement and choice
- Assessment
- Care Planning
- Review
- Discharge and Transfer
- Families and Carers
- Coordination

- Safety
- Your Records
- Comments compliments and complaints
- Our values and standards

It has been designed to promote our personalised care agenda, making safeguarding personnel and ensuring required information such as access to advocacy is routinely issued in our services.

3. Well led

3.1 Care Quality Commission Inspections

Recent results show that nearly two-thirds of NHS trusts require improvement following inspection by the Care Quality Commission. The majority of inspected NHS trusts have received a 'requires improvement' rating from the Care Quality Commission (CQC), according to papers put before their latest board meeting. Figures published ahead of the meeting on 20 April show that the CQC has now inspected 162 NHS trusts, of which 100 (62%) have been rated 'requires improvement'.

The Care Quality Commission has now inspected all non-specialist acute trusts. Of the trusts with a published provider rating, 70 out of 103 were rated as 'requires improvement', 21 were 'good', 10 were 'inadequate' and only two were 'outstanding'. 132 NHS acute trusts are also in deficit.

Mental health trusts had the greatest proportion requiring improvement. Out of the 37 inspected, 22 were rated as requiring improvement, 14 were good, one was inadequate and none were outstanding. The remaining inspections noted in the CQC's data were of eight specialist trusts, three of which required improvement, 12 community health services, four of which required improvement, and two ambulance trusts, one of which required improvement and one of which was inadequate. The CQC is also due to inspect how all community, mental health and acute trusts in the country are learning from patient deaths after the issues raised at Southern Health.

What we are doing

Our planned inspection will take place week commencing 6th June 2016. Our Inspection planning group continues to meet weekly. Progress to date on our preparation plans includes:

- We are in the process of inviting our stakeholders to 2 events in May when the Care Quality Commission will hear their views.
- Staff focus groups are being set up for the week the Care Quality Commission is on site and individual interviews have been arranged.
- Two data packs have been submitted which will provide the inspection team with data and information about our performance in each of the core services.

- A draft visit timetable has been formulated and this is in the process of being confirmed.
- A hub of information in preparation for the Trust's planned CQC inspection has been created on Connect, the Trust intranet site. There is useful information for the comprehensive Care Quality Commission (CQC) inspection, new documents and links will be added regularly in the weeks leading up to the inspection to keep staff informed. There is also a selection of example reports to view on the webpage which have been written by the CQC following inspections to services similar to our own, but delivered by different Trusts from across the country. We are encouraging staff to read the reports that are appropriate to their area of service delivery to view best practice and get an understanding of what the CQC expect to see when rating a service outstanding, good, requires improvement or inadequate.
- We have included learning from Southern Health in our scrutiny at the Quality committee and we will continually review our progress in line with our clinical commissioners to ensure we are meeting their requirements and learning from the MAZARS report.
- A video has been prepared and made available via connect by our Director of Nursing and Patient Experience setting out details about our inspection and what staff should expect. The video includes lots of useful information such as:

    - ✓ How the inspection will be organised and run
    - ✓ Which services and aspects of our care the inspectors will be looking at
    - ✓ How the inspection will give us a chance to shine and talk about what we do well, whilst still acknowledging areas for improvement.

4. EFFECTIVE SERVICES

Our quality and innovation agreements for 2016/17 are included for information.

National agreements

There are 2 national agreements for mental health trusts they are:

1. Staff Health and Wellbeing
2. Improving physical healthcare to reduce premature mortality in people with severe mental illness (PSMI)

This nationally agreed indicator states:

"Improving the health and wellbeing of our NHS staff is a priority for us all. **This brand new three part indicator** will focus on getting our staff better access to health and wellbeing initiatives, supporting them to make healthy choices and lead healthy lives. The collective effort we make will support good outcomes for patients, through delivering continuity of care, and will help contribute to the financial position of providers through reduced sick days and potentially through reduced agency spend."

The staff health and wellbeing agreements have 3 parts:

National CQUIN	Indicator
CQUIN 1a	Introduction of health and wellbeing
CQUIN 1b	Healthy food for NHS staff, visitors and patients
CQUIN 1c	Improving the uptake of flu vaccinations for front line staff within Providers

We have agreed 2 local indicators which are:

- Safety planning - We have chosen this as a priority as a key element in our plans is to improve patient safety. The safety plan approach will help develop clinical practice and service user autonomy.

- Think Family - We have chosen this as a priority to embed learning in all our services from serious case reviews and serious incidents where Think! Family has emerged as a theme. In 2015 we established a Board-level committee, which includes executive leadership, whose responsibility is to monitor and receive reports on Think! Family

Implementation plans and leads for each agreement are being confirmed. Progress is reported to the Quality Committee and the provider/commissioner Quality Assurance Group.

Derbyshire Healthcare NHS
NHS Foundation Trust

Appendix 1

Safeguarding Adults & Families in our Trust 2016 to 2019

January 2016

Better together

Introduction

This strategy sets out the direction of travel for our Trust and our proposed way forward on many issues under a collective heading of the 'Safeguarding Adults and Families' agenda.

Safeguarding adults is integral to our identity and values as an organisation. We ensure that we focus on what we do 'day to day' encompasses the following core elements of Safeguarding Adults.

- Prevention of harm and abuse through provision of high quality care.
- Effective responses to allegations of harm and abuse; responses that are in line with local multi agency procedures and the legislative position as set out in 'The Care Act 2014' amongst other responsibilities.
- Ensuring we use learning from enquiries and experiences to improve services to patients.
- Encompassing an approach making safeguarding personal and following a family inclusive approach.

Lessons from inquiries such as Mid Staffordshire NHS Foundation Trust, Winterbourne View and the Mazars (2015) have highlighted the need to make safeguarding integral to care. Prosecutions by the Courts, enforcement measures by regulators and adverse media attention, all demonstrate the high cost to patients, staff and services, where there are failures in safeguarding patients. However, the cost in terms of poor experience and a failure to safeguard well-being of individuals may have a longer term detrimental impact on peoples' quality of life, which the cost is priceless.

This strategies key aim is to ensure all of our services and communities put people- Our service receivers and their families at the centre of their thinking and their actions, and that we as statutory services in our Trust walk alongside people supporting them and safeguarding their lives with them.

Whilst making sure that services are fit for purpose for the future, we must recognise that services delivered in the past may not have had the same aspiration or attention to walking alongside and may have been focused upon protection. Our future and the quality of our services is in doing both. Our organisation, our communities has had instances where our protection systems have failed. Individuals have been victims of crime in our care. We should ensure that any historical abuse, intentional or unintentional or through the psychological impact of unsafe or out dated practices in both Mental Health and Learning disability services that have occurred are investigated and responded too no matter which decade that they occurred in. Any difficulties or historical situations are considered in the eyes of the victims or survivors and are addressed and that we offer tailored support in such circumstances coming apparent now and in our future. We must always recognise organisational memory and the impact that interactions with care agencies may have had on people in our care.

Why is this a priority?

In essence, Derbyshire NHS Foundation Trust are committed to -

- Keeping patients safe from harm, transparent in reporting and tackling abuse where issues are raised.
- Compliance and support for legislative changes set at a National level.
- Supporting families and carers to develop family resilience to keep people safe as part of our preventative Safeguarding Family practices.
- Ensuring care in delivered in accordance with the principles and requirements of the Mental Capacity Act (2005), Mental Health Act (1983) Code of Practice 2015, Deprivation of Liberty Safeguards.
- Recognising the impact of trauma and its links with safeguarding both Children and Adults, including both present and historical abuse.
- Supporting our workforce to enable them to make safe assessments and decisions.
- Reducing restrictive practice and supporting the wider agenda of Positive & Proactive Care (2015).
- We have a statutory responsibility to demonstrate adherence with 'The Care Act' (2014) and the national PREVENT duty (2015) to support our communities and preventing individuals being radicalised wherever we can.
- We will consider learning from Kerr Haslam and we will consider specifically clinical professionals registered and non-registered and how we spot early warning signs for staff abuse on patients or families.
- Amendments to the 'Serious Crime Act' (2015) adds a new offence of coercive and controlling behaviour to existing legislation on Domestic violence coupled with Nice Guidance Q5116 Domestic violence and abuse: multi-agency working, strengthens the requirement for the organisation to make these issues a priority within Safeguarding Adults agenda in the Trust.
- The Department of Health's Female Genital Mutilation (FGM) Prevention Programme states that in a patient's healthcare record, we must now record FGM and fulfil our statutory reporting procedures. The law in relation to FGM has been strengthened in the Serious Crime Act (2015) needs to be embedded into our practitioners thinking and into routine clinical practice.
- The role we play in Public Protection, MAPPA and our role in Domestic Homicide Reviews, Safeguarding (Adults) Review and Serious Case Reviews needs to be continually refined and embedded into clinical practice.

The Care Act sets a direction of travel for making safeguarding personal and family orientated practice, laying down for the first time this requirement in statute. We need to embrace this development and refine our clinical standards to adopt this into practice

The strengthening of the Prevent agenda and the inclusion of the Prevent duty for the NHS sets the wider context of safeguarding in the local community.

The organisation will continue to reflect and adapt its responses to changes in legislation and respond to changes patterns of abuse within the local community.

This document will set a direction in which safeguarding principles and approaches will underpin our approaches to delivering care and designing our services.

Context

- The Care Act (2014) outlines the statutory requirements and responsibilities which places Safeguarding Adults with equity to the long standing responsibilities around Children as defined in the 'Children's and Families Act' (2014). It recognises the importance of the individual in making decisions about their life and care, placing a co-ordinating responsibility on the Local Authority to ensure appropriate enquiry and support is offered. The statutory responsibility and approach is monitored via the two Safeguarding Adults Board within Derby City and Derbyshire County, of which we are a contributing member.
- The National PREVENT strategy requires us to ensure staff are trained to recognise and respond to possible radicalisation, support a multi-agency approach, and identify Board level accountability for its delivery.
- The Mental Capacity Act (2005) provides the legal frame work for assessing people who may lack capacity to consent and ensuring that their rights to autonomy are protected and where capacity is compromised then care is delivered within the persons best interest and this is clearly documented.
- The Deprivation of Liberty (DoLs) safeguards are defined to prevent harm from occurring from depriving a person of their liberty. Clear process and responsibilities ensure a person's rights are upheld and best interests served. This includes the use of least restrictive practices, options in providing care, and best practice around such approaches is now supported by national guidance
- The role of carers is acknowledged in the Care Act (2014). Their potential vulnerability and their need for involvement should be central to the development of approaches and care services.
- Positive and Proactive Care lays down a challenge to work ambitiously at reducing restrictive interventions and blanket rules in the care we provide.
- Local Safeguarding Boards offer a 'Dignity Challenge' – which acknowledges many existing approaches such as single sex sleeping accommodation, chaperoning and working with REGARDS.
- The Duty of Candour (2015) requires us to inform people when harm may have occurred in our care, and this may extend to safeguarding.

Safeguarding Adults in our Trust

Within Derbyshire Healthcare NHS FT**,** there are a number of aspects of practice embedded and being developed. We are a multi-speciality community provider, working with families in the antenatal period, throughout life's journey and at that journey's end. We provide support in a number of ways, and recognise the role we play in identifying possible abuse and acting to support both individuals and families.

The introduction of the 'Care Act' in 2015, 'The Prevent Duty 2015', 'The Code of Practice 2015' and strengthening of 'The Crime Act 2015' and in regards to Domestic

Violence and Female Genital Mutilation, has set a challenging agenda that the Trust is required and excited to respond to. We will demonstrate this by Department of Health mandatory reporting (FGM 2015) and though requirements to report to our Trust Board and other NHS reporting requirements.

We will develop a number of initiatives underway such as family inclusive education in response to FGM and add elements of safeguarding to existing family and carer support mechanisms, for example 'Living Well with Dementia.'

As an organisation, we have 'Think Family' being embedded to widen Practitioners' scope, understanding and interventions for the individual as part of a family.

The organisation provides assurance to our Commissioners and wider community by completion of the Safeguarding Adults assessment Framework (SAAF) on an annual basis. We await the outcome of the consultation and subsequent publication of the Inter-Collegiate Document for Safeguarding Adults.

We continue to provide assurance by our compliance with the Safeguarding Adults assessment Framework this is enshrined within schedule 4 of the NHS Standard Contract with the clinical commissioning groups.

There are different types of Safeguarding Adults concerns our workforce should be adept and competent in spotting the early warning signs of harm and putting in place effective strategies with individuals in these areas:

- Financial
- Sexual
- Psychological /Emotional
- Neglect/ Acts of omission
- Institutional abuse, neglect and poor practice
- Self-neglect
- Discriminatory abuse
- Domestic violence – including psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence and Female Genital Mutilation
- Modern slavery – encompasses slavery, human trafficking, forced labour and domestic servitude

What are the most common forms of enquiry to the Safeguarding Adults team that this strategy should reflect in its strategic aims and work plan?

- Concerns about historical abuse
- Institutional abuse
- Care concerns – possible neglect, lack of services
- PREVENT referrals – to identify possible risk of radicalisation
- Public protection – the links with offender care, the responsibility to the individual and the wider community
- MARAC *(Multi-Agency-Risk-Assessment-Conference) is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners,*

Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and non-statutory services

Feedback: What have we been told? Have service receivers or care groups raised concerns?

There are a number of feedback mechanisms into the NHS and social care. It is important that we ensure that we capture information and act where needed to spot early warning signs of safeguarding needs or prevent actual abuse. This may be specific concerns or disclosures, or it may be a body of evidence that may lead to concerns about care – for example an approach or a service not being appropriate. We will ensure that we listen to concerns and experience of our patients, act where needed and in support of an individual and their wishes, and ensure that organisational memory shapes services, whenever we receive any concerns.

There is a growing national recognition of the extent of historical abuse, and the impact of individuals both in their well-being, the adverse events that abuse has had on individual's lives. We are mindful of the incidence of trauma and mental illness and the number of individuals who have experience child and adult abuse who attempt and complete suicide.

We are very mindful that the national discussions on abuse both by high profile individuals and institutions which has resulted in people coming forward and speaking out we hope this means that people feel better supported to raise concerns about their past experiences. Individuals may now also feel able to look back at an experience in care or in their life in general and feel that reflecting back, this was 'not how it should have been'. We will ensure that we provide support and a compassionate approach in all cases, providing the tailored support and in line with people's own preferences about how the situation should be managed.

We work in a multi-agency approach, with key partners being the wider health community, Police and criminal justice services, and local authority partners, this is key to our success.

Through analysis of complaints and patient feedback, concerns around possible historical abuse have been identified. These are being explored sensitively, specific incidents may not have happened in our care settings, however whenever an individual raises a concern we will support people in the best way possible to ensure that their concerns are heard and acted upon in line with the Safeguarding Adults Policies and procedures.

Through the experiences shared at the forthcoming National Enquiry into Historical Child Abuse and as the national agenda around safeguarding adults continues to develop, the organisation needs to ensure such learning is embedded into our culture and practice. This is an area that the Trust through this strategy and associated work plan that we are planning to pace the Trust on the front foot of developments.

Where were we?

How are we getting it wrong, and why we need to change?

We know from feedback from complaints, reported incidents and audit that that there are improvements that we can make to the way we support Safeguarding Adults in our Trust, ensuring voices are heard, making safeguarding personal and that as staff we ensure that we follow our statutory duties and legislation.

It is with sadness that I report that patients have been harmed both historically and in the present by our staff. We will ensure that incidences of abuse are listened to, rigorously investigated, with transparent reporting ensuring involvement by the Police and social care. Patients will be listened to and support given unconditionally. The Trust will act swiftly and firmly following its disciplinary procedures and if founded will press for extensive legal action.

Incidents where staff are dismissed through abusive acts towards service receivers or family members will lead to an application to the disbarring service and where applicable registering bodies. Staff will be supported in teams should they have any concerns about other staff or other statutory employees to speak out and raise formal safeguarding concerns, ensuring teams and individuals are supported extensively in speaking out against abuse in clinical and non-clinical areas.

The Price Waterhouse Cooper audit of the Trust's compliance with the Mental Capacity Act (2015) and its application identifies that we have considerable work to do in regards to training, policy, central team data collection, knowledge sharing and documentation. There will be an action plan setting out the goals to be achieved and timescales for completion. The introduction of the DoLs Technician will assist to ensure that we are compliant and supporting best practice. We will re-audit to ensure that we continue to challenge ourselves and understand where we are and where we need to improve.

The Care Act 2014 challenges us to move safeguarding adults from something done unto someone to working collaboratively with them to make Safeguarding personal, raising the profile of Making Safeguarding Personal via a communication strategy, Safeguarding embedded in supervision and ensure that Safeguarding training has this as an underlying principle.

The CQC visit in 2015 in regards to Children's Safeguarding across Derby City identified that we have difficulties in embedding the "Think Family Strategy" across our Mental Health Services. Children and Adult Safeguarding Leads are working together to ensure that Think family is embedded within our care provision. The Safeguarding Adult Lead will support the Derby City Safeguarding Board in the 'Think Family' agenda as one of its priorities for 2016/2017.

Our Carers raise with us that we are not inclusive of them in delivering care to their family member this is a key strategy in the preventative agenda of Safeguarding families. The Trust has utilised the 'Triangle of Care' – a carer engagement approach for mental health services. This has been a welcome addition to the different approaches that are utilised across the Trust. We will make a commitment to build

upon this approach and embedding across our clinical areas. We will take part in the self- assessments and attend and challenge sessions as organised by the 'Triangle of Care', we will ensure that we feedback our performance to the Safeguarding Committee.

We need to further develop and embed approaches which ensure that safeguarding children and adults work symbiotically to strengthen transitions and pathways.

We have not had a structured strategy and co-ordinated approach to Safeguarding Adults across the organisation, leading to inconsistencies in Safeguarding Adults practice, difficulty in providing assurance on safeguarding activity, outcomes for patients and markers of best practice. The Board level commitment and introduction of the Safeguarding Committee has been welcome. The Trust will strengthen this by having a co-ordinated programme of work for the lifetime of this strategy.

The work plan will be transparent and accountable to the Safeguarding Committee to give the Board assurances that we have a strategic direction, an effective work plan and we are making progress.

Our strategic aims -

- We will ensure our culture within Derbyshire Healthcare NHSFT embraces the principles of safeguarding adults, recognising the impact of trauma in early years and throughout life.
- Our workforce will be trained and supported to recognise abuse and support individuals and their families in a tailored way.
- The organisation will demonstrate a commitment to the delivery of high standards and reporting in line with our statutory requirements.
- The overall approach will be one of honesty, transparency and learning from adversity.

Recommendations to the Trust Board

- To acknowledge the position of Adult Safeguarding and the need to support families.
- Support the work plan for safeguarding and timescales to deliver.
- Acknowledge and support the reporting schedule and requirements.
- Acknowledge the challenging and evolving national agenda around safeguarding adults.

Work plans per strategic aim, a SMART action plan with key timescales will be designed by the operational safeguarding group and will be reported to the Safeguarding committee to provide assurance.

Improving care in safeguarding adults

Strategic Aim	In our Trust - The Work Plan
Make Safeguarding Adults integral to patient care and to seek partnership working with our patients.	Provide two Safeguarding Leads to offer formal advice and sign post to other services. Safeguarding Lead to offer supervision particularly where the safeguarding concerns are complex and distressing. Improve access to training for staff on domestic violence, neglect. Ensure that up to date information is available for patients and staff via the inter/intranet and leaflets. Monitor training compliance through our Safeguarding committee. Monitor telephone and email advice for trends and patterns as well as to inform the Safeguarding training plan
Ensure that the Trust adheres with Safeguarding Adults Assurance Framework and PREVENT returns.	Safeguarding Lead to ensure compliance within the timeframes and include feedback to Safeguarding Committee and Annual Report.
Safeguarding Lead to support Trust strategy and initiatives on reducing restrictive practices across the organisation.	Ensure involvement in working groups and influence agenda in reducing restrictive practices and organisational harm. To advise on least restrictive options within the Safeguarding context.
Improve carer experience.	To support and Lead on embedding the Triangle of care, Family inclusive practice initiatives monitoring actions and feedback from carers, reporting how we are doing to the Safeguarding Committee.
Benchmark assessment of DHCFT against NICE Guidelines on Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively (Q5116)	Report on benchmarking results and action plan to improve our clinical practice and minimise any clinical variation.

Leadership, Assurance and Accountability

Strategic Aim	In our Trust - The Work Plan
Our primary focus will be on providing a positive and therapeutic culture/ making safeguarding personal will be embedded in routine practice.	Safeguarding Lead to ensure that the markers for best practice are met by the organisation. We horizon scan the national agenda in this arena and embed any national and local practice changes into our clinical standards and requirements for our staff.

Strategic Aim	In our Trust - The Work Plan
Boards must maintain and be accountable for overarching Safeguarding Adults strategy.	The Safeguarding Committee is the responsible Committee and this is a Board level Committee. Board summary reports are and will be received at the public session of the Trust Board.
Governance structures and transparent polices around the Care Act and Safeguarding Adults will be in place.	The Safeguarding Committee is the responsible Committee and will have oversight of all sub groups
Providers must have clear local policy requirements and ensure these are available and accessible to users of services and carers.	This policy and SAPP will be consulted upon and ratified by the Safeguarding Committee.
Our Trust will report on the use of Safeguarding Adults processes to service Commissioners, who will monitor and act in the event of concerns.	The Trust currently reports all incidents and concerns and this will be scrutinised in our inspections by our CCGS and regulators.
Boards must receive and develop actions plans in response to service failures in Safeguarding Adults care.	The Trust Board will have oversight of the whole Safeguarding Adults strategy and interventions will receive the annual audit of any service failures and associated service improvement plans through the Safeguarding Committee.
Executive Director of Nursing and Safeguarding Adults Lead to participate at Safeguarding Adults boards for Derby city and Derbyshire County Councils	Attend Safeguarding Boards for Adults. Safeguarding Lead to continue to participate at Safeguarding Adult sub groups.
Development of the Safeguarding Adults Doctor role and associated job plan.	To revisit the Safeguarding Adults job description, work plan and key objectives.

Transparency

Strategic Aim	In our Trust - The Work Plan
Providers must ensure that internal audit programmes include reviews of the quality, design and application of safeguarding adult support plans, or their equivalents.	We will re-design how we do this now, but the writing of this will be led by those who have used our service and we will audit whether we have made safeguarding personal as part of our annual audit cycle.

Strategic Aim	In our Trust - The Work Plan
Accurate internal data must be gathered, aggregated and published by providers including progress against the 'Care Act' and SA requirements in the Annual Report.	Data to be collected via the Datix system and interface discussion with social care. To be reported quarterly via Safeguarding Committee. Safeguarding themes to be forwarded to the Quality Leadership Teams to ensure a link between safeguarding and clinical standards.
Accurate internal data must be gathered, aggregated and reported on Safeguarding Adults concerns, action and learning	Our current reporting systems report through Datix, complaints. Feedback via Practice Matters will be monitored.
Goddard compliance	Raise awareness of Goddard across the Trust from "board to ward" Ensure that information is retained in line with Goddard requirements.

Monitoring and oversight

Strategic Aim	In our Trust - The Work Plan
Care Quality Commissions (CQC) monitoring and inspection against compliance with the regulation on Safeguarding	Our Trust welcomes openness and transparency into the care we provide. We will benchmark against the Safeguarding CQC regulations as part of this strategy and we will review any areas to improve as recommendations to be added to our work plan.
CQC will review organisational progress	We welcome this approach and we will include this in our reviews of our work and areas to review and continually improve.

Our key success criteria

How will we know we have implemented the key concepts of this strategy within two years?

1. We will provide a number of mandatory and developmental training opportunities for our workforce to access to broaden their knowledge and experience. These will include case study and reflective practice.

2. We will monitor the number of and context of complaints of safeguarding adults concerns due to staff attitude or harm. We accept and understand this initially may increase as we open up our culture to reporting and would then reduce.

3. We aspire to actively promote a preventative culture, which has an increase in positive personalised language and is positive reinforcing of individuals and their

plans, their rights and their decisions in safeguarding or everyone and this is demonstrably felt in our services.

The Trust Board has:

- Ring-fenced some core investment or re-allocate its resources or deployment of its resources to enable this strategy to be implemented, provide capacity for the team to prioritise this work.
- Adapt its organisational procedures to enable this strategy and associated work plan to occur.

We recommend to the Trust Board to:

- Endorse this strategy and lead by example in modelling its principles.

You can email or call our Safeguarding leads

Karen Billyeald Area Service Manager for Learning Disabilities based at Kingsway House West Wing 01332 623700 karen.billyeald@derbyshcft.nhs.uk

Gill Baker Clinical Team Leader based at St Andrews House 01332 gill.baker@derbyshcft.nhs.uk

or myself Tracey Holtom based at Kingsway House West Wing 01332 623700 ext: 31537 tracey.holtom@derbyshcft.nhs.uk

T. D. Holtom.

Tracey Holtom Lead Professional Safeguarding Adults

Please tell us your thoughts.

Derbyshire Healthcare NHS Foundation Trust
Trust H
Kingsway Site
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www.derbyshirehealthcareft.nhs.uk

Appendix 2

Derbyshire Healthcare NHS Foundation Trust

By Tina Ndili, Head of Safeguarding Children and Dr Joanne Kennedy, Named Doctor for Safeguarding Children

1. Introduction

Our overall aim through the implementation of this strategy is to provide outstanding Safeguarding Services in Derby and Derbyshire for children, young people and their families. To safeguard, protect and promote the welfare of children and young people whilst supporting families to flourish and to achieve optimum wellbeing, health and development with the best possible outcomes.

This will be achieved through the accomplishment of the following key goals:

- Working with our partner agencies to focus services on Early Intervention and Prevention – taking a team around the family approach in light of limited and diminishing resources.

- Providing safeguarding services of excellent quality to Children, Young people and their families

- Improving the experience of vulnerable children, young people and families through the development and delivery of Services and the integrated delivery of collaborative care with our partner agencies.

- Ensure that all staff are well trained, competent and equipped to support children, young people and their families.

- Ensuring that we work to a holistic family based approach with the needs of the child being 'paramount' and at the centre of our care.

- The implementation of the actions with the Safeguarding Children Workplan 2016/17 to achieve the set outcomes.

This Safeguarding Strategy is enacting and empowering strategy which describes the priorities for continual improvement of the culture, workforce, quality of practice, leadership and performance management and quality assurance within our Trust to achieve the strategic impact priorities that have been set by ourselves within the work plan, alongside the Derby City and Derbyshire Safeguarding Boards.

2. Vision

Our vision is "to work together with children, young people and their families in order to keep them safe, achieve their full potential and continuously improve their outcomes". We will respect and encourage the participation of children, young people, their carers and their families in service development and delivery. We need to value and respect the staff working with families and to learn from our mistakes when things go wrong in an environment which promotes 'Think Family' – this should be a 'golden thread' throughout the Trust's work and recognised as integral to the Trust's strategy and not merely an element of Safeguarding. The Trust's aim is to promote a culture of respectful challenge, curiosity and transparency and ensures that our workforce is highly trained, competent, motivated, effectively supported and supervised to safeguard and promote resilience.

3. What we want to achieve

This strategy highlights the 5 key priority areas which are critical for Safeguarding Children, young people and their families.

4. Our Priorities

The Safeguarding Children Workplan 2015/2016 details the actions required to achieve these priorities. These priorities have been grouped into five key themes that will assist in making this strategy achievable. These are:-

- Culture
- Workforce
- Leadership
- Quality of Practice
- Performance management and quality assurance

The above key themes are integrated into the required outcomes as documented within the workplan.

Culture

A change in the culture of the organisation is critical to achieve our aims. It is important that there is a clear understanding within the organisation that safeguarding is everyone's responsibility, and that this function is not something separate from their everyday practice. Key to this is the 'Think Family Principles'. A closer stronger working relationship built on trust, is needed internally across Adult and Children's Services and externally with partner agencies with openness to sharing information, joint assessments and care plans to achieve better outcomes for children and families. We need to work together to support safeguarding through the effective implementation of early intervention and prevention strategies and joint identification of risk through assessment and Care Planning. Person centred care planning and listening to the voice of the child is essential so they feel listened to, valued, respected and supported. Similarly we need to ensure the Workforce feels empowered, listened to, valued, respected and supported at all levels of the organisation. We require the development of a culture that supports openness, enquiry and an appropriate level of challenge where learning, including learning from Serious Incidents, is welcomed. Ensuring the workforce takes ownership for continuous learning and self-development is essential. Staff need a clear understanding of their roles and responsibilities within 'Safeguarding Families' ensuring that everyone who works with children, young people and their families understands how safeguarding links to their everyday practice and how their work builds resilience within families, for example, through support for parenting. Safeguarding depends on strong partnerships within and with other agencies and the Safeguarding Board and a culture of consistent, respectful cooperation and representation to the Board and its subgroups across the City and Shire is essential. The workplan outcomes focus on ensuring that resources within the Safeguarding team are sufficient and creatively operationalised. For systems and process to be in place to ensure that supervision, advice and training is in place to support the cultural change/ transformational change process needed with frontline staff and services. Audit programmes are in place and designed to monitor improvement and effective change in practice to improve outcomes for children.

Workforce

Workforce refers to everyone who works with children, young people and their families within DHCFT. This includes all staff both Clinical and non-clinical including Adult Mental Health Services, Substance Misuse, Child and Family Services and Volunteers at all levels. We need to ensure our workforce is competent and that staff understands safeguarding pathways, policies and procedures and their role in implementing them. We want to develop a workforce by ensuring the delivery and attendance of both internal and multiagency wide training and development programmes and from the findings and actions of local and National Serious Case Reviews, Learning Reviews and Internal Serious Untoward Incidents in order to improve practice and achieve best outcomes for Children and their families. We need to give assurance to the Trust Board and the Safeguarding Board that staff are trained and the impact on practice of all learning and actions from recommendation's are fully embedded across the organisation. We require diligence in recruiting safe staff who do not pose a risk to Children and vulnerable adults and effective, prompt management to ensure minimisation of risk to children if a member of the workforce or Volunteer at any level of the organisation appears to pose a risk to others. The capacity of the workforce will be monitored and analysis of risk/impact in line with issues of resources will be undertaken to ensure safe and effective practice. An outcome of the Safeguarding Children Workplan is for the Safeguarding Team to engage with any transformational change projects to ensure safeguarding children practice is a fundamental part of the planning and delivery of services and to identify any related risks. Capacity and resource issues of and within the workforce that potentially may impact on services and practice will form part of this assessment and analysis of the impact of this will be reported on to the committee and Derby/Derbyshire Safeguarding Children Board. This will also include the assurance that staff are supported and empowered and know how to access support when required promoting a support fostering environment that is equitable across both adults and children's services. This will be shared with our partner agencies in order to highlight potential/actual risk.

Leadership

One of the main priority areas for improving safeguarding is Leadership. By Leadership we mean senior staff within the organisation that lead and motivate the Workforce, to work together to gain the skills, knowledge and expertise, to deliver safe and effective services for children, young people and their families, and to ensure that a clear vision and values that are embedded within the workforce.

The leadership teams across the organisation:

- Needs to be visible and available to support and advise staff and to facilitate a culture of mentoring and support to be adopted and embedded in delivering better safeguarding outcomes for families.

- Need to have a "grip" on Safeguarding within the organisation jointly.

- Need to ensure effective working arrangements between the Safeguarding Boards, the Trust and key partners as identified within the safeguarding children workplan by ensuring these systems and structures are in place.

- Need to ensure a clear and effective governance structure and quality assurance framework that confirms evidence of leadership of Safeguarding via the Safeguarding Operational Groups and the Safeguarding Vulnerable Adults and Children Committee.

- Needs to develop and embed a clear system for communicating with practitioners at all levels within the Trust and with partners that is open, honest and reliable – this should empower staff and ensures a no blame culture.

- Needs to develop an effective framework to ensure the voices and views of the child, young people and their families are listened to and acted on. Similarly Leaders are required to listen to and value the workforce.

- need to engage with any transformational projects to ensure that Safeguarding is a fundamental part of delivery and planning of services

- needs to understands their responsibilities within Section 11 of the Children Act , Markers of Good Practice, CQC and Ofsted and ensure effective scrutiny and respectful challenge of Safeguarding Practice within the organisation .

- Needs to interpret and ensure operationalization of Local and National Policy Guidance and Legislation. For example :

    - New domestic violence NICE guidance (out February 2016)
    - Serious crime act (2015) in relation to female genital mutilation and domestic abuse being strengthened
    - The prevent duty (2015) .
    - Care act (2014) and the key changes (2015).

- Needs to ensure and provide evidence of their own professional development in order to be compliant with the 'Roles & Competences for Healthcare Staff, Intercollegiate Document 2014" whilst identifying and developing talent in order to identify future Safeguarding Professionals and Leaders.

A major challenge for all organisations including DHCFT is talent spotting and the development of our next Leaders in Safeguarding. Named roles are no longer ones that can be stepped into with no prior development or training given the breath of experience and knowledge required to fulfil the roles. Development plans, additional training and shadowing need to be developed before a Named Professional commences in a Safeguarding role to ensure there is no "knowledge gap" in key strategic roles particularly that of the Named Doctor.

Quality of Practice

Quality of practice, relates to improving the quality and consistency of assessments, information sharing, partnership working, interventions, person centred care planning, record keeping and documentation, professional management and supervision all within a timely manner with clear SMART targets. Our aim is to develop and ensure consistent interpretation and implementation of lessons learnt, recommendations, guidance, policies and procedures across the Trust, to improve the quality of safeguarding practice by all staff. Audits provide evidence of and evaluate continued improvement of clinical practice, as part of the Safeguarding

Children workplan. A comprehensive yearly audit plan will be develop in line with outcomes of serious case reviews, serious incident learning reviews and serious incidents. Further learning and recommendations from audit will inform the training needs analysis and deliver of the Trust training programme. To improve the quality of practice the trust also needs to ensure the organisation captures user feedback and involvement in order to capture and embed the voice of children, young people and their families and carers. The evidence of what is captured and collated will be used and embedded into services. NICE guidance informs practice in order to ensure quality and safe practice – the guidance is adhered to at all times. There are a number of new issues on the horizon for DHCFT to be mindful of and staff need to have an awareness of these and of the challenges they present. The internal training strategy and programme include outcomes for all of the list below and all clinical staff. These new and existing challenges include:-

New and Emerging Communities

- ✓ Sexual Exploitation
- ✓ Trafficking and Human Slavery
- ✓ FGM
- ✓ Substance Misuse including New Psychoactive Substances
- ✓ Domestic Abuse
- ✓ Safe Sleeping,
- ✓ Suicide and Self Harm
- ✓ Missing Children
- ✓ E-safety
- ✓ Radicalisation and Extremism
- ✓ The needs of those more vulnerable in our society including children with disabilities
- ✓ Looked After Children
- ✓ Priority Families

Performance Management and Quality Assurance

Performance management relates to the reporting systems and data by which the Trust can ensure the quality and effectiveness of safeguarding within the organisation. Quality Assurance provides the Trust, the Safeguarding Boards, Commissioners and regulatory bodies with an understanding of the standard and consistency of our services to ensure that they are delivered to the highest possible standard for children, young people and their families. Data is collated and evidence provided to assure the above of the quality of our services. Assurance internally within the Trust is provided through the Safeguarding Operational Groups via evidence on the delivery of the various action plans from Serious Case Reviews, CQC, MOGP (section 11), Think Family and the Safeguarding Children Work plan. Analysis of the themes and issues arising from the advice system and safeguarding referrals will serve to inform training, policy, guidance and professional development. Decision making processes, thresholds and the need for escalation of cases will be monitored via the above channels to ensure that the organisation is part of the multi-agency quality framework and feeds into the 'Health Quality Assurance Group' and the Safeguarding Boards' quality assurance processes, providing assurance that performance indicators in relation to Safeguarding Children are met.

5. Making it Happen

The Trust has made a strong commitment to Safeguarding by reviewing its Safeguarding Governance structures in line with the "Safeguarding Children : 'Roles and Competences for Healthcare Staff, Intercollegiate Document 2014" which states that the Safeguarding Named Nurses and Doctors directly reports to the Executive Lead for Safeguarding Children. The 'Safeguarding Vulnerable Adults and Children Committee' now directly reports to the 'Trust Board'. We need now to ensure the implementation and action for each priority within the strategy, and in line with the actions and timescales outlined within the Safeguarding Children Workplan 2016/17 will be communicated throughout the Trust and reviewed yearly.

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 27th April 2016

Integrated Performance Report Month 12

Purpose of Report

This paper provides the Trust Board with an integrated overview of performance as at the end of March 2016 with regard to workforce, finance and operational delivery. It also now includes a first iteration of Quality performance indicators

Recommendations

The Board of Directors is requested to:

1) Consider the content of the paper and consider their level of assurance on the current performance across the areas presented.
2) Consider the format of the report and define any changes it requires for subsequent iterations.

Executive Summary

Most of the high level executive summary content is found at the first page of the main report.

In response to Board feedback at March board, the first steps have been made in starting to draw themes from across the component parts of the integrated report: Team hotspots for high agency usage, vacancy levels and sickness have been identified and this information will be used in future reports along with additional triangulated analysis to analyse those teams' operational, financial and quality performance.

Strategic considerations

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

Board Assurances

This report should be considered in relation to the relevant risks in the Board Assurance Framework.
As an integrated performance report the content of 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 papers and aspects of detailed content supporting the overview presented are regularly provided to, Finance and Performance Committee, People and Culture Committee and Quality Committee.

Governance or Legal issues

he integrated nature of this report is in response to the Deloitte Well Led Review and specifically recommendation R 22: The Board needs to introduce an integrated performance report which encompasses key operational, quality, workforce and finance metrics

Information supplied in this paper is consistent with returns to the Regulator
This report has replaced the previous operational and financial reports reported to Trust Board

Equality Delivery System

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.

Report presented by:	**Claire Wright, Director of Finance** **Carolyn Gilby, Acting Director of Operations** **Jayne Storey, Director of Workforce** **Carolyn Green, Director of Nursing**
Report prepared by:	**Rachel Leyland, Deputy Director of Finance** **Peter Charlton, General Manager, Information Management** **Liam Carrier, Workforce Systems & Information Manager** **Clare Grainger, Head of Quality Performance**

Highlights for the end of the financial year

- Achieved forecast year end surplus
- FSRR 4 for year end (FSRR of 2 in final quarter, see compliance return paper for supporting information)
- Cash better than plan
- Capital behind plan (as expected)
- CIP achieved in full (£1.1 non recurrent)

Challenges

- Mitigations of financial risks for 16/17
- Closing of CIP gap
- Containment of costs in first quarter of 16/17

Highlights

- Fully compliant with all monitor targets
- Health Visiting and IAPT continue to be compliant

Challenges

- PbR clustering
- Outpatient Cancellations continue to be high
- Outpatient letters compliance continues to be a challenge however we are currently ahead of the commissioner agreed trajectory

Highlights

- Compulsory Training compliance continues to increase
- Annual turnover remains on target

Challenges

- Appraisal compliance remains below target
- Sickness absence rates continue to increase
- Vacancies remain high

NB: This is a report section in phased development, in line with EPR roll out, in the new financial year

Highlights

- Red rated areas are not hitting performance but achievable by target date, (Think Family / Safety planning)

Challenges

- 6 strategic risks, 5 currently graded as high. 5 operational risks, 4 graded as high, 1 as extreme relating to recruitment of community paediatricians.
- Flu vaccinations July + 2016 commencement

FINANCIAL OVERVIEW – YEAR TO DATE AS AT MARCH 2016

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Governance	FSRR	Financial Sustainability Risk Rating	Outturn	3	4	G		FSRR of 4 is better than the plan, and there is no change to the overall FSRR or the individual metrics this month, all as per the forecast. However the 'in-quarter' FSRR is at a 2 with adverse changes on most of the metrics apart from Liquidity which remained at a 4. This is reported in more detail in the Compliance Board report.
			In Qtr 4	4	2	R		
		Debt Service Cover	Outturn	3	3	G		
			In Qtr 4	3	2	R		
		Liquidity	Outturn	4	4	G		
			In Qtr 4	4	4	G		
		Income and Expenditure Margin	Outturn	3	4	G		
			In Qtr 4	4	2	R		
		Income and Expenditure Margin Variance	Outturn	3	4	G		
			In Qtr 4	3	1	R		
I&E and profitability	Income and Expenditure	Income and Expenditure position £'000	In-Month	136	-214	R -350		In month deficit due to non-recurrent expenditure in month that was previously forecast. Surplus at the end of the financial year as per forecast. EBITDA lower than plan in month due to additional non-recurrent expenditure.
			Outturn	1,271	1,841	G 570		
	Profitability	Profitability - EBITDA £'000	In-Month	705	441	R -264		
			Outturn	8,181	9,146	G 965		
		Profitability - EBITDA%	In-Month	6.4%	3.9%	R -2.5%		
			Outturn	6.2%	7.0%	G 0.8%		
Liquidity	Cash	Cash £m	Outturn	10.097	12.198	G 2.101		Cash remains ahead of plan due to the I&E surplus and lower capital expenditure. Capex is lower than plan at the end of the financial year.
	Net Current Assets	Net Current Assets £m	Outturn	1.545	3.138	G 1.593		
	Capex	Capital expenditure £m	Outturn	3.450	3.152	R -0.298		
Efficiency	CIP	CIP achievement £m	In-Month	0.403	0.371	R -0.032		CIP is different to plan in month due to phasing of schemes. Achieved full plan at the end of the financial year.
			Outturn	4.200	4.200	G 0		
			Recurrent	4.200	3.087	R -1.113		

OPERATIONAL OVERVIEW – MARCH 2016

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Monitor	CPA 7 Day Follow-up	Month	95.00%	96.15%	G	↓	Fully compliant with monitor targets
			Quarter	95.00%	96.58%	G	→	
		CPA Reviews in Last 12 months	Month	95.00%	95.60%	G	→	
			Quarter	95.00%	95.60%	G	→	
		Delayed Transfers of Care	Month	7.50%	1.74%	G	↑	
			Quarter	7.50%	2.47%	G	→	
		Data completeness - Identifiers	Month	97.00%	99.41%	G	→	
			Quarter	97.00%	99.41%	G	→	
		Data completeness - Outcomes	Month	50.00%	94.83%	G	→	
			Quarter	50.00%	94.83%	G	→	
		Community Care Data Activity - Completeness	Month	50.00%	93.62%	G	→	
			Quarter	50.00%	93.60%	G	↑	
		Community Care Data - RTT Completeness	Month	50.00%	92.31%	G	→	
			Quarter	50.00%	92.31%	G	→	
		Community Care Data - Referral Completeness	Month	50.00%	76.15%	G	→	
			Quarter	50.00%	76.80%	G	↑	
		18 Week RTT incomplete	Month	92.00%	97.07%	G	→	
			Quarter	92.00%	97.18%	G	→	
		Early Interventions New Caseload	Month	95.00%	100.70%	G	↑	
			Quarter	95.00%	100.70%	G	↓	
		Clostridium Difficile Incidents	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Crisis Gatekeeping	Month	95.00%	100.00%	G	→	
			Quarter	95.00%	100.00%	G	→	
		IAPT RTT within 18 weeks	Month	95.00%	99.11%	G	→	
			Quarter	95.00%	99.18%	G	→	
		IAPT RTT within 6 weeks	Month	75.00%	92.35%	G	→	
			Quarter	75.00%	92.48%	G	→	

OPERATIONAL OVERVIEW – MARCH 2016

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Locally Agreed	CPA Settled Accommodation	Month	90.00%	97.76%	G	→	The Payment by Results Advisor continues to work with teams and individuals offering training, support and advice. We are taking the opportunity of the WorkPro road-test to emphasise the importance of timely and accurate clustering. In addition outcomes-based payment systems are to be introduced and we are implementing performance management for compliance. Health of the Nation Outcome Score assessments are part of clustering so by improving the clustering position we will improve the Health of the Nation Outcome Score position by default
			Quarter	90.00%	97.76%	G	→	
		CPA Employment Status	Month	90.00%	98.28%	G	→	
			Quarter	90.00%	98.28%	G	→	
		Data completeness - Identifiers	Month	99.00%	99.41%	G	→	
			Quarter	99.00%	99.41%	G	→	
		Data completeness - Outcomes	Month	90.00%	94.83%	G	→	
			Quarter	90.00%	94.83%	G	→	
		Patients Clustered not Breaching Today	Month	80.00%	79.73%	R	↓	
			Quarter	80.00%	80.74%	G	↑	
		Patients Clustered regardless of review dates	Month	96.00%	94.74%	R	→	
			Quarter	96.00%	94.90%	R	→	
		CPA HONOS assessment in the last 12 months	Month	90.00%	88.29%	R	→	
			Quarter	90.00%	88.29%	R	→	
		7 Day Follow-up - all inpatients	Month	95.00%	96.55%	G	↓	
			Quarter	95.00%	97.05%	G	↑	
		Ethnicity coding	Month	90.00%	90.36%	G	↓	
			Quarter	90.00%	90.36%	G	↓	
		NHS Number	Month	99.00%	99.98%	G	→	
			Quarter	99.00%	99.98%	G	→	
	Schedule 4	Consultant Outpatient Trust Cancellations	Month	5.00%	5.36%	R	→	Associate Clinical Directors to review cancellation reasons and discuss with consultant concerned where reasons do not appear valid and a list of cancellation reasons has been agreed and added to Paris to enable reporting and monitoring. The letters action plan is being implemented and continues to perform above trajectory. The dashboard target is 100% and we will request that commissioners reduce this.
			Quarter	5.00%	5.49%	R	→	
		Consultant Outpatient DNAs	Month	15.00%	13.23%	R	↑	
			Quarter	15.00%	13.86%	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%	89.76%	R	↓	
			Quarter	90.00%	91.54%	G	↑	
		Outpatient letters sent in 15 working days	Month	100.00%	95.70%	R	→	
			Quarter	100.00%	95.94%	R	↑	
		Inpatient 28 day readmissions	Month	10.00%	7.86%	G	↑	
			Quarter	10.00%	9.05%	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	→	
		18 weeks RTT greater than 52 weeks	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Discharge Fax sent in 2 working days	Month	98.00%	98.11%	G	↓	
			Quarter	98.00%	99.01%	G	→	

OPERATIONAL OVERVIEW – MARCH 2016

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Fixed Submitted Returns	18 weeks RTT greater than 52 weeks	Month	0	0	G	→	Fully compliant with fixed submitted return targets
			Quarter	0	0	G	→	
		18 Week RTT incomplete	Month	92.00%	97.30%	G	→	
			Quarter	92.00%	97.75%	G	→	
		Mixed Sex accommodation breaches	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Completion of IAPT Data Outcomes	Month	90.00%	96.45%	G	→	
			Quarter	90.00%	95.42%	G	→	
		Ethnicity coding	Month	90.00%	90.42%	G	↓	
			Quarter	90.00%	91.22%	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	95.00%	97.30%	G	↓	Fully compliant with breastfeeding targets
			Quarter	95.00%	99.10%	G	→	
		% 6-8 Week Breastfeeding coverage	Month	95.00%	97.00%	G	↓	
			Quarter	95.00%	97.63%	G	↓	
		% Still Breastfeeding at 6-8 Weeks	Month	65.00%	72.90%	G	↑	
			Quarter	65.00%	72.73%	G	→	
	IAPT	Recovery Rates	Month	50.00%	51.93%	G	↓	Fully compliant with IAPT targets
			Quarter	50.00%	54.26%	G	↑	
		Partial and Full Recovery Rates	Month	65.00%	74.34%	G	↑	
			Quarter	65.00%	73.50%	G	↑	
	Safer Staffing	Inpatient Safer Staffing Fill Rates	Month	90.00%	101.22%	G	↑	Detailed ward level information shows specific variances
			Quarter	90.00%	101.18%	G	→	

WORKFORCE OVERVIEW – MARCH 2016

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Workforce Dashboard	Monitor Key Performance Indicator (KPI)	Turnover (annual)	**Mar-16**	10%	**10.45%**			Annual turnover remains within the Trust target parameters and is below the regional Mental Health & Learning Disability average of 12.69%. Monthly sickness absence has decreased this month, however the annual sickness absence rate continues to increase, running at an annual rate of 5.56% as at March 2016. The regional average annual sickness absence rate for Mental Health & Learning Disability is 5.04% (as at December 2015 latest available benchmarking data). The average budgeted vacancy rate for the year was 15.25% peaking at 16.24% this month. Employees who have received an appraisal within the last 12 months has increased slightly and Medical appraisals are now being recorded accurately. Contracted staff in post ratio for qualified nurses remains within target. Compulsory training compliance continues to increase and is
			Feb-16		10.54%			
		Sickness Absence (monthly)	**Mar-16**	3.9%	**5.67%**			
			Feb-16		6.26%			
		Vacancies (budgeted full time equivalent)	**Mar-16**	10%	**16.24%**			
			Feb-16		15.91%			
		Appraisals (all staff)	**Mar-16**	90%	**69.12%**			
			Feb-16		67.82%			
		Appraisals (medical staff only)	**Mar-16**	90%	**72.07%**			
			Feb-16		42.47%			
		Qualified Nurses (to total nurses, midwives, health visitors and healthcare assistants)	**Mar-16**	65%	**66.41%**			
			Feb-16		66.04%			
	Other KPI	Compulsory Training (staff in-date)	**Mar-16**	95%	**88.59%**			
			Feb-16		88.48%			

QUALITY OVERVIEW – MARCH 2016

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Quality	Quality Strategy	Percentage of current Inpatients with a recorded Capacity Assessment	Month	100.00%	0.37%	R	→	Awaiting FPR roll out
			Quarter	100.00%	0.37%	R	→	
		Percentage of all patients with a care plan in place which has been reviewed with 12 months	Month	90.00%	N/A	R	→	Awaiting FPR roll out
			Quarter	90.00%	N/A	R	→	
		Seclusion incidents	Month	0	7	R	→	Restrictive practice reduction strategy, monitoring and downward trend.
			Quarter	0	37	R	↑	
		Physical Restraint incidents	Month	0	30	R	↓	Developing a six month average as a baseline
			Quarter	0	95	R	↑	
	CQUINs or contractual levy	Flu Jab Up-take	Month	75.00%	N/A	R	→	22.7% 2015/16. Sickness less than 1%
			Quarter	75.00%	N/A	R	→	
		Think Family Training	Month	90.00%	N/A	R	→	TF - 709 staff trained, 40% of eligible group. Target 2016/17.by December 2016
			Quarter	90.00%	N/A	R	→	
		The safety plan training	Month	90.00%	N/A	R	→	SP - 41.85 % of eligible group. Target 2016/17.by December 2016
			Quarter	90.00%	N/A	R	→	
		The number of LD or Autism admissions without a CTR before admission	Month	0	6	R	→	Monitoring from Q1
			Quarter	0	6	R	→	

Financial Section

Governance – Financial Sustainability Risk Rating (FSRR)

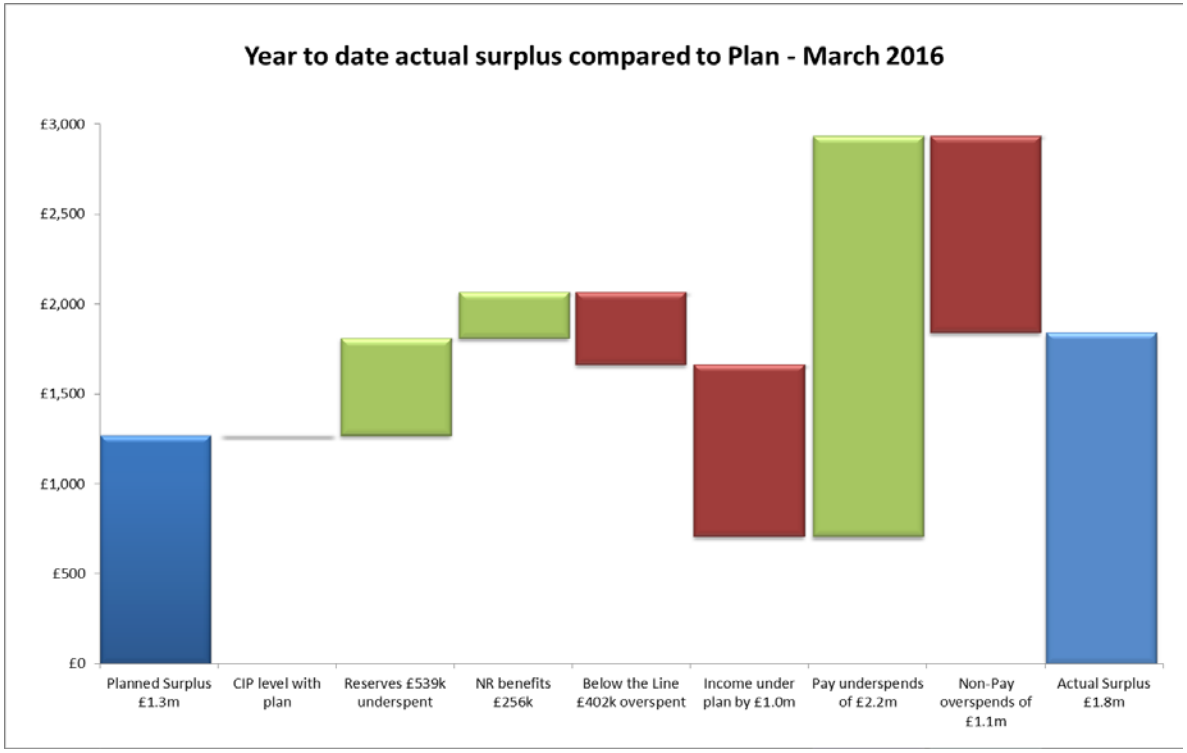
The FSRR for the end of the financial year is an overall 4 which is better than the plan of a 3 and is as per last month's forecast. The in-quarter risk rating is 2 driven by the deficit. We are monitored on the year-to-date 4 not in-quarter 2. The headroom down to a FSRR of 3 at the end of the financial year was £0.5m.

Income and Expenditure and Profitability

STATEMENT OF COMPREHENSIVE INCOME **MAR 2016**

	Current Month			Year to Date		
	Plan £000	Actual £000	Variance Fav (+) / Adv (-) £000	Plan £000	Actual £000	Variance Fav (+) / Adv (-) £000
Clinical Income	10,173	10,259	86	121,914	120,613	(1,302)
Non Clinical Income	832	1,152	319	10,248	10,304	56
Pay	(8,164)	(7,893)	271	(98,335)	(95,371)	2,965
Non Pay	(2,136)	(3,078)	(941)	(25,646)	(26,400)	(754)
EBITDA	**705**	**441**	**(264)**	**8,181**	**9,146**	**965**
Depreciation	(280)	(294)	(14)	(3,389)	(3,610)	(222)
Impairment	(200)	(514)	(314)	(300)	(713)	(413)
Profit (loss) on asset disposals	0	0	0	0	31	31
Interest/Financing	(181)	(177)	5	(2,221)	(2,133)	88
Dividend	(108)	(185)	(77)	(1,300)	(1,592)	(292)
Net Surplus / (Deficit)	**(64)**	**(729)**	**(665)**	**971**	**1,128**	**157**
Technical adj - Impairment	(200)	(514)	(314)	(300)	(713)	(413)
UnderlyingSurplus / (Deficit)	**136**	**(214)**	**(350)**	**1,271**	**1,841**	**570**

Clinical Income was better than plan in month but remains behind plan at the end of the year. This was £43k better than forecast.
Non Clinical income was higher than plan in the month improving the outturn position by £290k compared to forecast.
Pay expenditure was less than the plan in the month and the year end position is £411k more favourable than forecast.
Non Pay was overspent in the month by £941k due to additional non-recurrent expenditure some of which was not in the forecast. The non pay outturn worsened by £544k compared to the forecast.
The previous forecast assumed some costs to be pay related but were later classified within non-pay.



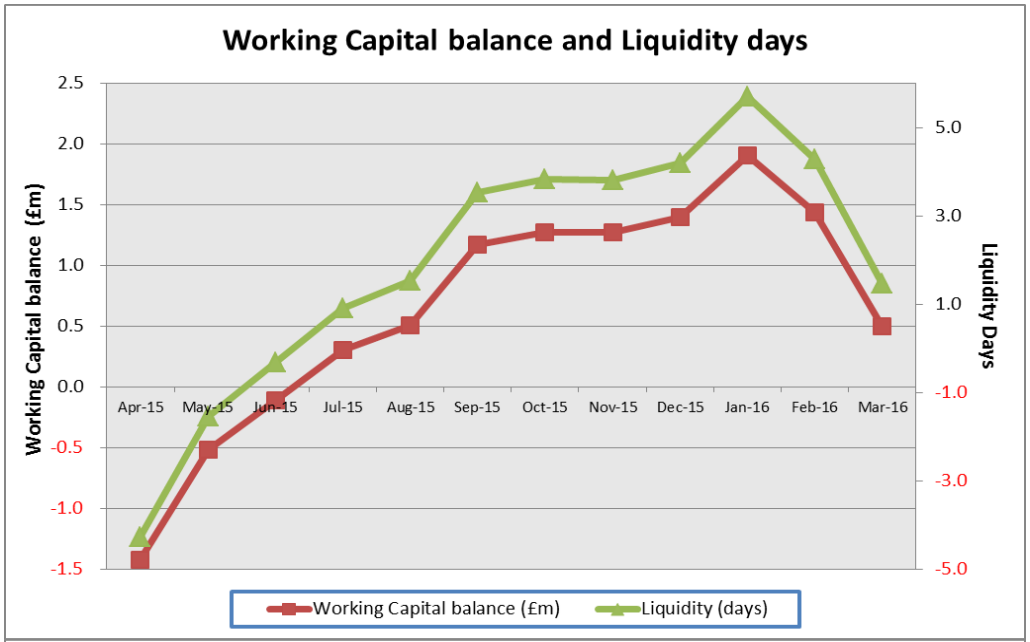
Summary of key points

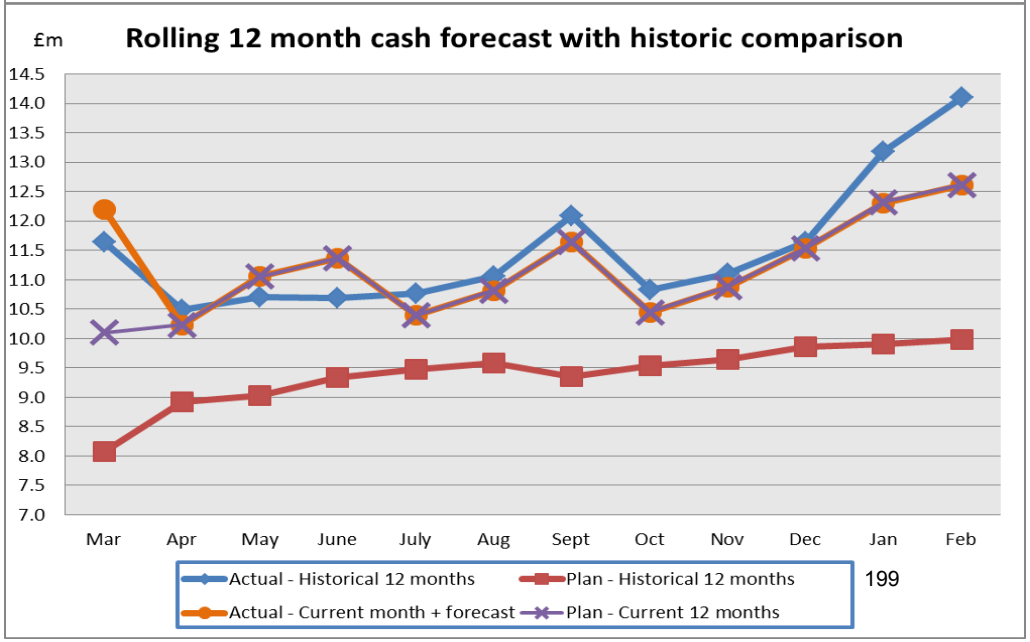
- Overall adverse variance to plan in the month mainly driven by non-recurrent expenditure some of which was previously included in the forecast.
- Income is better than plan in the month due to some additional non-recurrent income and additional Education Income
- However remains behind plan at the end of the financial year which is mainly driven by the lower occupancy and activity levels in cost per case services, some of which have corresponding expenditure reductions.
- Expenditure is overspent in the month due to non-recurrent expenditure and year end movements most of which were previously forecast. However expenditure remains underspent at the end of the financial year due to service developments, lower occupancy levels, uncommitted contingency reserves and some non-recurrent benefits.
- The overall surplus for the end of the financial year is as per the previous month's forecast of £1.8m.

Part of the non-recurrent expenditure relates to Consultancy and Legal Fees. During 2015/16 the following amounts have been spent:

- External Consultancy Fees for investigations and Well Led review £300k
- Legal costs including for the Employment Tribunal, investigations and business as usual £408k

Liquidity



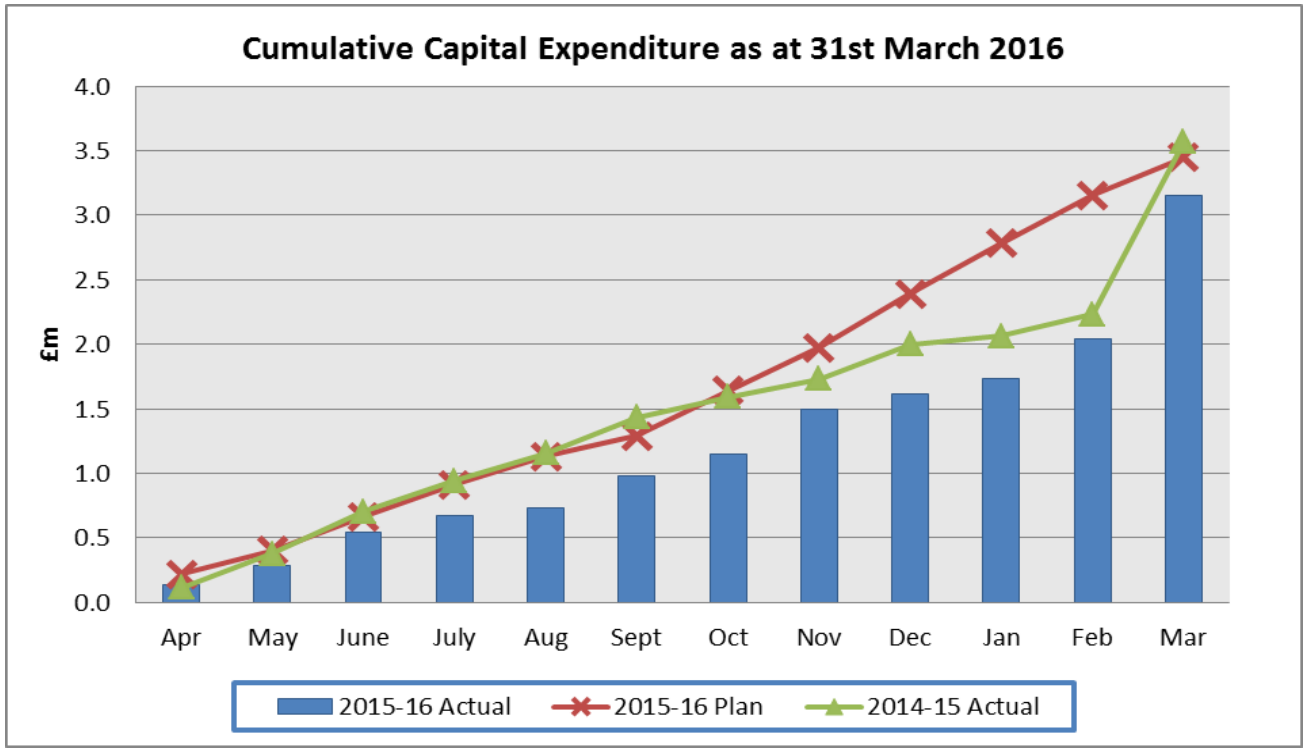


The first graph shows the working capital balance (net current assets less net current liabilities adjusted for assets held for sale and inventories) and how many days of operating expenses that balance provides.

During this financial year working capital has continued to improve due to improved cash levels. The downward trend at the end of the financial year is reflective of the reduction in cash due to year end transactions.

The Trust Board is reminded that sector benchmarking information recently provided by external auditors illustrates that the peer average continues to be around +24 days, therefore our liquidity of +1.5 days, must remain a strategic priority for us to continue to improve.

Cash is currently at £12.2m which was £0.7m better than forecast and £2.1m better than the plan. This is due to cash related Income and Expenditure surplus and capital expenditure being less than plan along with timing of payables and receivables.



Capital Expenditure ended the year as per the forecast of £0.3m lower than the plan due to the reprioritisation for urgent capital schemes.

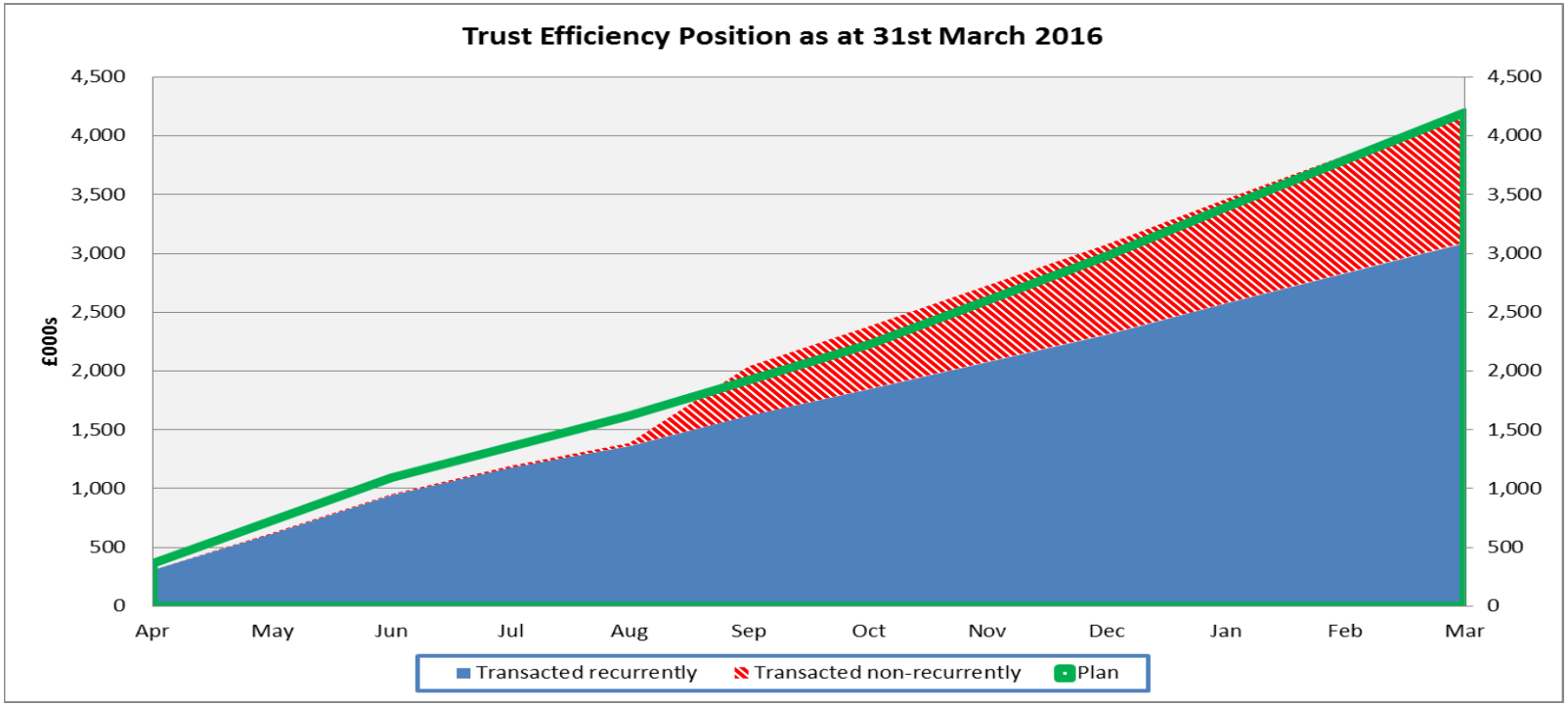
The 2015/16 schemes have been regularly reviewed by Capital Action Team (CAT) and reprioritisation to fund clinical priorities was approved, which is the reason for the change in expected capital expenditure compared to original plan.

A summary of the capital expenditure for this year is shown in the table below.

2015-16 Capital Expenditure	Original Plan	Actual Expenditure	Variance
	£'000	£'000	£'000
Estates			
Backlog Maintenance	400	396	4
Estates Staff	135	129	6
London Road - Rykneld and 63 Duffield Rd enabling	100	99	1
Kitchen - Hartington Unit	45	45	0
Cherry Tree refurb and potential extension	276	79	197
Kingsway carparking and link road	230	77	153
Recovery and Resilence Hub	120	58	62
Ilkeston Resource Centre - car park barriers	40	27	13
Radbourne Unit (seclusion, escalation, lifts, and other alterations)	45	373	(328)
Operating Lease Commitments - Decors etc	25	25	0
Neighbourhood changes	0	64	(64)
Kedleston Ceiling & Security Fencing	0	135	(135)
Other Estates schemes	0	275	(275)
Sub-total Estates	**1,416**	**1,782**	**(366)**
IM&T			
Patient Level Information Costing System	100	99	1
PC and Server replacement	171	232	(61)
Small IT projects	95	20	75
Electronic Paper Records	450	93	357
IM&T staffing	250	202	48
Sub-total IM&T	**1,066**	**646**	**420**
Other			
Transformation	712	513	199
Environment - eg CQC, ligature risks	150	161	(11)
Infection Control	50	3	47
Other Miscellaneous	56	47	9
Sub-total Other	**968**	**724**	**244**
Total Capital Expenditure 2015-16	**3,450**	**3,152**	**298**

Efficiency

Cost Improvement Programme (CIP)

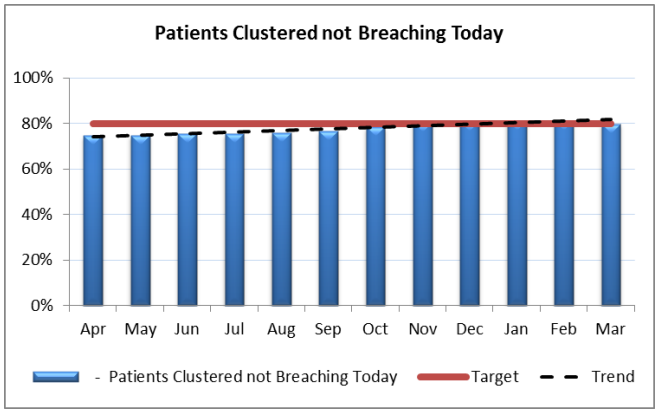


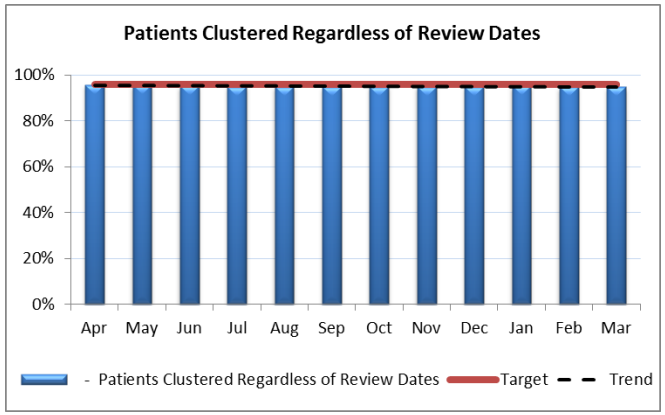
The full programme of £4.2m has been fully achieved as forecast. During the year there was some changes between planned schemes but replacement schemes were found. This led to non-recurrent savings of £1.1m.

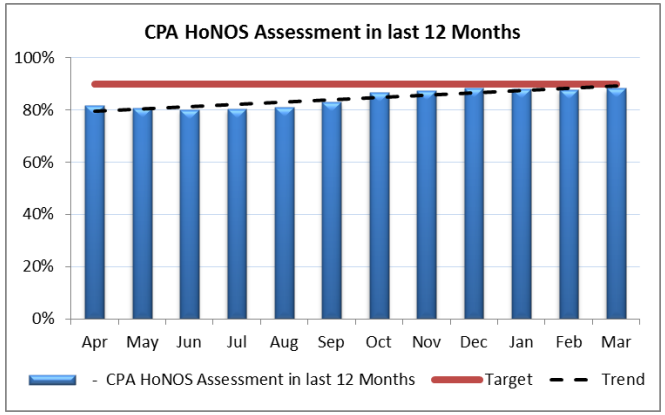
Programme Assurance Board continues to performance-monitor CIP delivery which is reported to Finance and Performance Committee who have delegated authority from Trust Board for oversight of CIP delivery.

Operational Section

Clustering and CPA HoNOS Assessments







The PbR Advisor continues to work with teams and individuals offering training, support and advice. We are taking the opportunity of the WorkPro road-test to emphasise the importance of timely and accurate clustering. We highlight the importance of Clusters for understanding demand and in the commissioning of relevant training.

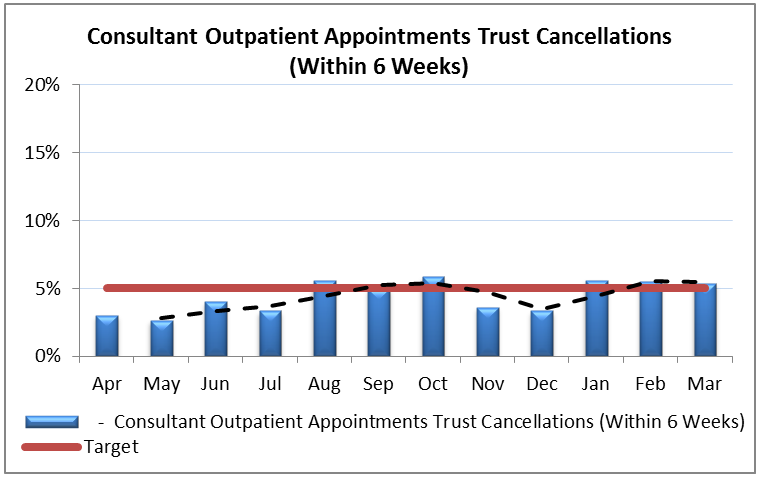
We now have an added driver to improve compliance in that Monitor are pressing for outcomes-based payment systems to be introduced. In light of this we are implementing performance management for NTPS compliance
Medical Director's Bulletin December 2015 briefed the medical staff re these new Monitor clustering requirements and has resulted in the PbR Advisor receiving more requests for help and support with clustering

An e-learning package on mental health currencies and payment was recently developed and went live on 12th January 2016.

We are awaiting feedback from the recent Monitor visit, which may identify additional action required.

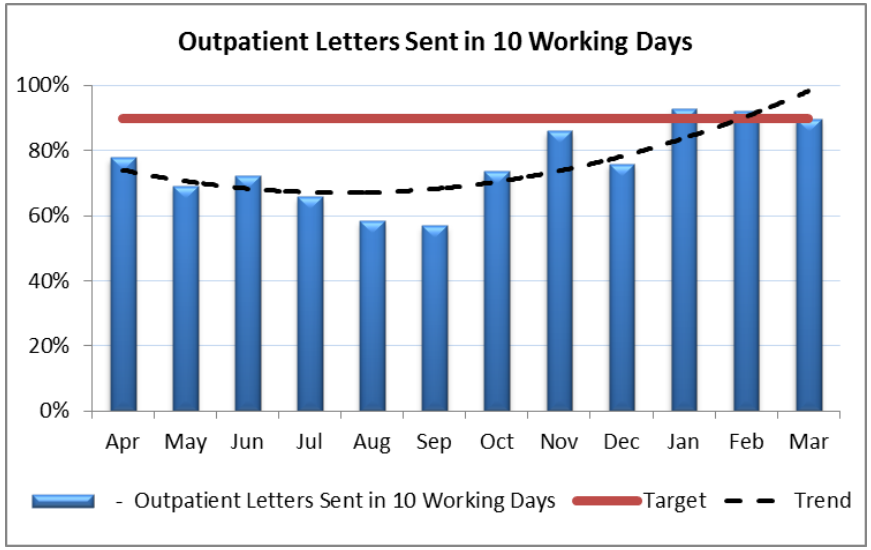
CPA HoNOS assessments are conducted as part of the PbR Process.

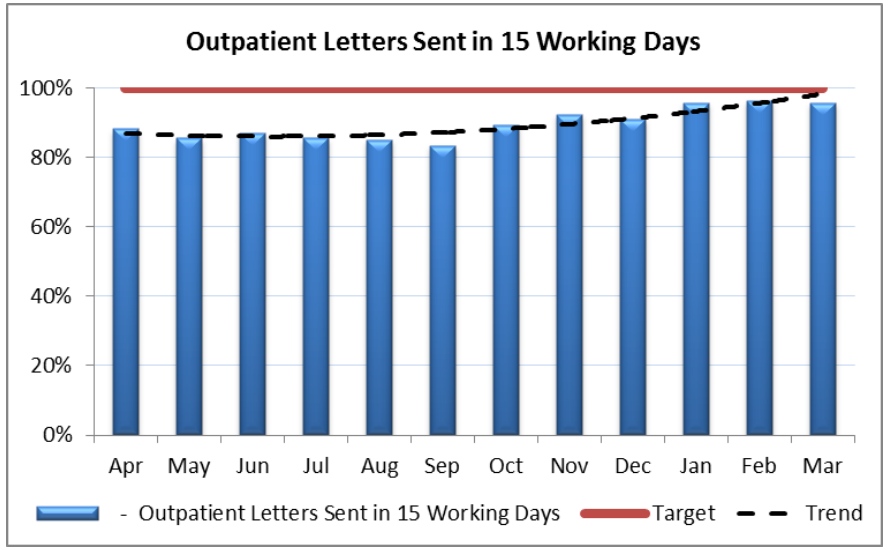
Consultant Outpatient Appointments Trust Cancellations (within 6 weeks)

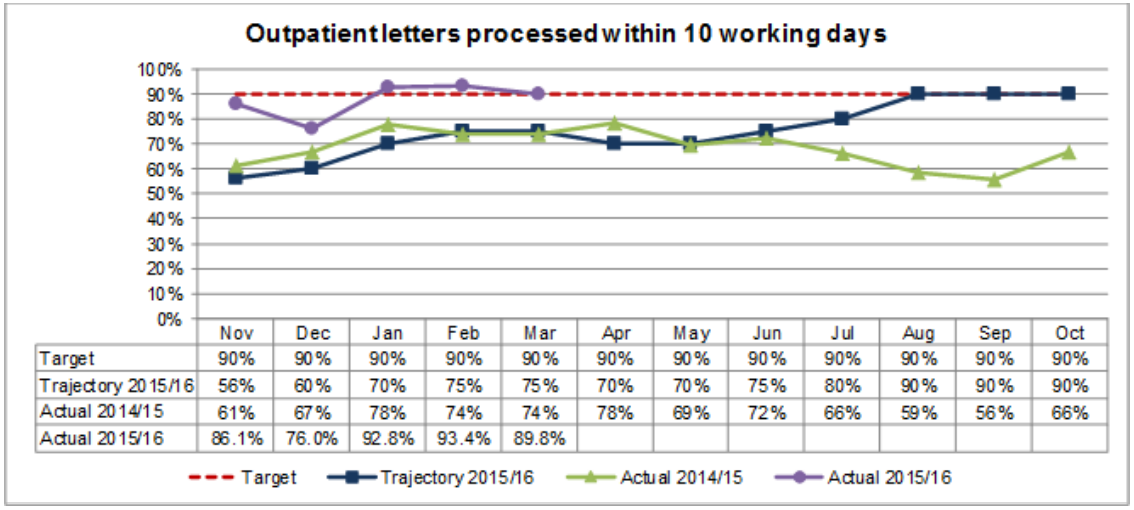


- A manual audit of cancellations found that the main reasons for cancellation were as displayed in the table
- Associate Clinical Directors to review cancellation reasons and discuss with consultant concerned where the reason does not appear valid, if applicable.
- List of cancellation reasons has been agreed and added to Paris to enable easier reporting and monitoring.

Reason	%
clinic closed	39.8%
change day for locum	11.2%
clinician absent from work	10.0%
clinician on annual leave	10.0%
virtual appt - patient not inconvenienced	6.4%
clinic time extended	4.0%
industrial action	3.6%
clinic moved due to an appeal - moved in advance or patient telephoned and appt arranged to suit	2.8%
neuroradiology meeting	2.4%
compulsory training	2.0%
patient rearranged the appointment	1.6%
booked incorrectly - clerical error	1.2%
no junior doctor	1.2%
patient attended	0.8%
rescheduled as worker unable to attend	0.8%
clinician required to attend court	0.4%
patient on holiday	0.4%
no interpreter available	0.4%
patient cancelled the appointment	0.4%
appt not required	0.4%
patient deceased	0.4%







	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Trajectory 2015/16	56%	60%	70%	75%	75%	70%	70%	75%	80%	90%	90%	90%
Actual 2014/15	61%	67%	78%	74%	74%	78%	69%	72%	66%	59%	56%	66%
Actual 2015/16	86.1%	76.0%	92.8%	93.4%	89.8%							

The action plan is being implemented. We continue to perform above trajectory.

- To continue to implement and monitor the action plan against recovery trajectory
- To request that the commissioners reduce the 100% target

WARD STAFFING

Ward name	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	99.2%	101.5%	100.0%	100.0%	No	NONE REQUIRED
Child Bearing / Perinatal Inpatient	125.4%	191.8%	103.3%	154.7%	Yes	the current fill rate tolerances for registered nurses on days was broken to backfill 1.8 WTE vacancy and care staff (day and night) due to long term sickness absence and covering high levels of observation.
CTC Residential Rehabilitation	101.6%	100.5%	100.0%	100.0%	No	NONE REQUIRED
Enhanced Care Ward	80.2%	97.0%	80.3%	116.9%	Yes	We had 3 qualified members of staff on long term off sick in march, one unqualified member of staff was on maternity leave, one vacancy for an unqualified member of staff. From 20/03/16 we had high levels of observations.
Hartington Unit Morton Ward Adult	94.7%	105.3%	72.2%	141.7%	Yes	the reason is we are currently carrying x 4.36 Band 5 vacancies on the ward and in addition to that x 1 band 5 is currently acting up into a Band 6 role on the ward. Thus we are having difficulty in having x 2 qualified staff on nights every night.
Hartington Unit Pleasley Ward Adult	113.4%	81.3%	157.6%	80.3%	Yes	The reason we are under on care staff during the day is because the shifts have been covered by qualified. This is because we had some short term sickness and annual leave during March and qualified staff have been prepared to work extra shifts. The reason we are over on Registered Nurses at night is because we are now in a position to start to rota 2 Registered Nurses on to nights as opposed to one.

WARD STAFFING

Ward name	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 (%)		
Hartington Unit Tansley Ward Adult	87.5%	112.7%	52.5%	188.2%	Yes	The reasons for the staffing skill mix deficits on Tansley ward are due to Band 5 vacancies, 4 of which have been recruited into however the successful candidates do not qualify until September 2016. The remaining posts are out to current central recruitment process and the next interview date is 04/05/2016. In addition to vacancy 1 Band 5 nurse is on special leave so unavailable for duty. Remaining Band 5 nurses are helping to provide extra cover by working Bank shifts.
Kedleston Unit	93.5%	97.2%	100.0%	104.0%	No	NONE REQUIRED
KW Cubley Court Female	102.8%	93.3%	91.2%	101.8%	No	NONE REQUIRED
KW Cubley Court Male	96.6%	93.7%	82.0%	108.3%	Yes	the reason for the low fill rate on night duty was due to high levels of qualified nurse sickness on the unit.
LRCH Ward 1 OP	99.2%	96.7%	100.0%	100.0%	No	NONE REQUIRED
LRCH Ward 2 OP	100.7%	97.0%	100.0%	98.4%	No	NONE REQUIRED
RDH Ward 33 Adult Acute Inpatient	98.8%	102.4%	97.5%	98.6%	No	NONE REQUIRED
RDH Ward 34 Adult Acute Inpatient	95.7%	113.5%	63.3%	228.6%	Yes	This is an on going issue at night due to high level of vacancies, we are currently working with one qualified and two nursing assistants on the night shift.
RDH Ward 35 Adult Acute Inpatient	93.0%	110.4%	94.5%	122.2%	No	NONE REQUIRED
RDH Ward 36 Adult Acute Inpatient	92.5%	106.3%	79.5%	117.5%	Yes	NO COMMENTS RECEIVED

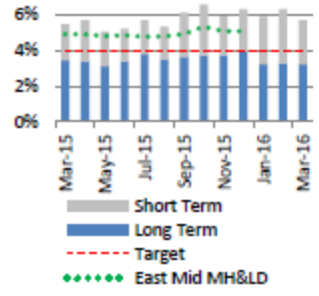
Workforce Section

WORKFORCE DASHBOARD

Wellbeing

Sickness Absence

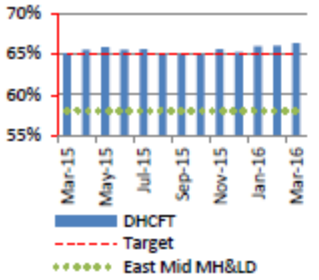
	Jan-16	Feb-16	Mar-16
(Monthly)	5.86%	6.26%	5.67%
Target			3.90%



The Trust annual sickness absence rate is currently 5.56% (0.14% increase from last month). Anxiety/stress/depression/other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 22.66% of all sickness absence, followed by Surgery at 11.55% and Cold, Cough, Flu - Influenza at 10.38%.

Qualified Nurses

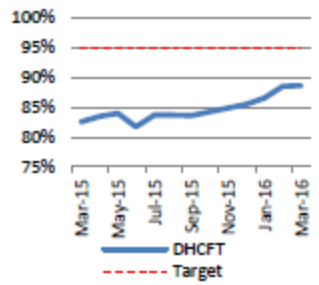
	Jan-16	Feb-16	Mar-16
(To total nurses, midwives, health visitors and healthcare assistants)	65.99%	66.04%	66.41%
Target			65%



Contracted staff in post qualified nurses to total nurses, midwives, health visitors and healthcare assistants remains within target at 66.41%. Vacancy rates can impact on this measure. The NHS average is 61.38% and the East Midlands Mental Health & Learning Disability average is 58.04%.

Compulsory Training

	Jan-16	Feb-16	Mar-16
(Staff in-date)	86.52%	88.48%	88.59%
Target			95%

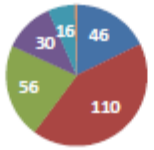


Compulsory training compliance continues to increase rising from 82.49% in March 2015 to 88.59% in March 2016 (6.1% increase). Compulsory training compliance is above the 85% main contract commissioning for quality and innovation (CQUIN) target.

Motivation

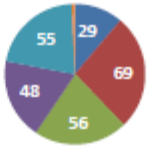
Staff FFT Q4 2015/16 & Staff Survey 2015

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



1 - Extremely Likely
2 - Likely
3 - Neither likely nor unlikely
4 - Unlikely
5 - Extremely unlikely
6 - Don't Know
7 - No Response

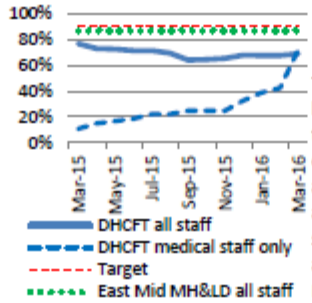
How likely are you to recommend this organisation to friends and family as a place to work.



	2014	2015	National Average
Overall staff engagement	3.75	3.73	3.81

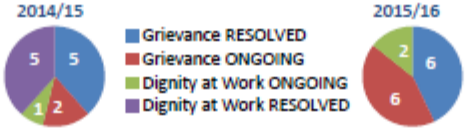
Appraisals

	Jan-16	Feb-16	Mar-16
(All staff)	67.67%	67.82%	69.12%
Target			90%



The number of employees who have received an appraisal within the last 12 months has increased during March 2016 and Medical appraisals are now being recorded accurately. According to the latest staff survey results, the national average for Mental Health & Learning Disability Trusts is 91%.

Grievances/Dignity at Work

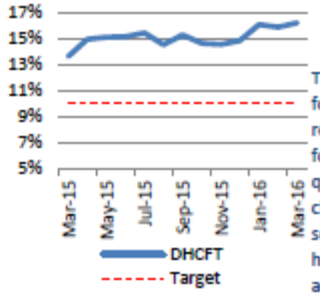


Grievances lodged at the formal stage included working relationships with colleagues, matters related to the disciplinary process and a collective grievance connected to conditions of service. Dignity at work complaints were raised formally under the dignity at work process and included an alleged act of physical and verbal aggression involving two members of staff each raising their own complaint, treatment and behaviour of peers/colleagues and a counter complaint from an earlier case.

Attendance

Vacancy

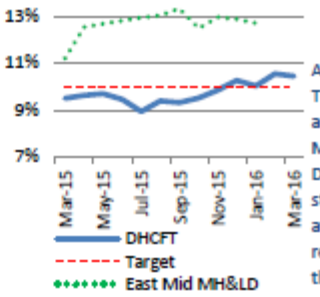
	Jan-16	Feb-16	Mar-16
(Budgeted full time equivalent)	16.12%	15.91%	16.24%
Target			10%



The average budgeted vacancy rate for the year was 15.25%. Active recruitment during March 2016 was for 58 posts. 53.45% were for qualified nursing, 15.52% admin & clerical, 10.34% medical, 8.62% scientific & technical, 6.9% allied health professionals, 3.45% additional clinical services and 1.72% Estates.

Turnover

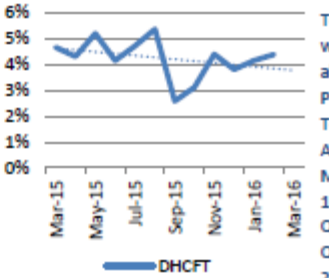
	Jan-16	Feb-16	Mar-16
(Annual)	10.03%	10.54%	10.45%
Target			10%



Annual turnover remains within Trust target parameters at 10.45% and is below the average for East Midlands Mental Health & Learning Disability Trusts. The number of staff leaving remains static at an average of 22 per month. It is the reduction in contracted staff in post that is causing an increase in turnover.

Agency Usage

	Jan-16	Feb-16	Mar-16
(Spend)	4.16%	4.39%	5.95%



Total agency spend in March 2016 was 5.95%. Of total agency spend for all staff groups, Allied Health Professionals and Scientific & Technical accounted for 0.61%, Admin & Clerical and Estates 0.56%, Medical 3.10%, Qualified Nursing 1.54% and other 0.14%. Agency Qualified Nursing spend against total Qualified Nursing spend in March 2016 was 4.2%.

Quality Section

Illustrative Inpatient Dashboard

Ward Quality Dashboard

Audrey House Residential Rehabilitation

Ward Staffing Information (E-Rostering)

Audrey House Residential Rehabilitation	Shift										
	Late (17/04)	Night (17/04)	Early (18/04)	Late (18/04)	Night (18/04)	Now	Late (19/04)	Night (19/04)	Early (20/04)	Late (20/04)	Night (20/04)
Registered - Actual	1	1	2	1	1	1	2	1	1	1	1
Registered - Required	1	1	1	1	1	1	1	1	1	1	1
Unregistered - Actual	1	1	1	2	1	2	1	1	2	2	1
Unregistered - Required	2	1	2	2	1	2	2	1	2	2	1

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Incidents Raised (DATIX)

Audrey House Residential Rehabilitation	Number
⊞ Degree of Injury	5
⊞ Incident Category	5
⊞ Incident Loctaion	5
⊞ Incident Outcome	5
⊞ Incident Status	5

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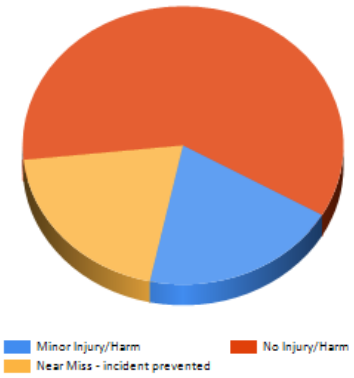

Clinical Stability

Audrey House Residential Rehabilitation
Vancancies : Not Known
Lead Consultant in post for > 1 year : Not Known
Lead Consultant : Dr Mahendra Kumar
Shift Manager : Lauren
Ward Manager : Sara Tissington
Ward Manager in post for > 1 year : Yes
Comments : None

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Complaints & Compliments (DATIX)

Audrey House Residential Rehabilitation	This Week	Last Week	This Month	Last Month	This Quarter	Last Quarter	This Year	Last Year
Complaints	0	0	0	0	0	0	0	2
Compliments	0	0	0	0	0	0	0	3

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Friends & Family Question

Audrey House Residential Rehabilitation	How likely are you to recommend our service or team?				
	Extremely Unlikely	Unlikely	Neither	Likely	Extremely Likely
This Week	0	0	0	0	0
Last Week	0	0	0	0	0
This Month	0	0	0	0	0
Last Month	0	0	0	0	0
This Year	0	0	0	0	0
Last Year	0	0	0	1	0

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Staff Training (ESR)

	Target	Improvement

Last Updated

Information on each ward will be available next month

Strategic Risks

- Failure to achieve clinical quality standards
- Failure to deliver the agreed transformational change at the required pace.
- Risk to delivery of national and local system wide change.
- Failure to deliver short term and long term financial plans
- Loss of public confidence due to Monitor enforcement actions and CQC requirement notice and adverse media attention
- Loss of confidence by staff in the leadership of the organisation at all levels

<u>Mitigation</u>

Risks escalated to Audit Committee and Board though board assurance framework processes. Allocated board committees undertaking ‘deep dives’ on robustness of controls and actions for each.

Operational/Clinical Risks

- Long waiting lists due to difficulty in recruiting paediatricians
- Non-compliance with medicine management standards
- Lack of pharmacists for on-call rota
- Lack of parking for clinicians at bases
- Nursing vacancies across Radbourne Unit

<u>Mitigation</u>

Risks monitored though operational senior management teams, and escalated to Trust Operational Management Meeting.

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	Apr-16	May-16	Jun-16	Jul-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
		Deadline for papers	**18 Apr**	**16 May**	**20 Jun**	**18 Jul**	**26 Aug**	**26 Sep**	**24 Oct**	**28 Nov**	**3 Jan**	**23 Jan**	**20 Feb**
RG	Apologies given		X	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	X
RG	Minutes/Matters arising/Action Matrix	FT Constitution	X	X	X	X	X	X	X	X	X	X	X
RG	Board Forward Plan	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X	X
RG	Board review of effectiveness of the meeting	Statutory Outcome 3	X	X	X	X	X	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE													
RG	Chairman's report	Licence Condition FT4	X	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	X
MP/ CW	APR Monitor Annual Plan submissions and governance statements, including financial plan and budgets (subject to change for Monitor deadlines each year) *Confidential*	FT Constitution/Monitor Risk Assurance Framework (RAF)	X										X
CW	Monitor Compliance Return (Public)	Monitor Risk Assurance Framework (RAF)	X			X			X		X		X
CG	Information Governance Updates	Strategic Outcome 1 Strategic Outcome 3 Information Gov toolkit	X						X			X	
JSt	Staff Survey Results and Action Plan	Strategic Outcome 3 and 4	X										X
SH	Review S.O.'s, SFI's, SoD	FT Constitution Standing Orders						X					
SH	Trust Sealings	FT Constitution Standing Orders		X									
SH	Annual Review of Register of Interests	FT Constitution Annual Reporting Manual	X										
SH	Board Assurance Framework Update	Licence Condition FT4				X		X			X		X
SH	Raising Concerns (whistleblowing)	Strategic Outcome 1 Public Interest Disclosure Act			X						X	X	
SH	Whistleblowing Policy - annual nomination of NED role (one year rotation)	Francis Report		X									

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	Apr-16	May-16	Jun-16	Jul-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
SH	Committee Reports (following every meeting) - Audit - Finance & Performance - Mental Health Act - Quality Committee - Safeguarding -People Committee	Strategic Outcome 3	X	X	X	X	X	X	X	X	X	X	X
MP	Governance Improvement Action Plan	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X	X
SH	Fit and Proper Person Declaration	Licence Condition FT4		X									X
OPERATIONAL PERFORMANCE													
CG, CW, JSt, CG	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
QUALITY GOVERNANCE													
CG	Position Statement on Quality (Incorporates Strategy and assurance aspects of Quality management)	Strategic Outcome 1 CQC and Monitor		X	X		X	X	X	X	X	X	X
CG/ JSy	Safeguarding Children Annual Report	Children Act Mental Health Standard Contract						X					
CG/ Jsy	Safeguarding Adult Annual Report	CQC Mental Health Standard Contract						X					
CG	Control of Infection Report	Health Act Hygiene Code		X									
CG/ JSy	Integrated Clinical Governance Annual Report including MHA/Governance/Complaints and Compliments/SIRI's/Patient Safety/NHS Protect (LSMS) and Emergency Preparedness/H&S (including H&S and Fire Compliance and Associated Training)	CQC and H&S Act							X				
CG	Annual Community Patient Survey	Clinical Practice CQC							X				
JSy	Re-validation of Doctors	Strategic Outcome 3			X								