Derbyshire Healthcare NHS
NHS Foundation Trust

NOTICE OF BOARD MEETING
WEDNESDAY 27 JULY 2016
TO COMMENCE AT 1.00 PM IN CONFDERENCE ROOMS A&B,
FIRST FLOOR
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 –	-	Richard Gregory
3.	1:30	Apologies for Absence		Richard Gregory
4.	1:30	Declarations of Interest	**A**	Richard Gregory
5.	1:30	Minutes of Board of Directors meeting held on 30 June 2016	**B**	Richard Gregory
6.	1:35	Matters arising – Actions Matrix – to follow	**C**	Richard Gregory
7.	1:40	Chairman's Verbal Update	-	Richard Gregory
8.	1:50	Acting Chief Executive's Report	**D**	Ifti Majid
OPERATIONAL PERFORMANCE, QUALITY AND STRATEGY				
9.	2:00	Integrated Performance and Activity Report	**E**	Carolyn Gilby Claire Wright Jayne Storey Carolyn Green
10.	2:15	Position Statement on Quality	**F**	Carolyn Green
11.	2:25	Compliance Return	**G**	Samantha Harrison
12.	2:35	- Board Committee Escalations from the Audit & Risk Committee* (19 July), People & Culture Committee* (15 July) Quality Committee (7 July) Mental Health Act Committee (3 June) - Ratified Minutes of meetings held in June (Quality Committee, People & Culture Committee, and ratified minutes of Audit & Risk Committee held in May) are included for information only ** to follow*	**H**	Committee Chairs
13.	2:45	Annual Members Meeting Arrangements	**I**	Anna Shaw
3:00 B R E A K				
14.	3:15	Deep Dive – Children's Services	**J**	Carolyn Gilby
15.	3:35	Equality and Diversity Workforce approach for 2016 -17	**K**	Owen Fulton
GOVERNANCE				
16.	3:45	Board Assurance Framework Update	**L**	Carolyn Green
17.	3:55	Governance Improvement Action Plan Corporate Governance Framework	**M**	Mark Powell Samantha Harrison
18.	4:05	Annual Audit Letter	**N**	Caroline Maley
CLOSING MATTERS				
19.	4:10	Any other business		Richard Gregory
20.	4:15	Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework		Richard Gregory
21.	4:20	2016/17 Board Forward Plan	**O**	Samantha Harrison
22.	4:25	Meeting effectiveness		Richard Gregory

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.

There is no meeting scheduled for August
The next meeting will be held on 7 September 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.

Overleaf page

Declaration of Interests Register 2016-17

NAME	INTEREST DISCLOSED	TYPE
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	-
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	Nil	-
Ifti Majid	Nil	-
Caroline Maley	Director – C D Maley Ltd Trustee – Vocaleyes Ltd.	(a) (a, d)
Mark Powell	Nil	-
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)
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

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

Held in Conference Training Rooms 1 & 2
Research and Development Centre, Kingsway, Derby DE22 3LZ

Thursday, 30 June 2016

MEETING HELD IN PUBLIC
Commenced: 1pm Closed: 4:40pm

PRESENT:	Richard Gregory	Interim Chairman
	Caroline Maley	Senior Independent Director
	Phil Harris	Non-Executive Director
	Maura Teager	Non-Executive Director
	Ifti Majid	Acting Chief Executive
	Claire Wright	Executive Director of Finance
	Carolyn Green	Director of Nursing & Patient Experience
	Carolyn Gilby	Acting Director of Operations
	Dr John Sykes	Executive Medical Director
	Mark Powell	Director of Business Development & Marketing
	Jayne Storey	Director of Workforce OD & Culture
	Samantha Harrison	Director of Corporate Affairs & Trust Secretary
IN ATTENDANCE:	Richard Eaton	Communications Manager
	Sue Turner	Board Secretary and Minute Taker
For item DHCFT 2016/0	Bev Green	Releasing Time to Care Lead (Service Improvement)
For item DHCFT 2016/0	Louise Jenkins	Senior Nurse, The Lighthouse
For item DHCFT 2016/0	Jackie and Max	Service Receivers
For item DHCFT 2016/0	Kath Lane	Acting Deputy Director of Operations
For item DHCFT 2016/0	Tim Slater	General Manager Campus
For item DHCFT 2016/0	Garry Southall	Principal Workforce & Organisational Development Manager
For item DHCFT 2016/0	Susan Spray	Principal Workforce & Organisational Development Manager
APOLOGIES:	Jim Dixon	Deputy Chair and Non-Executive Director
VISITORS:	John Morrissey	Lead Governor
	Gillian Hough	Public Governor, Derby City East
	Aydin Sami	Administrator, Ilkeston Community Hospital

DHCFT 2016/089	**INTERIM CHAIRMAN'S WELCOME, OPENING REMARKS AND APOLOGIES** The Interim Chairman, Richard Gregory, opened the meeting by welcoming all present.
DHCFT 2016/090	**SERVICE RECEIVER STORY** Carolyn Green introduced Jackie and her son Max who were accompanied by Louise Jenkins, Senior Nurse at the Lighthouse. Jackie very kindly agreed to talk about her experience of the Lighthouse service and described day to day life caring for Max's complex health needs. Max is a pleasure to look after and has a beautiful smile, he was

	disabled at birth and has a rare form of epilepsy for which he is prescribed medication as well as rescue medication. Max is also non-verbal, he has had a tracheotomy and is fed via gastrostomy, he also has brittle bones and uses a wheelchair. Max has had several operations and cannot do much for himself and is prescribed considerable medication that needs to be administered correctly. Jackie has three other children and since receiving support from the Lighthouse when Max was eight, Jackie and her family are now managing to live a fuller life and are far happier. Louise explained that the Lighthouse's main priority is to keep Max safe and provide family respite. He has complex needs which are quite difficult to manage. To stabilise Max's care Louise set up training sessions for all the staff to learn how to meet Max's needs and this has provided Jackie and her family with comfort knowing that Max and other children like him can receive respite care which enables families to spend time together to function normally. Max is always happy at the Lighthouse and has access to sensory rooms and fun equipment. Carolyn Green asked Jackie what improvements in the support and care for Max she and her family could have received. Jackie wished Max could have accessed the Lighthouse at a much earlier age as caring for him has been very difficult. Staff at the Lighthouse know Max very well and Louise makes sure that any new staff are trained to care for his needs. Jackie suggested that photographs showing how Max likes to sleep or sit could be used as useful guidance to staff who care for children like Max. Carolyn Green pledged to supply the Lighthouse with a camera so photographs can used to inform staff of not just Max's needs, but those of other children in the Lighthouse's care as a patient safety improvement under the Trust's innovation network. The Board asked to know more about staff training for children with such complex needs. Louise described the enormous element of care involved looking after children like Max and stressed that the complex needs of these children is ever increasing. Tracheotomy and rhesus training is something that needs to be looked at to enable the right level of training to be continuous with the staff who join the Lighthouse team on an ongoing basis. Training has been concentrated on nursing staff and Louise has set up a system to ensure staff undergo training so they are compliant, but she has noticed there has been reluctance / as well as skills competence and the ability to retain this skill set from social care staff to take on training within their roles. Louise was keen for the training packages to be completed and ratified and Carolyn Green suggested that Louise be invited to attend the Physical Care Committee which would help and support her in her endeavours. The Board considered Jackie's story to be truly inspirational and felt gratified to hear how Louise and the Lighthouse team cared for Max had responded to Jackie's and her family's needs. **ACTION: Bev Green and Carolyn Green to arrange for a camera to be provided for use at the Lighthouse through the Trust innovation network.** **RESOLVED: The Board of Directors expressed thanks to Jackie for sharing her experience and appreciated the opportunity to hear at first hand the service the Trust had provided.**
DHCFT 2016/091	**MINUTES OF THE MEETING DATED 25 MAY 2016** The minutes of the meeting held on 25 May were accepted and agreed subject to the list of attendees being amended to record apologies received by Jayne Storey.
DHCFT 2016/092	**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.
DHCFT 2016/093	**CHAIRMAN'S VERBAL REPORT** Richard Gregory updated the Board on progress made in Derbyshire on the Sustainability and Transformation Plan (STP) which involves the Trust heading towards a more integrated service which will improve quality of patient care across all providers including health and social care. He explained that because this is a national initiative and the Trust was being encouraged to move at pace, a special meeting of the Trust's Council of Governors and Derbyshire Community Health Services NHS Foundation Trust's (DCHS) Council of Governors will take place to update governors on the work that will bring together all local NHS providers, commissioners, local authorities and the voluntary sector, to develop a comprehensive and joined-up plan for the future. **RESOLVED: The Board of Directors noted the Interim Chairman's verbal update.**
DHCFT 2016/094	**ACTING CHIEF EXECUTIVE'S REPORT** Ifti Majid presented his report which provided the Board with feedback on changes within the national health and social care sector as well as providing an update on developments occurring within the local Derbyshire health and social care community. The report also updated the Board on feedback from external stakeholders such as commissioners and the Trust's staff. The report was also used to support strategic discussion on the delivery of the Trust strategy. Ifti Majid informed the Board that the 21C Joined Up Care Public Consultation went live on 29 July the proposals of which were contained in the publication of the consultation document that was circulated at the meeting. Attention was drawn to the inaugural report of the NHS Workforce Race Equality Standard (WRES) that had been published by the NHS Equality and Diversity Council which he thought gave interesting reading. This is the first time WRES data has been published nationally and Ifti was pleased to report that the Trust is rated higher than the national average. He was also pleased to report that an update on the Trust's Equality and Diversity Workforce approach for 2016 - 17 would be presented to the Trust Board at the next meeting in July. Following the referendum last week, Ifti Majid made a public statement which acknowledged the contribution of staff from ethnic areas which was fully supported by the Board. *"In common with other senior healthcare leaders, I want to take this opportunity to recognise the vital contribution made to the delivery of our services by staff who are not UK nationals.* *"Their skill, commitment and dedication are key to ensuring the ongoing quality of our services.* *"I am saddened by reports over the last week about the increase in abuse towards non-UK nationals following last week's referendum. I would like to make it absolutely clear that within our Trust we will not accept this sort of behaviour and I would urge all of our staff to use existing mechanisms to alert us to any such incidents.* *"As a Trust, I am confident that we can demonstrate our belief in tolerance and respect by valuing and supporting individuals regardless of their background or nationality."*

	Ifti Majid reported that formal feedback following the CQC inspection visit at the beginning of June was still awaited and initial issues raised at the time are being dealt with immediately. Carolyn Green added that some high level areas were around quality priorities. Improvements have been made but there are still some areas that need to reach full 100% compliance. There is work to be carried out within the positive and safe risk reduction strategy to ensure our data is accurate and work is also being carried out on seclusion and segregation compliance as this had been raised as a concern by the CQC. At this point Richard Gregory took the opportunity to thank governors for contributing to the CQC inspection which had proved extremely valuable. Ifti Majid's report also included the Listen, Learn and Lead matrix which set out the latest round of team visits by Directors. **RESOLVED: The Board of Directors noted the contents of the Acting Chief Executive's report**
DHCFT 2016/095	**INTEGRATED PERFORMANCE AND ACTIVITY REPORT** This report provided the Trust Board with an integrated overview of performance as at the end of May 2016 with regard to workforce, finance and operational delivery and quality performance. Claire Wright pointed out key points emerging from the report relating to Finance. She explained how IAPT performance income had deteriorated which was mainly due to sickness and vacancy aspects. She also highlighted the work currently taking place to progress gaps in the Cost Improvement Programme (CIP) which will be assessed further in July. Claire Wright informed the public and visitors to the meeting that the Board had agreed during its confidential session this morning to accept NHSI's offer of £0.83m sustainability and transformation funding. This would create a £2.5m surplus control total in place of the currently agreed £1.7m surplus. Carolyn Gilby highlighted key points relating to operational functions and was pleased to point out that the Trust was fully compliant with NHSI targets. Discussion took place on whether there was more demand for early intervention work and it was agreed that this would be raised with commissioners. Carolyn Gilby added that new NICE guidance is being adhered to which the Trust has not measured against before and this was being reviewed with commissioners within the terms of new monitoring within contract management. It was noted that Workforce KPIs were looking more favourable although sickness absence remains a concern. Specific action has been taken in this area and staff have been asked if they would like to work extra hours. Jayne Storey pointed out that a recent report from BUPA showed that 60% of stress issues reported by staff were home related issues, not work related. Stress management training for managers has been offered and is being actively encouraged. Meetings had also taken place with First Care who manage the Trust's absence system to help develop best practice and learning and there is some really proactive information in this area. Caroline Maley was concerned about the level of vacancies and it was pointed out that the majority of vacancies had arisen due to staff moving to other areas of the organisation rather than from staff leaving the Trust. Carolyn Green provided a brief overview of quality issues and explained that quality measures were currently being developed further with redesign of clinical record keeping. She was also working with the Quality Leadership Teams to improve standards of compliance on areas such as seclusion and segregation. Specific work will also take place to improve monitoring of seclusion and segregation recording rates which will be

	cross referenced against DATIX incidents through the Mental Health Act Committee. Some of the Trust's feedback with regard to the recording of segregation was related to when the Radbourne unit was closed to admissions and the 136 suite was closed due to an incident involving a very dangerous service user. This was a particularly difficult issue which had been escalated to NHS England as a near miss incident. The Board felt some valuable points were raised while discussing the integrated report which drew attention to areas of risk and vulnerability to staff and patients and Ifti Majid asked for thanks to be extended to individual teams for achieving such positive results. **RESOLVED: The Board of Directors scrutinised the content of the report and obtained assurance on the current performance across the areas presented.**
DHCFT 2016/096	**TRUST COMPLIANCE – ACCESSIBLE INFORMATION STANDARD** Carolyn Gilby provided an update on the Trust's compliance with the Accessible Information Standard. Members of the Board considered that the report contained a broad range of information and was assured that the Trust would be fully compliant with the Accessible Information Standard by the end of July. **RESOLVED: The Board of Directors:** **1) Acknowledged progress made with the Accessible Information Standard implementation plan** **2) Acknowledged full implementation compliance in advance of 31 July 2016**
DHCFT 2016/097	**POSITION STATEMENT ON QUALITY** Carolyn Green presented her report which provided the Board of Directors with an update on the Trust's continuing work to improve the quality of services it provides in line with the Trust's Strategy, Quality Strategy and Framework and strategic objectives. The Board noted that the position statement set out: 1. Caring through the Trust's work with carers in carer's week 2. Responsiveness of our services through the Blue Light system 3. Safe services which includes some work which has commenced on seclusion, Mental Capacity Act and physical health checks 4. Well-led: The CQC visit inspection week and next steps 5. Effectiveness of our Learning Disabilities (LD) Strategic Health Facilitation in winning funding from NHS England and Patient activation bid key aspects of the Trust's Quality priorities in Physical Healthcare and Personalised care. **RESOLVED: The Board of Directors:** **1) Received the Quality Position Statement** **2) Gained assurance on its content**
DHCFT 2016/098	**REVALIDATION OF DOCTORS** John Sykes presented the framework of quality assurance which provided the Board with assurance that doctors working in the Trust are fit to practise. The number of doctors who were suspended/excluded from practice was queried by Richard Gregory and John Sykes agreed to provide Richard Gregory with corrected data outside of the meeting. This corrected data would allow the Designated Body Statement of Compliance with the Medical Profession to be drafted to form a letter for signature by Richard Gregory for submission to NHS East Midlands.

	ACTION: John Sykes to provide Richard Gregory with corrected data regarding suspended/excluded doctors **RESOLVED: The Board of Directors** **1) Considered the report** **2) Scrutinise the contents** **3) Sought additional assurance regarding the number of doctors suspected/excluded from practice that would be dealt without outside of the meeting.**
DHCFT 2016/099	**COMPLIANCE RETURN – GOVERNANCE STATEMENTS 4, 5 AND 6 INCLUDING DELEGATED AUTHORITY** Sam Harrison presented her paper which supported the requirement for the Board to submit Governance Statements four, five and six to NHS Improvement (NHSI) by 30 June (statements one, two and three were previously submitted in May). Members of the Board confirmed their agreement with Statement 6: "*The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.".* This enabled Sam Harrison to return Statement 6 to NHSI by 5pm in line with requirements and would also be uploaded onto the Trust's website. Due to the notified changes in the phasing of the submission of compliance returns to NHSI for 2016/17 which no longer fit with the Trust's governance arrangements, the Board approved delegated authority to the Chair of the Audit and Risk Committee, and the Chair of the Finance and Performance Committee for the sign off of future submissions. Once submitted, these will be circulated to the Board for information at the next Public Trust Board meeting. **RESOLVED: The Board of Directors:** **1) Gave agreement for Governance Statement 6 to be returned to NHSI by 5pm, 30 June 2016** **2) Approved delegated authority to the Chair of the Audit and Risk Committee and Chair of the Finance and Performance Committee for the sign off of compliance returns.**
DHCFT 2016/100	**BOARD COMMITTEE ESCALATIONS** Short assurance summaries were received from committee chairs which identified key risks, successes and decisions made. Each summary was scrutinised and escalations were noted. The ratified minutes of meetings held in May were received for information and no issues were raised. **RESOLVED: The Board of Directors received the Board Committee escalations and ratified minutes of meetings held in May.**
DHCFT 2016/101	**DEEP DIVE – VACANCIES, SICKNESS AND RECRUITMENT** A "deep dive" into the Trust's Sickness Absence information and links to other employee relations activity was presented to the Board in September 2015 and was subsequently updated and presented to the Finance & Performance Committee in January 2016. Kath Lane, Acting Deputy Director of Operations, presented today's "deep dive" which was generated in response to the Board's request for a further deep dive into the number of vacancies, sickness levels, and recruitment undertaken within the Trust. The report

	highlighted the 20 teams on the KPI Hot Spot Triangulation within the Workforce Dashboard for May 2016, and a focus on the top 6 teams within the Trust on the Board Dashboard for May 2016. This approach involved joint analysis between Workforce and Organisational Development functions together with Operational Management to develop action plans against the KPIs. The trajectory for recruitment in the updated Operational Recruitment Plan previously presented to the People and Culture Committee was also taken into account. Kath Lane, Tim Slater, Garry Southall and Susan Team Spray from both the Operational and Workforce functions attended the meeting and drew attention to the action plan that had been formulated to stabilise the situation. They described the work taking place to establish how this model was functioning and how an analysis was being carried out to see how deep routed issues impacted on staff attendance. It was clear that sickness absence is symptom of what is happening within the teams. This has influenced the model and this evidence will be used to inform current and future ways of working. High levels of stress have been experienced in the Enhanced Care Ward (ECW) due to significant incidents that have occurred over the last six months. The impact these incidents have had on ECW cannot be under estimated and stronger working relationships are being are being developed across port folios in order to deliver a more integrated approach to bring together combined objectives to achieve secure care plans. At this point the team took the opportunity to thank John Sykes and the Board for their support in seeing them through the difficult times they experienced in the case of a particular patient. It was understood that the main reason for absence is due to stress. It was pointed out that 60% of stress related absence is due to stress in people's home life and is not work related. Analysis of case load sizes did not show correlation with stress levels. The Workforce team has been working very closely with managers to provide them with coaching so they are aware of the health and attendance policy to encourage people back into the workplace. In addition to this, stress management courses are being run throughout the county and managers are being encouraged to attend. Evidence now shows that mangers are feeling more confident to tackle issues at an earlier stage. The report also showed that absence is linked with high levels of activity. Enormous strides are being made to recruit more staff but staff retention is the real challenge, although vacancies in neighbourhood posts were showing an improvement. Targets were highlighted in the report and the Board was interested to know how challenging these targets would be. It was acknowledged that there would be always be seasonal variances in sickness absence; statistics show when these will be spiked and work would take place to pre-empt this as much as possible. Richard Gregory stressed the importance of setting aspirational targets that can be achieved the need to be confident in the plans and processes. He also added that the People & Culture Committee recently agreed these targets should be revised and a benchmarking exercise is taking place and will be submitted to the People &Culture Committee in September to show what has been achieved. Richard Gregory asked how the Board could support the teams. Tim Slater wished for the Board authorise the process to speed up the development of the electronic recruitment system which is currently being developed within IM&T. It was recognised that a strong business partner model is required (the HR and Operations model needs enhancement) and the capacity/resource within the Workforce Team needs to improve all and all these issues will be progressed through the People & Culture Committee. The Board was pleased to see Operations and Workforce functions working together to face the challenges they have been presented with. The Board supported promoting different ways of thinking and creating an open minded staff culture and asked to be kept informed so progress can be measured.

	RESOLVED: The Board of Directors: **1) Acknowledged the report and noted the progress that is taking place to recruit staff and support areas with staffing challenges.** **2) Acknowledged the work taking place to consider those areas that trigger more than one KPI on the Workforce Dashboard, and following analysis by Operational Management and the Workforce & OD Department be assured that appropriate support and assistance are provided to those teams.** **3) Considered incorporating data / KPIs against teams that demonstrate excellence in order to encourage the sharing of best practice and supporting other teams who may require assistance**
DHCFT 2016/102	**<u>REPORT FROM COUNCIL OF GOVERNORS MEETING</u>** Sam Harrison presented her report which updated the Board on discussions held at the Council of Governors meeting held on 1 June. The Board noted the issues discussed with governors during the meeting. **RESOLVED: The Board of Directors noted the discussions at the Council of Governors meeting held on 1 June 2016**
DHCFT 2016/103	**<u>GOVERNANCE IMPROVEMENT ACTION PLAN</u>** Mark Powell presented his report which provided Board members with an update on progress of all tasks within the GIAP, including the identification of tasks that are off track, including those that the Board has responsibility for oversight. Members of the Board recognised that the main focus of attention during the last four weeks had been on tasks with a delivery deadline up to, and including the end of June. It was understood there had been limited opportunity to look beyond this in any great detail due to significant resource being directed towards the Trust's recent CQQ inspection. In addition, due to the timing of the Board Committee meetings only the People and Culture Committee had met to discuss and receive assurance on the tasks that they have oversight for on behalf of the Board, the outcome of which was indicated in the 'comments on progress' and in the updated RAG ratings sections in the GIAP. This resulted in issues being mainly to do with actions around the People Plan, Engagement and Corporate Governance. Mark Powell explained that to progress these issues he, Jayne Storey and members of the HR team would build emphasis behind individual issues that need to be improved as quickly as possible and he was confident that significant progress would be seen to have been made on specific tasks by the July meeting of the People & Culture Committee. Mark Powell also informed the Board on progress made on the development of KPIs and associated assurance mechanisms which were areas that NHSI had asked the Trust to focus on and to consider as part of the GIAP. These areas will be discussed and finalised at the Board Development Session on 13 July and will be submitted to the July Board for approval. Members of the Board understood that whilst the HR resource plan was fully recruited to, the HR team had been further challenged by a number of other requests on their time during June which had resulted in reduced capacity to focus on the GIAP. However, following further discussion, Board members were satisfied that corrective action was being taken to address the development of specific tasks and actions and looked forward to receiving evidence that significant progress has been made with the GIAP at the July Board meeting.

	RESOLVED: The Board of Directors: **1) Reviewed the content of the full GIAP** **2) Discussed the recommendations rated as 'off track' or 'some issues' and was assured by the mitigation provided from the responsible Director, individual Directors or Committee Chairs.**
DHCFT 2016/104	**BOARD FORWARD PLAN** The forward plan was noted and would be updated in line with today's discussions. **RESOLVED: The Board of Directors noted the forward plan for 2016/17**
DHCFT 2016/105	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK OR GIAP** The BAF would be influenced by information received on the Sustainability and Transformation Plan and would be linked to the BAF submission to be received at the July Board.
DHCFT 2016/106	**BOARD PERFORMANCE AND CONTENT OF MEETING** The Board felt that good discussions were held during the meeting. It was reiterated that any questions applicable to the agenda and at the Chair's discretion should be received by the Board Secretary up to 48 hours prior to the meeting for a response to be provided by the Board at each meeting.

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

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

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - JULY 2016	
Date	**Minute Ref**	**Action**	**Lead**	**Status of Action**	**Current Position**
25.5.2016	DHCFT 2016/077	Board Committee Escalations - People & Culture	Jayne Storey	A dynamic process will be developed to provide assurance to the Board that policies are being adhered to	The ER tracker continues in its development, training is being developed to ensure all managers are equipped to understand and follow policies. Principle HR Managers are aligned to Service Areas to ensure a closer relationship. Regular meetings take place with staff side to pick up concerns.
25.5.2016	DHCFT 2016/079	Trust Strategy	Ifti Majid	Ifti Majid was given authority via Chief Executive Action to ensure the changes to the Strategy suggested by the Board would be implemented	All updates have been made to the final strategy document
25.5.2016	DHCFT 2016/080	Deep Dive - Neighbourhoods	Claire Wright	Building requirements of Neighbourhood teams in STP developments and as part of the Estates strategy to be considered by Claire Wright.	The next 6 monthly progress update of the Trust estates strategy to Finance and Performance Committee will include a section on neighbourhood estate requirements and will also include a section summarising progress with the Derbyshire STP estates workstream. Will be agenda item at November F&P meeting.
25.5.2016	DHCFT 2016/080	Deep Dive - Neighbourhoods	Ifti Majid Richard Gregory	Ifti Majid and Richard Gregory to consider raising with NHSI systemic issues and explore any system or national in built delays to recruitment	Discussion took place with NHSI about recruitment – agreed we would look to add in some metrics to GIAP to monitor recruitment times
25.5.2016	DHCFT 2016/081	GIAP	Mark Powell	A rating mechanism will be produced by Mark Powell that would provide the Board with an objective view of each recommendation.	Populated KPI and outcome provided as part of the GIAP report
30.6.2016	DHCFT 2016/081	Patient Story	Carolyn Green	Bev Green and Carolyn Green to arrange for a camera to be provided for use at the Lighthouse through the Trust innovation network	Camera is being ordered from funds from service Improvement budget.

	Action Ongoing/Update Required	**ORANGE**
	Resolved	**GREEN**
	Action Overdue	**RED**

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

Acting Chief Executives Report to the Public Board of Directors

Purpose of Report:

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

National Context

1. The National Confidential Inquiry into suicide and homicide by people with mental illness, has published a report which considers suicide by children and young people in England. The report found that there were 145 suicides and probable suicides by children and young people in England between January 2014 and April 2015. The suicide rate in this age group is low overall, but is highest in the late teens. The majority of deaths were in males (70%). Over a quarter (28%) had been bereaved, 36% had a physical health condition with the most common conditions being acne and asthma. Academic pressures were comment and almost a third of those in education were facing exams or exam results at the time of death. The majority (54%) had indicated their risk through previous self-harm and 27% had expressed suicidal ideas in the week before they died. Almost half (43%) were not known to any service or agency.

2. The Nuffield Trust has published 'Reshaping the workforce to deliver the 'care patients need'. The Nuffield Trust was commissioned by NHS Employers to examine how best NHS staffing can be reorganised to support new ways of delivering care to patients.

   The report finds that equipping the existing non-medical workforce – NHS nursing, community and support staff – with additional skills is the best way to develop the capacity of the health service workforce. The key recommendations from the report include:

   *Utilising the support workforce***:** This subset of the workforce is large and highly flexible, while short training times mean that numbers can be expanded relatively quickly. Evidence suggests that support workers can provide good-quality, patient-focused care, as well as reduce the workload of more highly qualified staff.

   Extending the skills of registered healthcare professionals: such as nurses, pharmacists, physiotherapists and paramedics. This provides opportunities to manage the growing burden of chronic disease including long term mental ill health more effectively, could release some savings, and could help bridge some of the workforce gaps that are forecast.

Advanced practice roles for nurses: including those that require a further period of study, typically a two year Masters qualification, offer opportunities to fill gaps in the medical workforce.

Importantly the report also warns that reshaping the NHS workforce, if not carefully implemented could increase patient demand, and cost money rather than save money. Therefore, the authors identify 10 important lessons for Organisations seeking to redesign their workforce In addition; the authors argue that the Health Education England (HEE) budget and specialist workforce planning expertise should be protected by ring-fencing monies to support local workforce design. Locally this report is being considered by the enabling workforce work stream as part of the STP

Local Context

3. The Sustainability and Transformation Plan for Derbyshire outlines a county-wide approach to show how the local NHS will cope with a number of challenges over the next five years. This work brings together all local NHS providers and commissioners, Local Authorities and the voluntary sector, so we can develop a comprehensive – joined-up – local plan.

The ethos of this plan requires a collaborative approach across the local health economy, to address three key challenges or 'gaps':

- The health and wellbeing gap – how can we prevent unnecessary ill-health and early death?
- The care quality gap – how can we ensure we meet care targets and improve quality?
- The finance gap – how can we make sure that we can deliver improved services within the available money?

At the confidential Board meeting in June and at the July Council of Governors meetings both Derbyshire Healthcare NHS FT and Derbyshire Community Health NHS Foundation Trust (DCHS) discussed initial ideas about how closer working between the two Trusts could have a significant positive impact and support the system to meet these challenges.

A wide variety of options exist for defining the level of collaboration between the two organisations and we are at the very early stages of considering these possibilities. We have agreed to develop a 'strategic options case' to consider all possible options, benefits and impact. This strategic options case will be led through a new formal partnership-based programme. It is anticipated that initial thoughts would be presented to both Boards towards the end of the calendar year.

This direction of travel has been further re-enforced by a letter sent to all CEOs from Jim Mackey Chief Executive of NHSI, making it a clear expectation for STP areas to be able to provide details of how back office functions could be delivered with greater efficiency by the end of July 2016. In Derbyshire we have commenced a piece of work to understand what the scale of such opportunities might be. In order to support the pace required for this providers have 'paired up' to explore options, with our Trust working with DCHS.

4. The 30th June Sustainability and Transformation Plan (STP) submission was made by the Derbyshire system within the required timescales. The submission review meeting is scheduled for the 25th July and I will be attending the meeting with Simon Stevens and Jim Mackey as part of the Derbyshire submission team.

5. The 21C public consultation, 'Better Care Closer to Home' continues with many events already being held across North Derbyshire. In addition feedback is being received via questionnaire, social media and telephone calls. I would like to extend my thanks to our staff who have both been involved in the presentations at these events and who have attended as part of giving feedback to the consultation. I would urge all staff who live or work in the North of the County to take advantage of the range of ways of giving feedback as part of the consultation. The consultation continues through until the 5th October 2016

6. Many people may not be aware of the current consultation that is underway by Sheffield City Region as part of their devolution bid. This consultation has significant potential impact for our local area as Chesterfield Borough Council has decided to be a formal member of the devolution bid and North East Derbyshire District Council and Derbyshire Dales District Council are associate members. In effect this means when the Mayor is elected next year some responsibilities including for example transport will pass from Chesterfield Borough Council to the new Sheffield City Region Mayor. The devolution deal covers a range of themes including transport, skills, creating new jobs, inward investment and support to help local businesses export as well as committing to working with Government on new ways to incentivise local growth. It is vital we as a healthcare provider in North Derbyshire understand more about these actual and potential plans. The STP group in Derbyshire will be responding to the consultation to share concerns about the need for joined up provision of services that impact the wider determinants of health as part of Derbyshire local health and wellbeing strategies.

   You can read more about the Sheffield City Region devolution consultation on www.sheffieldcityregion.org.uk

Within our Trust

7. On the 14th July I attended the Trusts BME Network. This is a vital group that requires the support of the organisation to become more established and to act as a focus for driving both a dialogue and action through our Organisation to support equality of development, promotion and wellbeing for our staff from a BME background. I would like to propose to the Board that at the September Board we allocate the deep dive session to discussing the Trusts position against the national Workforce Race Equality Standard that I shared last month and we invite members form our BME Network to join us. In addition I propose we invite a member from the group to join our People and Culture Committee.

8. The British Summer successfully challenged our League of Friends Summer Fair on the 9th July and we had to postpone the event due to the amount of rain. I am delighted that we have successfully now held the event and I would like to extend my sincere thanks to all members of the League of Friends for their ongoing support, not just in relation to the Summer Fair but for everything they do each day to improve the

experience of people with mental health difficulties.

9. Listen, Learn, Lead – There have been 3 new visits to teams this month, one having being cancelled. These can be seen on the actions tracker in appendix 1.. Some of the key themes emerging from visits this month included:
    - Capacity in community services and impact on patients of vacancies
    - The need for greater connectivity through the Organisation so teams feel clear what is expected of them
    - The impact of the STP work around Place on our Neighbourhoods
    - Too many temporary staff having an impact on continuity
    - Travel expenses not covering individuals outlay

Finally I would like to wish two current Board members well as they move on to pastures new. Jayne Storey leaves us at the end of August and Carolyn Gilby is retiring at the end of September. Thank you both for your hard work, dedication and support during your time with us.

Strategic considerations

- This document is relevant to supporting the Board achieve all of it strategic objectives however the feedback from staff is particularly of note in supporting the Board being connected to service delivery

Board Assurances

- The Board can take assurance that Trust level of engagement and influence is high in the health and social care community
- The Board should be assured that the level of visibility of Executive Directors is increasing and having positive impacts
- Partial assurance should be derived around closing off actions linked to the listen learn lead matrix

Consultation

None

Governance or Legal Issues

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

Equality Delivery System

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

Recommendations

The Board of Directors is requested to:

1) Note the contents of the update
2) Agree to receive a deep dive looking at equality and diversity in the workplace
3) Agree to the offer of a place at the people and Culture Committee to the Trusts BME Network

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

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

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team	Status
06/07/2016	S.Derbyshire Neighbourhood - Dale Bank View	Ifti Majid	Very well attended, staff came to see me either individually or in groups. Key themes that emerged included:speed of getting personal specific IT equipment, concerns over staffing levels and amount of temporary staff. Told there was a jobs freeze. Leading to lack of stability and poor morale. Lease car mileage not being being sufficient for high mileage users. Some concerns expressed around visibility of middle managers and communication flowing freely up and down organisation. Current duty system creating pressure and stress on team. General sense that the team felt uncontained	1. Chase up IT equipment 2.Alert kath lane to the issues 3. Team development time needed	ifti Majid for all items	Items immediatley fed back supported by email on 11/07/16	**Action Ongoing**
05/07/2016	Psychodynamic Psychotherapy Team, St Andrews House	Ifti Majid	Two key issues discussed, capacity of the teamand associated concerns about having to ration their service and the perceived historical erosion. Secondly the role of dynamic psychotherapy in the new neighbourhoods, the link with the development of 'place' in the STP and how they were concerned around involvement in some pathways in particular the development of the complex trauma pathway.Also spoke around the issues associated with complex investigations linked to people receiving therapy	1. review learning of complaints where action taken that may have been against clinical advice	Carolyn Green	06/07/2016	**Action Ongoing**
01/07/2016	Bayheath House (Open visit with RG)	Ifti Majid	No Attendees	Nil	Nil	Nil	**Complete**
28/06/2016	Early Interventions Service	Carolyn Green	I attended the clincal referrals meeting and the team meeting. This is a team which is rising to the challenge of national standards, a changing referral criteria. Clinical challenges of a wide funnel of types of individuals be referred to the service and the need to have a wide range of clinica assessment skills to meet an all age criteria, complex presentations which are often emerging trauma, autism, rather than 1st episode psychosis and, without resourced and access referral pathways, these issues are leading to pressure on the team. Clinical flow issues with the recovery teams not having capacity are also impacting upon the service. Support from the QLT and SMT to fully resolve some of these issues would be appreciated. CG gave an overview of the strategy, clincial commissioning and context and the team felt this was helpful to understand.	1. Support from Joe Wileman to have and confirm a team away day. 2. Support from Head of Nursing / Lead professional to have a wider skill set for an all age service. A skill mix review to consider the needs of adults of working age and older adults with a first episode psychosis, including the need for access to specialised support if illness related to head in just or other causes. 3. Support form Joe Wileman and Head of Nursing on consider the needs of individuals with autsim, and have an accessible alternative waiting list. 4. Support to invest in recover y teams, to remove the pressure on EI teams to transition to recovery teams when needed. 5. Sometime the team do not have time to have supervision and development sessions. Support to ensure the team have time to have supervision and training/in-reach support form community learning disability on what is a CTR and how to do it well from Karen Billyead.	Carolyn Green		**Action Ongoing**
22/06/2016	Recovery Team 1 and Derby City Pathfinder Service	Carolyn Gilby	Visit had been difficult and manager felt that he hadn't known what to expect from his 1:1 and had reflected that maybe Quality visits could be more like a CQC visit. There was a long discussion regarding the move to St Andrews House and the parking issues mainly around safe transport of medicines. The relationship between the neighbourhood teams and Campus areas was raised as it was felt that communications had worsened and that this needed to be improved. Consultant handover between community and inpatient was felt to be worse and that the old system was better. The culture regarding risk was felt to be getting better but there was a feeling that there was still too much bureaucracy and that there is a need for positive risk taking with accountability, it was felt that the serious incident team set the tone/culture for risk taking in the organisation. Forensic community team, this was felt to be a gap in service provision but it was a much needed service.	1. Future Quality Visits themes and process lead (Carolyn Green) 2. St Andrews move and Car Parking issues lead (Claire Wright) 3. Inpatient and community communications issues lead (Carolyn Gilby) 4. Consultant Handover between Inpatient and Community lead (John Sykes) 5. Culture and tone regarding Risk and the SIG lead (John Sykes) 6. Forensic community team commissioning gap lead (Mark Powell)	1. Carolyn Green; 2. Claire Wright; 3. Carolyn Gilby; 4. John Sykes; 5. John Sykes; 6. Mark Powell.	6. Community Forensic service gap identified as part of contract negotiations with commissioners for 16/17. Commissioners made it clear that they were unwilling to commission this service	**Action Ongoing**
03/06/2016	North Dales OA CMHT	Ifti Majid	Meeting Cancelled by Team	Nil	Nil	Nil	**Complete**
03/06/2016	Hartington Unit (Open visit with RG)	Ifti Majid	No attendees	Nil	Nil	Nil	**Complete**
20/05/2016	Finance Team	Carolyn Gilby	Finance mangers had found it difficult to have CIP conversations with budget holders when the ET had cost so much. There was a feeling of embarrassment and anger that the ET had happened in the first place. Team itself was very stable and was both supportive and felt supported. There was discussion regarding the upcoming CQC visit and also discussed the quality visits and whether there was anything they should be doing differently./ There were no actions to be taken	None			**Complete**

03/05/2016	Cubley Court	Ifti Majid	Met with nursing and medical staff. Staffing levels remaining a concern in context of increased acuity due to DRRT keeping less well at home. Concerns that senior managers and clinical leaders are not visible enough on ward area though positive feedback for SLM. Some worries about the sense of 'blame culture', particularly linked to incidents and SIRI investigations. Very hot on unit in summer and staff wondered about summer uniforms. Concerns about the speed of Paris 'go live' and support during the DGO 'live' period, mixed views about approach taken but general feeling some reconfiguration needed to make easily usable for tasks such as admissions. Medical and nursing capacity eroded by changes around DOLS and MHA.	1.Ifti to do visit to London Road site. 2.Investigate possibility of summer uniforms (scrubs) 3.Further support re training on Paris in handovers etc. to optimise use. 4.Possibility of formalising staff rotation scheme for those who want it. 5.Can physical healthcare diagnostic interventions, such as ECG, phlebotomy, be done by trained ward staff?	1. Ifti Majid 2.Carolyn Green 3.Carolyn Gilby 4.Jayne Storey 5.Carolyn Green	1. Ali arranging visit for Ifti to London Road. 3. Carolyn Gilby put team in touch with Paris training team.	**Action Ongoing**
20/04/2016	South Derbyshire Community LD Service	Ifti Majid	Discussed the issues arising out of Aston Hall and the impact this was having within LD staff group. The team spoke about how responsive and visible the middle management and clinical leaders were in the service. Discussion about delays in recruitment and impact. Parking issues in Derby City particularly at St Andrews. Access to admin is a problem as means clinical staff spending time doing admin. Briefly discussed ET media coverage and financial impact. Discussed quality visits and LD service show case and great discussion around finances and opportunities	1. Exec team to consider radical options to support St Andrews staff 2.Consideration to be given to allowing a combined LD quality visit next year in the vein of showcase. 3.Workshop type discussion around financial efficiency opportunities	1. Ifti Majid 2.Carolyn Green 3.Claire Wright	3. Claire requested finance manager arrange workshop session as required.	**Action Ongoing**
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.	**Action Ongoing**
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 years 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		**Action Ongoing**
04/04/2016	High Peak Older Adults Team	Ifti Majid	Started with discussing move to neighbourhood, a cause for concern for many staff in team, worries about space, impact on OA speciality and clinical space. That said they talked about the plans in place to resolve some of the issues. Discussed relationship with Stepping Hill and DCHS, sometimes struggle to get people admitted to Stepping Hill. Discussed some concerns around the MAS process in particular differences across the County	1. SPOE Numbers - PARIS not generating correct SPOE number for High Peak 2.Need to be able to filter duty desk to High Peak only 3.Some personnel changes still needed on system	1- 3 Carolyn Gilby	John Staley contacted the team to address any PARIS issues 12/07/2016.	**Complete**
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.	1. Need to receive clarity about the recent changes in operational management	1. Carolyn Gilby	29/06/2016.	**Complete**
26/02/2016	Southern Derbyshire Crisis and Home Treatment Team	Mark Powell	1. The team would like to change their name from Crisis and Home Treatment to something akin to Assessment and Home Treatment. 2. 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. 3. 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. 4. The team wanted senior management to be aware of the ill feeling that some patients are expressing to them as employees of the Trust and that at times they are taking the brunt of this public ill feeling when they shouldn't be. 5. An issue was raised regarding a line in the Deloitte report regarding leadership being an issue in the team. 6. 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. I explained that the Trust was talking to commissioners about the development of a community PD service and that the service specification for this could be shared if required. 7. An issue was raised about staff from Melbourne House and then deployment to the Hub. 8. A question was asked about block contract payment and I explained about the 2 new proposed payment methods form 2017. 9. A question was asked about the current status of neighbourhoods as the team were unclear on this. 10. I asked if it was possible to come back to another meeting in 2 months' time and I think that the team were agreeable to this.	1. Mark Powell to see whether a name change was possible. 2. Guidance to be sent to deal with ET questions (actioned 29/02/2016). 4. Senior management to be made aware of the ill feeling from patients to staff due to the public perception following media attention. 5. Mark to talk to Michelle about a line in the Deloitte report with regard to leadership being an issue - to understand context. 6. Carolyn Gilby to talk to commissioners with regard to the development of a community PD service. 7. Issue to be resolved re: staff from Melbourne House deployed to the Hub. 8. Short summary re: block contract payment to be sent (actioned 29/02/2016). 9. Current status of neighbourhoods to be sent.	1, 4, 5 & 6 - Mark Powell 7 & 9 - Carolyn Gilby	Actions and summary sent to Team 29/02/2016. 1. Will be discussed as part of the wider STP work programme which is focusing on the MH urgent care offer. 4. ELT made aware of this through Listen, learn, lead process 5. Action complete 6. Proposal presented to Commissioners, but commissioners unwilling due to financial constraints to commission for 16/17 7. A paper is going to TOMM, 27/05/16, for consideration and further feedback will be available via Tim Slater and Hannah Burton following this. 9. Neighbourhoods went live on the 1st of April and currently are about the integration of the Adult and OA teams. Claire Biernacki invited to attend a team meeting for further clarification if required. Mark Powell arranging a further follow up meeting with the team	**Action Ongoing**

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

Integrated Performance Report Month 3

Purpose of Report:

This paper provides the Trust Board with an integrated overview of performance as at the end of June 2016 with regard to workforce, finance, operational delivery and quality performance.

Executive Summary

Most of the high level executive summary content is found at the first page of the main report.
This month's report continues to develop the integrated reporting, with Quality baselines being established and monitoring of supervision uptake and compliance, as a key quality metric, has been included.
The data has been triangulated and a key theme drawn out from the information in the report.

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 this report provides assurance across several BAF risks related to workforce, operational performance, quality performance, financial performance and regulatory compliance.

Consultation

The contents of this paper have been considered at Finance and Performance Committee, Quality Committee and People and Culture committees

Governance or Legal Issues

The 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.

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

This report has a neutral impact on REGARDS groups

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.

Report presented by: Claire Wright, Director of Finance
Carolyn Gilby, Acting Director of Operations
Carolyn Green, Director of Nursing and Quality
Jayne Storey, Director of Workforce, OD and Culture

Report prepared by: Peter Charlton, Head of IM&T
Rachel Leyland, Deputy Director of Finance
Hayley Darn, Nurse Consultant
Liam Carrier, Workforce Systems and Information Manager

Highlights
- FSRR better than plan in the month, Forecast on plan for year end
- Surplus better than plan in month and forecast to achieve plan at year end
- Cash better than plan

Challenges
- CIP forecast to deliver and assurance required on forecast delivery
- Mitigations of Financial risks during 16/17
- Agency expenditure – exception report required to NHSI

Highlights
- Fully compliant with all NHSI targets

Challenges
- PbR clustering
- Outpatient Cancelations
- Ethnicity Coding is on a downward trajectory

Highlights
- Compulsory training compliance remains high and is above the 85% main contract commissioning for quality and innovation (CQUIN) target.
- Appraisal compliance continues to increase.

Challenges
- Monthly and annual sickness absence rates continue to rise.
- Budgeted Fte vacancy rates remain high.

Highlights

This is a report section is in phased development, in line with EPR roll out.
- Red rated areas are not hitting performance but achievable by target date, (Recording of capacity to consent increasing and Supervision compliance increasing)
- Think Family / Safety planning roll out compliance are significantly improved

Challenges
- New risks added due to staffing pressures in the Radbourne Unit and activation of emergency planning

FINANCIAL OVERVIEW – JUNE 2016

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend
Governance	FSRR	Overall Financial Sustainability Risk rating	YTD	3	4	G	
			Forecast	4	4	G	
		Debt Service Cover	YTD	2	3	G	
			Forecast	3	3	G	
		Liquidity	YTD	3	4	G	
			Forecast	4	4	G	
		Income and Expenditure Margin	YTD	3	4	G	
			Forecast	4	4	G	
		Income and Expenditure Margin Variance	YTD	4	4	G	
			Forecast	4	4	G	
I&E and profitability	Income and Expenditure	Control Total position £'000	In-Month	105	278	G	new
			YTD	141	651	G	new
			Forecast	2,531	2,531	G	new
		Underlying Income and Expenditure position £'000	In-Month	-103	71	G	
			YTD	-66	443	G	
			Forecast	1,701	1,701	G	
		Normalised Income and Expenditure position £'000	In-Month	-103	177	G	
			YTD	-66	449	G	
			Forecast	1,701	1,629	R	
	Profitability	Profitability - EBITDA £'000	In-Month	713	918	G	
			YTD	1,989	2,516	G	
			Forecast	9,806	9,840	G	
		Profitability - EBITDA %	In-Month	6.1%	8.2%	G	
			YTD	5.8%	7.6%	G	
			Forecast	7.1%	7.4%	G	
Liquidity	Cash	Cash £m	YTD	11.366	11.676	G	
			Forecast	13.153	12.355	R	
	Net Current Assets	Net Current Assets £m	YTD	3.685	6.221	G	
			Forecast	7.570	5.778	R	
	Capex	Capital expenditure £m	YTD	0.619	0.533	R	
			Forecast	3.450	3.450	G	
Efficiency	CIP	CIP achievement £m	In-Month	0.358	0.194	R	
			YTD	1.075	0.515	R	
			Forecast	4.300	3.470	R	
			Recurrent	4.300	1.955	R	

Key:

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

Plan In-month or Year end Trust plan

Achieving plan/within parameters
Slight variance to plan/within paramenters
Not achieving plan/outside parameters

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

OPERATIONAL OVERVIEW – JULY 2016

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	NHSI	CPA 7 Day Follow-up	Month	95.00%	96.88%	G	↓	Fully compliant with NHSI targets.
			Quarter	95.00%	97.78%	G	↑	
		CPA Reviews in Last 12 months	Month	95.00%	95.51%	G	→	
			Quarter	95.00%	95.51%	G	→	
		Delayed Transfers of Care	Month	7.50%	1.53%	G	→	
			Quarter	7.50%	1.99%	G	→	
		Data completeness - Identifiers	Month	97.00%	99.50%	G	→	
			Quarter	97.00%	99.50%	G	→	
		Data completeness - Outcomes	Month	50.00%	94.01%	G	→	
			Quarter	50.00%	94.01%	G	→	
		Community Care Data Activity - Completeness	Month	50.00%	93.50%	G	→	
			Quarter	50.00%	93.63%	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%	75.54%	G	↓	
			Quarter	50.00%	76.38%	G	↓	
		18 Week RTT incomplete	Month	92.00%	92.08%	G	↓	
			Quarter	92.00%	93.16%	G	↓	
		Early Interventions New Caseload	Month	95.00%	173.50%	G	↑	
			Quarter	95.00%	173.50%	G	↑	
		Clostridium Difficile Incidents	Month	7	0	G	→	
			Quarter	7	0	G	→	
		Crisis Gatekeeping	Month	95.00%	100.00%	G	↑	
			Quarter	95.00%	99.20%	G	→	
		IAPT RTT within 18 weeks	Month	95.00%	99.18%	G	→	
			Quarter	95.00%	99.54%	G	→	
		IAPT RTT within 6 weeks	Month	75.00%	92.20%	G	↑	
			Quarter	75.00%	91.09%	G	↓	
		Early Intervention in Psychosis RTT Within 14 Days	Month	50.00%	81.25%	G	↓	
			Quarter	N/A	86.44%	###		

Key:

Period

Month Current Month

Quarter Current Quarter

Achieving target

Not achieving target

↑ → ↓ Trend compared to previous month/quarter

OPERATIONAL OVERVIEW – JULY 2016

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Locally Agreed	CPA Settled Accommodation	Month	90.00%	96.52%	G	→	The majority of clinicians now successfully manage their PbR caseloads either independently or through positive engagement with available support however the PbR Advisor is working with teams offering training, support and advice.
			Quarter	90.00%	96.52%	G	↓	
		CPA Employment Status	Month	90.00%	97.47%	G	→	
			Quarter	90.00%	97.47%	G	→	
		Data completeness - Identifiers	Month	99.00%	99.50%	G	→	
			Quarter	99.00%	99.50%	G	→	
		Data completeness - Outcomes	Month	90.00%	94.01%	G	→	
			Quarter	90.00%	94.01%	G	→	
		Patients Clustered not Breaching Today	Month	80.00%	82.11%	G	→	
			Quarter	80.00%	81.04%	G	→	
		Patients Clustered regardless of review dates	Month	96.00%	95.16%	R	→	
			Quarter	96.00%	95.19%	R	→	
		7 Day Follow-up - all inpatients	Month	95.00%	96.20%	G	↓	
			Quarter	95.00%	97.35%	G	→	
		Ethnicity coding	Month	90.00%	90.52%	G	↓	
			Quarter	90.00%	90.52%	G	↓	
		NHS Number	Month	99.00%	99.97%	G	→	
			Quarter	99.00%	99.97%	G	→	
	Schedule 4	Consultant Outpatient Trust Cancellations	Month	5.00%	6.51%	R	↓	The main reasons given for cancellation was when the clinican was absent from work or no Locum was available.
			Quarter	5.00%	6.78%	R	↓	
		Consultant Outpatient DNAs	Month	15.00%	14.52%	G	→	
			Quarter	15.00%	14.48%	G	→	
		Under 18 admissions to Adult inpatients	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Outpatient letters sent in 10 working days	Month	90.00%	90.01%	G	↓	
			Quarter	90.00%	91.12%	G	→	
		Outpatient letters sent in 15 working days	Month	95.00%	95.47%	G	→	
			Quarter	95.00%	95.48%	G	→	
		Inpatient 28 day readmissions	Month	10.00%	11.02%	R	↓	The Head of Nursing is reviewing readmissions.
			Quarter	10.00%	9.04%	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%	98.90%	G	↓	
			Quarter	98.00%	99.34%	G	→	

OPERATIONAL OVERVIEW – JULY 2016

Enc E

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 Targets.
			Quarter	0	0	G	→	
		18 Week RTT incomplete	Month	92.00%	92.11%	G	↓	
			Quarter	92.00%	94.31%	G	↓	
		Mixed Sex accommodation breaches	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Completion of IAPT Data Outcomes	Month	90.00%	95.67%	G	→	
			Quarter	90.00%	96.08%	G	→	
		Ethnicity coding	Month	90.00%	90.45%	G	↓	
			Quarter	90.00%	91.17%	G	→	
		NHS Number	Month	99.00%	99.99%	G	→	
			Quarter	99.00%	99.99%	G	→	
Other Dashboards	Health Visiting	% 10-14 Day Breastfeeding coverage	Month	98.00%	99.60%	G	→	
			Quarter	98.00%	99.90%	G	→	
		% 6-8 Week Breastfeeding coverage	Month	98.00%	98.30%	G	→	
			Quarter	98.00%	99.00%	G	→	
	IAPT	Recovery Rates	Month	50.00%	56.68%	G	↑	
			Quarter	50.00%	53.75%	G	→	
		Reliable & Recovery Rates	Month	65.00%	73.28%	G	↑	
			Quarter	65.00%	71.25%	G	↓	
	Safer Staffing	Inpatient Safer Staffing Fill Rates	Month	90.00%	103.8%	G	↓	Detailed ward level information shows specific variances
			Quarter	90.00%	103.4%	G	↑	

WORKFORCE OVERVIEW – JUNE 2016

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance		Trend	Key Points
Workforce Dashboard	NHSI Key Performance Indicator (KPI)	**Turnover** (annual)	**Jun-16**	10%	**10.86%**	↗	G	↑	Annual turnover remains within the Trust target parameters and is below the regional Mental Health & Learning Disability average of 12.68% (as at April 2016 latest available data). Monthly sickness absence has increased significantly compared to the previous month and is 1.01% higher than in the same period last year. The annual sickness absence rate continues to increase running at 5.58% as at June 2016. The regional average annual sickness absence rate for Mental Health & Learning Disability Trusts is 5.05% (as at March 2016 latest available data). The budgeted vacancy rate this month has decreased by 0.27% to 17.48%. The number of employees who have received an appraisal within the last 12 months continues to increase, now reporting at 71.29%, an increase of 1.70% compared to the previous month. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £594k of which £445k related to Medical staff. Compulsory training compliance has decreased slightly this month by 0.38% but still remains above the 85% main contract non CQUIN.
			May-16		10.44%		G		
		Sickness Absence (monthly)	**Jun-16**	3.9%	**6.20%**	↗	R	↑	
			May-16		4.87%		R		
		Vacancies (budgeted full time equivalent)	**Jun-16**	10%	**17.48%**	↘	A	↑	
			May-16		17.75%		A		
		Appraisals (all staff - number of employees who have received an appraisal in the previous 12 months)	**Jun-16**	90%	**71.29%**	↗	R	↑	
			May-16		69.59%		R		
		Appraisals (medical staff only - number of employees who have received an appraisal in the previous 12 months)	**Jun-16**	90%	**83.96%**	↘	R	↑	
			May-16		84.82%		R		
		Qualified Nurses (to total nurses, midwives, health visitors and healthcare assistants)	**Jun-16**	65%	**68.31%**	↗	G	↑	
			May-16		67.50%		G		
		Agency Usage (£ year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Jun-16**	£0	**£594k**	↗	R	↑	
			May-16		£351k		R		
		Agency Usage (% year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Jun-16**	0%	**78.00%**	↗	R	↑	
			May-16		69.00%		R		
	Other KPI	**Compulsory Training** (staff in-date)	**Jun-16**	95%	**90.49%**	↘	A	↑	
			May-16		90.87%		A		

Key:

Period	Current month and previous month
Plan	Trust target
↗	Variance to previous month

Achieving target/within target parameters
Approaching target/approaching target parameters
Not achieving target/outside target parameters

Trend based on previous 4 months
Turnover parameters (8% to 12%)
Vacancy parameters (10% to 20%)

QUALITY OVERVIEW – JULY 2016

Enc E

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%	58.00%	R	↑	Awaiting FSR roll out (data from PARIS), this is an increasing target based upon roll out of electronic records, Capacity to Consent to treatment increasing (Blue Light June 2016). Awaiting FSR roll out for full care planning measurement. See CPA care planning performance until completed Restrictive practice reduction strategy, monitoring in place. 12 month average as a baseline. Supervision complaince is increasing, this is up-take and recording. Review of whether the professional supervision seperate recording is adding value will be undertaken. The monitoring metric and recording of safeguaridng supervision, requires redesign as a every three month/ or as required advice line is recording system is difficult to performance manage.
			Quarter	100.00%	44.00%	R	↑	
		Percentage of all patients with a care plan in place which has been reviewed with 12 months	Month		N/A			
			Quarter		N/A			
		Seclusion incidents	Month	20	13	G	↓	
			Quarter	60	56	G	↓	
		Physical Restraint incidents	Month	55	32	G	↓	
			Quarter	165	116	G	↓	
		Clinical Supervision	Month	90	50.50%	A	↑	
		Management Supervision	Month	90	69.10%	A	↑	
		Safeguarding Supervision	Month	90	34.10%	R	↑	
		Professional Supervision	Month	90	16.40%	R	→	
	CQUINs or contractual levy	Flu Jab Up-take	Month	45.00%	N/A			The implemtnation period for the Flu jab does not commence until until vaccinations start Oct 2016. Safety Planning training increased by 31% on target to reach 90% by Target date.
			Quarter	45.00%	N/A			
		Think Family Training (target 90% by March 2017)	Month	90.00%	63.88%	G	→	
			Quarter	90.00%	N/A		→	
		The safety plan training (target 90% by March 2017)	Month	90.00%	81.72%	G	↑	
			Quarter	90.00%	N/A			
		The number of LD or Autism admissions without a CTR before admission	Month	0	4	R	→	
			Quarter	0	10	R	→	

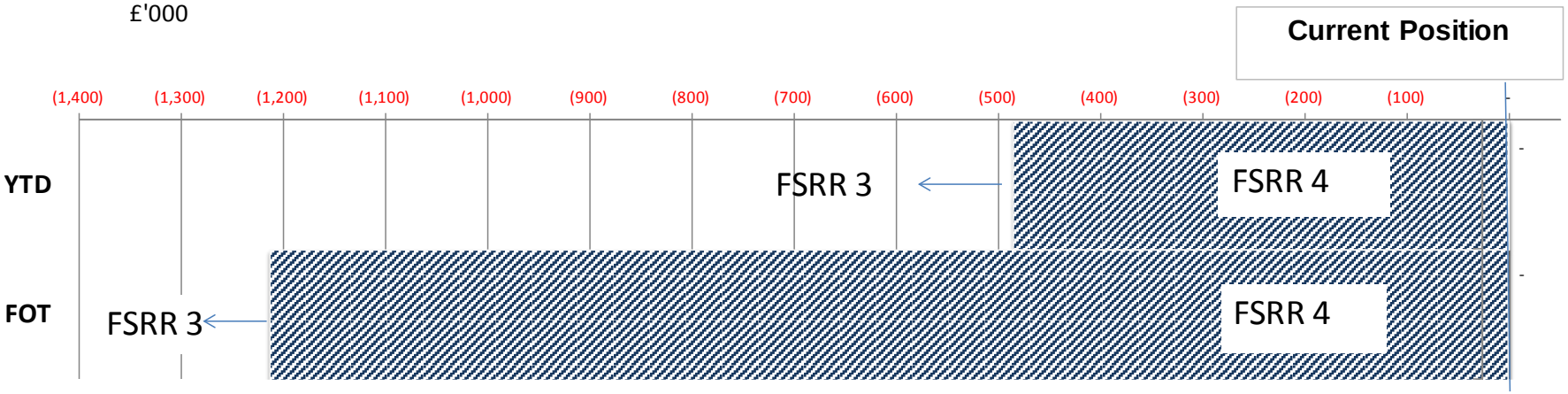
Financial Section

Governance – Financial Sustainability Risk Rating (FSRR)

Enc E

The FSRR at the end of June is a 4 which is better than plan. The forecast continues to be a rating of 4 as per the plan.

The headroom down to a FSRR of 3 year to date and forecast is £0.5m and £1.2m respectively. The headroom is shown in the graph below:



The FSRR for each of the quarters is shown in the table below:

	Quarter 1		Quarter 2		Quarter 3		Quarter 4	
	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual
Capital Service Capacity rating	2	3	3	3	3	3	3	3
Liquidity rating	3	4	3	4	4	4	4	4
I&E Margin rating	2	4	3	4	4	4	4	4
I&E Margin Variance rating	4	4	4	4	4	4	4	4
FSRR	**3**	**4**	**3**	**4**	**4**	**4**	**4**	**4**

NHS Improvement are currently consulting on a proposed Single Oversight Framework which includes new financial metrics to measure financial sustainability, efficiency and controls.

Income and Expenditure

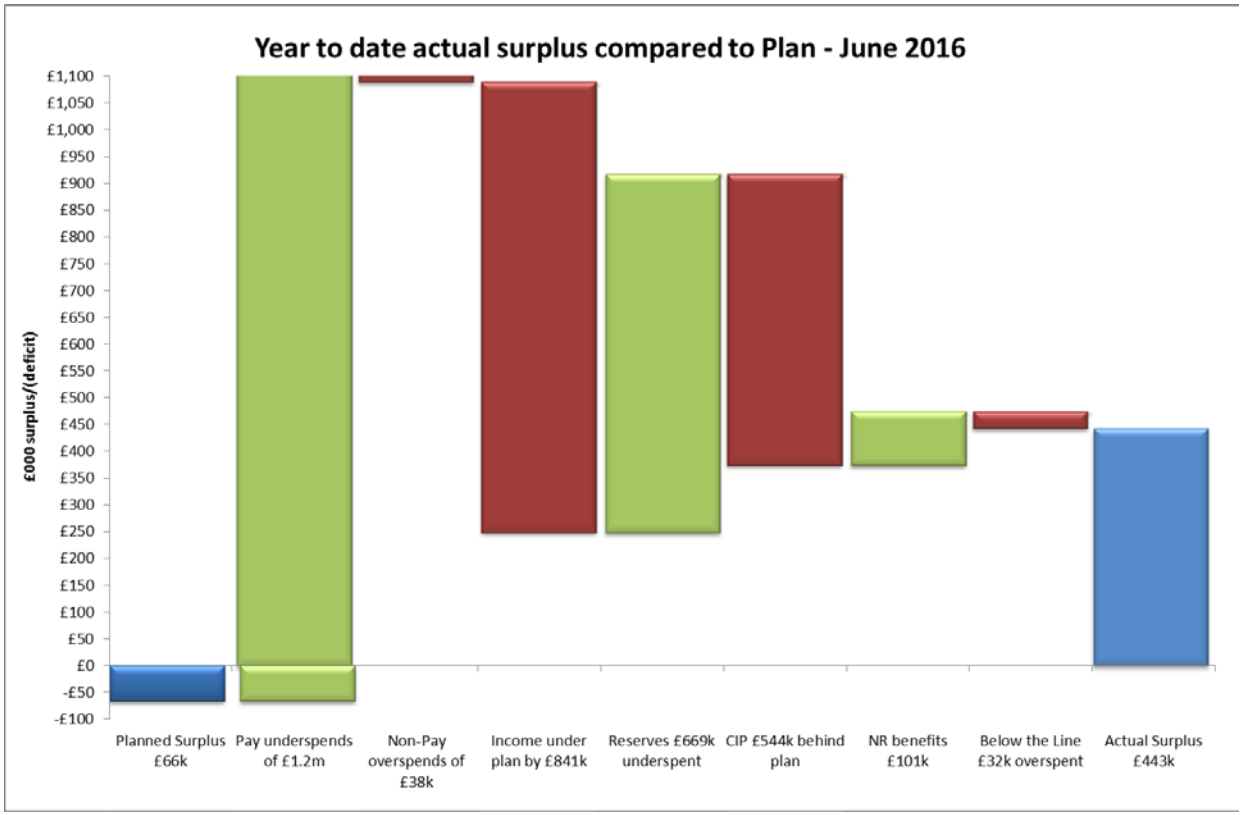
Statement of Comprehensive Income — June 2016

	Current Month			Year to Date			Forecast		
	Plan	Actual	Variance Fav (+) / Adv (-)	Plan	Actual	Variance Fav (+) / Adv (-)	Plan	Actual	Variance Fav (+) / Adv (-)
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical Income	10,891	10,462	(430)	31,837	30,887	(951)	127,406	124,016	(3,390)
Non Clinical Income	849	776	(73)	2,548	2,277	(270)	10,190	8,945	(1,245)
Employee Expenses	(8,864)	(8,016)	848	(25,821)	(23,997)	1,824	(101,492)	(96,553)	4,939
Non Pay	(2,163)	(2,303)	(140)	(6,575)	(6,650)	(76)	(26,298)	(26,568)	(270)
EBITDA	**713**	**918**	**205**	**1,989**	**2,516**	**527**	**9,806**	**9,840**	**34**
Depreciation	(295)	(337)	(43)	(884)	(915)	(31)	(3,534)	(3,611)	(77)
Impairment	0	0	0	0	0	0	(300)	(300)	0
Profit (loss) on asset disposals	0	0	0	0	0	0	0	0	0
Interest/Financing	(180)	(169)	11	(564)	(552)	13	(2,141)	(2,099)	41
Dividend	(133)	(133)	(0)	(400)	(400)	0	(1,600)	(1,600)	0
Net Surplus / (Deficit)	**105**	**278**	**173**	**141**	**651**	**509**	**2,231**	**2,230**	**(0)**
Technical adjustment - Impairment	0	0	0	0	0	0	(300)	(300)	0
Control Total Surplus / (Deficit)	**105**	**278**	**173**	**141**	**651**	**509**	**2,531**	**2,530**	**(0)**
Technical adjustment - STF Allocation	208	208	0	208	208	0	830	830	0
Underlying Net Surplus / (Deficit)	**(103)**	**71**	**173**	**(66)**	**443**	**509**	**1,701**	**1,700**	**(0)**

Due to the timing differences between the submission of the annual plan and the conclusion of contract negotiations a set of income and expenditure assumptions were included in the plan that are not in the actual or forecast position. Therefore there will be variances across Income, pay and non-pay but mostly with nil effect.

The Statement of Comprehensive Income shows both the control total of £2.5m which includes the Sustainability Transformation Fund (STF) and the underlying surplus / (deficit) against the underlying plan with the STF excluded.

Clinical Income is £430k less than plan in month and is forecast to be £3.4m worse by the end of the year of which a significant proportion is due to differences in planning assumptions with offsetting expenditure reductions. There is however forecast underperformances on activity related income.
Non Clinical income is less than plan in the month by £73k with a forecast outturn of £1.3m behind plan. £0.4m relates to a miscellaneous income target with no income forecast against it.
Pay expenditure is £848k less than the plan in the month and the year end position is £4.9m more favourable than plan which is due to planning assumptions (with offsetting income reductions) but also vacancies and recruitment.



Summary of key points Enc E

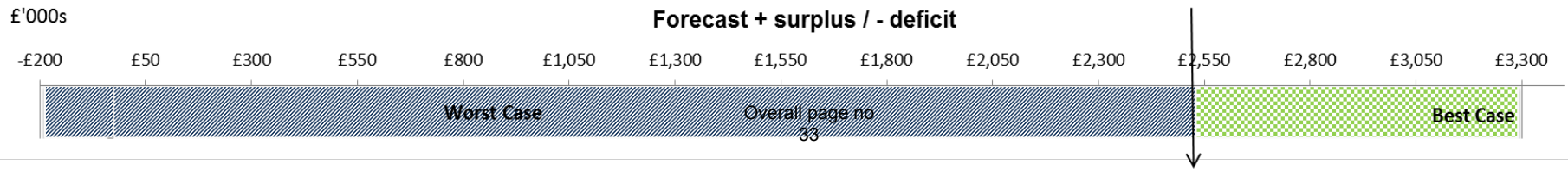
Overall favourable variance to plan year to date which is driven by the following:

- Pay budget is significantly underspent which is mainly driven by vacancies across the Trust. Some of this relates to planning assumptions which are different to final contract negotiations (which is offset by corresponding income reductions), new service developments that are in the process of being recruited to. These also have associated non-pay underspends.
- Reserves are underspent in month as expenditure is now forecast to start from next month and spans across the financial year, so is in a different phasing to the original plan.
- This is helping to offset the CIP which is behind plan in the month.

The forecast includes a set of assumptions based on knowledge and expectations at this point in time. At this early stage in the financial year there is a large performance range from worst-case to best-case outturn which is primarily dependant on the successful mitigation of emerging risks.

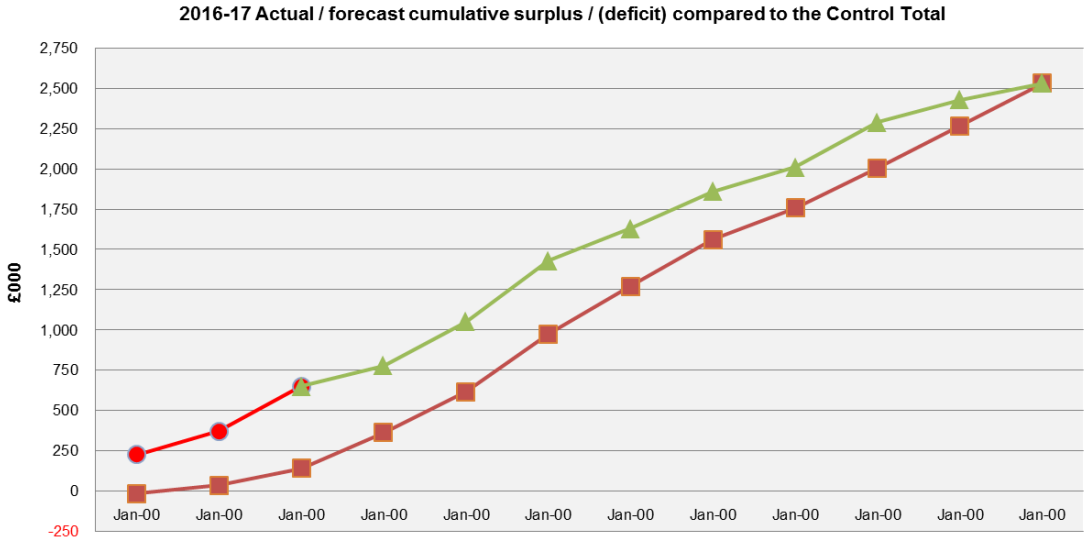
Forecast Range

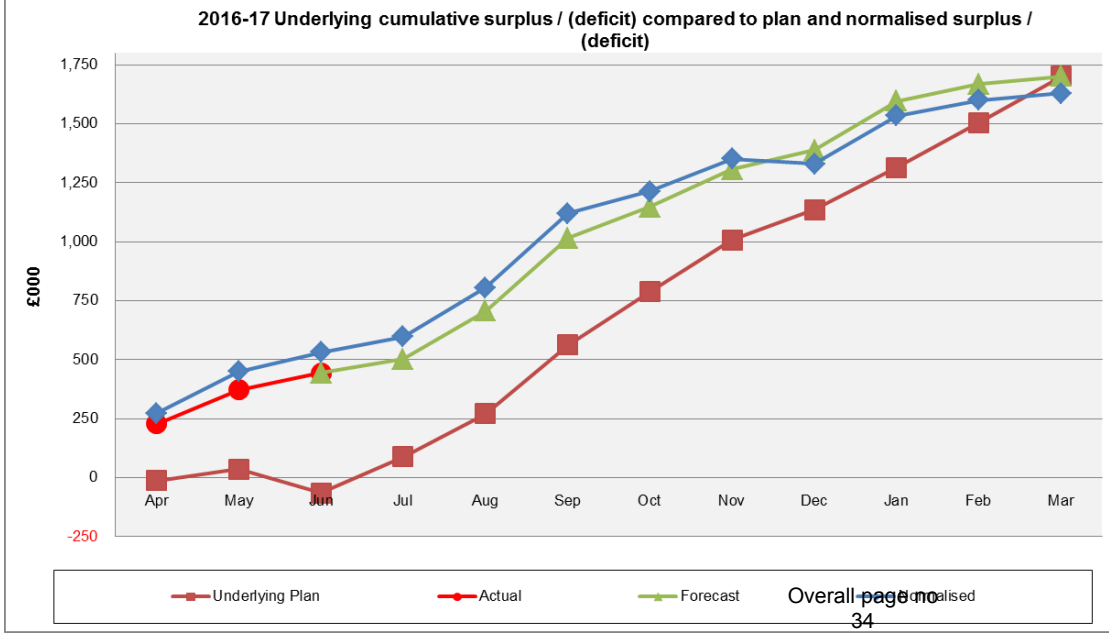
Best Case	Likely Case	Worst Case
£3.3m Surplus	£2.5m surplus	£0.2m deficit



Normalised Income and Expenditure position

Enc E





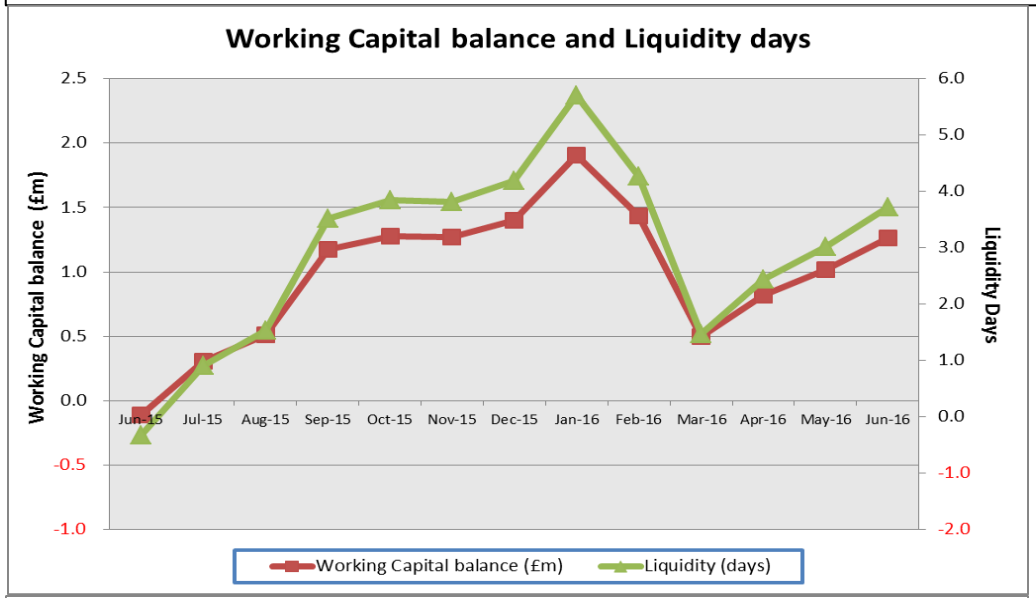
The first graph shows the actual and forecast cumulative surplus against the control total (including the Sustainability Transformation Fund (STF). The surplus is forecast to remain ahead of plan in the first part of the financial year and then slowly reduce back down to the planned control total.

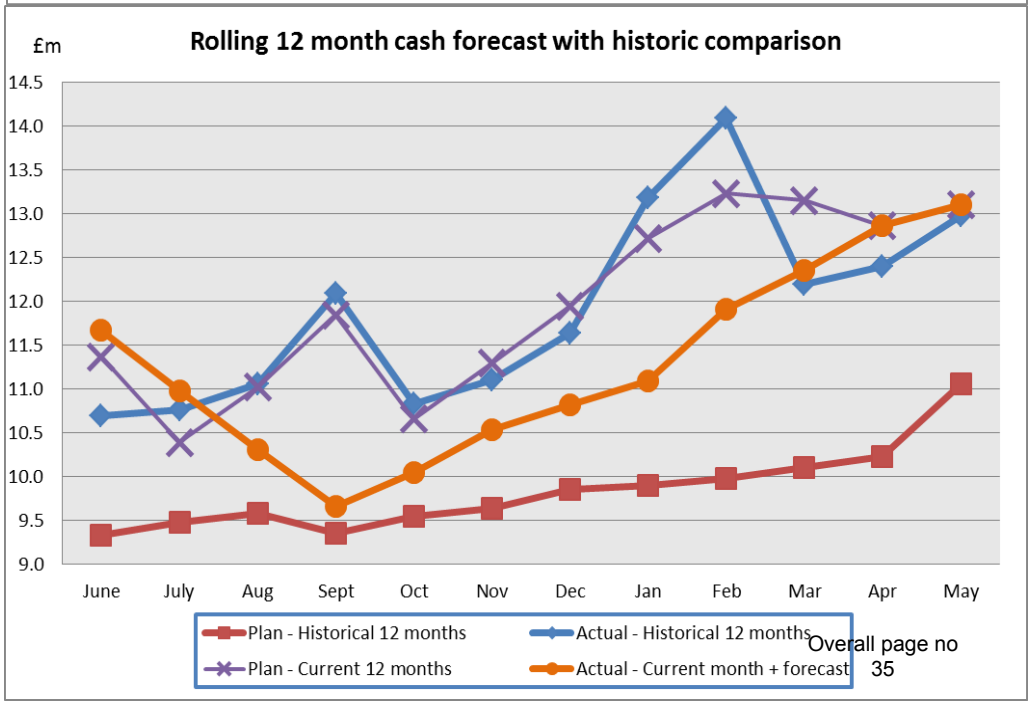
The second graph shows the underlying actual and forecast surplus against the underlying plan excluding the STF.

This graph also shows the normalised financial position. This is referring to the position removing any one off non-recurrent items of cost or income that is not part of the business as usual.

There is some additional non-recurrent income in the year to date and forecast position along with additional non-recurrent costs related to Governance Improvement Action Plan. In the normalised position these have been removed.

Liquidity



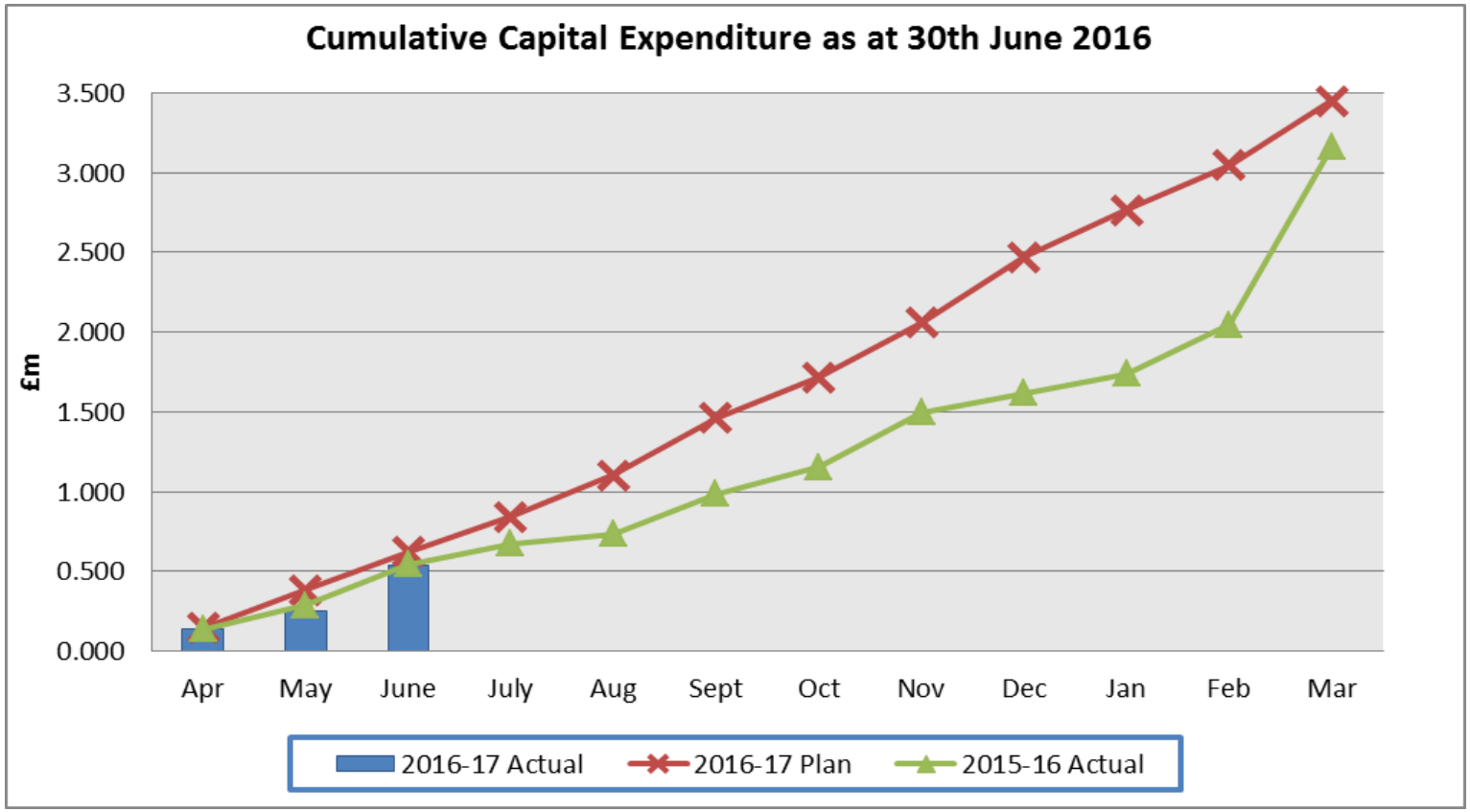


The first graph shows the working capital balance (net current assets less net current liabilities adjusted for assets held for sale and inventories) and how many days of operating expenses that balance provides.

During last financial year working capital continued to improve due to improved cash levels. The downward trend at the end of last financial year is reflective of the reduction in cash due to year end transactions. June continues to show a further improvement.

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 must remain a strategic priority for us to continue to improve.

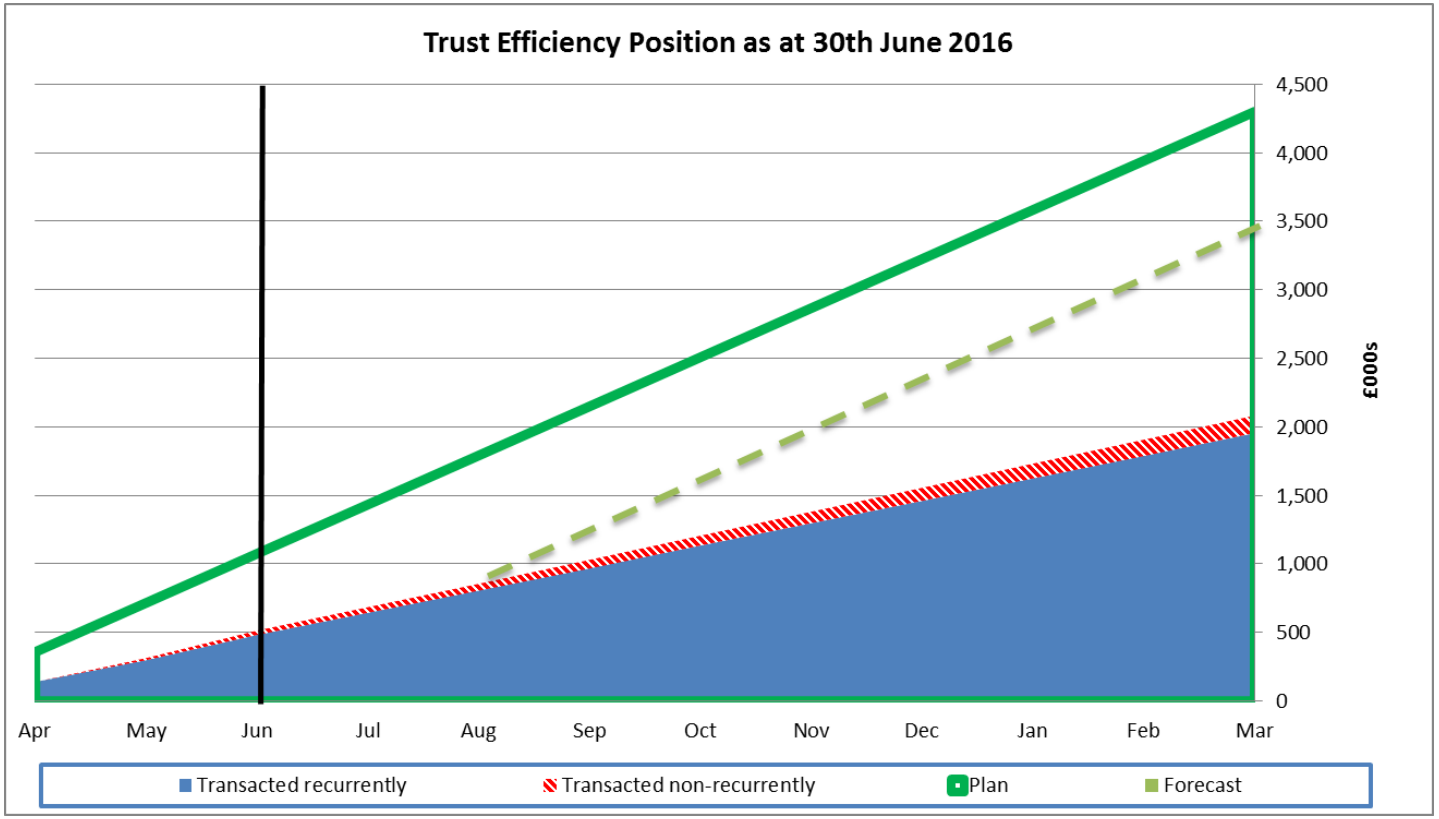
Cash is currently at £11.7m which was £0.3m better than the plan in the month. This is due to cash related Income and Expenditure surplus.



Capital Expenditure is £83k behind plan year to date but is forecast to spend to the plan of £3.45m by year end.

The 2016/17 schemes are regularly reviewed by Capital Action Team (CAT) including the reprioritisation to fund any new schemes. Some reprioritisation of schemes has recently taken place to fund new more urgent schemes.

Cost Improvement Programme (CIP)



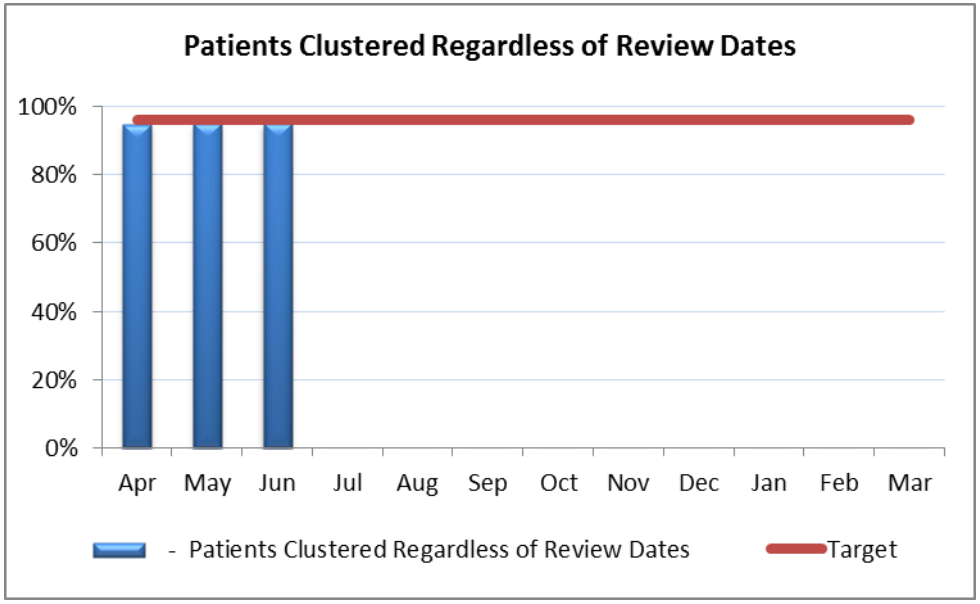
At the end of June there was a shortfall against the year to date plan of £560k. The full year amount of savings identified at the end of June reporting is £2.1m leaving a gap of £2.2m.

The forecast assumes that a further £1.38m will be achieved by the end of the financial year leaving unfound CIP of £0.8m.

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

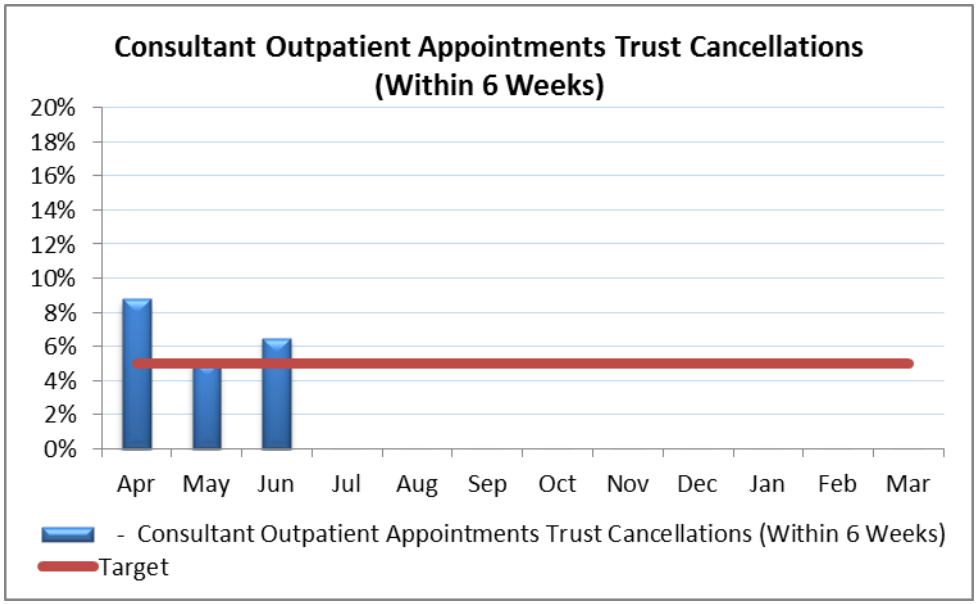


The majority of clinicians now successfully manage their PbR caseloads either independently or through positive engagement with available support.

Solutions being deployed on an ongoing basis:

- to data cleanse
- to make improvements in practitioner clustering
- to highlight to staff responsible for clustering the issues needing to be resolved
- PbR Advisors continue to target support to those clinicians with the largest clustering backlogs.
- Taught Course "Understanding HoNOS and Care Clusters – Flustered About Clusters?" has now been introduced.

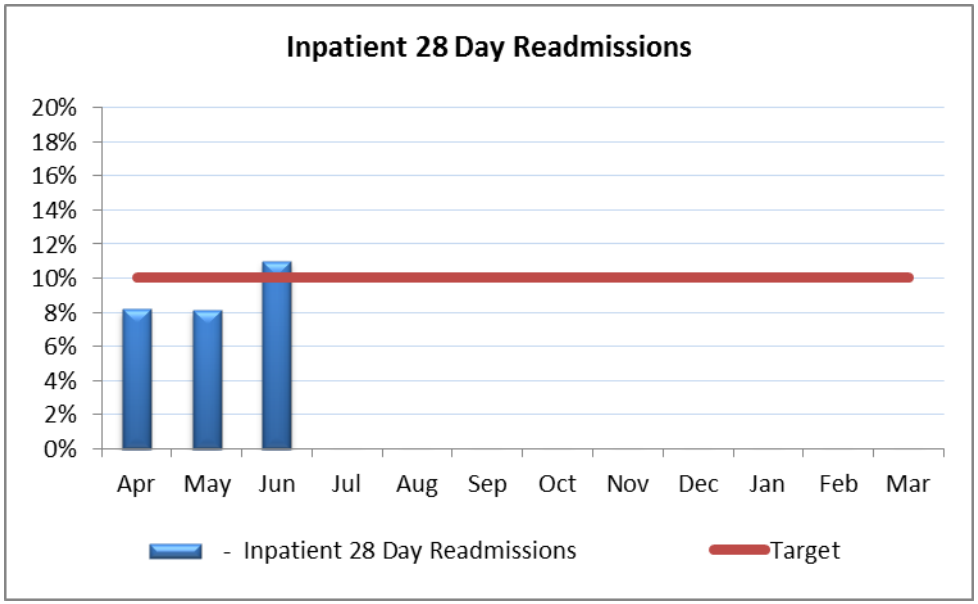
Consultant Outpatient Appointments Trust Cancelations (within 6 weeks)



The main reasons given for cancellation were clinician absence from work (108), no locum available (83) , virtual clinic – patient not aware of appointment (10) and clinician on study leave (10).

- Associate Clinical Directors to review cancellation reasons and discuss with consultant concerned where the reason does not appear valid, if applicable.
- List of clinic cancellation reasons has been agreed and added to Paris to enable easier reporting and monitoring.
- IM&T have been asked to explore the possibility of adapting Paris to enable the recording of cancellation reasons for individual appointments, not just whole clinics.

Inpatient 28 Day Readmissions



This month the 10% threshold was exceeded by 1 readmission.

- Head of Nursing to review the readmissions.

Enc E

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	151.7%	75.8%	136.7%	63.3%	Yes	
CHILD BEARING INPATIENT	113.0%	130.9%	100.0%	150.0%	Yes	The current fill rate tolerances for care staff day and night have been broken as a result of two long tern sickness absences, high clinical activity with patients on higher observations and the support with infant care needed.
CTC RESIDENTIAL REHABILITATION	113.3%	91.7%	100.0%	103.3%	No	
ENHANCED CARE WARD	86.5%	91.9%	65.4%	106.8%	Yes	We are currently carrying RN Vacancies and high levels of short term sickness. We continue to attempt to recruit into these vacancies and have further interviews scheduled for 20/07/16. All shifts have been led by trust employed RN. Deficits in numbers covered by trust and Bank NAs where possible.
HARTINGTON UNIT - MORTON WARD ADULT	98.9%	104.6%	67.8%	194.4%	Yes	We are currently carrying x 4.36 Band 5 vacancies which are all out for recruitment. In addition to that we have x1 Band 5 who is acting up into a Band 6 role on the ward. We are therefore mostly only able to place x1 qualified nurse on duty rather than the safer staffing level of 2, we are then covering this shortfall with non qualified staff.
HARTINGTON UNIT - PLEASLEY WARD ADULT	114.0%	69.2%	95.7%	95.3%	Yes	

Enc E

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	69.8%	134.1%	50.0%	203.3%	Yes	Tansley Ward is currently running with a high level of Band 5 vacancies against funded posts. In June there are 10.2 whole time equivalent (wte) Band 5 vacancies and only 8.7 wte Band 5 nurses in post. Of those 8.7 wte Band 5 nurses in post 1 full time nurse was removed from clinical duty at the end of February pending investigation into concerns who has no potential return date and a part time Band 5 nurse has just had surgery so neither are available for duty at present. The impact of the vacancies and absence has been significant on our ability to maintain even minimum numbers of Band 5 nurses on shift at 2/2/1. Actions taken to address: • Rotas are written approximately 3 months in advance via the e-roster to allow for staff to plan their time and to identify any potential qualified bank shifts they can do to bring us up to minimum numbers of 2 registered nurses on early and late duties and 1 qualified nurse on night duty. • Lead and Senior nurses working clinically in the numbers and on bank to bring numbers up to minimum and provide leadership. • Block booking Bank HCA to bring overall staffing numbers up to 5/5/3 • Booking HCAs into shifts where there is one Band 5 to enable redeployment from another ward where possible and providing HCA cover to ensure that the other ward does not work below minimum numbers. • Starting to implement 5 ways to well-being to look at staff
KEDLESTON LOW SECURE UNIT	118.8%	95.0%	113.3%	106.7%	No	
KINGSWAY CUBLEY COURT - FEMALE	87.2%	113.3%	53.3%	152.2%	Yes	
KINGSWAY CUBLEY COURT - MALE	85.6%	125.8%	91.7%	174.4%	Yes	

Enc E

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 (%)		
LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP	110.0%	68.9%	75.0%	173.3%	Yes	
LONDON ROAD COMMUNITY HOSPITAL - WARD 2 OP	108.3%	81.7%	100.0%	110.0%	Yes	
RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT	98.6%	99.4%	91.9%	101.6%	No	
RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT	84.4%	126.0%	66.7%	250.0%	Yes	Ward 34 continue to carry a high number of vacancies which we are trying to address with in recruitment, also ward 34 has had high clinical activity and a high number of engagement levels.
RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT	77.4%	141.2%	71.4%	201.9%	Yes	It is due to a number of unfilled vacancies for Band 5's and a heavy usage of unqualified bank staff.
RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT	93.9%	100.0%	100.0%	110.1%	No	

Workforce Section

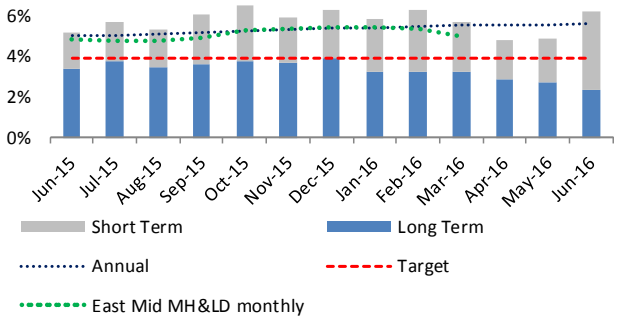
Wellbeing

Sickness Absence

(Monthly)

Apr-16	May-16	Jun-16
4.81%	4.87%	**6.20%**

Target 3.9%



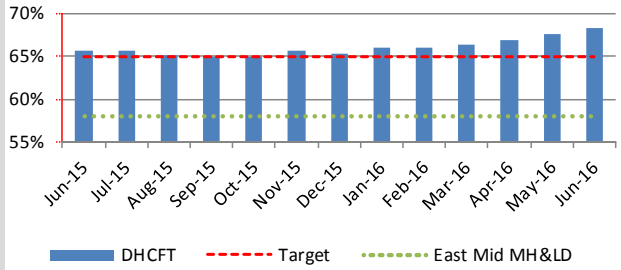
The Trust annual sickness absence rate is currently 5.58% (0.04% increase compared to last month).
Anxiety/stress/depression/other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 25.78% of all sickness absence, followed by surgery at 10.49% and other musculoskeletal problems at 9.52%.

Qualified Nurses

(To total nurses, midwives, health visitors and healthcare assistants)

Apr-16	May-16	Jun-16
66.89%	67.50%	**68.31%**

Target 65%



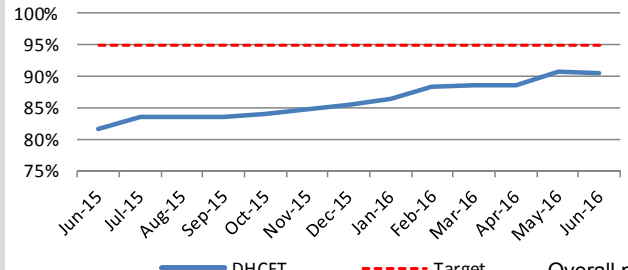
Contracted staff in post qualified nurses to total nurses, midwives, health visitors and healthcare assistants remains within target at 68.31%. Vacancy rates can impact on this measure. The NHS average is 61.38% and the East Midlands Mental Health & Learning Disability average is 58.04%.

Compulsory Training

(Staff in-date)

Apr-16	May-16	Jun-16
88.58%	90.87%	**90.49%**

Target 95%



Compulsory training compliance continues to remain high running at 90.49%. Compared to the same period last year compliance rates are 8.81% higher. Compulsory training compliance remains above the 85% main contract commissioning for quality and innovation (CQUIN) target.

Enc E

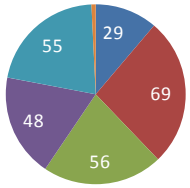
WORKFORCE DASHBOARD

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.

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

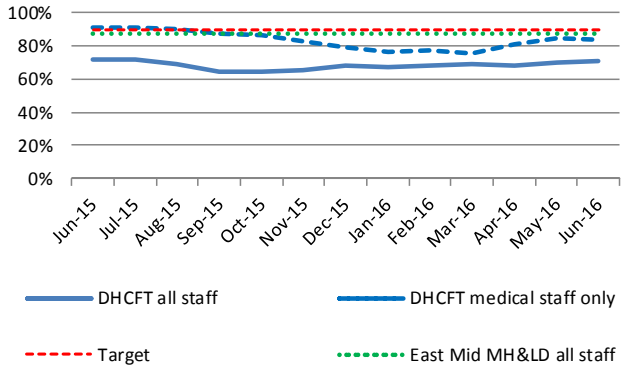


	2014	**2015**	National Average
Overall staff engagement	3.75	**3.73**	3.81

Appraisals

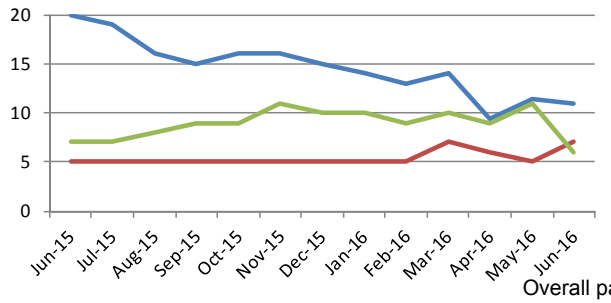
	Apr-16	May-16	**Jun-16**
(All staff)	68.12%	69.59%	**71.29%**

Target 90%

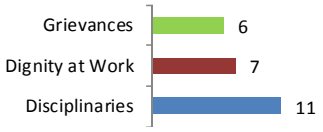


The number of employees who have received an appraisal within the last 12 months has increased by 1.70% during June 2016 to 71.29%. Medical staff appraisal compliance rates are running at 83.86%. According to the latest staff survey results, the national average for Mental Health & Learning Disability Trusts is 91%.

Grievances/Dignity at Work/Disciplinaries as at 30/06/16



6 grievances currently lodged at the formal stage, 1 new case received, 1 case transferred to Dignity at Work and 5 cases resolved. 7 dignity at work cases currently lodged, 1 new case and 1 case transferred from the grievance process. 11 disciplinaries in progress, 2 proceeding to a hearing as there is no case to answer and 2 on hold due to other processes taking place.



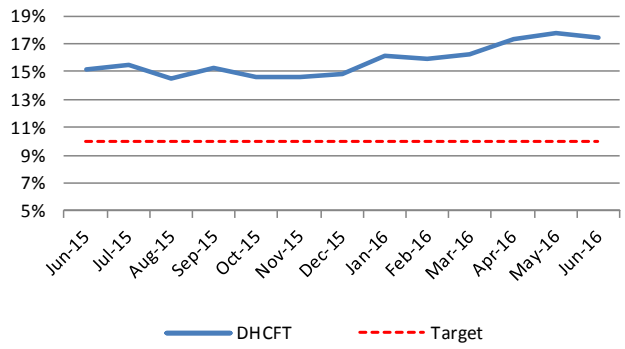
Enc E

Vacancy

(Budgeted full time equivalent)

Apr-16	May-16	Jun-16
17.30%	17.75%	**17.48%**

Target 10%



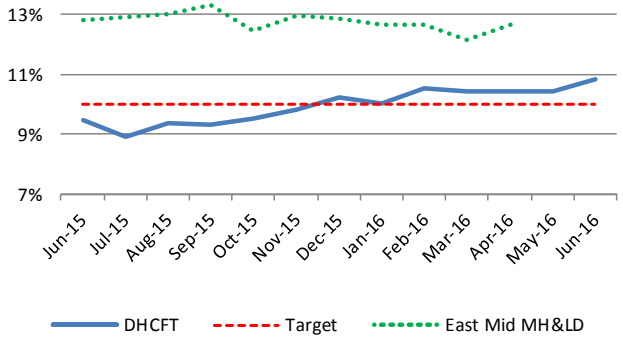
The budgeted vacancy rate has decreased by 0.27%. April 2016 included additional full time equivalent investment for 2016/17. Active recruitment during June 2016 was for 93 posts. 58% were for qualified nursing, 16% admin & clerical, 10% allied health professionals, 8% additional clinical services, 5% scientific & technical and 3% medical. The Trust target for contracted staff in post is 90% which allows 10% funded Fte surplus for sickness and annual leave cover in In-Patient areas.

Turnover

(Annual)

Apr-16	May-16	Jun-16
10.42%	10.44%	**10.86%**

Target 10%

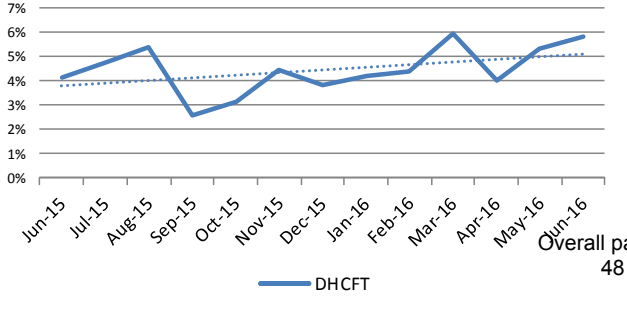


Annual turnover remains within Trust target parameters at 10.86% and is below the average for East Midlands Mental Health & Learning Disability Trusts. The average number of employees leaving each month has increased slightly from 21 to 22. During June 2016 22 employees left the Trust which included 7 retirements.

Agency Usage

(Spend)

Apr-16	May-16	Jun-16
4.03%	5.29%	**5.79%**



Total agency spend in June 2016 was 5.79% (6.30% including medical locums). Of total agency and locum spend for all staff groups, Qualified Nursing represented 1.2%, Medical 3.6% and other agency usage 1.5%. Agency Qualified Nursing spend against total Qualified Nursing spend in June was 3.2%. Agency Medical spend against total Medical spend in May was 20.4%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £594k of which £445k related to Medical staff.

Quality Section

Strategic Risks (Board Assurance Framework)

Risk Description	Risk rating	Trend
1a) Failure to achieve clinical quality standards	HIGH	↑
2a) Risk to delivery of national and local system wide change.	HIGH	↔
3a) Loss of public confidence due to Monitor enforcement actions and CQC requirement notice and adverse media attention	HIGH	↔
3b) Loss of confidence by staff in the leadership of the organisation at all levels	HIGH	↔
4a) Failure to deliver short term and long term financial plans	EXTR	↔
4b) Failure to deliver the agreed transformational change at the required pace	HIGH	↔

Risk 1a) Likelihood raised from 3 (possible) to 4 (likely), following further gaps in controls identified through CQC inspection.

Clinical Risks (Significant)

Risk Description	Risk rating	Trend
Long waiting lists due to difficulty in recruiting paediatricians	EXTR	↔
Non-compliance with medicine management standards. Lack of facilities to assure compliance with medicines management standards	HIGH	↔
Nursing vacancies, leadership and succession planning across Radbourne Unit	HIGH	↔
Lack of commissioned services: ADHD, patients discharged from prison	HIGH	↔
Waiting times for psychological assessment, neighbourhood teams, pressure from transfer between neighbourhood teams.	HIGH	↔
Increased risk of fire, violence and aggression, lone working and workplace stress on Radbourne Unit.	HIGH	↑

New high level risks identified at the Radbourne Unit linked to impact of the smoking ban and staffing pressures.

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 27 July 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:

1. Responsiveness of our Patient Experience team.
2. Safe services which includes some of our work safer staffing and markers of good practice.
3. Well-led- Our quality visit programme and safeguarding systems and processes.
4. Effectiveness through our work on smoking cessation.

Strategic considerations
To give an insight into our key areas as key questioning by the Care Quality Commission and to provide assurance level information on our services and their performance.

(Board) Assurances
Compliance with the key areas covered by the Care Quality Commission key lines of enquiry.

Consultation
This paper has not been previously presented but does reference information available to the Quality leadership teams and quality governance structures

Governance or Legal issues
Evidence of our compliance with the Health and Social Care Act 2008 (Regulation activities) regulations 2014 Part 3 and 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
2) Gain assurance and information on its content and seek clarity or challenge on any aspect of the report

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
July 2016

1. SAFE SERVICES

1.1 CQC scoping paper on: Investigating deaths across mental health, acute and community settings – reviewing and improving

The Mazars report (an independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust) was published in December 2015. As part of the Governments response to this investigation the Health Secretary has asked the Care Quality Commission to undertake a review of the way in which NHS Trusts investigate deaths and learn from these investigations.

The CQC have been asked to:

- Undertake a review into the investigation of deaths in a sample of all types of NHS trusts (acute, mental health and community trusts) in different parts of the country.

- As part of this review, CQC will assess whether opportunities for prevention of death have been missed, for example by late diagnosis of physical health problems.

A national report will be published in winter 2016. As part of this best practice will be shared and changes to systems and processes will be in place for all trusts from spring 2017. Our lead professional for patient safety attended a conference where this review was discussed last week and some trusts have already been contacted to take part in the review.

We will:

- Consider the scoping paper in our Serious Incident Group and at our Quality Committee and Quality Assurance Group (provider/commissioner forum).
- Await the finding of the review and discuss how we can learn from best practice.

1.2 Safer Staffing

In early July the National Quality Board (NBQ) published **'**Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time'. This document includes an updated set of NQB expectations for nursing and midwifery staffing to help NHS provider boards make local decisions that will deliver high quality care for patients within the available staffing resource.

On 14th July the CEO for NHS Improvement wrote to trusts confirming their position on safer staffing. The letter said that' An approach to deciding clinical staffing levels based on patients' needs, acuity and risks, which is monitored from 'ward to board', will enable NHS provider boards to make appropriate judgements about delivering safe, sustainable and productive staffing.

Last week they published an improvement resource, which clearly stated that there is a need to manage staffing within our triple aim which includes managing within the funds available. Carolyn Green Director of Nursing and Patient Experience has met with Ray

Walker Merseycare national lead and shared our work and is collaborating , and will receive briefings and assist as required.

Night staff should be allowed rests to ensure safety, says CQC

The Care Quality Commission has said NHS trusts should comply with guidelines on allowing doctors and nurses to rest at night, reports. The comments by the chief inspector of hospitals, Sir Mike Richards, come as a coroner heard a junior doctor died in a car accident after probably falling asleep while driving home after a nightshift. Earlier this month a survey of nearly 500 junior doctors from 150 NHS trusts revealed many doctors were actively discouraged from taking naps despite evidence based guidelines from the Royal College of Physicians dating back over a decade. Sir Mike said trusts should consider the guidelines and staff should raise concerns if they are worried about their working conditions. He said: “We expect all providers to do all they can to provide safe, effective, high quality and compassionate care, which includes having regard for best practice guidance. Where healthcare professionals have concerns about their working conditions we would encourage them to raise these concerns internally with senior colleagues and the trust’s Freedom to Speak Up guardian.”

We will
We will consider our skill mix reviews and plans in line with the best evidence and workforce available to meet demand. We will work with our Human resources team and our unions to explore what this would mean in practice to out guidelines?

1.3 Markers of Good Practice quality site visit

On 5th July 2016 we received the following e mail confirmation from NHS Southern Derbyshire Clinical Commissioning Group.
“We would like to take this opportunity to thank you and the safeguarding team for facilitating the Markers of Good Practice quality site visit this morning which included CCG Commissioners/ Designated Professionals. Public Health Commissioners and the Derby Safeguarding Children Board Independent Chair.

We were all impressed and assured with the evidence that Derbyshire Healthcare Foundation Trust Safeguarding Children Service have provided to demonstrate that your Organisation is compliant with the required safeguarding children arrangements as highlighted in the self-assessment tool. As Commissioners we were also very satisfied that you and your team were able to answer questions to some of the points that we required additional information on.

The next step from today’s visit is that we will forward you the minutes with agreed action points as soon as possible. We will also send you an electronic copy of the findings from the front line staff audit undertaken and a RAG rating traffic light summary for your records. Once the minutes have been confirmed we will develop an action plan on the agreed actions.

We will

Consider our report at our Safeguarding Operational group and Safeguarding Committee plan any actions in line with feedback from the independent multi-agency quality assurance group that reviewed all of our evidence produced for Markers of Good Practice quality/ part

of our Section 11 Audit under the Children Act to explore what this would mean in practice to out guidelines?

2. CARING SERVICES

2.1 Consultation CQC's NHS Patient Survey Programme

The Care Quality Commission have launched a consultation on proposed changes to the patient survey programme. The Care Quality Commission are proposing a number of changes to the coverage and timeliness of the surveys and are seeking feedback on how they can enhance the quality and presentation of survey results. The consultation document confirms that there will be no changes to the mental health community survey as the survey was extensively updated in 2014 to ensure its continued relevance. They will continue to review the survey and listen to feedback from trusts.

3. EFFECTIVE SERVICES

3.1 Making a difference: smoking cessation in mental health settings

The innovation network which was formed by Rethink Mental Illness has published the finding from their work on smoking cessation in mental health settings.

Our commitment to improving physical health

Rethink Mental Illness formed the independent Schizophrenia Commission in 2011 to examine care provision for people living with schizophrenia, psychosis and other severe mental illnesses.
The Commission's wide range of members were very concerned about physical health outcomes. In particular, the Commission as struck by the evidence that people living with mental illness die 15-20 years earlier than the general population, and tobacco use is the single largest contributor to reduced life expectancy. The Commission was very clear that action on high smoking levels should be "an absolute priority".

What the pilots hoped to achieve?

The pilots sought to evaluate whether a programme of staff education and provision of information to people using mental health services leads to:

- Better recording of smoking status and any actions relating to smoking cessation in care records,
- Reduced smoking rates among people in contact with secondary mental health services,
- An increased awareness and confidence among staff to initiate conversations about
- Smoking, to signpost and offer support where possible.

What the pilots did?

Each pilot site introduced the following:

- A programme of staff training,
- Co-produced resources and materials to support individuals to be informed about

- The choices available, project steering groups involving people who use services.

The report sets out some encouraging statistics stating that 'since the introduction of smoking cessation initiatives there has been a reduction overall in those who identify as a 'smoker'. Some organisations had rates as high as 78% before the pilots, down to 23% afterwards'. The report describes the good progress made by organisations and describes the work done in the pilot organisations.

In summary overall:

- A decrease from 63% to 55% of individuals who identify as a smoker.
- Smoker status was recorded in 100% of service user records. This demonstrates the checking and recording of smoking status.
- Double the amount of smokers are now given smoking cessation information (up from 45% to 90%).
- An increase from 40% to 89% of smokers who were given additional information to consider stopping smoking.
- A total of 91% of smokers are now engaged in discussions about smoking cessation, up from 54% at the start of the pilots.

As a pilot site our work in described and will be presented on 19th July at Chesterfield at a national learning event. The report makes a number of recommendations for other organisations, and our Trust compared to other organisations involved in the trial has had a good outcome.

We will:

Continue our work to ensure smoking support is embedded across in our organisation, to support out FRESH project group to implement the NICE March 2016 revised guidance for mental health settings on how to move mental health secondary care organisations to a smoke free environment. To undertake a full analysis of this report and their recommendations to support our Trust in its strategy to move to a Smoke free organisation.

Support our staff in this significant cultural change. In the long term interests of our staff and our patients. We will listen and not disregard the challenges some of our in-patients staff and family and carer feedback on how challenging this is, but respond and be responsive and solution focused in how we assist them to make this change.

4. RESPONSIVE

4.1 Responsiveness to formal concerns

An example of listening to concerns:

On 4th July 2016 we received a concern from Healthwatch Derbyshire. The patient experience team received the concern at 13:08 and followed it up immediately; by 13.37 they had resolved the issue. We continue to have a positive relationship with Healthwatch Derbyshire organisation, responding to feedback in a timely and effective manner.

We have received a copy of our community patient survey, the final release of this data and national benchmark is embargoed, however we are responding to its findings both on

aspects we have done well and any we need to build upon and areas where we continue to have the similar levels of performance to continually improve.
We will:

Continue our work to ensure our patient experience and feedback intelligence group are responsive to our patients through our community partners in their feedback and we will review our findings of our community survey in our clinical service aswell as our responsiveness for good practice to expand upon and areas to action plan to improve.

5. WELL LED

4.1. Initial findings from Quality visits

The Quality visit programme is well underway for 2016 and the programme will be completed by the end of September. The programme continues to be valued by teams and both commissioners and governors have been involved in a lot of visits so far. The visits are moderated in October quality improvements made by teams are recognised at the annual award event to be held in December this year. Some early findings and best practice have included:

April and May visits best practice examples showcased

- Good work on pathway development and improved working relationship with the wards and training opportunities for ward staff. (ECT visit on 21st April 2016)
- The health visiting team have adapted 'The Solihull Support Programme' in which children within services are monitored up until the age of 19.The team have also driven the Teeth ember initiative which support children and families to improve oral hygiene and the team secured £1000 funding to support this project. (Health Visiting visit on 13th May 2016)
- A new approach to care planning and development of personalised care plans in a new format which was completed jointly with patients, professionals and carers/family which reflected the Triangle of Care model. (Cherry Tree Close visit 20th May 2016)
- Accessible information practices to ensuring that people who use the services have the information in the most appropriate format examples included care plans, social stories, and keeping safe plans. (Amber Valley CLDT 4th May 2016)

Examples of some the issues raised April and May

- The team shared some of the challenges they have experienced with PARIS EPR but remained locally, solution focussed. It was evident that they were problem solving as a team by being engaged through the Clinical Reference Group and utilising the support of the PARIS and IMT team as and when necessary.
- The team are not up to full complement and recognised that the service is still evolving. The team often have competing demands such as many clinics and various meeting requests i.e. early help assessment, safeguarding, review meetings.
- The team spoke about the challenges of the caseloads and the increasing demand.

We will:

Continue to monitor the actions agreed during the visits and best practice examples are recorded in each report which is available on the intranet following moderation for teams to learn from.

Listen to the feedback both performance data and soft intelligence from quality visits and factor this into our organisational; management actions and decision making to support team in areas with clinical pressure.

5.2 CQC publishes review of child safeguarding and looked after children services in England

The Care Quality Commission (CQC) published their review of child safeguarding and looked after children services (Not seen, Not heard) in England on 8th July 2016. The review is the result of two years of research, looking into the quality of care that young people receive with local authority areas.

The report includes a call to healthcare staff and leaders to do more to identify and listen to children at risk of harm. The report concludes that health professionals have improved the way they assess risk and recognise safeguarding concerns, but that services are not consistently protecting and promoting the health and welfare of children. It urges everyone working with children to do more to listen to and involve children in need in their care. More must be done by health providers, including staff in hospitals, health visitors and GPs, as well as commissioners, to ensure that services are improving outcomes for children, strengthening the quality of information sharing and joint working, the report says. The report sets out examples which included strong leadership as follows:

Designated professionals were represented at the two trusts' safeguarding board in Stockton on Tees and were an integral part of the safeguarding governance and reporting framework. The LSCB had formed a multi-agency learning lessons and an improving practice sub group. The designated nurse was the vice chair. This group was managing the investigations of a recent spate of incidents across member organisations and monitoring the progress of actions against agreed action plans.

The executive nurse and designated safeguarding children professionals provided clear and effective leadership on safeguarding children practice. Key professionals and the designated safeguarding team met weekly to embed safeguarding

We will:

- Maintain current practice at this time
- Benchmarking against the CQC findings and recommendations, will be completed for the Safeguarding committee to provide Board assurance on out trust performance and encompass any good practice into our work plan

Report prepared by: Clare Grainger, Head of Quality on behalf of Carolyn Green Director of Nursing and Patient Experience

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

Quarterly Compliance Return – Quarter 1 2016/17

Purpose of Report

To summarise for Trust Board the key elements of the Quarter 1 compliance return for approval.

Executive Summary

This quarter the financial return and the governance return have been separated.

The financial return is due for submission on 22nd July (moved from 15th July) and does not require sign off by the Trust Board. However the financial return has been reviewed by the chair of the Audit and Risk Committee and the chair of the Finance and Performance Committee. The governance return however does required Trust Board sign off.

Information contained in the quarter 1 governance compliance return is summarised below.

1. Targets and Indicators

There is one indicator that is showing red which relates to outstanding CQC actions. An extract of that section is contained in the report.

2. Organisation Health Indicators

In this quarter it has been reported that there are four voting Executive posts on the Board.

3. Elections

There have been 2 elections in the quarter, one for Public and one for Staff.

4. Financial performance

Financial performance for the quarter is contained in the Integrated Performance Report to Trust Board.

- In the quarter the surplus is ahead of plan and forecast to achieve the control total.
- Financial Sustainability Risk Rating of 4 in the quarter which is better than plan. Forecast to achieve the plan of 4 at the end of the financial year.
- Capital is slightly behind plan in the quarter but is forecast to achieve full spend by the end of the financial year.

Strategic considerations

This report is linked to the strategic five year plan previously submitted to Monitor (now NHS Improvement) in June 2014 which was updated for 2016/17 financial planning in April 2016.

Board Assurances

This report should be considered in relation to the financial risk contained in the Board Assurance Framework 2016/17:

3a Failure to deliver short term and long term financial plans could adversely affect the financial viability and sustainability of the organisation
and
3b There is a risk that the Monitor enforcement actions and CQC requirement notice, coupled with adverse media attention may lead to significant loss of public confidence in our services and in the Trust of staff as a place to work.

Furthermore, failure to deliver the governance improvement action plan could lead to a risk of further breaches in licence regulations with Monitor and the CQC and further regulatory action

and

2a Failure to deliver the agreed transformational change, at the required pace could result in reduced outcomes for service users, failure to deliver financial requirements and negative reputational risk

and

Risk to delivery of national and local system wide change. If not delivered this could cause the Trusts financial position to deteriorate resulting in regulatory action.

Consultation

The financial return has been reviewed by the Chair of Audit and Risk Committee and the Chair of Finance and Performance Committee.

Governance or Legal Issues

This report supports the requirement of the NHS Improvement 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 NHS Improvement.

This return is required to be submitted to NHS Improvement in accordance with their Risk Assessment Framework 2016/17 by noon 29 July 2016.

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 NHS Improvement (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 Q1 Governance return** to be otherwise appropriately signed and returned to Monitor by noon 29 July 2016.

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

Report prepared by: **Rachel Leyland, Deputy Director of Finance**

Targets and Indicators

An extract from the Targets and Indicators tab is shown below.

Declaration of risks against healthcare targets and indicators for 201617 by Derbyshire Healthcare NHS Foundation Trust

	Annual Plan	Quarter 1	
	Risk declared	Declaration	Comments / explanations
Risk of, or actual, failure to deliver Commissioner Requested Services	No	No	
Date of last CQC inspection	N/A	06/06/2016	
CQC compliance action outstanding (as at time of submission)	No	Yes	2 actions outstanding
CQC enforcement action within last 12 months (as at time of submission)	No	No	
CQC enforcement action (including notices) currently in effect (as at time of submission)	No	No	
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	No	No	
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	No	No	
Overall rating from CQC inspection (as at time of submission)	N/A	N/A	not known at this stage
CQC recommendation to place trust into Special Measures (as at time of submission)	N/A	No	
Trust unable to declare ongoing compliance with minimum standards of CQC registration	No	No	
Trust has not complied with the high secure services Directorate (High Secure MH trusts only)	N/A	N/A	

Board Committee Summary Report to Trust Board
People & Culture Committee
15 July 2016

Identification of key risks, successes, decisions made/escalated from the meeting

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee) and for what reason
GIAP 2.1 Actions from June					
HR2 - Resource Plan	Management Trainer appointed, Ian Shepard, commencing 1st August 2016	Positive assurance.	Programme of leadership and training being developed and to complete in 6 months (February 2017)	Review of resources to prioritise against plan	None
HR3/HR4/HR5 HR model, Structure and metrics	Model updated since last meeting to include narrative	Positive assurance provided with review of 3-year implementation Measures to be provided quarterly to PCC	This was off track – now on track	Approved Model. Update 3-year Model implementation trajectory and in light of the STP and back office function review Metrics to focus on outcomes and targets, e.g. cost efficiencies	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) and for what reason
PC2/4 People Plan for approval	People Plan refined and clarified following June PCC re identified leads, and specific KPI's	Positive assurance provided	Timescale to deliver against plan (recognised previously as a timing due to Trust strategy) and now to prioritise	Progress noted Review of resources to prioritise against plan Dialogue with key stakeholders to take place against the Plan Updates to be provided to PCC	None
PC3 Communications system to record feedback from staff	Update provided since last PCC on system to record feedback received from staff	Positive assurance provided		Monitoring of feedback system via Engagement Group Tri-monthly reports to be provided to PCC	None
WOD1- HR function to audit compliance against 2 selected HR policies	**Acting Up Policy –** HR function compliance audit revealed there was too much discretion for acting up arrangement	Positive assurance in terms of undertaking audit of Acting Up Policy	Outcome that Policy not fit for purpose, to be updated and circulated and agreed in advance of the next PCC	Reviews and comments re Policy by PCC members to Owen Fulton by 22.07.16	None
	Professional Registration and Re-Registration Policy - HR function compliance audit revealed partial assurance of Policy	Positive assurance in terms of undertaking audit of Professional Registration and Re-Registration Policy	Update Policy to include nurse revalidation and ensure monitoring compliance through TOMM	Review Policy to incorporate the new Qualified Nursing Re-validation programme The six-monthly monitoring audit to be re-introduced and summary to be presented at TOMM	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) and for what reason
WOD2 Review and ensure that recruitment and acting up policies are fit for purpose	As for WOD1	As for WOD1 – positive assurance	As for WOD1	As for WOD1	None
WOD6 Implement integrated team meetings	Integrated team meeting had not taken place	Partial assurance	Circumstances prevent the integrated team meeting to take place	Integrated team meeting to take place	None
WOD7 Ensure the backlog of cases made known to the CQC are concluded – standing agenda item	ER Tracker not included in the PCC papers. Tabled at the meeting	Positive assurance Narrative to be provided to support future tracker submissions (Rose Boulton and Liam Carrier)	The length of time cases are on tracker to resolve – mitigate by focussed activity, case management review approach and to feed into overall policy review.	WOD 7 AND WOD 1 to be read in conjunction – Rose Boulton to circulate the front sheet of the ER Tracker to show progress and trajectory	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) and for what reason
GIAP 2.2 Key tasks for delivery in July					

PC2 Develop a clear plan which outlines an on-going focus on pulse surveys to enable targeted activity	Focus of Engagement Group – prepare and planning for Staff Survey. Plan to also provide feedback which has been lacking from previous Survey Toolkit for engagement and video presented	Positive assurance this also links into behaviour framework to help match NHS employers model and toolkit Teams to be asked key questions about the future and not the past Audits of team meetings and 360 feedback – change listening events Team briefings to be reintroduced into the Trust Induction and Engagement Link Workers to be reviewed and developed Real partnership with Staff side during the Engagement forum Leadership development ideas and wider engagement piece Positive assurance provided, evidence required to be presented at each PCC meeting	Resource to complete within timeframe Review of resources to prioritise against plan	Approach approved approach with updates to be provided to PCC meetings on specific actions to maintain impetus Executive Director to cover in Jayne Storey's absence of Co-chair of Engagement Group agreed by Carolyn Gilby on a temporary basis	Inform and provide presentation to Board, Council of Governors in September 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) and for what reason**

PC2 Develop and implement a leadership development programme	Reference PC2 above, see Appendix 2 to work with Training & Education Group to develop leadership and talent management framework. Agree resources from ELMA	Partial assurance Deadline of 31 October 2016 for implementation	Clarity regarding the responsible people to lead this	?	None
PC5 HR and OD to undertake a refresh of the behavioural framework	Reference PC2 above, and see Appendix 2 – Use NHS Employers Mapping Tool and resource to map against NHS Constitution. Use Pulse Survey. Ensure added into Trust policies and recruitment processes.	Partial assurance Deadline to use Tool and mapping to be agreed by September 2016 Deadline of 31st October 2016 regarding policies and recruitment processes	Clarity regarding the responsible people to lead these actions	?	None
WOD1-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	See also WOD7	Positive assurance Narrative to be provided to support future tracker submissions (Rose Boulton and Liam Carrier)	See WOD7	WOD 7 AND WOD 1 to be read in conjunction – Rose Boulton to circulate the front sheet off the ER Tracker to show progress and trajectory	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) and for what reason
Workforce Plan – Final draft	Key points and updates of the Plan presented	Positive assurance Incorporate additional information from PCC July meeting ACP NHS England – are accessing non-medical prescriber programmes, and exploring further programmes for the development of responsible clinician, and apprenticeships Positive feedback received from Staff Side via JNCC	Update with latest thinking with the scale of work to be undertaken, including new roles required for the future	Approach approved and work noted todate	Present to Board Development session

EDS2 Update	BME group paper well received. Comments on Trust's commitment following abeyance. Commitment from BME to participate in a working party– awaiting response by 29 July 2016 Briefings and electronic process to launch throughout the Trusts Submission to the CCGs and workforce information to provide commissioner assurance	Partial assurance	Observation – working portfolio emphasis on a named person	Report quarterly to the PCC	Board receive final version in July Presentation to Governors on 21 July
Agenda Item	**Summary of issue discussed**	**Assurance and actions required**	**Key risks identified**	**Decisions made**	**Escalations to Trust Board (or referral to other committee) and for what reason**
Workforce KPI Dashboard	Highlights on each section provided, e.g. sickness as demonstrates the reasons for absence are not the usual reasons, and therefore caused a spike in the percentage of sickness for the Trust	Positive assurance	Rise in short-term absences initially due to reasons, may develop into long-term sickness	Drill down the data to extrapolate the areas for reasons for absence, and explore whether there is a correlation to the recent difficulties experienced with client group at Radbourne Unit Report back to PCC in August 2016	None

Board Committee Summary Report to Trust Board
Quality Committee - meeting held on 7 July 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	The SI report was presented, good discussion and challenge.	The Director of Nursing has formally written to the bodies with commissioning responsibilities, Hardwick CCG and NHS England, to raise our concerns about the incident relating to PICU beds. There will be an independent investigation. This issue is outside the responsibility of our trust and in relation to other organisations. Pathway for children and adult services should be considered in any reported incidents and whether the transition has contributed to the outcome in any way in either a positive or negative way Challenge about patients not engaging with staff, the language used and what is being done to ensure staff engage with patients.	The issue about PICU is already on the risk register. Risk review strongly features in investigation reports with very little reference to safety planning	To escalate patient safety risks Consider how we are evidencing the implementation of the safety planning programme. Transitions between children and adults in particular to be made as a priority for new governance group to look at. How we manage to change practice to a more proactive engagement policy rather a DNA / disengagement policy. Reversing the perception that patients have to engage with staff to receive services.	None
Early warning system for ILS training and work plan	CG presented the paper. The Quality Committee had previously asked for further information on the possibility of transferring our clinical approach Derbyshire	Agreed	None	Paper endorsed and agreed for proposals to be progressed and monitored by the Physical Care Committee.	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)
	Early Warning Score (DEWS) to the National Early Warning Score (NEWS). A proposal over a 12 month period has been outlined				
Annual Clinical Audit Plan prior to going to A&R Committee in July	Clinical audit programme 2016-17 was presented. QLT has requested that summary reports are provided instead of the very detailed reports – these will be available for scrutiny if required and will be submitted to the newly formed Quality Governance Group	Acknowledgement of progress made and the contribution of the QLT's to the overall process. Partial assurance with some gaps in performance.	Risks when audits are delayed.	Template for trust wide committees to be provided. The template will set out immediate actions, summary actions and actions recommended for QLT's. Audit will pilot template on behalf of trust wide committtees. Previous performance to current performance to be included for outstanding actions.	QC to report to Audit and risk committee on level of assurance and risk.
Community Paediatrics Performance Report – Clinical risk issue BAF1a	CG presented the report in the absence of JS. Wider level of discussion helpful. Detail in paper useful in understanding complexity and mitigations.	Welcome the paper, the vision and the changes proposed. Staff encouraged to support this work and be open minded about this change in the broader context of workforce issue locally and nationally recognised. Workforce plan being formulated. 'Shaping caring review implications' to be considered. Partial assurance due to challenges set out in paper.	None	To be considered in future nursing conferences and in the wider multi-professional forum	To be noted at TB
Quality priority **Reducing Restrictive Practice**	CG presented the report.	Partial assurance exception report next time.	Compliance with Strategy	Exception report next time. SB and QLT's to agree leads for core business, etc. this can be set out in work plan for next meeting.	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Action Plan					
Quality priority **Recovery & Wellbeing Progress Report**	KW presented a comprehensive paper highlighting some of the challenges and lessons learnt from the hub for example.	Partially assured on its quality priority for recovery and noted the progress made.	Additional work required in this area to evidence outcomes for patients and service delivery particularly in the Neighbourhoods.	None	None
Annual Complaints and Compliments Report	AR presented the report.	Good report with benchmarking information providing useful comparisons as a form of assurance. High level of assurance around process, thematic and trends good, gaps identified in some areas such as Children and Young People Services.	None	Thematic analysis of over- arching action planning on complaints taking place. Children's and CAMHS on different uses of social media for example, and how they make accessible information available on complaints. Consider if there is 'under-reporting' in some areas.	Board to receive assurance on complaints.
Quality governance and proposals, governance improvement action plan	CGr presented the paper, and summarised the proposals set out in response to the governance improvement action plan. ToR of Quality Committee sub-groups	Agreed that this is based on a 12 month lead in to the full strategy implementation. TOR agreed. Agree right direction of travel to implement trust strategy of clinically led and operationally supported. Transition period of 12 agreed with quarterly feedback to QC on progress.. Structural change agreed GIAP action completed.	None	Assurance paper for December with some early findings/lessons learnt.	None

Board Committee Summary Report to Trust Board
Mental Health Act Committee - meeting held on 3 June 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)
CQC Visit Report and CQC Visit Plan	Milestone needed to demonstrate progress on chronic issues eg Section 17 process	Christine Henson to report in August	Lack of capacity in MH Act office	RG to seek assurance re recruitment to NH Act office. Ops to be represented t next meeting	N/A
Electronic T2/T3 Forms	Now available for use	Will be subject to further audit	Non-compliance with Code of Practice	Agreed use of electronic forms	N/A
Mental Health Act Committee Report	Activity scrutinised. High use of CTOs from private providers	To further analyse CTO activity from private providers	Use of CTOs may not represent best practice	To receive further information in next report	N/A
Incident Investigation Regarding Misuse of CTO Procedure	Illegal detention	Duty of candour met	Action plan has been completed	Useful for MH Act Committee to scrutinise individual cases where concern raised	N/A
Derby City AMHP Update Including Quarterly DoLs Report, Derbyshire County Council AMHP Update	Lower use of 136 in City but more assessments in cells. Increase n MH Act detentions in over 65s	Consistent with expectations	Implications if cells no longer used as Place of Safety	To receive further reports to establish trends	N/A
Terms of Reference Review	Quorum agreed	Changes agreed	Nil	Terms of Reference amended	N/A

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
2015/2016 Year End Effectiveness Report	Objectives of Terms of Reference 2015/16 met	Objectives met	Nil	Terms of Reference amended to be subject to effectiveness review	N/A
Review of Policies Required by the Revised Mental Health Act 2983 And Code Of Practice 2015	Fully compliant as regards Mental Health Act /Mental Capacity Act	Full assurance	Monitoring/updating – process in place	Congratulations to Rachel Kempster and team	N/A
Issuing and Absent Patient Joint Policy & Procedures	Approved	Compliant with Mental Health Act Code of Practice	None	Adopted	N/A
Mental Health Act 1983 Hospital Managers Scheme of Delegation Policy and Procedures	Approved	Compliant with Mental Health Act Code of Practice	None	Adopted	N/A
Locking of Doors on Open Wards all Units Policy and Procedures	Approved	Compliant with Mental Health Act Code of Practice	None	Adopted	N/A
Human Rights & Equality Policy	Approved	Compliant with Mental Health Act Code of Practice	None	Adopted	N/A

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Adult Inpatient Visiting Policy and Procedure	Approved	Compliant with Mental Health Act Code of Practice	None	Adopted	N/A
Mental Health Act 1983 Section 4 Emergency Application for Detention Policy and Procedures	Approved	Compliant with Mental Health Act Code of Practice	None	Adopted	N/A
Checklist for Observation of Patients Policy and Procedures	Approved	Compliant with Mental Health Act Code of Practice	None	Adopted	N/A
Mental Health Review Tribunal Guidance	Approved	Compliant with Mental Health Act Code of Practice	None	Adopted	N/A
Mental Health Act 1983 – Receipt and Scrutiny of Section Papers Policy and Procedures	Approved	Compliant with Mental Health Act Code of Practice	None	Adopted	N/A
Mental Health Act 1983 – Urgent Treatment Policy and Procedures	Approved	Compliant with Mental Health Act Code of Practice	None	Adopted	N/A
2015-2016 Forward Plan	Agreed		None	Adopted	N/A

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE QUALITY COMMITTEE

HELD ON 23 JUNE 2016

IN MEETING ROOM 1,
ALBANY HOUSE, KINGSWAY, DERBY DE22 3LZ

PRESENT:	Maura Teager	Chair and Non-Executive Director
	Phil Harris	Non-Executive Director
	Carolyn Green	Director of Nursing and Patient Experience
	Dr John Sykes	Executive Medical Director
	Carolyn Gilby	Acting Director of Operations
IN ATTENDANCE:	Sue Turner	Board Secretary and Minute Taker
	Emma Flanders	Lead Professional for Patient Safety
	Sangeeta Bassi	Chief Pharmacist
	Rachel Kempster	Risk & Assurance Manager
	Clare Grainger	Head of Quality & Performance
	Lesley Watson	Senior Capital Manager
	Rubina Reza	Research & Clinical Audit Manager
	Chris Fitzclark	Derbyshire Mental Health Alliance
	Ruth Hindle	Derbyshire Mental Health Alliance
	Sandra Austin	Derby City & South Derbyshire Mental Healthcarers Forum
For item QC/2016/105	Edward Komocki	Consultant in Old Age Psychiatry
For item QC/2016/106	Rob Morgan	Health & Safety Manager
For item QC/2016/108	Lesley Fitzpatrick	Operational Lead, Liaison Team
For item QC/2016/108	Jennifer Ness	Research Project Manager
APOLOGIES:	Samantha Harrison	Director of Corporate Affairs and Trust Secretary

QC/2016/099	**WELCOME AND APOLOGIES** The Chair, Maura Teager, opened the meeting and welcomed everyone and introductions were made around the table. Maura Teager also welcomed Sandra Austin who would be attending forthcoming meetings as a representative from the Derby City and South Derbyshire Mental Health Carers Forum.
QC/2016/100	**MINUTES OF THE MEETING DATED 12 MAY 2016** The minutes of the meeting held on 12 May 2016 were accepted and agreed.
QC/2016/101	**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.
QC/2016/102	**POSITIVE & SAFE UPDATE REPORT** In the absence of Sarah Butt, Carolyn Green presented the Quality 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 Conduct (2015). Carolyn Green explained how the Trust has been working to drive the strategy implementation through the Positive and safe Steering Group and an action plan was developed to provide assurance against identified priorities. Progress has been made although there have been challenges to delivering the strategy, particularly in regards to the following: • Compliance and adherence to the revised Seclusion and long term Segregation Policy. Staff knowledge, the pace of the new build for Kedleston and the accuracy of recording of seclusion and segregation • Use of prone restraint and reporting and recording • Pace in completion of PMVA training review • Understanding and application of Mental Capacity Act in practice and diligence in record keeping It was noted that these areas demonstrate risk issues in relation to the BAF Principle risk 1a: Failure to deliver quality standards as required by our regulators which may lead to harm of our service users. The Committee recognised that progress against the action plan has been made in a number of areas including safe wards, policy reviews and compliance and the introduction of positive behavioural support plans to EPR. The Committee understood that the recent Care Quality Commission inspection identified areas that required further improvements and work was taking place to identify where policy has been followed and recorded and where it has not in order to improve these practices in a sustainable way. The report highlighted areas where there is inconsistency in the understanding of seclusion and segregation and work has taken place to improve knowledge at clinical care level. It was noted that there had been limited training opportunities for staff in relation to seclusion practice and training material is in the process of being enhanced. As a result, this report would be received on a monthly basis by the Committee until this issue is no longer rated as red on the action plan. In addition a Blue Light had been issued regarding seclusion practice, reporting and monitoring and the Seclusion Policy had been revised. Carolyn Green formally asked that the Mental Health Act Committee receives a report on Seclusion Practice and data validation checks of the information it receives. It was agreed that this would take place at next meeting of the Mental Health Act Committee scheduled to take place on 26 August. As a result of the CQC inspection the Seclusion and Long Term Segregation Policy had been improved with further specifications to spell out seclusion practice more clearly. Although John Sykes wished to include in the policy further clarity on medical review functions, the policy was ratified on the understanding that these enhancements would be included in the ratified version. Carolyn Green informed the Committee that compliance checks would require a review of existing capacity to redistribute or reprioritise and/or additional capacity and she would be raising this issue at ELT in order to review or redesign existing resources. **ACTION: Reducing Restrictive Practice Action Plan to be received on a monthly basis until inconsistency in the understanding of seclusion and segregation is no longer red rated. Completion date and by whom to be included in the action plan for all areas rather than meeting names and**

	estimated time scales for delivery. **ACTION: Seclusion Practice to be an agenda item for the Mental Health Act Committee at its next meeting on 26 August.** **RESOLVED: The Quality Committee** **1) Considered the report** **2) Scrutinised the contents** **3) Provided feedback and made recommendations for additional improvements.**
QC/2016/103	**ANNUAL REPORT ON MEDICINES MANAGEMENT** Sangeeta Bassi presented her report and updated the Quality Committee regarding medicines management within the Trust. This report also included the updated Terms of Reference for the Drugs and Therapeutics Committee and the Medicines Safety Committee. The main priorities for 2016/17 and achievements were highlighted by Sangeeta Bassi and it was noted that considerable progress had been made in line with the Pharmacy Strategy in line with current resources. It was noted that a number of incidences related to medication had increased by 57% although 96% were of minor harm or no harm. This was seen as positive and showed evidence that the reporting culture had improved. The Committee was asked to approve the Drugs and Therapeutics terms of reference. These were considered to be very detailed and it was recommended that the last page be amended to show that the report of the work of the Drugs and Therapeutics Committee will be produced according to the work plan. The Committee considered this annual report showed an improving level of assurance although gaps in assurance were clearly defined in the report. For this reason it was agreed that the report would be received on a quarterly basis until a higher level of assurance can be obtained. **RESOLVED: The Quality Committee:** **1) Noted the progress made in line with the Pharmacy Strategy to date, and the priorities and challenges for 2016/17.** **2) Ratified the amended Terms of Reference for the Drugs and Therapeutics Committee in line with the amendment noted above.**
QC/2016/104	**NICE UPDATE** Rachel Kempster's report updated the Quality Committee with progress on plans for improving the Trust's systems and processes for monitoring the effectiveness of implementation of NICE guidance and advice. The Committee noted that the listing of all NICE guidelines published, identification of relevance and priority, and identification of a lead committee and lead reviewer, has now been transferred to the Connect page using SharePoint that has been applied to the publication of policies and procedures. The next steps would involve developing and implementing a process for lead committees to review and update NICE guidance for which they are responsible. Reporting from Connect page would be developed to enable timely monitoring and reporting on implementation of NICE guidance. The Committee agreed with the progress identified in the report and looked forward to

	receiving a further report on progress in three months. **RESOLVED: The Quality Committee:** **1) Agreed the progress reported and plans to improve monitoring and reporting on progress against NICE guidance** **2) Agreed to receive a further report on progress in 3 months..**
QC/2016/105	**RESULT OF MEDICAL APPRAISAL** John Sykes report provided the Quality Committee with the assurance that doctors working in the Trust are fit to practise. In addition to the report, Edward Komocki gave a presentation to the Committee that detailed the robust governance process for revalidation of doctors and the appraisal system. This assured the Committee that a process is in place to ensure all doctors complete their appraisals within the required timeline and where there were exceptions these were clearly identified with mitigations It was agreed that John Sykes would escalate to the Royal College of Psychiatrists the need for accessible information, and inclusion of carers in process. The accessible information standard and carer support would also be the subject of a report provided to the Committee at a later date. The Committee noted that this report would also be received by the Board in June in order to obtain official sign off by the Chairman. **RESOLVED: The Quality Committee considered the report and was assured by the robust governance process for revalidation of doctors and the appraisal system:**
QC/2016/106	**FIRE TRAINING EXCEPTION REPORT** Rob Morgan presented the Quality Committee with an Exception Report for escalation on Fire Training that was submitted to the Health Safety & Security Committee which gave an overview of present fire training compliance in inpatient areas. It was understood that this report had been escalated to the Committee by the Health & Safety Security Committee because the level of training compliance of fire wardens had not been shown on training passports, mapped to service area rather than service line. It was noted that the Health & Safety Team would provide bespoke training direct to those areas currently showing a deficit and the Committee looked forward to receiving evidence from the Health Safety and Security Committee that progress has been made once the additional course capacity and training has been rolled out. **RESOLVED: The Quality Committee noted the content of the Fire Training Exception Report.**
QC/2016/107	**PUBLIC SECTOR EQUALITY DUTY (PSED)** Carolyn Green presented to the Quality Committee a position statement on the Trust's compliance with the Equality Act 2010 and the Public Sector Equality Duty (PSED). This report set out the organisation's current compliance and plans in place for future work. The report also included benchmarking data taken from the first national report on workforce race equality standards.

	Carolyn Green reminded the Committee of the work that had been recently carried out to provide gender sensitive services within the Trust. Carolyn Green explained that this report covered the patient experience aspect of PSED. A separate PSED report had been received at the People and Culture Committee in June as this Committee is the lead for workforce issues and would address issues of bullying and harassment which were flagged in the Trust's staff survey. In addition to both of these reports, a draft PSED report will also be received by the Trust Board in the confidential session in June and a final report will be submitted to the Board in public session at the July meeting. Carolyn Green pointed out that the Mental Health Act Committee would be asked to review the data on Community Treatment Orders by BME groups and the use of the Mental Health Act in groups with protected characteristics and make recommendations to this Committee to ensure the Trust meets its requirements. The Mental Health Act Committee will need to review the use of in-patient beds for specific groups which will require significantly more detailed analysis to exclude any trends or potential discrimination for named groups / males under the restrictions of a CTO, and to make recommendations to the Quality Committee on any clinical practice improvements that may be required. In addition a written update report to the Quality Committee would also be required from the People & Culture Committee addressing potential discrimination in workforce issues and required action plan. **ACTION: Mental Health Act Committee to make recommendations to the Quality Committee in a report to the September meeting as to the use of the Mental Health Act in relation to equality duty to ensure the Trust meets its equality requirements.** **ACTION: Progress report to be received at the September meeting from the People & Culture Committee showing workforce issues and required action plan.** **RESOLVED: The Quality Committee reviewed the report and associated recommendations that would ensure the Trust meets its requirements to take due regard to its Trust wide responsibilities.**
QC/2016/108	**<u>SOUTHERN DERBYSHIRE LIAISON TEAM – EVALUATION REPORT</u>** Lesley Fitzpatrick presented her report which provided the Quality Committee with the findings from the evaluation of the South Derbyshire Liaison Team based at the Royal Derby Hospital (RDH). The report explained how a new psychiatric liaison team based upon the Rapid Assessment Interface and Discharge (RAID) model of liaison psychiatry was commissioned in South Derbyshire in April 2013 by Hardwick CCG. The team is based within the RDH and replaced three previous psychiatric services. The aim of the new liaison team is to be a rapid response 24/7, age inclusive service providing a comprehensive range of specialist knowledge for patients and staff within the RDH. The service has a one hour target for becoming involved in the care of patients with mental health or substance misuse care needs presenting to the Emergency Department ED and a 24 hour target for patients on a hospital ward. The clinical effectiveness, patient experience and measurable impact was extensively demonstrated in the report and gave the committee significant assurance on progress. It was noted that one of the main challenges met by the team was with regard to

	multiple sets of notes and duplicate recording in both acute and PARIS systems. If this was corrected the team would be far more efficient as PARIS was considered to be the more successful system. This issue has been raised at SIRI meetings and there is a real need to find a long term solution. This issue has now been included in the risk register as part of PARIS FPR risks. The Committee recognised the achievements and challenges that the team had overcome over the last two years and felt it would be good to share the team's achievements as an example of remodelling approaches to skills and services throughout the organisation. The report identified areas for organisational learning and delivered a critical message about creating the right environment for the development of a service for patient centred care that improved outcomes **RESOLVED: The Quality Committee received assurance on the quality of care demonstrated and noted the Southern Derbyshire Liaison Team Evaluation Report.**
QC/2016/109	**DELIVERING THE PREVENTION CHALLENGE - OUR PHYSICAL HEALTHCARE QUALITY PRIORITY** April Saunders presented to the Quality Committee an overview of the health promotion and preventative measures being delivered in Adult Mental Health services. This paper detailed a range of areas where work has been undertaken including: • CQUIN – Physical health of those with an SMI • Physical Care Committee • Health promotion • Education • Audit • Local and national context and policy initiatives The report also contained an update on smoke free and FRESH group improvements. The Committee recognised the need to sustain the momentum of smoking cessation and was pleased to note that the Trust was working with other trusts to learn how to meet the challenges ahead. The report showed good progress in sustainability and engaging with wider partners. The recommendations contained in the report were clearly noted and the results of the statistics will be included in the Quality Position Statement issued to the Board in July. **RESOLVED: The Quality Committee:** **1) Considered the contents and context of the report, received good assurance on the work in progress** **2) Noted the plans for staff training against standards** **3) Noted the plans for compliance audit via CQUIN and other methods**
QC/2016/110	**SERIOUS INCIDENT REPORT** Emma Flanders, Lead Professional for Patient Safety, provided the Quality Committee with information relating to all Serious Incidents (SIs) occurring during May 2016. It was noted that there has been a decrease of 9 externally reportable incidents from April 2016 to May 2016. There has been an increase by two for catastrophic incidents, and an increase of one for major, in May 2016, compared to April 2016.

	There are no specific patterns or issues arising within the analysis of the major/ catastrophic incidents reported in May 2016. There is currently 11 overdue action from SIRI investigations. Duty of Candour 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 April 2015. Improvement issues and themes have emerged from SIRI investigations concluded in May as documented and were noted by the Committee. These themes will be communicated to staff in the 'Practice Matters Bulletin' and to the Quality Leadership Teams. Chris Fitzclark raised the matter that external incidents had not been included in this month's summary and it was agreed these would be included in forthcoming reports. The Committee discussed the risks associated with outstanding actions from SI investigations and it was agreed that it would be helpful if the report indicated what risks the outstanding actions carried and the action required for completion in order to identify the Committee's responsibilities to support this. Emma Flanders and John Sykes would include this in the next report. In the meantime Maura Teager would meet with Emma Flanders to discuss in more detail the issues relating to outstanding actions. The National Reporting and Learning System Report (NRLS) was discussed as it was noted that the Trust had dropped to the bottom of the benchmarking graph for patient related incidents. Rachel Kempster and Emma Flanders pointed out they had analysed this detail and considered there had been no significant change in the number of incidences. Rachel Kempster drew the Committee's attention to the Risk Matrix which was a new addition to the report this month and suggested this could be taken forward as a Communications feature. Maura Teager acknowledged the need to structure the Committee's agenda in line with the GIAP but requested that the SI report returns to the agenda as a principal item for discussion at future meetings. **ACTION: Level of risk and mitigation to be provided in future reports.** **ACTION: SI Report to feature at the beginning of the agenda at forthcoming meetings.** **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 SI Group.**
QC/2016/111	**<u>GOVERNANCE IMPROVEMENT ACTION PLAN</u>** The Quality Committee received the Governance Improvement Action Plan which provided an update with respect to its oversight of the GIAP. There was no attendance from the GIAP programme manager to present the report.. The Committee noted the assurance received on progress of tasks from the action plan **RESOLVED: The Quality Committee noted the Governance Improvement**

	Action Plan and progress against actions
QC/2016/112	**POLICY GOVERNANCE UPDATE** Rachel Kempster presented her report which updated the Quality Committee, following the last full update report received in February 2016, on progress to review and update policies that are overdue for review. The report also set out the Trust's position against an informal benchmarking exercise with seven other Trusts, and lessons learnt. The report also showed progress against the action on the Governance Improvement Action Plan (GIAP) - ClinG2 - regarding the issue raised that the Trust would benefit from a robust and thorough policy review programme. Rachel Kempster pointed out that inclusion of the policy status spreadsheet began to be included at Board Committees, but has yet to be fully embedded and would be included alongside the action matrix of Board Committees. It was agreed that this would now become routine for committees such as Quality Committee, Mental Health Act Committee and Safeguarding Committee, People & Culture Committee. The Committee noted the considerable progress made since February with regard to the review and ratification of policies overdue for review, 99.38% of policies are now in date and all policy categories now meet the Trust's goal of 95% of policies being in date. It was agreed that the gap in assurance on the Board Assurance Framework on the timely update of policies and procedures should now be closed and the national benchmarking information and analysis of concerns against the Deloitte report and findings were considered. The committee do not wish to have a devolved protocol or procedure without a systematic analysis of the practices contained in those procedures **ACTION: Inclusion of a policy status spread sheet is to be included alongside the action matrix of Board Committees** **RESOLVED: The Quality Committee** **1) Received and noted the status of policies overdue for review. Significant assurance on improved performance in this areas since the Well led review and review of policy governance over the last twenty four month and 12 months.** **2) Agreed the recommendations in Section 2 – benchmarking, and Section 3 – GIAP of the report** **3) Agreed to a further update in 3 months**
QC/2016/113	**RISK REGISTER ESCALATION** Rachel Kempster presented her report which provided the Quality Committee with a summary of current 'Top (High Level) Risks', to ensure the Committee was aware of the Trust's most significant risks at a strategic and operational level. This report identified risks currently rated as high or extreme on the trusts risk register. These have been identified through the strategic and operational risk processes and escalation. The report also identified emerging themes from risks currently graded as moderate. The Committee was reminded that a summary of risks rated as high or extreme on the Trust's risk register was presented to the Board in May 2016 as part of the new Integrated Performance Report. Discussions took place on the recognition of risks at a strategic and operational level to be addressed by the Quality Committee and risks that would be included in an

	over-arching report received by the Audit & Risk Committee. It was agreed that the next report due to be received at the August meeting would clearly indicate the risks relevant to this Committee. **ACTION: Report to be received at the August meeting to clearly indicate risks relevant to Quality Committee.** **RESOLVED: The Quality Committee:** **1) Agreed to continue with bi-monthly reporting, providing a summary of 'top (high level) risks' clearly identified for the Quality Committee and a summary of emerging themes identified through moderate graded risks** **2) Agreed for a summary of the high level risks to continue to be included in the Integrated Performance Report to Board**
QC/2016/114	**<u>QUALITY COMMITTEE YEAR END EFFECTIVENESS REPORT</u>** Clare Grainger provided a report to Quality Committee on the effectiveness of the Quality Committee for 2015/16, comparing the work of the Committee to its Terms of Reference. In compiling this paper, the primary source of evidence has been the minutes and to Trust Board which outlines the key areas discussed, the levels of assurance gained and actions required. Although the quality of the papers had improved over the year which had contributed to a higher quality of discussion on the content of the reports, it was agreed that papers would be more concise and more assurance driven and a clear-cut executive summary would be included in the front sheet. The report highlighted particular issues the Committee had addressed and concluded that the Committee had succeeded in meeting the objectives of its terms of reference and the Committee agreed it had been effective throughout 2015/16. **RESOLVED: The Quality Committee** **1) Considered the effectiveness of Quality Committee against the terms of reference for the Committee that were in place during 2015/16** **2) Considered the recommendations set out at the beginning of the report which were accepted and a review of the Clinical Cabinet meeting** **3) Confirmed that the Committee was effective during that time against the required areas and responsibilities of the committee** **4) Noted the issues and requirements for the Committee looking ahead to 2016/17**
QC/2016/098	**<u>ITEMS RECEIVED FOR INFORMATION</u>** The Quality Leadership Team Minutes and the Quality Assurance Group Summary were both received for information and were not discussed. There was no attendance from the QLT chairs or named leads. Although apologies had been received from the Clinical Director whilst on extended leave, a named representative from the QLTs from both meetings should attend and confirmation of named leads and confirmation of sustained commitment and attendance is required. **ACTION: Carolyn Green to feedback to the QLT teams**
QC/2016/099	**<u>ANY OTHER BUSINESS</u>** Carolyn Gilby confirmed the triangulation of the Children's and CAMHS central teams and that a forward plan had now been produced in line with recommendations contained in the GIAP.

QC/2016/100	**ITEMS ESCALATED TO THE BOARD OR OTHER COMMITTEES** **1. Public Sector Equality Duty (PSED):** • Mental Health Act Committee to look at data on Community. Treatment orders by BME groups, use of the Mental Health act and use of in-patient beds requires significantly more detailed analysis to exclude any trends or potential discrimination for named groups / males under the restrictions of a CTO. • People and Culture Committee to look at data on workforce issues and required action plan. Report to be received back to Quality Committee from both committees in September confirming action in this area and mitigation plans. **2. Formal sign off of compliance statement of revalidation of doctors to be made by the Chairman and report t presented for information.**
QC/2016/101	**EFFECTIVENESS OF THE MEETIING** The Committee recognised the recommendations made by the GIAP regarding the structure of the agenda but felt it restricted its corporate responsibilities to meet its terms of reference and scheme of delegation requirements in addition to a focus on the quality priorities. The meeting was well attended. Reports contained outputs from the recent CQC visit. It was of concern that no representation had been made from the QLTs and it was agreed that attendance from both QLTs is required at each meeting.
Date and Time of next meeting: The next meeting of the Quality Committee will take place on: **Thursday, 7 July 2016 at 2.15 pm** ***Venue: Meeting Room 1 – Albany House, Kingsway, Derby***	

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE PEOPLE & CULTURE COMMITTEE

Held in the CEO's Office, Ashbourne Centre, Kingsway, Derby DE22 3LZ

Thursday, 16 June 2016

PRESENT:	Phil Harris	Delegated Chair and Non-Executive Director
	Jim Dixon	Non-Executive Director and Deputy Trust Chair
	Jayne Storey	Director of Workforce, OD & Culture
	Sam Harrison	Director of Corporate Affairs & Trust Secretary
IN ATTENDANCE:	Sue Turner	Board Secretary & Minute Taker
	Mark Powell	Director of Business Development & Marketing
	Jenna Davies	
	Rose Boulton	Principal Workforce & OD Manager
	Liam Carrier	Workforce Systems & Information Manager
	Anna Shaw	Deputy Director of Communications
	Owen Fulton	
APOLOGIES:	Richard Gregory	Chairman
	Dr John Sykes	Executive Medical Director
	Carolyn Gilby	Acting Director of Operations
	Lee Fretwell	Chair, Staff Side
	Robert Quick	Governor, North East Derbyshire

P&C/2016/055	**WELCOME AND APOLOGIES** In Richard Gregory's absence, Phil Harris acted as the Committee's Chair. He welcomed everyone and opened the meeting.
P&C/2016/056	**MINUTES OF THE MEETING HELD ON 18 MAY 2016** Minutes of the meeting held on 18 May 2016 were approved with the following amendment: **P&C/2016/048 Draft People Plan:** The final sentence "It was also agreed that a final, detailed People Plan would be received at the next meeting in June for approval" would be amended to read "It was noted that a final, detailed People Plan might be received at the next meeting in June.".
P&C/2016/057	**ACTIONS MATRIX AND MATTERS ARISING** The committee agreed to close all completed actions. Updates were provided by members of the committee and were noted directly on the actions matrix. **P&C/2016/058 GIAP WOD 7 Monitoring of Adherence to the grievance, disciplinary, whistleblowing policies:** Rose Boulton confirmed that Maura Teager was assured by the ER tracking system demonstrated to her and the data it contained regarding adherence to the grievance, disciplinary, whistleblowing policies. This would be added to the minutes as a post meeting note.

	P&C/2016/045 GIAP Recruitment of operational vacancies and communications plan: Recruitment trajectory is being monitored and driven by the Operational Group. The Committee accepted there might be challenges in meeting this trajectory and it will be necessary to receive reports on a monthly basis on what constitutes "off track", including caveats. In order to provide assurance to the Committee, operational narrative from TOMM/PCOG will be built into the monthly HR metrics report. Verbal update is to be provided by Carolyn Gilby at July meeting and a formal report will be received in September. **ACTION: Carolyn Gilby to provide a verbal update on recruitment of operational vacancies at July meeting followed by a formal report in September.**
P&C/2016/ 058	**<u>GOVERNANCE IMPROVEMENT ACTION PLAN</u>** Mark Powell presented the People and Culture Committee with an update in respect to its oversight of GIAP actions and provided an overview of the actions the Committee is responsible for seeking assurance on delivery. The Committee wished it to be acknowledged that although some progress had been made, staffing capacity and demands on time spent during the recent CQC inspection had impacted on the progress of GIAP tasks and actions. The GIAP timeline of 30 June was recognised and actions reported as "off track" or rated as having "some issues" were discussed. Actions from the May meeting were scrutinised and discussed as follows: **I.** **HR2 Resource Plan:** Jayne Storey reported that she was now in receipt of CVs for the role of Management Trainer and was hopeful these would prove to be suitable candidates. A programme of leadership and a training plan ~~map~~ is being developed in order to complete this task. It was recognised that the priority is to have the resource in place in order to deliver this challenging work plan. **II.** **PC2/4 People Plan for approval:** Since last month's meeting the People Plan had been refined and designed to be high level and recognised key actions that would make a positive impact within the organisation. The plan contained specific actions to support the delivery of the GIAP and the People Strategy and Jayne Storey proposed to provide update reports to the Committee on a quarterly basis. It was recognised that the People Plan is a dynamic document which contained high level activities, discussion as to the level of detailed is required within the plan for the Committee. A number of areas required refinement and the groups supporting this Committee would be tasked to take actions forward and provide the Committee with a report. Specific KPIs will also be developed to show what the People Plan is delivering and will also include a rag rating aligned with the GIAP. Jayne Storey pointed out that staff governors have had sight of the People Plan and it had been agreed that the building blocks contained in the people Strategy would be themed within the People Plan and the language used will be recognised by staff at every level. It was pointed out by Sam Harrison the People Plan should also encompass succession planning as this would be a matter that the Remuneration Committee would need to focus on. As this report was circulated as a late paper the Committee did not feel it had received adequate time to digest its contents and did not feel able to approve the People Plan. It was agreed that Mark Powell would work with Rose Boulton and the HR team to refine the People Plan so it contains more specific detail of completion of key tasks in order to enable the Committee to approve the People Plan at next month's meeting. **ACTION: Mark Powell to work with the HR team to produce a revised People**

Plan that will contain more clarity and reflect end dates for submission at the July meeting for approval.

III. **PC3 Communications System to record feedback from staff:** Anna Shaw reported on the two communications components of PC3.

- **Develop a comprehensive internal communications plan which clearly articulates engagement approaches, both formal and informal:** The internal communications plan approved at the May meeting. Capacity within the communications team to deliver this programme has not yet been resolved and will be discussed further at ELT. In the meantime, skills will be developed within the existing team to progress the plan and the team will reprioritise their current commitments. It was pointed out that the Engagement Group will be pivotal in driving the communications plan forward and further development of the implementation plans for engagement approaches are to be taken forward in conjunction with Sue Walters, Engagement Lead on her return from annual leave.

- **Develop a clear system to record feedback received from staff:** Progress is underway to develop a SharePoint database which will be held on Connect to record feedback received from staff. This database was still in the early stages of development and will be maintained by the communications and workforce teams. The Engagement Group will be tasked at their next meeting on 21 June with looking at the detail of the information contained on the database and as the Engagement Group is a sub-group of this Committee progress updates will be regularly received through the Engagement Group's reports. Staff governors had been made aware of the development of the People & Culture Committee and would be invited to attend meetings on a rotational basis.

ACTION: Anna Shaw to ensure the Engagement Group addresses the detail in the SharePoint database at the next meeting on 21 June and to provide an update report on PC3 at the next meeting in July.

The Committee was pleased to note the underlying work that was taking place and that the Engagement Group would be working with the communications team to ensure alignment of activities to drive positive staff engagement. The Committee asked that trends and concerns from staff feedback be captured by the Engagement Group and is then to form part of a regular progress report received by this Committee. Triangulation of information and how it is to be used is to be informed to the wider organisation by the Engagement Group and this Committee is to receive assurance that this is taking place. The Committee looked forward to receiving an update at next month's meeting.

IV. **W1 Freedom to Speak Up/Raising Concerns Action Plan:** Sam Harrison updated the Committee on progress made following the May meeting. The action plan has been reworked to align with existing work within the Trust and good practice across the NHS. This plan provided the Committee with assurance of the steps in place to embed an organisation culture triangulated with management training to enable staff to feel able and actively encouraged to raise concerns. Timescales have been met so far and this will ensure on-going effectiveness. It was noted that Freedom to Speak Up and Raising Concerns is regularly monitored by the Audit &Risk Committee.

The Committee recognised the progress made, and the final end date for evaluation review is March 2017 (with other time lines specific to individual actions) and received assurance that this GIAP task was on track. It was agreed that update reports would

be received by the Committee on a quarterly basis and this is already reflected in the forward plan.

V. **WOD7 Monitoring of adherence to the grievance, disciplinary, whistleblowing policies:** Jayne Storey provided a verbal update on the system for case tracking adherence to grievance, disciplinary and whistleblowing policies. There was still the challenge of how we could ensure 'adherence' to policies, but a number of controls would be put in place to mitigate that risk. The Committee understood that the internal audit scoping had commenced and the close out meeting had been arranged for early July. In addition a case management review report will be received by the Committee which will provide the organisation with recommendations which will be implemented and will result in changes to policies and systems. The Committee agreed this action is on track pending CQC feedback and that a constructive narrative is to be developed within the GIAP to show this action is going in the right direction. The forward plan would be updated to reflect monthly overviews of the tracker

ACTION: Forward Plan to reflect monthly overviews of the case tracking system.

Key Tasks for delivery in June were reviewed and discussed as follows:

VI **HR3/HR4/HR5 HR Model, Structure and Metrics:** Jayne Storey updated the Committee on progress made in the development of the HR model and explained that progress has been made by aligning senior HR Managers to service areas to ensure some central control, consistency and cover in a relatively small team. The absence of some members of staff has been mitigated by a number of acting up positions and the next phase is to review the service offering. It was noted that the proposed HR model diagram identified the effectiveness of the HR function and the impact on the organisation but not the acting up structure.

The Committee acknowledged the progress that had been made but received partial assurance on the HR model. It was agreed that more detail was required and Jayne Storey was asked to produce for the next meeting in July a document to outline the HR model, structure and metrics in line with the recommendations contained in the GIAP and to show how the model would work in practice.

ACTION: Revised HR model, structure and metrics to be received at July meeting.

VII **PC5 Comprehensive communications plan to ensure Trust values are visible across the Trust:** Sam Harrison presented a report prepared by Anna Shaw which assured the Committee that a comprehensive communications plan is in place to ensure values are visible across the Trust. It is expected that the development of the new Engagement Group will support the achievement of a values-driven, positive culture across the organisation and engagement approaches are to be taken forward in conjunction with Sue Walters, Engagement Lead on her return from leave.

The Committee was assured by core messages behind all the communications activities which reflected the Trust's values. The Committee was further assured by the communications approach and considered this GIAP action to be on track.

VIII **WOD1 HR Function to audit compliance against two selected HR Policies:** Jayne Storey provided a verbal update on the status of the policies selected for internal audit. The policy for Professional Registration had been selected for internal audit and another would be prioritised (Health and Attendance Policy) for audit by the

	end of June. The Committee acknowledged the on-going activity to review, develop and gain JNCC approval of all 40 people related policies and the ambitious timeline set for the end of September. The review of the two policies (as per GIAP) would be presented to the July meeting. However, the Committee was mindful that the achievement of the policy review would be dependent on JNCC approving the policies it has responsibility for, this will be raised with JNCC in June **ACTION: Review of two people related policies to be agenda item at the July meeting.** **IX** **WOD2 Review and ensure that recruitment and acting up policies are fit for purpose:** Jayne Storey provided the Committee with partial assurance that the Recruitment and Acting Up Policy is robust and that examples of acting up position have been followed correctly and have been complied with. The Committee agreed that evidence of this will be shown in a report to the next meeting in July. **ACTION: Evidence to show compliance with the Recruitment and Acting Up Policy to be subject of a report to the next meeting in July** **X** **WOD6 Implement Integrated Team Meetings:** Jayne Storey informed the Committee that integrated team meetings have now been set up for HR/education and training and will start to take place in July. The Committee received partial assurance that this task was complete and required confirmation that the integrated team meeting has taken place. This will be provided at the next meeting in July and a narrative is included in the GIAP to explain why this has been difficult to establish. **ACTION: Confirmation that integrated team meeting has taken place by the July meeting and narrative to be included in the GIAP to explain why this meeting has been difficult to establish.** **XI** **WOD7 Ensure backlog of cases made known to CQC are concluded:** Jayne Storey informed the Committee that all the cases were included in the tracker. It was not clear which specific cases CQC referred too, but an expectation that those which had protracted timescales would be progressed as a matter of urgency. It was agreed that the ER tracker front page will continue to be overviewed by the Committee on a monthly basis along with narrative and this would be reflected in the forward plan. **ACTION: WOD7 tracker for backlog of cases made known to CQC to appear on a monthly basis in the forward plan.** **RESOLVED: The People & Culture Committee noted the progress made to date on the actions it is responsible for seeking assurance on delivery within the GIAP.**
P&C/2016/ 059	**<u>WORKFORCE PLAN – PROGRESS UPDATE</u>** As agreed at the April meeting a draft Workforce Plan 2016/17 was received and considered by the Committee. It was recognised that the draft plan is still very much in development and Jayne Storey was confident that a revised workforce plan that will have been reviewed by stakeholder groups will be received at the July meeting. This revised draft will also include focus on education commissioning and will contain more information on service line level which will ensure it is a

	more meaningful Workforce Plan. It was understood that the strategy will control how the workforce is adapted over the next five years and work would be carried out with Mark Powell to ensure the plan is aligned with the Trust Strategy. In addition to this the STP plan work stream will be developed which will more than likely determine how multi-disciplinary roles are developed and it is anticipated that at that stage a more detailed chronological Workforce Plan will need to be developed. The Committee agreed that the draft Workforce Plan 2016/17 showed a good start to what was considered to be a dynamic document and that long term organisational modelling and development would be developed further in the forthcoming draft. It was recommended that a financial analysis linked to the workforce plan would be a useful feature in the document as this would be critical to ensure financial sustainability of the organisation. **ACTION: Revised draft Workforce Plan 2016/17 to be submitted to the July meeting.** **RESOLVED: The People & Culture Committee:** **1. Considered the report** **2. Recommended that a financial analysis linked to the workforce plan be carried out** **3. Agreed that a revised Workforce Plan 2016 would be received at the next meeting in July.**
P&C/2016/ 060	**<u>EDS2 UPDATE</u>** Owen Fulton attended the meeting and provided an update on the equality and diversity aspect of the Trust's workforce which highlighted key risks of failing to be all inclusive. It was pointed out that it would be difficult to produce evidence of equality and diversity activity over the last 12 – 24 months but progress has now been made. In future the Trust would be required to show evidence that stakeholders and partners are mindful of equality and diversity in order to enable BME and other protected groups represent the workforce population. The Committee also discussed the purpose of the 4Es and whether this fits into the current governance structure. It was understood that the 4Es was not a mechanism by which the Board receives assurance and Anna Shaw explained that 4Es was being reviewed in conjunction with Kath Lane.. The Committee acknowledged its responsibility in obtaining oversight of equality and diversity and noted that engagement is taking place within the organisation. It was agreed that the annual workforce diversity report and analysis would be presented and discussed at the June meetings of both the Quality Committee and Confidential Board. The annual E&D declaration would be made at the July 2016 Trust Board meeting. The Committee anticipated that significant progress will be seen when an update on EDS2 is received at the July meeting. **ACTION: EDS2 Progress Update to be submitted to the July meeting.** **RESOLVED: The People & Culture Committee:** **1. Acknowledged the EDS2 Update for 2016/2017** **2. Recognised the gap from the previous 2014/2015 requirements** **3. Agreed to receive an update on progress at the in July meeting of the Committee**
P&C/2016/ 061	**<u>HR METRICS</u>** The Workforce KPI Dashboard provided the Committee with the latest key Workforce metrics

	at Trust level and the next steps to be followed and turnover remained static at 10.44%. The KPI dashboard was scrutinised during the meeting and it was noted that sickness absence had in the short term increased slightly and the vacancy trajectory was progressing satisfactorily which may offset CIP. Hotspots and triangulation focus was included in this month's report which identified teams that are in most need of attention and support. The Committee felt the report could be enhanced further by including PCOG (Performance and Contract Operational Group) actions or narrative from PCOG discussions which would provide assurance that actions are progressing. In addition to this dialogue from TOMM (Trust Operational Management Meeting) would also enhance the report and provide further assurance to the Committee. **RESOLVED: The People & Culture Committee scrutinised and noted the information contained in the HR Metrics report.**
P&C/2016/ 062	**ANY OTHER BUSINESS** **Mindful, Health and Wellbeing CQUIN:** Rose Boulton alerted the Committee to the 50% increase in this CQUIN (flu vaccination) delivery target which was considered to be a huge task. It was agreed that an overview of CQUIN delivery would be discussed further when the Mindful, Health and Wellbeing Group report is received at the July meeting.
P&C/2016/ 063	**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/ 064	**ITEMS ESCALATED TO THE BOARD OR OTHER COMMITTEES** It was agreed that items escalated to the Board will be identified through the GIAP.
P&C/2016/ 065	**IDENTIFIED RISKS** The Committee identified the key risks as follows: • GIAP • General resource risk
P&C/2016/ 066	**EFFECTIVENESS OF THE MEETING** Challenges were carried out on the detail of the GIAP and discussions which were extremely valuable. Preparation for the CQC visit meant time constraints were difficult for papers to be completed and submitted to the agreed timeframe.
Date and Time of next meeting: The next meeting of the People & Culture Committee will take place on **Friday, 15 July 2016 at 2.00 pm in *Meeting Room 2 – Albany House, Kingsway, Derby.***	

MINUTES OF THE AUDIT & RISK COMMITTEE HELD ON TUESDAY, 24 MAY, 2016 AT 10.30 AM HELD IN MEETING ROOM 1, ALBANY HOUSE, KINGSWAY, DERBY DE22 3LZ

PRESENT:	Caroline Maley	Chair/Senior Independent Director
	Phil Harris	Non-Executive Director
IN ATTENDANCE:	Claire Wright	Executive Director of Finance
	Richard Gregory	Interim Chairman
	Ifti Majid	Acting Chief Executive
	Sam Harrison	Director of Corporate Affairs and Trust Secretary
For item AUD 2016/055	Mark Powell	Director of Business Development and Marketing
	Rachel Leyland	Deputy Finance Director
	Stacey Forbes	Financial Controller
	Joan Barnett	Engagement Manager, Grant Thornton
	Mark Stocks	Engagement Lead, Grant Thornton
	Anna Shaw	Deputy Director of Communications & Involvement
	John Morrissey	Governor
	Heidi Josephs	Minute Taker

WELCOME AND APOLOGIES

The Chair, Caroline Maley opened the meeting and welcomed everyone present. John Morrissey is here today attending this meeting as an observer.

AUD 2016/053	**MINUTES OF THE AUDIT & RISK COMMITTEE MEETING DATED 16 MARCH 2016** The minutes of the meeting held on 28 April were accepted and approved as an accurate record of the meeting.
AUD 2016/054	**ACTION MATRIX** All updates provided by members of the Committee were noted directly to the matrix.
AUD 2016/055	**GOVERNANCE IMPROVEMENT ACTION PLAN (GIAP)** Mark Powell presented his paper which provided an update in respect to an oversight of GIAP actions and gave an overview of the actions that this Committee is responsible for seeking assurance on delivery. Mark Powell referred to the report and discussed the recommendations of actions that have been completed and sought confirmation that actions turned blue had been completed. Sam Harrison presented her paper and sought assurance that the Committee was satisfied with the proposals made. It was noted that this item was discussed at the Board Development Session on the 11 May and the report has been updated to reflect these discussions. The Committee also noted the refreshed version of the Corporate Governance Framework and considered it ambitious to complete this document on time as it is a fundamental document for the organisation to set out high level decision making.

	Caroline Maley drew attention to the timeline on the last page of the report and requested the opportunity to discuss the first two items again before the next Audit and Risk Committee scheduled to take place on 19 July. This resulted in GIAP actions CG4-2, CG4-4, CG4-5 and CG5 receiving a completion date of 19 July. Caroline Maley confirmed she was satisfied with the recommendations contained in the report and that significant progress was being made with GIAP actions and tasks. The Committee also discussed the range of policies contained in ClinG2 and agreed more definition was required on what the Committee planned to address. **ACTION: Sam Harrison to circulate the elements of the corporate governance framework to members of the Committee prior to the next meeting.** **ACTION: Mark Powell to bring a document to the next meeting that sets out more detail in terms of the role of this Committee in assuring ClinG2 (policy review) and assurances that we should be providing along with the dashboard produced by Rachel Kempster.** **RESOLVED: The Audit & Risk Committee:** **1) Received the report and was assured that actions outlined in the GIAP have been delivered within the timeframes agreed.** **2) Approved the recommendations put forward in this report**
AUD 2016/056	**<u>FREEDOM TO SPEAK UP – WHISTLEBLOWING POLICY</u>** Sam Harrison presented the first regular report to this Committee which mapped out the arrangements in place to address concerns within the Trust and advised the key routes and roles where concerns can be raised. It was noted that these topics were covered at the People and Culture Committee, whose role is to analyse the themes of any concerns that are raised. The role of the Audit and Risk Committee is to oversee the robustness of processes put in place. There are currently several activities underway including the Listen Learn Lead events and events where Directors attend Team meetings with issues raised reported to the Trust Board. Concerns can also be raised in person or anonymously by phone. To demonstrate effectiveness the Trust is also looking for improvements on responses to the staff survey. Jayne Storey has requested that pulse check groups be set up that can be used to assess staff's perceptive on raising concerns. The Committee agreed that the Trust would be required to demonstrate in the long term what action has been taken to respond to raising concerns. It was also necessary to promote a culture that people are comfortable with regarding raising concerns. It was note that reports on Freedom to Speak Up and Whistleblowing will be regularly received at both Committees addressing each Committee's role. Phil Harris asked if a check is made with individuals before closing off concerns raised and this process was confirmed . It was confirmed that we do. Richard Gregory advised that he is used to different procedures and queried the processes within the NHS to ensure external support if required. Sam Harrison undertook to clarify the role of the Trust in those concerns raised with external parties and who may act as an investigator. Sam Harrison confirmed that all key elements within the national policy issued on 1 April 2016 were covered in the Trust's policy. This had recently been updated to include the name of the Trust lead NED for this issue, Jim Dixon and Carrina Gaunt as Freedom to

	Speak Up Guardian. The role of the guardian is to be a focal point for individuals who have concerns. In addition the Communications Team have created a podcast featuring Sam Harrison and Carrina Gaunt which will appear in Monthly Connect following this month's Board meeting. Phil Harris queried the role of Staff Side regarding concerns raised and Sam Harrison confirmed that she will be meeting with Carrina Gaunt and Lee Fretwell, Staff Side, who will be helping to ensure close working going forward. Staff Side have also offered to carry out surgeries are keen to work with us as in an informal role. It was agreed that the Committee would receive twice yearly reporting on the adequacy of systems in place. Caroline Maley confirmed that although this policy has been in place since March last year there are still some issues to resolve. Appropriate investigations will be undertaken to look at the issues discussed. Richard Gregory requested that the Trust be compliant with its own policy and also the national policy. **ACTION: Sam Harrison to review and address the issues raised by the Committee. In particular clarity on the process around the national confidential helpline calls and who may act as an independent investigator is required.** **RESOLVED: The Audit and Risk Committee:** **1) Received partial assurance from the update on arrangements set in place by which Trust staff may raise concerns** **2) Agreed to receive twice yearly reporting on the adequacy of systems in place, noting that themes and progress on the Freedom to Speak up action plan will be reviewed by the People and Culture Committee.**
AUD 2016/057	**<u>TERMS OF REFERENCE</u>** Sam Harrison presented the revised update for discussion and approval by the Committee and explained there was now consistency across the Board Committees in overseeing terms of reference. The terms of reference outline the role of this Committee to provide assurance to the Board on key areas and also reiterate its role in overseeing implementation of the Trust Strategy. This year the role of the Committee includes overseeing the progress in key areas of the Governance Improvement Action Plan. Changes were made at the October meeting relating to Counter Fraud work and a larger section has been added at 7.19 relating to the approval of the annual accounts. We have amended the whistle blowing section to accommodate the new terminology of Raising Concerns. Caroline Maley advised that the Committee recognised these amendments and reviewed these as accepted. In response to Richard Gregory's comment that additional emphasis should be included on the risk remit of the Committee and include 'deep dives', Caroline Maley referred to section 7.3 which covered this. Regarding the final approval on the annual report Richard Gregory noted arrangements in place for the Audit and Risk Committee to approve the annual report and accounts by delegated authority from the Board in place for the current year but requested that this be reviewed for forthcoming years. The Annual Report and Accounts, including the Quality Account is the responsibility of the Board and Mark Stocks confirmed he was content with the Board delegating authority to the Audit and Risk Committee. Ifti Majid advised that he understands the issue raised and confirmed that in future the Committee would be given a clear assurance of review and agreement made by other key Committees involved in the production of the documents. Caroline Maley confirmed that she was confident that the

	Annual Report and Accounts have been through a robust preparation period and has been reviewed by many individuals and committees. Richard Gregory verified that he was happier knowing the Quality Committee have reviewed the Quality Account and Mark Stocks assured the Committee that this procedure is extremely common and that he was satisfied with this sign off process. **ACTION: Sam Harrison to look at the approval of the accounts process as part of the March 2017 annual review of the terms of reference.** **The Audit and Risk Committee:** **1) Considered the changes to the terms of reference as outlined** **2) Approved the terms of reference of the Committee for immediate adoption.**
AUD 2016/058	**COMMITTEE ASSURANCE SUMMARY REPORTS (QUALITY COMMITTEE AND MENTAL HEALTH ACT COMMITTEE** Sam Harrison presented the summary reports and referred to the Mental Health Act Committee report and the action on page 42 regarding the Emergency Department at Chesterfield Royal Hospital FT and negotiations around this unit as a place of safety. Ifti Majid clarified this issue in terms of escalation to the Board but there was no action required for this Committee and that this item would be discussed at the Board meeting tomorrow. Attention was drawn to the summary report for the Quality Committee. Page 46 referred to the Community Capacity, Mental Health and Community Paediatric Model and referenced a BAF issue. It was noted that a significant risk had been added and it was agree that Sam Harrison would follow this issue up with Clare Grainger to clarify whether this risk should form part of the existing BAF or become a new BAF risk in its own right. Caroline Maley advised that although the format of this report has improved more detail and explanation was required and this could be discussed at tomorrow's Board meeting. **ACTION: Sam Harrison to clarify the Community Capacity, Mental Health and Community Paediatric Mode BAF risk issue with Clare Grainger.** **RESOLVED: The Audit & Risk Committee noted the Assurance Summaries received from the Quality Committee and Mental Health Act Committee.**
AUD 2016/059	**SUMMARY OF KEY CHANGES FROM DRAFT TO AUDITED AND FINAL ANNUAL REPORT INCLUDING QUALITY REPORT AND ANNUAL ACCOUNTS 2015/16** This report was presented to the Committee in order to gain approval of the Annual Report, Quality Report and Annual Accounts. It was confirmed that the Annual Accounts changes were minor and the Audit and Risk Committee was satisfied that no further comments were raised. The Quality report changes were also minor and were noted. The Committee considered the changes made to the Remuneration report and these were reviewed on a page by page basis. Minor amendments had been made on the full table and this had been agreed with Joan Barnett of Grant Thornton. The wording regarding the payment figures for the previous CEO have been further clarified since draft and this had been shared widely and agreed and had been highlighted in particular when the Annual Report had been circulated to the full Board. Other minor changes were discussed and noted. Claire Wright, Sam Harrison and Anna Shaw confirmed they had checked the detail and were satisfied with this section. It was also confirmed that overall, Claire Wright, the

	Executive Team and the Auditors are all satisfied with this document. In response to Richard Gregory's question on seven-day follow up audit, Joan Barnett confirmed that this item was detailed on page 135 of the Quality Report. Richard Gregory offered his comments on some selected sections and some preferences for consideration of additional minor amendments. Mark Stocks pointed out the short timescale between today's Committee meeting and the submission date. Anna Shaw and Joan Barnett pointed out they would meet after the Audit and Risk Committee to finalise paperwork. The Committee confirmed that in future the Chairman's input would need to be facilitated more explicitly prior to the May Committee meeting taking place. It was suggested that some amendments would be better reflected in the Annual Review Summary document for this year. **ACTION: Anna Shaw to work with Joan Barnett on minor amendments to the Annual Report for comment by the Chairman.** **RESOLVED: The Audit & Risk Committee approved the detail contained in the report.**
AUD 2016/060	**REVIEW OF AUDITED ANNUAL REPORT AND ACCOUNTS 2015/16** This item was discussed, reviewed and approved as per agenda item 2016/059 above.
AUD 2016/061	**LETTERS OF REPRESENTATION** Claire Wright advised that the Letters of Representation required signing by Caroline Maley and Ifti Majid. The Committee confirmed and agreed the content of the letters as stated for signature. **RESOLVED: The letter of representation on Trust Headed Paper was agreed and signed at the meeting by the Audit Committee Chair and the Acting Chief Executive.**
AUD 2016/062	**PROPOSED OPINION ON THE ACCOUNTS** Mark Stocks presented his report and highlighted the main points Proposed Opinion on The FTCs (Consolidation Schedules) and the Audit Findings Report. With regard to the annual accounts, Mark Stocks presented the audit findings and confirmed this was a clean audit in their terms. The team had worked well together and to a good standard. The only issue identified was around property, plant and equipment and the increased work Grant Thornton carry out around information regarding the size of buildings and some differences between District Valuer and Trust information. There were a couple of related recommendations regarding this finding. For the value for money assessment – this had been adversely impacted by NHS Improvement enforcement action regarding the employment tribunal and governance rating. Therefore the Value for Money opinion is qualified in this regard. Mark Stocks emphasised that this qualification is an "except for" qualification that meant value for money was satisfactory apart from the identified governance weaknesses With regard to the Quality Report, Mark Stocks highlighted the main points and confirmed it complied with the NHS Improvement guidance and there were no amendments required.

	Caroline Maley thanked all the teams for completing this piece of work. Joan Barnett referred to the acknowledgement on page 7 of their report. The high quality of the information provided had been achieved during very difficult circumstances and Joan Barnett thanked everyone for their contributions. **RESOLVED: The Audit & Risk Committee received and noted Grant Thornton's proposed opinion on the accounts.**
AUD 2016/063	**INTERNAL AUDIT REPORT ANNUAL REPORT AND ASSOCIATED OPINIONS** Sam Harrison advised the Committee that Internal Audit had confirmed they were generally satisfied. The head of internal audit opinion was noted in the annual governance statement. **RESOLVED: The Audit & Risk Committee received and noted the contents of the Internal Audit Annual Report 2015/16.**
AUD 2016/064	**ANNUAL COUNTER FRAUD REPORT** Penny Gee was not present for this item. The Committee discussed the report and obtained assurance on the range of work undertaken and the conclusions that the Trust's counter fraud, bribery and corruption arrangements are embedded. **RESOLVED: The Audit & Risk Committee received and was assured by the contents of the Annual Counter Fraud Report.**
AUD 2016/065	**FINAL APPROVAL OF ANNUAL REPORT AND ACCOUNTS 2015/16 (INCLUDING PHYSICAL SIGNING OF DOCUMENTATION** The Chair of Audit and Risk Committee confirmed that the Committee was content to approve and adopt the Annual Accounts and Report including the Quality Report for 2015/16 on behalf of the Trust Board. Richard Gregory, Ifti Majid, Caroline Maley and Claire Wright signed the paperwork. Caroline Maley noted that the completed the annual report from the Audit Committee would go to the Board meeting tomorrow. **RESOLVED: The Audit Committee accepted and approved the Annual Report and Accounts 2015/16 for signature.**
AUD 2016/066	**2016/17 FORWARD PLAN** The forward work plan was noted and will be further reviewed by Sam Harrison and Caroline Maley on an ongoing basis.

AUD 2016/067	**MEETING EFFECTIVENESS** Caroline Maley confirmed that it would be necessary to ensure that the Committee is comfortable next year in light of the final amendments raised by Richard Gregory today. Claire Wright emphasised the need to be clear that next May's Audit and Risk Committee is held not for amendments, it is for the approval and adoption of the final audited versions. In support of this Directors and contributors will highlight in their May front sheets supporting the reports that they have received the sign-offs by the Chairman, Executive Team and Quality Committee for the relevant component parts. The Chair thanked all those present for their attention and attendance and closed the meeting at 12.30pm. It was recommended that at the next meeting reports will be received from Internal Audit, GIAP and a deep dive will be held BAF risk 2a Transformation. **Date of next meeting:** Tuesday, 19 July at 14:00pm. Venue: Meeting Room 1 – Albany House, Kingsway, Derby DE22 3LZ.

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

Annual Members' Meeting

Purpose of Report
This paper provides an update on preparations for the forthcoming Annual Members' Meeting.

Executive Summary
- The Annual Members' Meeting will take place on Thursday 22 September 2016 at Ilkeston Resource Centre. The formal meeting will commence at 4.30pm, with a 'market place' of stalls opening at 2.30pm.
- This year's theme is 'prevention'.
- The Governance Committee has discussed AMM arrangements twice at recent meetings. A mini group of interested governors is being formed to discuss further details.

Strategic considerations
- This year the Lead Governors has agreed to provide a reflection of the year on behalf of the Council of Governors.
- The Trust's auditors will be presenting to a meeting of the Council of Governors instead of the AMM.

(Board) Assurances
- The format of the event has been shaped by feedback received from the 2015 AMM (from governors, members and staff)
- Governors are involved in arrangements for the 2016 AMM.

Consultation
Not applicable.

Governance or Legal Issues
The Trust's Annual Report and Accounts (and summary document) will be presented at the AMM.

Equality Delivery System
None.

Recommendations
The Board of Directors is requested to note the preparations underway for the forthcoming AMM.

Report prepared by:	**Anna Shaw** **Deputy Director of Communications and Involvement**
Report presented by:	**Samantha Harrison** **Director of Corporate Affairs**

Board of Directors 27 July 2016

Annual Members' Meeting (AMM)

This year the event will take place on Thursday 22 September 2016 at Ilkeston Resource Centre. The formal meeting will commence at 4.30pm, with a 'market place' of stalls opening at 2.30pm. This year's theme is 'prevention'.

Arrangements for the event are being influenced by the feedback received from last year's AMM, discussions at the former Membership Development Working Group of the Council of Governors and through the current Governance Committee. This includes preparations for a guest speaker, which we hope to confirm shortly.

The Governance Committee has discussed AMM arrangements twice at recent meetings and a mini group of interested governors is being formed to discuss further details.

Promotion for the event has already commenced, with information being shared with Trust members, governors and staff. Similarly to last year, people are being asked to put forwards any questions they would like to receive answers to during the meeting.

The Trust's Annual Report and Accounts will be presented at the AMM, alongside a summary document.

Speakers will include Ifti Majid, Claire Wright, Carolyn Green and John Morrissey (Lead Governor). A number of people who have used or supported individuals who have used our services will also share their experiences of the Trust.

The Board is asked to note and support these arrangements.

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

Children's Services Performance Report

Purpose of Report
The Board have requested a review of the performance of Children's Services.

Executive Summary
The following report details the performance of Children and CAMHs services and provides some narrative to aid understanding and prompt discussion. There are some obvious areas of achievement within these services over recent time including a successful tender, and obtaining additional investment from commissioners to develop additional services. However the service also encounters a range of challenges including the increasing demand and expectations for services which combined with difficulties in recruiting clinical staff has resulted in lengthy waiting lists in some service areas. Plans are in place to address the waiting list difficulty but there is an awareness that the benefit of these changes will take time to fully impact the patient experience for children and young people in Derbyshire.

Strategic considerations
- To maintain a high level of operational performance

(Board) Assurances
- Operational performance

Consultation
- This report is not being considered at any other committee or meeting

Governance or Legal issues
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Equality Act 2010
- Health and Safety at Work etc Act 1974

Equality Delivery System
This report is not requesting the Board agree to any service delivery changes that have an impact on any particular protected group. The Report details current performance against a range of performance criteria and the Board may wish to explore the impact of any variance in performance on particular groups.

Recommendations
The Board of Directors is requested:
1) To acknowledge the current performance of the services
2) To note the actions in place to ensure sustained performance

Report presented by: **Carolyn Gilby**
Acting Director of Operations

Report prepared by: **David Tucker**
General Manager, Children's Services

Derbyshire Healthcare NHS
NHS Foundation Trust

Children's Services Performance Review

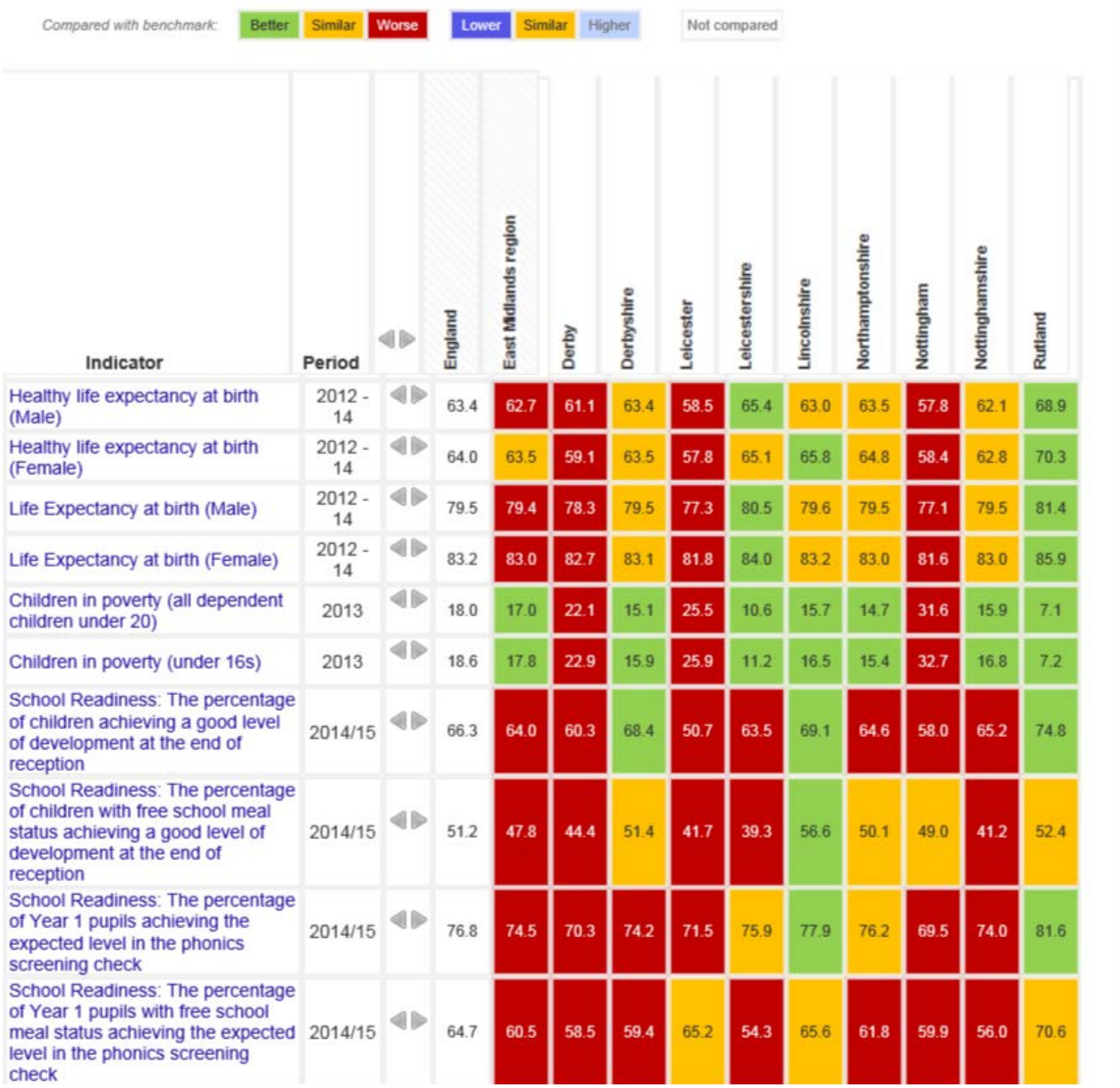
Based on June 2016 Data

Better together

Contents

1 Demographics of the population served

The information below is a copy of the health outcomes for residents in the East Midlands region. As can be seen from this there are a number of Health Outcomes that are poorer for people living in Derby when compared to other local areas. For example, lower life expectancy; more likelihood of a child living in poverty; Pupil absence from school. In addition "smoking at time of delivery" is higher and breastfeeding initiation is lower when compared to other areas within the East Midlands region. Increasingly commissioners of Children's and CAMHs service are utilising this data in order to commission local services and the most recent service specification for 0-19 years service aims to tackle some of these health inequalities.



Compared with benchmark: Better | Similar | Worse | Lower | Similar | Higher | Not compared

Indicator	Period	England	East Midlands region	Derby	Derbyshire	Leicester	Leicestershire	Lincolnshire	Northamptonshire	Nottingham	Nottinghamshire	Rutland
Healthy life expectancy at birth (Male)	2012 - 14	63.4	62.7	61.1	63.4	58.5	65.4	63.0	63.5	57.8	62.1	68.9
Healthy life expectancy at birth (Female)	2012 - 14	64.0	63.5	59.1	63.5	57.8	65.1	65.8	64.8	58.4	62.8	70.3
Life Expectancy at birth (Male)	2012 - 14	79.5	79.4	78.3	79.5	77.3	80.5	79.6	79.5	77.1	79.5	81.4
Life Expectancy at birth (Female)	2012 - 14	83.2	83.0	82.7	83.1	81.8	84.0	83.2	83.0	81.6	83.0	85.9
Children in poverty (all dependent children under 20)	2013	18.0	17.0	22.1	15.1	25.5	10.6	15.7	14.7	31.6	15.9	7.1
Children in poverty (under 16s)	2013	18.6	17.8	22.9	15.9	25.9	11.2	16.5	15.4	32.7	16.8	7.2
School Readiness: The percentage of children achieving a good level of development at the end of reception	2014/15	66.3	64.0	60.3	68.4	50.7	63.5	69.1	64.6	58.0	65.2	74.8
School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception	2014/15	51.2	47.8	44.4	51.4	41.7	39.3	56.6	50.1	49.0	41.2	52.4
School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check	2014/15	76.8	74.5	70.3	74.2	71.5	75.9	77.9	76.2	69.5	74.0	81.6
School Readiness: The percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check	2014/15	64.7	60.5	58.5	59.4	65.2	54.3	65.6	61.8	59.9	56.0	70.6

1.03 - Pupil absence	2013/14		4.51	4.51	4.94	4.26	4.63	4.35	4.56	4.42	5.10	4.53	3.76
1.04 - First time entrants to the youth justice system	2014		409	435	536	279	573	312	402	601	715	385	220
1.05 - 16-18 year olds not in education employment or training	2014		4.7	4.4	6.4	4.0	6.3	3.1	5.3	5.0	6.2	1.9	*
2.01 - Low birth weight of term babies	2014		2.9	2.7	*	2.4	4.2	2.2	2.2	2.5	3.1	2.9	*
Breastfeeding initiation	2014/15		74.3	71.6	70.2	73.4	76.9	74.4	*	74.3	71.1	69.0	81.5
Breastfeeding prevalence at 6-8 weeks after birth	2014/15		43.8	44.4	*	*	62.1	47.2	38.0	43.2	48.6	39.8	52.8
Smoking status at time of delivery	2014/15		11.4*	13.7	14.4	15.1	11.8	10.3*	*	15.1	*	*	*

Under 18 conceptions	2014		22.8	21.6	26.1	16.2	25.3	18.5	22.4	23.3	32.8	21.1	9.8
Under 18 conceptions: conceptions in those aged under 16	2014		4.4	4.4	4.6	3.9	3.9*	3.9	4.3	4.3	7.1	4.6	*
Reception: Prevalence of overweight (including obese)	2014/15		21.9	21.7	21.9	21.6	21.8	20.3	22.2	21.2	26.7	20.7	21.8
Year 6: Prevalence of overweight (including obese)	2014/15		33.2	32.4	34.3	30.8	35.1	30.0	33.3	32.4	37.9	31.0	24.6
Hospital admissions for accidental and deliberate injuries in children (aged 0-4)	2014/15		137.5	112.8	65.8	113.8	78.7	88.5	135.9	150.8	114.3	111.4	45.0
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2014/15		109.6	92.8	68.2	96.0	70.0	75.3	114.6	112.3	88.2	89.7	68.0
Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)	2014/15		131.7	124.2	138.0	144.1	72.7	99.9	127.1	180.1	92.9	128.2	132.1
2.08 - Emotional wellbeing of looked after children	2014/15		13.9	15.5	16.0	15.8	15.1	16.5	15.3	12.8	16.1	15.4	8.7
2.09i - Smoking prevalence at age 15 - current smokers (WAY survey)	2014/15		8.2	7.6	7.7	8.0	4.8	6.9	7.9	8.7	8.2	7.4	9.5
2.09ii - Smoking prevalence at age 15 - regular smokers (WAY survey)	2014/15		5.5	5.3	5.1	5.4	3.5	4.5	5.6	6.2	6.7	5.3	4.5
2.09iii - Smoking prevalence at age 15 - occasional smokers (WAY survey)	2014/15		2.7	2.3	2.6	2.7	1.4	2.5	2.3	2.5	1.5	2.1	5.0
3.02 - Chlamydia detection rate / 100,000 aged 15-24 <1,900 1,900 to 2,300 ≥2,300	2014		2012	2050	2011	2096	1757	1616	2045	2224	2807	1900	1390
3.02 - Chlamydia detection rate / 100,000 aged 15-24 (Male)	2014		1355	1392	1373	1486	1066	1204	1427	1524	1824	1236	888
3.02 - Chlamydia detection rate / 100,000 aged 15-24 (Female)	2014		2664	2717	2638	2716	2410	2071	2668	2898	3803	2581	2054
3.03i - Population vaccination coverage - Hepatitis B (1 year old)	2014/15		-	-	100*	*	18.2*	0.0*	*	70.4*	95.5*	100*	*
3.03i - Population vaccination coverage - Hepatitis B (2 years old)	2014/15		-	-	100*	*	67.6*	61.9*	*	95.5*	83.3*	90.0*	*
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old) <90% ≥90%	2014/15		94.2	96.2	95.0*	97.0*	96.1*	97.5*	95.1*	98.0*	92.4*	96.0*	*
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old) <90% ≥90%	2014/15		95.7	97.5	97.4*	98.3*	97.7*	98.7*	96.2*	98.2*	95.9*	96.9*	*
3.03iv - Population vaccination coverage - MenC <90% ≥90%	2012/13		93.9*	94.8*	89.5	95.5*	96.0	97.3*	94.3*	96.5	92.4	93.7	*

Compared with benchmark: Better | Similar | Worse | Lower | Similar | Higher | Not compared

Indicator	Period	England	East Midlands region	Derby	Derbyshire	Leicester	Leicestershire	Lincolnshire	Northamptonshire	Nottingham	Nottinghamshire	Rutland
3.03v - Population vaccination coverage - PCV <90% ≥90%	2014/15	93.9	95.7	94.5*	96.0*	95.5*	97.3*	94.6*	97.7*	91.7*	95.7*	*
Population vaccination coverage - Hib / MenC booster (2 years old) <90% ≥90%	2014/15	92.1	94.3	93.1*	96.5*	94.4*	97.0*	90.4*	96.4*	90.8*	93.8*	*
Population vaccination coverage - Hib / Men C booster (5 years) <90% ≥90%	2014/15	92.4	94.3	95.1*	97.7*	93.2*	97.1*	89.2*	94.9*	92.5*	93.9*	*
3.03vii - Population vaccination coverage - PCV booster <90% ≥90%	2014/15	92.2*	94.2*	92.7*	95.9*	94.5*	96.9*	90.1*	96.6*	90.8*	94.1*	*
3.03viii - Population vaccination coverage - MMR for one dose (2 years old) <90% ≥90%	2014/15	92.3	94.3	93.0*	95.3*	94.8*	96.8*	91.4*	96.6*	90.8*	93.5*	*
3.03ix - Population vaccination coverage - MMR for one dose (5 years old) <90% ≥90%	2014/15	94.4	96.0	96.4*	97.2*	95.9*	97.6*	94.2*	95.9*	93.5*	96.5*	*
3.03x - Population vaccination coverage - MMR for two doses (5 years old) <90% ≥90%	2014/15	88.6	91.2	89.9*	94.9*	92.0*	94.7*	84.7*	93.4*	86.5*	91.3*	*
3.03xii - Population vaccination coverage - HPV <previous year's England value ≥previous year's England value	2013/14	86.7	90.9	92.3	83.9	88.6	96.4	92.4	93.7	90.4	88.3	93.6
4.01 - Infant mortality	2011 - 13	4.0	4.2	4.7	2.6	6.4	3.6	4.3	4.6	5.2	3.7	3.0
Tooth decay in children aged 5	2011/12	0.94	0.92	1.09	0.67	2.06	0.95	0.78	0.94	1.32	0.64	1.09
Antenatal infectious disease screening – HIV coverage	2013/14	98.9	99.1	-	-	-	-	-	-	-	-	-
Antenatal sickle cell and thalassaemia screening - coverage	2013/14	98.9	99.5	-	-	-	-	-	-	-	-	-
Newborn bloodspot screening coverage	2014/15	95.8	93.7	93.6	*	92.1	92.9	97.9	92.3	91.1	93.1	94.3
Newborn hearing screening coverage	2013/14	98.5	99.0	99.4	98.8	99.7	99.4	99.0	98.6	98.9	98.9	99.7

Data source:
http://fingertips.phe.org.uk/profile/cyphof/data#page/0/gid/8000025/pat/6/par/E12000004/ati/102/are/E06000015

2 CAMHS

i. Introduction

Specialist CAMHS works with young people from 5 to 18 who have moderate to severe mental health difficulties. The service works closely with GP's, schools, and other community services providing consultation and training as well as direct work with the child, young person and family either at home, in the community or in clinical bases. We use a wide variety of evidence based approaches to assist the child and their families/carers in addressing some of their difficulties.

In 2011 Derbyshire Healthcare NHS Foundation Trust CAMHS service was successful in its bid to be in the first phase of a unique opportunity to join the National Children and Young People's Improving Access to Psychological therapies (CYP-IAPT) 4 year Department of Health initiative. The C&YP IAPT transformation of services project aims to build on the strengths of the existing services for children & young people, whilst working with our partner agencies to build more robust pathways of care and a sustainable CAMHS that is equipped to meet the needs of our young population over the coming years. Progress to date: Over 50% of the Specialist CAMHS workforce is now trained in evidence based treatment modality (CBT, Parenting Therapy, DBT, EMDR, and Family Therapy) and or a specialist assessment (Sensory assessments, ADOS / DISCO ASD assessments etc.).

Other developments include the 7 day RISE service and the new specialist Eating disorder service as a result of Future in Mind investments. CAMHs is fully engaged in the Single Point of Access (SPoA) initiative. Currently CAMHs are working through on-going service transformation towards implementing a care pathway model of service delivery which will enable children and young people to access a more responsive and NICE guidance compliant service and provide greater opportunities for more collaborative working with partner agencies . Challenges include retaining the highly skilled trained staff to ensure the IAPT principles are fully embedded enabling the sustainability of the planned pathway service model.

ii. Performance dashboard

	Apr, 2016			May, 2016			Jun, 2016		
	No.	%	Target	No.	%	Target	No.	%	Target
Monitor Targets									
Data Completeness: Identifiers	2,080	99%	97%	2,080	99%	97%	2,025	100%	97%
Locally Agreed									
Data Completeness: Identifiers	2,080	99%	99%	2,080	99%	99%	2,025	100%	99%
Ethnicity Coding	2,080	86%	90%	2,080	84%	90%	2,025	81%	90%
Schedule 4 Contract									
Outpatient Letters Sent in 10 Working Days	69	77%	90%	84	71%	90%	60	76%	90%
Outpatient Letters Sent in 15 Working Days	69	84%	95%	84	86%	95%	60	91%	95%

Narrative:

- Data completeness and Ethnicity coding deficits relate to referrals details being incomplete at referral point and the reminder of the information cannot be gathered until the actual initial assessment point.
- Outpatient letter delays; on review with Consultants, there were inaccuracies identified. Some letters are delayed due occasional contentious issues that need to be reviewed with families with the aim of on-going engagement prior to being sent to GP. Some of the letters

are actual ADOs reports and have got mixed up in the flow system. The action plan is for further analysis to be undertaken to understand reported inaccuracy problems and for training to be provided to Consultants so separate reports can be separated out from GP letters. However there are some clear breaches related to Consultants on annual leave or working part time and the action is for the Senior CAMHS administrator and ASM to monitor more closely until the timeframes are achieved.

iii. Workforce dashboard

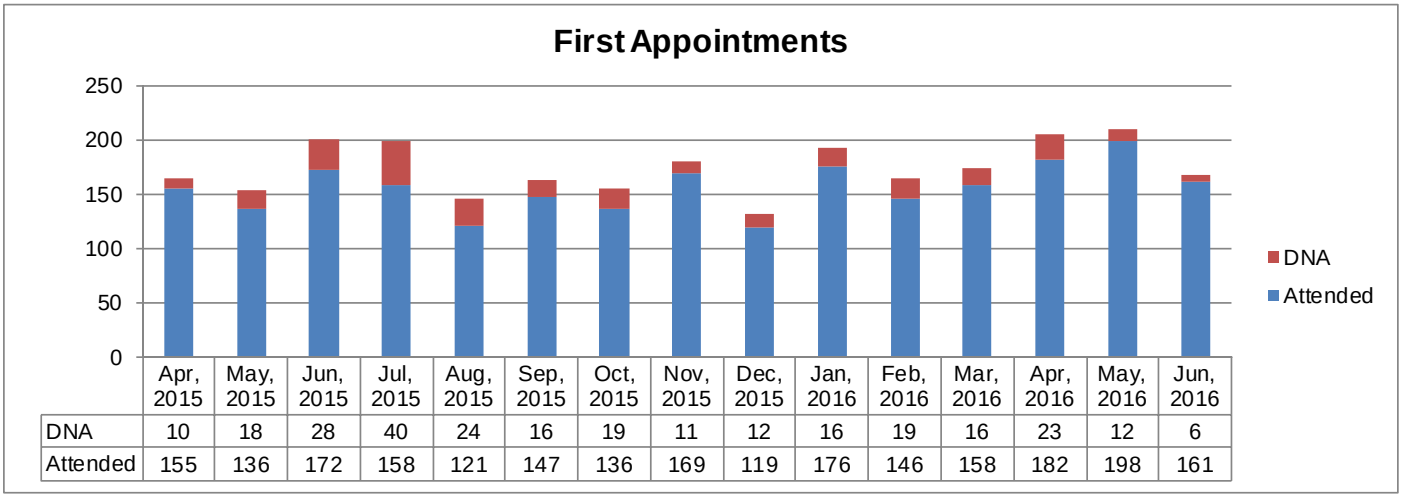
	Apr, 2016		May, 2016		Jun, 2016	
	Actual	Target	Actual	Target	Actual	Target
Headcount	90	N/A	92	N/A	91	N/A
FTE	82.01	N/A	82.31	N/A	81.31	N/A
Outstanding RTW	0	N/A	0	N/A	0	N/A
Annual Turnover	5.81%	10%	9.20%	10%	N/A	N/A
Appraisal Completion	66.67%	90%	76.09%	90%	72.53%	90.00%
Sickness Absence	4.06%	4.7%	2.43%	4.7%	N/A	N/A
Bank Usage	9.74%	4.98%	9.96%	4.98%	N/A	N/A
Agency Usage	6.50%	1.9%	6.31%	1.9%	N/A	N/A
Compulsory Training	85.75%	85%	85.12%	85%	85.71%	85.00%
Trust Induction	33.33%	100%	0.00%	100%	N/A	N/A
Workplace Induction	50.00%	100%	50.00%	100%	N/A	N/A

Team	Staff	Managerial Supervision		Clinical Supervision		Professional Supervision		Safeguarding Children	
		% Compliance *	% Supervisions Completed **	% Compliance *	% Supervisions Completed **	% Compliance *	% Supervisions Completed **	% Compliance *	% Supervisions Completed **
CAMHS Admin	13	100.0%	100.0%	N/A	N/A	N/A	N/A	N/A	N/A
County South MST	5	20.0%	20.0%	50.00%	70.0%	25.0%	25.0%	0.0%	0.0%
Derby City CAMHS	11	72.7%	83.3%	18.18%	34.1%	9.1%	9.1%	45.5%	47.2%
Derbys CAMHS Liaison	11	54.5%	87.7%	72.73%	84.3%	9.1%	9.1%	54.5%	55.8%
Derbyshire County CAMHS	25	48.0%	64.0%	52.17%	66.8%	8.7%	8.7%	4.3%	4.8%
District CAMHS Medical	10	10.0%	10.2%	0.00%	0.0%	0.0%	0.0%	0.0%	0.0%
LD CAMHS	3	66.7%	88.9%	66.67%	63.0%	0.0%	0.0%	0.0%	0.0%
Psychology CAMHS	1	100.0%	100.0%	100.00%	100.0%	100.0%	100.0%	0.0%	0.0%
Young Persons CAMHS	11	81.8%	87.9%	9.09%	40.4%	0.0%	0.0%	0.0%	0.0%
Total	**90**	**58.9%**	**70.3%**	**37.84%**	**54.4%**	**8.1%**	**8.1%**	**16.2%**	**17.1%**

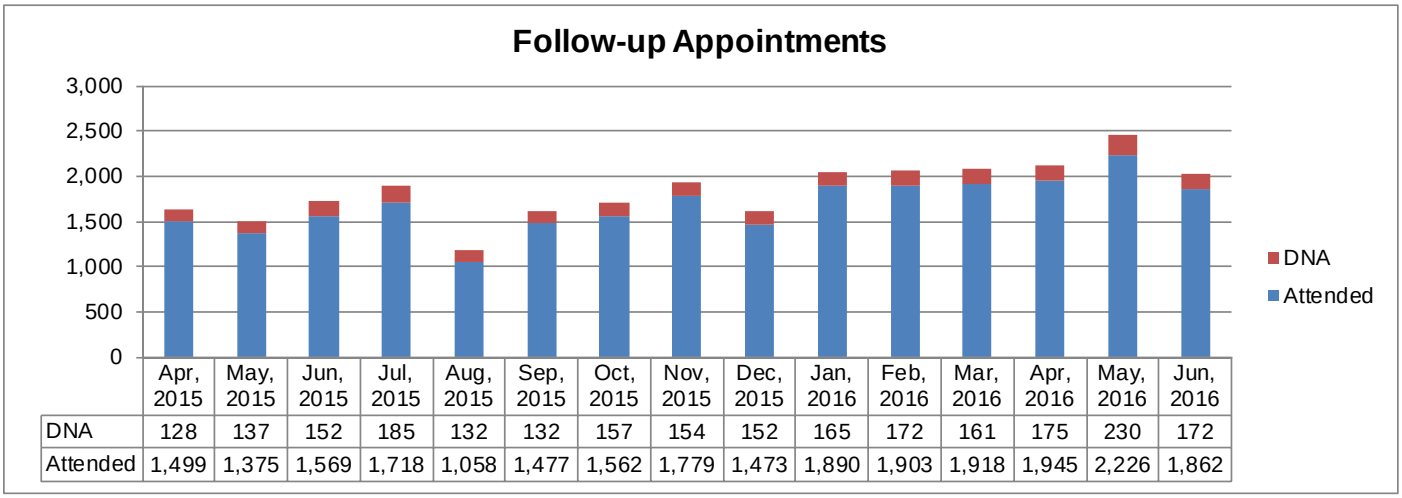
Narrative:

- There is a sense that appropriate levels of supervision are generally accessed within the service. Therefore the data above reflects a reporting compliance issue and the action plan is for Team Managers to access team admin support for inputting and to address backlog.
- Managers/leaders are working through the outstanding appraisals.
- Agency and bank usage remains high in the service. There are currently 3 vacant medical posts which have temporary backfill. Also a number of other clinical vacancies as a result of temporary or permanent movement of staff. Agency and bank usage monitored between SLM and GM using established tool.

iv. Activity



	Apr, 2015	May, 2015	Jun, 2015	Jul, 2015	Aug, 2015	Sep, 2015	Oct, 2015	Nov, 2015	Dec, 2015	Jan, 2016	Feb, 2016	Mar, 2016	Apr, 2016	May, 2016	Jun, 2016
DNA	10	18	28	40	24	16	19	11	12	16	19	16	23	12	6
Attended	155	136	172	158	121	147	136	169	119	176	146	158	182	198	161



	Apr, 2015	May, 2015	Jun, 2015	Jul, 2015	Aug, 2015	Sep, 2015	Oct, 2015	Nov, 2015	Dec, 2015	Jan, 2016	Feb, 2016	Mar, 2016	Apr, 2016	May, 2016	Jun, 2016
DNA	128	137	152	185	132	132	157	154	152	165	172	161	175	230	172
Attended	1,499	1,375	1,569	1,718	1,058	1,477	1,562	1,779	1,473	1,890	1,903	1,918	1,945	2,226	1,862

Narrative:

- There have been an average of 174 first appointment slots per month, 10% of which were DNA'd.
- There have been an average of 1,844 follow-up appointment slots per month of which 9% were DNA'd.
- DNA. On-going attempts are being made to reduce the DNA rate including reminder phone calls to families of planned appointments. Amendments to the appointment letter are also being made to help families appreciate the importance of attending appointments. All services within CAMHs offer out of hours appointments to avoid young people missing school to attend and there is a plan to further expand out of hours services.

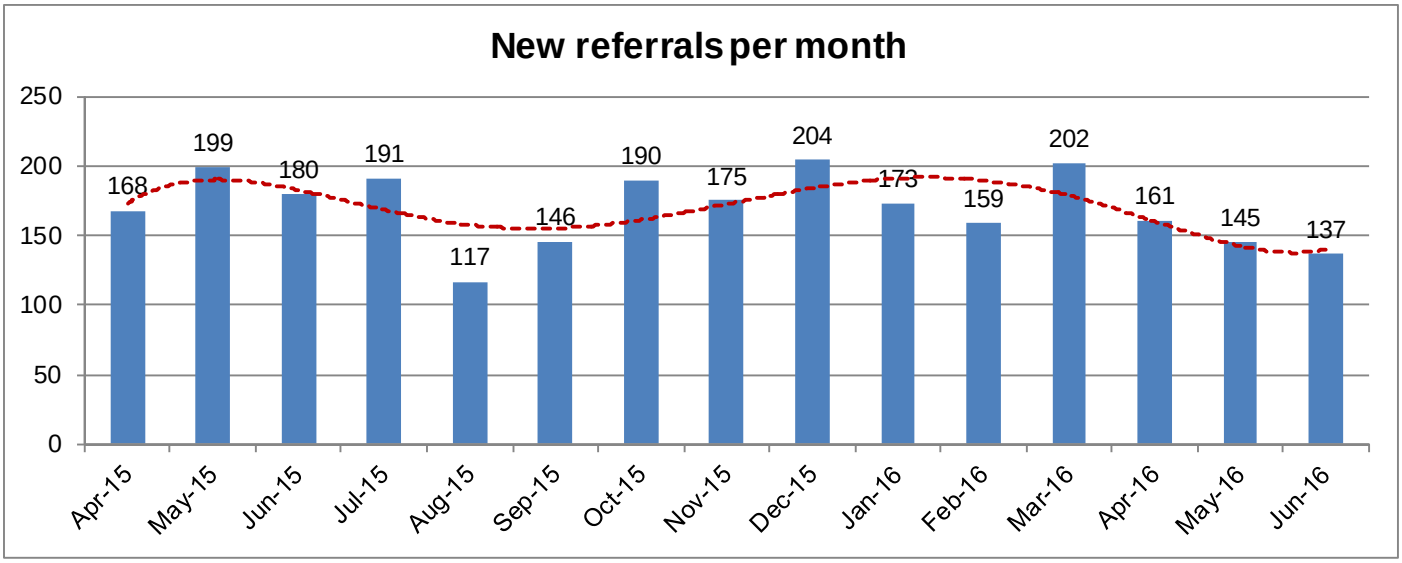
CAMHS RISE

The introduction of a 7 day and extended hours liaison service has significantly reduced the number of admissions and total bed days for children and young people at Derby Teaching Hospital.

v. Current waiting lists

Team	0-6 weeks	6-12 weeks	12-18 weeks	18-24 weeks	Grand Total
External waits	**110**	**64**	**23**	**3**	**200**
City CAMHS LD	1				1
County South CAMHS	55	30	11	1	97
County YPSS		3	2		5
Derby City CAMHS	42	28	10	1	81
Derby City YPSS				1	1
Derbys CAMHS Liaison	6				6
Derbyshire LD CAMHS	5	3			8
SENAD	1				1
Internal waits	**32**	**55**	**54**	**10**	**151**
CAMHS Eating Disorders	2				2
County South CAMHS	18	24	28	2	72
Derby City CAMHS	2	30	26	8	66
Derbys CAMHS Liaison	8	1			9
Derbyshire LD CAMHS	2				2
Grand Total	**142**	**119**	**77**	**13**	**351**

The CAMHs service is currently going through a period of transition, moving away from a geographic determined towards a pathway based model. The IAPT training programme has enabled a skilled workforce to deliver evidence based interventions generating measurable outcomes. The service currently experiences waits for assessment and treatment both of which are being monitored with commissioners at this time. It is expected that the new service structure will help generate capacity within the service and reduce the waiting times for all children and young people.



vi. Feedback

There has been no feedback recorded on the Friends and Family Tool for CAMHS this year. This is because young people and parents raise concern that the F & F questionnaire duplicates questions being asked through the routine IAPT routine outcome measurements used across the service. In that CAMHs has been using question 11 from the "Chi esq – patient service questionnaire" which asks about if they would recommend our service to a friend?

> Service user analysis for Q1- Q4:
> Would you recommend our service to a friend?
> 3% don't know, 2% not true, 14% partly true and 80% certainly true
> For carers:
> Would you recommend our service to a friend?
> 26% don't know, 10% not true, 12% partly true and 60% certainly true

Key themes coming out of the data is:

- Patients are requesting greater access to information – standardising approach
- Patients are requesting that we need to be working together more – communication with other agencies
- Improve accessibility – venues and opening times
- To improve outcomes there needs to be improved access to specialist skills
- Smarter use of goal based outcomes

A "you said and we did" action plan has been developed in response to the identified key themes.

vii. Complaints, concerns and compliments

There have been 15 complaints and concerns received this financial year and 61 compliments.

Service Area	Complaints	Concerns	Compliments	Total
CAMHS	4	3	3	10
Children's Services - Management Team			1	1
Community Paediatrics		5	1	6
Health Visiting	3		8	11
Therapy & Complex Needs			48	48
Grand Total	7	8	61	76

viii. Incidents

There have been 12 incidents reported this financial year which related to CAMHS:

Category	Insignificant	Minor	Moderate	Major	Catastrophic	Total
abuse/aggression - other party to staff		1	1			2
abuse/aggression - patient to other party		1				1
bed crisis				3		3
fire		1				1
information security & missing records		1				1
medication		1				1
referral, intervention, transfer and discharge		1				1
self-harm			1	1		2
Total		6	2	4		12

- The underlying theme of all 4 major incidents was the shortage of mental health inpatient beds for under 18s, resulting in young people being inappropriately placed until a bed could be found. DHcFT are not commissioned to provide inpatient care for children and young people 18 years of age but will be involved in the assessment and support whilst the bed is being located.

3 Universal and Specialist Community Services

i. Introduction

Currently the Universal and Specialist Community Services are made up from three service lines:

1. Children's Public Health 0-19 Years Services
2. Children's Therapies and Complex Needs
3. Looked After Children

From August 2016, the Looked After Children service line will join with the Children's Therapies and Complex Needs service line.

Children's Public Health 0-19 Years Services

Public Health Nursing for pre-school aged children is commissioned for people who live in Derby City, whereas Public Health Nursing for children and young people of school age and above is commissioned for those in attendance at a school or college within Derby City.

Following a successful tender process, DHcFT in partnership with Ripplez and Derby Teaching Hospital commenced delivering to the new contract and service specification from 1st July 2016. The journey towards transformation has begun and the period of consultation with the workforce was completed in May 2016.

The workforce has been restructured, and this has resulted in some staff being in new positions with support to develop additional knowledge and skills to deliver the service model and specification required. A small number of staff are being supported to find new roles within the Trust but outside of this service line.

The process is obviously unsettling for the entire staff group and we have continued to make efforts to ensure that staff feel supported and have access to suitable training and development opportunities throughout this period, e.g. one to ones; interview skills training; resilience training; compassionate mind training

For some time we experienced a high turnover of experienced health visitors and school nurses. (However this is not the case over recent months as illustrated below). We were unable to recruit during the period of consultation and the most recent interviews in July 2016 have appoint 4.8wte Health Visitors and 1.0 wte school nurses. In order to manage the higher turnover among this staff group we have agreed to an “over recruitment plan” that should ensure a more consistent level of staff in place at all times.

A large number of newly appointed staff are also newly qualified and therefore we have put a support programme in place through preceptorship and regular supervision both clinical and safeguarding.

Children’s Therapies and Complex Needs

The service continues to experience increasing number of referrals to the various elements of the service. A large number of referrals are for ASD and ADHD pathways.

Increased expectations of families and carers is placing additional demands on services.

The transition towards EHC Plans has placed additional demands upon assessing and supporting children and young people with special educational needs.

As a result there are considerable waiting list issues within the service line. Plans are in place to address this but it is not expected to have immediate impact as further reductions to capacity are experienced.

Challenges are experienced by the Children in Care team where children and young people are placed outside of the local area and the completion of health assessments and reviews are dependent on the health services within that local area. Currently in negotiation with commissioners regarding alternative arrangements which would ensure more timely response.

ii. Performance dashboard

	Apr, 2016			May, 2016			Jun, 2016		
	No.	%	Target	No.	%	Target	No.	%	Target
Monitor Targets									
Community Care Data - Activity Information Completeness	104,621	94%	50%	103,743	94%	50%	103,203	94%	50%
Community Care Data - RTT Information Completeness	104,621	92%	50%	103,743	92%	50%	103,203	92%	50%
Community Care Data - Referral Information Completeness	104,621	77%	50%	103,743	77%	50%	103,203	75%	50%

Narrative:

- Targets met. Some areas for improvement identified.

iii. Workforce dashboard

	Apr, 2016			May, 2016			Jun, 2016		
	Actual	Target		Actual	Target		Actual	Target	
Headcount									
Child Therapy & Complex Needs	96	N/A		106	N/A		103	N/A	
Children In Care	8	N/A		8	N/A		8	N/A	
Universal Children's Services	174	N/A		169	N/A		167	N/A	
FTE									
Child Therapy & Complex Needs	73.07	N/A		81.15	N/A		78.66	N/A	
Children In Care	4.69	N/A		4.69	N/A		4.69	N/A	
Universal Children's Services	136.97	N/A		134.00	N/A		132.75	N/A	
Annual Turnover									
Child Therapy & Complex Needs	8.91%	10%		9.80%	10%		N/A	10%	
Children In Care	12.50%	10%		12.50%	10%		N/A	10%	
Universal Children's Services	2.97%	10%		5.94%	10%		N/A	10%	
Appraisal Completion									
Child Therapy & Complex Needs	64.58%	90%		85.85%	90%		88.35%	90%	
Children In Care	37.50%	90%		25.00%	90%		37.50%	90%	
Universal Children's Services	74.14%	90%		76.92%	90%		75.45%	90%	
Sickness Absence									
Child Therapy & Complex Needs	3.17%	4.7%		3.26%	4.7%		N/A	4.7%	
Children In Care	2.08%	4.7%		8.52%	4.7%		N/A	4.7%	
Universal Children's Services	3.46%	4.7%		3.69%	4.7%		N/A	4.7%	
Bank Usage									
Child Therapy & Complex Needs	0.83%	4.98%		0.47%	4.98%		N/A	4.98%	
Children In Care	0%	4.98%		0%	4.98%		N/A	4.98%	
Universal Children's Services	0.33%	4.98%		0.13%	4.98%		N/A	4.98%	
Agency Usage									
Child Therapy & Complex Needs	0%	1.9%		1.48%	1.9%		N/A	1.9%	
Children In Care	0%	1.9%		0%	1.9%		N/A	1.9%	
Universal Children's Services	0%	1.9%		0%	1.9%		N/A	1.9%	
Compulsory Training									
Child Therapy & Complex Needs	85.04%	85%		88.15%	85%		89.85%	85%	
Children In Care	93.65%	85%		88.89%	85%		95.24%	85%	
Universal Children's Services	91.76%	85%		93.61%	85%		93.09%	85%	
Trust Induction									
Child Therapy & Complex Needs	0%	100%		100%	100%		N/A	100%	
Workplace Induction									
Child Therapy & Complex Needs	100%	100%		66.67%	100%		N/A	100%	

Narrative:

- The Children in Care team is a very small team and therefore turnover rates and sickness rates are disproportionality affected when there is termination/sickness of just one member of staff.

- All service lines experience the challenge of needing to improve completion of annual appraisals in a timely manner. There are some reports from managers that the appraisal is completed but they experience problems with recording the appraisal on the electronic system. Plans in place to address.

			Managerial Supervision		Clinical Supervision		Professional Supervision		Safeguarding Children	
Service Line	**Team**	**Staff**	% Compliance *	% Supervisions Completed **	% Compliance *	% Supervisions Completed **	% Compliance *	% Supervisions Completed **	% Compliance *	% Supervisions Completed **
Child Therapy & Complex Needs	CS - Administration	6	50.0%	72.2%	N/A	N/A	N/A	N/A	N/A	N/A
	LD Nurses	4	25.0%	58.3%	100.00%	100.0%	0.0%	0.0%	33.3%	33.3%
	Neuro Developmental Team	10	40.0%	66.7%	44.44%	67.1%	33.3%	33.3%	66.7%	68.8%
	Paediatric Continence	2	50.0%	83.3%	0.00%	40.0%	0.0%	0.0%	0.0%	0.0%
	Paediatric Medical	15	53.3%	53.3%	80.00%	81.4%	73.3%	73.3%	66.7%	64.4%
	Paediatrics Admin Team	18	27.8%	59.9%	N/A	N/A	N/A	N/A	N/A	N/A
	Schools Therapy	32	68.8%	85.1%	46.88%	65.8%	6.3%	6.3%	31.3%	36.1%
	Specialist Schools Nurses	7	0.0%	57.1%	0.00%	27.9%	42.9%	42.9%	28.6%	35.3%
	The Lighthouse DH	11	54.5%	66.7%	18.18%	27.0%	36.4%	36.4%	0.0%	0.0%
	Total	**105**	**47.6%**	**68.9%**	**46.25%**	**62.2%**	**28.8%**	**28.8%**	**37.2%**	**40.2%**
Children In Care	Children in Care Admin	4	0.0%	2.8%	N/A	N/A	N/A	N/A	N/A	N/A
	Looked after Children	5	20.0%	73.3%	20.00%	42.1%	0.0%	0.0%	0.0%	0.0%
	Total	**9**	**11.1%**	**42.0%**	**20.00%**	**42.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Universal Children's Services	Across Localities	19	42.1%	73.7%	35.29%	60.8%	0.0%	0.0%	30.8%	34.1%
	Child & Family Admin	4	50.0%	58.3%	N/A	N/A	N/A	N/A	N/A	N/A
	Locality 1 + 5	43	34.9%	58.9%	25.00%	58.6%	2.8%	2.8%	52.8%	50.9%
	Locality 2	49	65.3%	82.0%	41.86%	73.6%	2.3%	2.3%	30.2%	31.7%
	Locality 3 + 4	55	32.7%	49.5%	26.09%	52.7%	0.0%	0.0%	41.3%	42.4%
	Risky Behaviour Team	3	100.0%	100.0%	50.00%	77.8%	0.0%	0.0%	100.0%	100.0%
	Total	**173**	**45.1%**	**64.8%**	**31.94%**	**61.8%**	**1.4%**	**1.4%**	**40.7%**	**41.3%**
Total		**377**	**48.3%**	**66.7%**	**36.96%**	**59.6%**	**10.2%**	**10.2%**	**33.0%**	**33.8%**

Narrative:

- Supervision frequency has increased and is reflective of the additional time spent by managers with teams in critically analysing challenging scenarios in a more coaching related style. Changing recording practice is not however correlational to the increased activity, but staff are reporting their satisfaction with the change of reporting mode.
- Safeguarding supervision is implicit in all supervisory conversations that can be comprised of a number of elements; direction for operational issues, support, reflective analysis, and performance related themes. There have been issues in separating the components and achieving accurate compliance against the standards. Teams have been encouraged to be vigilant in their acknowledgement of directive and supportive time given to these activities. More formal provision of safeguarding supervision has been made available through the cascade Named Nurse model, more evident in Children's Public Health 0-19 Years Services. Complex Health Teams have latterly had agreement to receive this from the Safeguarding Department. On-going discussions to achieve consistency across policy/expectations, practice and reporting of safeguarding supervision are planned.
- Professional supervision is more pertinent to staff groups with specialist professional roles requiring additional support and reflective opportunity against best practice/regulatory standards. Nurses can make effective use of clinical and operational supervision to meet these requirements and therefore struggle to comply with additional professional supervision performance standards.

iv. Activity

TPP Unit	Service Line	Apr, 2016	May, 2016	Jun, 2016
Community Paediatrics	First Face to Face	194	240	209
	First Other	34	25	18
	Follow Up Face to Face	279	297	273
	Follow Up Other	195	197	169
	Total Attended	**702**	**759**	**669**
	DNA	28	26	22
	% DNA	3.84	3.31	3.18
	No Of Referrals	183	197	144
	No of Discharges	152	259	214
	Median Waiting Time (days)	173.0	156.0	198.0
	Average Waiting Time (days)	198.5	197.9	231.4
Community Therapy (Occupational Therapy)	First Face to Face	60	36	56
	First Other	4	5	9
	Follow Up Face to Face	165	212	264
	Follow Up Other	111	127	134
	Total Attended	**340**	**380**	**463**
	DNA	13	9	11
	% DNA	3.68	2.31	2.32
	No Of Referrals	31	43	40
	No of Discharges	30	19	49
	Median Waiting Time (days)	139.0	110.5	122.0
	Average Waiting Time (days)	258.2	194.3	219.9
Community Therapy (Physiotherapy)	First Face to Face	38	40	34
	First Other	8	10	7
	Follow Up Face to Face	490	525	510
	Follow Up Other	139	160	156
	Total Attended	**675**	**735**	**707**
	DNA	32	45	34
	% DNA	4.53	5.77	4.59
	No Of Referrals	30	35	21
	No of Discharges	44	82	75
	Median Waiting Time (days)	102.5	100.0	112.0
	Average Waiting Time (days)	108.8	207.5	236.9
Health Visiting	First Face to Face	921	958	1037
	First Other	234	234	257
	Follow Up Face to Face	4204	3650	3855
	Follow Up Other	1223	1071	1167
	Total Attended	**6582**	**5913**	**6316**
	DNA	399	408	405
	% DNA	5.72	6.45	6.03
	No Of Referrals	1060	1125	1230
	No of Discharges	1781	1168	1122
School Nursing Service	First Face to Face	922	1133	459
	First Other	102	88	72
	Follow Up Face to Face	747	873	633
	Follow Up Other	325	239	255
	Total Attended	**2096**	**2333**	**1419**
	DNA	25	10	8
	% DNA	1.18	0.43	0.56
	No Of Referrals	429	451	293
	No of Discharges	775	703	433
Specialist Nursing (ADHD)	First Face to Face	8	24	23
	First Other	0	10	36
	Follow Up Face to Face	115	132	127
	Follow Up Other	94	119	137
	Total Attended	**217**	**285**	**323**

TPP Unit	Service Line	Apr, 2016	May, 2016	Jun, 2016
	DNA	7	7	14
	% DNA	3.13	2.40	4.15
	No Of Referrals	125	66	104
	No of Discharges	38	20	17
	Median Waiting Time (days)	13.0	19.0	36.0
	Average Waiting Time (days)	39.3	27.8	51.0
Specialist Nursing (Continence)	First Face to Face	34	29	30
	First Other	22	48	20
	Follow Up Face to Face	25	19	20
	Follow Up Other	27	33	16
	Total Attended	**108**	**129**	**86**
	DNA	15	8	7
	% DNA	12.20	5.84	7.53
	No Of Referrals	35	27	36
	No of Discharges	24	27	42
	Median Waiting Time (days)	98.0	102.5	127.0
	Average Waiting Time (days)	95.5	88.8	94.3
Specialist Nursing (Health Visitors)	First Face to Face	8	15	8
	First Other	2	2	2
	Follow Up Face to Face	97	100	80
	Follow Up Other	34	27	21
	Total Attended	**141**	**144**	**111**
	DNA	4	2	1
	% DNA	2.76	1.37	0.89
	No Of Referrals	9	13	13
	No of Discharges	11	4	8
	Median Waiting Time (days)	115.0	104.0	112.0
	Average Waiting Time (days)	98.7	85.2	96.8
Specialist Nursing (Learning Disabilities)	First Face to Face	12	7	8
	First Other	19	9	9
	Follow Up Face to Face	32	40	25
	Follow Up Other	16	4	18
	Total Attended	**79**	**60**	**60**
	DNA	1	0	0
	% DNA	1.25	0.00	0.00
	No Of Referrals	8	12	19
	No of Discharges	14	20	7
	Median Waiting Time (days)	56.0	122.0	124.0
	Average Waiting Time (days)	72.9	126.4	124.0
Specialist Nursing Children in Care	First Face to Face	11	6	12
	First Other	0	0	3
	Follow Up Face to Face	27	14	20
	Follow Up Other	11	8	22
	Total Attended	**49**	**28**	**57**
	DNA	0	0	0
	% DNA	0.00	0.00	0.00
	No Of Referrals	13	13	16
	No of Discharges	15	11	25

Narrative:

- Delivery model includes a mixture of Home visits and clinic based appointments but generally there is a low level of DNA across all services. Text message reminders for appointments are utilised in most areas.

- Waiting times for OT and Physiotherapy are of particular concern. Management within these service areas is developing pathway and throughput issues which will help caseload management and capacity issues.
- Wait times for the Continence Team have risen in correlation to the changes to the Children's Public Health 0-19 Years Services resulting in a gap in service provision. Currently in discussion with commissioners regarding provision for the shortfall.
- Waiting times for Paediatricians. See below.

Looked after Children – 2015/16 data agreed with the Local Authority:

Activity	Number completed	Cohort size	%	%2014-2015
Annual health assessment over 5 years	258	294	87.7%	88.5%
6 monthly review health assessments	48	58	84.5%	77.4%
Immunisations up to date	350	352	99.4%	97.8%
Dental checks up to date	278	352	79%	92.5%

97% of children are registered with a dentist, however disappointingly only 79% have up to date dental checks. It would appear that carers are not making appointments for the children they care for. Action - to have a section in the foster carer/residential care worker training to stress the importance of good oral health and having regular dental checks.

It remains difficult to achieve 100% compliance for health assessments and reviews for a number of reasons including; where the young person has declined; reliance on hosting authorities completing the assessments within the specified timescales.

v. Current waiting lists

Unit	0-14 Weeks	14-18 Weeks	18-26 Weeks	26+	Total Waiting	Average Weeks Waiting	Max Weeks Waiting
Community Paediatrics	411	111	204	585	1311	27.16	168.29
Community Therapy (Occupational Therapy)	96	24	37	96	253	43.66	209.71
Community Therapy (Physiotherapy)	75	10	23	55	163	51.06	208.00
Specialist Nursing (ADHD)	185	3	3	2	193	5.60	38.43
Specialist Nursing (Continence)	60	17	39	8	124	13.84	35.86
Unit Unknown	19	0	0	0	19	1.93	6.86
Total	**901**	**172**	**319**	**800**	**2192**	**28.66**	**224.71**

Narrative:

- Waiting times for Paediatricians. Extensive waiting times for first appointment with community paediatrician.

Initiatives undertaken in an attempt to reduce the waiting list:

1) Attempts at recruitment are ongoing. Joint Role with Derby Teaching Hospital. Over the past year we have successfully recruited one Community Paediatrician in to a post jointly established between ourselves and the hospital paediatricians at Derby Teaching Hospital. Consultant Paediatrician. Currently there are 2 vacant posts within the service. One Consultant Paediatrician has been appointed following interviews on 24/06/16 and the further vacancy will be re-advertised. Speciality Grade. Currently there are 2 vacant posts within the service. 3 applicants for the Speciality Grade vacancies will be interviewed on 20/07/16.
2) There are ongoing attempts to secure suitable locum cover but this has proved difficult. The service is currently utilising one agency locum paediatrician
3) Managers and the Associate Clinical Director meet on a regular basis to review the situation and adjust responses accordingly. This has resulted in the redistributing of resources within the areas covered to ensure a level of cover in all areas.
4) Data cleanse exercise has been completed to ensure that information held on SystmOne is accurate and up-to-date.
5) During the early part of 2016, the current medical workforce (Paediatricians and CAMHS) facilitated extra clinics on Saturday mornings to provide additional clinical capacity. It was noted that not all families wanted to attend appointments at weekends and working overtime is not a sustainable way to manage waiting list problems for the service.
6) Referrals are triaged through a single point of access to ensure the most suitable pathway is identified. Referrals are prioritised as required to ensure risk factors are considered within timeliness of response.
7) Communication with GPs has taken place to describe challenges being faced and how they are able to escalate referrals should they become aware of deteriorating clinical situations.
8) The transformational changes implemented in 2015 were a result of acknowledging difficulty in recruiting community paediatricians. As a result changes to the pathway were established and vacant medical hours were re-engineered to enable the recruitment of 5 additional nurses to the Neuro-Disability Team. As a result follow-up contacts for Children and Young People on the ADHD pathway will be completed by the nurses rather than by Community Paediatricians thus enabling the paediatricians to offer more new patient slots within their clinics and subsequently reduce the waiting times. However the recruitment of these nurses took longer than anticipated and the advanced level of skills required for the role has resulted in an intensive training programme being developed for them upon commencement into role. . Therefore this has contributed to a delay in the impact that these staff have been able to have on the overall waiting times for children and young people so far. The longer term intention is that these staff will also need to be trained as NMP's. Further action to be taken

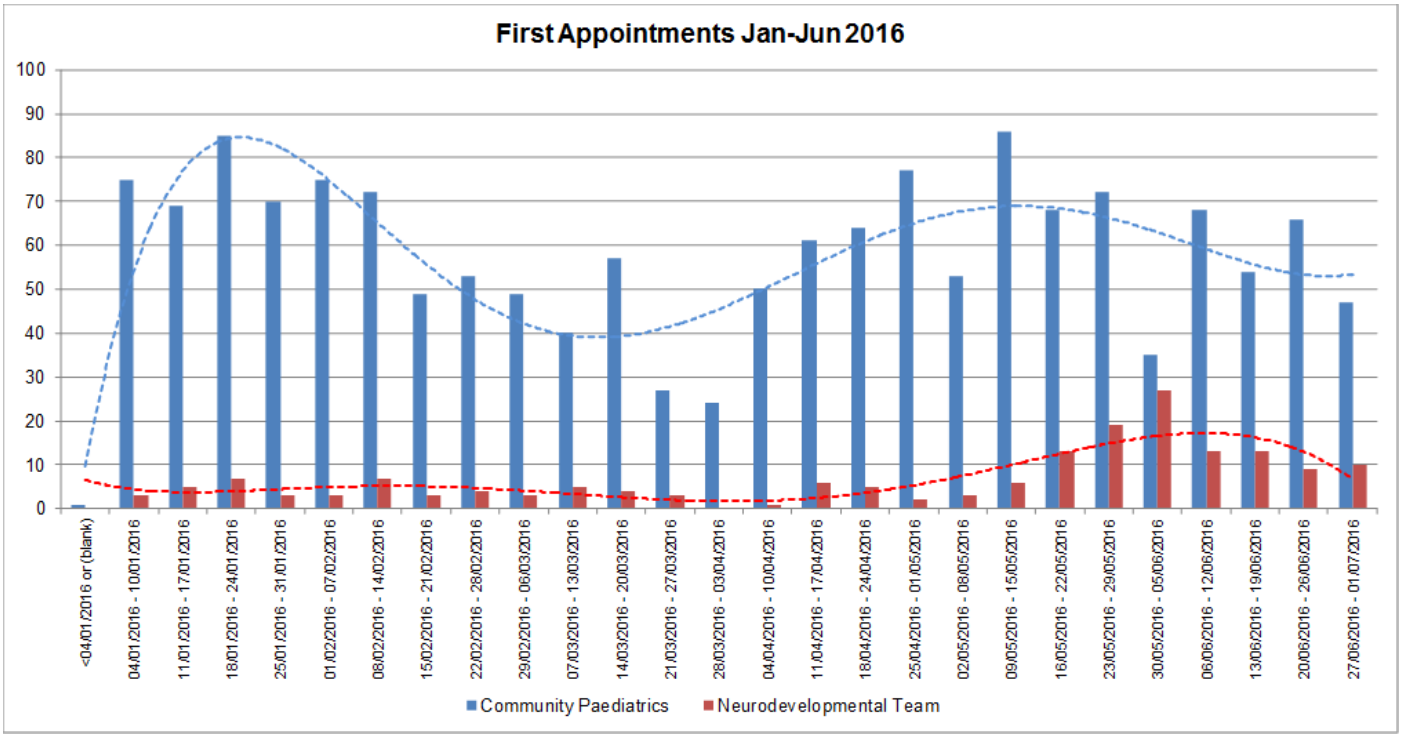
Consideration will need to be given to further developing the Neuro-disability team to expand the role of the nurse and facilitate greater input during the assessment process for ADHD and ASD. Additional resources and training will be required to support this as it will reduce the need for the Paediatrician at the front end of the assessment pathway and help to further reduce the waiting times being experienced by Children and Young People on the ND pathway.

On-going work is being carried out to explore other innovative solutions which will involve skill mixing and interagency employment to increase the clinical capacity of the team.

The ND team has been working with the Community Paediatricians in the transfer of appropriate work to release capacity to see new referrals for assessment. It is envisaged that following the period of training the additional nurses will be able to facilitate all follow up contacts currently delivered by the paediatricians. The ND team is now operating fully and the process of transfer of this work is underway.

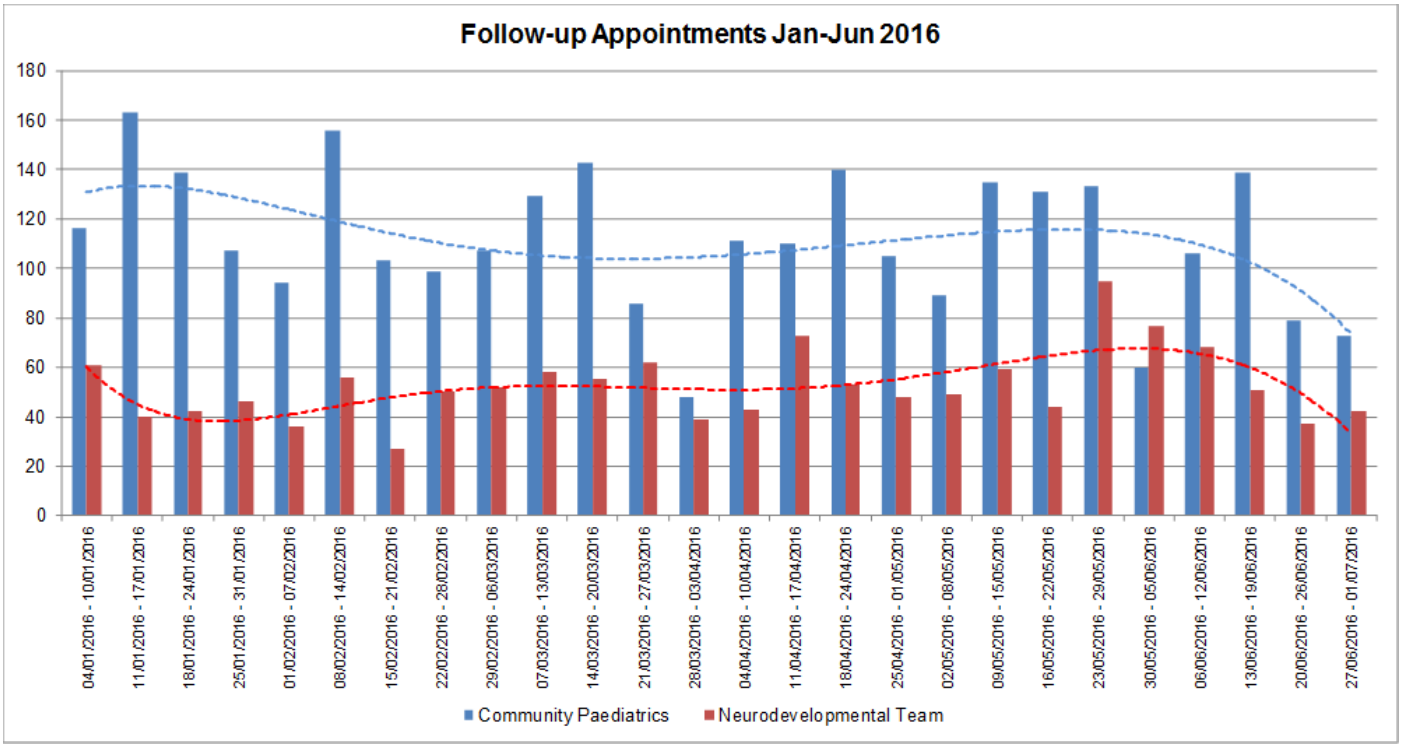
Due to there being no prescribing capacity within the ND team, cases can only be transferred following titration of medication. We are working with Sangeeta Bassi regarding securing support from a pharmacy prescriber who could be made available from September 2016. Sangeeta confirms that this person will require a three to four month training period before they would be able to take on the role of prescribing within this service. Therefore this option could generate prescribing capacity from January 2017.

The chart below indicates the first patient contact being completed by the ND team and the Community Paediatricians over the first 6 months of this year. Due to the recent changes introduced to the ND pathway described above, we would expect to see an increase in the number of new patients being seen by the paediatricians and the ND team over the next few weeks. However we fear that the loss of the capacity (2 left post in June and 1 leaves in July) of the three Dr's (2 left post in June and 1 leaves in July) will counter balance the benefit that the recent changes will make and therefore we may not see any increase in number of new patient appointments with the paediatricians.



The chart below compares the follow up activity between the ND team and the Community Paediatricians. As a result of the recent changes to the pathway we would expect to see an increase in FU activity for the ND team and a corresponding reduction in FU activity for the

Community Paediatricians. We will need to monitor this over the next few weeks and months to ensure that the changes are having the intended impact on service delivery and subsequent waiting times.



Implementation of the multi-agency pathway (WS2) with DCHS and Derby Teaching Hospitals will impact upon the paediatrician waiting list. This has the potential to remove the paediatrician from the role of ‘gate-keeper’ to the pathway and enable appropriate children and young people to be seen by the psychology department (Derby Teaching Hospital) ahead of an appointment with the paediatrician.

The commissioners have recently identified £300,000 of non-recurrent funding available to help resolve the waiting list problem. A multi-agency task group is currently in the planning stage of progressing this initiative, and it must be noted that securing temporary staff will present all organisations with a significant challenge at this time.

The deployment of a Psychologist employed by DHcFT being line managed by Derby Teaching Hospitals will reduce the need for the Paediatrician from the front end of the pathway and therefore reduce the delay in initiating the assessment. This is due to commence on 1st July 2016.

A recruitment process has commenced for a Waiting List Initiative Co-ordinator who will evaluate the data for readiness, prepare the profile of children for assessment and deploy a choose and book system of clinic management. It will be possible to provide a trajectory regarding the impact at a later date once the analysis of the current waiting lists is completed.

vi. Feedback

Team	Negative responses	Neutral	Positive responses	Total
CYP	**1**	**7**	**227**	**235**
HEALTH VISITORS			66	66
OCCUPATIONAL THERAPY			1	1
PAEDIATRICIAN	1	5	114	120
PHYSIOTHERAPY			1	1
SCHOOL NURSE		1	9	10
SPECIALIST NURSING SERVICE		1	36	37

There was no reason given for the negative response.

Of the 4 comments received relating to the 7 neutral responses, 3 of the comments were positive.

Children in Care team have received significant negative feedback about the tool used for the Friends and Family Test which is also the experience of other LAC nursing teams in the local region. As a result a very short questionnaire was developed with the support of some young people and questionnaires are completed at initial and review health assessments and are completed by the carer or the young person if appropriate. The questionnaires are used to capture the voice of the child and the carer to identify the level of service provided and if they feel any improvements can be made to improve the assessment/review experience. The questionnaire asks three questions:

- Was your appointment on time?
- Was the health assessment explained to you?
- Were you listened to?

The questionnaire also includes a space for free text and comments have included “Like to see the same nurse”, “Opportunity to speak to professionals alone”, “Appreciate advice” and “Opportunity to share concerns and frustration and support”.

vii. Complaints, Concerns and compliments

There have been 5 concerns, 3 complaints and 56 compliments received this financial year.

Team	Complaints	Compliments	Total
Children's Services - Management Team		1	1
Children's Services - Management Team		1	1
Community Paediatrics		1	1
Paediatrics - Southern Derbyshire		1	1
Health Visiting	3	6	9
Infant Feeding Team		1	1
Locality 1 - Borrowash Team	1		1
Locality 1 - Chaddesden Team	2		2
Locality 2 - Alvaston/Boulton Team		1	1
Locality 2 - Chellaston/Melbourne Team		3	3
Locality 4 - Mickleover/Littleover Team		1	1
Therapy & Complex Needs		48	48
Children's Physio & OT Team - County - Amber Valley & W. Derbys		1	1
Neuro Developmental Team		47	47
Grand Total	3	56	59

Service Area	Concerns
Children's Services - Management Team	
Community Paediatrics	5
Health Visiting	
Therapy & Complex Needs	
Grand Total	5

A significant number of concerns have been are being raised by GPs, MPs and CCGs in relation to significant Community Paediatric waiting times. Managers are organising a co-ordinated response to these groups with particular emphasis on the Erewash area due to considerable capacity limitations over the last year described above.

viii. Incidents

There have been 53 incidents reported this financial year which related to Children's Services:

Category	Insignificant	Minor	Moderate	Major	Catastrophic	Total
Abuse/Aggression - Other Party to Patient			1			1
Abuse/Aggression - Patient to Staff	1	1	1			3
Abuse/Aggression - Staff to Staff		1				1
Accident		10				10
Death					1	1
Fall	1	1				2
Infection Control		1				1
Information Security & Missing Records	1	4	2			7
Medical Equipment/Device		1				1
Medication	1	3	1			5
OTHER - See 'Description' Section	5	3	2			10
Referral, Intervention, Transfer and Discharge	2	3	4			9
Security	1					1
Staffing levels		1				1
Total	12	29	11		1	53

There is a need to raise awareness among the workforce to record compliments on Datix.

A number of medication incidents have been incurred following compromised requirements in Specialist Nursing Teams as a result of working in the premises of another provider i.e. Special Schools and Residential Short Stay provision. Steps have been taken to pragmatically manage the issue, to include:

- Re-auditing of medicines management in close liaison with Chief Pharmacist
- Appraising environments of NHS England requirements
- Deployment of Senior Pharmacist to work protected one day per week for Complex Health Services – Monitoring and auditing practice and providing advice and consultation to the service and partner agencies to ensure a greater degree clinical efficacy.

4. Conclusion

<u>Opportunities</u>

NHS England is currently looking to commission a Regional Paediatric Sexual Assault Service (East Midlands) for a period of 3 years. The service model will provide scheduled non-acute clinics and an acute response which includes a measured and appropriate approach to managing out of hour's cases. Currently NHS England are seeking expressions of interest from providers who may be interested in tendering for the service. There will be an impact incurred for the community paediatricians and we are currently in discussions with Nottingham regarding how we join up service provision and consider partnership working.

Challenges

- Community Paediatric waiting times – see above.
- Clarity around Special Schools contracts. Clarification of service specification and subsequent capacity to deliver that service required.
- Integrated provision at the Lighthouse posing governance and risk issues – staffing, capacity, continuity, compliance with best practice standards.
- Capacity to address outcome of SEND Reforms – inconsistencies between local authorities; transformational changes with LA staff.
- Mobilisation of workforce and clinical changes towards an integrated Children's Public health 0-19 Service.
- Recruitment of clinical staff including School Nurses, Health Visitors, Consultant Psychiatrists and Paediatricians.
- Shared access to electronic recording systems used by social care partners e.g. Children in Care team.
- Given capacity issues and pressures on services, it has been difficult to identify full cost improvement for 2016/17.
- Transitions across Children's and CAMHs services and towards adult services. Draft policy currently out for consultation.

Achievements

- Successful partnership tender for Children's Public Health 0-19 Years Services.
- Achievement of Baby Friendly status.
- Single Point of Access – The development of a SPoA in both the County and the City, bringing together a range of Health and relevant Social Care providers on a weekly basis to ensure that information is shared to determine most suitable care pathways for children and young people referred to services.
- Electronic prescribing – enabling Community Paediatricians to produce electronic prescriptions from SystmOne.
- Recent CQC inspection – Positive feedback received from CQC regarding a number of services including CAMHs, Children in Care, Ivy House School.
- Development of allocated resource within pharmacy department to support Children's services.
- Developments of partnership working with DCHS, Derby Teaching Hospital and social care developing pathways for children and young people in Derby City and Derbyshire. E.g. Workstream 2 and Waiting List Initiative.
- Operationalisation and performance of CAMHs RISE service.
- Additional investment in CAMHs Eating Disorder Service.

Derbyshire Healthcare NHS Foundation Trust
Report to Trust Board 27 July 2016.

EDS2 2016-17 update

Purpose of Report

To provide an update on the Equality and Diversity Workforce approach for 2016 -17

Executive Summary

The Trust has a legal obligation to comply with the Equalities Act 2010 under section 3 of the Act.

The equality duty was developed in order to harmonise the equality duties and to extend it across the protected characteristics. It consists of a general equality duty, supported by specific duties which are imposed by secondary legislation. In summary, those subject to the equality duty must, in the exercise of their functions, have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

These are sometimes referred to as the three aims or arms of the general equality duty. The Act explains that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

The Act states that meeting different needs involves taking steps to take account of disabled people's disabilities. It describes fostering good relations as tackling prejudice and promoting understanding between people from different groups. It states that compliance with the duty may involve treating some people more favourably than others.

The equality duty covers the nine protected characteristics: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Compliance with the general equality duty is a legal obligation enshrined in:

- The Equality Act 2010 (Public Sector Equality Duty, s149)
- The Human Rights Act 1998

- The NHS Constitution
- Health and Social Care Act 2012 (Section 14)

It is therefore incumbent upon the Trust to try and ensure that its workforce reflects the population in which it works with particular emphasis on the nine protected characteristics.

Risks

1. As a Trust the risks associated with none attainment of the above could result in our CCG and external partners withdrawing our services and eliminating us from tendering for new business within Derby and greater Derbyshire.

2. Workforce risks are two fold as evidence in the WRES and staff survey 2015:

- Bullying and harassment of employees from BME backgrounds.
- Potential glass ceiling within the organisation relating BME.

3 Establish link with the Quality Committee to produce a whole EDS2 workforce and Service user package.

4. To establish with workforce stakeholders (network) e.g. disabilities, LGBT, Age (55+).

Next Steps

1. EDS2 Consultation timeline (appendix 1)
2. Progress against the goals and outcomes of the EDS2 2016/17 (appendix 2)
3. Workforce Race Equality Standard 2016/17(appendix 3)
4. EDS2 update for June Board – draft
5. EDS2 annual declaration July

Consultation

As per consultation timeline attached.

Equality Delivery System

Proposed as a positive impact as Race, Economic Disadvantage, Gender, Age, Religion, Disability and Sexual Orientation (REGARDS) population specifically within this paper - in developing the programme of change and engagement - clearer emphasis with regards to Equality will be identified – particularly within our systems and processes.

Recommendations

The Board of Directors is requested to :

- To acknowledge this paper and to seek assurance in the continued development of E and D throughout 2016/17.

- Seek assurance that updates on progress will be reported to the People & Culture Committee

Report presented by: Owen Fulton, Principal ER Manager

Report prepared by: Owen Fulton, Principal Employee Relations Manager & supported by Paul Beardsley

Appendix 1 EDS2 CONSULTATION TIMELINE June 2016.

Document.	Committee/ Board.	Methodology	Date.
Equality Deliver System 2.			
	People, Culture Committee.	Briefing paper – verbal overview.	16 June 2016.
	4E's - Equality, Experience, Engagement & Enablement.	Briefing paper – verbal overview.	21 June 2016.
	Black and Minority and Ethnic Committee.	Briefing paper – verbal overview.	27 June 2016.
	Joint Negotiating CC.	Briefing paper – verbal overview.	28 June 2016.
	Trust Executive Board.	Briefing paper – verbal overview.	29 June 2016.
	All Staff.	Briefing paper via team meetings and electronic distribution.	30 June 2016.
	Governors.	Briefing paper – verbal overview.	21 July 2016

Draft June 2016

The goals and outcomes of EDS2

Goal	Number	Description of outcome	Undeveloped	Developing	Achieving	Excelling	Evidence	Gap	Actions	Lead
A representative and supported workforce	3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels		✓			Improved workforce data regarding protected characteristics. Workforce identifying with Disabilities increase by 7%.	Identfied under representation of Men within the Nursing roles.	Establish positive action focus group who will report into People and	Owen/ Liam Carrier and Emma Smith
	3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations		✓			Commencement of Job Evaluation panels December 16 after 2 years for lack of staff side representation. National Training provided in	Needs further National training to recruit more Job Evaluators. Also need	Secure continued funding for supporting the job evaluation	Paul Beardsley and Operational HR
	3.3	Training and development opportunities are taken up and positively evaluated by all staff		✓			All training opportunites are advertised on Connect and recorded through the OLM system. Each training course is then	Needs to provide access to training report via OLM to people and	Evidence of applying reasonable adjustments within training	Owen Fulton and Learning and Development team
	3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source	✓				Our staff survey identifies that 14% of BME staff feel they have experienced bullying and harrassessment from managers or work colleagues.	Although the trust has protective policies and provides	The people and culture committee to investigate data of the staff	Paul Beardsley and Operational HR
	3.5	Flexible working options are available to all staff consistent with the needsof the service and the way people lead their lives		✓			DHCFT has a special leave, Flexible working and worklife balance policy. Staff are able to apply for Career breaks.	The Trust does not record number of people who have flexible	Workforce planning team and HR develop system of recording	Julieann Trembling and Health and Wellbeing Group
	3.6	Staff report positive experiences of their membership of the workforce	✓				The Staff survey results identify that the workforce would not recommend our organisation as a place to work. Staff nominations through	Need to develop sample test in line with EDS recommendatio ns of particular	Implement the workforce strategy and monitor via Workforce and OD along with	Julieann Trembling and Health and Wellbeing Group
Inclusive leadership	4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations		✓			The Trust holds a 4E's group on a quarterly basis which is incorporate sensor members of the Trust and representatives from	Further examples of senior managers involvement	Communication s team to record senior management engagement	Owen Fulton and Jane Storey/ Education and Learning Team.
	4.2	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	✓				Board papers and polices are impact assessed. Currently this element is not recorded and therfore needs further development.	Need to establish a third party assessor of Board papers.	Work with Trust Chairman, NEDS and goverers to establish	Jayne Storey
	4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	✓				Managers ensure that staff are completing manitory E&D online training. Staff survey results are highlighting that staff are experiencing bullying and	Feedback required through the appraisal process from staff that culture objectives are	Organisation to provide specific team based inclusion training. 4E's/People	Jayne Storey
Over all Scoring				✓						

Derbyshire Healthcare NHS
NHS Foundation Trust

Appendix 3

DHCFT NHS Workforce Race Equality Standard April 2015 to be refreshed July 2016 - Baseline (DRAFT)

Workforce metrics **For each of these three workforce indicators, the Standard compares the metrics for white and BME staff.**		**DHCFT comparison data 14/15 (31.3.2015)** **Comparison data 15/16 to be added mid-June 2016**	**Target Date**	**Lead**	**Workforce Team Actions**
1	Percentage of BME staff in Bands 8-9, VSM (including executive Board members and senior medical staff) compared with the percentage of BME staff in the overall workforce	Number of BME staff in Bands 8-9 and VSM = 10 (excluding consultants/medical other) Total number of staff in Bands 8-9 and VSM =160. **Percentage of BME staff 6.25%** (10/160) Number of BME staff in overall workforce = 292 Total number of staff in overall workforce = 2433 **Percentage of BME staff in overall workforce 12%** (292/2433) The difference between % of BME staff in bands 8-9 & VSM and the overall workforce is 5.75%.	August 16 August 16	Workforce Group to action and feed into People and Culture Committee. Owen Fulton and Paul Beardsley.	To further explore our data to ensure we are referencing comparable figures. For example we will look at how many BME staff are employed across the Trust in consultant and medical roles. To establish a Workforce Positive Action Task Group who will develop a detailed action plan to address potential under-representation. The group will also proactively look at how to establish a growing BME talent pipeline to widen the talent pool for senior posts. The task group will engage with the Trust's BME Staff Network to explore these issues, ensure BME voice and establish their views more widely in the Trust.

2	Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts.	No. shortlisted White 1158 /BME 319 No. appointed White 230/ BME 41 Relative likelihood of white staff being appointed from shortlisting compared to BME staff (Ratio 0.199/0.129) is therefore 1.54 times likely		Brenda Rhule has attended the People Forum. August 2015	As Indicator 1 Workforce Positive Action Task group to work with BME Staff Support Network to explore potential barriers and bias across the employment pathway e.g. interviews and values assessment. Wider options include introducing good practice requirements for interview panels to be balanced in terms of ethnicity and wider REGARDS characteristics. Where this is not possible, the Trust could invite representation from the BME Staff Network on to interview panels It is proposed that a BME Staff Network representative is invited to participate in the People Forum. To be reviewed within our recruitment policy by the policy Group
3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary	Awaiting data for two year rolling period. *Note: this indicator will be based on data from a two year rolling average of the current year and the previous year.	August 2016	Workforce Group to be completed in August 2016.	Workforce team to provide data and analysis to ascertain if BME people are disadvantaged/disproportionately affected by Trust practices including disciplinary procedures.

	investigation*				
4	Relative likelihood of BME staff accessing non-mandatory training (MT)and CPD as compared to White staff (excludes 183 ethnicity not stated)	Total number of staff in workforce - White 1958 & BME 292 Number of staff accessing non-mandatory training and CPD (episodes) is White = 11249 and BME =1320 Likelihood of white staff accessing non-MT & CPD = 5.745 (11249/1958) Likelihood of BME staff accessing non-MT & CPD = 4.520 (1320/292) Relative likelihood of White & BME staff accessing 5.745/4.520 = 1.27 times greater	August 16	As Indicator 1	As indicator 1
National NHS Staff Survey findings For each of these four staff survey indicators, the Standard compares the metrics for each survey question response for White and BME staff					**Action**
5	KF 18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Survey 2014 - White 32% and BME 33% National average 2014 for MH Trusts 29%	August 2016	Owen Fulton and Sue Walters	Update from survey 2015 Further analysis of data to identify any patterns or discrepancies between the Trust's own data against the national average.
6	KF 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White 23% and BME 23% National average 2014 for MH Trusts 21%	August 2016	As above	
7	KF 27. Percentage believing that trust provides equal opportunities for career progression or promotion	White 87% and BME 71% National average 2014 for MH Trusts 86%	August 2016	As above	

8	Q23. (K28) In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White 10% and BME 27%. National average 2014 for MH Trusts 12% This is nearly 3 times higher for BME people.	August 2016	As above	
Boards Does the Board meet the requirement on Board membership in 9?					**Action**
9	Boards are expected to be broadly representative of the population they serve.	• Board of Directors =14 of which BME = 1 (7%) • The Trust is representative if one uses the combined city/county census population (BME 6.74%)	September 2016	People and Culture Committee do a report of where we are at. Owen Fulton and Paul Beardsley.	Further exploration of the Trust's data across staff working in the city and county, to provide greater insight into proportionality Executive lead for WRES (to be agreed at Board) Consider integrating board develop/programme. Looking ahead at the board composition and its representation of the population we serve. Annual workforce diversity report and analysis to be presented and discussed at Board.

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

Board Assurance Framework (BAF) update for 2016/17, (Issue 2)

Purpose of Report: To meet the requirement for Boards to produce an Assurance Framework. This report details the second issue of the BAF for 2016/17.

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 is the second formal presentation of the Board Assurance Framework to the Audit & Risk Committee for 2016/17.

Executive Summary

- There has been significant review and update of each risk during the last quarter
- Since Issue 1 of the BAF for 2016/17 the risk rating for 2 of the 6 risks has been increased. This in relation to the risks around: achievement of quality standards; and delivery of the financial plan.
- None of the risks currently identified in the BAF have revised their risk rating down.
- The risks have been re-ordered in line with the Trusts revised strategic objectives, so risks previously identified as 2a, 2b etc have been amended.
- The Audit and Risk Committee have requested that the Executive Leadership Team review the current risks in light of the revised strategic objectives.
- The Audit and Risk Committee agreed that risks 2a) System change and 4b) Transformation be considered for merging in the next Issue of the BAF.
- A link to the operational risk register has also been included this month, with the reference number for related high/extreme operational risks cited against the relevant line in the BAF. A headline summary of these risks has also been included fore reference.
- All dates for 'deep dives' of individual BAF risks are planned for the year, and 1 has been completed on track. Currently all deep dives will be undertaken by the Audit & Risk Committee (as all risks are rated as either high or extreme) but this is subject to change dependent upon the current risk rating of each risk.
- The Audit & Risk Committee (and Board) will receive the BAF four times during the year, in line with Monitors governance guidance.

Strategic considerations
All risks identified in the BAF relate to risks to the achievement of strategic outcomes, as this is its main purpose.

(Board) Assurances
This paper provides an update on all Board Assurance Risks

Consultation
Executive Leadership Team – 27th June 2016
Audit and Risk Committee – 19th July 2016

Governance or Legal issues
Governance or legal implications relating to individual risks are referred to in the BAF itself. The work being undertaken as part of the Governance Improvement Action Plan (GIAP) clearly reads across to the risks raised in the BAF.

Equality Delivery System
None

Recommendations

- For the Board to approve this second issue of the BAF for 2016/17

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

Report prepared by: **Rachel Kempster, Risk and Assurance Manager**

Board Assurance Framework (BAF) update for 2016/17, (second issue)

There has been significant review and update of each risk since it was last reviewed by the Audit & Risk Committee and then Board in March 2016. Changes since Issue 1 are highlighted in blue text in the detailed spreadsheet attached.

Since Issue 1 (March 2016), the risk rating of 2 of the risks has been increased. This has been made by the executive director with lead responsibility for the risk following discussion with the named responsible committee. Risks which have increased in their risk rating are summarised below:

Risk title	Director Lead	Previous risk rating	Current risk rating	Rationale for change
Failure to achieve clinical quality standards required by our regulators which may lead to harm to service users and/or staff	Executive Director of Nursing and Patient Experience	MOD	HIGH	Likelihood raised from 3 (possible) to 4 (likely), following further gaps in controls identified through CQC inspection
Failure to deliver short term and long term financial plans could adversely affect the financial viability and sustainability of the organisation	Executive Director of Finance	HIGH	EXTREME	Likelihood raised from 3 (possible) to 4 (likely) due to worsened level of assurance over CIP delivery. Although Month 1 and 2 performance to date is ahead of plan the future run rate worsens

The risks in the BAF have been re-ordered in Issue 2 in line with the revised Trust strategic objectives. A summary of the amended order is shown below for clarity:

		Revised strategic outcome	Revised order of risks	Previous strategic outcome	Previous order of risks
Strategic Outcome	1	We will deliver **quality** in everything we do providing safe, effective and person centred care	1a) Clinical Quality	People receive the best quality care	1a) Clinical Quality
	2	We will develop strong, effective, credible and sustainable **partnerships** with key stakeholders to deliver care in the right place at the right time	2a) System change	People receive care that is joined up and easy to access	2a) Transformation 2b) System change
	3	We will develop our **people** to allow them to be innovative, empowered, engaged and motivated. We will retain and attract the best staff.	3a) Regulatory compliance 3b) Loss of confidence in leadership	The public has confidence in our healthcare and developments	3a) Financial plan 3b) Regulatory compliance
	4	We will **transform** services to achieve long-term financial sustainability	4a) Financial plan 4b) Transformation	Care is delivered by empowered and compassionate teams	4a) Loss of confidence in leadership

The Audit and Risk Committee were asked to consider if they would recommend a wider review of the risks in the BAF in light of the revised strategic objectives. The

Committee requested the Executive Leadership Team undertake this review and recommend any amendments.

As the Derbyshire wide Sustainability and Transformation Plan (STP) system wide planning and local transformational planning are no longer distinct from one another, it was requested to the Audit and Risk Committee on 19th July that risks 2a) System change and 4b) Transformation be considered for merger. The Committee agreed for this to be undertaken and submitted in Issue 3 of the BAF.

A line to the operational risk register has also been included in the BAF this month, with the reference number for any related operational risks (with a current risk rating of high or extreme) cited against the relevant line in the BAF. A headline summary of these risk is also included at the end of the BAF spreadsheet.

'Deep dives' have become embedded into the BAF process during the last year to enable review and challenge of the controls and assurances associated with each risk. These are undertaken by the lead responsible committee for each risk. As in 2015/16, where risks on the BAF remain high or extreme (currently all risks), the Audit & Risk Committee will undertake this 'deep dive' to enable sufficient challenge to the highest risks facing the organisation.

The programme for deep dives for 2016/17 is planned as follows: This is however subject to change dependent upon the current risk rating of each risk.

Risk ID	Subject of risk	Director Lead	Quality Committee	Finance & Performance Committee	People & Culture Committee	Audit & Risk Committee
1a	**Clinical quality**	Carolyn Green	(X) →	→	→	Oct 2016
2a	**System change**	Mark Powell		(X) →	→	Mar 2017
3a	**Regulatory compliance**	Ifti Majid				Jan 2017
3b	**Loss of confidence in leadership**	Jayne Storey			(X) →	Dec 2016
4a	**Financial plan**	Claire Wright		(X) →	→	Oct 2016
4b	**Transformation**	Mark Powell		(X) →	→	Jul 2016 Completed

Note: The arrows show where the Audit & Risk Committee will receive the risk 'deep dives' rather than the lead responsible committee, if the risk remains high or extreme. Currently all risks are rated as high or extreme, so will be subject to a 'deep dive' by the Audit & Risk Committee.

BOARD ASSURANCE FRAMEWORK 2016/2017 v2.3 (Re-ordered against revised strategic objectives)

Definitions:
Strategic Outcomes: What the organisation aims to deliver
Principal Risk: What could prevent this objective being achieved. Specify impact.
Director Lead: Lead Director for reporting into the BAF. Other Directors may also have responsibility for managing the risk
Key controls: What controls/systems we have in place to assist in securing delivery of our objective (Describe process rather than management groups)
Assurances on Controls: Where can we gain evidence that our controls/systems on which we place reliance, are effective
Positive Assurances: We have evidence that shows we are reasonably managing our risks and objectives are being delivered
Gaps in Control: Where are we failing to put control/systems in place? Where are we failing in making them effective?
Gaps in Assurance: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective

Key:
Internal Audits Reports15/16
Internal Audits planned 16/17
Clinical Audit Programme 16/17
Changes since last reviewed by Board, March 2016
Cross reference to ID of related operational high/extreme risk (see

Strategic Outcomes 1. We will deliver quality in everything we do providing safe, effective and person centred care

	Principal Risk	Director Lead and named responsible Committee	Risk Rating	Impact (1-5)	Likelihood (1-5)	Key Controls	Gaps in control	Assurances on Controls (Internal)	Positive Assurances	Gaps in Assurance	Action plan: To increase effective controls. To gain assurance.	Action: due/review date	Progress on action	Risk Register ID
1a	Failure to achieve clinical quality standards required by our regulators which may lead to harm to service users and/or staff Likelihood raised to 4, following further gaps in controls identified through CQC inspection	Executive Director of Nursing and Patient Experience Quality Committee	HIGH	4	4	1) Quality Framework (Strategy) outlining how quality is managed within the trust 2) Board committee structures and processes ensuring escalation of quality issues 3) Quality governance structures and processes in to manage quality related issues 4) Quality visit programme, providing partial evidence of compliance with CQC requirements 5) Incident, complaints and risk investigation and learning, including robust mechanisms for monitoring resulting actions plans 6) Agreed clinical policies and standards, available to all staff via Connect 7) Engagement with clinical audit and research programmes 8) 'Duty of Candour' monitoring and reporting processes 9) Annual skill mix review	Clinical buy in to review of NICE guidelines ~~Timely review of all policies~~ Embeddedness of QLT's Embedded personalised care planning. Robust compliance monitoring for record keeping, capacity and consent, physical health cheeks and clinical standards Compliance with medicines management policy Including compliance with storage of medicines at the correct temperature), and gaps in capacity of pharmacy team (3302) (3301) (20844) (3035) Demands of the Derbyshire population out strips capacity (3260), in particular community teams, paediatrics. Ability to recruit and retain adequate numbers of staff to ensure safe practice i.e. inpatient wards at Radbourne (3386) (3410) (2675) (2681) (2678) and Hartington Units, paediatricians (3262), CMHT (20857) 20819), psychology (20867) (3385) Clinical dashboards to monitor early warning signs of service failure (1565) MHA data validation of seclusion and rapid tranquilisation incidents. Inadequate physical environment for seclusion at Kedleston Unit. Ineffective training compliance with restrictive practice requirements of the MHA Code of Practice Lack of local PICU beds (3314)	Service improvement mapping and contributions i.e. positive and safe, reduction in the use of seclusion Clinical Audit Programme and action plans where gaps identified Audits of compliance with NICE Guidelines National Audits i.e. National Audit of Schizophrenia and POMH UK Audits 'Clinical interest' led audits focused on local resolution of issues	National Community Patient Survey results (above average results) National Inpatient survey (above average results) HealthWatch survey 2014 (significant assurance) CQC visits / inspection Benchmarking data identifies higher than average qualified to unqualified staffing ration on inpatient wards	Achievement of Quality Framework in relation to care planning and capacity and consent , reconfirmed by audit 2015/16 Mental Capacity Act and early findings from CQC comprehensive inspection June 2016, identifying significant lack of knowledge by staff in recording of capacity and consent. Clinical audits identifying gaps due to inconsistent application of process i.e. capacity and consent, nutritional screening, DNAR, DEWS scoring, recording of allergies. Supporting staff retention through practice development and embedding uptake of clinical supervision Unfilled clinical vacancies due to lack of available medical staff and recruitment to new investment.	Further engage clinical leadership (though QLT's in particular) in the review and implementation of NICE guidelines.	30/09/2016	Paper to QC June 16 reported all NICE guidelines now published on Connect page. Firm process for embedded ownership by QLTs underway.	20830
											Ensure the now small number of policies overdue for review is completed and that tight processes remain in place going forward. ELT to support Quality Governance Committee to ensure all policies are reviewed and updated.	Completed	Performance improved from 58 % of policies being in date 2 years ago to over 95% currently in date. 95% compliance to be maintained through a policy expiring alert system, policy monitoring at operational and assurance level committees and the inclusion in the Board quality dashboard a policy compliance metric.	
											Embedding of actions resulting from incidents and complaints into the medium to long term through Quality Leadership Teams	Completed	Redesigned agenda/structure and forward plan in place for QLT's	
											Continue to monitor progress against implementation of the quality strategy in relation to compliance with care planning and capacity and consent requirements, including the implementation of actions resulting from the recent 2015/16 Mental Capacity Act audit	30/08/2016	Funding approved and post being recruited to a MCA/MHA Team Leader to develop systems, monitor impact and implement training around capacity and consent and compliance with the MCA Act (DoLS applications).	
											Implement improvement plan for medicines management, as highlighted in Board deep dive into medicines management (Sept 2015) and hence to commissioners.	31/07/2016	Report to Quality Committee June 16 reported on progress against pharmacy strategy. Review monthly until further assurance received.	
											Implement measures to ensure medicines are being stored at the correct temperatures.	31/07/2016	Lack of compliance with correct storage temperature of medicines is being managed through portable air conditioning units whilst capital bids to install permanent solutions are being implemented.	
											Raise risks with commissioners regarding community team capacity and forensic community offer. Recruit to new investment	31/07/2016	£1m additional investment received, £2m shortfall remains. Deep dive reports to Quality Committee on plans to safety manage waiting lists for paediatricians and CMHT's considered. Update report planned. People and Culture Committee received plan for recruiting to new investment and existing vacancies.	
											Implementation of clinical dashboards to monitor early warning signs of service failure	31/07/2016	Revised quality monitoring dashboard to be presented to July 16 Board.	
											Implementation of action plans resulting from gaps identified through clinical audit projects	31/07/2016		
											Increase uptake of clinical and managerial supervision	31/07/2016	Revised supervision policy. Performance monitoring though TOMM, reported to Board through Integrated Performance Report.	
											Reinstate practice development groups	31/07/2016	Groups commenced early 2016. Plan to review impact Sept 2016.	
											Recruit to/remodel medical workforce (20871)	30/09/2016	Medial workforce plan to People and Culture Committee July 2016, to reduce vacancies and/ore remodel service	
											Ensure consistency of understanding and application by clinical staff and clinical leaders of seclusion, in line with the MHA Code of Practice. Ensure the monitoring of incidents of seclusion is robust and cross referenced between ward, MHA office and Datix held data.	31/08/2016	Issue a 'Blue Light' to staff regarding care of patients in seclusion and segregation care and reporting of these incidents. Sent 17/6/16. A system to improve xchecks between data held by the MHA office and	
											PICU bed manager being appointed to review pathway. Cluster analysis of incidents requested via CCG through STEIS incident reporting.	30/09/2016		

Strategic Outcome 2: We will develop strong, effective, credible and sustainable partnerships with key stakeholders to deliver care in the right place at the right time

	Principal Risk	Director Lead and named responsible Committee	Risk Rating	Impact (1-5)	Likelihood (1-5)	Key Controls	Gaps in control	Assurances on Controls (Internal)	Positive Assurances	Gaps in Assurance	Action plan: To increase effective controls. To gain assurance.	Action: due/review date	Progress on action	Risk Register ID
2a	Risk to delivery of national and local system wide change. If not delivered this could cause the Trusts financial position to deteriorate resulting in regulatory action	Director of Strategic Development Finance and Performance Committee (Audit Committee)	16	4	4	1) Programme of public consultation to support system wide changes 2) Stakeholder and relationship management in order to develop and maintain partnerships 3) Trust leads Mental Health programme of work for the STP	Unclear system wide governance to oversee delivery of national priorities Lack of clarity around collaboration and competition	NHSA agreement of Derbyshire STP short term Regular STP reports to Trust Board Regular system wide service change proposals reported to Trust Board			Delivery of Monitor operational plan	Completed	Monitor Plan for 16/17 approved by Trust Board and sent to Monitor within the agree timeframe.	20832
											Agree system wide Sustainability and Transformation Plan (STP)	Completed	STP plan for Derbyshire was submitted on the30/6/16 in line with national expectations.	
											Implementation of Sustainability and Transformation Plan (STP)	From 01/10/2016		

Strategic Outcome 3. We will develop our people to allow them to be innovative, empowered, engaged and motivated. We will retain and attract the best staff.

	Principal Risk	Director Lead and named responsible Committee	Rating	5)	(1-5)	Key Controls	Gaps in control	Assurances on Controls (Internal)	Positive Assurances	Gaps in Assurance	Action plan: To increase effective controls. To gain assurance.	Action: due/review date	Progress on action	Risk Register ID
3a	There is a risk that the Monitor enforcement actions and CQC requirement notice, coupled with adverse media attention may lead to significant loss of public confidence in our services and in the trust of staff as a place to work. Furthermore, failure to deliver the governance improvement action plan could lead to a risk of further breaches in licence regulations with Monitor and the CQC and further regulatory action	Acting Chief Executive Audit Committee	15	5	3	1) Governance committees and structures, with clear responsibility to lead on specific GIAP actions 2) Newly established People and Culture Committee, with clear responsibility to lead on specific GIAP actions 3) Governance processes to deliver the governance improvement action plan including reporting to ELT and monthly reporting to Board 4) Listen, Lead and Learn - executive visibility plan 5) Formal reporting to regulators on a monthly basis. 6) Ongoing engagement with regulators	Identified in the governance improvement action plan.	Well led self assessment	Monitor agreement of governance improvement action plan 2016/17 Governance and improvement action plan 2016/17 Performance Management Framework (planned Q3) 2016/17 Committee Effectiveness (planned Q2)	Outcomes from Deloitte and CQC reviews	Implement actions from Governance Improvement Action Plan. To be undertaken via weekly review of the GIAP at the ELT, robust monitoring of progress through identified board committees, monthly monitoring reports to Board, monthly reporting to MHS Improvement and the CQC.	Monthly	As of end May 2016, the GIAP is generally on track. 1 item (PC4) is off track and a number have some issues which are being closely monitored by ELT, relevant board committees and Board.	20834
											Internal audits to be undertaken on key areas identified in the governance improvement action plan, i.e. compliance with policies and procedures	31/07/2016	Plan underway for PwC to undertake deep dives on specific actions	
											Agree framework with Deloitte over remaining quarters of the year to undertake a full well led review	31/03/2017		
3b	Risk of a fundamental loss of confidence by staff in the leadership of the organisation at all levels	Director of Workforce, OD and Culture People and Culture Committee (Audit Committee)	15	5	3	1) Appointment of new Director for Workforce, OD and Culture to focus and deliver the immediate requirements of the governance improvement action plan and the HR function and organisational culture going forward 2) Leadership development programme 3) Communication Strategy to engage and inform staff 4) Trust values outlining expected behaviours of all staff 5) Monitoring and delivery of the Training and Development Framework and Training Plan	Defined People Strategy and People and Workforce Plans ~~Lack of unification of HR and associated functions~~ Limited informal engagement by Board with staff Lack of partnership agreement with staff side Delivered operational recruitment plan, with clear impact on use of temporary staff Review and implementation of HR policies	Staff Values Poll Listen, learn, lead initiative by Executive Team Staff survey action plan, reviewed an supported by Board	HEE annual quality visit 2016/17 Governance and improvement action plan 2016/17 Compliance with HR policies and procedures (planned Q1)	Gaps in CQC/Monitor governance standards (as identified in GIAP action plan) Safer staffing data identified in 2015/16 HR Processes: Recruitment. Staff survey	Implement actions from Governance Improvement Action Plan To be undertaken via weekly review of the GIAP at the ELT, robust monitoring of progress through identified board committees, monthly monitoring reports to Board, monthly reporting to NHS Improvement and the CQC.	Monthly	Progress as detailed above	20835
											Facilitated session with ACAS arranged to support staff side partnership agreement.	31/08/2016		
											Seek resource and support from Derbyshire human resources system to support delivery of People Plan	Completed	Resources secured through external recruitment	
											Implement actions from internal audit report (2015/16 HR Processes: Recruitment) in relation to safer staffing reports.	Completed		
											Establish a robust action plan to support staff survey outcomes	30/09/2016	Action plan completed. New engagement group in place to monitor progress against the action plan. Mindful, health and Well Being group re-established to support work to reduce work related stress.	
											Complete Workforce Plan and supporting Training Plan	31/07/2016	Workforce plan in progress.	
											Roadmap' outlining programme of engagement agree by P&CC May 16.	30/09/2016	Implementation of 'Roadmap' underway	
											Delivery of operational recruitment plan	30/09/2016	Range of initiatives underway. Statement of intent agreed by PCC May 16.	

Strategic Outcome 4. We will transform services to achieve long-term financial sustainability

	Principal Risk	Director Lead and named responsible Committee	Risk Rating	Impact (1-5)	Likelihood (1-5)	Key Controls	Gaps in control	Assurances on Controls (Internal)	Positive Assurances	Gaps in Assurance	Action plan: To increase effective controls. To gain assurance.	Action: due/review date	Progress on action	Risk Register ID
4a	Failure to deliver short term and long term financial plans could adversely affect the financial viability and sustainability of the organisation	Executive Director of Finance Finance and Performance Committee (Audit Committee)	20 EXTREME	5	4	1) Monthly Financial Performance Reporting to Public Trust Board meetings providing assurance on financial performance, including integrated performance reporting to enhance triangulation when assessing finance, quality, workforce and operational performance 2) Reporting to Finance and Performance Committee to gain assurance on all aspects of financial (and other resources) management on behalf of the Board, including oversight of CIP delivery and contractual performance 3) Project Assurance processes and systems for in-year monitoring of CIP delivery and escalation procedures 4) System of delegated budgetary responsibility - in line with standing financial instructions and scheme of delegation 5) F&P and PCOG meeting monitoring of contractual performance that impacts on contractual payments including activity levels, CQUIN and contract levers/penalties. 6) Service Line Reporting and other financial reporting systems and action planning at Finance & Performance, Performance and Contracts Overview Group (PCOG), Integrated Services Delivery Group (ISDG), Divisional meetings, IAPT Board and other groups	Future payment systems beyond 1617 not yet defined by Regulators or agreed with commissioners Control Totals for required surplus imposed by Regulator will require stretch levels of CIP delivery Additional regulatory reporting and controls having negative impact on capacity and flexibility in financial planning	Monthly financial reporting systems on current and forecast performance include "challenge and review" each month before reporting Pre-submission scrutiny of annual operational financial plan prepared and submitted to Monitor Delivers FSRR of at least 3 each quarter Pre-submission scrutiny of health system Sustainability and Transformation Plan (STP) (5 year plan) Budget-setting operational requirements are signed-off by those responsible for their delivery (and the Trust Board) In-year financial forecasts are co-owned by finance and the individuals responsible for their delivery Existence of contingency reserve and the contingency reserve access request process Large proportion of income guaranteed through block contract for 1617 .	External Audit: the Audit Findings for DHCFT (year ended 31 March 2016) . Issued with Unqualified Opinion Confirmed NB - VFM assessment and governance (see gap in assurance) External Audit: Bespoke Key Financial Indicators 2015 report show that aside from the gap in assurance for liquidity (as the only red indicator) - the other indicators are amber or green (benchmarked against MH FT peers) . Strongest indicator is EBITDA. Generally improving position on metrics or benchmarked position Monitor: In year compliance reporting: FSRR rating has always been 3 or 4 Monitor: "Green" rating for Trust's current 5 year strategic financial plan (only 30% of Trusts rated as green). (NB Awaiting assessment of new health system STP - TBC) Internal Audit: 2015/16 Cash forecasting and controls (low risk) Internal Audit 2015/16 Contract Assurance Shared Business Services (SBS) (medium risk) Internal Audit 2015/16 Off payroll arrangements (medium risk)	Re: External Audit benchmarking for Financial KPIs and resilience: Main area to improve is liquidity ET/Governance reviews/investigations and subsequent regulatory impact created negative external assurance (e.g. need to develop integrated reporting and update F&P TOR and had negative impact on External Audit VFM Assessment for 1516 annual accounts and report) TBC Residual gaps in assurance related to exceeding agency controls on: % cost ceilings, pay rate caps, use of approved frameworks and high cost off payroll compliance (and gaps identified in Internal Audit Report on off payroll medium risk) ELT 16th May 2016 determined that the remaining CIP gap of c £2m as at that date was significant enough to increase the probability that a significant level of non-delivery of CIP will impact on the ability to achieve the financial plan for 16/17	To minimise control gap around future payment systems: Attendance at events, keeping up to date with current thinking from Regulator, discusssions with commissioners (joint exec ownership between DoF and Director of Business Development)	Oct-16	Actions are ongoing and contractual progress is reported to F&P	20833
											To minimise gap in control re control total required by Monitor - continue financial planning and financial control and ensure CIP delivery. Due the worsened level of assurance over CIP delivery as at mid May there have been additional CIP emergency meetings and action planning meetings. Progress will be reported to ELT every meeting, to F&P May and Board in June 16. Extraordinary F&P meeting arranged for June 2016 to focus on CIP.	April 16 submission	April 16 submit final 1617 plan -updated for contract outcomes. also Q1 will evidence performance against 1617 plan and trajectory to deliver control total delivery. Month 1 and 2 performance to date is ahead of plan but future run rate worsens. Assured delivery of control total requires the CIP gap to be closed	
											To minimise control gap for regulatory capacity and inflexibility in planning - ensure long term financial plans are deliverable and effectively monitored, continue to improve liquidity.	October 17 submission	Long term STP submission being developed	
											To improve assurance gap on EA benchmarking indicators: continue to improve liquidity and build cash reserves (e.g. through retention of disposal proceeds), maintain tight financial control	31/03/2017	Progress continues - see latest board financial reporting for current metrics	
											To improve assurance gap related to financial components of governance gaps: achieve delivery of the relevant governance improvement actions and compliance with findings recommendations from Deloitte et al	Completed	Papers provided to F&P and Board during the year are being amended as required. E.g. Enhanced financial dashboard reporting actioned from Feb 16 board onwards. Also from March board 16 onwards Trust Board receive a new integrated performance report. PCOG and F&P reports from Feb/March 16 included additional content on forward financial risks and trends.	
											To improve assurance related to agency usage: Internally monitor and manage reduction in use of agency staffing and monitor the delivery of improvement trajectories and also report progress on trends to relevant committees and Trust Board. (Action owner = Ops director) Also achieve further evidence of assurance on rostering and longer term workforce planning to reduce reliance on agency (reported through People committee) (Action owner= Workforce Director)	end Q1	Increased scrutiny and oversight continues - however agency usage is still in excess of NHSI ceiling Additional operational processes and procedures have been put in place, and are being further enhanced, to comply with reporting requirements to Monitor and to internally monitor and manage reduction in use of relevant temporary staffing . Progress will be reported as part of regular performance reporting to both Trust Board, F&P Committee and People and Culture Committee. Update 8/7/16 Month 3 agency info is highest spend yet against the 1617 monthly ceiling - so even though control measures and oversight are in place even more needs to be done as they are not yet taking effect. due for discussion at F&P and board in July	
4b	Failure to deliver the agreed transformational change, at the required pace could result in reduced outcomes for service users, failure to deliver financial requirements and negative reputational risk	Director of Strategic Development Finance and Performance Committee (Audit Committee)	HIGH 15	5	3	1) New 5 year Strategy 2016 - 2021 outlining strategic direction for Trust 2) Tight plans for implementing transformational change , with clear objectives and metrics for internal and external reporting. 3) Programme of engagement events with staff and stakeholders to consult with and agree the programme for implementing transformational change	Plans have not as yet identified full CIP for year and pipeline going forward. Embedded coaching culture to deliver empowered leadership and accountability Capacity of operational managers to deliver transformational plan, alongside other project demands. Sufficient engagement with staff side	Board reporting on strategy implementation with associated board discussion and challenge	2015/16 Transformation 2016/17 Data security and handling (planned Q2)	Gaps in assurance on CIP schemes	Fully develop transformational project plans submitted for current and future years with assurance on cost out in line with Trust strategy and national policy	31/10/2016	There is a £2m gap in the efficiency programme, all the current plans are being progressed but there is more work being done on cost avoidance rather than cost out and there will be LEAN projects after the lean training has been delivered. The Financial risk on the BAF has been reassessed and has increased and the issue has been discussed at F&P on 23/05/16 and confidential session of the Board on 25/05/16.	20831
											Transformational plans progressed according to project implementation and plans and delivered according to timescales.	31/10/2016	Strategy implementation event delivered with senior leaders set out the process re implementation of the Trust Strategy over the next 6 months.	
											Develop a performance framework to support empowered leadership and accountability to ensure decision making is undertaken at the right level.	31/08/2016	Accountability framework being developed as part of GIAP action. First meeting of senior management team planned for 27/06/2016.	

Abbreviations

ACAS	Advisory, Conciliation and Arbitration Services
CEO	Chief Executive Officer
CIP	Cost Improvement Programme
COSRR	Continuity of Services Risk Rating
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation payment
CRG	Clinical Reference Group (accountable to QLT's)
DEWS	Derbyshire Early Warning System - tool to identify sharp physical health decline

Cross reference to ID of related operational high/extreme risk

ID	Directorate	Date of next review	Risk Subtype	Title	Risk level (current)
1565	Campus - Radbourne Unit	30/06/2016	Clinical - Points of Ligature	Risk of death through strangulation	High Risk
2669	Campus - Radbourne Unit	31/08/2016	H&S - Violence and Aggression	Violence and Aggression	High Risk
2675	Campus - Radbourne Unit	31/08/2016	H&S - Work Related Stress	Workplace Stress	High Risk
2678	Campus - Radbourne Unit	31/08/2016	H&S - Lone Working	Lone Working	High Risk
2681	Campus - Radbourne Unit	31/08/2016	H&S - Fire Safety	Fire	High Risk

DNAR	Do Not Attempt Resuscitation order
DoF	Director of Finance
EBITDA	Earnings before interest, taxes, depreciation and amortization
ELT	Executive Leadership Team
F&P	Finance and Performance Committee
FRR	Financial Risk Rating
FSRR	Financial Sustainability Risk Rating
GIAP	Governance Improvement Action Plan
HR	Human Resources
IAPT	Improving Access to Psychological Therapies
NICE	National Institute for Health and Care Excellence
PARIS	Electronic Patient Record solution provided by Civica
PCOG	Performance and Contracts Overview Group
PICU	Psychiatric Intensive Care Unit
POMH-UK	Prescribing Observatory for Mental Health
PYE	Part Year Effect
QAG	Quality Assurance Group (led by Commissioners)
QC	Quality Committee
QIA	Quality Impact Assessment
QLT	Quality Leadership Teams (accountable to Quality Committee)
SLA	Service Level Agreement
STP	Sustainability and Transformation Plan
TOMM	Trust Operational Management Meeting
VFM	Value for Money

3035	Pharmacy	02/08/2016	Clinical - Staffing levels	Pharmacy Staffing	High Risk
3260	Neighbourhood Services	31/07/2016	Commissioning Risk	Lack of ADHD service for adults	High Risk
3262	Community Paediatrics	30/09/2016	Clinical - Staffing levels	Long waiting lists following reduction in staffing levels	Extreme Risk
3301	Pharmacy	31/07/2016	Clinical - Medication/ Pharmaceutical	Medicines Management - Non-Compliance with Medicines Management standards	High Risk
3302	Pharmacy	29/07/2016	Clinical - Staffing levels	Pharmacy on call services	High Risk
3314	Neighbourhood Services - City	31/07/2016	Commissioning Risk	Lack of pathway for patients discharged from prisons	High Risk
3356	Neighbourhood Services - City	22/04/2016	Clinical risk - Other	Lack of parking for clinicians at base	High Risk
3385	Neighbourhood Services - City	30/04/2016	Clinical risk - Other	Waiting Times for Psychological Assessment and Intervention	High Risk
3386	Campus - Radbourne Unit	08/07/2016	Clinical - Staffing levels	Vacancies, reduced leadership, capacity for succession planning	Extreme Risk
3410	Campus - Radbourne Unit	03/10/2016	Clinical - Staffing levels	Vacancy levels above 30%	High Risk
20819	Neighbourhood Services - City	13/06/2016	Operational - Business Continuity	Waiting lists for assessment and interventions	High Risk
20844	Pharmacy	31/08/2016	Clinical - Medication/ Pharmaceutical	Lack of Facilities to Assure Compliance with Medicines Management Standards - Clinical Areas (Trust-Wide)	High Risk
20857	Neighbourhood Services - North	31/07/2016	Clinical risk - Other	Transfer of patients through the change in neighbourhood boundaries	High Risk
20867	Learning Disabilities Services	07/09/2016	Clinical - Therapeutic activity	Lengthy waiting times for psychological involvement	High Risk
20871	Neighbourhood Services - City	29/07/2016	Clinical - Staffing levels	Adult consultant psychiatrist vacancy	High Risk

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 27 July 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, including those that the Board has responsibility for oversight

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 July is the forth monthly 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.

Tasks Rag Rating	
Completed	57
On track	39
Some Issues	18
Off Track	9

Board Rag Rating	
Completed	4
On track	42
Some Issues	7
Off Track	0

The tables above provide an overview of the current status of RAG ratings for both specific tasks and overall Board assurance against each high level recommendation.

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 July, with significant progress

being made against a number of areas aligned to HR systems, processes and plans. This follows challenge from Board members at June's Board meeting regarding the number of red areas in the GIAP.

- The Quality Committee (June), and Remuneration Committee met after the paper deadline for the June's Board meeting therefore an update has been provided as part of this report

- The Quality Committee (July), People and Culture Committee, and Audit 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 progresses and in the updated RAG ratings sections in the GIAP.

To focus the Board's attention, a number of specific areas have been identified for discussion. These have been identified from the Board BRAG rating column.

Board RAG Rating - 'Some Issues'

- ***CorpG1, 2, 4,7 9 and 12*** *- Governance Framework review*

Mitigation – The Board is aware of, and agreed, that the final approval of the Corporate Governance Framework would take place at July's Trust Board meeting. Audit and Risk Committee has overseen the development of this framework and received it for approval on 19th July.

- ***WOD7*** *- The trust should monitor the adherence to the grievance, disciplinary, whistle-blowing policies and the current backlog of cases concluded.*

Mitigation – This recommendation remains as 'some issues' pending the outcome of an internal audit review of particular cases being addressed via these policies. It is expected that this audit reports formally to the lead Director in the next month.

Completed Actions - for Closure

- ***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.*

Key Performance Indicators

Board members agreed a final set of KPI's at its Board Development session on Wednesday 13th July. These are included with this report for formal Board approval and once approved will be presented each month.

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 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. Note the progress made against a number of specific HR and People related actions

2. Approve the revised KPI's

3. Approve the closure of recommendation FF1

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

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

6. Agree at the end of the Pubic Board meeting whether any further changes are required to the GIAP following presentation of papers, outcomes of item specific discussions and/or other assurances provided throughout the meeting

Report prepared by: **Jenna Davies (GIAP Programme Manager)**

Report presented by: **Mark Powell (Director of Strategic Development)**

	Issue Raised/ Action	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	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																		
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.				R25		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	1) Availability of competent staff in areas required within timeframe and budget 2) Acceptance and integration of additional staff into existing teams 3) Internal Process will have a negative impact of the timescales of recruitment to the interim roles 4) There is a risk that the Director of Workforce, OD and Culture will be unable to identify sufficiently experienced interims with the appropriate skills to undertake the roles 5) There is a risk that the high number of interims within the HR and OD team may cause further relationship issues 6) There is a risk that the high number of interims within the HR and OD team may lead to inconsistency and issues with sustainability.	1) Lack of extra external resource to support delivery of actions will significantly impact on successful delivery of the GIAP 2) Further Regulatory Action if there is not enough progress against the GIAP deliverables. 3) The resource plan approved resources for 6 months, there is a risk that lack of further resourcing will impact on the delivery and implementation of the GIAP Actions. 3) External and internal audit will be unable to provide assurance against the GIAP deliverables.	A resource plan will identify costs	Director of Workforce, OD and Culture	People and Culture Committee	20th 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, OD and Culture 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 would be appointed to, except 1, 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. 6) Following the request from P&CC, a revised HR resource plan was presented to, and agreed, by ELT on Monday 25th April. 7) 7 of the 8 posts will have been recruited and in post by the 31st May. the final one is currently out for advert which closes on the 10th May. 8) Two posts have been removed from the plan as they are considered BAU and are acting up positions. 4 of the 6 posts have currently been recruited to. Of the remaining 2 posts 1 will be recruited by the end of May and 1 will not. 9) At the June meeting of People and Culture Committee the Director of Workforce provided an update on the recruitment of the outstanding post. noting that the Trust had been out to advert twice and no candidate was appointed. Agency's have now been instructed and 9 CVs have been received, with 5 being identified for interview. 10. Management Trainer has now been recruited and will be in post on the 1st August 2016, a further resource plan is being presented to ELT.	1) Sickness absence rate (3.9%) 2) Vacancy rates (10%) 3) Staff appraisals (90%) 4) Staff turnover (10.45%) 5) Mandatory training (95%) 6) Agency spend (£3.03 Million) 7) HR policies in date (100%) 8) Time to recruitment 9) Headcount per employee	1) Positive assurance received from internal audit on a number of audits related to the delivery of the GIAP 2) Revised HR model in place 3) Approved of internal HR metrics in place 4) Approved set of organisational HR metrics in place 5) Integrated Performance report	On Track
							2) Deliver the Resource Plan	31st March 2016	Some Issues				Director of Workforce, OD and Culture	People and Culture Committee					

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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.				R27		1) In consultation with the team develop and deliver the new model for HR	30th June 2016	Off Track	1) Inability to deliver HR service model due to staff sickness and lack of engagement from existing staff 2) The high levels of interims in the HR department may decrease the level of engagement of permanent staff to adequately consult on the changes to the HR model	1) Function not 'fit for purpose' to support the organisation in delivery of the Trust strategy 2) Failure to integrate into wider Derbyshire system plans 3) HR function will not be sustainable moving forward	External support may be required on both the developmental and delivery stages	Director of Workforce, OD and Culture	People and Culture Committee	19th October 2016	1) A customer survey will be distributed to all Band 7's within the organisation week commencing 9th May. From the results and feedback of the survey the team will consider the HR model and areas of focus. In addition the team will also develop a customer charter and a service level agreement. 2) The customer survey was sent out to staff and closes on the 20th May. To date 50 responses have been received. 3) A paper setting out the new model for HR will be presented at June's P&CC 4) A revised HR model based on the one suggested by Deloitte was presented to the People and Culture in June. The Committee acknowledged the current capacity issues in HR and noted the progress but agreed that the proposal only gave partial assurance and that further detail about the model and how it would work in practice was required before the Committee could be assured. It was agreed that a further paper would be presented to the Committee which set out this detail. 5) A further paper was presented to People and Culture Committee in July. It was agreed that the HR model, structure and metrics were approved but would be refreshed as part of the STP.			On Track
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.				R28		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	Off Track	1) Inability to deliver HR service model due to staff sickness, lack of engagement and capacity 2) The high levels of interims in the HR department may decrease the level of engagement of permanent staff to adequately consult on the changes to the HR model 3) The high level of interims may cause confusion about the overall HR structure	1) Function not 'fit for purpose' and inefficient to support the organisation in delivery of the Trust strategy 2) The OD and HR functions will not be co-ordinated and not be able to deliver the necessary OD change.	External support may be required on both the developmental and delivery stages	Director of Workforce, OD and Culture	People and Culture Committee	19th October 2016	1) Work is currently underway to define a new structure of working which allows for further cohesion between the OD and HR functions. 2) There are no plans to change the HR structure in the short term. 3) A paper will be presented to People and Culture Committee on the 16th June 2016 4) A revised HR model based on the one suggested by Deloitte was presented to the People and Culture in June. The Committee acknowledged the current capacity issues in HR and noted the progress but agreed that the proposal only gave partial assurance and that further detail about the model and how it would work in practice was required before the Committee could be assured. It was agreed that a further paper would be presented to the Committee which set out this detail. The paper would include an outline of the SLA and customer charter. 5) A further paper was discussed and approved by the People and Culture Committee in July, with an agreement that the team would progress as quickly as possible to embed the new way of working			On Track
	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	Some Issues	1) Failure to recognise and accept the need to change by exciting teams 2) Failure to ensure capacity within the team to deliver the proposed actions 3) Failure to deliver an appropriate People Strategy will impact on the	1) Lack of focus in key areas, inefficient use of resources 2) Function not 'fit for purpose' and inefficient to support the organisation in delivery of the Trust strategy 3) The People Committee are unable to receive the appropriate		Director of Workforce, OD and Culture	People and Culture Committee		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			

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HR5					**R35**		2) Develop an internal suite of metrics to measure functional effectiveness	31st March 2016	**On Track**	4) Lack of partnership agreement with staff side, to deliver the People Strategy	assurance that the changes to the HR model are having the appropriate impact 4) The Board will not be sufficiently sighted on the on workforce improvements.	None Required	Director of Workforce, OD and Culture	People and Culture Committee	6th July 2016	assured by the proposed metrics and agreed that this was now back on 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 3) Metrics to be populated in May and adopted in June 4) Revised Metrics were presented to People and Culture on the 16th June, the people and Culture Committee agreed further work was required to define the KPIs based on the revised HR model and Structure 5) Revised Metrics were presented and approved by the People and Culture Committee in July.			**On Track**
	CORE 2- PEOPLE AND CULTURE																		
PC1	The Trust should adopt an Organisational Development and Workforce Committee	**HR 11.2 HR 11.4 HR 11.7 WL Q4**	**Gov2**				1) Terms of Reference Developed	29th January 2016	**Completed**	1) Failure of the People and Culture Committee to remain strategic and be well supported by functioning sub-groups will reduce its efficiency and ability to maintain oversight of the GIAP actions	1) Failure to ensure appropriate governance and accountability to deliver the People Strategy	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 sub groups were approved at P&CC 20.04.16	1) Improvement in monthly Pulse Check scores 2) People plan metrics to be reflected once agreed 3) A reduction in work based stress	1) people and Culture Committee minutes 2)Evidence of the delivery of the People plan 3) Audit assurance of the effectiveness of the People and Culture Committee 4) Evidence of the delivery of the Communications Plan	On Track
							2) Terms of Reference approved by Board	29th January 2016	**Completed**										
							3) First Committee meeting	17th February 2016	**Completed**										

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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.				R9		1) Develop a programme of work against the delivery of the people strategy	30th June 2016	off Track	1) Consultation fatigue and lack of belief that the organisation is willing and able to change. 2) Outcomes of the pulse checks are not adequately considered and change embedded. 3) Staff do not have the capacity to attend engagement events due to operational pressures, 4) Due to the high level of change on the organisation there is limited opportunity for innovation. 5) Due to capacity the team are unable to deliver the leadership development programme	1) Failure to articulate expected values and behaviours 2) Failure to engage staff impacting on productivity and patient care	Resources required to be identified within People plan.	Director of Workforce, OD and Culture	People and Culture Committee	17th 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 4) P&CC requested a fully detailed People Plan to be presented at its May meeting. This plan will outline a work programme which underpins this key recommendation 5) A survey has been distributed to all staff asking them if we should refresh the Trust Values, the feedback of the survey will be discussed at the Board Development Session 11th May 2016 6) The Survey results were discussed at the Board Development session and at People and Culture Committee in May. Based on the feedback from the survey and other feedback from engagement events, it has been agreed that the values will be refreshed and not rewritten as part of the new Trust Strategy. 7) Health and Well- Being events already happen within the organisation and a paper highlighting this will be presented to the Committee in June. A further comprehensive plan will be presented at the July Committee meeting which will align to the People Plan. 8) A revised People Plan was presented to the People and Culture Committee in June, unfortunately due to capacity linked to the CQC inspection the paper was only received by members on the day and therefore members did not gain assurance on the updated paper. The Committee requested, at its July meeting, a revised plan to be developed which would provide clarity on ownership of actions, clearly defined KPIs, timescales and deliverables. 9) A revised People plan was discussed and approved by the People and Culture Committee in July. The Committee noted that the committee agenda would now reflect the Plan. 10) A Paper outlining the engagement approach and plan was presented to the People and Culture Committee in July. The paper and the next steps were approved by the Committee			On track
							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	Off Track				Director of Workforce, OD and Culture						
							6) Develop and implement a leadership development programme	31st July 2016	On Track				Director of Workforce, OD and Culture						
	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	Completed	1. Capacity of the communications team to support the delivery of the plan 2. lack of mechanisms are in place to record and feedback to staff 3) lack of capacity within the OD and workforce function to support effective engagement	1. Failure to support the delivery of the Trust strategy 2. Failure to engage staff impacting on productivity and patient care		Director of Corporate Affairs	People and Culture Committee		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. 2) May's People and Culture Committee received an internal Comms plan. It was agreed that the plan would be further developed in line with the engagement plan and supported by the Engagement group of People and Culture. The Committee also requested further action and clarity on how staff feedback was going to be recorded and then how it could be used in a positive way. 3) At June's meeting of the People and			

	Issue Raised/ Action	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	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
PC3					R10		2) Develop a clear system to record feedback received from staff	31st May 2016	Off Track			Comms resource may be required	Director of Corporate Affairs	People and Culture Committee	8th June 2016	Culture Committee a revised report was presented which outlined the Comms approach to recording feedback. The Comms team have developed a SharePoint database which will be held on Connect. The database will be visible only to members of the communications and workforce teams and allow for a single system to be updated and maintained by both teams. The Committee noted the progress but it was agreed that the Engagement group would provide feedback to July's P&CC on how the feedback would be used. 4) A further paper detailing how feedback would be monitored was presented to the People and Culture Committee in July. It was noted that the system would be used by Comms and HR to log feedback from staff. The System would then be used to identify common themes and priority areas which would be monitored by the engagement group and reported to the P&CC on a quarterly basis.			On Track
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.				R26		1) Refresh People Strategy including reporting metrics	29th April 2016	Off Track	1) Capacity to deliver an agreed People Strategy 2) Lack of partnership agreement with staff side, to deliver the People Strategy 3) Delays in the development of the Trust strategy will impact on the development of the people strategy 4) The People plan lacks the required detail to deliver the required change. 5) The people plan is not aligned to the Trust Strategy	1) Failure to support the delivery of the Trust strategy 2) Failure to engage staff impacting on productivity and patient care 3) Failure to establish distributed leadership and detrimental impact on ED's	Identified within the resource plan	Director of Workforce, OD and Culture	People and Culture Committee	6th 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 May meeting for approval. 3) A revised people plan was discussed at the People and Culture Committee in May, it was agreed that there was limited assurance on the plan but agreed the principle actions. The Committee requested, at its June meeting, a revised plan to be developed which would provide clarity on ownership of actions, clearly defined KPIs, timescales and deliverables. 4) A revised People Plan was presented to the People and Culture Committee in June, unfortunately due to capacity linked to the CQC inspection the paper was only received by members on the day and therefore members did not gain assurance on the updated paper. The Committee requested, at its July meeting, a revised plan to be developed which would provide clarity on ownership of actions, clearly defined KPIs, timescales and deliverables. 5) A revised People plan was discussed and approved by the People and Culture Committee in July. The Committee noted that the committee agenda would now reflect the Plan.			On Track
							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					
	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	Completed	1) Failure to articulate expected values and behaviours	1) Failure to engage staff impacting on productivity and patient care 2) There is a risk that the pace required may impact on sustainable change 3) There is a risk in term of communications support due to capacity within the team.		Director of Workforce, OD and Culture	People and Culture Committee		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. 2) As part of the review of the Trust values the Director of workforce, OD, and Culture has delivered a podcast to staff explaining this specific part of the GIAP. This has been supplemented with a short organisational survey distributed via the intranet to seek staff's views on whether the current values are still valid, valid with small changes or whether a full re-write of them is required. 3) A Board discussion took place on the 27th April which focused on the feedback from the Board Development session and reflections on the Trust values. Board			

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PC5					R8		2) Set a programme of engagement with staff to consultant on the refresh of the values	31st May 2016	Completed			Investment in external consultants to support culture change programme	Director of Workforce, OD and Culture	People and Culture Committee	10th August 2016	members agreed to wait for feedback on the survey before agreeing next steps. 4) A survey has been distributed to all staff asking if we should refresh the Trust Values. Intranet survey results will be discussed at the Board Development Session 11th May 2016 5) The People and Culture Committee received positive assurance on the review of the Trust values and the approach taken to refresh the Trust values in the new Trust Strategy. 6) A further update was presented to the People and Culture Committee in June, noting that proactive Communication was underway, ensuring that the values are referenced in all communications. It was also noted that the Comms around the values was being aligned to the communications around the new Trust strategy. 7) A Paper outlining the engagement approach and plan was presented to the People and Culture Committee in July. The paper and the next steps were approved by the Committee			On track
							3) Ensure a comprehensive Comms plan in place to ensure values are visible across the Trust; and	30th June 2016	Completed				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	Some Issues				Director of Workforce, OD and Culture	People and Culture Committee					
	CORE 3 CLINICAL GOVERNANCE																		
ClinG1	Refresh the role of Quality Leadership Teams to increase their effectiveness as core quality governance forums.				R24		1) Agree and implement a QLT forward plan process to ensure all required papers are received at each meeting	30th April 2016	Completed	1) Clinicians will not deliver quality priorities 2) QLTs do not meet sufficiently in order to meet there TOR 3) QLTs do not receive the adequate level of support to enable them to be effective. 4) QLTs are not reporting to the appropriate operational group within the executive leadership governance structure	1) The Trust will not deliver the Quality Framework	Resource required to support time out days for QLT and CRG leadership teams	Director of Nursing	Quality Committee	6th October 2016	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 programme of work. 2) The Director of Nursing has met with the Chairs of the QLTs, and there are plans in place for further collective and individual development. 3) At a GIAP meeting the Director of Nursing requested support from Education to construct a 12 month development programme for Nurses and QLTs.	1) Trust Policies that are in date (100%) 2) Reduce the overall number of Trust policies (10%)	1) Revised Polices for Policies 2) Internal Assurance report on policy compliance 3) External Assurance report on effectiveness of QLTs 4) Quality Committee TOR 5) Policy dashboard in place and monitored through Board governance structures 6) External assurance received on the effectiveness of Quality Committee and its alignment to the Quality Strategy 7) Quality Sub group in place	On Track
							2) Develop and implement a standard escalation template to be used by QLT's	30th April 2016	Completed				Director of Nursing	Quality Committee					
							3) Review frequency of clinical reference groups so that QLTs are enabled to undertake their work as defined by TOR	30th April 2016	Completed				Director of Nursing	Quality Committee					
							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					
ClinG2	The Trust would benefit from a robust and thorough policy review programme.				R30		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	1) Inability to review and update policies with necessary pace due to capacity 2) Lack of partnership working with staff side may cause delays in approving and implementing HR policies 3) Failure to implement policies due to insufficient policy implementation processes.	1) Employees will not adhere to policies if there are too many or if there are not clear	Resource will be required to increase capacity within the risk management function	Director of Nursing	Audit and Risk Committee	10th 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 3) Policy tracker to be presented to the Audit Committee in July to provide assurance on the process 4) The Risk Manager has reviewed the number of Trust policies and benchmarked against other organisations. There is room to consolidate a number of policies but due to changes to professional clinical practice there are a number of new policies required.			On Track

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ClinG3	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.				R18		1) Board Development to focus on NED challenge of overdue actions and reports (see RR2)	31st March 2016	Completed	1) There is a risk that the Quality Committee agenda is to broad, and doesn't sufficiently focus on the delivery of the Quality Strategy 2) The quality TOR do not adequately reflect the quality strategy and priorities	1) Trust will not deliver Quality strategy and goals 2) The Board will not gain assurance from quality Committee 3) Non delivery of actions will result in the failure to achieve clinical quality standards required by our regulators which may lead to harm to service users and/or staff (BAF risk	Resource identified in Board Development RR2	Director of Corporate Affairs	Board of Directors	3rd November 2016	1)As part of the first task the Board Development programme was agreed at March Board meeting. This includes a session in June on holding to account 2) The Quality Committee approved the TOR at its meeting in May. Before this can be approved as completed there is requirement to ensure the agenda of Junes meeting is reflective of, and aligned to the Quality Strategy 3) The Agenda for the June meeting of the Quality Committee has been drafted to reflect the CQC domains and also align to the Quality Priorities. Further work is required to address the capacity of the Committee. 4) All Board Committee terms of reference have been reviewed and approved by their own Committee and will then be reviewed collectively by the Audit and Risk Committee.			On Track
							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 and Risk Committee					
							3) Introduce a Quality Governance Group that will report to Quality Committee	31st July 2016	Completed				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	Completed				Director of Nursing	Quality Committee					
	CORE 4; CORPORATE GOVERNANCE																		
CorpG1	The Trust should consider how its governance arrangements could better match its strategy and plans.	WL Q6	Gov1				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	1) There is a risk that the Board of Directors and Board Committees are not focused on the correct issues	1) Failure to deliver the Trust Strategy 2)Failure to receive assurance around strategy delivery 3) Increased bureaucracy within Organisation 4) Clinical disconnect from the Strategy 5) Failure to embed the Strategy 6) Capacity Issues within the current Board may impact on delivery of the Strategy	None Required	Director of Corporate Affairs	Board of Directors	29th 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 2) The Corporate Governance Framework has been discussed informally by ELT, and a Discussion Paper was presented to the Board Development Session 11 May 2016. From the feedback received from the Board Development session an updated Governance Framework is being presented to the Audit Committee and the Board for discussion.	1) 100% of Board Committee ToRs reviewed annually 2) 90% papers circulated 5 days prior to meeting 3) 80% of actions on the Integrated action matrix are on track 4) Each Board member will attend 80% of the Board Development programme 5) 100% of Board Members have undergone a 360 appraisal	1) Well led External review 2) Committee TOR 3) Completed actions matrix 4) Board Development programme agendas 5) 360 feedback reports and associated actions	Some Issues
CorpG2	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.				R14		1) Develop and approve a Corporate Governance Framework	31st May 2016	Some Issues	1) Failure to allocate sufficient resource to deliver this	1) Lack of clarity around roles may lead to failure to deliver key functions resulting in breach of regulatory conditions. 2) Clinical risk may increase due to lack of clinical ownership within governance structure. 3) Operational performance and operational performance assurance could deteriorate leading to a breach of regulatory or contractual requirements. 4) Inability to articulate corporate risks may lead to further breaches of statutory/ regulatory compliance targets	None required	Director of Corporate Affairs	Board of Directors	29th 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 2) The Corporate Governance Framework has been discussed informally by ELT, and a Discussion Paper was presented to the Board Development Session 11 May 2016. From the feedback received from the Board Development session an updated Governance Framework was presented to the Audit Committee and to the Board for discussion.			Some Issues

	Issue Raised/ Action	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	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

	Issue Raised/ Action	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	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
CorpG3	The Board and its committees need to have a greater focus on capturing, recording and holding to account for agreed actions.				R15		1) Board Development programme to be updated to include a session on holding to account which will include holding to account for agreed actions.	30th June 2016	Completed	1) Board development session does not take place in a timely manner	1) Increased risk of non delivery of Trust Strategy or contractual/regulatory requirements 2) Loss of confidence in the Trust Board by regulators and Stakeholders 3) Staff confidence in the Board will not improve	External Support needed in order to facilitate Board Development session	Director of Corporate Affairs	Audit and Risk Committee	14th July 2016	1) Board Development programme agreed at March Board meeting. This includes a session in June on holding to account. 2) The Corporate Governance Framework has been discussed informally by ELT, and a Discussion Paper was presented to the Board Development Session 11 May 2016. From the feedback received from the Board Development session an updated Governance Framework is being presented to the Audit Committee and Board for discussion. The Discussion paper also considers ED attendance, Minutes of committee meetings, and the action log process.			On Track
							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	Completed				Director of Corporate Affairs	Audit and Risk Committee					
CorpG4	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 -timely submission of papers and consistent use over cover sheets				R16		1) Undertake a comprehensive review of the Board Committee structures including TOR	31st May 2016	Completed	1) Capacity of NED's 2) Lack of clarity of attendance of Committees 3) Turnover of Board members	1) Board does not have sufficient capacity to service all committees 2) Appropriate assurance on performance, quality and finance is not able to be provided to the Board. 3) Lack of clarity may result in increased bureaucracy and reduced pace of action implementation.	None Required	Director of Corporate Affairs	Audit and Risk Committee	14th July 2016	1) ED attendance at Committees reviewed at ELT and will be reflected in revised TOR 2) 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 3) The Corporate Governance Framework has been discussed informally by ELT, and a Discussion Paper was presented to the Board Development Session 11 May 2016. From the feedback received from the Board Development session an updated Governance Framework is being presented to the Audit Committee and Board for discussion. The Discussion paper also considers ED attendance, Minutes of committee meetings, and the action log process. 4) The Board Committee structure has			Some Issues
							2) Arrange for Committee Chairs to meet on a quarterly basis	31st March 2016	Completed				Director of Corporate Affairs	Audit and Risk Committee					

	Issue Raised/ Action	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	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) Review ED attendance at Committees	27th January 2016	Completed				Director of Corporate Affairs	Audit and Risk Committee		been reviewed in the context of current priorities and following annual review of effectiveness of each Committee. It is proposed that arrangements for Board Committees be reviewed in 9 months (December 2016) to establish whether either of both of the Mental Health Act Committee and Safeguarding Committee may be incorporated into the work of the Quality Committee. Terms of reference for all Committees have been reviewed and aligned as far as possible. As part of the review, all terms of reference have been aligned for layout, consistency of content and all include reference to conducting a review of meeting effectiveness both at the end of each meeting and on an annual basis against the terms of reference. Each Committee will also produce a work plan which is laid out to illustrate how the remit, as specific by the terms of reference, will be covered in Committee business throughout the year. All Committees within their terms of reference are encouraged to refer issues between Board Committees where appropriate and to escalate items of both positive assurance and risk to the Trust Board			
							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	Completed				Director of Corporate Affairs	Audit and Risk Committee					
							5) Embed a process for the yearly review of the effectiveness of Board Committee against TOR	30th June 2016	Completed				Director of Corporate Affairs	Audit and Risk Committee					
CorpG5	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				R19		1)Undertake a comprehensive review of the Committee aligned to the TOR of the Committee	31st May 2016	Completed	1) Capacity of F&P Committee	1) Committee not able to meet requirements of ToR 2) Failure to provide assurance to Board 3) Key statutory reporting is not completed in a timely way	None Required	Director of Corporate Affairs	Audit and Risk Committee	14th July 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.			On Track
							2) Finance and Performance Forward Plan approved by F&P	31st May 2016	Completed				Director of Corporate Affairs	Audit and Risk Committee					
							3) Embed a process for the yearly review of the effectiveness of Board Committee against TOR	31st May 2016	Completed				Director of Corporate Affairs	Audit and Risk Committee					
CorpG6	The Audit Committee should reaffirm its role in seeking assurance over systems, controls and processes and not matters of operational or managerial detail.				R20		1) Ensure processes are in place for Audit Committee to undertake a review of its effectiveness	30th April 2016	Completed	1) Audit Committee agenda does not reflect TOR 2) Capacity of Audit Committee 3) NED Capacity	1) Inability to provide assurance to the Board 2) Failure to meet ToR	None Required	Director of Corporate Affairs	Audit and Risk Committee	27th April 2016	1) Committee Terms of Reference have been reviewed in line with Best Practice.			On Track
							2) Review reporting and monitoring process to ensure Audit Committee is receiving required assurance on systems, controls and processes	30th April 2016	Completed				Director of Corporate Affairs	Audit and Risk Committee					
							3) Review Audit committee TOR in line with best practice from across the NHS	30th April 2016	Completed				Director of Corporate Affairs	Audit and Risk Committee					

	Issue Raised/ Action	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	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
CorpG7	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.				R21		1) Aligned to the Corporate Governance Framework develop and approve an organisational accountability framework	30th June 2016	Some Issues	1) Capacity within teams and their ability to cope with competing priorities 2) Lack of clarity about the Executive Governance Structures 3) Senior leaders unable to engage due to capacity	1) Failure to deliver the Trusts Transformational change programme at the required pace. 2) Staff morale and engagement will reduce leading to a reduction in clinical quality. 3) Operational performance could reduce leading to failure to meet required contractual and regulatory outcomes.	None Required	Director of Operations	Audit and Risk Committee	19th July 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 2) The Corporate Governance Framework has been discussed informally by ELT, and a Discussion Paper was presented to the Board Development Session 11 May 2016. From the feedback received from the Board Development session an updated Governance Framework is being presented to the Audit Committee and Board for discussion.			Some Issues
							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 and Risk Committee					
CorpG8	The Board needs to introduce an integrated performance report which encompasses key operational, quality, workforce and finance metrics				R22		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	Completed	1) Lack of clear KPIs identified by Director leads 2) Issues with embedding the Quality Metrics into the integrated performance report will negatively impact the Boards ability to triangulate all organisational performance information and KPIs	1) Poor information leading to sub optimal decision making by the Board. 2) The Board not being sighted on key risks or poorly performing areas leading to delays in resolution. 3) Lack of clear KPIs for each section of the integrated performance report will result in trends not poor performance not being identified and improvements not monitored	None Required	Director of Operations	Board of Directors	25th 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 3) Quality Metrics were presented to Board as part of the Integrated performance report in April. It was agreed that further work would be undertaken to refine the metrics and would be included in the May report to the Board 4) A Local operating procedure is being drafted which outlines the process and responsibilities for the Integrated Performance report. It has been agreed as part of the development of the LOP that PCOG will take a formal role in pulling together all the relevant information and presenting to the relevant Directors for sign off.			On Track
	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	1) Lack of ED engagement in PCOG 2) Failure to clarify individual and collective roles within PCOG 3) Failure to clarify the role of PCOG within the executive governance structures 4) Failure to clarify the roles of PCOG and TOMM to avoid duplication 5) lack of clear escalation of operational issues from PCOG to the Board.	1) Performance and contract information is not able to be triangulated through the governance structure leading to increased risk of reduced quality, financial inefficiency or reduced operational performance.		Director of Operations	Audit and Risk Committee		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 4) PCOG has placed greater emphasis on its role in providing an oversight of performance and Contracting operational performance and issues. 5) The TOR of PCOG will be refreshed to place greater emphasis of the oversight of the Integrated performance report and to reflect attendance at the group. It has been agreed that not all ED need to be in attendance and deputies with operational oversight are better placed to be on the group, when the deputies are unable to attend the ED should attend in their place. 6) The TOR of TOMM will also be refreshed to ensure there is clarity of roles and responsibilities between the groups			
							2) Increasing ED attendance at PCOG	31st May 2016	Some Issues				Director of Operations	Audit and Risk Committee					

	Issue Raised/ Action	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	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
CorpG9					R23		3) Improving the quality of minutes and action trackers and the timeliness of papers to this forum.	31st May 2016	Some Issues			None Required	Director of Operations	Audit and Risk Committee	19th July 2016	7) Action tracker is now in place and is aligned to the minutes 8) The General Managers of Campus and Neighbourhoods form part of the membership of PCOG which provide oversight of the move to the Neighbourhood Model 9) The review of PCOG will now be aligned to the delivery of the Accountability Framework and will be delivered in July 2016			Some Issues
							4) Clarifying the role of PCOG in light of the move to neighbourhoods and campuses	31st July 2016	Some Issues				Director of Operations	Audit and Risk Committee					
CorpG11	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.				R3		1) Ensure a Board development programme which is linked to the Trust Strategy	31st March 2016	Completed	1) Failure of Board Members to engage with this change 2) Failure of the Board to be visible 3) Failure of the Board to gain adequate assurance.	1)The Board is not able to deliver the Organisational strategy 2)The Board breaches its regulatory requirements 3)The Board does not recognise and respond to increasing governance or clinical risks that are emerging	None Required	Director of Corporate Affairs	Board of Directors	1st April 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			On track
							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/ Nominations and Remuneration Committee (CoG)					
							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					
CorpG12	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.				R17		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	Some Issues	1. Failure to provide appropriate escalation processes to Board 2. inconsistent approach to summary reports fails to provide necessary assurance	1)There is a danger that key escalations from committees to board are missed resulting in increased clinical or organisational risk	None Required	Director of Corporate Affairs	Audit and Risk Committee	29th May 2016	1) Summary reports will be presented at the Board meeting in April 2) Summary reports from Board Committees were provided for April's Board meeting. It was agreed that further development and understanding of their purpose was required to ensure that they are an effective tool in the governance and assurance process. Board members agreed that there remained 'some issues' which required resolution for May's Board meeting.			Some Issues

	Issue Raised/ Action	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	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
CorpG13	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.	WL Q7	C1, C2 Gov7				Develop and Agree BAF 16/17	31st March 2016	Completed	1) None identified at this time	1) Board is not sufficiently aware of confidential risks	None Required	Director of Corporate Affairs	Audit and Risk Committee	31st March 2016	1) Board has agreed 16/17 BAF at march Board meeting 2) Board has agreed timetable for BAF deep dives 3) Once the new Trust Strategy has been formally approved, the BAF will need to be refreshed.			On Track
							Schedule BAF Deep dive reviews for Board Committees	31st March 2016	Completed				Director of Corporate Affairs					
CORE 5- COUNCIL OF GOVERNORS																			
CoG1	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.	WL Q3 WL Q4	Gov 4, Gov 5, Gov 6,			CQC 4- Should	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	Some Issues	1) The ongoing negative press and detail of the investigations may result in further distrust between the Board and Council of Governors 2) Turn over of Governors and Board Members will negatively impact on the relationship 3) Lack of clarity in relation to the role of SID	1) Failure to rebuild trust and confidence between the Board of Directors and CoG will impact on delivery of the Trust Strategy 2) Failure to progress the development of a positive and constructive relationship	None Required	Director of Corporate Affairs	Board of Directors & Council of Governors	1st April 2017	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 4) CoG is due to meet on the 1st June and will review tasks that it has oversight for. 5) Key principles and a draft policy has been identified from best practice for discussion at the next Governance Committee on 6 June. This encompasses arrangements already set in place including the twice yearly Council of Governors and Board session, the regular Non-Executive Director and Council of Governor sessions. Governors have also been invited to attend Board Committee meetings to observe the work of Committees and further understand the role and hold Non Executive Directors to account. 6) A proposal for an evaluation of the effectiveness of the Council of Governors has been drawn up and is to be discussed at the Governance Committee on 6 June 2016. Subject to discussion and approval, it is planned that this will be carried out in July 2016, the result reviewed by the Governance Committee and the findings used to develop an action plan for the governors to take forwards. 7) Revisions to the Code of Conduct have been discussed as part of the Governance Committee agenda on 12 April 2016 and 25 April 2016. A further draft has been circulated to governors prior to discussion at the Governance Committee meeting on 6 June 2016.	1) New Governors induction completed (100%) 2) 90% positive feedback received on the induction	1) Well led External review 2) Engagement Policy 3) Code of Conduct 4) Lead Governor role description	On Track
							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	Some Issues				Director of Corporate Affairs	Board of Directors & Council of Governors				

	Issue Raised/ Action	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	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
CoG2	**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		**Gov 4, Gov 5, Gov 6,**		R12	CQC 3- Should	1) Develop a new induction programme for the Council of Governors and roll out its delivery	31st May 2016	Completed	1) Governors will not hold NED's to account in an effective way 2) Governors may not be able allocate sufficient time to undertake induction and external training	1) Failure to rebuild trust and confidence between the Board of Directors and CoG will impact on delivery of the Trust Strategy 2) Failure to progress the development of a positive and constructive relationship 3) Failure to provide Governors with the necessary skills and knowledge for them to effectively discharge there duties	Requirement for external governance training	Director of Corporate Affairs	Council of Governors	1st April 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 4) CoG is due to meet on the 1st June and will review tasks that it has oversight for. 5) There is a planned induction event on 31 May to cover the areas of the role of governors, their context within the organisation and personal conduct as outlined by the Code of Conduct. The Chair, chief executive and wider Board members will attend and present at the event. New governors are invited to attend along with existing governors to refresh knowledge and to meet new governors. Those new governors who are unable to attend the session will have a bespoke 1:1 induction session with the Director of Corporate Affairs. 6) At the Council of Governors meeting on the 1st June 2016, the Governors confirmed that the actions were complete. All but one new Governor undertook induction on the 1st June 2016, the remaining Governor will undertake a one to one induction with the Director of Corporate affairs on the 22nd June 2016.			On Track
							2) Develop a CoG development plan for 2016/17 to include Governwell and other external training	30th April 2016	Completed				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					
CoG3	Prioritise the recruitment to the Council of Governors, ensuring that the role of the governor and vacancies are publicised.				R12		1) Chairman will engage stakeholders to ensure representation on the Council of Governors	31st May 2016	Completed	1) Incomplete CoG impacting on its effectiveness 2) Failure to ensure a Broad range of experience on the Council of Governors	1) Carrying vacancies will add additional pressure to existing Governors, who may resign due to capacity	Electoral reform services will manage the Governor Elections	Director of Corporate Affairs	Council of Governors	21st July 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: 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)			On Track
							2) Hold Governor elections	31st May 2016	Completed				Director of Corporate Affairs	Council of Governors	22nd July 2016				

	Issue Raised/ Action	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	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 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				R4		1) Develop and approve Board level, key divisional and corporate leaders succession plan	30th September 2016	On Track	1)Inability to identify key components of the succession plan 2) Due to sickness and vacancies may not adequately succession plan	1) Trust performance could deteriorate due to capacity and single points of failure 2) Risk to Business continuity	None Required	Director of Workforce, OD and Culture	Rem Com	1st April 2017		1) Each Board member has attended 80% of the Board Development programme 2) 100% of Board Members have undergone a 360 appraisal 3) Exec Directors have attended at least 80% of the executive development sessions 4) All Directors 100% compliance with their training requirements	1) Board Development programme agendas 2) 360 feedback reports and associated actions 3) Succession plans 4) Well led External review 5) Board Effectiveness Review	On Track
							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)	**WL Q2 WL Q3 HR Q11**	**G1, G2a**		R5	CQC 3- Should	1) Develop a Board Development plan for 2016/17	31st March 2016	Completed	1) Conflicting Priorities 2) Availability of external presenters 3) Perception of Value of the delivery of the Board Development Plan	1) Failure to develop as a Unitary Board which will impact on delivery of strategy 2) Failure to effectively challenge will impact on Board accountability and decision making 3) Non Achievement of development objectives	External resource will be required to facilitate Board Effectiveness sessions	Director of Corporate Affairs	Board of Directors	1st April 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 3) Board Development holding to account sessions planned for 15th June			On Track
							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.				R6	CQC 8- Should	1) Develop a 360 feedback process for BM's with forms and expectations on what and how to feedback	30th June 2016	On Track	1) Failure to provide clarity over Director portfolios 2) Failure to identify development needs of Directors which may impact on individual and collective performance 3) Failure of Directors to understand the role of Corporate Directors.	1) Capacity staff do not have the capacity to complete multiple 360 feedback forms 2) Capacity of Managers to effectively analyse the feedback required	Support required from external organisations	Director of Workforce, OD and Culture	Rem Com/ Nominations and Remuneration Committee (CoG)	1st April 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 5) 360 feedback has been completed for 3 NEDs and 1 ED 6) A paper detailing the process for 360 feedback for senior managers will be presented to the People and Culture Committee in June (this paper was not provided and will need to be provided at July's meeting)			On Track
							2) Implement 360 degree feedback for all BM's	30th September 2016	On Track				Director of Workforce, OD and Culture	Rem Com/ Nominations and Remuneration Committee (CoG)					
							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/ Nominations and Remuneration Committee (CoG)					
							4) Implement 360 degree feedback for all senior managers	31st March 2017	On Track				Director of Workforce, OD and Culture	Rem Com					
							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.				R1		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	Completed	1) Conflicting Priorities and capacity within the Executive team may impact on the availability of Directors to attend Exec Development Sessions 2) Availability of external presenters 3) Perception of Value of the delivery of the ELT Development Plan	1) Failure to work cohesively as a team which will impact on performance	Support required from external organisations	Acting Chief Executive	Rem Com	1st April 2017	1) A paper setting out an ELT development programme will be presented the Remuneration Committee on 27.04.16 for consideration and approval			On Track
							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.				R5	CQC 7- Should	1) Training requirement for all ED's and NEDS are agreed by CEO and Chair, with passports updated accordingly	30th June 2016	On Track	1) Failure to ensure Directors have the required knowledge and skills to undertake their roles 2) Failure to identify the training requirements for individual directors based on individual roles,	1) Failure to continually develop will impact on Board performance 2) BMs ability to challenge may be impacted without the appropriate training and knowledge	Resource may be required for individual development	Acting Chief Executive / Chairman	Rem Com	5th October 2016	1) An assurance paper will be presented to the Remuneration Committee in October			On Track
							2) Developmental training requirements are discussed and agreed with Board members in their Appraisals	31st May 2016	Completed				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					

	Issue Raised/ Action	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	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 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	HR Q11			R34	CQC 1- Must	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	1) Failure to identify capacity to review HR policies 2) Failure of JNCC to approve policies in a timely manner 3) Failure to have robust HR leadership to support this work 4) Failure to effectively monitor adherence to HR policies 5) Failure to effectively implement and train staff on HR policies	1) If HR policies are not followed this will continue negative impact on Governance systems of assurance 2) There will be further Employment Relationship issues if managers fail to follow policies 3) Ongoing issues with the HR department may impact on staff morale 4) negative impact of the ET and enforcement action may impact on recruitment and retention	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	18th January 2017	1) Principal ER manager role has been advertised and is due to close on the 27th April. Post appointed to. 2) Director of Workforce, OD and Culture is meeting with internal audit week commencing the 9th May. It will be suggested that Internal Audit should review the Disciplinary and Health Attendance Policies 3) Internal audit scope being agreed to audit specific policy compliance 4) A timeline is in place to ensure all HR policies are reviewed by the end of September. 5) The People and Culture Committee were made aware that the HR team had not had chance to audit 2 policies. The Committee therefore agreed that the HR team will Audit the Acting up Policy and the professional registration policy, a report on the outcome will be presented to the Committee in July. 6) P&CC received 2 policy audits at its July meeting. Professional registration was approved, but further work was required on the acting up policy. A 1 week turnaround was agreed to address these issues.	1) Compliance with Mandatory Training (90%) 2) Improvement in the following areas of the staff survey KF 14, KF 27, KF 15, KF 21 3) 90% of Managers trained on HR policies before 31st December 4) Improvement in monthly Pulse Check scores 5) Managers completing Grievance, Disciplinary, and Whistleblowing policies training (85%)	1) Integrated Performance report 2) HR SLA delivery 3) Board and Committee minutes	On track
							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	Off 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 and Risk Committee					
WOD2	The trust should ensure that recruitment processes for all staff are transparent, open & adhere to relevant trust policies					CQC 9- Should	1) Review and ensure that Trust recruitment and acting up policies are fit for purpose	30th June 2016	Off track	1) Failure to identify capacity to review HR policies 2) Failure of JNCC to approve policies in a timely manner 3) Failure to have robust HR leadership to support this work 4)Failure to release managers to attend training	1) Inconsistency of recruitment process leading to challenge and litigation. 2) Failure to recruit competent and capable staff	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	15th July 2016	1) An audit of the recruitment processes took place in 2015 which only identified one area of low risk. This is to be considered as part of the wider HR policy review which will take place before September 2016 2) The People and Culture Committee were made aware that the HR team had not had chance to audit the acting up or recruitment policies. The Committee therefore agreed that the Acting up and Recruitment Policies would be audited for July's meeting. 3) A peer audit of the acting up policy was presented to the People and Culture Committee in July together with a revised policy. The Committee noted the recommendations within the audit and it was agreed that the revised policy be approved through JCNC.			On Track
							2) Agree a plan and deliver recruitment training to all appointing officers	31st March 2017	On Track				Director of Workforce, OD and Culture	People and Culture Committee					
							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					

	Issue Raised/ Action	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	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
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.				R29		1) Develop and implement a HR and related function Development programme, which includes building good working relationships	31st May 2016	Completed	1) Staff groups choose not to engage in the development process 2) Inconsistency of policy application leading to Employment Relation issues	1) Inability to deliver an effective HR service into the organisation presenting significant organisational risk	External resource and support required	Director of Workforce, OD and Culture	People and Culture Committee	15th March 2017	1) A high-level paper outlining the development for the HR team will be presented to the P&C committee in May 2) A Paper was delivered to People and Culture in may which outlined the approach and broad areas of development for the HR team.			On Track
							2) Implement Development Programme	31st May 2016	Completed				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.				R31		1) A training programme on HR policies and process is designed, available and accessible	31st December 2016	On Track	1) Capacity of managers to be released in order to attend training	1) Inconsistency of recruitment process leading to challenge and litigation. 2) Failure to recruit competent and capable staff	Additional capacity to develop core management training is required	Director of Workforce, OD and Culture	People and Culture Committee	15th January	The Post of Management Trainer has been advertised			On Track
WOD5	Consider a range of development interventions for the operational HR team to ensure employment law risks are mitigated.				R32		1) As part of the wider HR development programme (WOD 3) deliver specific interventions on employment law	30th September 2016	On Track	1) Inability to deliver team development programme 2) Failure to identify the risks associated with potential ETs 3) Failure to escalate risk relating to ETs	1) Failure to have the required knowledge and skills in the HR team	Specialist HR Employment law specialist request	Director of Workforce, OD and Culture	People and Culture Committee	19th October 2016				On Track
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				R33		1) Introduce a monthly pulse check for the HR team	31st May 2016	Completed	1) Failure to improve culture and behaviours 2) Members of the function will not accept joint team meetings 3) Effective management of HR ineffective due to interim arrangements	1) Failure to deliver an effective HR function 2) Failure to provide HR support to managers across the organisation may result in further employee relations issues	None required	Director of Workforce, OD and Culture	People and Culture Committee	17th July 2017	1) At the HR team meeting it was agreed to use emoji's as a pulse check for the team. The Process will be outlined to the People and Culture Committee verbally at its meeting in May 2) A Paper was delivered to People and Culture in May which outlined the approach and broad areas of development for the HR team. 3) A verbal update was delivered to the People and Culture Committee. it was noted that both teams have agreed in principle to an integrated team meeting, it was highlighted that there are delays in progressing this due to internal issues which are outside of the control of the Director of HR.			On Track
							2) Integrated Team meeting implement	30th June 2016	Some Issues				Director of Workforce, OD and Culture	People and Culture Committee					

	Issue Raised/ Action	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	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
WOD7	The trust should monitor the adherence to the grievance, disciplinary, whistle-blowing policies and the current backlog of cases concluded.					CQC 6- Should	1) Implement a proactive system which monitors adherence to the grievance, disciplinary, whistle-blowing policies, including a robust case tracking system.	31st May 2016	Some Issues	1) Failure to review the policies will result in further backlog of cases 2) Failure to deliver Speak up action plan at the required pace will lead to staff unable to raise issues 3) Lack of visibility of senior HR leaders 4) Failure to effectively Monitor adherence to HR policies 5) Failure to ensure backlog of cases are completed due to delays in the process outside of the Trusts control.	1) Failure to deliver effective HR process could lead to reduced staff morale	Resource Plan	Director of Workforce, OD and Culture	People and Culture Committee	19th October 2016	1) the Director of Workforce, OD and Culture 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. 2) Internal Audit scoping meeting to take place on 12th may 3) Case tracker to be presented at the People and Culture Committee in May 4) The People and Culture Committee understood the tracking system, but the committee were not assured that adherence to the policy was being monitored through the process outlined. 5) In order to provide assurance it has been agreed to internally audit the case tracker. The scope is currently being developed with internal audit team. 6) An update was provided to the People and Culture Committee in June. the Director of Workforce and OD noted that the Audit of the policies and the case tracker was underway and she is due to meet internal audit on the 5th July 2016 to review the feedback from the Audit. In addition work was underway to review a number of cases and implement a lessons learnt approach to cases. Work is also underway to align whistleblowing cases to the HR tracker. 7) The Director of Workforce, OD and Culture noted that the backlog of cases had not been completed, noting that CQC spent a day in HR reviewing the current cases. As part of the CQC interview the Director of Workforce, OD and Culture explained the delays and mitigations relating to the outstanding cases.			Some Issues
							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 and Risk Committee					
							3) Ensure the backlog of cases made known to the CQC at the time of the inspection are concluded.	30th June 2016	Some Issues				Director of Workforce, OD and Culture	People and Culture Committee					
WOD8	The trust should continue to make improvements in staff engagement and communication					CQC 11- Should	1) Develop a clear staff engagement plan that takes account of listen, learn	30th June 2016	On Track	1) lack of clarity around the ownership of engagement actions 2) Capacity of the Comms team to effectively support the engagement plan 3) Failure to align the engagement plan to the people plan.	1. Failure to articulate expected values and behaviours 2. Failure to engage staff which will have a negative impact productivity and patient care 3. Failure of the Board and Senior Managers to be visible 4. Failure of JCNCC to approve policies 5. Failure to articulate outcome measures for the delivery of the engagement plan	1) Resource may be required for Pulse Check	Director of Workforce, OD and Culture	Board of Directors	1st April 2017	1) Director of Workforce and OD to meet with Director of Corporate Affairs to discuss the engagement plan			On Track
							2) Publish and implement agreed engagement plan	31st December 2016	On Track				Director of Workforce, OD and Culture	People and Culture Committee					
							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					

	Issue Raised/ Action	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	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 8- RAISING CONCERNS AT WORK																		
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	WL 3 WL 2					1) Freedom to speak up action plan will be refreshed and approved	31st March 2016	**Completed**	1) Capacity within teams and their ability to cope with competing priorities 2) Failure to deliver the freedom to speak up action plan due to capacity 3) Failure to identify the necessary leads to deliver the action plan	1) Action plan will not deliver culture change required		~~Director of Workforce, OD and Culture~~ Director of Corporate Affairs	People and Culture Committee	1st April 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. 5) The People and Culture Committee considered a revised plan in May, the Committee received limited assurance on the plan and noted that there was a lack of clarity around role and responsibility / training / support for Speak up Guardian/NED lead. It was also noted that there should be engagement from staff and staff side on the plan. It was agreed that the Director of Corporate Affairs would present a clearer plan to the June Committee meeting. 6) The Committee received an updated Freedom to speak up / Raising Concerns action plan, which had been updated in line with comments received the previous month by the Committee. The Committee received positive assurance and agreed that the plan would be added to the committees forward plan for quarterly updates.	1) 95% of Managers have completed whistleblowing training 2) 100% compliance against the whistleblowing policy 3) Improvements in the following staff survey results a) Q13b improve the score from 67% to 71% b) Q13c improve the score from 52% to 59%	1) Refreshed raising concerns at work policy and process approved by Board 2) Freedom to Speak up action plan delivered 3) Internal Audit to provide assurance on compliance with the Whistleblowing policy	**On Track**
							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~~ Director of Corporate Affairs	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.					CQC 2 must	1) Develop fit and proper persons policy and have it ratified by Board of Directors	24th February 2016	**Completed**	1) Delays in receiving clear DBS checks	1) Failure to fulfil a statutory requirement 2) Failure of the Fit and Proper person process may result in Directors not undergoing to necessary checks	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) P&CC received a verbal update from the Director of Corporate Affairs on the monitoring and filing system for Fit and Proper Persons information for each Director. The Committee were assured that it was in place and recognised that the Board of Directors would receive a full compliance declaration at its May meeting. 4) A paper will be presented to Board in May by the Chairman in which he will declare that all Directors are fully compliant 5) At the May board meeting the Chairman confirmed that all directors were fit and proper and he had been assured by the necessary paper work.	1) 100% of Directors are fully compliant with the Fit and Proper person test 2) 100% of Directors personal files evidence fit and proper persons requirements	1) Board Minutes 2) Fit and Proper person evidence files	**On Track**
							2) Ensure that HR maintain the Fit and Proper Persons tracker	30th April 2016	**Completed**				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	**Completed**				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	**Completed**				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	**Completed**				Chairman	Board of Directors					

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CORE 10- CQC																			
CQC1	The trust should ensure that the outcome of this focussed inspection impacts directly upon the organisational strategy					CQC 5- Should	1) The CQC targeted report is used as a key guide in Trust strategy development days	30th June 2016	**Completed**	No significant risks identified	1) Failure to develop a new Strategy which supports cultural change	None Required	Director of Business Development	Board of Directors	29th June 2016	1) During its development the new Trust Strategy has considered the outcome of the CQC inspection as part of the development of strategic priorities, particularly with reference to 'our people'	1) Reduction in t vacancy rate to 10% (16.24% March) 2) Increase the recruitment to operational Vacancies as per recruitment trajectory		On Track
CQC2	The trust should continue to proactively recruit staff to fill operational vacancies.					CQC 10- Should	1) Develop and agree a proactive operational recruitment plan, including in reach to the local University and wider health community	30th April 2016	**Completed**	1) Lack of capacity and capability in the HR team in order to support operational Staff 2) there is a risk that recruiting managers do not follow policies 3) Inadequate supply of experienced staff 4) Poor retention levels of staff 5) Regulatory action has a negative impact on recruitment and retention	1) Failure to recruit could impact on patient safety 2) Staff confidence in the Board will not improve 3) Sustainability of workforce	None Required	Director of Operations	People and Culture Committee	18th January 2017	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. 2) Confirmation was sent to Committee members to confirm that HR had the capacity to deliver plan in the timeframes suggested. This action has now been completed 3) People and Culture Committee in May received an updated recruitment plan. The Committee were assured by the paper and the suggested trajectory. It was agreed that an update paper would be provided to the September meeting of P&C and the Trajectory would be added to the GIAP KPIs 4) The recruitment plan was discussed at the people and culture Committee in June, it was agreed that a progress update would be provided to the meeting in July			**On track**
							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 Committee					
							3) Develop and implement an internal communications plan which supports pro-active recruitment	31st May 2016	**Completed**				Director of Corporate Affairs	People and Culture Committee					
	CORE 11- MONITOR ENFORCEMENT UNDERTAKINGS																		
M1	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; •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		X		**R13**	X	1) Governance Improvement Action plan approved by Board of Directors	30th March 2016	**Completed**	1) Failure to create sufficient capacity within the key group of officers responsible for delivering the Plan 2) do not adhere to the roles and responsibilities set out in the governance arrangements of the improvement plan 3)The roles and responsibilities relating to programme governance are not understood 4) Executive Team focus on what is urgent rather than what is important, inability to prioritise	1) Risk of further enforcement action 2) Risk to the viability of the organisation 3) Risk of reputational damage	Programme Manager to be appointed PMO admin support appointed responsible Director identified	Responsible Director	Board of Directors	31st March 2017	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) 80% of Actions are on Track or Completed 2) 80% of rag ratings in the Board Assurance Colum are on Track or Completed 3) 80% of deliverables are presented to committees within timeframes 4) 80% of risks identified are scored as 15 or below (after mitigation)	1) External assurance reports on the GIAP and governance Framework 2) Enforcement notice removed 3) External well led governance review 4) Board minutes	On Track
							2) GIAP and Governance and Delivery Framework sent to Monitor	18th March 2016	**Completed**				Responsible Director	Board of Directors					
							3) Governance and Delivery Framework developed and approved	30th March 2016	**Completed**				Responsible Director	Board of Directors					
							4) Governance Action plan delivered	31st March 2017	**On Track**				Responsible Director	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**	1) Failure to gain external assurance in a timely manner	1) Failure to deliver enforcement undertakings 2) Failure to provide assurance to regulators may result Further Regulatory action	External Assurance from professional service consultancy e.g. Deloitte resource will be required	Acting Chief Executive	Board of Directors	31st March 2017	1) A scope of work is being agreed with internal auditors to provide assurance in a number of specific areas of the plan.	1) External assurance process undertaken in a timely manner	1) External positive assurance report	On Track

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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**	1) Failure to allocate sufficient resources	1) Failure to deliver enforcement undertakings	None Required	Acting Chief Executive	Board of Directors	31st March 2017	1) April and May reports provided to NHSI and CQC	1) Positive Formal correspondence with monitor on the delivery of the plan 2) Positive and credible relationship with Monitor	1) Enforcement notice removed	On Track

Core 1 - HR and Associated Functions	target	Monthly rolling/Annual	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Documentary evidence of demonstrable outcomes	Comments
1) Sickness absence rate	5.04%	Monthly	5.50%	6.20%	5.04%	5.04%	5.04%	5.04%	5.04%	5.04%	5.04%	5.04%	5.04%	1) Positive assurance received from internal audit on a number of audits related to the delivery of the GIAP 2) Revised HR model in place 3) HR team metrics in place with evidence of improvement 4) Improvement in organisational HR metrics evidenced through Integrated Performance report 5) Trust Board minutes 6) P&CC minutes	1) The first 5 metrics and the associated targets are taken from the Trusts integrated performance report. 2) From notice given to appointee in post measure will be complete once the information is available. 3) The Trust annual sickness absence rate reflects the East Midlands average
2) Vacancy rates	10%	Monthly	17.30%	17.48%	15.76%	14.99%	14.22%	13.45%	12.68%	11.91%	11.14%	10.37%	10%		
3) Staff appraisals	90%	Monthly	69.59%	71.29%	72.52%	74.72%	76.92%	79.12%	81.32%	83.52%	85.72%	87.92%	90.12%		
4) Staff turnover	10.00%	Monthly	10.44%	10.86%	10.34%	10.30%	10.26%	10.22%	10.18%	10.14%	10.1%	10.6%	10%		
5) Mandatory training	90%	Monthly	90.87%	90.49%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90%		
6) Agency spend £	3million	rolling		1,350,000	1,740,000	1,910,000	2,080,000	2,250,000	2,420,000	2,590,000	2,760,000	2,930,000	2,999,999		
7) From notice given to	TBC	Monthly													
Core 2 - People and Culture															
1) Improvement in Pulse Check scores	TBC	Quarterly												1) P&CC minutes 2) Evidence of the delivery of the People plan 3) External assurance of the effectiveness of the People and Culture Committee 4) Evidence of the delivery of the Communications Plan	1) We are currently using the Friends and Family test to track improvements in this area. This KPI specifically relates to the question "would you recommend the Trust as a place to work".
2) Staff Friends and Family Test	62%	Quarterly	38%	x	x	x	50%	x	x	x	62%	x	x		
Core 3 - Clinical Governance															
1) Trust Policies that are in date	95%	Monthly	99%	99%	95%	95%	95%	95%	95%	95%	95%	95%	95%	1) Revised Policy for Policies 2) Internal Assurance report on policy compliance 3) External Assurance report on effectiveness of QLTs 4) Quality Committee TOR	
Core 4 - Corporate															
1) 100% of Board Committee ToRs reviewed annually	100%	Annual	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	1) Well led External review 2) Committee's TOR 3) Completed actions matrix 4) Board Development programme agendas 5) 360 feedback reports and associated actions	1) All the terms of reference for each Board Committee have been reviewed and a further review is due to take place in December 2) The second metric relating to the circulation of papers, is based on the monthly cycle of meetings and when the papers are distributed. Some months there are less meetings than others. 3) The action matrix figure is based on the action matrix which is circulated to the respective Board Committee meetings on a monthly basis
2) 90% papers circulated 5 days prior to meeting (unless the Chair has agreed that a	90%	Monthly	71%	71%	75%	77%	79%	81%	83%	85%	87%	89%	91%		
3) 80% of actions on the Integrated action matrix are on track or completed	80%	Monthly	65%	75%	68%	69.5%	71%	72.5%	74%	75.5%	77%	78.50%	80%		
Core 5 - Council of Governors															
1) All new Governors completed induction within three months of starting in post	100%	rolling	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	1) Well led External review 2) Engagement Policy 3) Code of Conduct 4) Lead Governor role description	
Core 6 - Role &															
1) Each Board member has attended 75% of the Board Development programme	75%	Rolling	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	1) Board Development programme agendas 2) 360 feedback reports and associated actions 3) Succession plans 4) Well led External review 5) Board Effectiveness Review	1) Board member attendance at Board Development will be measured on a rolling basis.
2) 100% of Board Members	100%	Annual	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%		
3) Exec Directors have attended at least 75% of the	75%	Monthly	75%	75%	76%	76.5%	77%	77.5%	78	78.5%	79%	79.5%	80%		
4) All Directors 100%	90%	Monthly	74%	76.5%	79%	81.5%	84%	86.5%	89%	91.5%	94%	96.50%	100%		
Core 7 - Workforce and OD															
1) Improvement of KF 27- % reporting most recent experience of harassment, bullying or abuse	47	Annual	57	x	x	x	x	x	x	x	x	x	57	1) Board and Committee minutes 2) HR SLA delivery 3) Staff Survey	
2) KF 21% believing the organisation provides equal	89%	Annual	84%	x	x	x	x	x	x	x	x	x	89%		
3) 90% of Managers trained on HR policies before 31st	90%	Monthly								90%					
Core 8 - Raising Concerns															
1) 100% compliance against	100%	6 month												1) Raising Concerns policy 2) Freedom to Speak up / Raising concerns action plan 3) Internal Audit assurance on compliance with the Raising Concerns policy	
2) Improve scores in staff survey score Q13a- % saying if	96%	Annual	98%	x	x	x	x	x	x	x	x	x	98%		
3) Improve scores in staff survey score Q13b- "I would	71%	Annual	67%	x	x	x	x	x	x	x	x	x	71%		
4) Improvement in score against Q13c "I am confident	59%	Annual	52%	x	x	x	x	x	x	x	x	x	59%		
Core 9 -Fit and Proper person															
1) All Directors are fully	100%	Annual	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	1) Board Minutes 2) Fit and Proper person evidence files	
2) 100% of Directors personal files evidence fit and proper	100%	Annual	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Core 11 - NHS improvement															
1) 80% of BRAG ratings are on Track or Completed	80%	Monthly	77%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	1) External assurance reports on the GIAP and governance Framework 2) Enforcement notice removed 3) External well led governance review 4) Board minutes	

Derbyshire Healthcare NHS Foundation Trust
Report to Public Trust Board 27 July 2016

Governance Improvement Action Plan (GIAP)

Actions relating to the Corporate Governance Framework

Purpose of Report:

To present the revised Corporate Governance Framework to the Public Trust Board and confirm completion of related requirements within the Governance Improvement Action Plan.

Executive Summary

- There are several interrelated actions within the GIAP which require the Trust's Corporate Governance Framework and accompanying documents to be refreshed and updated to ensure robust governance arrangements are embedded within the organisation.
- As previously reported to the Board as part regular GIAP reporting, it was flagged at an early stage that the timeline outlined for completion of the tasks to redevelop the Corporate Governance Framework were not feasible due in part to the required sign-offs from Board Committees for their individual terms of reference. A revised timeline was agreed as 27 July 2016 for presentation of the Corporate Governance Framework to the Board.
- Details of the proposed nature of the review and timeline for interrelated sign-offs by Board Committees was discussed at the Board Development Session on 11 May 2016 and the updates and responses to the various GIAP actions were considered and additional comments to the draft framework documents were noted and incorporated.
- The Audit and Risk Committee, as the Committee with the role of overseeing the GIAP actions relating to the Corporate Governance Framework, considered a draft update at the Audit and Risk Committee on 24 May and recommended the Framework for approval to the Trust Board following review of a further draft at the Committee meeting on 19 July 2016.

Strategic considerations

- The Corporate Governance Framework is an essential document for the Trust which outlines the decision making and assurance arrangements for the Trust to effectively delivery its Strategy. Review of the Corporate Governance Framework is a requirement outlined in the Governance Improvement Action plan.
- The Corporate Governance Framework as presented represents the Board level governance and assurance structures. Following this, there are plans to confirm governance and assurance structures throughout the organisation, and to develop

a clear accountability framework for communication and implementation throughout the Trust.

Board Assurances

- The Committee can receive assurance from the updates provided on the GIAP actions as outlined.

Consultation

- Following the advisory internal audit undertaken by PWC during 2014 on the Trust's governance framework a piece of work was undertaken during 2014/15 to review the existing governance framework. This was developed with the involvement of several Board members and was presented in draft form to the Board of Directors on 29 April 2015. The framework was not approved at this time, pending a further review of governance arrangements and the subsequent review of Trust governance arrangements led by Deloitte LLP undertaken in the latter part of 2015.

- Recommendations arising from the Deloitte review relating to the Corporate Governance Framework are incorporated in the Trust's GIAP as part of a wider programme of actions. The actions relating to the Framework are assigned to the Audit and Risk Committee for review of progress, and assurance on delivery and outcomes. The draft Framework was discussed at the Audit and Risk Committee on 24 May 2016 and it was confirmed that GIAP tasks CorpG4 (2), CorpG4 (4) and CorpG4 (5) were complete. The Committee reviewed and approved a final draft, subject to minor amendments at their meeting on 19 July.

- The updates on the actions relating to the Framework were discussed at the Board Development Session on 11 May and Board meeting on 27 May 2016.

Governance or Legal Issues

- The Corporate Governance Framework is an essential document for the Trust which outlines the decision making and assurance arrangements for the Trust to effectively delivery its Strategy. Review of the Corporate Governance Framework is a requirement outlined in the Governance Improvement Action plan.

Equality Delivery System

- None

Recommendations

The Board is requested to:

1) Receive and ratify the Corporate Governance Framework for implementation throughout the Trust.
2) Agree that the GIAP actions outlined are now complete: CorpG1 (1), ClinG3 (2) and CorpG4 (1).

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

GIAP Actions relating to Corporate Governance Framework:

The actions outlined in the Trust's Governance Improvement Action plan require that:

CorpG1: The Trust should consider how its governance arrangements could better match its strategy and plans.

Key tasks identified to address the action as outlined are as follows, with progress and response outlined:

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

The proposed corporate governance framework helps deliver the Trust strategy by providing a structured approach to seeking assurance on progress in key areas and ensuring there are rapid and effective mechanisms to escalate risks to the delivery of strategic objectives. The BAF is the tool used to identify risks to achieving strategic objectives and relevant Committees are assigned BAF risks to carry out appropriate review of mitigating actions taken, gaps in control and assess the ongoing likelihood and impact of the risk. The Audit and Risk Committee takes an oversight role on the Board Assurance Framework and scrutinises red rated risks directly through scheduled deep dives. Terms of reference of all Board Committees are to include reference to their role in providing assurance on the delivery of Trust Strategy.

ACTION STATUS: COMPLETE

CorpG2: *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.*

Key tasks identified to address the action as outlined are as follows, with progress and response outlined:

1) Develop and approve a Corporate Governance Framework

The revised corporate governance framework will clearly outline the role of the Board and its Committees. A timeline has been followed to update the Standing Orders, Standing Financial Instructions and Scheme of Delegation involving the Audit and Risk Committee. Revised structures for forums reporting into Board Committees are being developed and will separately reported to the Trust Board as part of the accountability framework.

ACTION STATUS: SOME ISSUES (awaiting accountability framework and PCOG and QLT details to be clarified)

ClinG3*: 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.*

Key tasks identified to address the action as outlined are as follows, with progress and response outlined:

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 and Risk Committee and People and Culture Committee

All Board Committee terms of reference have been reviewed and approved by their own Committee and have been reviewed collectively by the Audit and Risk Committee. There has been considerable focus on the role of the Quality Committee, both to ensure that this is aligned with other Committees and with the revised remit of the Audit and Risk Committee, and with the creation of the People and Culture Committee. The Quality Committee terms of reference and workplan are aimed to focus on the delivery of the Quality Framework and quality priorities and ensure that business of the Committee is focussed on seeking assurance for the Board on these issues. The Committee structure reporting into the Quality Committee has also been reviewed and will be strengthened over forthcoming months to ensure the Quality Committee have a manageable and appropriate focus for their agenda.

ACTION STATUS: COMPLETE

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
-timely submission of papers and consistent use over cover sheets

Key tasks identified to address the action as outlined are as follows:

1) Undertake a comprehensive review of the Board Committee structures including TOR:

The Board Committee structure has been reviewed in the context of current priorities and following annual review of effectiveness of each Committee. Through informal discussion with Executive Directors it is recognised that there is potential to reduce the number of Board Committees, specifically to consider whether the Safeguarding

Committee and Mental Health Act Committee should remain as Board Committees. It is proposed that these two Committees remain as Board Committees for the current time for following reasons:

- The Quality Committee has undergone a thorough review of both its terms of reference and also the supporting and reporting structures that lie beneath it. Future plans include the establishment of a Quality subcommittee which will focus on a variety of operational issues, and allow the Quality Committee to retain its focus on seeking assurance, oversight and considering escalated issues. As the subcommittee and associated Quality Leadership Teams are not yet fully developed, and the revised focus of the role of the Quality Committee is emerging, it is proposed that it would not be appropriate at this time for the Safeguarding Committee to be subsumed within the remit of the Quality Committee. In addition, it is recognised that the Safeguarding Committee has a challenging strategic agenda and that its status as a Board Committee was supported by the CQC in their last safeguarding inspection.

- For similar reasons, it is proposed that the Mental Health Act Committee should remain an independent Board Committee. There is some work to be done to support the administration and work of this Committee to ensure focus on assurance of key processes and establish a cycle of business for oversight and review. It should be noted that other mental health foundation trusts do retain a mental health committee as a Board Committee in its own right.

It is proposed that arrangements for Board Committees be reviewed in 9 months (December 2016) to establish whether either of both of the Mental Health Act Committee and Safeguarding Committee may be incorporated into the work of the Quality Committee.

- Oversight of risk – as part of the review of roles and responsibilities of Board Committees the role for oversight of risk management has been reviewed. It has been agreed that the Audit Committee is renamed as the Audit and Risk Committee to reflect the aim that it is this Board Committee which will have overall oversight of risk management processes within the Trust. As outlined in the terms of reference, this will encompass seeking assurance on the effectiveness of the Trust's risk management strategy, oversight of the Board Assurance Framework and seeking assurance from other Board Committees, notably the Quality Committee, that there are robust procedures in place to monitor and scrutinise clinical and other operational risks. The Audit and Risk Committee will seek to ensure that the Trust has in place a culture which supports effective risk management, mitigation and organisational learning and that this is embedded in the organisation.

Terms of reference for all Committees have been reviewed and aligned as far as possible. As part of the review, all terms of reference have been aligned for layout, consistency of content and all include reference to conducting a review of meeting effectiveness both at the end of each meeting and on an annual basis against the terms of reference. Each Committee will also produce a work plan which is laid out to illustrate how the remit, as specific by the terms of reference, will be covered in Committee business throughout the year. All Committees within their terms of reference are encouraged to refer issues between Board Committees where appropriate and to escalate items of risk to the Trust Board. An assurance and escalation summary has been developed and has been implemented from 1 April 2016. The terms of reference have been reviewed with a view to reaffirming focus on the assurance role of Board committees, avoiding duplication and ensuring focus on the key purpose of each Committee in support of delivering the Trust's strategic objectives.

ACTION STATUS: COMPLETE

Confirmation of Timeline for approval of elements of Corporate Governance Framework

To complete the review of the Corporate Governance Framework, including its component elements, required sign off by a range of Committees and the Board. The timeline below illustrates when the various components were discussed and approved:

	Component of Corporate Governance Framework	**Forum for discussion/approval**	**Date**
1	Board Roles and Responsibilities	Board Development Session	11 May 2016 REVIEWED
2	Structure, process, Assurance and Escalation	Board Development Session	11 May 2016 REVIEWED
3	Scheme of Delegation: Part One - Decisions Reserved for the Board	Audit and Risk Committee	19 July 2016 REVIEWED
4	Responsibilities Delegated to Board Committees: Terms of Reference 4a: Audit and Risk	Audit and Risk Committee	24 May 2016 APPROVED with amendments
	4b: Finance and Performance	Finance Committee	APPROVED 29 March 2016
	4c: Quality	Quality Committee	APPROVED 12 May 2016
	4d: Mental Health Act	Mental Health Act Committee	3 June 2016 APPROVED
	4e: Safeguarding	Safeguarding	5 August 2016

		Committee (to be approved out of Committee)	APPROVED
	4f: Remuneration and Appointments	Remuneration and Appointments Committee	25 May 2016 APPROVED
	4g: People and Culture	People and Culture Committee	15 February 2016 APPROVED
	Appendix A – Board Committee Assurance Summary report template	Board Development Session	11 May 2016 APPROVED in part APPROVED at 25 May Board
	Appendix B – Board Front Sheet Template	Board Development Session	11 May 2016 APPROVED
	Appendix C – Standing Orders	Executive Leadership Team Audit and Risk Committee	4 July 19 July 2016 REVIEWED
	Appendix D – Standing Financial Instructions	Executive Leadership Team Audit and Risk Committee 19 July	4 July 2016 19 July 2016 REVIEWED
	Full Corporate Governance Framework	Public Board Meeting	27 July 2016

Derbyshire Healthcare NHS Foundation Trust

CORPORATE GOVERNANCE FRAMEWORK DOCUMENT JULY 2016

Appendices:

1. BOARD OF DIRECTORS – ROLES AND RESPONSIBILITIES

1. This Document

This document describes the role and working of the Board and is for the guidance of the Board, for the information of the Trust as a whole and serves as the basis of the terms of reference for the Board's own committees.

2. Role and Purpose

The Health and Social Care Act (2012) states that the principal purpose of the Trust is to 'provide goods and services for the purposes of the health service in England.' It may provide goods and services for any purposes relating to the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and the promotion and protection of public health. More than half of the Trust's income must come from fulfilling its principal purpose.

The Trust has a Board of Directors which exercises all the powers of the Trust on its behalf, but the Board may delegate any of those powers to a Committee of Directors or to an Executive Director. In addition, certain decisions are made by the Council of Governors, and certain Board of Director decisions require the approval of the Council of Governors.

The Board consists of Executive Directors, one of whom is the Chief Executive, and Non-Executive Directors, one of whom is the Chair.

The Board leads the trust by undertaking three key roles:

- Formulating strategy
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable, and
- Shaping a positive culture for the Board and the organisation.

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

Each Director also has a duty to avoid conflicts of interest and not to accept benefits from third parties (as well as to declare interests in proposed transactions or arrangements with the Trust).

The practice and procedure of the meetings of the Board, and of its Committees, are not set out here but are described in the Board's standing orders.

3. General Responsibilities

The general responsibilities of the Board are:

- To maintain and improve quality of care.
- To work in partnership with service users, carers, local health organisations, local government authorities and others to provide safe, effective, accessible, and well governed services for patients, service users and carers.
- To ensure that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity.
- To ensure relationships are maintained with the Trust's stakeholders, regulators, public, governors, staff and patients, such that the Trust can discharge its wider duties.
- To exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner.
- To ensure compliance with all applicable law, regulation and statutory guidance.

In fulfilling its duties, the Trust Board will work in a way that makes the best use of the skills of Non-Executive and Executive Directors.

3.1 Leadership

The Board provides active leadership to the organisation by:

- Ensuring there is a clear vision and strategy for the Trust that people know about and that is being implemented, within a framework of prudent and effective controls which enable risk to be assessed and managed.
- Ensuring the Trust is an excellent employer by the development of a workforce strategy and its appropriate implementation and operation.
- Implementing effective Board and Committee structures and clear lines of reporting and accountability throughout the organisation.

3.2 Quality

The Board:

- Ensures that the Trust's quality of service responsibilities for clinical effectiveness, patient safety and patient experience, are achieved.
- Has an intolerance of poor standards, and fosters a culture which puts patients first.

- Ensures that it engages with all its stakeholders, including patients and staff on quality issues and that issues are escalated appropriately and dealt with.

- Produces an annual Quality Report in line with statutory requirements.

3.3 Strategy

The Board:

- Sets and maintains the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives, taking into account the views of the Council of Governors.

- Determines the nature and extent of the risk it is willing to take in achieving its strategic objectives.

- Monitors and reviews management performance to ensure the Trust's objectives are met.

- Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required.

- Develops and maintains an annual plan, with due regard to the views of the Council of Governors, and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders.

- Ensures that national policies and strategies are effectively addressed and implemented within the Trust.

3.4 Culture, Ethics and Integrity

The Board:

- Is responsible for setting values, ensuring they are widely communicated and adhered to and that the behaviour of the Board is entirely consistent with those values.

- Promotes a patient-centred culture of openness, transparency and candour.

- Ensures that high standards of corporate governance and personal integrity are maintained in the conduct of Trust business.

- Establishes appeals panels as required by employment policies particularly to address appeals against dismissal and final stage grievance hearings.

- Ensures that Directors and staff adhere to any codes of conduct adopted or introduced from time to time.

- Ensures the application of appropriate ethical standards in areas such as research and development

3.5 Governance/Compliance

The Board:

- Ensures that the Trust has comprehensive governance arrangements in place that guarantee that the resources vested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements.

- Ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective and safe services taking account of patient and carer experiences and maintaining the dignity of those cared for.

- Ensures compliance with the principles, systems and standards of good corporate governance and has regard to guidance issued by NHS Improvement and appropriate codes of conduct, accountability and openness applicable to Foundation Trusts.

- Formulates, implements and reviews standing orders and standing financial instructions as a means of regulating the conduct and transactions of Trust business.

- Ensures the proper management of and compliance with the Mental Health Act and other statutory requirements of the Trust.

- Ensures that the statutory duties of the Trust are effectively discharged.

- Ensures that all paragraphs of NHS Improvement's licence conditions relating to governance arrangements are complied with.

3.6 Risk Management

The Board:

- Ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities.

3.7 Committees

The Board:

- Is responsible for maintaining Committees of the Trust Board with delegated powers as prescribed by the Trust's standing orders, scheme of delegation and/or by the Trust Board from time to time.

3.8 Communication

The Board:

- Ensures an effective communication channel exists between the Trust, its governors, members, staff and the local community.

- Meets its obligations in respect of the Council of Governors and members and ensures governors are equipped with the skills and knowledge they need to undertake their role.

- Ensures the effective dissemination of information on services, strategies and plans and also provides a mechanism for feedback.

- Shares the agenda and minutes of public Board meetings and agenda of the confidential Board meetings with the Council of Governors and ensures that those Board proceedings and outcomes that are not confidential are communicated publically, primarily via the Trust's website.

- Ensures that the business of the Board is conducted openly in public, except where special reasons apply.

- Holds an annual meeting of its members which is open to the public.

- Publishes an annual report and annual accounts.

3.9 Finance

The Board:

- Ensures that the Trust operates effectively, efficiently, economically.

- Ensures the continuing financial viability of the organisation.

- Ensures the proper management of resources and that financial responsibilities are achieved.

- Ensures that the Trust achieves the targets and requirements of stakeholders within the available resources.

- Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

- Makes recommendations to the Council of Governors on any transaction as defined in the Constitution as 'significant.'

4. Role of the Chair

- The Chair is responsible for leading and presiding over the Trust Board and the Council of Governors and for ensuring that they successfully discharge their responsibilities.

- The Chair is responsible for the effective running of the Board and Council of Governors.

- The Chair is responsible for ensuring that the Board and the Council of Governors play their part in the development and determination of the Trust's strategy and overall objectives, and ensuring they work well together.

- The Chair is the guardian of the Board's and the Council of Governors' decision-making processes and provides general leadership of the Board and the Council of Governors.

5. Role of the Chief Executive

- The Chief Executive (CEO) reports to the Chair and to the Board directly. All members of the management structure report either directly or indirectly, to the CEO.

- The CEO is responsible to the Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for consideration and approval by the Board.

- The CEO is responsible for implementing the decisions of the Board and its committees and providing information and support to the Board and Council of Governors.

6. Deputy Chair

For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chair, the Chair and the Directors of the Trust may appoint a Non-Executive Director to be Deputy Chair for such a period, not exceeding the remainder of his/her term as Non-Executive Director of the Trust, as they may specify on appointing him/her. If the Chair is unable to discharge their office as Chair of the Foundation Trust, the Deputy Chair of the Board of Directors shall be the acting Chair of the Foundation Trust.

7. Role of the Senior Independent Director

The Board of Directors will appoint one of the Non-Executive Directors to be the Senior Independent Director, in consultation with the Nominations Committee of the Council of Governors. The Senior Independent Director shall be available to members and Governors if they have concerns, which contact through normal channels has failed to resolve or for which such contact is inappropriate. They will also have a key role in the appraisal process for the Chair of the Foundation Trust. The Senior Independent Director may be the Deputy Chair.

8. Accountability

- The Chair and Non-Executive Directors are accountable to the Council of Governors for the performance of the Board of Directors. To exercise this accountability effectively the Non-Executive Directors will need the support of their Executive Director colleagues.

- The Trust Secretary shall support the Chair on matters relating to induction, Board development, and training for Board Directors. The Trust Secretary will also support the Chair on matters relating to the Council of Governors including induction, development and training of governors.

9. Council of Governors

The Board is accountable to the community it serves and discharges that responsibility through its relationship with the Council of Governors. The Council of Governors represents the community and its major stakeholders, including staff, through elected and nominated members.

The statutory general duties of the Council of Governors are:

- to hold the non-executive directors individually and collectively to account for the performance of the Board, and
- to represent the interests of the members of the corporation as a whole and the interests of the public.

Governors provide an important assurance role for the Trust by scrutinising the performance of the Board. The Board and Council of Governors are committed to work together constructively, based on openness and transparency, good communication and strong mutual understanding. They respect the different roles of each and the have common aim to work in the best interests of the organization.

10. Other Matters

The Trust Board shall be supported by the Director of Corporate Affairs and Trust Secretary whose duties in this respect will include:

- Agreement of the agenda, for Board and Board Committee meetings, with the relevant Chair, in consultation with the Chief Executive, or the lead Executive Director for that Committee.
- Collation of reports and papers for Board and Committee meetings.
- Ensuring that suitable minutes are taken, keeping a record of matters arising, actions and issues to be carried forward.
- Ensuring that Board procedures are complied with.
- Supporting the Chair in ensuring good information flows within and between the Board, its Committees, the Council of Governors and senior management.
- Advising the Board and Board Committees on governance matters.

A full set of papers comprising the agenda, minutes and associated reports and papers will be sent within the timescale set out in standing orders to all Directors and others as agreed with the Chair and Chief Executive from time to time. The agenda and minutes of public Board meetings and agenda for the confidential Board meetings will be shared with the Council of Governors.

The Board and all Board Committees shall self-assess its performance following each Board meeting and undertaken an evaluation of its performance on an annual basis.

2. STRUCTURE AND PROCESSES FOR ASSURANCE AND ESCALATION

Board Committees

- To support the Board in effectively carrying out its responsibilities (see Roles and Responsibilities), Committees have been formally established by the Board.

These Board Committees are established in accordance with the FT Constitution and standing Orders of the Board, also in support of the Monitor (now NHS Improvement) Licence, FT4:

> *"The Licensee shall establish and implement effective Board and Committee structures; and clear responsibilities for its Board, for Committees reporting to the Board and for staff reporting to the Board and those Committees."*

Roles of the Committees

The Audit and Risk Committee

- This is the principal Committee for seeking independent assurance on the general effectiveness of the Trust's internal control and risk management systems and for reviewing the structures and processes for identifying and managing key risks. It is responsible for reviewing the adequacy of all risk and control related statements prior to approval by the Board and for seeking assurances on these controls. In discharging its responsibilities the Committee takes independent advice from the internal auditor or seeks any other legal or professional advice as required to discharge its responsibilities.

The Finance and Performance Committee

- The prime purpose of the Committee is to gain assurance on all aspects of financial and operational performance, on behalf of the Board. The Committee also oversees and approves business developments as well as considering progress with commercial and contractual matters.

- The Finance and Performance Committee is responsible for agreeing terms of reference and annual work programmes for its supporting sub-committees. It also receives agreed assurance and escalation reports as defined in the forward plan for the Committee.

The Quality Committee

- The prime purpose of the Committee is to obtain assurance that high standards of care are provided and that adequate and appropriate governance structures, processes and controls are in place to promote safety and excellence in patient care. The Committee monitors risks arising from clinical care and ensures the effective and efficient use of resources through evidence-based clinical practice.

- The Quality Committee is responsible for agreeing terms of reference and annual work programmes for its supporting sub-committees. It also receives agreed assurance and escalation reports as defined in the forward plan for the Committee.

The Mental Health Act Committee

- The Committee monitors and obtains assurance on behalf of the Hospital Managers and the Trust as the detaining authority that the safeguards of the Mental Health Act are appropriately applied. It also monitors related statute and guidance and reviews the reports following Mental Health Act inspections by the Care Quality Commission.

People and Culture Committee

- The Committee supports the organisation to achieve a well-led, values driven positive culture. The Committee is to provide assurance to the Board that the appropriate structures, processes and systems are in place to ensure an effective capable workforce to meet the Trusts current and future needs including workforce engagement and development.

The Safeguarding Committee

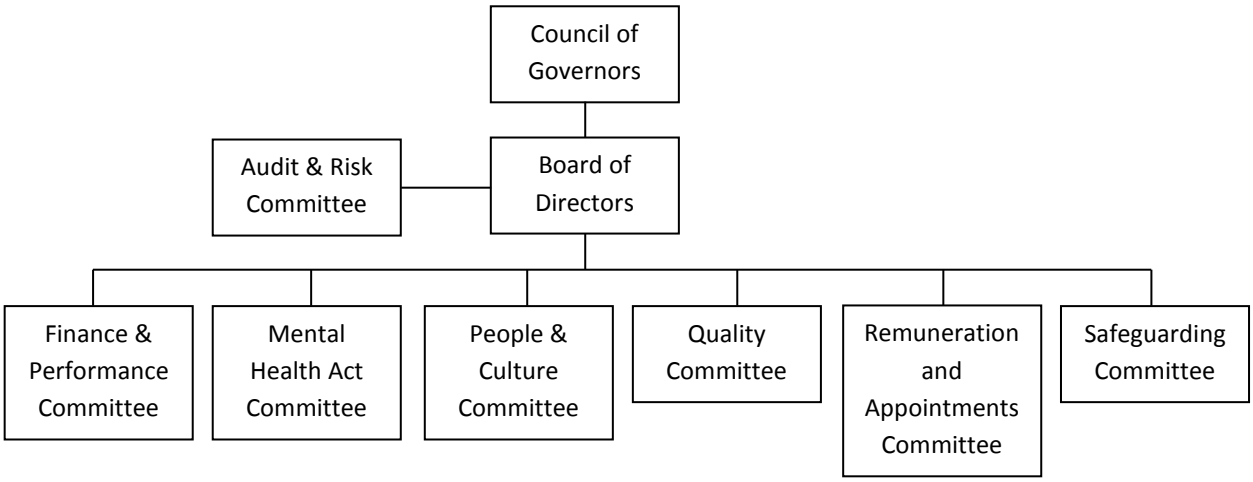
- The Committee is responsible for setting the Safeguarding Quality Strategy, to provide quality governance and gain assurance on all aspects of the safeguarding agenda. The Committee's purpose is to provide assurance to the Trust Board that the organisation is effectively discharging and fulfilling its statutory responsibility for safeguarding to ensure better outcomes for children and vulnerable adults.

The Remuneration and Appointments Committee

- To be responsible for identifying and appointing candidates to fill Director positions on the Board including the Chief Executive, voting and non-voting Executive Directors. To establish and keep under review a remuneration policy in respect of Executive Directors and to advise upon and oversee contractual arrangements for Executive Directors.

Structure

The current Board Committee structure is shown below:-



Assurance and Escalation

- The Board Assurance Framework (BAF) provides a structure and process to enable the organisation to focus on the risks that might compromise the achievement of its strategic objectives. It maps out the key controls to mitigate the risks and provide a mechanism to inform the Board of the assurances received about the effectiveness of these controls. It is a dynamic tool which is regularly reviewed and supports the Chief Executive to complete the annual governance statement at the end of each financial year. The BAF provides an effective focus on strategic and reputational risk rather than operational issues highlighting any gaps in controls and assurances. Each risk on the BAF is also recorded on the risk register and any new risks which are considered to be strategic are escalated by Board, Committees or the Executive Leadership Team (ELT) for inclusion in the BAF. The BAF is regularly reviewed by each principal risk owner (Executive Director), to ensure the controls and assurances remain valid and any gaps in control are mitigated. Each Board Committee reviews any BAF entry which is relevant to the remit of that Committee. The total BAF is regularly overseen and scrutinised by the Audit and Risk Committee prior to submission to Board.

- The BAF supports the Board in identifying and managing all its strategic and high level systemic operational risks. The Trust will continue to develop and review the Trust's risk register to ensure all significant strategic, clinical, financial risks are identified and actively managed within the resources available.

- The Trust risk register is a 'live' database of all significant risks to the Trust. The process for qualitative review of the risk register is within the remit of the Quality Committee. This is discussed bi-monthly at the Quality Committee meeting and top risks, both strategic and operational, are identified and itemised. The Audit and Risk Committee has a role to oversee all the Trust's risk management arrangements and ensure that these are comprehensive, robust and effective.

- Board Committees are assigned relevant BAF risks that fall under their remit and will undertake deep dives on these risk areas. The BAF is reviewed by the Audit and Risk Committee who will undertake a deep-dive on those risks which are red rated under the risk management classification. The Audit and Risk Committee review the BAF four times per year prior to submission to the Board, in order to provide independent assurance. Issues for escalation may include matters which could incur reputational, operational or strategic risk or undermine public confidence, those which may affect the Trust's continuity of services rating and financial risk rating, and risks to the achievement of the Trust's strategy or forward plan.

The following measures provide for assurance and escalation of issues within the remit of each respective Committee, and where appropriate to the Audit and Risk Committee, and for escalation of issues to the Board.

Each Committee :

- Reviews at the outset of each meeting any relevant BAF item specifically assigned to the Committee

- Considers at each meeting any new issue which needs to be identified for inclusion in the BAF

- Co-operates with any request from the Audit and Risk Committee regarding a risk-

related matter, and provides assurance as appropriate

- Provides a summary of the business conducted at each Committee meeting to the following Audit and Risk Committee meeting and next Board meeting, including any specific areas requiring escalation, significant exception reports or other gaps in assurance

- Maintains and keeps under review a forward plan for the business of the Committee

- Conducts an annual self-effectiveness review, against its terms of reference,

- Provides to the Audit and Risk Committee an annual review of the scope of the Committee's business, including the setting of key objectives for the coming year.

The remit of each Committee is set out in terms of reference approved by the Board (see scheme of delegation). These are reviewed each year to ensure robust governance and assurance arrangements are in place.

Systems for Assurance and Escalation

The process for monitoring performance, receiving assurance and escalating risks and concerns flows through Board Committees, the Executive Leadership Team and the Board, allowing assurances and risks to be communicated and acted upon. An issue which requires escalation can start in any part of the organisation and this process ensures that managers and Executive Directors provide assurance, or escalate issues if necessary, through the ward to Board organisational structure. Issues identified through this process may relate to quality of services delivered, performance targets, financial issues, service delivery or achievement of strategic objectives.

The Executive Leadership Team (ELT)

ELT is chaired by the Chief Executive and attended by all Executive Directors (voting and non-voting). It is the primary method for holding the Executive Team to account for delivery against the effective development and implementation of strategy, monitoring and delivery of statutory duties, operational, financial, contractual, quality and clinical performance. There is an Executive Director lead for each Board Committee, thus providing an important link between the Board Committees and operational management.

Communication between the Board and Board Committees

As outlined, Board Committees prepare assurance and risk reports for both the Audit and Risk Committee and the Board itself. For the Audit and Risk Committee this serves to provide assurance that robust governance processes are in place across the organisation and that the Board Committees are working effectively. The Board will receive and duly act upon escalated issues, with each reporting Committee clearly articulating where appropriate what action is required by the Board. Similarly, Board Committees are encouraged to utilise the breadth of the Board Committee structure to escalate items to other Board Committees for action. As an example, the Finance and Performance Committee may escalate an item regarding cost improvement proposals to the Quality Committee to further explore and provide assurance on quality impact issues involved. Therefore the Committee with the appropriate expertise is being utilised to provide assurance to another Committee. Actions that are referred to other Board Committees will be recorded by both the escalating Committee and the receiving Committee. The action will not be formally closed off until confirmation from both Committees is received that the matter has been appropriately addressed.

In addition it is important that Board Committee chairs develop a close working relationship in overseeing the remit of all Board Committees' remit and activities. Board Committee chairs meet quarterly to ensure effective co-working and coordination. Their work will allow collective oversight of the business undertaken by each Committee, alignment of terms of reference, coordination of work plans and identification of themes or issues emerging. Board Committee chairs will also review those actions which have been referred across Committees to review the effectiveness of this approach and to identify further opportunities where this may be appropriately used.

Forward plan

The Director of Corporate Affairs and Trust Secretary will ensure that there is a forward plan for the Board and its Committees which aligns to the business annual planning cycle. This will ensure clarity between reporting papers and appropriate sign off and approval for direct communication and referral between the Board and its Committees.

Part One : Scheme of Delegation Decisions Reserved to the Board

REF	DECISIONS RESERVED TO THE BOARD
	General Enabling Provision The Board may determine any matter, for which it has delegated or statutory authority, in full session within its statutory powers.
	Regulations and Control 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chair and Chief Executive in public session in accordance with Standing Orders. 5. Approve a scheme of delegation of powers from the Board to Committees**.** 6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determine the extent to which that member may remain involved with the matter under consideration. 7. Approve arrangements for dealing with complaints. 8. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto, ie the structure and composition of the Board and its Committees. 9. Receive reports from Committees including those required by NHS Improvement or other regulator to establish and to take appropriate action. 10. Confirm the recommendations of the Trust's Committees where the Committees do not have delegated powers. 11. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on Trust. 12. Establish terms of reference and reporting arrangements of all Committees and sub-committees that are established by the Board. 13. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property. 14. Authorise use of the Seal. 15. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with Standing Orders.
	Appointments/ Dismissals 1. Appoint and dismiss Committees (and individual members) that are directly accountable to the Board. 2. Ensure all appointments are timely, all Board members are annually appraised and that any disciplinary issues are in line with Trust policy. 3. Confirm appointment of members of any Committee of the Trust as representatives on outside bodies. 4. Appoint appraise, discipline and dismiss the Director of Corporate Affairs and Trust Secretary.
	Strategy, Business Plans and Budgets 1. Define the strategic aims and objectives of the Trust.

REF	DECISIONS RESERVED TO THE BOARD
S.F.Is 3.2.2i S.F.Is 3.2.2ii	2. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by NHS Improvement. 3. Approve the Trust's policies and procedures for the management of risk. 4. Approve Outline and Final Business Cases for Capital Investment through the approval of the Capital Programme. 5. Approve budgets and Annual Plan. 6. Approve annually the Trust's proposed organisational development proposals. 7. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 8. Approve PFI proposals. 9. Approve proposals on individual contracts. Authority to authorise any one revenue order shall be limited to: • Over £500,000 – Board of Directors • £200,000 to £500,000 – Chief Executive or Director of Finance • £50,000 to £200,000 – Deputy Chief Executive or Deputy Director of Finance • £30,000 to £50,000 – Executive Directors (voting and non-voting but not Non-Executive Directors) • £10,000 to £30,000 – Deputy Director of Operations and General Managers • £1,000 to £10,000 – Heads of Operational Service Areas (or lower limit for individual budget holders as set by the Chief Executive) Authority for planned expenditure of capital resources shall be limited to: • Expenditure on individual project up to £100,000 – approved by the Capital Action Team • Expenditure on an individual projects up to £1,000,000 – jointly signed by the Director of Finance and one other Executive Director • Project in excess of £1,000,000 – Board approval required 10. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance (for losses and special payments). 11. Approve proposals for action on litigation against or on behalf of the Trust. 12. Review use of NHSLA risk pooling schemes CNST and RPST) to cover insurable risk 13. To approve the Annual Plan and such other business plan, budgeted and capital programmes submitted by the CEO on an annual basis, including the approval of cost improvement programmes. 14. To review proposals on service policies and priorities as negotiated with commissioners. 15. To consider advice from any such professional Advisory Committees as the Board may establish or recognise. 16. To approve written evidence on behalf of the Trust to be submitted to statutory or other official bodies. Where urgent action is required, the CEO should act on behalf of the Trust and consult with the Chair (or Deputy Chair in his/her absence), and report action taken at the next meeting of the Board. 17. To receive reports on the legally binding contracts entered into with commissioners. 18. To approve business cases requiring additional resources as set out within

REF	DECISIONS RESERVED TO THE BOARD
	Trust policy and Finance and Performance Committee terms of reference. 19. To identify key strategic risks, evaluate them and ensure adequate responses are in place and are monitored. 20. Ensure governors are appropriately consulted on matters deemed to be a significant transaction.
	Human Resources 1. To approve pay and terms and conditions of employment for Trust employees (except where covered by national agreements). 2. To receive decisions on disciplinary and grievance appeal panels in respect of senior positions 3. To receive updates on Freedom to Speak Up and Whistleblowing cases.
	Policy Determination *1.* Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff.
	Audit 1. Consider the annual report on the effectiveness of the Audit and Risk Committee and agree any proposed action, taking account of the advice, where appropriate, of the Committee. 2. Receive an annual report from the external auditor and agree action on recommendations where appropriate by the Audit and Risk Committee. 3. To consider the Audit reports on the affairs and accounts of the Trust.
	Annual Reports and Accounts 1. Authority for adoption of the Annual Report, Annual Accounts and Annual Quality Account is delegated to the Audit and Risk Committee – to be reviewed on an annual basis.
	Monitoring 1. Receive such reports as the Board sees fit from Committees in respect of the exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust by the Board as set out in management policy statements. All monitoring returns required by NHS Improvement shall be approved by the Board or by prior arrangement through delegated authority to the Chair of the Finance and Performance Committee and Chair of the Audit and Risk Committee. 3. Receive reports from the Director of Finance on financial performance against plan. 4. Receive reports from the Director of Finance on actual and forecast income from service contracts. 5. To receive reports from the CEO and Director of Finance upon the implementation of, and variances from, agreed business plans, service level agreements, budgets and capital programmes, and where appropriate take necessary action. 6. To make such directions regarding internal financial control and control of income/expenditure as required by NHS Improvement. 7. To authorise payments which require the prior approval of the Board under the SOs and SFIs. 8. To receive reports on external and internal issues affecting the services within the Trust from the CEO and other directors, and take action where necessary. 9. To make arrangements for the investigation of complaints. 10. To oversee the performance and learning in respect of serious incident management.

REF	DECISIONS RESERVED TO THE BOARD
	Buildings, Land and Equipment 1. To approve in principle the content and cost of individual capital schemes or single items of equipment over the expenditure limit of £1m and to accept tenders for such, including tenders for management consultancy. 2. To approve and review the list of contractors, architects, quantity surveyors, consultant engineers and other professional advisors considered suitable for undertaking building and engineering work for the Trust (within the terms of the European Community regulations). To determine matters relating to land and property transactions other than those covered by any delegation to the CEO and to approve any transactions subject to guidance from NHS Improvement. To approve capital programmes and determine guidelines within which the CEO may approve variations to the programme.
	General 1. To establish and maintain relationships with other relevant external bodies. 2. To consider any other matters not falling within the established policies and practice of the Trust or which officers think desirable or expedient to be considered by the Board. 3. To establish management arrangements as appropriate and to consider specific management of other aspects of the Trust's responsibilities. 4. To appoint Directors and officers of the Trust to represent the Trust on other bodies. 5. To approve the appointment of professional advisors where such approval is required in accordance with the SOs. 6. To approve significant Trust policies as required. 7. To approve any changes to the Trust's Corporate Governance Framework. 8. Establishment and agreement of terms of reference and constitution of Committees of the Board.

Audit and Risk Committee Terms of Reference

1. Authority

1.1 The Audit and Risk Committee (the Committee) is constituted as a committee of the Trust's Board of Directors. Its constitution and terms of reference are set out below, and are subject to amendment at future Board of Directors meetings. The Committee shall not have executive powers in addition to those delegated in these terms of reference.

1.2 As a Committee of the Board, the Audit and Risk Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's Strategic objectives which fall within the Committee's remit.

1.3 The Committee has a role during the 2016/17 financial year to oversee progress and provide assurance to the Board on the implementation of key tasks as outlined in the Trust's Governance Improvement Action Plan. The Committee is assigned as responsible committee for a range of tasks and is required to provide assurance to the Board on the progress towards completion of tasks and evidence of demonstrable outcomes in working towards ensuring that effective governance processes are embedded within the Trust.

1.4 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.5 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

2. Membership

2.1 The Committee shall be composed of at least three independent non-executive directors, at least one of whom should have recent and relevant financial experience. One of the members shall be appointed Chair of the Committee by the Board of Directors. The Trust Chairman shall not be a member of the Committee (but may attend by invitation as appropriate).

2.2 A quorum shall be two Non-Executive Directors.

3. Attendance

3.1 Only members of the Committee have the right to attend meetings, but the Director of Finance, Director of Corporate Affairs shall generally be invited to attend routine meetings of the Committee. Other Executive Directors and/or staff and executives shall be invited to attend those meetings in which the Committee will consider areas of risk or operation that are their responsibility and will be expected to attend as requested.

3.2 The Chief Executive as accountable officer should be invited to attend meetings and should discuss at least annually with the Committee the process for assurance that supports the governance statement. He/she should also attend when the Committee considers the annual governance statement and the annual report and accounts.

3.3 The External Auditor or his representative should normally attend meetings.

3.4 The Head of Internal Audit should also attend routine meetings.

3.5 A representative of the local Counter Fraud Service will attend at least two meetings of the Committee per year.

3.6 A governor representative may be invited to attend meetings of the Committee as an observer.

3.7 The Director of Corporate Affairs shall be the secretary to the Committee and will provide appropriate support and advice to the Chair and the Committee members.

At least once per year the Committee should meet privately with the external and internal auditors.

4. Access

4.1 The Head of Internal Audit, representatives of External Audit and Counter Fraud Specialist have a right of direct access to the Chair of the Committee.

5. Frequency of meetings

5.1 Meetings shall be held at least four times per year, the total number of meetings being determined by the assurance required by the Committee to discharge its responsibilities. The Board of Directors, Chief Executive, External Auditors or Head of Internal Audit may request an additional meeting if they consider that one is necessary.

6. Required frequency of attendance by members

6.1 Members of the Committee must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings.

7. Duties and Responsibilities

7.1 The Committee's duties and responsibilities can be categorised as follows:

Integrated governance, risk management and internal control

7.2 To review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities, clinical and non-clinical, that supports the achievement of the Trust's objectives.

7.3 In particular to review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the annual

governance statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances.

- the underlying assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

- arrangements for the effective management of clinical and corporate risk to underpin the delivery of the Trust's principal objectives

- arrangements in place for preventing and countering fraud, bribery and corruption and managing security in compliance with the related NHS Protect Standards.

- The Committee shall maintain an oversight of the Trust's general material control and risk management systems, including processes and responsibilities, the production and issue of any risk and control-related disclosure statements. The key record to guide the Committee's work will be the Board Assurance Framework (BAF).

7.4 As part of its integrated approach, the Committee will ensure appropriate information flows, to the Committee from executive management and from and between other Board Committees, in relation to the Trust's overall internal control atnd risk management position.

7.5 To monitor corporate governance (e.g. compliance with terms of the licence, constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests).

7.6 To develop and use an effective assurance framework to guide the Committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes so as fulfil its functions in connection with these terms of reference.

Internal audit

7.7 To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation.

7.8 To oversee on an on-going basis the effective operation of internal audit in respect of:

- Adequate resourcing
- Co-ordination with external audit
- Meeting the Public Sector Internal Audit standards 2013
- Providing adequate independent assurances
- Having appropriate standing within the Trust; and
- Reviewing and approving the internal audit plan ensuring that this meets the internal audit needs of the organisation..

7.9 To consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the

implementation of recommendations.

7.10 To consider the provision of the internal audit service, the cost of the audit.

7.11 To monitor the effectiveness of internal audit and to conduct an annual review of the internal audit function.

External audit

7.12 To make a recommendation to the Council of Governors in respect of the appointment, re-appointment and removal of an external auditor and related fees as applicable. To the extent that the recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

7.13 To discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy.

7.14 To assess the External Auditor's work and fees each year and based on this assessment, to make the recommendation above to the Council of Governors with respect to the re-appointment or removal of the Auditor. This assessment should include the review and monitoring of the External Auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

7.15 To oversee the conduct of a market testing exercise for the appointment of an auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the Auditor.

7.16 To review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

7.17 To develop and implement a policy on the engagement of the External Auditor to supply non-audit services.

7.18 To consider the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal of the auditors.

Annual accounts review

7.19 To approve the Annual Report and Accounts including the Quality Report and Annual Governance Statement on behalf of the Trust Board. In doing so the Committee will determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes;
- Changes in, and compliance with the accounting policies, practices and estimation techniques;
- Areas where judgment has been exercised;
- Explanation of estimates or provisions having material effect;
- Explanations for significant variances;
- The schedule of losses and special payments;

- Significant adjustments in the preparation of the financial statements and any unadjusted statements; and
- Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.
- Changes in and compliance with guidance relating to the preparation of the Quality Account
- Compliance with the Annual Reporting Manual requirements for the content of the annual report as published by NHS Improvement

7.20 To review all accounting and reporting systems for reporting to the Board of Directors, including in respect of budgetary control.

Raising Concerns (Whistleblowing)

7.21 To review the adequacy of the Trust's arrangements by which Trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

Standing orders, standing financial instructions and standards of business conduct

7.22 To review on behalf of the Board of Directors the operation of, and proposed changes to, the standing orders and standing financial instructions, the constitution, codes of conduct and standards of business conduct; including maintenance of registers.

7.23 To examine the circumstances of any significant departure from the requirements of any of the foregoing, and whether those departures relate to a failing, an overruling or a suspension.

7.24 To review the scheme of delegation.

Other

7.25 To review performance indicators relevant to the remit of the Committee.

7.26 To examine any other matter referred to the Committee by the Board of Directors and to initiate investigation as determined by the Committee.

7.27 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health sector and professional bodies with responsibilities that relate to staff performance and functions.

7.28 To review the work of all other Trust committees in connection with the Committee's assurance function.

7.29 The Committee may also request specific reports from individual functions within the Trust (for example, clinical audit).

7.30 The Committee may refer specific issues to the Board, Finance and Performance Committee and other Committees and make recommendations as appropriate.

8. Minutes and Reporting

8.1 The minutes of all meetings of the Committee shall be formally recorded and submitted, together with recommendations where appropriate, to the Board of Directors. The submission to the Board of Directors shall include details of any matters to be escalated in respect of which actions or improvements are needed. This will include details of any evidence of potentially *ultra vires*, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters. To the extent that such matters arise, the Chair of the Committee shall present details to a meeting of the Board of Directors in addition to submission of the minutes.

8.2 The Committee will report annually to the Board of Directors and the Council of Governors in respect of its work in support of the annual governance statement, specifically commenting on:

- the assurance framework and its fitness for purpose;
- the effectiveness of risk management within the Trust;
- the integration of and adherence to governance arrangements
- the appropriateness if the evidence that shows the organisation is fulfilling its regulatory requirements relating to its existence as a functioning business.
- the robustness of the processes behind the quality accounts; and
- any pertinent matters in respect of which the Committee has been engaged.

8.3 The Committee's annual report should also describe how the Committee has fulfilled its Terms of Reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed. The Trust's annual report shall include a section describing the work of the Committee in discharging its responsibilities.

8.4 The Committee will review its effectiveness at the end of each meeting.

9. Administrative Support

9.1 The Committee shall be supported by the Director of Corporate Affairs and Trust Secretary whose duties in this regard include, but are not limited to:

- Agreement of the agenda with the Chair of the Committee and attendees
- Preparation, collation and circulation of connected papers in good time
- Ensuring that those required to attend are invited to the meeting in good time
- Ensuring that the minutes are taken and keeping a record of matters arising and issues to be carried forward
- Manage the forward plan of the Committee's work
- Arranging meetings for the Chair with directors and advisers as necessary
- Advising the Committee as appropriate on pertinent issues/areas of interest/policy developments;
- Enabling training and development of Committee members as appropriate
- Reviewing every decision to suspend the standing orders.

10. Review of terms of reference

10.1 The terms of reference of the Committee shall be reviewed at least annually.

Finance & Performance Committee Terms of Reference

1. Authority

1.1 The Board of Directors approved the establishment of a Finance and Performance Committee as a Committee of the Board. The prime purpose of the Committee is to gain assurance on all aspects of financial and operational performance, on behalf of the Board. The Committee also oversees and approves business developments as well as considering progress with commercial and contractual matters.

The Committee may refer specific issues to the Board, Audit and Risk Committee and other Committees and make recommendations as appropriate. Matters formally delegated to the Finance and Performance Committee by the Board of Directors are:

- Cost Improvement Plan (CIP) reporting
- Contractual compliance performance reporting
- Treasury Management – to approve policy, procedures, controls and monitoring of policy implementation
- Working Capital Facility – to approve
- Estate strategy delivery oversight – twice yearly updates
- Indicative 5 year capital plan – approval
- Reference Costs: process - sign-off

1.2 Aside from those specific matters listed, the Committee otherwise gains assurance on matters through reports and exceptions provided to it.

The terms of reference as set out below are as approved by the Board. They may be subject to amendment at a future Board meeting.

2. Membership

2.1 The membership of the Committee shall comprise:

- Chair of Committee – Non Executive Director
- Two other Non-Executive Directors
- Executive Director of Finance
- Director of Operations
- Medical Director
- Director of Strategic Development

If the Chair is not present, one of the Non-Executive Directors will chair the meeting. Other staff may be required to attend, at the invitation of the Committee.

2.2 A quorum shall be three members, including at least one Executive Director and two Non-Executive Directors.

3. Attendance

Other staff may be required to attend, at the invitation of the Committee.

4. Frequency of meetings

Meetings should be held bi-monthly with additional meetings if required.

5. Duties and Responsibilities

5.1 To monitor the development and delivery of financial and operational aspects of the Trust strategy through:

- Detailed oversight of current and future financial performance including financial risks
- Detailed oversight of current and future operational performance

5.2 To monitor delivery of the cost improvement programme (CIP).

5.3 To oversee progress on contractual negotiations.

5.4 To receive reports on business and commercial matters.

5.5 To consider outline business cases and proposals and to approve or make recommendations to Board accordingly.

5.6 To receive reports or referrals from committees and other meetings, relevant to the work of this Committee.

5.7 The agenda for the Committee will be informed by a forward plan of regular items but will also receive reports on relevant issues requiring additional scrutiny and assurance pertaining to actual and anticipated performance and/or when required by Trust Board or Audit and Risk Committee.

5.8 To consider the Board Assurance Framework and high level risks, in particular as they relate to the remit of the Committee; and to comply with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

5.9 To conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

6 Minutes and Reporting

6.1 Minutes of meetings of the Committee shall be taken and formally recorded. Ratified minutes will be reported to the next full Board along with an assurance summary highlighting assurances received, actions requested, and referring issues for full Board discussion where appropriate. The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its remit and giving details of significant issues and how they have been addressed.

7 Review of terms of reference

7.1 The Terms of Reference shall be subject to review at least annually.

Quality Committee Terms of Reference

1. Authority

1.1 The Board of Directors has approved the establishment of a Quality Committee as a Committee of the Board in accordance with standing orders. The prime purpose of the Committee is to enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to:

- Promote safety and excellence in patient care;
- Identify, prioritise and manage risk arising from clinical care;
- Ensure the effective and efficient use of resources through evidence-based clinical practice; and
- Protect the health and safety of Trust employees

1.2 As a Committee of the Board, the Quality Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's Strategic objectives which fall within the Committee's remit.

1.3 The Committee has a role during the 2016/17 financial year to oversee progress and provide assurance to the Board on the implementation of key tasks as outlined in the Trust's Governance Improvement Action Plan. The Committee is assigned as responsible committee for a range of tasks and is required to provide assurance to the Board on the progress towards completion of tasks and evidence of demonstrable outcomes in working towards ensuring that effective governance processes are embedded within the Trust.

2. Membership

The membership of the Committee shall comprise:-

- Non-Executive Director – Chair of the Committee
- Non-Executive Director (2)
- Service Receiver representatives from a Mental Health representation group / currently Derbyshire Mental Health Alliance (2) with an additional named representative in reserve
- Carer representative from a named Carer organisation
- Executive Director of Nursing and Patient Experience
- Medical Director or a nominated Deputy
- Deputy CEO/ Director of Operations

In attendance:

- Head of Quality & Performance
- Lead professional for Patient Safety
- Chairs or Deputy Chair of Divisional level Quality Leadership Teams
- The Divisional Clinical Directors (1)
- Chief Pharmacist
- Research and Clinical Audit Manager
- Risk and Assurance Manager

- Senior Psychologist

Also may attend:

- Chief Executive Officer
- Chairman
- Assistant Director of Education
- Head of Transformation
- Director of Workforce, OD and Culture
- Director of Corporate Affairs

If the Committee Chair is not present, the meeting shall be chaired by another Non-Executive Director.

3. Quorum

A quorum shall be three members, including at least one Executive Director and two Non-Executive Directors.

4. Frequency

Meetings shall be held monthly.

5. Duties and Responsibilities

In respect of general governance arrangements:

a. To ensure that all statutory elements of operational risk and quality governance are adhered to within the Trust including the requirements of our regulators, NHS Improvement and the Care Quality Commission (regulations).

b. To provide a clear link with the Trust's Strategy and Quality framework when agreeing quality governance priorities and monitor scrutinise these areas to provide assurance and inform the Board on the strategic direction for Quality and monitor the performance of the clinical services.

c. To provide direction to the quality governance activities of the Trust's services and divisions. This will include setting strategy, delegating activities and monitoring clinical performance against this strategy or quality priorities.

d. To scrutinise, gain assurance and approve the Trust's Quality Position Statements and Integrated Risk and Quality Governance Annual Reports before submission to the Board.

e. To have final sign off of the Trust Quality Account prior to Audit and Risk Committee approval

f. To approve the terms of reference and membership of its reporting sub-committees, the primary reporting committee will be the Executive chaired Quality sub group which will scrutinise the clinical performance of the key sub groups known as the Quality Leadership Teams at service level; and to oversee the work of those sub-committees and their clinical reference sub groups, receiving reports from them, reviewing their work plans and clinical escalation issues.

g. To agree to refer specific issues to the Board and other Board Committees where required and make recommendations as appropriate.

h. To receive and approve the annual Clinical Audit Programme consistent with the audit needs of the Trust and consistent with the Quality priorities.

i. To have oversight and gain assurance on the Trust's policies and procedures with respect to the use of clinical data and patient identifiable information to ensure that this is in accordance with all relevant legislation and guidance including the Caldicott Guidelines and the Data Protection Act 1998.

j. To make recommendations to the Audit and Risk Committee concerning the annual Internal Audit plan, to the extent that it applies to matters within these terms of reference; and to comply with any request from the Audit committee for assurance in relation to the Board Assurance Framework and the Risk Register

k. To have overview responsibility and gain assurance for all regulations and standards as described by the Care Quality Commission as part of our responsibilities under the Care Quality Commission (Registration) Regulations 2009 and Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

l. To promote within the Trust a culture of open and honest reporting of any situation that may threaten the quality of patient care in accordance with the Trust's policy on raising concerns and monitoring the implementation of that policy. This will include an approach that enables an open patient safety culture and gain assurance on its implementation.

m. To oversee the system within the Trust for obtaining and maintaining any licences relevant to clinical activity in the Trust.

n. To ensure that risks to patients are minimised through the application of a comprehensive risk management system including clinical risk registers and associated monitoring.

o. To oversee the process and gain assurance within the Trust to ensure that appropriate action is taken in response to adverse clinical incidents, mortality, complaints and litigation and those examples of good practice are disseminated within the Trust and beyond if appropriate.

p. To ensure a clear link with the Mental Health Act Committee on aspects of quality governance that are cross cutting clinical standards across mental health act or mental capacity act legislation that impacts upon clinical standards.

q. To maintain a forward plan of regular agenda items as identified by the scheme of delegation.

r. To ensure a clear link and be assured with the Commissioners Quality Assurance Group, and that escalated clinical concerns, gaps in commissioning and patient safety concerns are discussed and monitored through the joint commissioner and provider risk and issues log.

s. In addition to the Quality subcommittee who will monitor the Quality Leadership Teams and Divisional Quality Reference Groups. To gain assurance and monitor the work of the Trust-wide groups which report the Quality Committee, currently the Serious Incident Requiring Investigation (SIRI) group, the Physical Health Care committee, Health and Safety committee, Drugs and Therapeutics Committee, Patient Experience Group and any short term named task and finish groups established to design or develop Trust Clinical Strategy.

t. To co-operate with and assist the work of other Trust-wide groups which report or scrutinise the work of the Quality Committee, e.g. governors' Governance Committee or the Council of Governors.

u. To receive assurance on how the Trust has developed and planned for all clinical service re-design with sign off of any associated clinical safety plans to mitigate any significant or material changes in service, which have been designed and developed by the Quality Leadership Teams.

v. To conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

w. To oversee the development of an annual review of performance of the Committee against key areas of delegated authority and provide a check that all areas of governance and responsibility have been monitored.

6. Minutes and Reporting

6.1 Full minutes of meetings of the Committee shall be taken and formally recorded. The Committee will produce a written assurance summary report to the next full Board highlighting assurances received, actions requested, and referring issues for full Board discussion where appropriate. Ratified minutes will be reported to the next full Board meeting.

6.2 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its remit and giving details of significant issues and how they have been addressed.

7. Review of terms of reference

The terms of reference shall be subject to annual review.

Mental Health Act Committee Terms of Reference

1. Authority

1.1 The Board of Directors has approved the establishment of a Mental Health Act Committee as a Committee of the Board. The purpose of the Committee is to obtain assurance, on behalf of the "Hospital Managers" and the Trust as the detaining authority, that the safeguards and provisions of the Mental Health Act are appropriately applied; to take account of the provisions of related statute and guidance, such as Mental Capacity Act, Deprivation of Liberty Safeguards (DOLS) and Human Rights Act.

1.2 The Committee will exercise its responsibilities by fulfilling a scrutiny and monitoring role from receipt of regular activity data, and inspection reports; by obtaining assurance that best practice is deployed across the Trust.

1.3 As a Committee of the Board, the Audit and Risk Committee has an important role to provide assurance on the progress and risks arising relating to the delivery of the Trust's Strategic objectives which fall within the Committee's remit.

2. Membership

2.1 The Core membership shall comprise one Non-Executive Director of the Trust, (Committee Chairman) and two other Non-Executive Directors, the Medical Director, (or his nominated representative), the Executive Director of Nursing and Patient Experience, (or nominated representative) and the Director of Corporate Affairs (or nominated representative).

2.2 A minimum of three core members including at least two Non-Executive Directors.

3. Attendance

The associated membership shall comprise:-

- Mental Health Act Manager
- Representative of Associate Hospital Managers
- Representative of Consultant Medical Staff
- Local Authority Leads for Approved Mental Health Practitioners (AMHPs)
- Representative of Medical Staff in Training
- Head of Pharmacy
- Head of Patient Experience
- Other senior management/professional leads may be invited at the discretion of the Committee Chairman.

4. Frequency of Meetings

Meetings will be held quarterly.

5. Duties and Responsibilities

5.1 To receive information, and review if necessary, the number of patients subject to detention under each section of the Mental Health Act for the previous quarter.

5.2 To consider matters of recommended good practice, and in particular the requirements of the Code of Practice (Revised): Mental Health Act (1983) as amended and approve policy changes.

5.3 To receive and review, as required, other activity reports e.g. the use of seclusion.

5.4 To receive the Care Quality Commission Inspection Reports and the management response.

i. To review regularly the Trust's compliance with the statutory requirements of the Mental Health Act (1983).
ii. With regard to Section 136, to monitor use of this section through the multi-agency Section 136 sub-committee.

5.5 To consider the implications of related legislation, principally the Mental Capacity Act, DOLS, Human Rights Act guidance and other related ethical issues as appropriate.

5.6 To obtain assurances that training needs are met and in general help promote awareness of the requirements of the Mental Health Act and associated legislation.

5.7 When receiving information on Mental Health Act activity and reports, the Committee will pay due regard to the Trust's Equality and Diversity Agenda.

5.8 To regularly review the Trust's Policies and Procedures in relation to the Mental Health Act and Code of Practice requirements, and the duties of Associate Hospital Managers, including the protocols for the hearing of appeals and reviews.

5.9 To keep under review as a standing item at each meeting the Board Assurance Framework and high level risks, insofar as they relate to the remit of the Committee; and to comply with any request from the Audit Committee for assurance in relation to the Board Assurance Framework and the Risk Register.

5.10 To conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

5.11 To maintain a forward plan of regular agenda items.

6. Minutes and Reporting

Minutes of meetings of the Committee shall be taken and formally recorded. An assurance summary of the Committee's business will be presented to Board and the Audit and Risk Committee following each meeting. The Committee will present to the Audit and Risk Committee an annual report on its activities for the previous year, including a review of effectiveness against the terms of reference of the Committee.

7. Review of terms of reference

The Terms of Reference will be subject to annual review.

Safeguarding Committee Terms of Reference

1. Authority

1.1 The Safeguarding Committee (the Committee) is constituted as a standing committee of the Trust's Board of Directors. Its constitution and Terms of Reference are set out below, and are subject to amendment at future Board of Directors meetings. The Committee shall not have executive powers in addition to those delegated in these terms of reference.

1.2 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.3 As a committee of the Board the Safeguarding Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit.

2. Membership

2.1 The Committee shall be composed of at least three independent non-executive directors, at least one of whom should have recent and relevant safeguarding experience. One of the members shall be appointed Chair of the Committee by the Board of Directors, Director of Nursing and Medical Director or a nominated deputy, the Chief Executive/Deputy Chief Executive – Chief Operating Officer (either/or). The Trust Chairman shall not be a member of the Safeguarding Committee (but may attend by invitation as appropriate).

2.1 A quorum shall be three core members.

3. Attendance

- NED x 3, with 1 in Chair position
- Executive Director of Nursing and Deputy Chair
- Medical Director or nominated deputy
- Chief Executive, the Deputy Chief Executive – Chief Operating Officer (either/or)
- Head of Safeguarding Children
- Named Nurse – Looked after Children
- Named Doctor – Safeguarding Children
- Nominated lead Healthwatch Derby representative (lead organisation Derby city or Derbyshire to be confirmed – commencing with Derby city)
- Opportunities for people with care and support needs and carers to contribute to and inform its work, to be represented by this group with the Voice of the Child, Voice of the Adult and the Voice of the Carer represented by this group through listening events and its extended work
- Designated Nurse – Safeguarding Children (CCG)
- Named Safeguarding Adult representative from the CCG – Named Lead Chief
- Nurse and/ or Head of Safeguarding representing all CCGs

- HR member of workforce sub-group of DSCB (Derby and Derbyshire Safeguarding Children Boards)
- Divisional Director or General Manager – covering Children's Services, CAMHS
- Director of Transformation and Board level Director responsible for Education
- Named Divisional lead – Clinical Director/Associate Clinical Director/Head of Nursing/Nurse or other Consultant level 1 representative per Division
- Lead professional for Safeguarding Adults named Trust lead for MAPPA/MARAC named Trust lead for PREVENT/CHANNEL
- Named Doctor for Safeguarding Adults
- Named Police representative
- Named Public Health lead

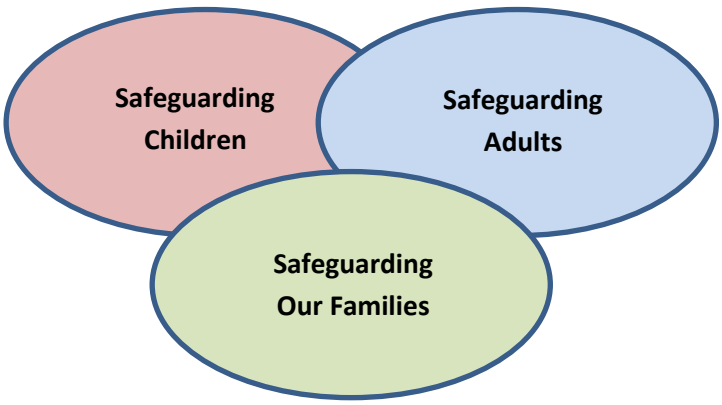
4. Frequency of meetings

4.1 Meetings shall be held at least four times per year, the total number of meetings being determined by the assurance required by the Committee to discharge its responsibilities.

5. Key Responsibilities

The Committee's duties and responsibilities can be categorised as follows:

5.1 To set the Safeguarding Quality Strategy, to provide quality governance and gain assurance to all aspects of the Safeguarding Agenda.



5.2 To lead the assurance process on behalf of the Trust for the following areas:

a. **Children's Act** has a statutory duty of care towards children (Children Acts 1989 and 2004) at risk of harm who are resident in Derby city and Derbyshire in our care. The committee will ensure as an organisation we have safeguards in place not only protects and promotes the welfare of vulnerable children, but that we have a significant impact on children in our care's health and well-being.

b. **The Care Act (2014)** Safeguarding adults at risk of abuse or neglect (Section

42 and named other relevant NHS legislation and NHS Safeguarding Adults policy and procedures.

c. **Counter Terrorism legislation** The Counter Terrorism and Security Bill, which is currently before Parliament (December 2014) at the time of writing, seeks to place duty on specified authorities (identified in full in Schedule 3 to the bill, and set out in this draft guidance) to have due regard to the need to prevent people from being drawn into terrorism. PREVENT.

d. **A formal link to the area Safeguarding Children's and Adults Boards** and provide systems leadership to our wider geographical and community safeguarding responsibilities and be the conduit for linking the community Safeguarding Board strategies with the Trust strategy.

e. **Promote a proactive and preventative approach** to safeguarding through our Flourishing Families agenda

f. Ultimately to provide assurance to the Trust Board that the organisation is effectively discharging and fulfilling its statutory responsibility for safeguarding to ensure better outcomes for children and vulnerable adults.

g. Ensure the Trust workforce is appropriately trained in safeguarding children and adults to their appropriate level depending on their role and responsibility.

h. To determine strategic and operational development that will enable the Trust to integrate best practice in Safeguarding across the Trust. The Committee has a responsibility to improve and develop Safeguarding practices consistent with national and local legislation, guidance and standards in Safeguarding children and vulnerable people.

i. To ensure that the Trust embeds Think Family principles within all aspects of care and service developments to enable 'Flourishing Families'.

j. To provide rigorous and transparent assessment of performance and effectiveness and quality of practice for Safeguarding of Children and Family and Vulnerable Adults Services within the Trust.

k. To advise the Trust Board of national and local standards and Derby and Derbyshire Safeguarding Board arrangements.

l. The Committee will oversee Serious Case Reviews, Independent Learning Reviews, Domestic Homicide Reviews and all Safeguarding major incidents and will advise service level Directors and operational managers of recommendations, lessons learnt and compliance requirements.

m. The Committee will oversee and assure itself that all Safeguarding Boards for Children's and Adults are appropriately represented and feedback from Boards to the Trust Board is in place

n. The Committee will oversee and assure itself on the PREVENT and Channel: Supporting Individuals Vulnerable to Recruitment by Violent Extremists agenda. Establish or use existing mechanisms for understanding the risk of radicalisation. Communicate and promote the importance of the duty; as

outlined in any counter terrorism legislation (2015) and ensure staff implement the duty effectively.

o. The Committee will oversee and assure itself on the Multi-Agency Public Protection Arrangements (MAPPA) with relevant agencies including the police. These processes ensure that the requirements for offenders in the community needs are met and duties to public safety are met fully.

p. The Committee will oversee and assure itself on the MARAC agenda, The Multi-Agency Risk Assessment Conference that the trust is discharging its duty The MARAC aims to: share information to increase the safety, health and well-being of victims/survivors - adults and their children; improve agency accountability; and improve support for staff involved in high-risk domestic abuse cases

q. To have authority in the setting the quality standards, defining and monitoring of clinical practice in safeguarding children and vulnerable adults people through delegated duties to the Safeguarding operational group.

r. To provide an annual report and assurances to the Trust Board committee on the compliance to national standards.

s. To conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

t. To oversee the development of an annual review of performance against key areas of delegated authority and provide a check that all areas of governance and responsibility have been monitored.

u. The named link between the Safeguarding committee and the Quality Committee to ensure consistency and cross Board committee discussion is the Executive Director of Nursing.

5.3 Safeguarding Adults Key Responsibilities

Schedule 2 of the Care Act (2014). That Geographical links to the Safeguarding Adults Boards must have a clear, agreed understanding of the roles, responsibilities, authority and accountability of its member agencies, therefore the Trust should annually

- Review suitable governance arrangements an effective infrastructure and adequate resources.
- Deliver operational and strategic requirements
- Provide links to other boards and partnerships
- Provide links to other boards and partnerships
- Provide a person-centred, outcome focused safeguarding policy and procedures
- Ensure that there is awareness training for all health and social care staff and Police who work directly with people with care and support needs
- Ensure that there is a specialist training for all practitioners who have direct responsibilities for safeguarding work
- Develop and publish a Trust strategy specifying each service areas responsibilities

- Link with the wider community to inform its work and learn of the work of the Board
- Sign off the Safeguarding Adult Annual reports, detailing what the Trust and its members have achieved, including how they have contributed to the Board's objectives and what has been learned from and acted upon from the findings of Safeguarding Adults Reviews and Case Reviews and other Domestic Homicide reviews and associated audits
- Arrangements for the quality assurance of the effectiveness of safeguarding work

5.4 Safeguarding Children Key Responsibilities

- Scrutinise the Safeguarding Children's Annual report, oversight of the Section 11 audit work and assurance that the Trust discharges its duty responsibly in line with National requirements.
- Review suitable governance arrangements an effective infrastructure, adequate resources
- Deliver operational and strategic requirements
- Provide links to other boards and partnerships
- Provide a child centred, outcome focused safeguarding policy and procedures
- Ensure that there is training for all health and social care staff and Police who work directly with people with care and support needs
- Develop and publish a Trust strategy specifying each service areas' responsibilities
- Sign off the Children's, Looked After Children Annual Reports, detailing what the Trust and its members have achieved, including how they have contributed to the board's objectives and what has been learned from and acted upon from the findings of Safeguarding Serious Case Reviews

5.5 Groups and Officers Reporting Schedule:

Group/Officer	**Report**	**Frequency**
Safeguarding Operational group	Operational delivery to the Board level committee	Bi-monthly
Liaison/Key Communications Group/Officer	**Liaison by (person/means)**	**Frequency**
Safeguarding Key Liaison (Trust Link Professionals Group)	Committee Co-ordinator	Monthly
Internal Safeguarding Children Operational Group	Head of Safeguarding Children	Bi-monthly
Internal Safeguarding Adults Operational Group	Head of Safeguarding Adults	Bi-monthly
Learning and Development Meetings	Head of Learning & Development	Monthly
Risk Management Group (DMHST)	Chair	Monthly
Derby Safeguarding Children Board	Chair	As required
Derbyshire Safeguarding Children Board	Chair	As required
Derby Safeguarding Adults Board	Chair	As required
Derbyshire Safeguarding Adults Board	Chair	As required
LSCB (Derby) Quality Assurance	Committee Co-ordinator	As required
LSCB (Derbyshire) Quality Assurance	Committee Co-ordinator	As required
LSCB (Derby) Serious Case Review Group	Chair or Committee Co-ordinator as appropriate	As required

Liaison/Key Communications Group/Officer	Liaison by (person/means)	Frequency
LSCB (Derbyshire) Serious Case Review Group	Chair or Committee Co-ordinator as appropriate	As required
LSCB Derby and Derbyshire Policy and Procedures Group	Committee Co-ordinator	Quarterly
Named and Designated Professionals	Committee Co-ordinator	Quarterly
Named and Designated Professionals Group – Policy and Procedures	Committee Co-ordinator	Quarterly
LSCB Learning and Development Group	Learning & Development Representative	Monthly

6. Minutes and Reporting

6.1 The minutes of all meetings of the Safeguarding Committee shall be formally recorded and submitted, together with recommendations where appropriate, to the Board of Directors.

6.2 The submission to the Board of Directors shall include details of any matters to be escalated in respect of which actions or improvements are needed.

6.3 The Safeguarding Committee will report annually to the Audit and Risk Committee in respect of its work.

7. Review of terms of reference

7.1 The terms of reference of the Safeguarding Committee shall be reviewed at least annually.

Remuneration and Appointments Committee Terms of Reference

1. Authority

1.1 The Remuneration and Appointments Committee (the Committee) is constituted as a standing Committee of the Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings.

1.2 The Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Committee.

1.3 The Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to exercise its functions.

1.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

1.5 As a Committee of the Board, the Audit and Risk Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's Strategic objectives which fall within the Committee's remit.

1.6 The Committee has a role during the 2016/17 financial year to oversee progress and provide assurance to the Board on the implementation of key tasks as outlined in the Trust's Governance Improvement Action Plan. The Committee is assigned as responsible committee for a range of tasks and is required to provide assurance to the Board on the progress towards completion of tasks and evidence of demonstrable outcomes in working towards ensuring that effective governance processes are embedded within the Trust.

2. Membership

2.1 The membership of the Committee shall consist of:

- Trust Chair, and
- All Non-Executive Directors on the Board of Directors.
- The Trust Chair will chair the Committee.

2.2 A quorum shall be three members.

When appointing or removing the Chief Executive, the Committee shall be the committee described in Schedule 7, 17(3) of the National Health Service Act 2006 as amended by the Health and Social care Act 2012 (the Act) (that is all the non-executive directors). When appointing or removing the other executive directors the Committee shall be the committee described in Schedule 7, 17(4) of the Act (that is the Trust chair, the chief executive and the non-executive directors).

3. Attendance

3.1 Meetings of the Committee may be attended by:

- Chief Executive
- Director of Workforce, Organisational Development and Culture; and
- Director of Corporate Affairs; and
- Any other person who has been invited to attend the meeting by the Committee so as to assist in deliberations

4. Frequency of Meetings

Meetings shall be held monthly or as required.

5. Key Responsibilities

Monitor's Code of Governance (July 2014) - These terms of reference are based in part, on best practice as set out in that code and have been drafted referring to the provision in the code. The code states as two of its principles that;

"There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration."

"There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board. Directors of NHS foundation trusts must be "fit and proper" to meet the requirements of the general conditions of the provider licence."

These terms of reference are intended to ensure that the Trust's procedure for the appointment of the chief executive and other directors (excluding Non-Executive Directors) to the Board of Directors reflect these principles.

To be responsible for identifying and appointing candidates to fill all the executive director positions on the Board and for determining their remuneration and other conditions of service.

5.1 Appointments role

a) To be responsible for identifying and appointing candidates to fill all the executive director positions on the board including the Chief Executive, voting and non-voting Directors. Non-executive Directors are appointed through the Nominations and Remuneration Committee of the Council of Governors.

b) Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate, and make recommendations to the board, and nomination committee of the Council of Governors, as applicable, with regard to any changes.

c) Give full consideration to and make plans for succession planning for the Chief Executive and other executive board director roles taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the board in the future.

d) To advise upon and oversee contractual arrangements for executive

directors, including but not limited to termination payments.

e) Ensure that a proposed executive director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise.

f) Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

g) Consider any matter relating to the continuation in office of any board executive director including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract. The Committee will oversee ongoing compliance with the Fit and Proper Person requirements of Directors.

5.2 Remuneration Role

a) Establish and keep under review a remuneration policy in respect of executive board directors.

b) Consult the Chief Executive about proposals relating to the remuneration of the other executive directors.

c) In accordance with all relevant laws, regulations and Trust policies, decide and keep under review the terms and conditions of office of the Trust's executive directors (voting and non-voting) on locally-determined pay in accordance with all relevant Foundation Trust policies, including:

- salary, including any performance-related pay or bonus;
- provisions for other benefits, including pensions and cars; and
- allowances.

d) In adhering to all relevant laws, regulations and Trust policies:

- establish levels of remuneration which are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust;

- use national guidance and market benchmarking analysis in the annual determination of remuneration of executive directors (both voting and non-voting) on locally-determined pay, while ensuring that increases are not made where Trust or individual performance do not justify them;

e) Monitor, and assess the output of the evaluation of the performance of individual executive directors, and consider this output when reviewing changes to remuneration levels.

6. Minutes and Reporting

6.1 The minutes of all meetings of the Committee shall be formally recorded. These will be retained by the Chair and not shared with Executive Directors.

6.2 The Committee will report to the full Board of Directors (confidential session) after each meeting.

6.3 The Committee shall ensure that Board of Directors emoluments are accurately reported in the required format in the Trust's annual report.

6.4 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting and an annual review of effectiveness against its terms of reference. The annual review will be submitted to the Audit and Risk Committee.

7. Review of terms of reference

The terms of reference of the committee shall be reviewed by the Board of Directors at least annually.

People & Culture Committee Terms of Reference

1. Authority

1.1 The People and Culture Committee is constituted as a standing committee of the Foundation Trust's Board of Directors. Its constitution and Terms of Reference shall be as set out below, subject to amendment at future Board of Directors meetings. The People and Culture Committee shall not have executive powers in addition to those delegated in these terms of reference.

1.2 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice and to secure the attendance of both internal and external officers with relevant experiences and expertise it if considers this necessary.

1.3 As a Committee of the Board, the People and Culture Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's Strategic objectives which fall within the Committee's remit.

1.4 The Committee has a role during the 2016/17 financial year to oversee progress and provide assurance to the Board on the implementation of key tasks as outlined in the Trust's Governance Improvement Action Plan. The Committee is assigned as responsible committee for a range of tasks and is required to provide assurance to the Board on the progress towards completion of tasks and evidence of demonstrable outcomes in working towards ensuring that effective governance processes are embedded within the Trust.

2. Membership

2.1 The membership of the Committee will comprise:

- Non-Executive Directors x 3 (one will be appointed as the Chair)
- Director of Workforce, Organisational Development and Culture
- Medical Director
- Director of Operations

2.2 A quorum shall be three (not less than two non-executive directors and one executive director).

3. Attendance

3.2 Only members of the Committee have the right to attend and vote at Committee meetings. The Committee may require other officers of the Trust, and other individuals may attend all or any part of its meetings as and when is necessary. It is expected that a member of staff side, a governor and a member of the communications team will attend each meeting.

3.3 The Board of Directors will appoint the Chair of the Committee

3.4 The Trust Board has delegated authority to any Non-Executive Director of the Trust to act as nominated deputy in the absence of any Non-Executive and this attendance will count towards the quorum.

3.5 The Board Secretary will be in attendance and provide administrative support.

3.6 Members are expected to attend a minimum of 8 meetings per year. A register of attendance will be maintained and reviewed by the Committee annually.

4. Frequency of Meetings

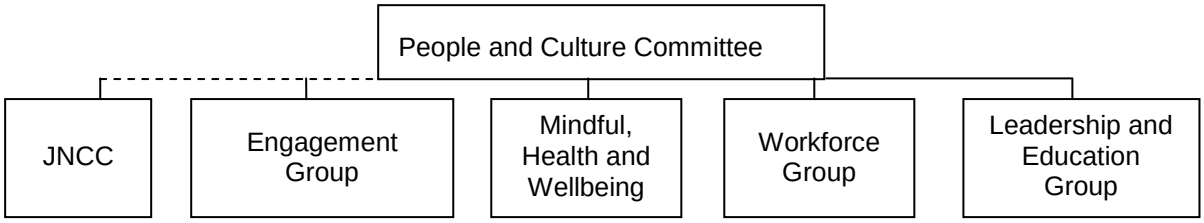
The Committee will meet on a monthly basis with additional meetings being called when necessary

5. Duties and Responsibilities

5.1. The Committee will support the organisation to achieve a well led, values driven positive culture. The Committee is to provide assurance to the Board that the appropriate structures, processes and systems are in place to ensure an effective capable workforce to meet the Trusts current and future needs.

5.2 The Committee will monitor the implementation of the People Strategy and report progress to the Board by exception

A number of supporting groups / forums will be accountable to the People and Culture Committee whilst not exhaustive; it is anticipated that the following groups will have a direct or indirect relationship and will be agreed within the Committee



5.2 The Committee will oversee and monitor workforce performance

5.3 The Committee review and monitor the Workforce metrics and Board Assurance Framework and ensure the Board is kept informed of any significant workforce risks

5.4 The Committee is to be assured that mechanisms are in place to review and monitor the effectiveness and capability of the workforce across the whole Trust and that appropriate actions are taken to address issues of poor performance and bring about continuous quality improvement.

5.5 The Committee is to be assured that the Trust identifies lessons for improvement and implements these in all relevant areas

5.5 The Committee is to be assured that National standards, guidance and best practice are systematically reviewed and embedded within the Trust

5.6 The committee is to be assured that the views of staff and appropriate others are systematically and effectively engaged in organisational development activities

5.7 The Committee will oversee the leadership, training and education framework and monitor progress.

5.8 The Committee will monitor the implementation of agreed action plans in relation to organisational interventions and measure the effectiveness of change.

5.9 The Committee will review its effectiveness by self-assessment on an annual basis and at the end of each meeting. The annual review will be presented to the Audit and Risk Committee.

Summary of Role:

- Ensure the People Strategy, structures, systems and processes are in place and functioning to support employees in the provision and delivery of safe and high quality patient care
- Oversees the development and implementation of an effective People Strategy which supports the Trust Strategy
- Ensure that the People Strategy and associated plans are aligned and focussed on meeting the needs of the organisation
- To achieve a well-led values driven positive culture at all levels of the organisation
- To ensure a systematic approach to the management of change to deliver an empowered, high performing workforce
- The workforce plans are 'fit for purpose' and have sufficient flexibility to meet the changing needs of the Trust.
- Have an understanding of the current and future capability required and develop a robust process to inform workforce plans.
- There are robust performance processes in place for the effective management of the workforce to ensure the Trust meets it priorities.
- To drive a positive culture and high staff engagement
- To ensure the learning and education needs of the organisation are understood and met

6. Minutes and Reporting

6.1 Minutes of meetings of the Committee shall be taken and formally recorded. Ratified minutes will be reported to the next full Board meeting.

6.2 An assurance summary highlighting assurances received, actions requested, and referring issues for full Board discussion where appropriate will be received at the next full Board meeting. The Chair of the Committee shall draw to the attention of the Board of Directors any issues that require disclosure to the full Board, or require executive action.

7. Review of terms of reference

The terms of reference will be reviewed at least annually.

Appendix 1

Board Committee Summary Report to Trust Board
Name of committee:
Date meeting held:

New format summary report in response to Governance Improvement Action Plan – From Core 4 Corporate Governance Action reference CG 12 (Deloitte Recommendation 12)

"Reintroduce short summary reports from committee chairs to supplement minutes. These should identify key risks, successes, decisions made/escalated from the meeting"

Agenda Item **As stated on the agenda**	**Summary of issue discussed** **Summary of agenda item as discussed**	**Assurance and actions required** **Record where positive assurance or limited assurance was received. This section to also include identified successes where relevant and any further work required.** **Actions agreed to be listed here with lead director/officer identified.**	**Key risks identified** **Risks that may impact on the issue under discussion (eg risks to delivery of project) or have wider impact (eg impact on BAF risks)**	**Decisions made** **A summary of all decisions made as part of agenda item discussion**	**Escalations to Trust Board (or referral to other committee) and for what reason** **Areas of concern to escalate to the Board or Board Committee for action (to be specified)**

Appendix 2

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors [date]

Title

Purpose of Report:
Why is the paper coming to the Board / the Committee?

Executive Summary

- Clearly describe all that you want to draw attention to, if the reader were not to read the whole document
- Pull out the key messages/findings in report - don't expect the reader to extract it themselves
- Consider: What are the answers to the question 'so what'?
- Openly disclose the key risks and issues to note, make any necessary explicit cross-reference to BAF, annual plan, specific strategy outcomes, CQC /Monitor/legislation /compliance risks etc
- Focus on trends and forward looking insight – not just the 'here and now'
- Clarify the key next steps and actions being taken to correct or capitalise on the key risks and issues
- Does it have a potential financial implication? If so be explicit – business case will be needed and referenced for financial impact
- Does it have a potential impact on quality? – if so be explicit
- Does it have workforce implications? - if so be explicit
- Does it have a transformation impact – if so be explicit
- Remember the audience, especially if this is public document – use appropriate accessible plain English

Strategic considerations

- What is the wider context of this document (national/local/Trust)
- Draw out or build on the explicit *strategic* links – e.g. Trust strategy outcomes, other specific strategies
- Include here any specific strategic questions that the Board/committee should consider?
- Distinguish between *assurance* considerations which should be included below and *strategic* considerations

(Board) Assurances

- What are the specific assurances that the Board/committee can obtain from this paper? Be open and transparent on what is full assurance compared to partial assurance
- Note the key difference between Board assurance and other organisational risks – note if the risk is on the risk register (which includes BAF risks) and include reference to Risk ID from Datix if at all possible
- If this paper is to a committee which has specific responsibility for specific BAF risks – include an extract of the BAF risk affected to demonstrate how this responsibility is being discharged by this paper.
- If this paper is to Board and raises an issue that impacts on an existing BAF risk – include the relevant extract of the BAF

Consultation

Include the following as relevant

- Include explicit dated reference here to where another committee/meeting has considered content from this or a draft of this paper
- Is this paper coming as a result of escalation to Board by any other committee? If so explain
- If this is a follow up/update to a previous Board/committee paper on the same topic - explicitly cross reference to last paper
- Include if relevant, whether Governors have been or should be involved, have Public/Patient been involved, other stakeholders as relevant
- Has any technical advice been sought? – if so explain

Governance or Legal Issues

Spell out any governance, compliance or legal issues relating to this report, or confirm there are none – eg CQC, regulatory framework, health and safety

Note to authors: it is highly unlikely that a paper going to Trust Board should have no governance, compliance or legal implications

Equality Delivery System

- Outline any impact on REGARDS groups, or confirm none

Recommendations

The Board of Directors is requested to:

1)
2)

What do you want the Board to do with this paper?
NB: Be explicit if certain wording needs to be minuted – put that *actual wording* in the recommendation

1) Approve…
2) Receive assurance from (scrutinise current performance/discharge responsibilities)…
3) Accept the proposal…
4) Decide/approve/endorse decision of/…
5) Note …

Report presented by:

Report prepared by:

Appendix 3

Derbyshire Healthcare NHS Foundation Trust

Standing Orders of the Board of Directors

and

Standards of Business Conduct

CONTENTS

1. Introduction to Standing Orders

Who should read these Standing Orders?

1.1. You should read these Standing Orders and be aware of their relevance to you as you discharge your responsibilities if you:

- Are a Director of the Trust
- Attend Board meetings
- Are a member of a Committee or sub-committee established by the Board, or attend its meetings
- Are a senior officer of the Trust
- Are involved in letting contracts on behalf of the Trust
- Are responsible for any aspect of the procurement of goods and services on behalf of the Trust
- Have a pecuniary interest in a contract that the Trust is entering into
- Are required to sign any legal document on behalf of the Trust

Statutory Framework

1.2. The Derbyshire Healthcare NHS Foundation Trust (the Trust) is a public benefit corporation which was established under the 2006 Act on 1 February 2011, subject to its Constitution and Provider Licence.

1.3. The headquarters of the Trust is at The Ashbourne Centre, Kingsway Site, Kingsway, Derby, DE22 3LZ.

1.4. NHS Foundation Trusts are governed by a regulatory framework that confers the functions of the Trust and comprises the 2006 Act, the Constitution and Terms of Authorisation. The powers of the Trust are set out in the 2006 Act subject to any restrictions in the Terms of Authorisation.

1.5. The Trust will be bound by such other statute and legal provisions or guidance which governs the conduct of its affairs.

1.6. As a public benefit corporation the Trust has specific powers to contract in its own name and to act as a corporate trustee. The Trust has a common law duty as a bailee for patients' property held by the Trust on behalf of patients. The Trust also has statutory powers to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

1.7. In accordance with paragraph 27 of the Constitution, the Standing Orders of the Board of Directors is to be set out in Annex 7 to the Constitution. The Trust adopts Standing Orders for the regulation of proceedings and business.

NHS Framework

1.8. In addition to the statutory requirements the Secretary of State (through the Department of Health), the Care Quality Commission or NHS Improvement may issue further requirements and guidance. These are normally issued under cover of a circulation or letter. The Board will be made aware of additional statutory requirements as they arise and amendments made to the Trust's Corporate Governance Framework as appropriate. Codes of Conduct and Accountability make various requirements concerning possible conflicts of interest of Directors. The Codes (and the Constitution) also require the establishment of Audit and Remuneration Committees with terms of reference formally agreed by the Trust Board.

Delegation of Powers

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

1.10. Where officers are designated in these Standing Orders, they may designate their responsibility through approved Schemes of Delegation.

2. Interpretations and Definitions

2.1. At any meeting, the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (in which he should be advised by the Chief Executive or the Director of Corportate Affairs and Trust Secretary (hereafter referred to as the Trust Secretary), except where this would contravene any statutory provision or direction made by the Secretary of State (applicable to NHS Foundation Trusts) or such authorisation as may be given by the Independent Regulator.

2.2. All references in these Standing Orders to the masculine gender shall be read equally applicable to the feminine gender.

2.3. For convenience and unless the context otherwise requires the terms and expressions contained within paragraph 40 of the Constitution relating to Interpretation are incorporated and are deemed to have been repeated here verbatim for the purposes or interpreting words contained in this document:

> *"COMMITTEE" means a Committee or Sub-Committee appointed by the Trust.*
>
> *"COMMITTEE MEMBERS" shall be persons formally appointed by the Trust to sit on or to Chair specific Committees.*
>
> *"CONTRACTING AND PROCURING" means the systems for obtaining the supply of goods, material, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal or surplus and obsolete assets.*

“NOMINATED OFFICER” means an Officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

“OFFICER” means and employee of the Trust or any other person holding a paid appointment or office with the Trust.

“SFIs” means Standing Financial Instructions.

“SOs” mean Standing Orders.

3. BRIBERY ACT

3.1. Implementation of the Bribery Policy:

3.1.1 It is a long established principle that public sector bodies, including the NHS, must be scrupulously impartial and honest in the conduct of their business and that as an employee of the Trust you should remain above suspicion.

3.1.2 The introduction of the Bribery Act 2010 places responsibility on the organisation to ensure robust procedures are in place to prevent bribery and corruption taking place within the Trust. The Trust believes it is the responsibility of all employees to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interest and their NHS duties.

3.1.3 All individuals within healthcare organisations are capable of being prosecuted for taking or offering a bribe. There is no maximum level of fines that can be imposed and an individual convicted of an offence can be imprisoned for up to ten years. The Bribery Act 2010 came into force on 1 July 2011 and creates five basic offences:

- Bribing another person with the intention of inducing that person to perform a relevant function or activity improperly or to reward that person for doing so
- Accepting a bribe with the intention that a relevant function or activity should be performed improperly as a result
- Bribing a foreign public official
- A Director, manager or officer of a commercial organisation allowing or turning a blind eye to bribery within the organisation (the question of whether any particular organisation falls within the definition of a ‘commercial organisation’ will be considered on the facts of individual cases. It is, however, reasonable to assume that an NHS Trust or NHS Foundation Trust could be deemed a ‘commercial organisation’ for the purpose of this Act).
- Failing to prevent bribery – where a person (including employees, agents and external third parties) associated with a relevant commercial organisation bribes another person intending to obtain or retain a business advantage. This is a strict liability offence which can be committed by the organisation unless it can show, in its defence, that it had adequate procedures in place to prevent bribery.

3.1.4 As an employee you have a responsibility to respond to other employees, patients and suppliers impartially, to achieve value for money from the public funds with which you are entrusted and to demonstrate high ethical standards of personal conduct. Recognising the statements of this nature cannot allude to every possible contingency, it is assumed that all employees are able to distinguish between acceptable and unacceptable behaviour in the conduct of their duties. Staff must not misuse or make official 'commercial in confidence' information to persons or organisations not reasonably needing access, particularly if its disclosure would prejudice the principle of a purchasing system for the Trust based on fair competition. If, however you are uncertain about the correctness or propriety of any proposed business transaction, or in relation to hospitality, declaration of interests or commercial sponsorship then you must seek advice from a senior manager.

3.1.5 The aim of this policy is to:

Provide you as an employee of the Derbyshire Healthcare NHS Foundation Trust (DHCFT) with clear guidance to ensure that you are aware of your responsibilities in relation to the conduct of business within the NHS and the consequences of failing to observe those responsibilities.

3.1.6 It is an offence for a person to offer, promise or give a financial or other advantage to another person in one or two cases:

- Case 1 applies to where that person intends the advantage to bring about the improper performance by another person of a relevant function or activity or to reward such improper performance
- Case 2 applies where the person knows or believes that the acceptance of the advantage offered, promised or given in itself constitutes the improper performance or a relevant function or activity.

3.1.7 DHCFT staff must not:

- Abuse their past or present official position to obtain preferential rates for private deals
- Unfairly advantage one competitor over another or show favouritism in agreeing sponsorship
- Misuse or make available official 'commercial in confidence' information
- Accept any inducements or inappropriate hospitality or gifts

3.1.8 You should refer to the Trust Raising Concerns (Whistleblowing) Policy for guidance on how to report concerns that you do not feel able to raise though normal reporting channels.

3.2 Breaches of the Bribery Policy

3.2.1 Alleged breaches of this policy will be investigated under the terms of the Trust Disciplinary Procedure.

3.2.2 In accordance with the Trust's Fraud and Corruption Policy all suspicions of fraud and/or corruption occurring within the NHS will be referred to the Trust's Local Counter Fraud Specialist and/or NHS Protect for formal investigation. Should evidence of fraud or corruption be discovered the Trust may initiate disciplinary, criminal and civil sanctions as appropriate.

3.2.3 Under the Prevention of Corruption Act, 1906 and 1916, it is an offence for employees to corruptly to accept any gifts or consideration as an inducement or reward for:

- Doing, or refraining from doing, anything in their official capacity or
- Showing favour or disfavour to any person in their official capacity

Under the Prevention of Corruption Act 1916, any money, gift or consideration received by an employee in public service from a person or organisation holding or seeking to obtain a contract will be deemed by the courts to have been received corruptly unless the employee proves the contrary. (Refer to Trust Declaration of Interests, Hospitality and Sponsorship Policy for further information).

3.2.4 The Bribery Act creates the offence of offering or receiving bribes and if failure to prevent a bribe being paid on an organisation's behalf. It makes it an offence for a person to offer, promise or give a financial or other advantage to another person if:

- That person intends the advantage to bring about the improper performance by another person of a relevant function or activity or to reward such improper performance or
- That person knows or believes that the acceptance of the advantage offered, promised or given in itself constitutes the improper performance of a relevant function or activity

3.2.5 The maximum sentence for bribery committed by an individual is 7 to 10 years imprisonment. The offence applies to bribery relating to any function of a public nature, connected with a business, performed in the course of a person's employment or performed on behalf of a company or another body of persons. Therefore bribery in both the public and private sectors is covered by the Act.

You should be aware that breaches of these Acts renders you liable to prosecution which may also lead to loss of employment and pension rights in the NHS.

4 THE TRUST

4.1 **Composition of the Trust –** in accordance with the Constitution the composition of the Board of the Trust shall comprise:

- A Non-Executive Chair
- Up to 6 other Non-Executive Directors (one of whom may be nominated as the Senior Independent Director); and
- Up to 6 Executive Directors (voting)

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

The Board may appoint one of the Non-Executive Directors as the Senior Independent Director, in consultation with the governors.

4.2 **Appointment of the Chair and Directors** – The Chair and Non-Executive Directors are appointed (and removed) by the Council of Governors, through their Nominations and Remuneration Committee. The Chief Executive will be appointed or removed by the Non-Executive Directors and the appointment (but not the removal) will be subject to approval by the Council of Governors. The Trust shall appoint a Remuneration and Appointments Committee and/or other nominated persons whose members shall be the Chair, Non-Executive Directors and the Chief Executive whose function will be to appoint the other Executive Directors of the Trust.

4.3 **Terms of Office of the Chair and Directors** – the provisions governing the period of tenure of the office of the Chair and Directors and for the termination or suspension of office of the Chair and Directors are set out in the Constitution and these Standing Orders. Non-Executive Directors, including the Chair, shall be appointed by the Council of Governors for specified terms at intervals of usually no more than three (3) years. Any term beyond six years (eg two three year terms) shall be subject to rigorous review and shall take into account the need for progressive refreshing of the Board. Non-Executive Directors may be in exceptional circumstances serve longer than six (6) years but in such circumstances shall be subject to annual re-appointment.

4.4 **Appointment of Deputy Chair** – for the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chair, the Council of Governors may appoint a Non-Executive Director to be Deputy Chair for such a period, not exceeding the remainder of his term as Non-Executive Director of the Trust, as they may specify on appointing him.

4.5. Any Non-Executive Director so elected may at any time resign from the office of Deputy Chair by giving notice in writing to the Chair and the Directors of the Trust may thereupon appoint another Non-Executive Director as Deputy Chair in accordance with the governors' Nominations and Remuneration Committee Terms of Reference.

4.6 **Powers of Deputy Chair** – where the Chair of the Trust has ceased to hold office or where he has been unable to perform his duties as Chair owing to illness, or any other cause, the Deputy Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes his duties.

4.7. **Joint Directors**

(1) Where more than one person is appointed jointly to a post of Director those persons shall count for the purposes of Standing Order 2.1 as one person.

(2) Where the office of Director of the Board is shared jointly by more than one person:

a) Either or both of those persons may attend or take part in meetings of the Board
b) If both are present at a meeting they should cast one vote if they agree
c) In the case of disagreements no vote should be cast
d) The presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 5.26 Quorum.

4.8. **Role of Directors –** the Board will function as a corporate decision-making body within which all Directors (voting) will be equal. Their role as members of the Board will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory functions. In exercising these functions the Board will consider guidance from NHS Improvement's 'the NHS Foundation Trust Code of Governance' as amended from time to time.

1) **Executive Directors** - Executive Directors shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

2) **Chief Executive** - The Chief Executive shall be responsible for the overall performance of the Trust. He is the **Accounting Officer** for the Trust and shall be responsible for ensuring the discharge of obligations under financial directions and in line with the requirements of the NHS Foundation Trust Accounting Officer Memorandum for Trust Chief Executives.

3) **Executive Director of Finance** - The Executive Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. She shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant financial directions.

4) **Non-Executive Directors** - The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of, or when chairing, a Committee of the Trust which has delegated powers.

5) **Chair** - The Chair shall be responsible for the operation of the Board and Chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of appointment and with these Standing Orders. The Chair shall liaise with the Council of Governors over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance. The Chair shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

4.9 **Corporate Role of the Board**

1) All business shall be conducted in the name of the Trust
2) All charitable funds received in the Trust shall be held in the name of Derbyshire Community Health Services NHS Foundation Trust, acting as corporate trustee on behalf of the Trust
3) The powers of the Trust shall be exercised by the Board meeting in private session except as otherwise provided in Standing Order (5.1).

4.10 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in The Scheme of Delegation: Decisions reserved to the Board.

4.11 Lead Roles for Directors

The Chair will ensure that the designation of Lead roles or appointments of Board members as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (eg appointing a Lead Board Director with responsibilities for Infection Control or Child Protection Services etc).

5 MEETINGS OF THE TRUST

5.1 Admission of the Public and the Press – The meetings of the Board of Directors shall be open to members of the public and press unless the Board decides otherwise in relation to all or part of a meeting for reason of confidentiality or on other proper grounds.

In the event that the public and press are admitted to all or part of a Board meeting the Chair shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board business shall be conducted without interruption and disruption and the public will be required to withdraw upon the Board resolving that in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete its business without the presence of the public.

Nothing in these Standing Orders shall require the Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report or proceedings without permission granted by resolution of the Trust.

5.2. **Calling of Meetings** – Ordinary meetings of the Trust shall be held as such times and places as the Board determines.

5.3 One third or more members of the Directors may requisition a meeting in writing. If the Chair refuses, or fails, to call a meeting within seven days of the requisition being presented, the Directors signing the requisition may forthwith call a meeting.

5.4 **Notice of Meetings** – Before each meeting of the Trust Board, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or the Trust Secretary shall be delivered to every Director, sent by email and/or sent by post to the usual place of residence of such Director, so as to be available to him at least three clear days before the meeting.

Lack of service of the notice on any Director shall not affect the validity of the meeting.

5.5 In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

5.6 Failure to serve such a notice on more than three Directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice is delivered via email.

5.7 Before any meeting of the Board which is to be held in public, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Trust's website at least three clear days before the meeting.

5.8 **Agenda and Supporting Papers** – The Agenda will be sent to Directors three days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three clear days before the meeting, save in an emergency.

5.9 A Director desiring a matter to be included on an agenda shall make his request in writing to the Chair at least six clear days before the meeting subject to SO 5.3. Requests made less than six days before a meeting may be included on the agenda at the discretion of the Chair.

5.10 At any meeting of the Trust, the Chair, if present shall preside. If the Chair is absent from the meeting the Deputy Chair, if present shall preside. If the Chair and the Deputy Chair are absent such Non-Executive Director as the Directors present shall choose shall preside.

5.11 **Annual Members' Meeting** – The Trust will publicise and hold an annual meeting of its members by the end of September each year. The meeting must be open to members of the public.

5.12 **Chair's Ruling** – The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

5.13 **Voting** – All questions put to the vote at a meeting shall be determined by a majority of the votes of the voting Directors present and voting on the question and, in the case of an equal vote, the person presiding shall have a second or casting vote.

5.14 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

5.15 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any questions may be recorded to show how each Director present voted or abstained.

5.16 If a Director so requests, his vote shall be recorded by name.

5.17 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

5.18 An officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

5.19 **Minutes** – The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next meeting whereafter they will be signed by the Chair. The names of the Directors present at the meeting shall be recorded in the minutes.

5.20 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

5.21 **Suspension of Standing Orders** – Except where this would contravene any provision in the Constitution, the Terms of Authorisation any statutory provision or authorisation by the Independent Regulator any one or more of the Standing Orders may be temporarily or permanently suspended at any meeting, provided that at least two thirds of the Board are present signifying their agreement to such suspension, including one Executive Director and one Non-Executive Director.

5.22 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting. A separate record of matters discussed during this suspension shall be made and shall be available to the Directors.

5.23 The Audit and Risk Committee shall review every decision to suspend Standing Orders.

5.24 These Standing Orders shall be amended only if:

- At least half the total of the Trust's Non-Executive Directors present vote in favour of the amendment, and
- At least two-thirds of the Directors are present, and
- The variation proposed does not contravene any applicable statutory provision or direction;

5.25 **Quorum** – No business shall be transacted at a meeting of the Trust Board unless at least three of the whole number of the Directors are present including at least one Executive Director and one Non-Executive Director.

5.26 An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

5.27 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 8.5) he/she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

6 ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

6.1 Subject to SO 6.1.1 below and subject to the Mental Health Act 1983, the Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO 7.1 or 7.2 below, or by an Executive Director of the Trust in each case subject to such restrictions and conditions as the Board thinks fit.

6.1.1 **Hospital Managers Powers to Discharge** – When the Trust is exercising the functions of the managers referred to in Section 45 of the Mental Health Act 2007 those functions may be exercised by any three or more persons authorised by the Board, each of whom is neither an Executive Director of the Board nor an employee of the Trust.

6.2 **Emergency Powers** – The powers which the Board has reserved to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board for ratification.

6.3 **Delegation to Committees** – Subject to SO 6.1 above, the Board shall agree from time to time to the delegation of executive powers to be exercised by committees and sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board.

6.4 **Delegation to Officers** – The Chief Executive is responsible for those functions of the Trust which have not been retained as reserved by the Board or delegated to a committee. The Chief Executive shall determine which functions he will perform personally and shall nominate officers to undertake the remaining functions for which he will still retain accountability to the Trust.

6.5 The Chief Executive shall prepare a Scheme of Delegation identifying his proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board.

6.6 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Executive Director of Finance or other Executive Director to provide information and advise the Board in accordance with statutory requirements.

6.7 The Board shall comply with the arrangements set out in the Decisions Reserved for the Board and Scheme of Delegation.

6.8 **Overriding Standing Orders** – If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

7 COMMITTEES

7.1 **Appointment of Committees** – Subject to the Constitution and any applicable statutory provision or direction the Trust may appoint committees or sub-committees of the Trust, consisting wholly or partly of Directors of the Trust or wholly or partly of persons who are not Directors of the Trust. The Standing Orders of the Trust shall apply to committees and sub-committees of the Trust.

7.2 A committee appointed under SO 7.1 may appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include Directors of the Trust or other health service bodies in question); or wholly of persons who are not members of the Trust or other health service bodies or the committee of the Trust or other health service bodies in question.

7.3 Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as reporting back to the Board), as the Board shall decide.

7.4 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board.

7.5 The Board shall approve the appointments to each of the committees, which it has formally constituted. Where the Board determines and regulations permit, that persons, who are neither Directors nor Officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement of loss of earnings, and/or expenses in accordance where appropriate with national guidance.

7.6 Where the Board is required to appoint persons to a committee and/or to undertake statutory functions, and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with any regulations and direction.

7.7 The Chief Executive will be appointed or removed by the Non-Executive Directors subject to approval by the Council of Governors.

7.8 Appointment of Executive Directors other than the Chief Executive – it is for the Remuneration and Appointments Committee, consisting of the Chair, the Chief Executive and other Non-Executive Directors, to appoint or remove the Executive Directors.

7.9 Committees, sub-committees and joint committees established by the Board shall include:

Audit and Risk Committee

Remuneration and Appointments Committee

Quality Committee

Finance and Performance Committee

Mental Health Act Committee

Safeguarding Committee

People and Culture Committee

And any other such committees as required by the Board to discharge its responsibilities.

7.10 **Confidentiality** - A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board or shall otherwise have concluded on that matter, or if the Board shall resolve that any matter will remain confidential.

7.11 Committee meetings of the Board will not be held in public unless expressly stated.

8 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

8.1 Policy statements: general principles

The Board of Directors will from time to time agree and approve policy statements/ procedures which will apply to all or specific groups of staff employed by the Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Board of Directors minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

8.2 Specific Policy statements

Notwithstanding the application of SO 8.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following policy statements:

- Declaration of Interests, Hospitality and Sponsorship Policy for the Trust staff
- The staff Disciplinary and Appeals Procedures adopted by the Trust.

8.3 Specific guidance

Notwithstanding the application of SO 8.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by NHS Improvement and the Secretary of State for Health (applicable to NHS Foundation Trusts):

- Caldicott Guardian 1997
- Human Rights Act 1998
- Freedom of Information Act 2000
- Public Sector Equality Duty

8.4 Declaration of Interests

The NHS Code of Accountability and the Constitution requires the Board of Directors to declare interests which are relevant and material to the NHS Board of which they are a Director. All existing Directors should declare such interest. Any Directors appointed subsequently should do so on appointment.

8.5 Interests which should be regarded as 'relevant and material' are:

a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those dormant companies)

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS

c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS

d) A position of authority in a charity or voluntary organisation in the field of health and social care

e) Any connection with a voluntary or other organisation contracting for NHS services

f) Research funding/grants that may be received by an individual or their department

g) Interests in pooled funds that are under separate management.

8.6 If any Director has any doubt about the relevance of an interest, this should be discussed with the Chair or Trust Secretary.

8.7 Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

8.8 At the time Board of Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring.

8.9 Board of Directors' directorships of companies likely or possibly seeking to do business with the Trust should be published in the Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports.

8.10 During the course of a Board meeting, if a conflict of interest is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

8.11 **Register of Interests**

The Trust Secretary will ensure that a Register of Interests is established to record formally declarations of interest of Directors. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Board of Directors.

8.12 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be included.

8.13 The Register will be available to the public and the Trust Secretary will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

9 DISABILITY OF DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

9.1 Subject to the following provisions of this Standing Order, if the Chair, or a Director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

9.2 The Trust shall exclude a Director from a meeting of the Trust while any contract, proposed contract or other matter in which he/she has a pecuniary interest, is under consideration.

9.3 Any remuneration, compensation or allowances payable to a Director by virtue of 2006 Act shall not be treated as a pecuniary interest for the purpose of this Standing Order.

9.4 For the purpose of this Standing Order the Chair or a Director shall be treated, subject to SO 9.5, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

a) A nominee of his is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration;

Or

b) He is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

And in the case of married persons living together the interest of one spouse shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest to the other.

9.5 A Director shall not be treated as having a pecuniary interest in any contract or other matter by reason only:

a) Of his membership of a company or other body, if he/she has no beneficial interest in any securities of that company or other body;

b) Of an interest in any company, body or person with which he is connected as mentioned in SO 9.4 above which is so remote or insignificant that it cannot be reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

9.6 Where a Director:

a) Has an indirect pecuniary interest in a contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

b) The total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

c) If the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class, this Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his/her duty to disclose his/her interest.

9.7 Standing Order 10 applies to a committee or sub-committee of the Trust as it applies to the Trust and applies to any member of any such committee or sub-committee (whether or not he is also a Director of the Trust) as it applies to a Director of the Trust.

10 STANDARDS OF BUSINESS CONDUCT

10.1 **Policy** – Staff must comply with the national guidance contained in HSG(93)5 Standards of Business Conduct for NHS staff. The following provisions should be read in conjunction with this document.

10.2 **Hospitality** – Staff shall decline all except modest hospitality offers by potential or actual suppliers to the Trust. For the purpose of this Standing Order, modest hospitality shall be defined as that which is similar to the scale of hospitality which the NHS as an employer would be likely to offer.

The Trust shall maintain a hospitality register, detailing both the hospitality accepted and that which has been offered but declined. The register will be held by the Trust Secretary.

10.3 **Interests of Officers in Contracts** – If it comes to the knowledge of a Director or an officer of the Trust that a contract in which he has any pecuniary interest not being a contract to which he himself is a party, has been, or is proposed to be, entered into by the Trust he shall at once give notice in writing to the Trust Secretary of the fact that he is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

10.4 An Officer must also declare to the Chief Executive any other employment or business or other relationship of his, or of a cohabiting partner, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

10.5 All Board Directors are required, upon appointment, to subscribe to the NHS Code of Conduct and Code of Accountability.

10.6 **Canvassing of, and Recommendations by, Directors in Relation to Appointments** – Canvassing of Directors of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in the application form or otherwise brought to the attention of candidates.

10.7 A Director of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

10.8 **Relatives of Directors or Officers** – Candidates for any staff appointment shall when making application disclose in writing whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.

10.9 The Directors and every Officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.

10.10 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other Director or holder of any office under the Trust.

10.11 Where the relationship of an Officer or another Director to a Director of the Trust is disclosed, Standing Order Disability of Directors in proceedings on account of pecuniary interest (SO10) shall apply.

12. CUSTODY AND SEALING OF DOCUMENTS

12.1 **Custody of Seal** – The Common Seal of the Trust shall be kept by the Trust Secretary in a secure place.

12.2 **Sealing of Documents** – The Seal of the Trust shall not be fixed to any document unless the sealing has been authorised by a resolution of the Board or of a committee, thereof or where the Board has delegated its power.

12.3 Attestation of Sealings – The Common Seal of the Trust shall be affixed in the presence of those with delegated authority conferred by the Board.

12.4 **Register of Sealing** – An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal.

13. SIGNATURE OF DOCUMENTS

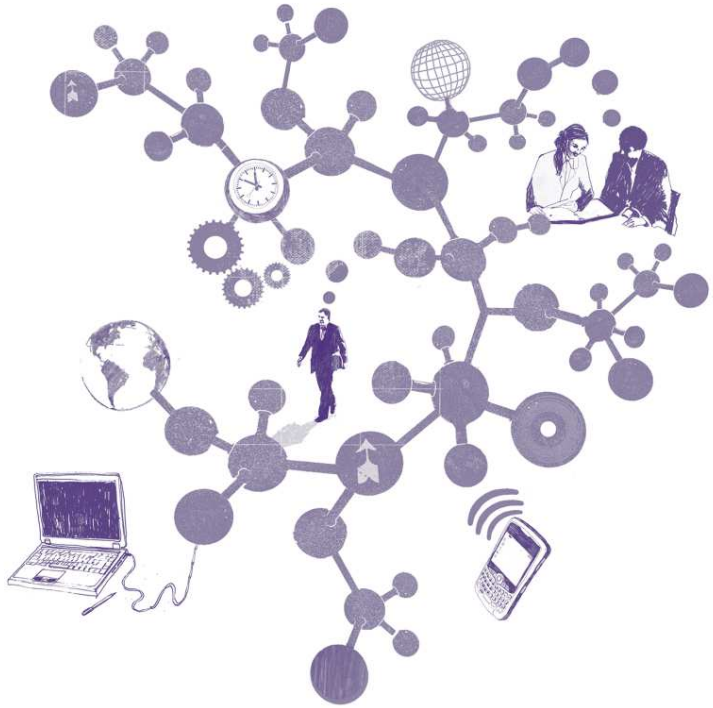
13.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive or Trust Secretary as designated signatory.

13.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed), the subject matter of which has been approved by the Board or committee or sub-committee to which the Board has delegated appropriate authority.

The Annual Audit Letter for Derbyshire Healthcare NHS Foundation Trust

Year ended 31 March 2016

19 July 2016



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Contents

Executive summary

Purpose of this letter

Our Annual Audit Letter (Letter) summarises the key findings arising from the work that we have carried out at Derbyshire Healthcare NHS Foundation Trust (the Trust) for the year ended 31 March 2016.

The Letter is intended to communicate key messages to the Trust, its Governors, and external stakeholders, including members of the public.

We reported the detailed findings from our audit work to the Trust's Audit and Risk Committee as those charged with governance in our Audit Findings Report on 24 May 2016.

Our responsibilities

We have carried out our audit in accordance with the NAO's Code of Audit Practice, which reflects the requirements of the Local Audit and Accountability Act 2014 (the Act). Our key responsibilities are to:

- give an opinion on the Trust's financial statements (section two)
- assess the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (the value for money conclusion) (section three).

In our audit of the Trust's financial statements, we comply with International Standards on Auditing (UK and Ireland) (ISAs) and other guidance issued by the NAO.

Our work

Financial statements opinion

We gave an unqualified opinion on the Trust's financial statements on 24 May 2016.

Value for money conclusion

We were satisfied that the Trust put in place proper arrangements to ensure economy, efficiency and effectiveness in its use of resources except for specific governance issues arising following the outcome of an employment tribunal held in June 2015. We therefore qualified our value for money conclusion in our report on the financial statements on 24 May 2016.

Consolidation template

We also reported on the consistency of the consolidation schedules submitted to Monitor with the audited financial statements. We concluded that these were consistent with the financial statements.

Quality Report

We completed a review of the Trust's Quality Report and issued our report on 24 May 2016. We concluded that the Quality Report and the indicators we reviewed were prepared in line with the Regulations and guidance.

Working with the Trust

During the year we have delivered a number of successful outcomes with you:

- An efficient audit – we delivered an efficient audit with you in May, delivering the accounts three days before the deadline, releasing your finance team for other work.
- Understanding your operational health – through the value for money work we provided you with assurance on your operational effectiveness, and your arrangements for working in partnership
- Improving your annual reporting – we benchmarked your annual report identifying areas where you could make improvements
- Improving your financial performance – we benchmarked your key financial indicators against other mental health foundation trusts to identify areas for improvement
- Providing assurance over data quality – we provided assurance over two key indicators plus another chosen by your governors
- Sharing our insight – we provided regular audit committee updates covering best practice. We also shared our thought leadership reports
- Providing training – we provided your teams with training on financial accounts and annual reporting
- Supporting development – we provided training to the Council of Governors on 5 July 2016 covering the role of the external auditor and the governors in the accounts process

We would like to record our appreciation for the assistance and co-operation provided to us during our audit by the Trust's staff. This is especially appreciated given the additional pressure staff were under this year.

Grant Thornton UK LLP
July 2016

Audit of the accounts

Our audit approach

Materiality

In our audit of the Trust's financial statements, we use the concept of materiality to determine the nature, timing and extent of our work, and in evaluating the results of our work. We define materiality as the size of the misstatement in the financial statements that would lead a reasonably knowledgeable person to change or influence their economic decisions.

We determined materiality for our audit of the Trust's accounts to be £2,507,000, which is 2% of the Trust's gross revenue expenditure. We used this benchmark as in our view, users of the Trust's financial statements are most interested in where it has spent the income it made in the year.

We also set a lower level of specific materiality for the areas of cash and senior officer remuneration.

We set a lower threshold of £125,350, above which we reported errors to the Audit and Risk Committee in our Audit Findings Report.

The scope of our audit

Our audit involves obtaining enough evidence about the amounts and disclosures in the financial statements to give reasonable assurance that they are free from material misstatement, whether caused by fraud or error.

This includes assessing whether:

- the Trust's accounting policies are appropriate, have been consistently applied and adequately disclosed;
- significant accounting estimates made by management are reasonable; and
- the overall presentation of the financial statements gives a true and fair view.

We also read the annual report to check it is consistent with our understanding of the Trust and with the accounts on which we give our opinion.

We carry out our audit in line with ISAs (UK and Ireland) and the NAO Code of Audit Practice. We believe the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Our audit approach was based on a thorough understanding of the Trust's business and is risk based.

We identified key risks and set out overleaf the work we performed in response to these risks and the results of this work.

Audit of the accounts

These are the risks which had the greatest impact on our overall strategy and where we focused more of our work.

Risks identified in our audit plan	How we responded to the risk
Occurrence of healthcare income The Trust receives 92% of its income from NHS commissioners of healthcare services. The Trust invoices these commissioners throughout the year and accrues for activity in the final quarter of the year. Invoices for this activity are not agreed until after the accounts are produced for audit. There is therefore a risk that income from healthcare may be overstated.	As part of our audit work we have: • Evaluated the Trust's policy for accounting for income for appropriateness and consistency with last year. • Gained an understanding of the Trust's system for accounting for healthcare income and the controls in place • Tested a sample of income to supporting documents and receipt of cash • Checked the consistency of income recorded by the Trust against expenditure recorded by the commissioners. **We did not identify any issues to report**
Completeness of operating expenditure on employees Expenditure on employees represents the largest single area of expense for the Trust, at 76% of total expenditure. The Trust accrues at year end using estimates for employee-related services. We therefore identified completeness of expenditure on employees as a risk requiring particular audit attention.	As part of our audit work we have: • gained an understanding of the systems used to recognise payroll expenditure and evaluating the design of the associated controls; • reconciled expenditure on employees recorded in the general ledger to the payroll system reports for each month to ensure that all transactions from the payroll system are reflected in the financial statements; • tested on a sample basis, payments made after year-end to confirm the completeness of accruals. **We did not identify any issues to report**
Completeness of operating expenditure on goods and services Expenditure on goods and services represents 21% of the Trust's total expenditure. Management uses judgement to estimate accruals of expenditure for amounts that have not been invoiced at the year end. We therefore identified completeness of operating expenditure on goods and services as a risk requiring particular audit attention.	As part of our audit work we have: • gained an understanding of the systems used to recognise expenditure on goods and services and year-end accruals, and evaluating the design of the associated controls; • tested, on a sample basis, payments made after the year end to 30 April 2016 to confirm the completeness of year-end payables and accruals; • reviewed the year-end reconciliation of the subsidiary system interface and general ledger control accounts to ensure that all transactions from the subsidiary system are reflected in the financial statements; and • Considered the completeness of reported accruals and provisions by review of Trust Board and Committee minutes and papers for events subsequent to the year end. **We did not identify any issues to report**

Audit of the accounts

Audit opinion

We gave an unqualified opinion on the Trust's financial statements on 24 May 2016, in advance of the national deadline.

The Trust made the accounts available for audit in line with the national timetable for submission, and provided a good set of working papers to support them. The finance team responded promptly and efficiently to our queries during the course of the audit.

Issues arising from the audit of the accounts

We reported the key issues from our audit to the Trusts Audit and Risk Committee on 24 May 2016.

Annual Governance Statement and Annual Report

We are also required to review the Trust's Annual Governance Statement and Annual Report. It provided these on a timely basis with the draft accounts with supporting evidence. Trust staff liaised with us as both of these documents were being prepared and thus assisted with the efficiency of the audit process.

Whole of Government Accounts (WGA)

We issued a group assurance certificate to the NAO in respect of Whole of Government Accounts, which did not identify any issues for the group auditor to consider

Value for Money conclusion

Background

We carried out our review in accordance with the NAO Code of Audit Practice, following the guidance issued by the NAO in November 2015 which specified the criterion for auditors to evaluate:

In all significant respects, the audited body takes properly informed decisions and deploys resources to achieve planned and sustainable outcomes for taxpayers and local people.

Key findings

Our first step in carrying out our work was to perform a risk assessment and identify the key risks where we concentrated our work.

The key risk we identified and the work we performed are set out in the table 2.

As part of our Audit Findings report agreed with the Trust in May 2016, we agreed recommendations to address our findings. We recommended that management ensures the Governance Improvement Action Plan (GIAP) is delivered by quarter 4, 2016/17.

As part of our Value for Money work, we also identified two areas of focus:

- a review of the Trust's financial resilience, as reflected in the medium term financial strategy, CIP delivery, and savings factored into annual budgets; and
- a review of the Trust's arrangements for working with partners and other third parties to support the delivery of strategic priorities (which was a new area for consideration in 2015/16

We identified no issues with the Trust's financial resilience; and noted that the Trust has been very proactive in working in partnership to support the delivery of strategic priorities.

Overall VfM conclusion

We are satisfied that, in all significant respects, except for the matter we identified in the table on the next page, the Trust had proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2016.

Value for Money – Table 2 Value for Money risks

Risk identified	Work carried out	Findings and conclusions
Governance Monitor's Governance Rating for the Trust as at 25 February 2016 was red and notes that the Trust is subject to enforcement action. This reflects the outcome of a recent Employment Tribunal judgement which has led to concerns around governance arrangements and has generated interest in the media. The Trust has been subject to external assessments of its governance arrangements including a Well Led review (incorporating a deep dive into HR processes) and a Monitor Action Plan in response to the concerns raised. Concerns have also been raised with the relationship between Directors and Governors at the Trust. The investigations have now been completed and the Trust has agreed to implement actions arising from these. These actions include: • Improve Board effectiveness • Ensure appropriate scrutiny of decisions by its leadership • Develop better HR processes • Ensure there is better engagement with the Council of Governors.	We: • reviewed how the Trust has responded to the issues raised by Monitor and the associated internal and external reviews of its governance • reviewed and assessed how the Trust refers to the concerns and outcome of external reviews in its Annual Report and Annual Governance Statements • considered the impact of the issues on the public interest.	• We found that the Trust has established an Governance Improvement Action Plan which was agreed with Monitor (now known as NHS Improvement Agency) and reports regularly on progress to Board. These reports are also shared with both NHSI and CQC. The Director of Business Development and Marketing is responsible for the oversight of the delivery of the GIAP. Lead Directors have been assigned ownership of the actions. Weekly one to one meetings are held with each lead director to discuss their tasks/actions, to obtain assurance on task delivery, and to agree associated evidence. The process is evolving to ensure the approach is meaningful and focusses on delivery. The GIAP is used to hold service managers to account for delivery of the action plan. The action plan is RAG rated and within this framework the Board identifies tasks that are off track. The monthly Board reports enable Board members to challenge whether actions have been taken and whether sufficient evidence is provided for completed actions. The Board also decides whether tasks and recommendations can be closed and archived. We consider that the issues identified indicate weaknesses in governance, particularly with regard to the application of human resources polices in prior years. We are, however, satisfied that the responses made by the Trust are appropriate. • We are satisfied that the Trust's Annual Report and Annual Governance Statement both openly refer to the concerns and outcome of the external reviews. • The Trust has been open with the public about the governance issues. As stated above, we are satisfied that the Trust's Annual Report and Annual Governance Statement fully reflect the issues. Overall we are satisfied that the Trust has taken appropriate action to respond to these issues. **On the basis of the issues identified we unable to conclude that the Trust had proper arrangements in place to demonstrate and apply the principles and values of sound governance.** **We are satisfied that the Trust has responded positively to the issues raised, and has made progress in addressing the improvement plan.**

Quality Report

The Quality Account

The Quality Report is an annual report to the public from NHS Foundation Trusts about the quality of services they deliver. It allows Trust Boards and staff to show their commitment to continuous improvement of service quality, and to explain progress to the public.

Scope of work

We were engaged by the Council of Governors of the Trust, as required by Monitor, to perform an independent assurance engagement in respect of the Trust's Quality Report for the year ended 31 March 2016 and certain performance indicators contained therein. Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

• the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual.*

• the Quality Report is not consistent in all material respects with the information sources specified in Monitor's *2015/16 Detailed Guidance for External Assurance on Quality Reports.*

• the two indicators in the Quality Report, identified as having been the subject of limited assurance, are not reasonably stated in all material respects in accordance with the NHS Foundation Trust *Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

Key messages

- We confirmed that the Quality Account had been prepared in line with the requirements of the Regulations.
- We confirmed that the Quality Account was consistent with the sources specified in the Guidance
- We confirmed that the commentary on indicators in the Quality Account was consistent with the reported outcomes
- Our testing of two indicators included in the Quality Account found that these were materially reasonably stated in accordance with the Regulations and six dimensions of data quality.

Quality Account Indicator testing

We tested the following indicators:

- admissions to inpatient services that had access to crisis resolution home treatment teams
- minimising delayed transfer of care and
- patients receiving follow-up contact within seven days of discharge from hospital: selected by the Council of Governors of the Trust in March 2016 as additional indicator for testing (this local indicator was not subject to a limited assurance opinion).

We reviewed the process used to collect data for the indicators. We checked that the indicator presented in the Quality Report reconciled to the underlying data. We then tested a sample of cases to check the accuracy, completeness, timeliness, validity, relevance and reliability of the data, and whether the calculation is in accordance with the definition.

Based on the results of our procedures, nothing came to our attention that caused us to believe that the indicators we tested were not reasonably stated in all material respects.

Conclusion

As a result of this we issued an unqualified conclusion on your Quality Report.

Working with the Trust

Working with you in 2016/17

We will continue to work with you and support you over the next financial year.

Nationally we are planning the following events:

- Health and Social Care Integration – we are working with the Manchester authorities so that we are able to share insight into how best to integrate health and social care. We will share the outcome of our work early in 2017
- Thought leadership – we are preparing thought leadership reports on Future of Primary Care and on NHS commercial structures
- Audit updates - we will continue to provide regular audit committee updates covering best practice and emerging issues in the sector
- Providing training – we will continue to provide financial accounts and annual reporting training
- Improving your annual reporting – we will benchmark your annual report and highlight potential areas for improvement
- Improving your financial performance – we will benchmark your key financial indicators against other mental health foundation trusts to identify areas for improvement
- Providing insight – we will update our Health and Well Being analysis and share our information on key health conditions and lifestyle needs in your area

Locally our focus will be on:

- An efficient audit – continuing to deliver an efficient audit
- Improved financial processes – we will focus our work on the asset register; and reviewing the exercise to ensure property floor space area recorded in the Trust's MICAD system agrees with information provided to the external valuer
- Understanding your operational health – we will focus our value for money conclusion work on the actions taken to deliver your Governance Improvement Action Plan
- Supporting development – we are in discussion with you on providing a Board workshop, and have offered to undertake further training for Governors.

Appendix A: Reports issued and fees

We confirm below our final fees charged for the audit and provision of audit-related service. We confirm there were no fees for the provision of non audit services.

Fees

	Planned £	Actual fees £	2014/15 fees £
Statutory audit	30,910	30,910	30,910
Total fees	**30,910**	**30,910**	**30,910**

Fees for other services

Service	Fees £
Audit related services	
Assurance on your quality report	7,300

Fees for other services

Service	Fees £
None	Nil

Reports issued

Report	Date issued
Audit Plan	December 2016
Audit Findings Report	May 2016
Annual Audit Letter	July 2016

Appendix B: Grant Thornton in Health

We are proud of our position as the largest supplier of external audit services to the NHS and the contribution we make to the challenges it faces. Here are some of our credentials showing how we deliver on this responsibility.

Our client base and delivery

- We are the largest supplier of external audit services to the NHS
- We audit over 120 NHS organisations
- 99% of 2015/16 audit reports were issued by the national deadline
- Our clients scored us 8 out of 10 or higher

Our connections

- We meet regularly with and second people to the Department of Health, CQC, NHS Improvement and NHS England
- We work closely with local government and blue light services
- We work with the Think Tanks and legal firms to develop workshops and good practice
- We provide thought leadership, seminars and training to support our clients and to provide solutions.
- In 2016 we issued reports on Mental Health Collaboration, and NHS governance and finance.
- We will publish reviews on the Future of Primary Care and on NHS commercial structures later this year.

Our quality

- We fully meet the criteria for appointment as external auditors.
- Our audit approach complies with the NAO's Code of Audit Practice, and International Standards on Auditing.
- We are fully compliant with ethical standards.
- We have passed all external quality inspections including QAD and AQRT.

Our support for the sector

- We are sponsors for HFMA and work with the provider faculty, mental health faculty and commissioning faculty. We regularly speak at HFMA events to share best practice and solutions.
- We provide auditor briefings into what is happening with department policy, sector regulation, and at other NHS organisations to help support our clients.
- We provide Key Issues Bulletins that summarise what is happening in the sector.
- We hold regular 'free to access' financial reporting and other training sessions for finance staff to ensure they have the latest technical guidance.

Our technical support

- We are members of all of the key NAO, ICAEW, and HFMA technical forums.
- We have specialists leads for Public Sector Audit quality and Public Sector technical.
- We provide national technical guidance on emerging auditing, financial reporting and ethical areas.
- Local teams are supported on information technology by specialist IT auditors.
- We use specialist audit software to identify and assess audit risk.

Our people

- We have over 30 engagement leads accredited by ICAEW to issue NHS audit reports.
- We have over 300 public sector specialists.
- We invest heavily in our people including technical and personal development training.
- We invest in the future of the public sector and employ over 80 Public Sector trainee accountants.

2015-2016 Board Annual Forward Plan

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
JSt	HR Investigation Action Plan				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								