Derbyshire Healthcare
NHS Foundation Trust

MEETING OF THE COUNCIL OF GOVERNORS
TO BE HELD IN PUBLIC SESSION

TUESDAY 18 JULY 2017

GOVERNOR & NED LUNCH
12:00 – 1:00 PM

COUNCIL OF GOVERNORS' MEETING
1.00 – 3.30 PM

CONFERENCE ROOMS A/B, RESEARCH & DEVELOPMENT CENTRE,
KINGSWAY, DERBY, DE22 3LZ

AGENDA

SUBJECT MATTER		ENC	LED BY	TIME
1.	Welcome, introductions and Chair's opening remarks Apologies and Declaration of Interests		Caroline Maley	1.00
2.	Minutes of the previous meeting held on Tuesday 2 May 2017	A	Caroline Maley	1.05
3.	Matters arising and actions matrix	B	Caroline Maley	1.15
4.	Chief Executive's Report	C	Ifti Majid	1.20
STATUTORY ROLE				
5.	Presentation of the Annual Report & Accounts and report from the External Auditor (Grant Thornton)	D	Claire Wright & Joan Barnett	1.35
6.	Governors Nominations & Remuneration Committee Report	E	Caroline Maley	2.05
HOLDING TO ACCOUNT				
7.	Integrated Performance Report as presented to the Public Trust Board on 28 June 2017	F	Claire Wright	2.15
8.	Staff engagement/staff survey update as presented to Public Trust Board on 28 June 2017	G	Margaret Gildea	2.25
BREAK 2.35 – 2.45				

Better together

9.	NED Update on Audit & Risk Committee by Barry Mellor	H	Barry Mellor	2.45
10.	Governance Committee Report	I	Shelley Comery	3.00
11.	Update on governor appointments and resignations	J	Anna Shaw	3.05
12.	Final Governance Improvement Action Plan as presented to Public Trust Board on 24 May 2017	K	Claire Wright	3.10
13.	Any other business	-	Caroline Maley	3.15
14.	Review of meeting effectiveness	-	Caroline Maley	3.20
15.	Close of meeting	-	Caroline Maley	3.25
FOR INFORMATION				
Ratified minutes of the Public Board meeting(s) held on 1 March 2017, 26 April 2017, 24 May 2016. Note of Confidential Council of Governors Meeting held on 6 June 2017		L M	-	
Governor meeting timetable Glossary of NHS terms		N O	-	
Next Meeting: 1.00 – 4.00 pm on Tuesday 26 September 2017 at the Winding Wheel, 13 Holywell Street, Chesterfield S41 7SA				

A brief confidential meeting of Council of Governors follows

Derbyshire Healthcare NHS Foundation Trust

MEETING OF THE COUNCIL OF GOVERNORS HELD IN PUBLIC SESSION

TUESDAY 2 MAY 2017

BELPER FOOTBALL CLUB
CHRISTCHURCH MEADOW, BRIDGE STREET, BELPER, DEB6 1BA

THE MEETING OPENED AT 1.00 PM AND CLOSED AT 3.30 PM

PRESENT	Caroline Maley	Acting Trust Chair
GOVERNORS PRESENT	Shelley Comery	Public Governor, Erewash North
From 2017/037	Rosemary Farkas	Public Governor, Surrounding Areas
	Ruth Greaves	Public Governor, Derbyshire Dales
	Paula Holt	Appointed Governor, University of Derby
	Gillian Hough	Public Governor, Derby City East
2017/033 - 039	Moira Kerr	Public Governor, Derby City East
	John Morrissey	Public Governor, Amber Valley South
	Kevin Richards	Public Governor, South Derbyshire
	Carole Riley	Public Governor, Derby City East
	April Saunders	Staff Governor, Nursing & Allied Professions
	Kelly Sims	Staff Governor, Administration & Allied Support Staff
	David Wilcoxson	Public Governor, Amber Valley North
IN ATTENDANCE	Denise Baxendale	Communications & Involvement Manager
	Donna Cameron	Assistant Trust Secretary (Note Taker)
From 2017/039	Carolyn Green	Executive Director of Nursing & Patient Experience
	Samantha Harrison	Director of Corporate Affairs & Trust Secretary
	Barry Mellor	Non-Executive Director
	Amanda Rawlings	Interim Director of People & Organisational Effectiveness
2017/033 - 039	Rehana Shaheen	Support Worker for Moira Kerr
	Dr Julia Tabreham	Non-Executive Director & Deputy Trust Chair
	Dr Anne Wright	Non-Executive Director
	Claire Wright	Deputy Chief Executive & Executive Director of Finance
	Richard Wright	Non-Executive Director
	Bernard Thorpe	Member of the Public/Public Governor, DCHS
	Brenda Greaves	Member of the Public/Public Governor, DCHS
	Hazel Nightingale	Member of the Public/Public Governor, DCHS
	John Raw	Member of the Public/Public Governor, DCHS
	David Waldram	Member of the Public
APOLOGIES	Margaret Gildea	Non-Executive Director
	Sarah Gray	Staff Governor, Nursing & Allied Professions
	Dr Jason Holdcroft	Staff Governor, Medical & Dental
	Lynda Langley	Public Governor, Chesterfield North
	Paula Lewis	Public Governor, Derby City West
	Ifti Majid	Acting Chief Executive
	Mark Powell	Acting Chief Operating Officer
	Helen Sentance	Public Governor, Erewash South
	Anna Shaw	Deputy Director of Communications & Involvement
	Gemma Stacey	Appointed Governor, University of Nottingham
	Dr John Sykes	Executive Medical Director
	Lynn Wilmott-Shepherd	Interim Director of Strategic Development

DHCFT/GOV/ 2017/33	**WELCOME, INTRODUCTIONS, OPENING REMARKS, APOLOGIES FOR ABSENCE, DECLARATIONS OF INTEREST** The Chair opened the meeting at 1.00 pm and welcomed attendees to Belper Football Club.

	Apologies were noted as above. No declarations of interests were received.
DHCFT/GOV/ 2017/34	**SUBMITTED QUESTIONS FROM MEMBERS OF THE PUBLIC** One question had been received on 29 April, via a governor, regarding completion of forms for personal health budgets. Due to the weekend/bank holiday it had not been possible to prepare a response prior to the meeting. **ACTION: A response will be prepared and sent via the governor and a copy included in the next Public Council of Governors' papers for information.**
DHCFT/GOV/ 2017/35	**MINUTES OF THE PREVIOUS MEETING** With the exception of one spelling mistake in the name of a member of the public in attendance, the minutes of the previous meeting, held on 7 March 2017, were accepted as a correct record.
DHCFT/GOV/ 2017/36	**ACTIONS MATRIX AND MATTERS ARISING** **Actions Matrix** Updates on progress were noted on the matrix. **Collaboration with DCHS – DHCFT/GOV/2017/02** Moira Kerr requested clarification on the voting arrangements that would be required to confirm that satisfactory assurance has been received throughout the acquisition process. Caroline Maley confirmed that 50% of ALL governors are required to be in favour, not just 50% of those in attendance. Post meeting note: the following is an extract from the Monitor/NHSI Transaction Manual to clarify this position: ***Extract From 'Supporting NHS providers: guidance on transactions for NHS foundation trusts' – (Monitor, 2015)*** *This means more than half of the total number of governors must approve, not just half the number that attends the meeting at which the decision is taken. If the other party to the proposed transaction is also an NHS foundation trust, more than half the governors of that foundation trust must also approve the transaction. (Page 59)*
DHCFT/GOV/ 2017/37	**ACTING CHIEF EXECUTIVE'S REPORT** Claire Wright, Deputy Chief Executive and Finance Director, presented the report on behalf of Ifti Majid, Acting Chief Executive, who had submitted apologies due to annual leave. The report included feedback on changes within the national health and social care setting, as well as providing an update on developments occurring within the local health and social care community. Next Steps on the 5 Year Forward View, which defines the four key priorities for the coming year, was highlighted. The Next Steps document

	includes a ten point plan to increase efficiency, which may be useful for governors to be aware of to hold the Board to account. The report also details how the Trust will enable the requirements/priorities. Ruth Greaves was encouraged by the government's investment into Child & Adolescent Mental Health Services (CAHMS) but concerned how changes in the sector would be reflected in the Outline Business Case (OBC). Claire Wright assured governors that the OBC would reflect the evolving picture in the NHS nationally and locally. Systems and organisations are working together, holding each other to account to deliver the aggregate overall 5 Year Forward View. Regular updates will continue to be provided. Rosemary Farkas joined the meeting. The Acting Chief Executive's update referred to a report by the Royal College of Psychiatrists, led by trainees, into morale and training within psychiatry. One of the Trust's junior doctors had been involved in the compilation of the report and gave a presentation on it to the Public Trust Board on 26 April 2017. The Board has committed to support local delivery of the core commitments made in the report. John Morrissey, who had been in attendance at the Public Trust Board, commended the Trust for taking on the implementation. In referring to the Trust's BME Staff Network Annual Conference, held on 17 March, Ruth Greaves queried the term 'reverse mentors'; a role being taken on by the Executive Team. Claire Wright advised that this is to improve understanding on what it is like to be someone with protected characteristics. Media coverage was noted and proactive and reactive media discussed. Sam Harrison confirmed the Communications Team is very active with local and national media releases. Social media sites are also a frequently updated communication tool. A development session had previously been held on the use of social media. Gillian Hough agreed to take this matter to Governance Committee for further discussion in order for needs and requirements to be outlined further and any development needs identified. Claire Wright highlighted the Trust's performance in recent CQC inspections and the lifting of the Warning Notice. Since this report had been written the Trust has received a very positive report from Deloitte LLP regarding the Trust's governance, which is currently with NHS Improvement. Gillian Hough referred to the report from the Royal College of Psychiatrists on morale and training for junior doctors. The report highlights that basic needs of doctors cannot be fulfilled as they do not have access to facilities to make or buy a hot drink or hot meal. Claire Wright added that these elements were 'desirable' and there is a need for realism in terms of the ability to provide these facilities in all areas of the estate where junior doctors may be working. Gillian Hough referred to a hot food machine available at the Royal Derby Hospital, suggesting the Trust review this. Caroline Maley agreed that the Trust could look into this suggestion. **ACTIONS: Options for junior doctors to access hot food out of hours to be looked into.**

	RESOLVED: The Council of Governors **1. Noted the contents of the update.**
DHCFT/GOV/ 2017/38	**<u>UPDATE ON DCHS AND DHCFT COLLABORATIVE WORKING</u>** Claire Wright presented the Summary Report from the Joint Integration Programme Committee (JIPC) held on 6 April 2017. The report provides a summary of the key discussions and highlighted issues to be aware of. In responding to Ruth Greaves' concern that this paper had been tabled, the Chair apologised the paper had not been included in the original pack when posted (on 25 April); but advised it had been emailed to all governors immediately following its scheduled discussion at the Confidential Board on 26 April. Ruth Greaves sought an update on the OBC; making the request that governors be given time to consider and digest its content. She also sought clarification whether the OBC would only contain one option, ie merger by acquisition by DCHS. Claire Wright responded that the OBC has not yet been written. The format of the OBC is prescribed by the Transaction Manual. The content will be based on the decision to merge or not, as previously agreed following presentation of the Strategic Options Case (SOC). In receiving the SOC the Council of Governors and the Board agreed to proceed to OBC. The OBC will focus on the transaction only. Caroline Maley added that the OBC is expected to provide enough evidence to say what the benefits are of the coming together of both organisations. Full financial modelling will form part of the Final Business Case (FBC). The vote on supporting the application does not take place until the FBC. Should the merger not conclude, the Trust will carry on as it is, continuing to work collaboratively as part of the STP process. Gillian Hough asked where the voice of mental health will be reflected in the process. Governors were reminded of the Engagement Events and Stakeholder Meeting to be arranged at the end of May and the Trust's close involvement with stakeholder organisations locally. Shelley Comery is aware of concern regarding the merger and its implications on the Mental Health Action Group; Caroline Maley agreed to double-check on the Trust's engagement with them on the process. Sam Harrison will also check who, from the Trust's stakeholder groups, are attending the engagement sessions. Governors were urged to continue to ask questions in order that responses and information can be provided to give assurance. Caroline Maley assured governors that the Board would only proceed if it was in patients' best interests. Claire Wright shared that the risk of governors not approving the merger is noted on the risk log. In responding to Moira Kerr's query regarding a need for public consultation, Sam Harrison confirmed that this is not a requirement for the transaction as no service changes are involved. John Morrissey referred to an article in the Royal College of Nursing which reports that ten years after the coalition government, nurses can expect to be 25% worse off financially. As recruitment, training and retention is already an issue, John Morrissey asked NEDs if the Trust's financial plan is viable; if clinical staff are not paid, they cannot be retained. Gillian Hough referred to recent concerns raised at the Governance Committee regarding funding for study leave, which can impact on recruitment and retention.

	Barry Mellor responded that at People & Culture Committee, there is oversight of the Strategic Workforce Plan, which clearly spells out national and local challenges. The plan is looking at new ways of working in order to recruit and retain staff. Amanda Rawlings assured governors that the workforce plan has already captured the concerns raised here. The plan receives scrutiny from staff governors and NEDs. It will shortly be presented to the Board. In parallel, work is being done to address recruitment challenges and the Executive Leadership Team retains close oversight at its weekly meeting. Paula Holt advised governors that the removal of the bursary for student nurses has not impacted on the numbers registering for training; in fact numbers have doubled at the University of Derby for those training to become mental health nurses. The next meeting of the JIPC is scheduled for Wednesday 3 May. Feedback will be reported at the Private Council of Governors Meeting, scheduled for Tuesday 6 June, to discuss the integration. **ACTION: Detail of stakeholder attendance at Engagement Event to be obtained.** **RESOLVED: The Council of Governors noted the summary report from the Joint Integration Programme Committee.**
DHCFT/GOV/ 2017/39	**<u>NON-EXECUTIVE DIRECTOR UPDATE – QUALITY DEEP DIVE</u>** Dr Julia Tabreham, Non-Executive Chair of Quality Committee, presented the deep dive report on quality. The Quality Committee identifies the experience of service users, carers and families, which support the Committee's purpose 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. A Quality Dashboard, a component of the Integrated Performance Report, monitors key performance indicators, which are closely followed by the Quality Committee and helps with a strategic focus. Recently there have been discussions exploring the possibility of having 'Quality Conversations' prior to the Committee meeting, which would be open to non-members and would provide an opportunity for the Trust to update on a variety of quality themes. Carolyn Green joined the meeting. Dr Julia Tabreham addressed questions that had been submitted by governors prior to the meeting. Q1. How many members of the Quality Committee are based in the North? If none why not? *Quality Committee is an assurance Committee of the Board and membership is made up of NED and Executives, therefore base is not a factor. Members and attendees represent services and professions, not geographic areas. Governors are able to attend as observers of this committee as agreed.*

	Q2. If the proposed lunch-time meetings take place how will they be included as it would not be logistically feasible for anyone to travel all the way to Kingsway for a lunch-time meeting. *Details of the lunchtime forums have not yet been sent. Ruth Greaves asked about a forum for people with complaints to speak to the Trust. Julia suggested an annual open conversation with people so they can shape the quality agenda and said she would talk to Dr Anne Wright about these ideas.* Q3. As we move towards the 'joined-up' care model and become involved in partnership working, how will you identify whether the quality of care is changing for our patients? What methods do you have to feedback and discuss with other organisations the results of such findings (including other NHS, LA, voluntary sector and community groups)? Has the Erewash Vanguard provided any helpful insights for this? *Experience through the Committee, quality visits and third sector work provides an opportunity to triangulate on quality of care. Any changes to performance are flagged through Quality Dashboard and monitored by Quality Committee. Carolyn Green added that the Erewash Vanguard has seen disinvestment from commissioners, which has impacted on the value it is able to provide.* Q4. In the recent Annual Quality Report the figure for in-service suicides has reduced yet the general population has seen an increased incidence of suicide this year. This demonstrates the need for Prevention and Early Intervention work. As we move towards a greater emphasis on this 'front end', how will you monitor the performance of the Trust in Preventative work? *The Quality Committee is fully briefed on local and national trends. There has been a 27% rise in Derby City and a 100% rise in the County; but this is in people who are unknown to the Trust so there are concerns regarding earlier intervention. Carolyn Green added that the Suicide Prevention Strategy is committed to a 'train the trainer' model and training is being rolled out to GPs and primary care staff.* Q5. An emerging concern is the use of 'Spice' by recreational drug-users. This has been blamed for an increase in psychosis and violent attacks. How does the Trust monitor such emerging trends, and what new measures are put in place to protect staff and also to handle this new type of patient? *Dr Julia Tabreham expressed equal concern regarding the impact of this substance, particularly in offender and prison pathways. Carolyn Green added that Public Health had commissioned the Trust to provide some guidance which has been done for youth and adult services in Substance Misuse Services. Teams have been briefed on how to spot people who have taken 'Spice'. Additional information has been provided to wards, educational sessions have been provided for Accident & Emergency staff and the substance misuse policy re-written. Data is monitored through a national*

	database. Locally it is also reviewed through drug related deaths in Derby. In terms of protecting staff, violence against staff is seen in other areas and all trends are closely monitored. Kelly Sims asked how the Quality Committee is addressing the increased figures, reported on the Dashboard, of the use of prone restraint. Dr Julia Tabreham confirmed there is ongoing dialogue on this item. Carolyn Green will be presenting a Deep Dive to the Quality Committee but assured governors that changes and improvements in reporting have led to the increase in figures, albeit there is a downward trajectory. Caroline Maley thanked Dr Julia Tabreham for the deep dive. Barry Mellor is scheduled to deliver his NED update at the next Public Council of Governors meeting. Moira Kerr and Rehana Shaheen left the meeting.
DHCFT/GOV/ 2017/40	**<u>INTEGRATED PERFORMANCE REPORT</u>** Claire Wright presented the Integrated Performance Report (IPR), providing the Council of Governors with an integrated overview of performance as at the end of March 2017. The focus of the work is on workforce, finance, operational delivery and quality performance. This same report was presented to the Public Trust Board on 26 April 2017. Since the report was written the STF Income from NHS Improvement, referred to on page 34, has been received. A total of £906,000 was allocated to the Trust. This goes to the 'bottom line' and can be used only for capital expenditure Ruth Greaves referred to increased waits for early intervention in psychosis (page 34) and asked for an update on the impact on patients. Carolyn Green confirmed that patients do receive some support in the meantime. The increase follows a national recommendation for the service to become ageless. CCGs were advised that if this occurred the team would not be able to meet the increased demand. Although performance has worsened the Trust is still performing better than average. The waiting list policy is performing well and all referrals are triaged. Responses were given to questions submitted by Lynda Langley, absent due to jury duty. Q1 Annual Appraisals are falling short of their targets - is there a reason for this? Clinical and Managerial areas are also falling short of their targets - again is there a reason for this? What is being done to improve the above? Amanda Rawlings advised that there had been a slight increase in appraisal rates since January (from 74.6 to 75.14%). The process for conducting non-medical staff appraisals has changed, following feedback that the paperwork and process itself was very cumbersome. A training package for leaders and staff has been rolled out. An increase in completion rates is expected. Medical appraisal rates are higher than all other staff.

	Q2 Staff Survey - In-patient focus 64 responses. Is there a reason for a low number of responses? Concern that 36 out of 64 responses were either Unlikely/Extremely Unlikely or Neither to recommend the Trust for treatment. A high number would not recommend the Trust as a place to work. I feel this demonstrates ongoing distrust and dissatisfaction with the Trust. Do the staff leaving the Trust go through Exit Interviews - if they do what reasons are being given for their departure. If these are not implemented are there any plans to introduce them? Amanda Rawlings clarified that 516 staff had taken part in the survey, of which 64 were from an inpatient area. . This was a Friends & Family Test conducted in February/March. The other pie chart on this page is a Staff Survey from September 2016 with 800 staff responses. Having compared both, improvements have been seen. The Staff Engagement Group is playing a significant role in supporting the People & Culture Committee. Four organisational projects are running to get the right balance of components to improve responses. Resource is being provided to teams that have lower end staff survey results and participation as they are likely to be struggling on people metrics. Shelley Comery asked how the questions are sourced. Amanda advised that they are mandated. As a member of the Staff Engagement Group April Saunders shared with governors that the group is working hard on this. There is still concern about bite size training for leaders; 22% have still not attended any training, 30% have not completed all elements of the training. This has been reported to the Board. Barry Mellor reinforced that NEDs have expressed that this is unacceptable and expect to see significant improvements. Executive Leads are being asked to make contact with those leaders to explore non-attendance. Amanda Rawlings also advised that the Leadership Development Strategy is going to People & Culture Committee in May. In response to the comment on exit interviews, the People & Culture Committee receives information on where staff who are leaving to go to. The vast majority, who are not retiring or going on maternity leave, are moving within the Derbyshire market and are frustrated at lack of career progression. The Trust has led on a piece of work to look at a multi-generational approach to this and some recommendations are being worked through. The report had been presented to People & Culture Committee in April. Richard Wright and Barry Mellor commented on the excellent value of the report. Q3 Paediatric current waiting times - what is the reason for the 50% as opposed to the 90% target? This is an issue of capacity versus demand. Locums have been brought in to keep up the volume of throughput. Claire Wright and Carole Riley mentioned that they have undertaken a quality visit to this area where the consultants had talked to them about waiting times. Carole Riley added that the longest waiting time is to receive the referral. **ACTION: The Generations4Change report to be shared with governors through Governor Connect.**

	RESOLVED: The Council of Governors noted the content of the report and received assurance on current performance across the areas presented.
DHCFT/GOV/ 2017/41	**GOVERNANCE IMPROVEMENT ACTION PLAN UPDATE** Sam Harrison presented the Governance Improvement Action Plan (GIAP) report, providing governors with an update on progress on delivery of the GIAP and to receive assurance on delivery and risk mitigation. This same report was presented to the Public Trust Board on 26 April 2017. The Board had been asked to formally approve 14 'blue forms' to confirm that the recommendation within each form had been completed. Governors were asked to note the Approval Pipeline. Two actions remain for completion, which involved external assurance. The focus will now shift to embedding and monitoring the work undertaken. The external review (Deloitte's report) is currently with NHS Improvement for consideration. The Trust hopes to share as much as possible. **RESOLVED: The Council of Governors** **1. Acknowledged and commended the significant work undertaken in implementing the GIAP** **2. Noted the report.**
DHCFT/GOV/ 2017/42	**REPORT FROM THE GOVERNANCE COMMITTEE** Gillian Hough presented the report from the Governance Committee's meetings of 15 March and 13 April meetings. **RESOLVED: The Council of Governors noted the report.**
DHCFT/GOV/ 2017/43	**REPORT FROM THE GOVERNORS NOMINATIONS & REMUNERATION COMMITTEE** Caroline Maley gave a verbal update from the above meeting, held on 25 April. The Committee received confirmation that Dr Anne Wright had concluded the Fit and Proper Persons Tests as per the Trust's Fit and Proper Persons Test Policy. Maura Teager's appraisal was reported on and feedback given following her exit interview. A draft year-end effectiveness report was reviewed and will be received by the Council of Governors in July. The Committee debated its Terms of Reference and membership. Council of Governors will receive the revised Terms of Reference for approval in July. **RESOLVED: The Council of Governors noted the update.**
DHCFT/GOV/ 2017/44	**PROTOCOL FOR GOVERNOR ATTENDANCE AT BOARD COMMITTEES** Sam Harrison presented the protocol for governor attendance at Board Committees, on the recommendation from Governance Committee. The protocol arose following a discussion regarding the role of governors

	on Committees. The purpose of the protocol is to provide clarification on the role and focus of governors at Board Committees. Board Committee Chairs support the protocol, which had been developed with reference to good practice in the NHS. This offers governors an additional opportunity to hold NEDs to account through observation. It is key that governors feedback on how they observe the NEDs holding the Executives to account to the Governance Committee or Council of Governors and this will be implemented going forwards. **ACTION: The protocol will be reviewed in six months' time.** **RESOLVED: The Council of Governors approved the protocol**
DHCFT/GOV/ 2017/45	**MINUTES OF MEETINGS** The Council of Governors received and noted the minutes of the Public Trust Board meetings held on 11 January 2017 and 1 February 2017. A summary of the Confidential Council of Governors meeting, held on 6 April 2017, was also received and noted. Paula Holt left the meeting.
DHCFT/GOV/ 2017/46	**MEETING EFFECTIVENESS** Attendees confirmed the meeting had been valuable. The NED deep dive was welcomed. Governors liked the venue. The lunch beforehand had worked well.
DHCFT/GOV/ 2017/47	**ANY OTHER BUSINESS** The Chair reported that there would be one item for discussion, but due to confidentiality it would take place in a brief private session.
DHCFT/GOV/ 2017/48	**CLOSE OF MEETING** With no further public business the meeting was closed at 15:30. A private meeting of the Council of Governors followed.

1. Monitor & Competition Markets Authority, (2015), *Supporting NHS providers considering transactions and mergers*, [Online], Available: https://www.gov.uk/government/publications/supporting-nhs-providers-considering-transactions-and-mergers [6 May 2017].

Derbyshire Healthcare
NHS Foundation Trust

QUESTIONS RECEIVED FROM MEMBERS OF THE PUBLIC
COUNCIL OF GOVERNORS MEETING
2 MAY 2017

QUESTION
'I have had representation from a member of our community who tells me of a Community Psychiatric Nurse (CPN) who was unable to fill out a Personal Health Budget for a service-user. This was despite the CPN acknowledging that a particular community-based service was beneficial to the service-user. In these days where we are being encouraged to access community-based resources, it is essential that CPN's are trained in the application process for these services.

What training do our staff (especially CPN's) get in Filling out Personal Health Budgets for our patients? What authorisation is required before a CPN can submit a Personal Health Budget'

RESPONSE
Personal health budgets are not always straightforward and have a level of complexity at this time that does require streamlining. This has been recognised by the Clinical Commissioning Groups (CCGs). The four CCGs are revising this policy and redesigning how this works. On completion of the policy the commissioners have agreed to share this with the Trust. All teams will then receive a protocol/ briefing and guidance on how to complete. If the change and complexity of a revised policy warrants a training intervention this will be reviewed.

The timescale is not known but estimated by the end of Quarter 2 for full implementation of the policy and revised briefing

Response provided 6 May 2017

Included in July Council of Governors' papers for information

COUNCIL OF GOVERNORS ACTION MATRIX - AS AT 12 JULY 2017							
Date of Minutes	**Minute Reference**	**Item**	**Lead**	**Action**	**Completion by**	**Current Position**	
07.03.17	DHCFT/Gov/2017/022	Acting Chief Executive's Report	Sam Harrison	Crisis Concordat information pertinent changes to the Policing & Crime Bill to be shared with Council of Governors.	18.07.17	A broader development session on the Crisis Concordat is planned to address this request. Session confirmed for 17 October. Will be led by Lynn Wilmott-Shepherd. A representative from the Derbyshire Constabulary will also be attending.	Green
			Sam Harrison	An update on STPs will be placed on a future agenda.	18.07.17	Included in Chief Executive Update report.	Green
02.05.17	DHCFT/Gov/2017/033	Submitted questions from members of the public	Carolyn Maley	One question had been received on 29 April, via a governor regarding completion forms for personal health budgets. Unfortunately due to the weekend/bank	18.07.17	A response was prepared and sent via the governor and a copy of both the question and the response is included in today's papers for information.	Green
02.05.17	DHCFT/Gov/2017/037	Acting Chief Executive's Report	John Sykes	Options for junior doctors to access hot food out of hours to be looked into.	18.07.17	National report discussed at Board and Consultants' meeting. Obtaining hot meals is an issue. Doctors mess has kitchen facilities including freezer and microwave. Meals also available for Kingsway and RDH but not after hours. Probably not enough demand for vending machine. Enquiry made re obtaining food from hospital kitchens supplying wards – awaiting reply.	Amber
02.05.17	DHCFT/Gov/2017/038	Update on DCHS & DHCFT Collaborative Working	Sam Harrison	Stakeholder attendance at Engagement Event to be reviewed.	18.07.17	Action no longer applicable following withdrawal from transaction.	Green
02.05.17	DHCFT/Gov/2017/044	Governor protocol for attendance at Board Committees	Sam Harrison	The protocol will be reviewed in six month's time	28.11.17	Agenda item for future meeting.	Yellow
02.05.17	DHCFT/Gov/2017/40	Integrated Performance Report	Amanda Rawlings	In response to questions raised regarding the Workforce Section of the IPR, the Generations4Change report (as presented to the People & Culture Committee on 20 April 2017) is to be shared with governors	18.07.2017	Report issued to Governors through Governor Connect on 4 May 2017.	Green

Key	**Agenda item for future meeting**		**YELLOW**	1	17%
	Action Ongoing/Update Required		**AMBER**	1	17%
	Resolved		**GREEN**	5	71%
	Action Overdue		**RED**	0	0%
				7	100%

Derbyshire Healthcare NHS Foundation Trust
Report to the Council of Governors – 18th July 2017

Acting Chief Executives Report to the Council of Governors

Purpose of Report:

This report provides the Council 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 Council on feedback from external stakeholders such as our commissioners and feedback from our staff. The report should be used to support the Council understanding key risks and opportunities facing the Trust and to aid holding the Board to account for the delivery of the Trust strategy

National Context

1. This month saw the release of the response to the first consultation associated with the CQC's new 5 year strategy, *Shaping the future*, published in May 2016. The strategy set out a vision for a more targeted, responsive and collaborative approach to regulation, supporting more people to get high-quality care. Between December 2016 and February 2017, the CQC consulted on how to develop and evolve their approach to implementing the strategy. This was the first of three Next Phase consultations. Feedback from phase 1 from providers included 3 key themes:
   - The need to ensure clarity, consistency and transparency in implementing the change
   - The need for flexibility in our approach, avoiding a one-size-fits-all approach in processes and methods
   - The need for proportionate regulation and closer and more collaborative working with other organisations at local and national level.

   The CQC have said they will introduce the new assessment framework and approach for NHS trusts from the second half of June 2017. This means that the first new provider information requests (PIRs) will be sent at that point, the first internal regulatory planning meetings will take place from August, the first next phase inspections will take place between September and November 2017, and the first next phase ratings and inspection reports will be published in early 2018.
   The CQC plan to roll out this approach slowly to enable them to evaluate, improve and refine this planned approach however they intend to fully embed the approach by spring 2019, by which all trusts can expect to have an assessment of the well-led key question and at least one core service inspection approximately once each year.

   It is important to note these changes as the Board is aware we are anticipating a further comprehensive review later this year. The Quality Committee will be key in managing this preparation and monitoring of the new inspection process.

2. After the recent cyber-attacks, NHS Improvement and NHS England have been tasked with working with NHS Digital's CareCERT team to check that the NHS is protected against any further attacks. All providers were required to complete a template which set out 39 of the critical CareCERT advisories issued over the last three months. These have been deemed most critical in preventing successful cyber-attacks. We were asked to note which of the 'advisories' our organisation has acted on. Once again thanks to our internal IM&T Team and ArdenGem for ensuring that as a Trust

we complied with this screening and improvement process.

The June Board received a comprehensive lessons learnt document relating to the cyber attack

3. It is of interest to the Derbyshire system that the Health Service Journal has completed some research on provider contracts and there is a significant increase in acute Trusts moving away from payment by result activity sensitive contracts on to block type arrangements. The analysis suggests 1 in 4 acute providers have now moved onto some form of block payment system an increase from 1 in 6 last year. Payment by Results was introduced by the Department of Health in the early 2000s, with the aim of improving efficiency, volume of activity and quality of care. But it has been increasingly criticised for creating perverse incentives and encouraging competition over collaboration and not supporting the move from hospital based care to a more community focus. NHS England had previously urged caution around the move to block contracts with concerns around capacity to respond to demand however this clearly suggests a shift in their approach. This is something that could be a significant plank in the strategy adopted by our system collaboration to support a more equal share of risk as long as it is considered in a way that supports transformation and development of community capacity rather than 'squeezing the funding bubble risk' from commissioners to providers.

Local Context

4. Following improvements made around CQC compliance that the Council have been notified of previously and the conformation that all breach requirements have been met I have received a letter from NHS England as part of the normal quarterly Nottinghamshire and Derbyshire Quality Surveillance Group (QSG). QSG is a forum which systematically brings together the different parts of the system to share information and intelligence relating to provider organisations. Partners will share a view of risks to quality across NHS commissioned services. I am delighted that our rating has now returned to green – routine monitoring which is the highest possible rating that can be achieved.

5. The Derbyshire Sustainability and Transformation Partnership continues to develop its reinvigorated approach with Board being asked to review and agree a revised system governance structure, principles for system working and a memorandum of understanding. As importantly each of the newly re-launched workstreams have been asked to submit their workplans and identified outcomes to form part of the STP update due for submission to NHS England during June. As the lead for the Mental Health Workstream I have agreed we will be focussing on the following 4 domains:
   - Mental Health Primary Care Support
   - Responsive Community Services
   - Dementia and Delirium
   - Forensic and Rehabilitation pathways

   Each domain is made up of a number of programmes of work and individual projects that will support the delivery of the agreed deliverables. This is a very significant alteration in the way we have historically worked. This mental health system plan is supported by senior staff from all Organisations and is the sole mental health plan for Derbyshire.

6. The 29th June was the first County Health and Wellbeing Board following the change in Council control with Carol Hart in the Chair. It was great to receive a document pulled together by the voluntary and non-statutory sector that was referred to as the shadow STP. The purpose of the document was to augment the submitted STP with areas where the voluntary and community sectors could get involved, particularly around supporting self-help and community resilience. In addition we received a revised falls pathway for the whole of Derbyshire and with respect to the health protection agenda heard about how Derbyshire is currently breaching response times following cervical smear tests with currently in excess of 50% of results taking 28 days to return – the standard is 21 days for return.

   The Fire and Rescue Service reported the Derbyshire response to the Grenfell Tower disaster in London.
   - There is only 1 high rise residential building in Derbyshire, this has been assessed and residents reassured.
   - Fire and Rescue service have assessed Derbyshire in-patient health provision and have found no serious issues
   - No Derbyshire properties contain the same cladding as at Grenfell
   - There are 28 building across Derbyshire with more than 6 floors and they have been prioritised for assessment.
   - Requests have now been received to assess all schools, Universities and adult education establishments.

Within our Trust

7. Following the dreadful fire at Grenfell Towers we have carried out a full review of all fire risk assessments within our Trust as well as having an external assessment by Derbyshire Fire and Rescue Service of our in-patient facilities. I am pleased that there are no serious defects noted however there are some actions required around training, evacuation confidence and minor works to fire compartments. These actions are all underway.

8. Over the last month our front line teams have continued to deliver services in the face of ongoing activity pressures both within in our wards and community services. We have agreed to work with the Emergency Care Improvement Programme (ECIP) on a project called Red2Green, which aims to reduce delays in the patient pathway. There is good evidence of this working in other Mental Health and Community Trusts and I am hopeful that this will help alleviate some of our pressures and provide our teams with some skilled, external support.

   Staffing to our agreed establishments continues to be a concern for me and the Executive Team. Operational and Clinical teams have worked together on developing plans to mitigate this risk as we progress towards key holiday periods and at the same time continue our efforts to recruit into all of our vacancies.

   The Trust's Cost Improvement target of £3.85 million continues to be a challenge to achieve. Whilst we have some plans in place to deliver part of this, work has continued across all service areas to deliver savings where it is possible to do so. I will keep CoG appraised of progress in my future reports.

9. Wednesday the 7th June saw BME staff from our Trust joining forces with Executive

Directors with the support of Stacy Johnson, Associate Professor from the University of Nottingham to develop our reverse mentoring for inclusion and diversity programme. We have some work to do to agree the details of this scheme but motivation is very high and Stacy did a great job in starting the conversations we need to have to make this a reality. This will form part of Harinder Dhaliwal's routine Equality and Diversity brief to the Board.

10. Over the last month I have been able to visit a number of corporate teams to discuss with them the decision to not progress the acquisition but also other issues they wanted to raise. At the point of writing this report I had visited Finance, Workforce& OD, Estates and IM&T. Feedback about our Trust decision was positive but clearly we now must focus on understanding more about the business case for our back office integration programme with DCHS, the models and benefits. In addition we have held four (at the point of writing) open engagement sessions with staff at Kingsway, Chesterfield, St Andrews House and Ilkeston Resource Centre. These sessions were fairly well attended and feedback was positive and we had some good conversations about what stability would look like to our staff, succession planning and the importance of creating career structures both inside our organisation and in the STP more broadly. We also spoke about methods of communication and transformational change programmes that some staff felt hadn't delivered the expected benefits

    We are planning to continue with open engagement sessions with an unstructured agenda to allow staff to meet senior leaders and share thoughts, concerns and ideas with them. In addition we have agreed that the fortnightly Executive Leadership Meetings will now circulate around the Trust with ELT members using that as an opportunity to be more accessible to staff throughout the Trust

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

Assurances

- Our strategic thinking includes national issues that are not immediately in the health or care sector but that could be of high impact.
- The Council can take assurance that Trust level of engagement and influence is high in the health and social care community
- Feedback from staff is being reported into the Board
- There is a new risk for the BAF related to IPP – this will require mitigations

Consultation

- The report has not been to any other group or committee

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

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

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

That said some of the reports both nationally and regionally have the potential to have an adverse impact on people with protected characteristics (REGARDS).

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

That equality impact assessment needs to determine a response to the three aims of the general equality duty:

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

Transformation done well has the potential to *improve* our delivery of equality, by for example, increasing the opportunity for communities to come together in more positive ways than those that exist in the way we currently deliver services

The Reverse Mentoring training is a specific example where the outcomes will positively impact on all three aims of the Equality Act for groups of staff, i.e. the BME staff community, in helping the executive to identify barriers and remove them, increase the opportunities for positive outcomes for BME groups, and support the creation of opportunities to bring communities and groups together in positive ways.

I believe the integrated approach we are taking to delivering the mental health transformation programme as part of the STP supports our need to focus through individual clinical pathways on protected groups to ensure that in each clinical pathway area we have a clear understanding of the barriers to engagement and outcomes for those groups within our communities.

Recommendations

The Council is requested to:

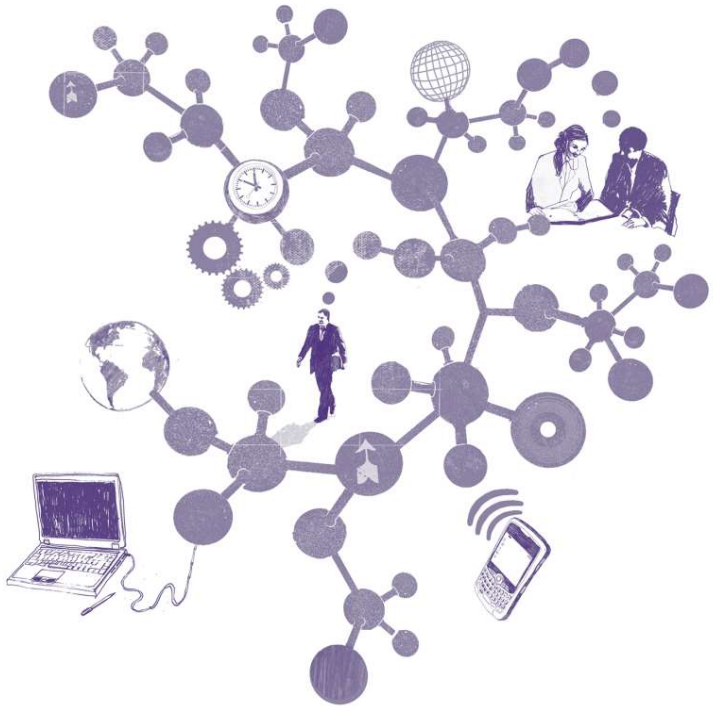
1) Scrutinise the report, noting the risks and actions being taken
2) Discuss and raise questions on the content therein.

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

Grant Thornton UK LLP –Annual Audit Letter Presentation for Derbyshire Healthcare NHS Foundation Trust

Year ended 31 March 2017

July 2017



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Overview

Our Annual Audit Letter summarises the key findings arising from the following work that we have carried out the Trust for the year ended 31 March 2017:

- auditing the 2016/17 accounts
- assessing the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources
- reviewing the Trust's Quality Report.

Opinion on the Financial Statements

Our annual work programme was conducted in accordance with the NAO's Code of Audit Practice ('the Code'), International Standards on Auditing (UK and Ireland) and other guidance issued by the NAO and NHSI.

The accounts process went well again. We were provided with a good set of accounts supported by comprehensive working papers. Finance and other staff were very helpful and co-operative contributing to an efficient audit.

We issued the following:

- an unmodified opinion on the accounts on 25 May 2017 (ahead of the national deadline).
- a group assurance certificate to the National Audit Office, in respect of Whole of Government Account.

We were also satisfied that the Trust's Annual Report, which includes the Annual Governance Statement, met the requirements set out in the NHS Foundation Trust Annual Reporting Manual and was consistent with the audited financial statements.

Opinion on the Financial Statements

There were no significant issues identified by the audit.

Only two points of note arose from the audit:

1. The net book values of land and buildings reported in note 16 is materially fairly stated. However, review of the Trust's Fixed Asset Register "RAM" database identified that revaluations of £5m were incorrectly allocated within depreciation rather than cost. The Trust has agreed to correct the fixed asset register early in 2017/18.
2. When reviewing the "mismatch" report provided by the Department of Health (DoH), which identifies mismatches of income and expenditure, we identified that the Trust had reported £4m more in expenditure than the income reported by a counter party. This relates to expenditure on bank staff. We are satisfied this Trust has correctly recorded this expenditure per the DoH Agreement of Balances guidance.

Use of Resources

We are required by the Code to satisfy ourselves whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We assess the Trust against the following Use of Resources criteria: Informed decision making, Sustainable resource deployment, and partnership working.

We focussed our work in two areas:

- the improvements put in place to address concerns raised by CQC in its report (September 2016)
- the actions taken by the Trust to deliver the Governance Improvement Action Plan and to remove NHSI enforcement action.

Use of Resources

We were satisfied that the Trust had:

- put the improvements in place to address CQC concerns. This resulted in CQC removing its warning notice on 22 March 2017.

- Taken appropriate action to deliver its GIAP. This was confirmed by NHSI, who in May 2017 issued a compliance certificate in respect of the entirety of the Trust's Enforcement Undertakings.

We are satisfied that the Trust took appropriate and timely action to address concerns raised by CQC and NHSI. However, the revised arrangements were not in place for the whole of the year and as at the 31 March 2017 the Trust continued to be subject to enforcement action by NHSI. On this basis we issued a qualified Use of Resources conclusion stating:

'On the basis of our work, we were satisfied that, **except for** the specific governance issues related to NHSI's enforcement action that was still in place as at 31 March 2017, **the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources** for the period ending 31 March 2017.'

Quality Report

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

We checked that

- the Quality Report had been prepared in line with the requirements set out in NHSI's *Annual Reporting Manual*
- it was consistent in all material respects with the sources specified in NHSI's Detailed Guidance on Quality Reports 2016/17.

We reviewed the following indicators:

- Proportion of delayed transfer of care bed days out of the total number of occupied inpatient bed days
- Percentage of Enhanced Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital
- Percentage of patients discharged from inpatient care who are followed up within seven days.

We provided an unqualified limited assurance opinion on the Trust's Quality Report.

Derbyshire Healthcare NHS Foundation Trust
Report to the Council of Governors – 18 July 2017

Governors Nominations & Remuneration Committee

Purpose of Report

This paper provides an update on the meeting held on held on 25 April 2017 and presents output for review/approval.

Executive Summary

The Governors Nominations & Remuneration Committee last met on 25 April 2017 and a verbal update of that meeting was provided at the May Council of Governors Meeting. At that time it was agreed that a revised Terms of Reference and a Year End Report for the Nominations & Remuneration Committee would be submitted to the July Council of Governors.

Summary of 25 April 2017 Meeting

- Dr Anne Wright concluded the requirements of the Fit and Proper Person Tests.
- Received the results of the annual appraisal and exit interview for Maura Teager which are summarised in Appendix 1.
- Received a draft year-end report for the Committee.
- Membership and the Terms of Reference were reviewed.

Year End Report – Appendix 2
The attached report summarises the business undertaken in 2016/17 based on the Committee's Terms of Reference. It is recommended to the Council of Governors to demonstrate the effectiveness of the Committee.

Terms of Reference – Appendix 3
A review of the Terms of Reference has resulted in some proposed amendments to membership.

- One additional staff governor member and one additional public governor member is proposed, bringing total membership to four public governors, two staff governors and two appointed governors.
- Quorum will remain three governors, two of whom must be public governors.
- It is suggested that by exception, in order to achieve quorum, a governor can be nominated to 'step in' from the same category.
- Initial appointments shall be to the end of a member governor's term.
- Every member of the Committee shall be entitled to one vote on any question to be determined by voting. In the event of there being equal votes cast, then the person presiding at such a Committee meeting shall have a casting vote.

Membership – Nominations for Staff, Public & Appointed Governors
The Council of Governors is asked to consider how it would wish to elicit interested parties.

We will approach Appointed Governors to invite them to express their interest to fill the vacancy. Council of Governors is asked to agree on tenure of the committee members.

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

Assurances

The Council of Governors can be assured from the updates provided that the Committee is meeting its requirements as set out in the Terms of Reference and statutory responsibilities.

Consultation

Governors consulted through involvement in the Committee.

Governance or Legal Issues

The Committee has fulfilled its Terms of Reference as set out below:

8. Performance Evaluation

8.1 The Committee shall review annually its collective performance and report this to the Council of Governors.

9. Review

9.1 The terms of reference of the Committee shall be reviewed by the Council of Governors at least annually.

Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

Recommendations

The Council of Governors is requested to:

1) Note that the Committee has conducted an annual review of its Terms of Reference and revisions are submitted to the Council of Governors for approval.

2) Consider how it would wish to elicit interest from Public and Staff Governors for membership of Nominations & Remuneration Committee.

3) Agree on tenure of membership for the Committee.

3) Receive the Committee's report of its collective performance as per the Terms of Reference.

4) Receive confirmation of the appraisal and exit interview held with Maura Teager, former Non-Executive Director.

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

Report prepared by: **Donna Cameron, Assistant Trust Secretary**

Derbyshire Healthcare NHS Foundation Trust
Report to the Council of Governors – 18 July 2017

Maura Teager, Non-Executive Director
Results of Appraisal & Confirmation of Exit Interview
Governors Nominations & Remuneration Committee

Purpose of Report

To provide the Council of Governors with a summary report on the outcome of the appraisal for Maura Teager, Non-Executive Director on her departure from the Trust. And to confirm an exit interview was held.

Executive Summary

The Chair led on the appraisal process for Maura Teager prior to her departure from the Trust. The Board and Council of Governors were asked to participate in the process and the results are presented for consideration.

The results of the appraisal and feedback on the exit interview were shared with the Governors Nominations & Remuneration Committee on 25 April 2017. A summary is presented to the Council of Governors to note the outcome of the process.

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

Assurances

The Board can be assured that process has been followed in consulting with Governors' Nominations & Remuneration Committee as per the Terms of Reference (extract below in *Governance or Legal Issues*).

Governors have approved the appraisal process, input into the appraisal and Nominations & Remuneration Committee assures the Council of Governors that a formal, rigorous annual appraisal has taken place.

Consultation

Each board member and governor has been invited to participate in the appraisal process. The process for the appraisal was previously presented to the Committee on 11 November 2016 and agreed.

As per the Terms of Reference of the Governors' Nominations & Remuneration Committee, members are asked to input into Non-Executive Director appraisals,

including approving the appraisal structure.

The full summary of the performance appraisal and exit interview were presented to Governors Nominations & Remuneration Committee on 25 April 2017.

Governance or Legal Issues

This paper should be considered in relation to the NHS Foundation Trust Code of Governance (the Code), where there is a requirement for a formal, rigorous evaluation of the performance of individual directors, with the Acting Trust Chair leading the process for evaluation of the Non-Executive Director

Equality Delivery System

This paper does not impact on any of the REGARDS groups.

Recommendations

The Council of Governors is requested to:

1. Receive assurance that a robust appraisal process has been followed for the appraisal of Maura Teager, Non-Executive Director, for the period 1 April 2016 to 30 March 2017.
2. Note the feedback received on the performance of Maura Teager.

Report prepared by: **Donna Cameron, Assistant Trust Secretary**

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

NON-EXECUTIVE DIRECTOR APPRAISAL

Name of appraisee	Maura Teager
Date of appraisal	14 March 2017
Date of first appraisal	N/A
Current appointment dates	31 March 2014 - 30 March 2017
Period of assessment	1 April 2016 - 30 March 2017
Board meetings attended	Board Meetings Quality Committee Meetings

The appraisal framework

The framework below outlines the process conducted, as previously agreed, based on the 360 degree feedback process involving the Trust Board and the Council of Governors.

Activity	**By when**
Self-assessment completed by the Non-Executive Director	10 March 2017
Peer assessment questionnaires completed and returned	February/March 2017
Summary of peer assessment produced and provided to Chair	6 March 2017
Appraisal/performance review meeting held and documentation completed	14 March 2017
Summary report by Chair Nominations and Remuneration Committee; a brief report, including any recommendations, is produced for the Council of Governors	25 April 2017
Summary report to Council of Governors	18 July 2017
Summary to Public Board	27 July 2017

Assessment of Performance against key objectives

Performance was assessed using a score system of one to four, as outlined below.

1.	An *outstanding performance*; making a critically important contribution to the work of the Board.
2.	A *fully satisfactor*y performance; demonstrated the range of skills and qualities required.
3.	A *generally satisfactory* performance but with room for development.
4.	A performance *giving cause for concern* across a significant number of areas requiring prompt improvement.

Summary of Feedback on Competencies

Maura Teager's performance was asssessed against agreed objectives. The overall rating of Maura Teager by the Trust Board is either Outstanding or Fully Satisfactory. Maura Teager's self-assessment against these competencies was similar. Views were aligned and any differences discussed. No areas for concern were raised.

The overall rating of Maura Teager by the Council of Governors is Outstanding/Fully Satisfactory.

360 Feedback & Comments

The feedback enabled free form comments to be made by the Trust Board and governors. Comments were received in each of the eight competencies.

Feedback on eight competencies were summarised and shared with Maura Teager. For each competency the positive comments were summarised alongside areas to consider, which were constructive comments, observations and advice. There was a lot of synergy between the comments. There were no issues with the comments received.

Significant contributions in 2016/17

- Providing NED Committee Chair and representative cover during a 6 month period when there was a shortfall
- NED representative on Consultant Appointment Panels
- Engaging with frontline staff beyond the Quality Visit Programme
- Support to Director of Nursing & Patient Experience
- Staying with the organisation when managing health challenges within her family
- Not allowing the fallout from the ET to derail her

No formal objectives had been set for the next year as her term ended on 30 March 2017. Maura had valued her time with the Trust and was ending her role 'leaving on a high'.

In summary, Maura has been a very strong NED, providing good insight, challenge and support where needed. Her contributions to the Trust are too many to be noted, and we are aware that many staff have valued her personal style that she has brought to the role.

The Chair noted: *I personally have found her a good sounding board when needed, and she brings a useful perspective when needed to challenges I have faced. I know that other colleagues would say the same. Thank you for all that you have done for the Trust over the 7 years that you have been a NED and we wish you all the best for the future.*

Derbyshire Healthcare
NHS Foundation Trust

Governors Nominations & Remuneration Committee
Year-End Report
2016/17

Nomination Role

Periodically review the balance of skills, knowledge, experience and diversity of the non-executive directors and, having regard to the views of the Board of Directors and relevant guidance on board composition, make recommendations to the Council of Governors with regard to the outcome of the review.

The Interim Trust Chair and two Non-Executive Directors (NEDs) stood down in 2016/17. Four NEDs were recruited; an Acting Trust Chair and Deputy Trust Chair were also appointed from internal candidates. As a result of this turnover, the Committee regularly reviewed the balance of skills, knowledge, experience and diversity of the NEDs to ensure that the required qualities and experience were reflected on the Trust Board, particularly in light of the merger by acquisition. Input was received from Executive representatives and recommendations made to the Council of Governors.

Review the results of the Board of Directors' performance evaluation process that relate to the composition of the Board of Directors.

The structure, size and composition of the Board has been actively reviewed during the year prior to the appointment to the Executive and Non-Executive Director roles as outlined. The Board's Remuneration and Appointments Committee has made recommendations to the Nominations and Remuneration Committee relating to the appointment of the new NEDs to include recommending a specific focus on identifying individuals with HR, Quality and clinical backgrounds for example to ensure the appropriate level of expertise and experience to bring to the Board.

Review annually the time commitment requirement for Non-Executive Directors.

Throughout the year and particularly during recruitment of Non-Executive Directors, the Committee has considered the time commitment required by Non-Executive Directors and sought assurance that the best use of is made of their time to maximise their input (August 2016).

Give consideration to succession planning for Non-Executive Directors, taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board of Directors in the future.

In light of the changes in NEDs in 2016/17, succession planning formed part of planning the recruitment and selection processes for new NEDs. The role description and advertisement for the Clinical NED role were produced hand in hand with the Committee to ensure the qualities sought reflected the requirements of the Board. The future leadership arrangements of the Trust were given significant focus in order to secure a replacement for the Interim Trust Chair. Timelines were regularly reviewed to minimise disruption to the organisation.

Make recommendations to the Council of Governors concerning plans for succession.

The Council of Governors were kept informed of discussions regarding plans for succession and recommendations made.

Keep the leadership needs of the Trust under review at non-executive level to ensure the continued ability of the Trust to operate effectively in the health economy.

The leadership of the Trust and its ability to support its service users was at the forefront of the Committee's discussions during a year which saw a lot of transition in the NEDs. Changes in the local, regional and national health economy played a significant role in the business of the Committee throughout the year. The Committee was clear that any changes in leadership must ensure that the mental health agenda remained a priority.

Agree with the Council of Governors a clear process for the nomination of a Non-Executive Director.

Governors, through the Nominations and Remuneration Committee, have been involved in oversight of the recruitment process and directly involved in shortlisting and interview. Other governors and Trust staff have also been involved in stakeholder sessions with candidates. Ahead of the two cycles of recruitment (July and October), a process for recruitment was received by the Committee and reported on to the Council of Governors. The Committee was involved in shortlisting of candidates on both occasions, with guidance from the Interim Chair, acting Chief Executive, Trust Secretary and Gatenby Sanderson recruitment consultants.

Keep up to date and fully informed about strategic issues and commercial changes affecting the Trust and the environment in which it operates.

The Interim Chair kept the Committee informed throughout the year regarding the potential changes in the health economy, locally and nationally and its potential impact on the Trust and service users. These updates also informed the NED recruitment process.

Take into account the views of the Board of Directors on the qualifications, skills and experience required for each position.

The views of directors were considered as part of the planning and recruitment processes followed during the year.

For each appointment of a Non-Executive Director, prepare a description of the role and capabilities and expected time commitment required.

The Committee provided input into the recruitment and selection process for the NED roles. Role descriptions, capabilities, qualities and time commitment were reviewed.

Identify and nominate suitable candidates to fill vacant posts within the Committee's remit, for appointment by the Council of Governors.

The Committee selected four new NEDs. Internal candidates were selected for the roles of Acting Trust Chair and Deputy Trust Chair.

Ensure that a proposed Non-Executive Director is a 'fit and proper' person as defined in law and regulation and in line with the Trust's Fit And Proper Person Test Policy.

The Committee was provided with evidence to assure that fit and proper person test policy was being effectively followed by the Trust. Assurance is given for all new appointments as soon as possible following appointment.

Ensure that a proposed Non-Executive Director's other significant commitments are disclosed to the Council of Governors before appointment and that any changes to their commitments are reported to the Council of Governors as they arise.

All NEDs are required to advise the Trust of any significant commitments. The declaration of interests register is updated on a regular basis to reflect any changes.

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. Determine whether or not any Non-Executive Director proposed for appointment is independent (according to the definition in the Foundation Trust Code of Governance and/or in the Trust's constitution or governance procedures).

All business interests are disclosed and conflicts of interest are sought prior to appointment.

Ensure that on appointment Non-Executive Directors receive a formal letter of appointment setting out clearly what is expected of them in terms of time commitment, Committee service and involvement outside Board of Director meetings.

Each successfully appointed candidate received a formal letter of appointment from the Chair, setting out clearly what is expected of them in terms of time commitment, Committee service and involvement outside Board of Director meetings.

Carefully consider what compensation commitments Executive Directors' terms of appointment would give rise to in an event of early termination to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing Executive Director's obligation to mitigate loss. Appropriate claw back provisions should be considered in case of an Executive Director returning to the NHS within the period of any putative notice.

Not applicable during the 2016/17 year.

Advise the Council of Governors in respect of the re-appointment of any Non-Executive Director. Any term beyond six years must be subject to a particularly rigorous review.

Not applicable during the 2016/17 year.

Advise the Council of Governors in regard to any matters relating to the removal of office of a Non-Executive Director.

Not applicable during the 2016/17 year.

Make recommendations to the Council of Governors on the membership of Committees as appropriate, in consultation with the chairs of those Committees.

The Committee reviewed the NED members of Board Committees at its January 2017 meeting to ensure best use of skills and fair apportionment of committee commitments.

Remuneration Role

Recommend to the Council of Governors remuneration and terms of service policy for Non-Executive Directors, taking into account the views of the Chair (except in respect of his own remuneration and terms of service) and the Chief Executive and any external advisers.

In 2016/17 recommendations were made to the Council of Governors to appoint four NEDs, the Acting Trust Chair and the Deputy Trust Chair. Each recommendation,

made with the support of the Interim Trust Chair, contained recommended remuneration in line with Trust policy. Conditions and terms of service were outlined in the case of each recommendation. This was benchmarked for other comparative Trusts.

In accordance with all relevant laws and regulations, recommend to the Council of Governors the remuneration and allowances, and the other terms and conditions of office, of the Non-Executive Directors.

Conditions and terms of service were outlined in the case of each recommendation.

Agree the process and receive and evaluate reports about the performance of individual Non-Executive Directors and consider this evaluation output when reviewing remuneration levels.

Reports following appraisal of NEDs held during the year (Caroline Maley, Maura Teager and Jim Dixon) were considered by the Committee. Feedback following the appraisal of the Interim Chair, Richard Gregory, was also presented.

Input into the Non-Executive Directors appraisals, including approving the appraisal structure and giving assurance to Council of Governors that satisfactory appraisals have taken place

NED appraisals for 2015/16 were reviewed and agreed. The Committee supported objective setting and agreed feedback for consideration of NED portfolio and development (August 2016). The appraisal structure was reviewed in-year

In November 2016 the Committee reviewed and approved the process for appraisal of the Trust Chair and NEDs. In the case of the Interim Trust Chair, an appraisal was conducted prior to his departure was presented to both the Committee and Council of Governors, providing assurance that satisfactory appraisal had taken place.

In adhering to all relevant laws and regulations establish levels of remuneration which:

> **are sufficient to attract, retain and motivate non-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;**
>
> **reflect the time commitment and responsibilities of the roles;**
>
> **take into account appropriate benchmarking and market-testing, while ensuring that increases are not made where trust or individual performance do not justify them; and**
>
> **are sensitive to pay and employment conditions elsewhere in the Trust.**

Benchmarking survey information was received on NED salary, time commitment and uplift for additional roles. Members observed that the Trust paid in line with other Trusts in terms of salaries and additional responsibilities. Time commitment was noted to be mid-range of those reported in the survey (January 2017). Time commitment was also considered when noting appraisal feedback (August).

Monitor procedure to ensure that existing Directors remain 'fit and proper' persons as defined in law and regulation;

The Committee received a paper to demonstrate that each of the Non-Executive Directors appointed in year had successfully completed the Fit and Proper Persons checks (January 2017), with the exception of Dr Anne Wright whose report will be received at the April 2017 meeting.

Oversee other related arrangements for Non-Executive Directors.

The Committee received details of exit interviews held in year with two outgoing Non-Executive Directors and the Interim Trust Chair. Lessons learned from the feedback were incorporated which included the creation of a comprehensive induction for NEDs.

The role description for the Senior Independent Director was amended and reviewed by the Committee twice. Firstly, in order to reflect this role as it has developed within the Trust. Secondly, to reflect the experience of the outgoing candidate (January 2017).

Membership

The membership of the Committee shall consist of governors appointed by the Council of Governors

- **Three Public Governors (including Lead Governor)**
- **Two Appointed Governors**
- **One Staff Governor**
- **Chairman of the Trust**

The Director of Corporate Affairs & Trust Secretary may attend as a non-member.

The Committee will normally be chaired by the Trust Chair. Where the Chair has a conflict of interest, for example when the Committee is considering the Chair's re-appointment or remuneration, the Committee will be chaired by the Vice-Chair

A quorum shall be three members, two of whom must be public governors.

Due to the availability of appointed governors, the membership of the Committee fell below maximum for the year, with just one appointed governor as a member. A change in membership was seen in January 2017 when Caroline Maley joined as

Acting Trust Chair following the departure of the Interim Trust Chair, Richard Gregory, at the end of December 2016.

Attendance

A summary of membership attendance is presented below . As and when required and by invitation the Chief Executive attended the meeting. Other attendees in year include representatives from the recruitment agency engaged to search for Non-Executive Director candidates and officers from Workforce & Organisational Development to oversee the selection process of candidates. In addition, governors were invited to observe meetings of the Committee when interviews were held for the position of Trust Chair.

Members	1 April 2016	4 July 2016 Shortlisting	19 July 2016 Interviews	20 July 2016 interviews	3 August 2016	21 September 2016	11 November 2016	14 November 2016 Interviews	23 November 2016 Interviews	13 December 2016 Interviews	13 January 2016	No of Meetings
Richard Gregory Interim Trust Chair (Until December 2016)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		10/10
Caroline Maley Acting Trust Chair (from January 2017)											Y	1/1
Paula Holt (nee Crick) Appointed Governor, University of Derby	Y	N	N	N	Y	Y	N	N	N	Y	N	4/11
April Saunders Staff Governor	Y	N	Y	Y	Y	Y	N	Y	Y	N	N	7/11
John Morrissey Public & Lead Governor	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	11/11
Ruth Greaves Public Governor	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	10/11
Moira Kerr Public Governor	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	9/11
Vacancy Appointed Governor	-	-	-	-	-	-	-	-	-	-	-	0/11
Other Attendees												
Ifti Majid Acting Chief Executive		X	Y	Y	X	X	X	Y	N	Y	N	4/10
Samantha Harrison (from May 2016) Director of Corporate Affairs & Trust Secretary		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10/10
Jenna Davies (Until May 2016) Interim Trust Secretary	Y											1/1

Frequency of Meetings

Meetings shall be held as required, but at least four times in each financial year.

In 2016/17 meetings were held in April, July, August, September, November and January. The Committee also met as an interview panel in July, November and December.

Minutes & Reporting

Formal minutes shall be taken of all Committee meetings and once approved by the Committee, circulated to all members of the Council of Governors unless a conflict of interest or matter of confidentiality exists.

Minutes have been received by the Committee.

The Committee will report to the Council of Governors after each meeting.

Summary reports were given to the Council of Governors on the business undertaken at each meeting and recommendations made as and when required.

The Committee shall receive and agree a description of the work of the Committee, its policies and all Non-Executive Director emoluments in order that these are accurately reported in the required format in the Trust's Annual Report.

Details of the work of the Committee are included in the Council of Governors section of the annual report

Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the Trust.

. Remuneration Consultants have not been engaged during 2016/17.

Performance Evaluation

The Committee shall review annually its collective performance and report this to the Council of Governors.

As part of its annual review, the Committee has reviewed its performance as presented in this report to the Council of Governors.

Terms of Reference shall be reviewed by the Council of Governor at least annually

The Committee reviewed its Terms of Reference in August 2016 and proposed changes were agreed. The revised Terms of Reference were ratified by the Council of Governors at its September 2016 meeting. It is against these Terms of Reference that the Committee has based its review for 2016/17.

The annual review of the Terms of Reference forms part of the forward plan for the Committee but they will continue to be reviewed as and when required.

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Terms of Reference of Nominations & Remuneration Committee

a) Authority

The Council of Governors' Nomination and Remuneration Committee (the Committee) is constituted as a standing Committee of the Council of Governors. Its constitution and terms of reference shall be as set out below, subject to amendment at future meetings of the Council of Governors. The Committee is authorised by the Council of Governors to act within its terms of reference. All members of staff are requested to cooperate with any request made by the Committee.

The Committee is authorised by the Council of Governors, subject to funding approval by the Board of Directors, to request professional advice 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 the exercise of its functions.

The Committee is also authorised to request such internal information as is necessary and expedient to the fulfilment of its functions.

b) Conflicts of Interest

The Chair of the Trust, or any Non-Executive Director present at Committee meetings, will withdraw from discussions concerning their own re-appointment, remuneration or terms of service.

1. Nomination Role

The Committee will:

1.1 Periodically review the balance of skills, knowledge, experience and diversity of the non-executive directors and, having regard to the views of the Board of Directors and relevant guidance on board composition, make recommendations to the Council of Governors with regard to the outcome of the review.

1.2 Review the results of the Board of Directors' performance evaluation process that relate to the composition of the Board of Directors.

1.3 Review annually the time commitment requirement for Non-Executive Directors.

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1.4 Give consideration to succession planning for Non-Executive Directors, taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the Board of Directors in the future.

1.5 Make recommendations to the Council of Governors concerning plans for succession.

1.6 Keep the leadership needs of the Trust under review at non-executive level to ensure the continued ability of the Trust to operate effectively in the health economy.

1.7 Agree with the Council of Governors a clear process for the nomination of a Non-Executive Director.

1.8 Keep up to date and fully informed about strategic issues and commercial changes affecting the Trust and the environment in which it operates.

1.9 Take into account the views of the Board of Directors on the qualifications, skills and experience required for each position.

1.10 For each appointment of a Non-Executive Director, prepare a description of the role and capabilities and expected time commitment required.

1.11 Identify and nominate suitable candidates to fill vacant posts within the Committee's remit, for appointment by the Council of Governors.

1.12 Ensure that a proposed Non-Executive Director is a ‘fit and proper’ person as defined in law and regulation and in line with the Trust’s Fit And Proper Person Test Policy.

1.13 Ensure that a proposed Non-Executive Director’s other significant commitments are disclosed to the Council of Governors before appointment and that any changes to their commitments are reported to the Council of Governors as they arise.

1.14 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. Determine whether or not any Non-Executive Director proposed for appointment is independent (according to the definition in the Foundation Trust Code of Governance and/or in the Trust’s constitution or governance procedures).

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1.15 Ensure that on appointment Non-Executive Directors receive a formal letter of appointment setting out clearly what is expected of them in terms of time commitment, Committee service and involvement outside Board of Director meetings.

1.16 Carefully consider what compensation commitments Executive Directors' terms of appointment would give rise to in an event of early termination to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing Executive Director's obligation to mitigate loss. Appropriate claw back provisions should be considered in case of an Executive Director returning to the NHS within the period of any putative notice.

1.17 Advise the Council of Governors in respect of the re-appointment of any Non-Executive Director. Any term beyond six years must be subject to a particularly rigorous review.

1.18 Advise the Council of Governors in regard to any matters relating to the removal of office of a Non-Executive Director.

1.19 Make recommendations to the Council of Governors on the membership of Committees as appropriate, in consultation with the chairs of those Committees.

2. Remuneration Role

The Committee will:

2.1 Recommend to the Council of Governors remuneration and terms of service policy for Non-Executive Directors, taking into account the views of the Chair (except in respect of his own remuneration and terms of service) and the Chief Executive and any external advisers.

2.2 In accordance with all relevant laws and regulations, recommend to the Council of Governors the remuneration and allowances, and the other terms and conditions of office, of the Non-Executive Directors.

2.3 Agree the process and receive and evaluate reports about the performance of individual Non-Executive Directors and consider this evaluation output when reviewing remuneration levels.

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2.4 Input into the Non-Executive Directors appraisals, including approving the appraisal structure and giving assurance to Council of Governors that satisfactory appraisals have taken place

2.5 In adhering to all relevant laws and regulations establish levels of remuneration which:

2.5.1 are sufficient to attract, retain and motivate non-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;

2.5.2 reflect the time commitment and responsibilities of the roles;

2.5.3 take into account appropriate benchmarking and market-testing, while ensuring that increases are not made where trust or individual performance do not justify them; and

2.5.4 are sensitive to pay and employment conditions elsewhere in the Trust.

2.6 Monitor procedure to ensure that existing Directors remain 'fit and proper' persons as defined in law and regulation;

2.7 Oversee other related arrangements for Non-Executive Directors.

3. Membership

3.1 The membership of the Committee shall consist of governors appointed by the Council of Governors.

- Four Public Governors (including Lead Governor)
- Two Appointed Governors
- Two Staff Governors
- Chair of the Trust

3.2 The Committee will normally be chaired by the Trust Chair. Where the Chair has a conflict of interest, for example when the Committee is considering the Chair's re-appointment or remuneration, the Committee will be chaired by the Vice-Chair.

3.3 A quorum shall be three members, two of whom must be public governors.

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3.4 By exception, in order to achieve quorum, a governor can be nominated to 'step in' from the same category.

3.5 The Committee will normally be chaired by the Trust Chair. Where the Chair has a conflict of interest, for example when the Committee is considering the Chair's reappointment or remuneration, the Committee will be chaired by the Vice-Chair.

3.6 Initial appointment terms shall be to the end of a member governor's term.

3.7 Every member of the Committee shall be entitled to one vote on any question to be determined by voting. In the event of there being equal votes cast, then the person presiding at such a Committee meeting shall have a casting vote.

4. Secretary

4.1 The Director of Corporate Affairs & Trust Secretary shall ensure appropriate administrative support to the Committee.

5. Attendance

5.1 Only members of the Committee have the right to attend Committee meetings.

5.2 At the invitation of the Committee, meetings shall normally be attended by the Chief Executive but the Chief Executive is not a member of the Committee and shall have no vote on any matter considered by it.

5.3 The Director of Corporate Affairs & Trust Secretary may attend as a non-member.

5.4 Other persons may be invited by the Committee to attend a meeting so as to assist in deliberations.

6. Frequency of Meetings

6.1 Meetings shall be held as required, but at least four times in each financial year.

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7. Minutes and Reporting

7.1 Formal minutes shall be taken of all Committee meetings and once approved by the Committee, circulated to all members of the Council of Governors unless a conflict of interest or matter of confidentiality exists.

7.2 The Committee will report to the Council of Governors after each meeting.

7.3 The Committee shall receive and agree a description of the work of the Committee, its policies and all Non-Executive Director emoluments in order that these are accurately reported in the required format in the Trust's Annual Report.

7.4 Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the Trust.

8. Performance Evaluation

8.1 The Committee shall review annually its collective performance and report this to the Council of Governors.

9. Review

9.1 The terms of reference of the Committee shall be reviewed by the Council of Governors at least annually.

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors – 28 June 2017

Integrated Performance Report Month 2

Purpose of Report

This paper provides Trust Board with an integrated overview of performance as at the end of May 2017. The focus of the report is on workforce, finance, operational delivery and quality performance.

Executive Summary

The Trust continued to perform well against many of its key indicators during May. This Executive Summary draws out a number of key issues for discussion by the Board of Directors.

For this month's report most of the Divisional KPI's have had targets added. At this stage these are draft and will evolve during the coming months. In addition, two 'example' daily staff fill rate graphs have been added to the report to enhance Board discussion on ward staffing alongside the Director of Nursing's assurance set out in this report

Key themes for month 2 / year to date

1. Continued concerns about high levels of patient activity and clinical capacity in community services to provide good quality and safe services.

Board members will note that the neighbourhood dashboard shows community caseloads remaining high, but also that waiting time for care coordination remains long because there isn't enough care coordination capacity to enable shorter wait times.

Quality Committee have previously received assurance that mitigating actions are being delivered to maintain the current position. The mitigation plan was reviewed again at the Trust Management Team on 19th June, with assurances being received that small improvements have been made in recruitment, which in turn has enabled the position to continue to be maintained.

2. Acute inpatient bed occupancy

Activity pressures continue on both Radbourne and Hartington Units and are highlighted by very high bed occupancy across all wards, resulting in a significant number of patients being placed out of area during May. This provides for a very poor patient experience and is very costly to the Trust. Patients being placed out of area in June had fallen considerably at the time of writing this report.

On 19th June, the Trust Management Team received an update on the work programme being undertaken to deliver the bed optimisation project. One of the aims of this project is to reduce length of stay and thus create bed capacity. Although difficult to deliver, it is envisaged that this work programme will have a positive impact.

In addition, the Trust has secured support from NHSI's improvement team to work with the Trust on understanding how we might better improve the flow of patients across our inpatient wards and through community services. This will also include the implementation of a Red2Green project, which is essentially an approach to minimise delays in patients pathway and improve collective decision making and accountably at ward level.

3. Staffing challenges

Despite the delivery of recruitment activities, staffing remains a constant challenge for many Trust services. As requested by the Board of Directors, the Director of Nursing has reviewed

the safer staffing report.

The Trust wide vacancy rate is 8%. This is well below the national and regional average.

There is a high level of RMN/ RNLD in the Trusts workforce. In addition, Campus skill mix is set at 5 staff on shift which is set at three registered professionals. This is above the national average.

Acute areas have had very traditional skill mix models, over 2016/ 17, pilots of occupational therapists working day shifts at the Hartington unit have been undertaken and in design at the Radbourne unit.

This is modelling recommended good practice by NHS Improvement and positive pilot work in South Staffordshire /Shropshire and Coventry and Warwickshire. In addition medicine optimisation technician trials are in planning and some wards (Tansley) have appointed staff into post.

In addition, Neighbourhood teams have been recruiting and these posts have become very attractive to in-patient staff who are actively applying for promotion to Band 6 opportunities.

There are specific campus areas that are experiencing fluctuations in vacancy rates as trust turnover remains stable, with staff moving from in-patient to community settings.

There are however some wards with no vacancies in specialist services and that have medium rates of vacancies (similar to Nottinghamshire Healthcare, and lower than Oxleas NHS Foundation Trust and South London and Maudsley NHS FT).

Trust recruitment rates and acute unit recruitment rates remain high in our organisation, however staff moving on from acute care is experiencing higher rates of turnover. This is a pattern also found in the US, Australia and in other organisations.

Bank rates remain over target in our campus areas however our own clinical staff are present and maintain consistency in care and practice.

Although we have key wards with lower staffing than planned rates, bed occupancy in the Cubley service and unit must be considered.

The Director of Nursing has partial assurance on staffing levels, against planned standards, however, is assured that safe and effective operational management is in place to mitigate all risks, however our performance in filling ward staffing is fluctuating significantly.

There needs to be a continued focus over the summer to restabilising key campus sites and ensure proactive operational management and planning. To mitigate this in particular at the Hartington unit, additional senior management support will be meeting with the Hartington campus team to ensure full mitigating actions are put in place to maintain safe services over this period.

If operational vacancies and mitigating plans are not fully realised there is a risk to patient experience and to the quality of the service which we provide.

Additional recruitment programmes led by Nursing, AHP and Quality service, to drive forward some recruitment diversification from RGN's, social workers and Occupational therapists are being additionally supported.

Staff have raised in engagement events that there continues to be posts advertised as nursing positions and not opened to Mental Health practitioners, this is being acted upon to address this issue.

<u>Quality and Operational Performance</u>

There are signs of improvement in the uptake of supervision in some service areas. However, there remains a concerted effort to create sufficient time to enable supervision to be undertaken.

The quality visit programme continues to focus on the importance of both innovation and key

workforce metrics of supervision and appraisal, with a clear steer that they are equally important. This has impacted upon morale of some staff, which have been rated inadequate at their Quality visit for well led for their performance in this area. Overall services do understand the rating grid and the clarity of expectation and there are signs of performance improvement.

The quality committee has reviewed longitudinal data on the positive and safe strategy considering the use of restraint and seclusion. Overtime this continues on a downward trajectory and performance this month with the number of episodes of patients held in seclusion has increased needs to be reviewed in this context.

The number of inpatients with a VTE assessment is increasing, although compliance remains low and has limited improvement. It has been recommended that this continues to be a main focus for the Executive Director for physical health and campus ACD's with their wider teams to significantly improve this trajectory. This is a key indicator for our emerging Physical Healthcare strategy which is in design and will be completed in September 2017.

Linked to the above, there has been increase in the number of serious incidents reported to the CCG and an increase in the number of incidents meeting the duty of candour requirements. This shows good governance of our model of operations in this area. The quality committee will assess and benchmark whether there is a trend over one quarter.

The no of incidents of patient to patient and patient to staff abuse has increased. We specifically monitor whether this related to clinical disturbance and or smoking related incidences. The June Lancet published the NIHR funded - Effect of implementation of a smoke free policy on physical violence in a psychiatric inpatient setting: an interrupted time series analysis established that smoke free strategies and policies actually reduced violence and resulted in a 39% reduction in physical assault. This research finding has been established in other international studies and can be replicated.

The number of falls on inpatient wards has increased, however initial base analysis demonstrates this is related to good reporting and less actual harm. The Director of Nursing has reviewed an analysis and the full analysis will be included in the Quality committee report in September.

Operational performance remains relatively stable with the vast majority of KPI's being achieved.

However, there are a number of indicators where it is becoming increasingly difficult to meet the require standard. The pressure to deliver core targets such as Care Programme Approach, Early Intervention in Psychosis and breastfeeding has, at times, been impacted on by the need to spread resources more widely. Management capacity has started to be refocused on the delivery of core standards. This has been discussed at length recently with NHSI to provide assurances that our focus remains on these key quality standards.

There are a number of other areas where performance remains variable, with further detail provided in the main body of the report.

<u>People Performance</u>

Staff attendance remains a significant challenge to the Trust with an annual sickness absence rate of 5.53%. In May the sickness absence rate for the month was 5.30% which is lower than the annual rate and 0.02% lower than in the same period last year (May 2016).

Compulsory training compliance remains high at 87.73% which is below our 90% target but above our main contract non CQUIN target of 85%. There has been a slight decrease in appraisal completion at 74.62% against a target of 90%; however medical staff appraisal completion has increased by 3.92% to 85.29%.

The budgeted full time equivalent vacancy rate for May was 8.43%, an increase of 0.39% compared to the previous month. During May 28 employees left the Trust and 20 people joined the Trust as new starters. Over the previous five months 97 employees have left the

Trust and 128 people joined the Trust. Changes in the 2017/18 budget included a large reduction in full time equivalents from 2016/17 investment not materialising and Cost Improvement Programmes.

Work continues on the recruitment action plan which covers how we plan to tackle each vacancy and includes campaigns and open days across the UK, incentives where necessary and overseas recruitment for hard to fill posts. Our recruitment process continues to improve with the introduction at the end of March 2017 of a new e-Recruitment system (TRAC) which enables managers and candidates to utilise a streamlined, interactive and responsive process, which reduces or eliminates paperwork and unnecessary delays.

Financial Performance

In surplus terms, the Trust is slightly behind plan in the month by £4k but is ahead of plan by £17k year to date. The forecast is to achieve the control total at the end of the financial year.

With regard to other financial performance factors, the Use of Resources (UoR) metrics is a 1 year to date and is forecast to be a 2 at the end of the financial year. Current performance is strong in all measures. Forecast-wise four of the five metrics remain strong at 2, 1, 1 and 2, but there is deterioration in agency spend against ceiling, which is forecast at a 3 by year end. This is, however, still better than last year and would meet our objective of being less than 50% above the ceiling. We also expect to achieve the required reduction in medical agency spend compared to last year.

Planning continues for cost improvement action required to achieve 17/18 control total financial plan. Plans exist for some of the Trust CIP cost reduction of £3.85m and work continues to close the gap. The Commissioner-driven QIPP disinvestment schemes that require £3.05m income and cost reduction are not yet agreed. These are incorporated into the Mental Health STP work stream planning

The numbers reported in this report are consistent with the numbers reported in the monthly finance return to NHS Improvement.

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

Assurances

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

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

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

Consultation

This paper has not been considered elsewhere however papers and aspects of detailed content supporting the overview presented are regularly provided to, Finance and Performance Committee, People and Culture Committee and Quality Committee.

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

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

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

Recommendations

The Board of Directors is requested to consider the content of the paper and consider the level of assurance obtained on current performance across the areas presented.

In addition, Board members are asked to provide feedback on KPI's where draft targets have been added.

Report presented by: **Mark Powell, Acting Chief Operating Officer**
Claire Wright, Director of Finance
Amanda Rawlings, Director of People and Organisational Effectiveness
Carolyn Green, Director of Nursing and Patient Experience

Report prepared by: **Peter Charlton, General Manager, Information Management**
Rachel Leyland, Deputy Director of Finance
Liam Carrier, Workforce Systems & Information Manager
Rachel Kempster, Risk and Assurance Manager
Peter Henson, Performance Manager

Enclosure F

Financial Perspective

Highlights
- Surplus slightly ahead of plan year to date
- Forecast achievement of control total
- Cash better than plan
- All UoR ratings strong YTD
- Agency spend is contained in ceiling (YTD)

Challenges
- Delivery of Cost Improvement Programme
- Containment of agency expenditure within ceiling set by NHSI

Operational Perspective

Highlights
- Underperformance against the breastfeeding coverage targets has been addressed

Challenges
- Achieving priority metric compliance
- Clustering
- Outpatient cancellation compliance
- Outpatient letters sent in 10 & 15 working days
- Discharge fax sent in 2 working days
- Delayed transfers of care

People Perspective

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

Challenges
- Monthly and annual sickness absence rates remain high.
- Budgeted FTE vacancies remain high
- Appraisal compliance rates remain low

Quality Perspective

Highlights
- No of patients with a Safety Plan is steadily increasing
- No of inpatients with a VTE assessment is increasing, although compliance remains low
- No of patients with a HCR20 assessment completed is increasing
- There has been a reduction in the number of complaints opened for investigation
- % of staff who have received clinical and management supervision has increased
- No of outstanding actions following serious incident investigations has reduced

Challenges
- No of incidents resulting in moderate to catastrophic actual harm has increased this month
- Linked to the above, there has been increase in the number of serious incidents reported to the CCG an increase in the number of incidents meeting the duty of candour requirements
- No of episodes of patients held in seclusion has increased
- No of incidents of patient to patient and patient to staff abuse has increased
- No of falls on inpatient wards has increased

FINANCIAL OVERVIEW – May 2017

Enclosure F

Category	Sub-set	Metric	Period	Plan	Actual	Rating	Trend	Key Points
Governance	Use of Resources (UoR) Metric	Overall Use of Resources Metric	YTD	1	1	Y	→	In May the Use of Resources Rating is an overall '1'. Forecast is a rating of '2' which is slightly worse than the plan of '1'. This is mainly driven by the agency metric which is forecast at a '3' for the end of the financial year. Following the lifting of the breech of our licence conditions we have moved out of segment 3 and into segment 2.
			Forecast	1	2	Y	→	
		Capital Service Cover	YTD	2	2	Y	→	
			Forecast	2	2	Y	→	
		Liquidity	YTD	1	1	G	→	
			Forecast	1	1	G	→	
		Income and Expenditure Margin	YTD	1	1	G	→	
			Forecast	1	1	G	→	
		Income and Expenditure variance to plan	YTD	1	1	Y	→	
			Forecast	1	2	Y	→	
		Agency variance to ceiling	YTD	1	1	Y	↑	
			Forecast	1	3	A	→	
	Single Oversight Framework	NHS I Segment	YTD		2	n/a	n/a	

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
I&E and profitability	Income and Expenditure	Control Total position £'000	In-Month	285	281	R	↑	At the end of May the surplus is slightly ahead of plan by £17k and is forecast to achieve the control total at the end of the financial year. EBITDA is slightly behind plan at the end of May by £31k and forecast £72k behind plan. This is offset by small underspends below the line on depreciation and Public Dividend Capital payments.
			YTD	463	480	G	↑	
			Forecast	2,765	2,765	G	→	
		Underlying Income and Expenditure position £'000	In-Month	246	241	R	↑	
			YTD	384	401	G	↑	
			Forecast	1,971	1,971	G	→	
		Normalised Income and Expenditure position £'000	In-Month	246	252	G	↑	
			YTD	384	452	G	↑	
			Forecast	1,971	2,162	G	↓	
	Profitability	Profitability - EBITDA £'000	In-Month	898	890	R	↑	
			YTD	1,728	1,697	R	↑	
			Forecast	10,159	10,087	R	→	
		Profitability - EBITDA %	In-Month	8.0%	7.6%	R	↗	
			YTD	7.7%	7.4%	R	↗	
			Forecast	7.6%	7.3%	R	→	

Category	Sub-set	Metric	Period	Plan	Actual	Rating	Trend	Key Points
Liquidity	Cash	Cash £m	YTD	13.424	14.638	G	↑	Cash is ahead of plan year to date and is forecast to be ahead of plan at year end. This mainly relates to additional STF income from 2016/17 that will be received during 2017/18. This additional income may be spent on capital bids, but this is not yet included in the capital or cash forecast. Net Current Assets are less than plan due to the removal of an Asset Held for Sale.
			Forecast	12.193	12.770	G	→	
	Net Current Assets	Net Current Assets £m	YTD	7.535	4.531	R	↑	
			Forecast	8.345	4.661	R	→	
	Capex	Capital expenditure £m	YTD	0.198	0.125	R	↓	
			Forecast	3.338	3.338	G	→	

Category	Sub-set	Metric	Period	Plan	Actual	Rating	Trend	Key Points
Efficiency	CIP	CIP achievement £m	In-Month	0.321	0.311	R	↑	CIP is currently behind plan. An additional amount of savings has been included in the forecast. However work continues to fully assured the CIP in totality.
			YTD	0.642	0.448	R	↓	
			Forecast	3.850	3.850	G	↑	
			Recurrent	3.850	1.170	R	↑	

Key:

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

Plan In-month or Year end Trust plan

Achieving plan
Not achieving plan

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

OPERATIONAL OVERVIEW – MAY 2017

Enclosure F

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	NHSI	CPA 7 Day Follow-up (M)	Month	95.00%	98.18%	G	→	All NHSi metrics are all compliant except "Priority Metrics" which is a new indicator since April 2017. Plans are being formulated to address the under-performance. For each metric we have indicated if it is monitored by NHSi Quarterly (Q) or Monthly (M).
			Quarter	95.00%	98.11%	G	↑	
		Data completeness - Identifiers (M)	Month	95.00%	99.38%	G	→	
			Quarter	95.00%	99.44%	G	→	
		Data completeness - Priority Metrics (M)	Month	85.00%	71.56%	R	↓	
			Quarter	85.00%	69.97%	R	↓	
		Crisis Gatekeeping (Q)	Month	95.00%	100.00%	G	→	
			Quarter	95.00%	100.00%	G	↑	
		IAPT RTT within 18 weeks (Q)	Month	95.00%	99.73%	G	→	
			Quarter	95.00%	99.88%	G	→	
		IAPT RTT within 6 weeks (Q)	Month	75.00%	94.23%	G	↑	
			Quarter	75.00%	93.94%	G	↑	
		Early Intervention in Psychosis RTT Within 14 Days - Complete (Q)	Month	50.00%	92.00%	G	↑	
			Quarter	50.00%	86.54%	G	↓	
		Early Intervention in Psychosis RTT Within 14 Days - Incomplete (Q)	Month	50.00%	50.00%	G	↓	
			Quarter	50.00%	52.73%	G	↓	
		Patients Open to Trust In Employment (M)	Month	N/A	8.99%		→	
			Quarter	N/A	8.76%		→	
		Patients Open to Trust In Settled Accommodation (M)	Month	N/A	59.64%		↓	
			Quarter	N/A	57.60%		→	
		Under 16 Admissions To Adult Inpatient Facilities (M)	Month	0	0	G	→	
			Quarter	0	0	G	→	
		IAPT People Completing Treatment Who Move To Recovery (Q)	Month	50.00%	52.25%	G	↓	
			Quarter	50.00%	54.04%	G	→	
		Physical Health - Cardio-Metabolic - Inpatient (Q)	Month	N/A				
			Quarter	N/A				
		Physical Health - Cardio-Metabolic - EI (Q)	Month	N/A				
			Quarter	N/A				
		Physical Health - Cardio-Metabolic - on CPA (Community) (Q)	Month	N/A				
			Quarter	N/A				

Key:

Period

Month — Current Month

Quarter — Current Quarter

Achieving target

Not achieving target

↑ → ↓ Trend compared to previous month/quarter

OPERATIONAL OVERVIEW – MAY 2017

Enclosure F

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Locally Agreed	CPA Settled Accommodation	Month	90.00%	95.59%	G	→	An action plan has been implemented. We should be able to start evaluating the impact of the actions as each is completed over the next few months.
			Quarter	90.00%	95.38%	G	→	
		CPA Employment Status	Month	90.00%	96.85%	G	→	
			Quarter	90.00%	96.59%	G	→	
		Data completeness - Identifiers	Month	99.00%	99.38%	G	→	
			Quarter	99.00%	99.44%	G	→	
		Data completeness - Outcomes	Month	90.00%	93.94%	G	→	
			Quarter	90.00%	93.60%	G	→	
		Patients Clustered not Breaching Today	Month	80.00%	77.31%	R	↓	
			Quarter	80.00%	77.62%	R	→	
		Patients Clustered regardless of review dates	Month	96.00%	94.03%	R	→	
			Quarter	96.00%	94.02%	R	→	
		7 Day Follow-up - all inpatients	Month	95.00%	93.65%	R	↓	
			Quarter	95.00%	95.74%	G	↓	
		Ethnicity coding	Month	90.00%	92.08%	G	↓	
			Quarter	90.00%	92.00%	G	↓	
		NHS Number	Month	99.00%	99.99%	G	→	
			Quarter	99.00%	99.99%	G	→	
		CPA Review in last 12 Months (on CPA > 12 Months)	Month	95.00%	95.45%	G	→	
			Quarter	95.00%	94.67%	R	↓	
		Community Care Data - Activity Information Completeness	Month	50.00%	94.46%	G	→	
			Quarter	50.00%	94.47%	G	→	
		Community Care Data - RTT Information Completeness	Month	50.00%	92.31%	G	→	
			Quarter	50.00%	92.31%	G	→	
		Community Care Data - Referral Information Completeness	Month	50.00%	73.46%	G	↓	
			Quarter	50.00%	73.84%	G	↓	
		Early Interventions New Caseloads	Month	95.00%	143.50%	G	↑	
			Quarter	95.00%	143.50%	G	↑	
		Clostridium Difficile Incidents	Month	7	0	G	→	
			Quarter	7	0	G	→	
		18 Week RTT Greater Than 52 weeks	Month	0	0	G	→	
			Quarter	0	0	G	→	

OPERATIONAL OVERVIEW – MAY 2017

Enclosure F

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Schedule 6	Consultant Outpatient Trust Cancellations	Month	5.00%	12.34%	R	⇨	The most common reason was clinician absent from work.
			Quarter	5.00%	11.96%	R	⇩	
		Consultant Outpatient DNAs	Month	15.00%	16.83%	R	⇩	
			Quarter	15.00%	15.47%	R	⇨	
		Under 18 admissions to Adult inpatients	Month	0	0	G	⇨	
			Quarter	0	0	G	⇨	
		Outpatient letters sent in 10 working days	Month	90.00%	88.46%	R	⇨	
			Quarter	90.00%	89.24%	R	⇧	
		Outpatient letters sent in 15 working days	Month	95.00%	94.51%	R	⇨	
			Quarter	95.00%	95.26%	G	⇧	
		Inpatient 28 day readmissions	Month	10.00%	6.94%	G	⇧	
			Quarter	10.00%	7.22%	G	⇨	
		MRSA - Blood stream infection	Month	0	0	G	⇨	
			Quarter	0	0	G	⇨	
		Mixed Sex accommodation breaches	Month	0	0	G	⇨	
			Quarter	0	0	G	⇨	
		Discharge Fax sent in 2 working days	Month	98.00%	97.27%	R	⇩	3 discharge faxes were sent outside the target
			Quarter	98.00%	98.68%	G	⇨	
		Delayed Transfers of Care	Month	0.80%	0.96%	R	⇨	2 patients on Ward 34 are causing the target to be breached
			Quarter	0.80%	0.80%	G	⇨	
		18 Week RTT Less Than 18 Weeks - Incomplete	Month	92.00%	95.80%	G	⇩	
			Quarter	92.00%	95.67%	G	⇩	

OPERATIONAL OVERVIEW – MAY 2017

Enclosure F

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	→	Compliant with Fixed Targets
			Quarter	0	0	G	→	
		18 Week RTT incomplete	Month	92.00%	95.80%	G	↓	
			Quarter	92.00%	96.89%	G	↑	
		Mixed Sex accommodation breaches	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Completion of IAPT Data Outcomes	Month	90.00%	97.39%	G	↑	
			Quarter	90.00%	96.78%	G	→	
		Ethnicity coding	Month	90.00%	92.65%	G	→	
			Quarter	90.00%	92.76%	G	→	
		NHS Number	Month	99.00%	100.00%	G	→	
			Quarter	99.00%	100.00%	G	→	
Other Dashboards	Health Visiting	% 10-14 Day Breastfeeding coverage	Month	98.00%	100.85%	G	→	Compliant with Health Visiting Targets
			Quarter	98.00%	100.63%	G	↑	
		% 6-8 Week Breastfeeding coverage	Month	98.00%	99.10%	G	→	
			Quarter	98.00%	99.18%	G	→	
	IAPT	Recovery Rates	Month	50.00%	52.19%	G	↓	Compliant with IAPT Targets
			Quarter	50.00%	53.80%	G	→	
		Reliable Improvement Rates	Month	65.00%	69.28%	G	↓	
			Quarter	65.00%	70.85%	G	↑	
	Safer Staffing	Inpatient Safer Staffing Fill Rates	Month	100.00%	99.3%	G	→	Detailed ward level information shows specific variances
			Quarter	100.00%	99.4%	G	↑	

WORKFORCE OVERVIEW – May 2017

Enclosure F

Category	Sub-set	Metric	Period	Plan	Actual	Variance		Trend	Key Points
Workforce Dashboard	NHSI Key Performance Indicator (KPI)	**Turnover** (annual)	**May-17**	10%	**10.59%**	↗	G	↓	Annual turnover remains within the Trust target parameters and is below the regional Mental Health & Learning Disability average of 13.03% (as at March 2017 latest available data). The monthly sickness absence rate is 0.85% higher than the previous month, however compared to the same period last year (May 2016) it is 0.02% lower. The annual sickness absence rate is running at 5.53% (as at April 2017 latest available data). The regional average annual sickness absence rate for Mental Health & Learning Disability Trusts is 5.20% (as at February 2017 latest available data). Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 28.98% of all sickness absence, followed by surgery at 19.74% and other musculoskeletal problems at 8.28%. The Funded Fte vacancy rate has increased slightly by 0.39% to 8.43%. The number of employees who have received an appraisal within the last 12 months has decreased slightly by 0.09% to 74.62%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £57k. Compulsory training compliance has decreased slightly by 0.44% to 87.73% but remains above the 85% main contract non CQUIN.
			Apr-17		10.16%		G		
		Sickness Absence (monthly)	**May-17**	5.04%	**5.30%**	↗	R	↓	
			Apr-17		4.45%		G		
		Sickness Absence (annual)	**Apr-17**	5.04%	**5.53%**	↘	R	↓	
			Mar-17		5.54%		R		
		Vacancies (including funded fte flexibility / cover)	**May-17**		**8.43%**	↗			
			Apr-17		8.04%				
		Appraisals (**all staff** - number of employees who have received an appraisal in the previous 12 months)	**May-17**	90%	**74.62%**	↘	R	↓	
			Apr-17		74.71%		R		
		Appraisals (**agenda for change staff only** - number of employees who have received an appraisal in the previous 12 months)	**May-17**	90%	**74.13%**	↘	R	↓	
			Apr-17		74.83%		R		
		Appraisals (**medical staff only** - number of employees who have received an appraisal in the previous 12 months)	**May-17**	90%	**85.29%**	↗	A	↑	
			Apr-17		81.37%		A		
		Agency Usage (£ year to date level of agency expenditure exceeding the ceiling set by NHSI)	**May-17**	£0	**£0.707m**	↗	R		
			Apr-17		£0.352m		R		
		Agency Usage (% year to date level of agency expenditure exceeding the ceiling set by NHSI)	**May-17**	0%	**8.83%**	↗	R		
			Apr-17		0.51%		R		
	Other KPI	**Compulsory Training** (staff in-date)	**May-17**	90%	**87.73%**	↘	A	↓	
			Apr-17		88.17%		A		

Key:

Period Current month and previous month

Plan Trust target

↗ Variance to previous month

Achieving target/within target parameters

Approaching target/approaching target parameters

Not achieving target/outside target parameters

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

QUALITY OVERVIEW – MAY 2017

Enclosure F

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Quality	Safe	No of incidents of moderate to catastrophic actual harm	Month	29	38			Plan: average last fin yr 2016/17 (month).
			Quarter	88	102			Plan: average last fin yr (Qtr) 2016/17. Actual: 2016/17 Q4 data
		No of deaths of patients who have died within 12 months of their last contact with DHcFT	Month	104	114			
			Quarter	312	458			Plan: average last fin yr (Qtr). Actual: 2016/17 Q4 data. *Alert as data for Qtr not complete*
		No of serious incidents reported to the CCG	Month	5	14			Plan - average last fin yr (month)
			Quarter	16	10			Plan: average last fin yr (Qtr). Actual: 2016/17 Q4 data
		No of episodes of patients held in seclusion	Month	10	22			
			Quarter	30	21			Plan: average last fin yr (Qtr). Actual: 2016/17 Q4 data
		No of incidents involving patients held in seclusion	Month	16	13			
			Quarter	47	39			Plan: average last fin yr (Qtr). Actual: 2016/17 Q4 data
		No of incidents involving physical restraint	Month	48	54			
			Quarter	143	170			Plan: average last fin yr (Qtr). Actual: 2016/17 Q4 data
		No of incidents involving prone restraint	Month	10	13			Month plan based on average from 1/7/16 when prone restraint collected on Datix as defined field
			Quarter	29	46			Qtr plan based on average for Q2/Q3/Q4. Actual 2016/17 Q4 data
		No of incidents of physical assault - patient on patient	Month	12	14			
			Quarter	37	31			Actual: 2016/17 Q4 data
		No of incidents of physical assault - patient on staff	Month	19	20			
			Quarter	56	42			Actual: 2016/17 Q4 data

QUALITY OVERVIEW – MAY 2017

Enclosure F

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Quality	Safe	No of falls on in-patient wards	Month	32	32			
			Quarter	96	94			Actual: 2016/17 Q4 data
		No of incidents of absconsion	Month	33	30			
			Quarter	99	120			Actual: 2016/17 Q4 data
		No of patients with a clinical risk plan (FACE or Safety Plan)	Month	100%	77.00%			
			Quarter	100%	77.77%			
		Of above, no of patients with a Safety Plan	Month	90%	21.30%			Safety Plan replaced FACE from 1/4/2017
			Quarter	90%	7.90%			
		% of staff compliant with Level 3 Safeguarding Children training	Month	85%	80.37%			
			Quarter	85%	NA			Qtr comparison not available
		% of staff compliant with Think Family training	Month	85%	82.60%			
			Quarter	85%	NA			Qtr comparison not available
		% of staff compliant with Clinical Safety Planning eLearning	Month	95%	95.12%			
			Quarter	95%	NA			Qtr comparison not available
		No of people with LD or Autism admitted without a CTR (Care & Treatment Review)	Month	0	NA			Concern re data quality . More robust systems to ensure data quality being worked up imminently with Commissioners.
			Quarter	0	NA			
		% of compliance with inpatients VTE assessment	Month	95%	9.02%			
			Quarter	95%	NA			
		HCR20 assessment completed, Low Secure	Month	100%	16.6%			Indicator relates to no of patients with HCR20 assessment completed in time. All assessments now completed, but these were not within the timescale. Variance shown as amber, if a breach occurs going forward, the variance will return to red.
			Quarter	100%	NA			

QUALITY OVERVIEW – MAY 2017

Enclosure F

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Quality	Caring	No of complaints opened for investigation	Month	12	9			
			Quarter	37	43			Actual: 2016/17 Q4 data
		No of concerns received	Month	35	31			
			Quarter	104	84			
		No of compliments received	Month	100	76			
			Quarter	300	236			
		No of investigations by the Parliamentary Ombudsman	2016/17	NA	0			Data is provided cumulatively from 1st April each year
			2017/18	NA	0			
		% of complaints upheld (full or in part) by the Parliamentary Ombudsman	2016/17	2	0			1 ongoing and 5 no further action
			2017/18	0	0			
		% of responded to (orange) complaint investigations completed within 40 working days, opened after 01/04/2016	Year	100%	19%			As at 26/05/2017, 174 (orange) complaints. 83 not responded to within 40 working days. 57 ongoing
			Year	100%	0%			As at 26/05/2017, 7 (red) complaints. 4 not responded to within 60 working days. 3 ongoing.
		No of incidents requiring Duty of Candour	Month	1	5			These figures will fluctuate based on the outcome of investigations.
			Quarter	2	2			
	Effective	% of in-patients with a recorded capacity assessment	Month	100%	90.19%			
			Quarter	100%	91.00%			
		% of patients who have had their care plan reviewed and have been on CPA > 12months	Month	90%	95.25%			
			Quarter	90%	95.95%			
		No of seclusion forms not received by MHA Office	Month	0	8			Seclusion pathway being moved to PARIS. From June 18
			Quarter	0	2			Actual: 2016/17 Q4 data
		% of CTO rights forms received by MHA Office	Month	100%	97.0%			
			Quarter	NA	NA	NA	NA	
		% of in patient older adults rights forms received by MHA Office	Month	100%	91.5%			
			Quarter	NA	NA	NA	NA	

QUALITY OVERVIEW – MAY 2017

Enclosure F

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Quality	Responsive	% of staff uptake of Flu Jabs	Month	45%	NA			Data to end of 30/11/16
			Year	45%	38.40%			Relates to 2016 campaign. Final data as shown in 16/17 Quality Account
		% of policies in date	Month	95%	94.14%			As at 07/06/2017
			Quarter	NA	NA	NA	NA	
	Well Led	% of staff who have received Clinical Supervision, within defined timescales	Month	100%	57.47%			% target increased to 100% to be in line with overall reporting
			Quarter	100%	NA	NA	NA	
		% of staff who have received Management Supervision, within defined timescales	Month	100%	67.90%			% target increased to 100% to be in line with overall reporting
			Quarter	100%	NA	NA	NA	
		No of outstanding actions following serious incident investigations	Month	0	30			Total overdue actions as at 31/05/2017
			Quarter	0	NA		NA	
		No of outstanding actions following complaint investigations	Month	0	56			Total overdue actions as at 31/05/2017
			Quarter	0	NA	NA	NA	
		No of outstanding actions following CQC comprehensive review report	Month	0	64			Figure as at 02/06/2017

Financial Section

Governance – Use of Resources (UoR) Rating

Enclosure F

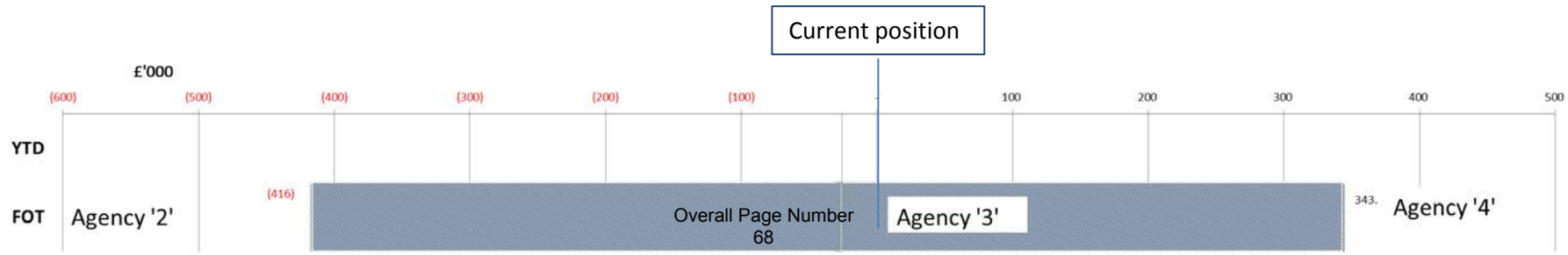
The Use of Resources rating at the end of May is a '1', with only the Capital Service Cover metric being at a '2'. The forecast rating is an overall '2' with the agency metric moving to a 3'.

The I&E Margin distance from plan starts to move from a '1' to a '2' at the end of quarter 1. This is because the actual I&E margin (2.3%) is -0.12% different to the planned I&E margin (2.4%). This is mainly driven by a lower forecast surplus and income being forecast higher than the plan due to the forecast assumptions for QIPP (in the forecast QIPP income has not been removed from the contract).

	YTD May 17		YTD @ Quarter 1		YTD @ Quarter 2		YTD @Quarter 3		YTD @ Quarter 4	
	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual
Capital Service Capacity rating	2	2	2	2	2	2	2	2	2	2
Liquidity rating	1	1	1	1	1	1	1	1	1	1
I&E Margin rating	1	1	1	1	1	1	1	1	1	1
Distance from Financial Plan	1	1	1	2	1	2	1	2	1	2
Agency distance from Cap	1	1	1	2	1	2	1	3	1	3
UoR	1	1	1	2	1	2	1	2	1	2
4 on any metric	No Trigger	No Trigger	No Trigger	No Trigger	No Trigger	No Trigger	No Trigger	No Trigger	No Trigger	No Trigger
UoR	1	1	1	2	1	2	1	2	1	2

As most of the metrics are in a healthy position and it is the agency metric that is driving the lower rating in the forecast, this is the area of focus from a headroom perspective.

The agency metric is currently forecast at a '3' for the end of the financial year. In order to reduce that metric down to a '2' by the end of March then we need to reduce agency expenditure by £416k. However if we spend an additional £343k above the current forecasted levels then this would move the metric to a 4 and trigger an override.



Enclosure F

Income and Expenditure

Statement of Comprehensive Income — May 2017

	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	10,379	10,675	296	20,758	21,214	457	124,378	127,793	3,415
Non Clinical Income	792	974	182	1,584	1,762	178	9,822	10,375	554
Employee Expenses	(7,947)	(8,205)	(258)	(15,915)	(16,366)	(451)	(95,932)	(99,029)	(3,097)
Non Pay	(2,325)	(2,554)	(228)	(4,698)	(4,913)	(215)	(28,108)	(29,053)	(944)
EBITDA	**898**	**890**	**(8)**	**1,728**	**1,697**	**(31)**	**10,159**	**10,087**	**(73)**
Depreciation	(278)	(273)	6	(556)	(543)	14	(3,338)	(3,318)	21
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	(176)	(180)	(4)	(390)	(361)	30	(2,146)	(2,120)	26
Dividend	(159)	(157)	2	(318)	(314)	4	(1,910)	(1,884)	26
Net Surplus / (Deficit)	**285**	**281**	**(4)**	**463**	**480**	**17**	**2,465**	**2,465**	**0**
Technical adjustment - Impairment	0	0	0	0	0	0	(300)	(300)	0
Control Total Surplus / (Deficit)	**285**	**281**	**(4)**	**463**	**480**	**17**	**2,765**	**2,765**	**0**
Technical adjustment - STF Allocation	40	40	0	79	79	0	794	794	0
Underlying Net Surplus / (Deficit)	**246**	**241**	**(4)**	**384**	**401**	**17**	**1,971**	**1,971**	**0**

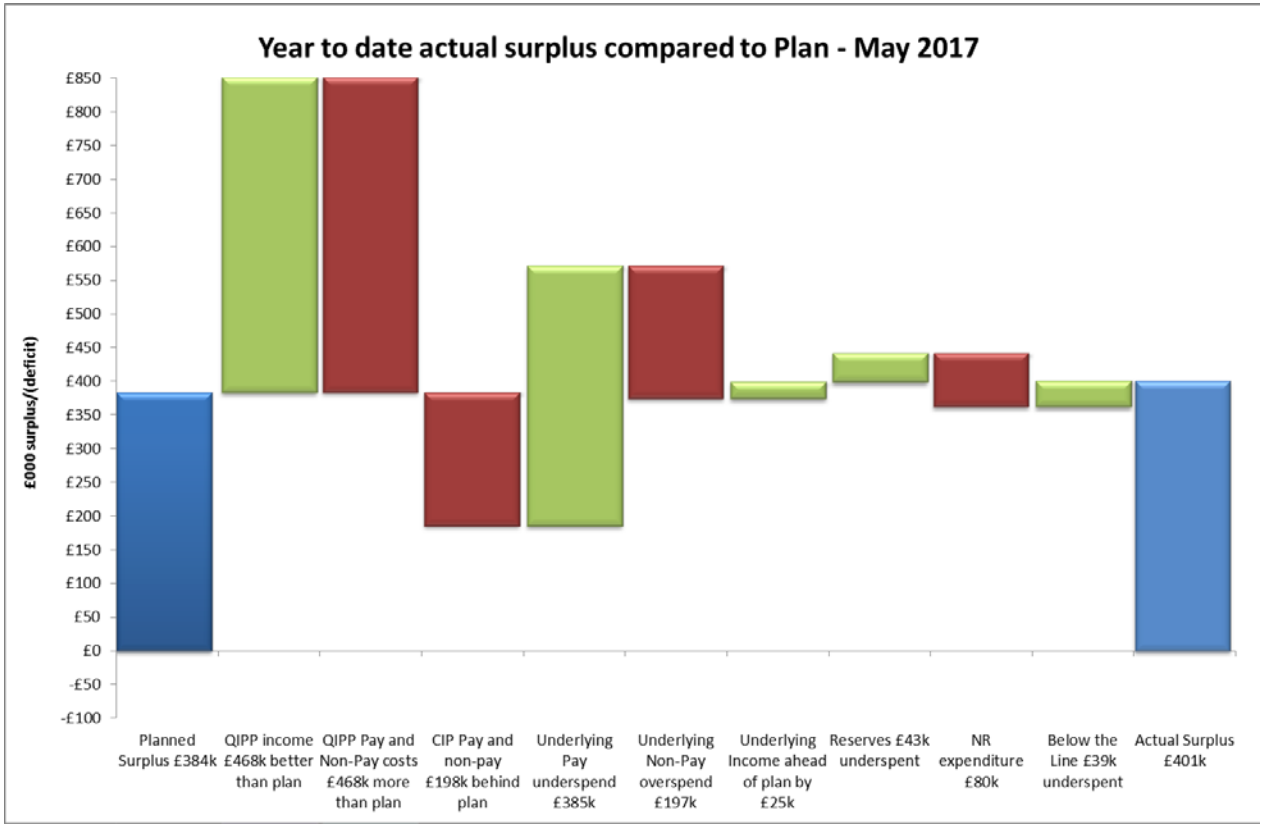
The Statement of Comprehensive Income shows both the control total surplus of £2.77m which includes the Sustainability Transformation Fund (STF) income and the underlying surplus / (deficit) against the underlying plan with the STF income excluded £1.97m.

Clinical Income is £457k more than plan year to date and at the end of the year is forecast to be £3.4m ahead of plan. This is mainly due to the income related to QIPP disinvestments not being removed from the contract as currently no further disinvestments have been identified (offsetting expenditure).

Non Clinical income is ahead of plan year to date by £178k and has a forecast outturn of £554k ahead of plan. This mainly relates to secondments (with corresponding expenditure) along with Education and Training income being higher than planned.

Pay expenditure is £258k more than the plan in the month and forecast £3.1m more than plan. This relates to costs not yet being released relating to QIPP disinvestments (offsetting income) and CIP forecast to be delivered in a different way to the plan.

Non Pay is underspent in the month by £228k but is forecast to be £944k more than plan at the end of the year which mainly relates to the overspend on the Acute Out of Area budget partly offset by other underspends.



Summary of key points for YTD variances

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

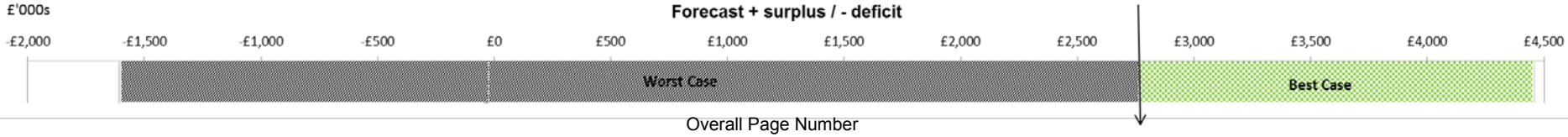
- QIPP income is more than plan which is equally offset by pay and non-pay expenditure being more than plan . This is due to the disinvestment not yet being fully agreed with Commissioners.
- CIP is currently behind plan in the month.
- Underlying pay underspends (exc. QIPP/CIP) due to various vacancies across the Trust, partially offset by bank and agency expenditure.
- Underlying non-pay overspend (exc. QIPP/CIP) driven by out of area expenditure higher than plan.
- Non-recurrent expenditure related to some temporary posts along with non-recurrent transaction costs.

Forecast Range

Best Case	Likely Case	Worst Case
£4.4m surplus	£2.7m surplus	£1.6m deficit

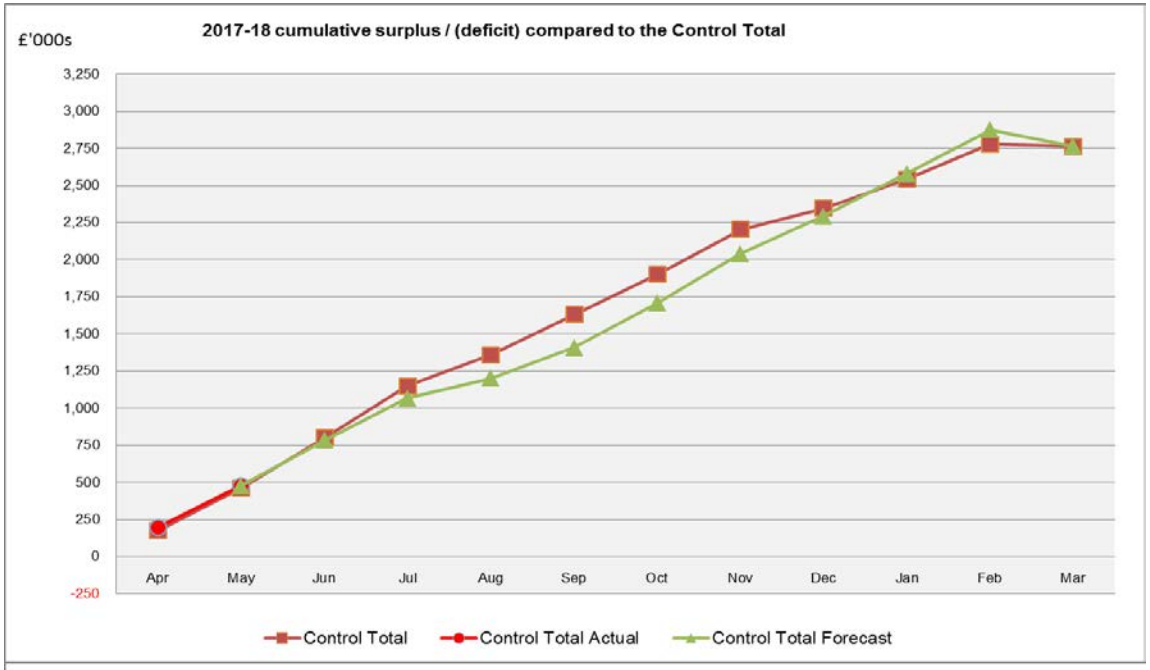
Forecast Range

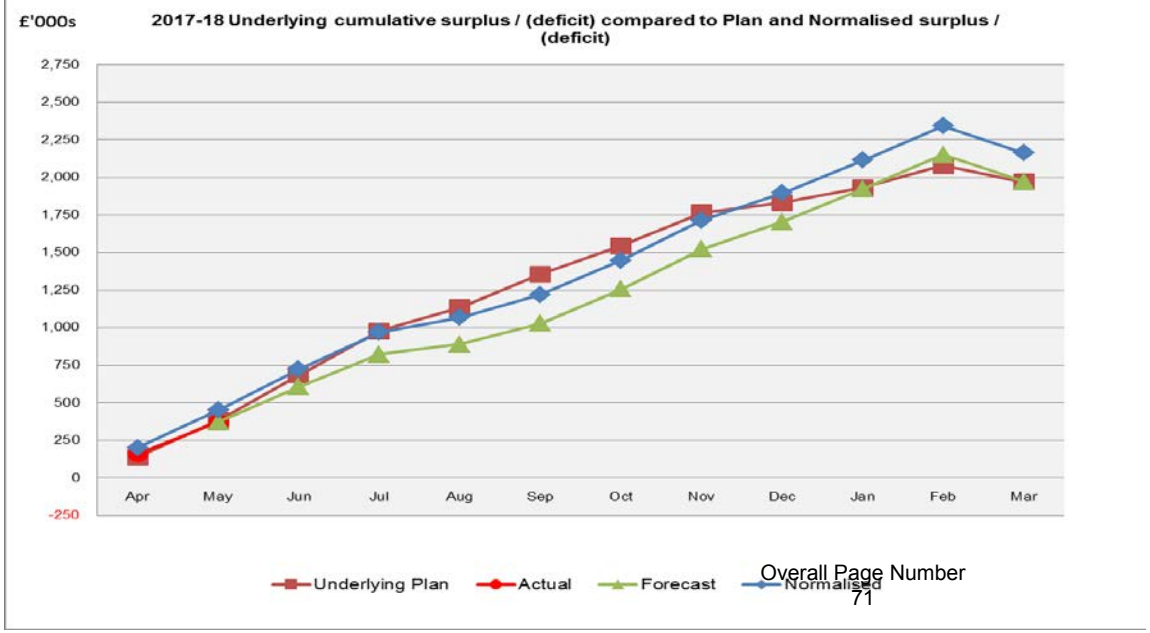
The main variables in the forecast range are: STF income loss, agency expenditure, CPC income and other unexpected pay and non-pay costs.



Normalised Income and Expenditure position

Enclosure F



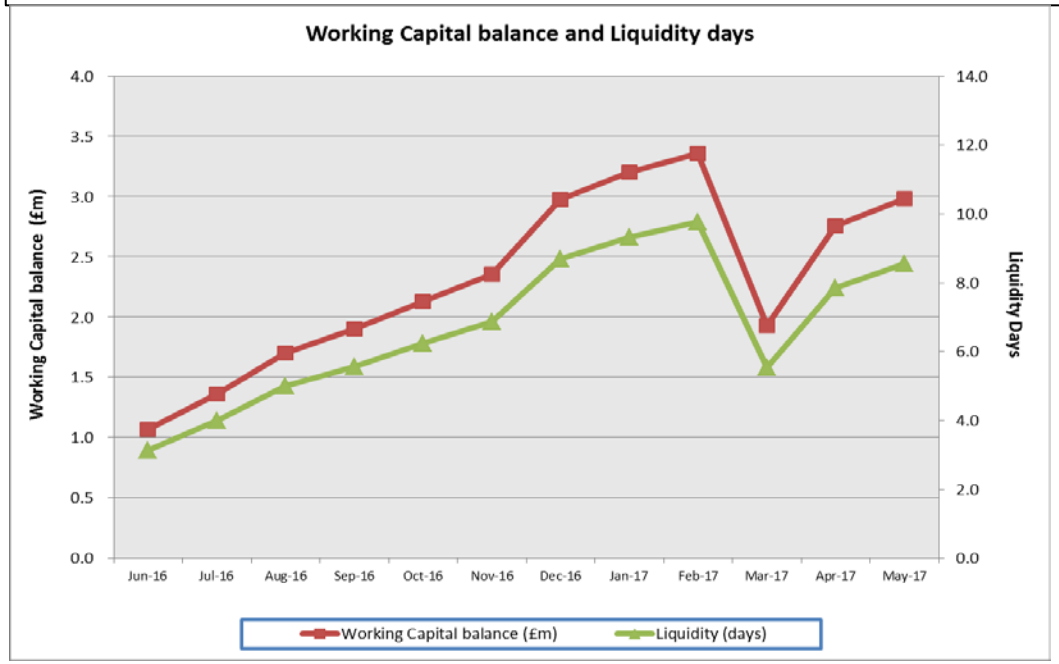


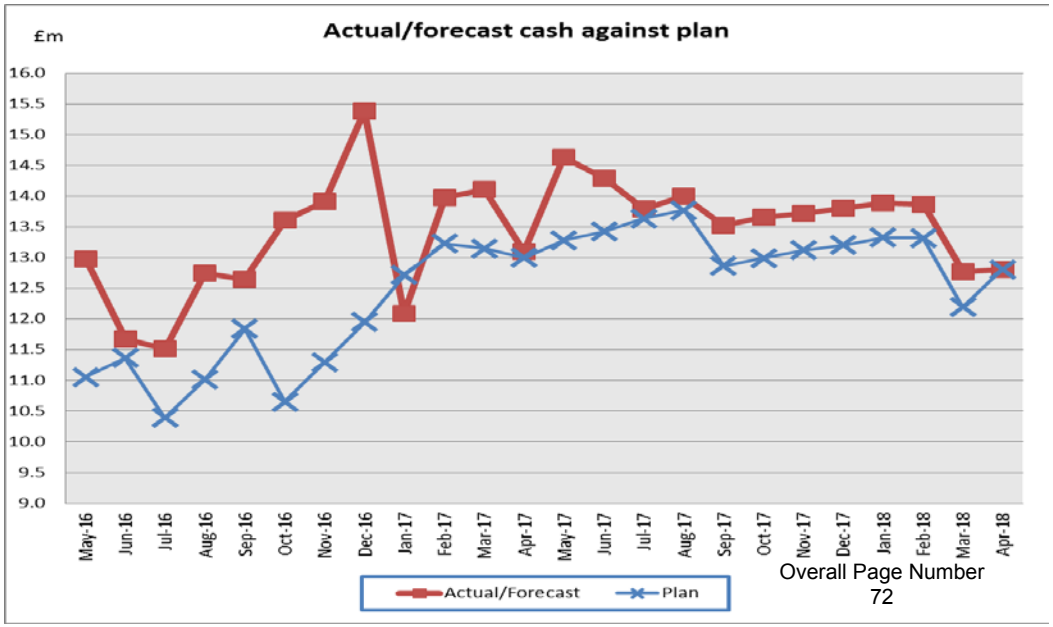
The first graph shows the actual cumulative surplus against the control total (including the Sustainability Transformation Fund (STF).
The second graph shows the underlying actual surplus against the underlying plan excluding the STF.

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 expenditure in the position related to temporary staff posts for part of the financial year, along with non-recurrent transaction costs. In the normalised position these have been removed.
As shown in the graph if these non-recurrent costs were not incurred then the forecast outturn would be higher than the plan.

Liquidity





The first graph shows the working capital balance for the last 12 months (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.

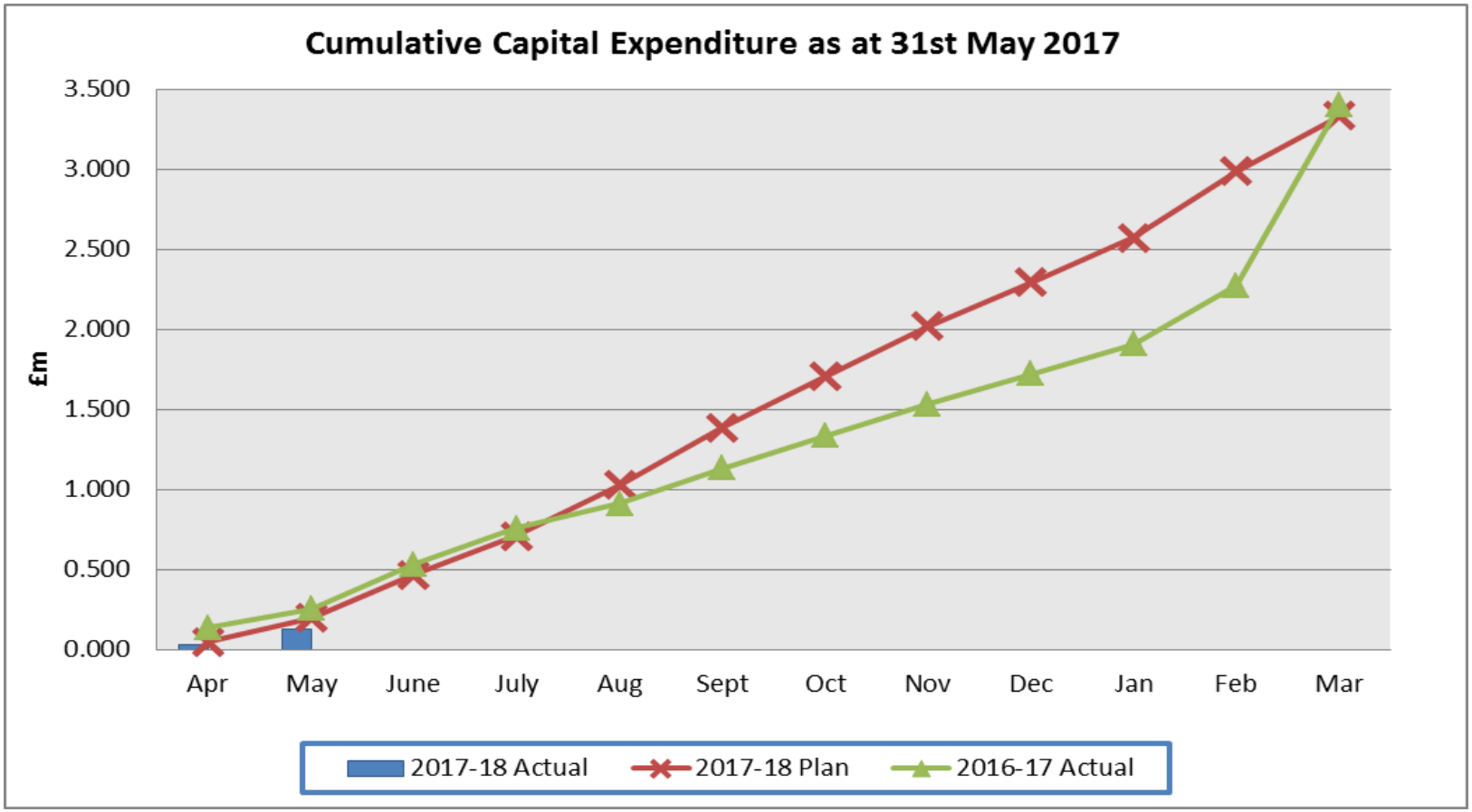
During the last 12 months working capital and liquidity continues to improve due to higher cash levels. The downturn in March is reflective of the increase in year end transactions such as provisions, along with an increase in payables mainly related to capital as works have concluded at the end of March.
The liquidity at May is just over 8 days which still gives a rating of 1 (the best) on that metric (-7days drops to a rating of 2).

The Trust Board is reminded that sector benchmarking information recently provided by external auditors illustrates that the peer average continues to be around +19 days, therefore our liquidity must remain a strategic priority for us to continue to improve and protect.

Cash is currently at £14.6m which is £0.9m better than the plan at the end of May and is forecast to be above plan by £0.6m. This is mainly due to the additional STF income related to 2016/17

Capital Expenditure

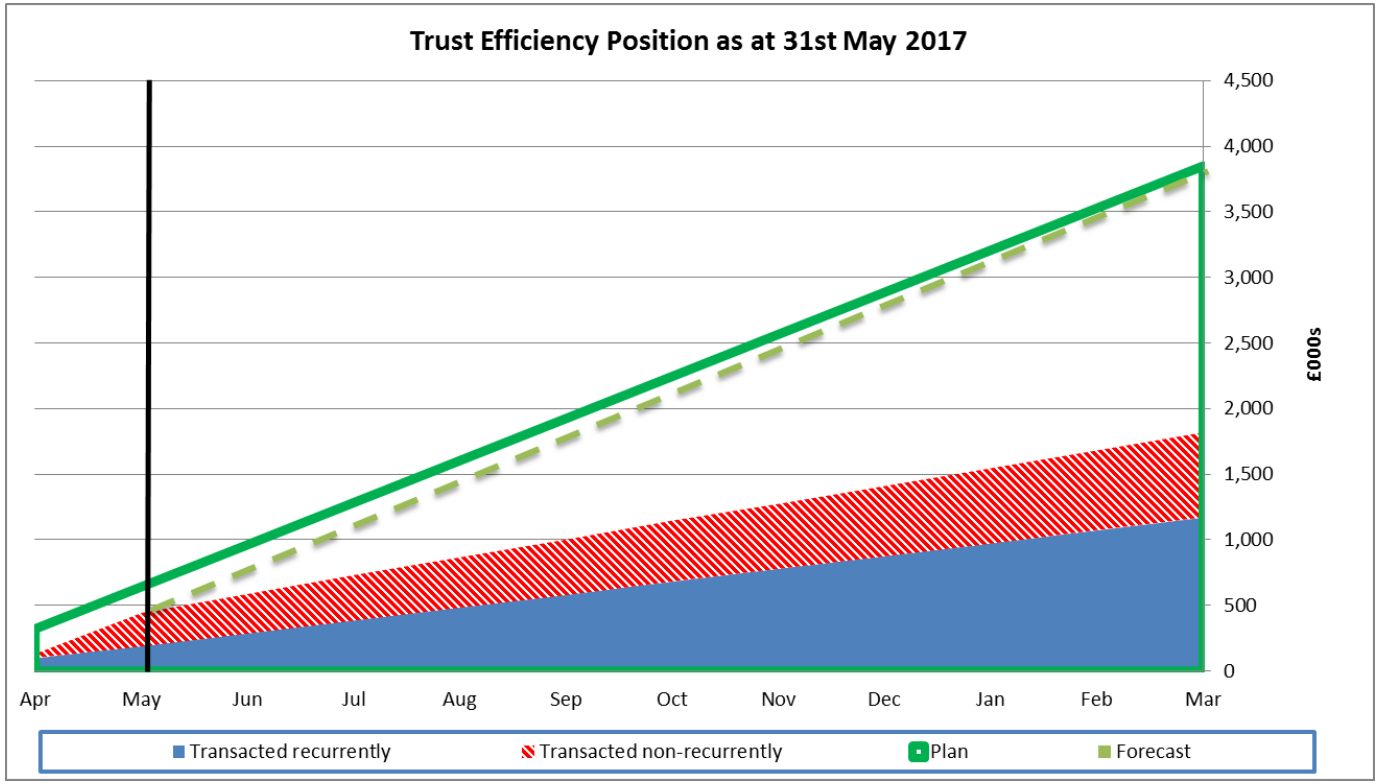
Enclosure F



Capital Expenditure is behind plan by £89k at the end of May. There is a fully committed plan which may need to be re-prioritised in year to take into account any urgent bids that arise, which will be monitored by the Capital Action Team.

Additional STF income which was notified to us in 2016/17 and will be paid in this financial year is expected to be added to the capital plan. This could be invested in schemes that will drive further efficiencies across the Trust.

Cost Improvement Programme (CIP)

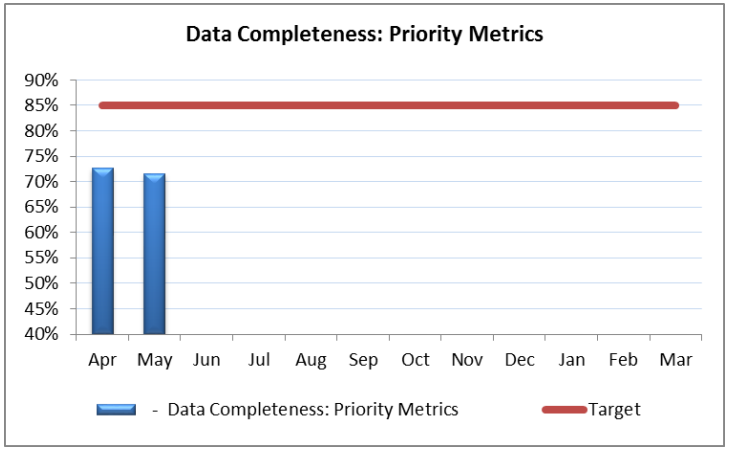


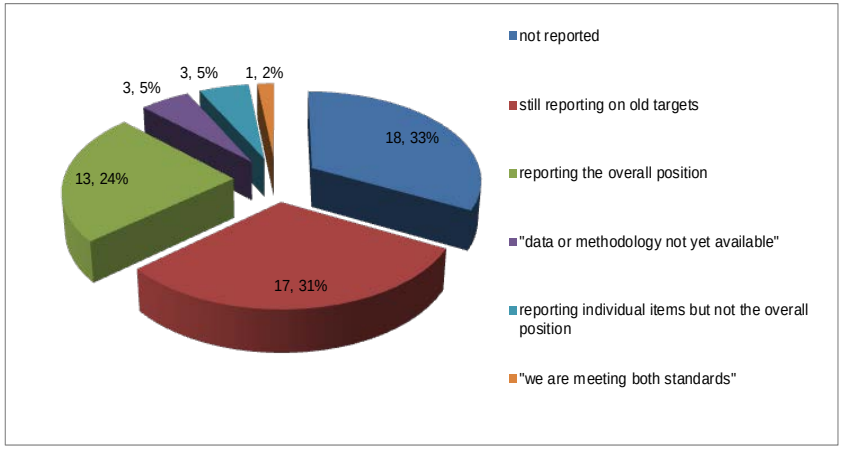
At the end of May there was £1.8m of assured CIP against a plan of £3.8m, which left a gap of £2m. Of this £1.8m assured CIP, £0.65m was assured non-recurrently. In order to achieve the control total the full CIP target needs to be achieved.

Trust Management Team and Executive Leadership Team 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

Data Completeness: Priority Metrics





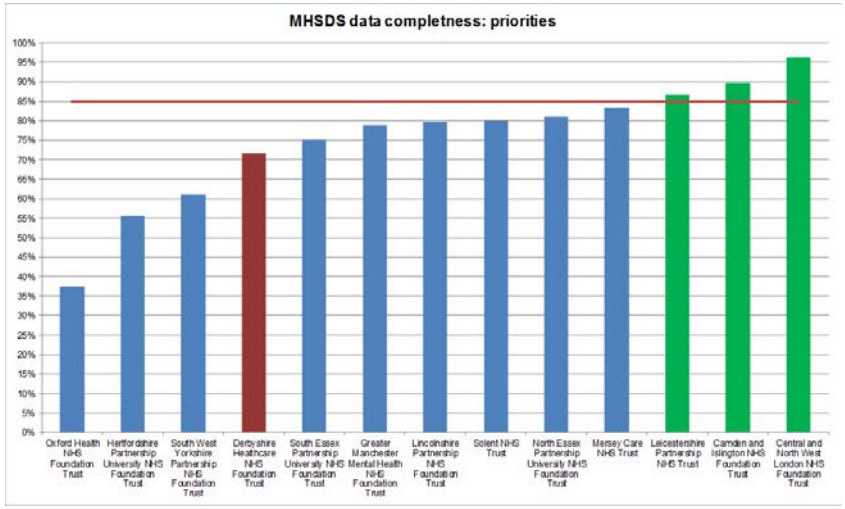
As previously reported, the performance dashboard was amended on 1st December 2016 to reflect the NHS Improvement Single Oversight Framework targets which came into force from 1st October 2016. The national requirement is to achieve the priority metrics target of 85%. Achieving this target will be extremely challenging without additional resource. There are currently 14,659 bits of additional patient information that need sourcing and inputting into the patient records concerned, which is an increase of 520 since last month. It is acknowledged there are capacity issues.

The national picture:

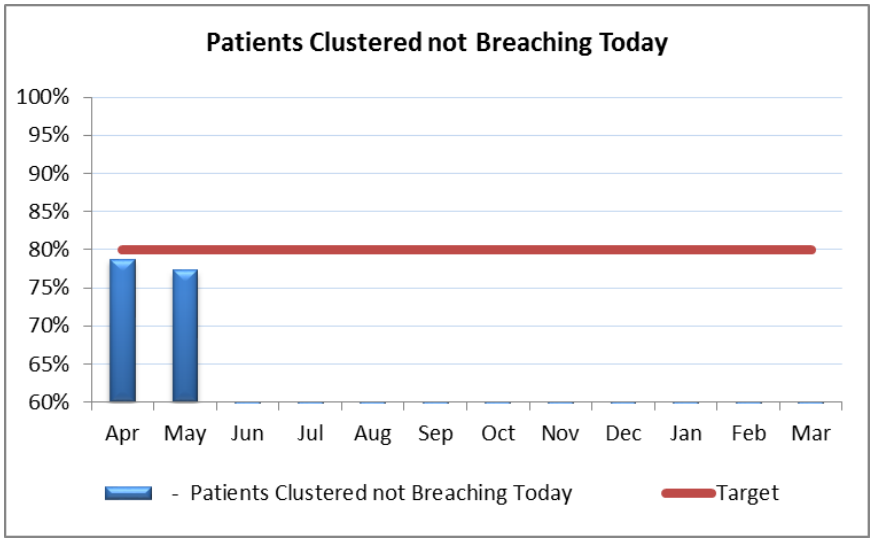
- Less than a quarter of Trusts in the country publish their position against this target, of which only 3 are exceeding the target threshold.
- Almost a third of Trusts are still reporting on the old MHMDS targets.

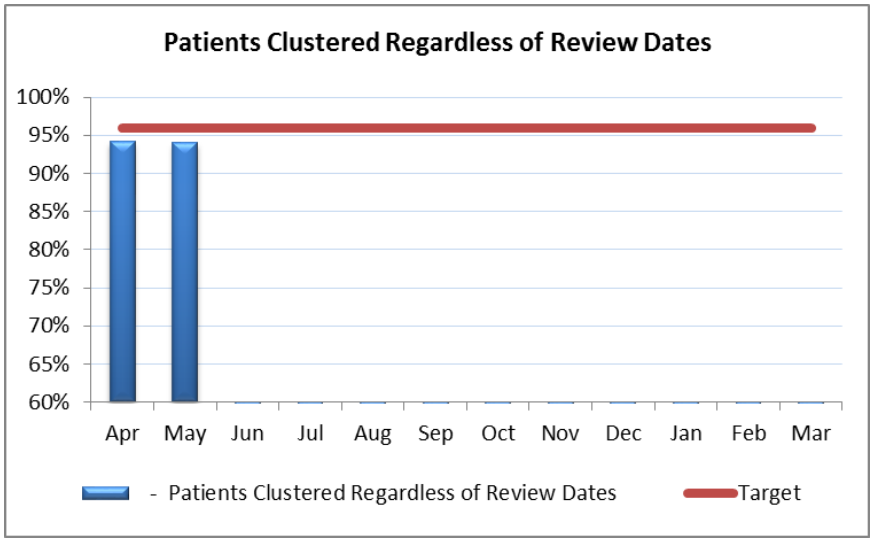
Actions:

Further more detailed discussion to take place between the respective MHSDS experts within our Trust and Central & North West London NHS Foundation Trust to establish whether there are any technical differences in our reporting methodologies which might explain the performance difference.



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



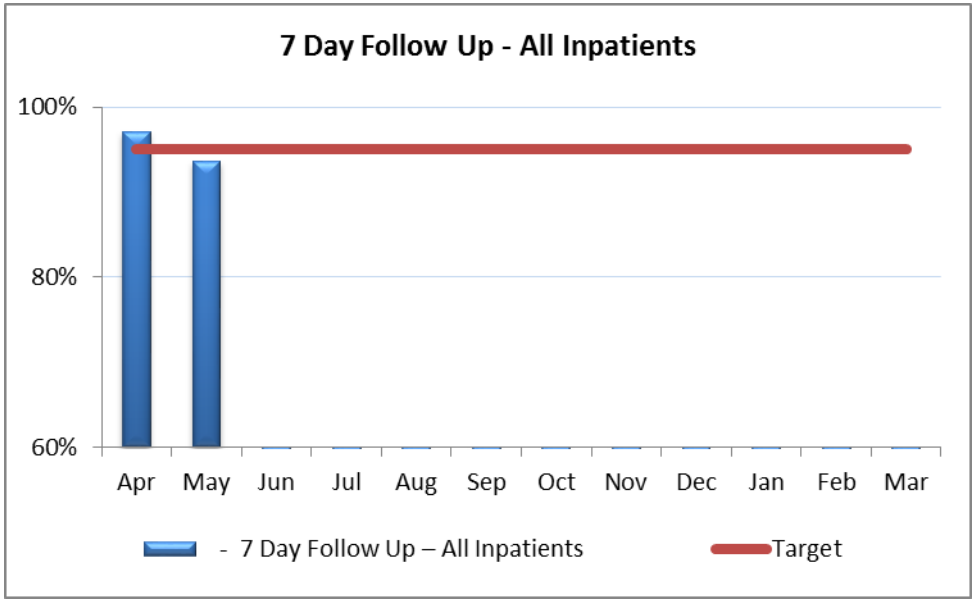


A paper was presented to the F&P Committee on the 22nd May. Standards need to be raised due to the importance of care clustering locally and nationally.

The following recommendations to be made into an action plan to be submitted to the next F&P 24th July:

- Staff should be encouraged to undertake training (with a particular focus on individual or teams where performance is weakest)
- Supervision - caseloads should be reviewed to include cluster information
- Audit/review to be undertaken focusing on anomalous clustering and red rules deviation
- Work to develop the integration of clusters into care pathways to be expedited
- The current two targets to be augmented by the schedule of 17 quality indicators approved by the Quality Committee

7 Day Follow-up - all inpatients

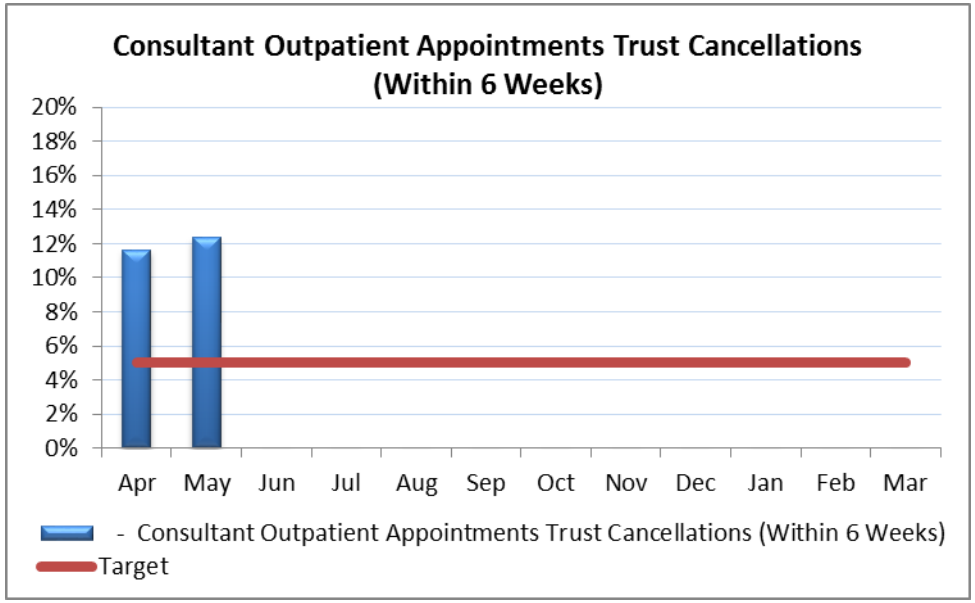


This locally agreed target was missed by 1 follow-up. Every effort is made to follow-up all discharged patients, but on occasion patients refuse to engage with services. An exception report is completed whenever a patient is not followed up In addition, if a patient is on CPA, has a history of self harm and/or has a medium to high suicide risk, it will be reported on Datix as a near miss incident. This enables us to establish whether any lessons could be learnt or improvements made to processes in order to minimise future breaches. Of the 6 patients not followed up within 7 days:

- Successful contact was made with 4 patients within 2 weeks of discharge
- 1 patient was readmitted before contact had been made
- 1 patient – numerous attempts to make contact but to date has been unsuccessful. Reported on Datix.

Action: Summary of each breach to be provided to commissioners. Quarterly review of breaches at Campus Assurance Meetings

Consultant Outpatient Appointments Trust Cancellations (within 6 weeks)



The majority of cancellations were owing to clinician absence, staffing issues and having no consultant.

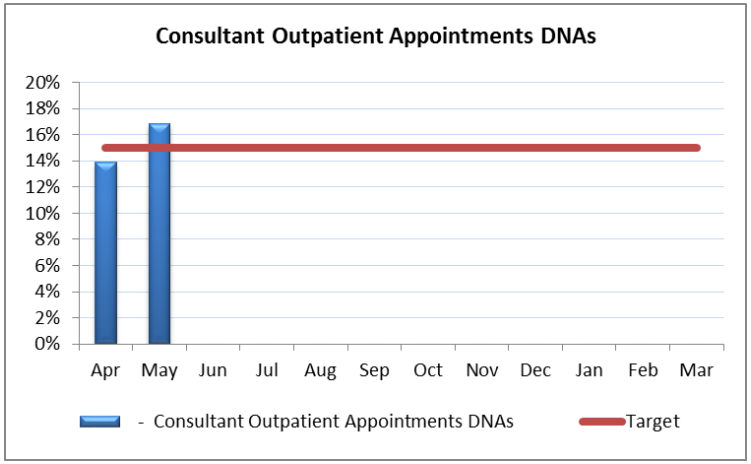
The number of appointments cancelled for annual leave was also high.

Actions:

- recruitment to vacant consultant posts is progressing slowly
- Review of annual leave cancellations to ensure patients are not being inconvenienced

Att Type	n	%
Clinician Absent From Work	331	30%
Moved - Staff Issue	157	14%
No Consultant	148	13%
Moved - Clinic Cancelled	127	11%
Clinician On Annual Leave	110	10%
Moved - Trust Rescheduled	99	9%
Moved - Location Issue	61	5%
Clinic Booked In Error	40	4%
Clinician Must Attend Meeting	14	1%
Clinician Must Attend Tribunal	8	0.7%
Paris System Issue	7	0.6%
Clinician on call/ night duty	5	0.4%
Clinician Must Attend Training	4	0.4%
MHA Assessment Urgent Work	1	0.1%
Grand Total	1112	100%

Consultant Outpatient DNAs

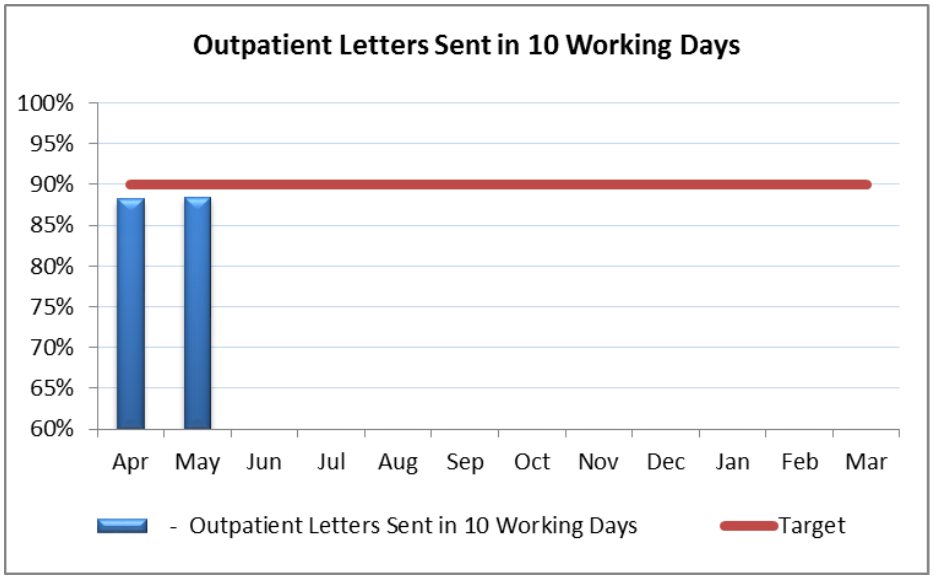


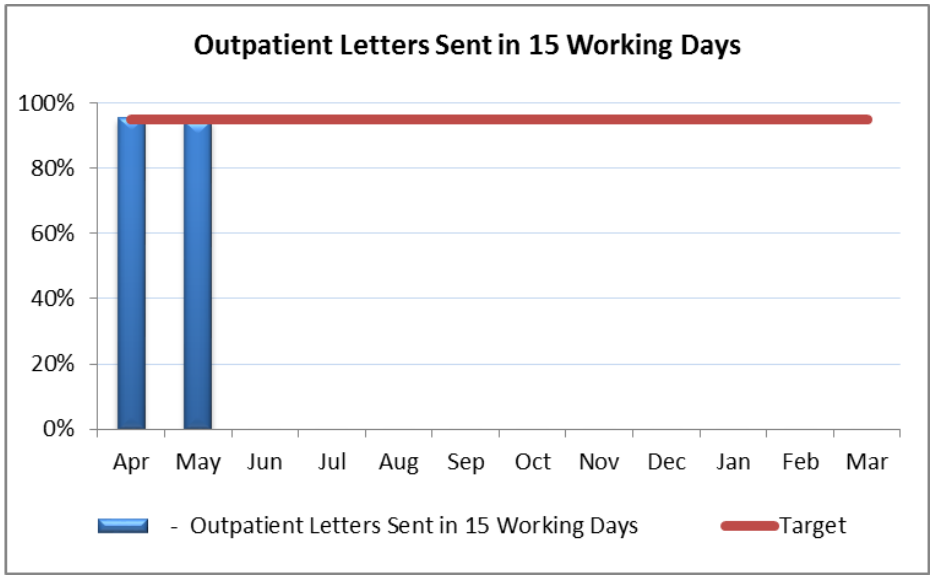
Despite the trust sending text message appointment reminders, the number of patients who did not attend scheduled outpatient appointments in May was high.

The most recent national data – quarter 4 2016/17:

Org Name	Total outpatient appts	DNA rate
LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	4,681	23%
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	47	21%
LANCASHIRE CARE NHS FOUNDATION TRUST	6,917	21%
BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST	4,129	20%
BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST	8,594	19%
PENNINE CARE NHS FOUNDATION TRUST	8,660	18%
SOUTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	5,176	17%
COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST	2,788	16%
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	29,835	16%
DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	11,272	15%
DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST	9,498	15%
SOUTH STAFFORDSHIRE AND SHROPSHIRE HEALTHCARE NHS FOUNDATION TRUST	3,736	15%
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	5,325	15%
NORTH EAST LONDON NHS FOUNDATION TRUST	9,811	15%
LEICESTERSHIRE PARTNERSHIP NHS TRUST	869	14%
NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	3,717	12%
SOMERSET PARTNERSHIP NHS FOUNDATION TRUST	2,411	12%
WORCESTERSHIRE HEALTH AND CARE NHS TRUST	8,731	12%
OXLEAS NHS FOUNDATION TRUST	868	12%
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	1,365	11%
SOLENT NHS TRUST	6,182	10%
STAFFORDSHIRE AND STOKE ON TRENT PARTNERSHIP NHS TRUST	6,790	9%
CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST	1,532	9%
BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	1,498	9%
LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	1,004	8%
DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	3,277	8%
SOUTHERN HEALTH NHS FOUNDATION TRUST	8,912	8%
HUMBER NHS FOUNDATION TRUST	1,409	7%
CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	888	7%
CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	400	6%
CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	548	0%
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	272	0%
EAST LONDON NHS FOUNDATION TRUST	2,666	0%
NAVIGO	-	-
WEST LONDON MENTAL HEALTH NHS TRUST	-	-
KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	-	-

Outpatient letters sent in 10 & 15 working days

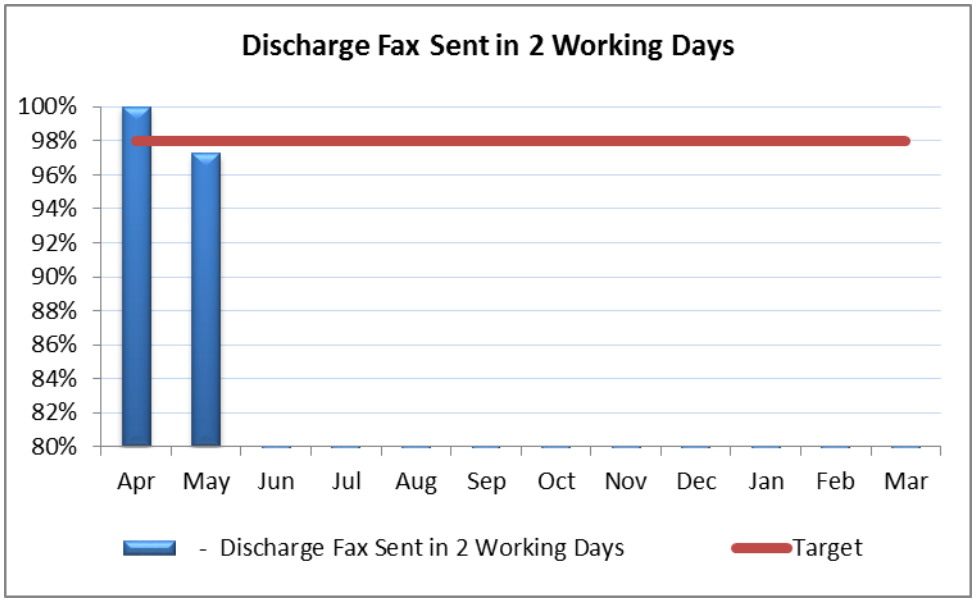




An action plan was devised and implemented towards the end of May which should start to have a positive impact on turnaround times. A summary of the action being taken is as follows:

- Support Consultants and Junior Doctors to ensure that letters have been dictated following outpatient appointments.
- Timely transcription of Letters on DictateIT
- To include Associate Clinical Directors in any escalation communications re late/delayed uploads
- Swift resolution of any queries which prevent transcription
- Prioritisation of letters awaiting transcription on DictateIT
- Support Consultants and Junior Doctors to ensure that letters are e-signed following typing

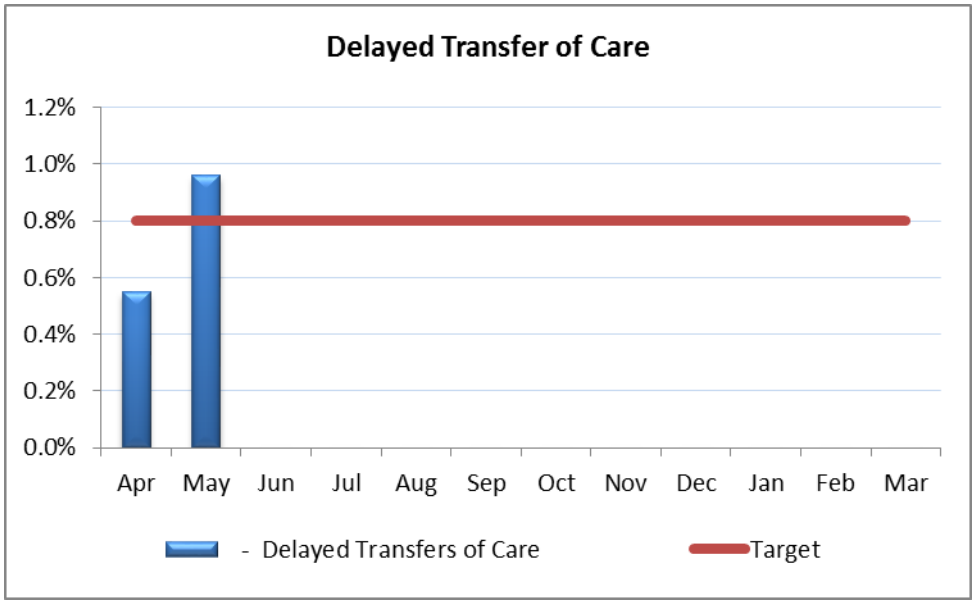
Discharge Fax sent in 2 working days



All but 3 discharge correspondences to GPs were sent within 2 working days.

The 3 minor delays were attributed to ward administrator illness. These were sent on day 3, 4 and 6.

Delayed Transfers of Care

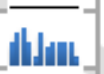


There are currently 2 patients, on ward 34, who are ready for discharge but whose discharge is being delayed. One delay is attributed to social care: awaiting provision of emergency accommodation; the other is attributed to both health and social care: awaiting funding and placement.

Campus Division Performance Dashboard 2017/18 Month 2

Enclosure F

Quality, Safety and Experience

Indicator	Period	Target	Actual	RAG	Previous months
CPA 7 day follow-up	Monthly	95%	98%	G	
Delayed transfers of care	Monthly	0.8%	1.0%	R	
Never events	Monthly	0	0	G	
Serious incidents reported to CCG via STEIS	Monthly	N/A	4	N/A	
Crisis gatekeeping	Monthly	95%	100%	G	
Mixed sex accommodation breaches	Monthly	0	0	G	
Under 16 admissions to adult facilities	Monthly	0	0	G	
New complaints opened for investigation	Monthly	<=4	1	G	
New concerns	Monthly	<=7	6	G	
Complaints upheld/partially upheld	Monthly	<=2	1	G	
Compliments	Monthly	>=40	36	R	
Friends and Family Test % positive	Monthly	89%	87%	R	
Complaint response breaches (final response sent >60 working days)	Monthly	0	2	R	

Performance

Indicator	Period	Target	Actual	RAG	Previous months
Hartington Unit bed occupancy – including leave	Monthly	85%	96%	R	
Hartington Unit bed occupancy – excluding leave	Monthly	85%	82%	G	
Hartington Unit length of stay	Monthly	36	57	R	
Radbourne Unit bed occupancy – including leave	Monthly	85%	102%	R	
Radbourne Unit bed occupancy – excluding leave	Monthly	85%	91%	R	
Radbourne Unit length of stay	Monthly	36	56	R	
Kingsway bed occupancy – including leave	Monthly	85%	73%	G	
Kingsway bed occupancy – excluding leave	Monthly	85%	68%	G	
Activity against contract – inpatient rehab.	Monthly	95%	70%	R	

People

Indicator	Period	Target	Actual	RAG	Previous months
Vacancy rate	Monthly	10%	7.0%	G	
Turnover	Monthly	10%	12.2%	R	
Sickness – in month	Monthly	5%	5.5%	R	
Annual appraisals	Monthly	90%	76.3%	R	
Mandatory training	Monthly	85%	88.4%	G	
Agency staff use	Monthly	1.9%	0.64%	G	
Bank staff use	Monthly	5%	12.7%	R	
Clinical supervision	Yearly	100%	41%	R	
Managerial supervision	Yearly	100%	49%	R	

Pulse Check

Indicator	Period	Target	Actual	RAG	Previous months
Kingsway					
Staff recommending as a place for care and treatment	Quarterly	79%	63%	R	
Staff recommending as a place to work	Quarterly	64%	39%	R	
Hartington Unit					
Staff recommending as a place for care and treatment	Quarterly	79%	Data not provided	N/A	

Campus Division Performance Dashboard 2017/18 Month 2

Enclosure F

Staff recommending as a place to work	Quarterly	64%	Data not provided	N/A	
Radbourne Unit					
Staff recommending as a place for care and treatment	Quarterly	79%	Data not provided	N/A	
Staff recommending as a place to work	Quarterly	64%	Data not provided	N/A	

Finance

Indicator	Period	Target	Actual	RAG	Previous months
Performance against budget £'000s	In month	2547	2628	R	
Performance against budget £'000s	Year to date	5055	5133	R	
Out of area placement expenditure £'000s	Year to date	81	328	R	

General Manager Summary:

- **Delayed transfers of care**
  The guidance for classification of a DTOC has been distributed. The ASMS are monitoring via the their operational meetings. Work is ongoing to improve the correct identification of DTOC.
- **Complaint response breaches**
  It is acknowledged that the sheer volume of complaints and investigations assigned to operational managers makes it very difficult to meet deadlines. As a result, 2 dedicated investigator posts have been created and recruited to. Once in post, the investigators should start to have a positive impact on turnaround times.
- **Adult acute inpatient occupancy and length of stay**
  Length of stay/ out of area placements project has commenced which is focusing on length of stay issues and will involve implementing a structured programme of improvement
- **Inpatient rehabilitation**
  Several discharges happened at once which bought occupancy levels down, including the transfer of a patient back to acute services. Audrey House is currently fully occupied, 2 patients however are on a discharge pathway. Rehabilitation referral process is being streamlined. Inreach work weekly to source referrals to both Hartington and Radbourne. Once a week referral meetings and future weekly updates to the wards to advise of bed occupancy rates and any waiting lists. Some referrals continue to be inappropriate for Rehabilitation services. Management to attend operational meetings to discuss referral process. Meeting being arranged for all referrals to be sent electronically via Paris.
- **Vacancies, sickness and associated bank use**
  Recruitment and Retention group is focusing on these issues.
- **Annual appraisals**
  The position has steadily been improving over time despite the rate of staff turnover and level of vacancy being carried.
- **Supervision**
  The volume of supervision being completed each month has increased significantly each month since March 2016. Owing to the way we report compliance on a rolling 12 months basis, any significant absence through maternity leave, long term sickness etc. makes the target unachievable. In Campus this is the case for 28 of our teams. Operations are currently exploring ways to more effectively capture ad hoc clinical supervision, which should improve the position: anecdotally we are aware that ad hoc supervision takes place which is not being recorded.
- **Finance**
  Overspend in May was as a result of a number of out of area placements and a need for additional temporary staffing at the Radbourne Unit to cover vacancies and acuity. Length of stay/ out of area placements project has commenced which is focusing on length of stay issues and will involve implementing a structured programme of improvement.

Central Services Division Performance Dashboard 2017/18 Month 2

Enclosure F

Quality, Safety and Experience

Indicator	Period	Target	Actual	RAG	Previous months
Never events	Monthly	0	0	G	
Serious incidents reported to CCG via STEIS	Monthly	N/A	3	N/A	
New complaints opened for investigation	Monthly	<=2	0	G	
New concerns	Monthly	<=3	4	R	
Complaints upheld/partially upheld	Monthly	<=0	0	G	
Compliments	Monthly	>=12	6	R	
Friends and Family Test % positive	Monthly	89%	null	N/A	
Complaint response breaches (final response sent >60 working days)	Monthly	0	1	R	

Performance

Indicator	Period	Target	Actual	RAG	Previous months
Activity against contract – ASD assessments (cumulative)	Monthly	100%	90%	G	
Activity against contract – perinatal inpatient bed days	Monthly	100%	41%	R	
Activity against contract – perinatal south community contacts	Monthly	161	128	R	
Activity against contract – eating disorder service contacts	Monthly	194	133	R	
Waiting list - ASD assessment: total and average wait (weeks)	Monthly	<=18	366 44	R	
Waiting list - dietetics: total waiting and average wait (weeks)	Monthly	<=18	1 0.4	G	
Waiting list – eating disorders: total waiting and average wait (weeks)	Monthly	<=18	8 5.4	G	
Waits – LD speech & language therapy: total and average wait	Monthly	<=18	171 36	R	
Waiting list - physiotherapy: total waiting and average wait (weeks)	Monthly	<=18	60 8	G	
Waiting list – psychological therapies: total and average wait	Monthly	<=18	69 14	G	

Performance

Indicator	Period	Target	Actual	RAG	Previous months
Waiting list - psychology: total waiting and average wait (weeks)	Monthly	<=18	596 27	R	
IAPT step 2 discharges	Monthly	67	96	G	
IAPT step 3 discharges	Monthly	516	630	G	
IAPT recovery rate	Monthly	50%	52.2%	G	
IAPT reliable improvement & recovery rate	Monthly	65%	69.3%	G	
Substance Misuse City:					
TOPS compliance - start	Quarterly	80%	98%	G	
TOPS compliance - review	Quarterly	80%	91%	G	
TOPS compliance - exit	Quarterly	80%	94%	G	
Waiting time into treatment over 21 days	Quarterly	0%	0%	G	
Substance Misuse County:					
TOPS compliance - start	Quarterly	80%	99%	G	
TOPS compliance - review	Quarterly	80%	93%	G	
TOPS compliance - exit	Quarterly	80%	96%	G	
Waiting time into treatment over 21 days	Quarterly	0%	1%	A	

People

Indicator	Period	Target	Actual	RAG	Previous months
Vacancy rate	Monthly	10%	3.2%	G	
Turnover	Monthly	10%	8.6%	G	
Sickness – in month	Monthly	5%	4.1%	G	
Annual appraisals	Monthly	90%	74%	R	

Central Services Division Performance Dashboard 2017/18 Month 2

Enclosure F

People					
Indicator	Period	Target	Actual	RAG	Previous months
Mandatory training	Monthly	85%	88%	G	
Agency staff use	Monthly	1.9%	1.0%	G	
Bank staff use	Monthly	5%	2.4%	G	
Clinical supervision	Yearly	100%	66%	R	
Managerial supervision	Yearly	100%	74%	R	

Pulse Check					
Indicator	Period	Target	Actual	RAG	Previous months
Learning Disability					
Staff recommending as a place for care and treatment	Quarterly	79%	65%	R	
Staff recommending as a place to work	Quarterly	64%	34%	R	
Substance misuse					
Staff recommending as a place for care and treatment	Quarterly	79%	78%	R	
Staff recommending as a place to work	Quarterly	64%	66%	G	

Finance					
Indicator	Period	Target	Actual	RAG	Previous months
Performance against budget £'000s	In month	£1792	£1731	G	
Performance against budget £'000s	Year to date	£3560	£3488	G	

General Manager Summary:

- **Complaint response breaches**
  It is acknowledged that the sheer volume of complaints and investigations assigned to operational managers makes it very difficult to meet deadlines. As a result, 2 dedicated investigator posts have been created and recruited to. Once in post, the investigators should start to have a positive impact on turnaround times.
- **ASD assessments**
  Meeting the assessments target for 2016/17 resulted in a backlog reports to be written up. Writing up these reports has impacted on capacity to undertake assessments towards the start of the new financial year. The backlog has now been addressed and we anticipate that the level of assessments completed over the next few months and going forward will bring us back into line with target.
- **Perinatal inpatient and community**
  Referrals to the service have been lower across all three team (including inpatients) which reflects a dip in the birth rate at the moment. Two clinicians (1 North and 1South) have reduced caseloads following returns from long term sickness and the North clinician is due to have surgery on the 7/6/17 so there will be a further absence. Dr Gandhi has introduced a joint antenatal clinic with maternity to screen cases which may have been referred to us previously. A significant amount of activity is not captured whereby professionals phone for advice for patients who are not known to services and there is nowhere to capture this data. A number of referrals in the North for psychological therapy have been declined due to difficulties recruiting into the 0.2 WTE vacancy. Actions being taken to improve the position:
  - To review if there are any ways telephone advice can be recorded/reported for patients not referred into the service.
  - To look into the possibility of secondment from DCHS to the one day vacant psychology post in the North. A further two days have been included in the Community Fund Development Bid due to be submitted in November.
- **Eating disorder service contacts**
  The full year target has been increased by 64% since 2016/17 and is set 12% higher than the level of activity achieved last financial year. Team to be briefed about the increased target and to consider ways to achieve compliance. There were reduced patient contacts owing to significant staff sickness/ absence, with 54 days lost during May. We are hoping to soon recruit temporary staff on a fixed term contract in order to address the capacity gap.
- **Annual appraisals**
  We had made some progress but it seems to have reached a plateau. This is a hot spot focus currently with the teams and actions and trajectories are being sought.
- **Supervision**
  This is moving in the right direction. In a few months we should see a step change. Owing to the way we report compliance on a rolling 12 months basis, any significant absence through maternity leave, long term sickness etc. makes the target unachievable. In Central this is the case for 18 of our teams. Operations are currently exploring ways to more effectively capture ad hoc clinical supervision, which should improve the position: anecdotally we are aware that ad hoc supervision takes place which is not being recorded.

Children's Services Division Performance Dashboard 2017/18 Month 2 Enclosure F

Quality, Safety and Experience

Indicator	Period	Target	Actual	RAG	Previous months
Never events	Monthly	0	0	G	
Serious incidents reported to CCG via STEIS	Monthly	N/A	0	N/A	
New complaints opened for investigation	Monthly	<=2	2	G	
New concerns	Monthly	<=5	7	R	
Complaints upheld/partially upheld	Monthly	<=2	2	G	
Compliments	Monthly	>=14	8	R	
Friends and Family Test % positive	Monthly	89%	86%	R	
Complaint response breaches (final response sent >60 working days)	Monthly	0	0	G	

Performance

Indicator	Period	Target	Actual	RAG	Previous months
CAMHS RISE – A&E referral rate (as a percentage of total referrals)	Monthly	73%	78.5%	G	
Children in care health assessments – children under 5	Monthly	72%	77%	G	
Children in care health assessments – children 5 and over	Monthly	74%	72%	R	
10-14 day breastfeeding coverage	Monthly	98%	98.6%	G	
6-8 week breastfeeding coverage	Monthly	98%	95.6%	R	
6-8 week breastfeeding prevalence	Monthly	43%	46%	G	
SEND process – letter 1 responses within 15 days	Monthly	79%	100%	G	
SEND process – letter 2 responses within 42 days	Monthly	46%	56%	G	

Performance

Indicator	Period	Target	Actual	RAG	Previous months
Paediatric current waits < 18 weeks	Monthly	92%	60%	R	
Paediatric waiting list: number waiting and average wait (weeks)	Monthly	<=18	988 19	R	
Paediatric new referrals (A) and attended 1st appointments (B)	Monthly	B>A	A 290 B 319	G	
CAMHS current waits < 18 weeks	Monthly	92%	96.4%	G	
CAMHS waiting list: number waiting and average wait (weeks)	Monthly	<=18	309 11	G	
CAMHS activity – attended contacts	Monthly	2037	2351	G	
CAMHS caseload	Monthly	1980	1780	G	
CAMHS RISE – referrals from A&E seen same day	Monthly	59%	71%	G	
CAMHS RISE – discharges with completed ESQ	Monthly	37%	33%	R	
CAMHS RISE – discharges with completed SFQ	Monthly	46%	37%	R	

People

Indicator	Period	Target	Actual	RAG	Previous months
Vacancy rate	Monthly	10%	7.9%	G	
Turnover	Monthly	10%	12.6%	R	
Sickness – in month	Monthly	5%	5.3%	R	
Annual appraisals	Monthly	90%	79.8%	R	
Mandatory training	Monthly	85%	88.1%	G	
Agency staff use	Monthly	1.9%	3.1%	R	
Bank staff use	Monthly	5%	1.8%	G	
Clinical supervision	Yearly	100%	85%	R	
Managerial supervision	Yearly	100%	80%	R	

Children's Services Division Performance Dashboard 2017/18 Month 2

Pulse Check					
Indicator	Period	Target	Actual	RAG	Previous months
Child Therapy & Complex Needs					
Staff recommending as a place for care and treatment	Quarterly	79%	71%	R	
Staff recommending as a place to work	Quarterly	64%	50%	R	
Universal Children's Services					
Staff recommending as a place for care and treatment	Quarterly	79%	80%	G	
Staff recommending as a place to work	Quarterly	64%	50%	R	

Finance					
Indicator	Period	Target	Actual	RAG	Previous months
Performance against budget £'000s	In month	£1233	£1219	G	
Performance against budget £'000s	Year to date	£2440	£2359	G	

General Manager Summary

- **Paediatric current waits < 18 weeks**
  Progress continues to be made towards achieving this objective. Report to be prepared for the next Quality Committee.
- **Sickness absence**
  Recruitment and Retention group has been launched to focus on these issues
- **Agency staff use**
  This issue is specifically impacting upon CAMHS Medical and Community Paediatrics. Recruitment plans are in place to reduce this over the next 2 months.
- **Supervision and annual appraisals**
  GM has generated a supervision and IPR dashboard for May 2017 and each SLM generated an action plan to address shortfall in performance. This is being monitored on fortnightly basis.
  Although significant progress has been made regarding recording, services are struggling to achieve required levels of supervision. Owing to the way we report compliance on a rolling 12 months basis, any significant absence through maternity leave, long term sickness etc. makes the supervision targets unachievable. In Children's Services this is the case for 21 of our teams. Operations are currently exploring ways to more effectively capture ad hoc clinical supervision, which should improve the position: anecdotally we are aware that ad hoc supervision takes place which is not being recorded.

Neighbourhood Services Division Performance Dashboard 2017/18 Month 2

Enclosure F

Quality, Safety and Experience

Indicator	Period	Target	Actual	RAG	Previous months
Never events	Monthly	0	0	G	
Serious incidents reported to CCG via STEIS	Monthly	N/A	2	N/A	
New complaints opened for investigation	Monthly	<=6	6	G	
New concerns	Monthly	<=17	14	G	
Complaints upheld/partially upheld	Monthly	<=2	2	G	
Compliments	Monthly	27	25	R	
Friends and Family Test % positive	Monthly	89%	80%	R	
Complaint response breaches (final response sent >60 working days)	Monthly	0	0	G	

Performance

Indicator	Period	Target	Actual	RAG	Previous months
North Derbyshire					
Community caseload per funded wte care coordinator (exc. waiting list)	Monthly	<=35	50	R	
Community waiting list: number waiting and average wait (weeks)	Monthly	<=18	1951 17	G	
Community referrals (A) and discharges (B)	Monthly	B>A	A 750 B 1070	G	
Community activity	Monthly	5491	5729	G	
Outpatient memory assessment service caseload	Monthly	1104	1070	G	
Outpatient caseload (exc. MAS)	Monthly	5117	5076	G	
Outpatient waiting list < 18 weeks	Monthly	92%	98%	G	
South Derbyshire					
Community caseload per funded wte care coordinator (exc. waiting list)	Monthly	<=35	41	R	
Community waiting list: number waiting and average wait (weeks)	Monthly	<=18	1504 19	R	

Performance

Indicator	Period	Target	Actual	RAG	Previous months
Community referrals (A) and discharges (B)	Monthly	B>A	A 466 B 495	G	
Community activity	Monthly	4326	4196	R	
Outpatient memory assessment service caseload	Monthly	549	547	G	
Outpatient caseload (exc. MAS)	Monthly	3419	3348	G	
Outpatient waiting list < 18 weeks	Monthly	92%	95.7%	G	
Derby City					
Community caseload per funded wte care coordinator (exc. waiting list)	Monthly	<=35	45	R	
Community waiting list: number waiting and average wait (weeks)	Monthly	<=18	1246 13	G	
Community referrals (A) and discharges (B)	Monthly	N/A	A 477 B 495	G	
Community activity	Monthly	4338	4819	G	
Outpatient caseload	Monthly	3273	3273	R	
Outpatient waiting list < 18 weeks	Monthly	92%	95.0%	G	

People

Indicator	Period	Target	Actual	RAG	Previous months
Vacancy rate	Monthly	10%	9.0%	G	
Turnover	Monthly	10%	9.3%	G	
Sickness – in month	Monthly	5%	10%	R	
Annual appraisals	Monthly	90%	75%	R	
Mandatory training	Monthly	85%	88%	G	
Agency staff use	Monthly	1.9%	3.9%	R	

Neighbourhood Services Division Performance Dashboard 2017/18 Month 2

Enclosure F

People					
Indicator	Period	Target	Actual	RAG	Previous months
Bank staff use	Monthly	5%	1.7%	G	
Clinical supervision	Yearly	100%	61%	R	
Managerial supervision	Yearly	100%	71%	R	

Pulse Check					
Indicator	Period	Target	Actual	RAG	Previous months
Locality 1					
Staff recommending as a place for care and treatment	Quarterly	79%	70%	R	
Staff recommending as a place to work	Quarterly	64%	47%	R	
Response rate	Quarterly	25%	15% (74)	R	
Locality 2					
Staff recommending as a place for care and treatment	Quarterly	79%	79%	G	
Staff recommending as a place to work	Quarterly	64%	63%	R	
Response rate	Quarterly	25%	11% (19)	R	
Locality 3					
Staff recommending as a place for care and treatment	Quarterly	79%	100%	G	
Staff recommending as a place to work	Quarterly	64%	0%	R	
Response rate	Quarterly	25%	19% (5)	R	
Locality 4					
Staff recommending as a place for care and treatment	Quarterly	79%	42%	R	
Staff recommending as a place to work	Quarterly	64%	42%	R	
Response rate	Quarterly	25%	35% (12)	G	

Finance					
Indicator	Period	Target	Actual	RAG	Previous months
Performance against budget £'000s	In month	£1951	£1891	G	
Performance against budget £'000s	Year to date	£3861	£3731	G	

General Manager Summary

- **Sickness**
  There has been a sharp increase in sickness absence in the month. Having had a few months where the trend had been more positive this is disappointing, however managers are aware in impacted teams and working to support people back to work as soon as possible.
- **Annual appraisals**
  It is becoming increasingly apparent that the capacity of the neighbourhood staff to meet key performance targets, including appraisals is challenged by the concentration on caseload and waiting lists. There is some capacity calculation work commencing to seek some improvement with this. In the interim all managers are prioritising appraisal completion, together with supervision rates as an urgent matter.
- **Agency staff use**
  We have exceeded target for use of agency staff and this has varied over the year, and between teams, trajectories have been set repeatedly, but are undermined by changing situations. However improving staff well-being and recruitment are key priorities for neighbourhood services through the next 6 months, which should benefit high pressured areas where sickness absence has created gaps and high turnover.
  Recruiting to medical posts has been extremely challenging throughout the year, this is a national issue and we have worked with other Trust departments to try and resolve this. Similar to the nurse situation solutions are found in one area, but then crop up in another. However this does mean that we are able to refine our processes and have more speed about processing solutions where it is possible. The last month has seen the medical gaps being covered more consistently.
- **Supervision**
  Owing to the way we report compliance on a rolling 12 months basis, any significant absence through maternity leave, long term sickness etc. makes the target unachievable. In Neighbourhood this is the case for 33 of our teams. Operations are currently exploring ways to more effectively capture ad hoc clinical supervision, which should improve the position: anecdotally we are aware that ad hoc supervision takes place which is not being recorded. The capacity of Band 6 staff to undertake supervision is being limited by their

having to manage large clinical caseloads. We are looking at freeing up capacity through reducing caseloads, although it is acknowledged this will have a negative impact on waiting lists. We have also set target percentage increases by team by month.

Enclosure F

WARD STAFFING

Ward name		Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Occupancy % Rate	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	79.35%	147.7%	77.3%	110.2%	84.6%	Yes	The report from the 1st May – 15th May is still stating in the template that we have 10.5 planned registered when it should be 21 registered an no unqualified at nights. However due to sickness and staff being moved to other wards where staffing as been short of qualified there have been times when we have worked on 1 qualified and 1 NA at time.
CHILD BEARING INPATIENT	41.40%	88.0%	69.1%	100.0%	119.4%	Yes	Current fill rate tolerances for registered nurses and care staff on days were broken due to backfill for 0.8 WTE maternity leave and x2 full time preceptorship nurses who are unable to take charge currently. Skill mix was adapted where possible.
CTC RESIDENTIAL REHABILITATION	70.83%	119.7%	75.9%	145.2%	82.3%	Yes	We currently have a some staffing issues.These are skewing the figures on days
ENHANCED CARE WARD	94.84%	84.6%	114.2%	74.2%	156.5%	Yes	These figure again reflect the vacancy rate for ECW in qualified staff. We have two new starter at the end of August unfortunately our second new starter is no longer coming and has taken a position with another trust. I am in process of re advertising posts. Despite vacancies are maintaining trust qualified Nurse in Charge cover on all shifts and competency requirements for same. Increased use of unqualified to cover both shortfalls in registered Nurse cover plus a period of high levels of observations due to clinical risk. Most of this cover has come from newly appointed trust staff, but still reliant on bank staff to cover additional night shifts. We always endeavour to use bank staff familiar with the area and staff with appropriate training in PMOVA where possible
HARTINGTON UNIT - MORTON WARD ADULT	92.20%	104.6%	146.7%	56.5%	277.4%	Yes	On Morton ward we have recently worked on higher numbers of staff due to very high continued activity which has been staffed by unqualified bank staff both during the day and night shifts. We are also carrying a high number of Band 5 vacancies which are covered by bank staff, this results in not being able to staff night shifts with x 2 qualified staff.

Enclosure F

WARD STAFFING

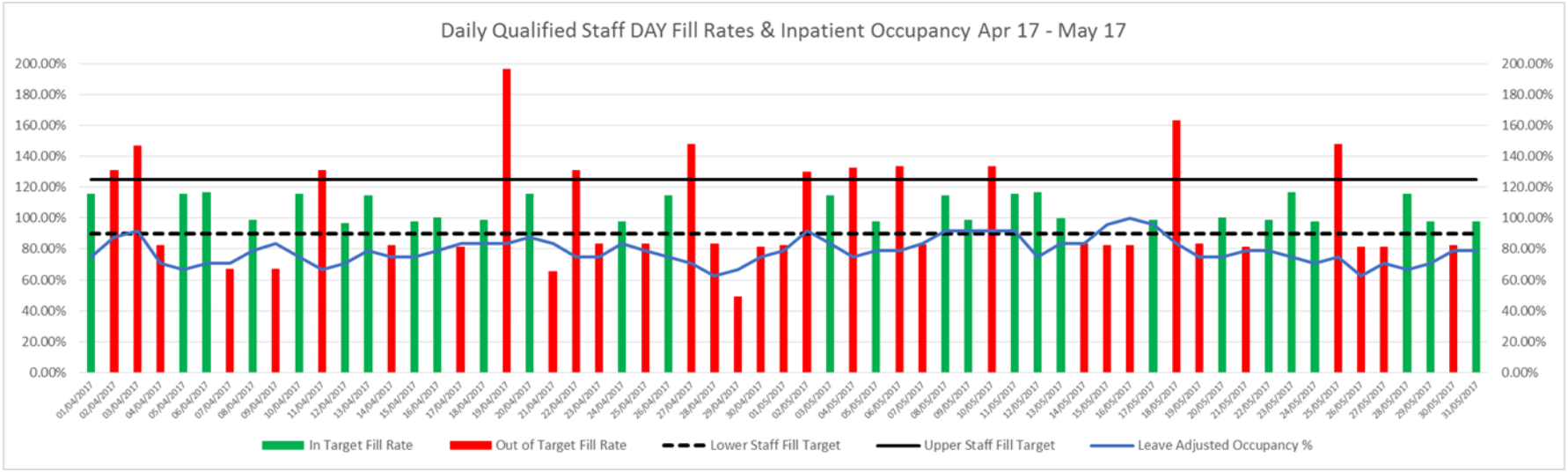
Ward name		Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Occupancy % Rate	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
HARTINGTON UNIT - PLEASLEY WARD ADULT	95.65%	99.2%	81.7%	44.1%	154.8%	Yes	No comment received
HARTINGTON UNIT - TANSLEY WARD ADULT	98.66%	94.2%	92.5%	56.5%	196.8%	Yes	Deficits in Registered Nurse duties have been filled by predominantly Bank HCA duties to enable overall staffing figures of 5/5/3 the reasons for the skills deficits are detailed: Vacancies: in May 4.4 wte Band 5 posts. 1 wte recruited into from October 17 after the candidate qualifies, we have maintained regular contact. 1 wte held for the development of the MOT role (Medicines Optimisation Technician) to support the registered nurses in the safety and governance of medicines we have interviewed and offered. 1 wte identified for a skills uplift to Band 6 and after interview has been offered to a member of staff currently acting into the post. 1.4 wte unfilled and subject to the rolling recruitment process. Absences: 1 wte Band 5 removed from the Ward pending investigation, interview due to take place in February was cancelled by the staff member as his representative was unable to attend, I have no further update. 0.6 wte Band 5 on maternity leave not due back until September. 0.6 wte Band 5 on long term sick however has now completed a phased return to work. 1 wte Band 6 on long term sick and has now completed a phased return to work. In addition to the registered nurses there is the following unregistered nurse absence: 0.5 wte Band 3 remains on long term sick following maternity leave. 1 wte Band 3 has returned from long term sick but is in the process of a phased return to work which includes the use of annual leave untaken from last year.This means that we continue to have Band 5 availability pressures before taking into account short term sickness, training or annual leave in addition only 60% of wte Band 6 is available for duty on day duty to cover Lead Nurse and
KEDLESTON LOW SECURE UNIT	63.55%	91.9%	79.9%	101.6%	100.0%	Yes	we currently have reduction in patient numbers in preparation for a refurbishment of Scarsdale which means we are running at lower staffing levels. Care staff will therefore be reduced in the day

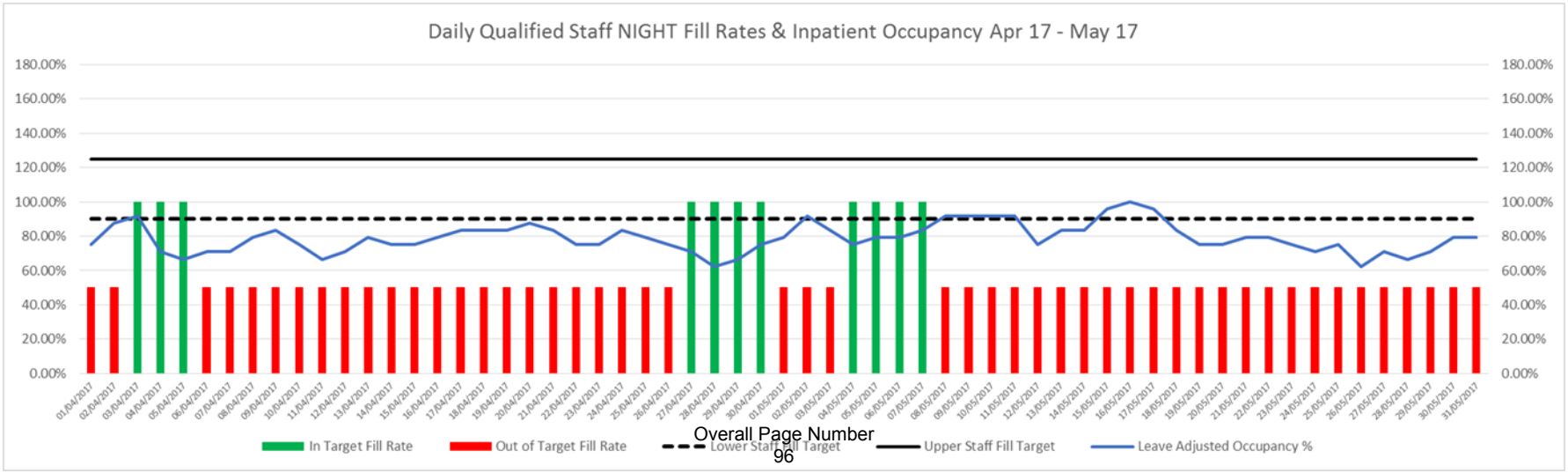
Enclosure F

WARD STAFFING

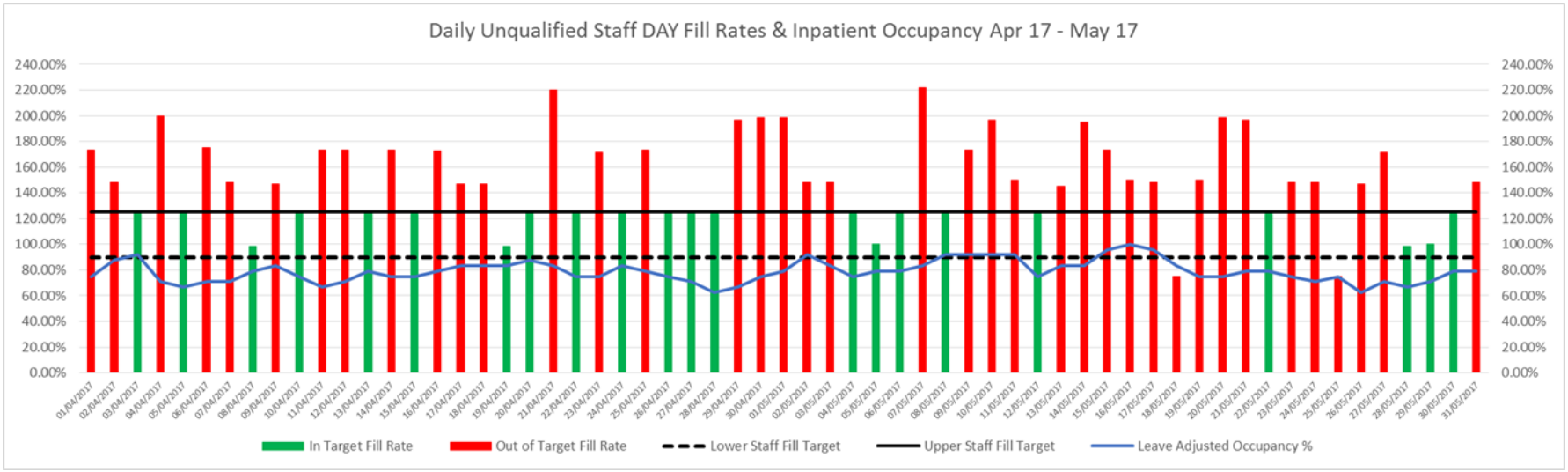
Ward name		Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Occupancy % Rate	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
KINGSWAY CUBLEY COURT - FEMALE	73.30%	117.4%	115.7%	67.8%	152.7%	Yes	
KINGSWAY CUBLEY COURT - MALE	56.45%	73.9%	108.1%	77.4%	129.0%	Yes	we reduced our staffing numbers to reflect the reduced numbers of patients, and moved staff to other wards to support them so as not utilise bank nurses.
LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP	104.66%	92.5%	113.2%	100.0%	154.9%	Yes	There have been significant number of levels of observation which have required additional staff over the norm This is a stand alone unit more numbers of care staff are incurred to maintain safety especially at night Ward 1 is carrying 3 RN vacancies and Care staff There is in addition 3 WTE sickness /Mat leave
RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT	101.94%	93.4%	167.0%	53.2%	322.6%	Yes	Ward 33 are unable to meet the required fill rates due to significant Band 5 Registered Nurse vacancies, on nights currently only able to roster 1 substantive Registered Nurse on shift, unqualified on nights and days have been rostered with regular staff to support.
RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT	104.35%	94.9%	131.8%	82.3%	209.7%	Yes	Ward 34 continue to carry vacancies which is being addressed by recruitment. New roster in place to facilitate 2 registered nurse on nights.
RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT	103.71%	83.9%	167.2%	62.9%	146.8%	Yes	All inpatient wards at the Radbourne unit remain affected by low recruitment into Registered Nursing vacancies. The current staffing establishment for Ward 35 is unable to meet the full demands for RN cover on each shift. In order to maintain safety and stability within the clinical areas, we have over recruited into HCA posts, hence the higher than required fill rates for unregistered staff. The Trust and individual ward areas continue to proactively recruit into RN vacancies and staffing/ skill mix are reviewed on an ongoing basis at ward level, operational level and Trust level.
RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT	100.16%	99.8%	131.1%	61.3%	254.8%	Yes	The figures reflect use of unqualified bank staff due to 3 members of staff on prolonged sickness and staff on mandatory training

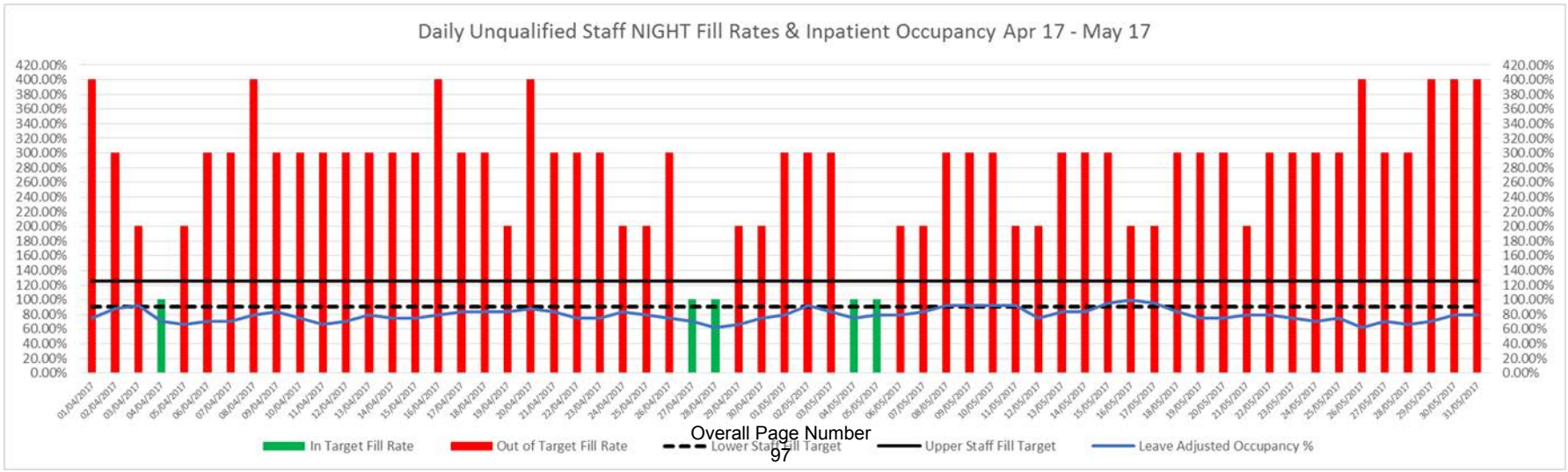
DAILY VIEW WARD STAFFING – MORTON WARD



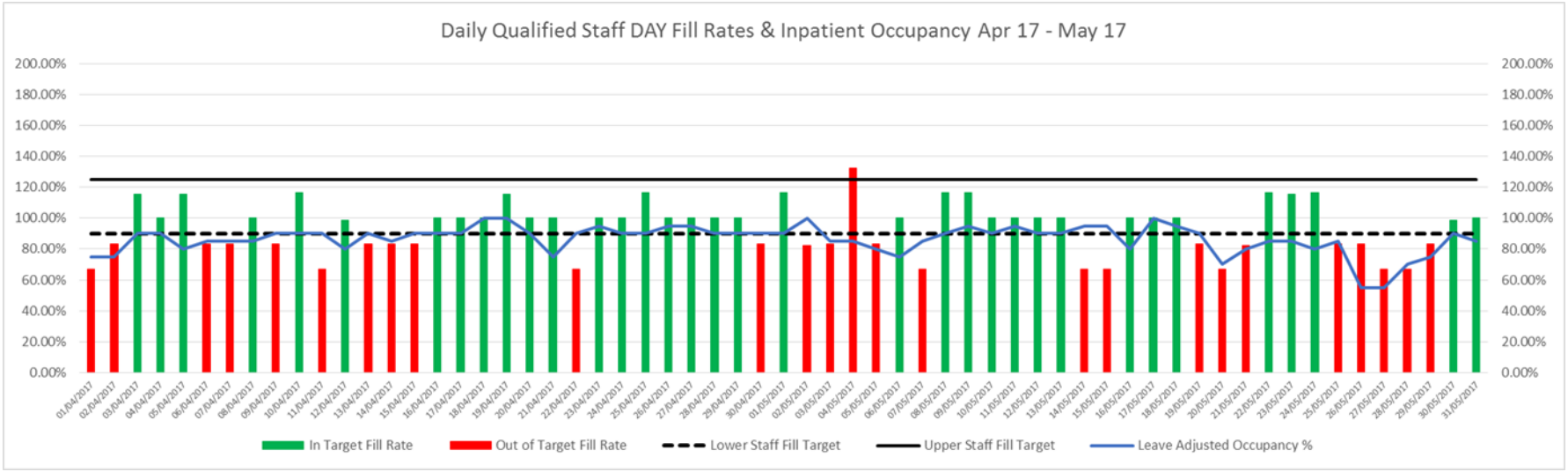


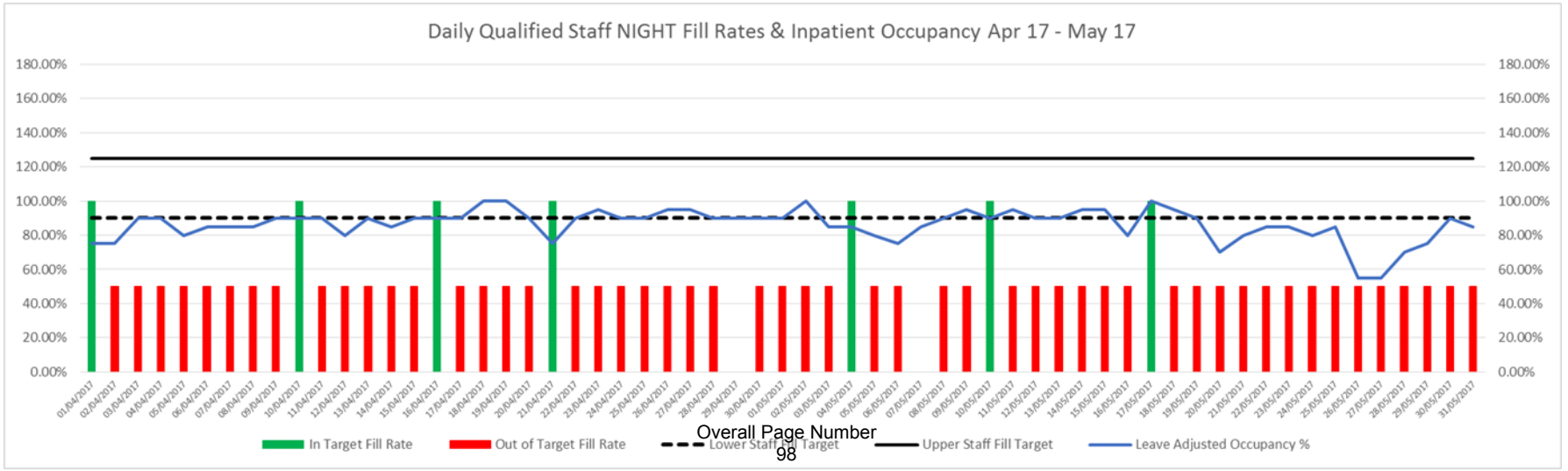
DAILY VIEW WARD STAFFING – MORTON WARD



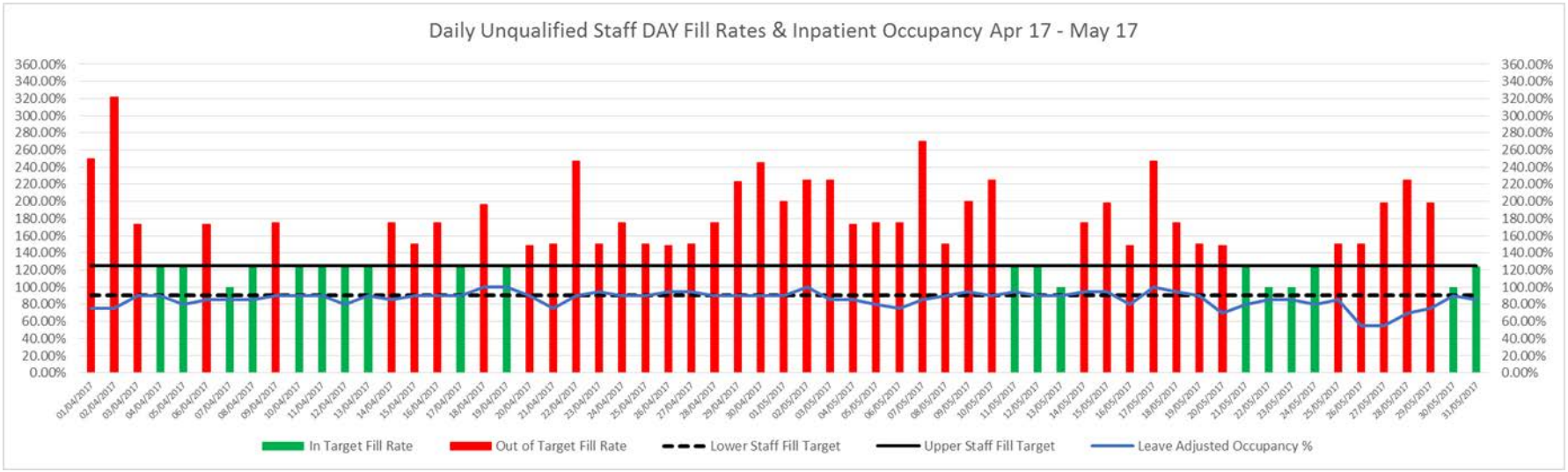


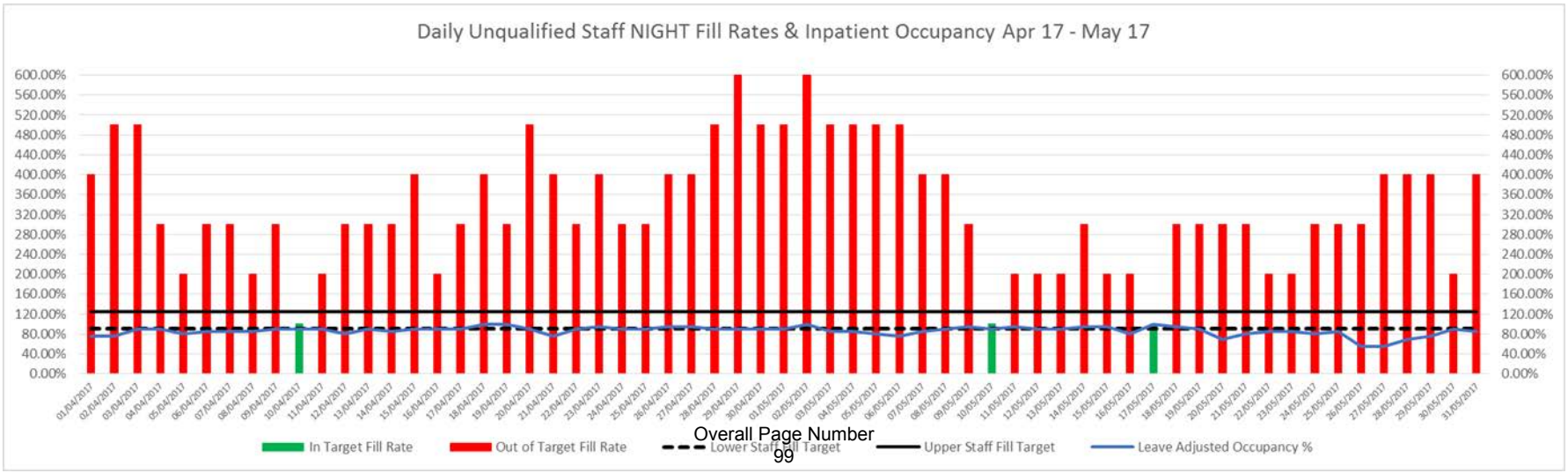
DAILY VIEW WARD STAFFING – WARD 33





DAILY VIEW WARD STAFFING – WARD 33





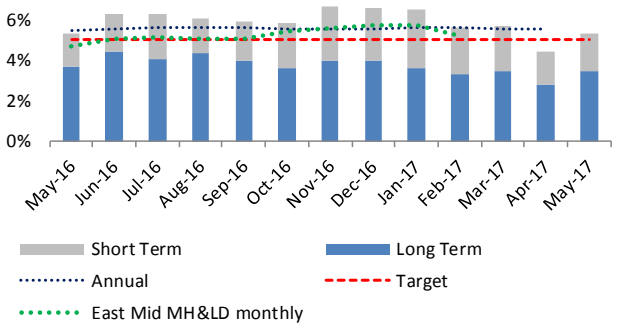
Workforce Section

WORKFORCE DASHBOARD

Sickness Absence

	Mar-17	Apr-17	May-17
(Monthly)	5.70%	4.45%	**5.30%**
(Annual)	5.54%	5.53%	**tbc**

Target 5.04%

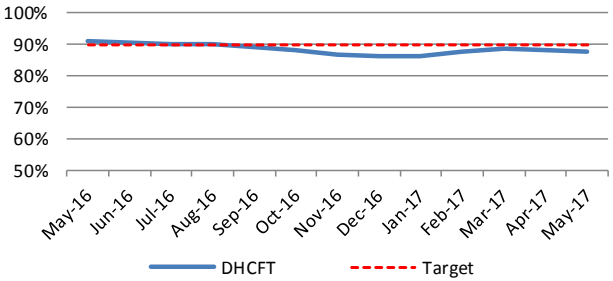


The monthly sickness absence rate is 0.85% higher than the previous month, however compared to the same period last year (May 2016) it is 0.02% lower. The Trust annual sickness absence rate is running at 5.53% (as at Apr 2017 latest available data). Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 28.98% of all sickness absence, followed by surgery at 19.74% and other musculoskeletal problems at 8.28%. Compared to the previous month short term sickness absence has increased by 0.15% and long term sickness absence has increased by 0.70%.

Compulsory Training

	Mar-17	Apr-17	May-17
(Staff in-date)	88.73%	88.17%	**87.73%**

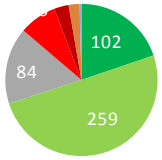
Target 90%

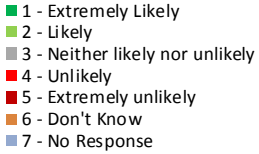


Compulsory training compliance continues to remain high running at 87.73%, which is a decrease of 0.44% compared to the previous month. Compared to the same period last year compliance rates are 3.14% lower. Compulsory training compliance remains above the 85% main contract commissioning for quality and innovation (CQUIN) target.

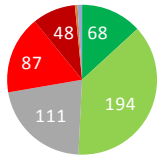
Staff FFT Q4 2016/17 (516 responses, 22.4% response rate) & Staff Survey 2016

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





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

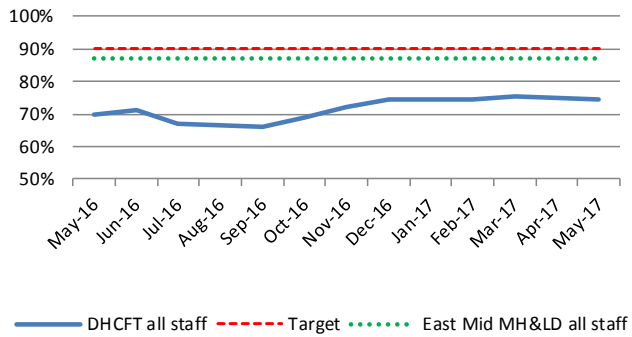


	2016	National average 2016	2015	National average 2015
Overall staff engagement:	**3.69**	3.84	3.73	3.81

WORKFORCE DASHBOARD

Appraisals (All staff)	Mar-17	Apr-17	May-17
	75.14%	74.71%	**74.62%**

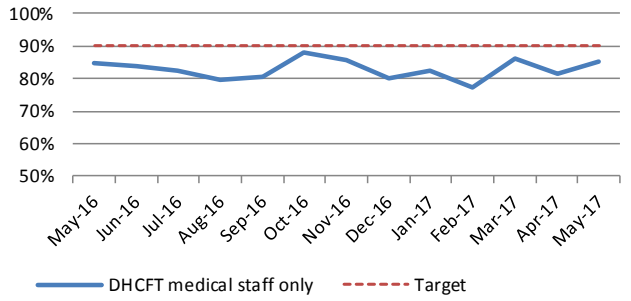
Target 90%



The number of employees who have received an appraisal within the last 12 months has decreased by 0.09% during May 2017 to 74.62%. Compared to the same period last year, compliance rates are 5.03% higher. According to the 2016 staff survey results, the national average for Mental Health & Learning Disability Trusts is 88.79%. Local benchmarking data for a range of Trusts in the East Midlands shows an average completion rate of 82.86%.

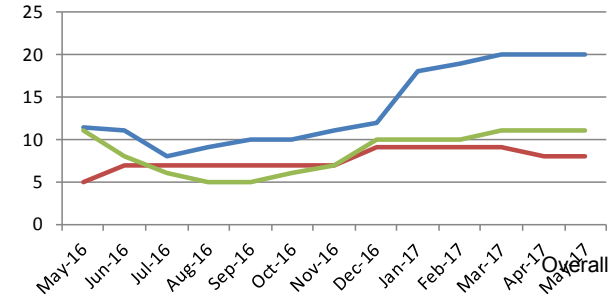
Appraisals (Medical staff only)	Mar-17	Apr-17	May-17
	86.11%	81.37%	**85.29%**

Target 90%

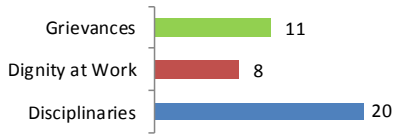


The number of Medical staff who have received an appraisal within the last 12 months has increased by 3.92% to 85.29%.

Grievances/Dignity at Work/Disciplinaries as at 31/05/2017

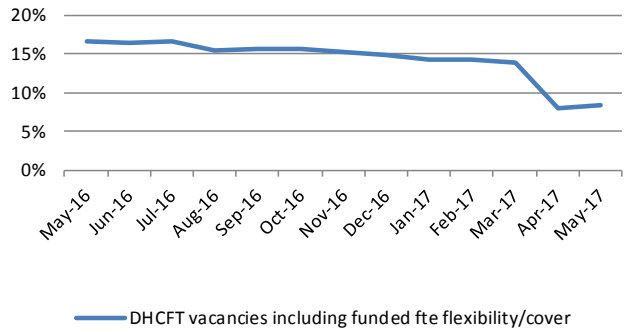


There continues to be eleven grievance cases lodged at the formal stage and efforts continue to resolving more grievances in the next period. Dignity at Work cases remain at 8. There are 20 Disciplinary cases, three new cases occurred in the period and three cases were resolved.



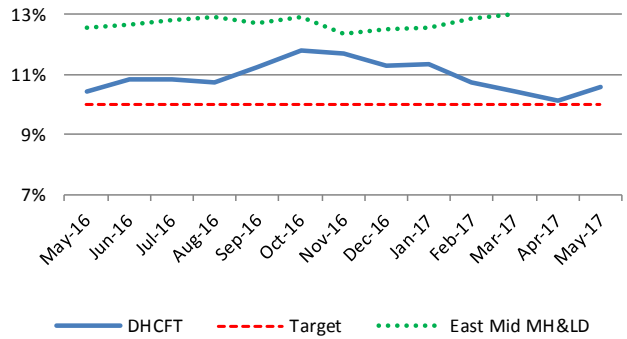
WORKFORCE DASHBOARD

Vacancy	Mar-17	Apr-17	May-17
(Funded full time equivalent) Including funded fte flexibility/cover	tbc	8.04%	**8.43%** ↗



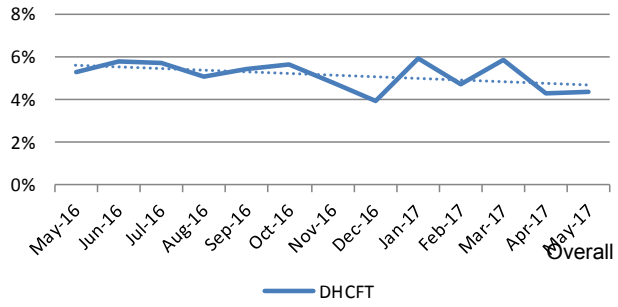
The Trust vacancy rate includes funded Fte surplus for flexibility including sickness and annual leave cover in In-Patient areas. Funded vacancy rates have increased slightly to 8.43% in May 2017. 2017/18 budget changes included a large reduction in Fte from 2016/17 investment not materialising and Cost Improvement Programmes. During the previous five months, 97 employees have left the Trust and 128 employees have joined the Trust.

Turnover	Mar-17	Apr-17	May-17
(Annual)	10.44%	10.16%	**10.59%** ● ↗
			Target 10%



Annual turnover remains within Trust target parameters at 10.59% and remains below the average for East Midlands Mental Health & Learning Disability Trusts. The average number of employees leaving over the last 12 months has increased by 0.94 to 21.36. During May 2017 28 employees left the Trust, an increase of 10 compared to the same period last year (May 2016). May 2017 leavers included 7 retirements.

Agency Usage	Mar-17	Apr-17	May-17
(Spend)	5.86%	4.31%	**4.33%** ↗



Total agency spend in May was 4.33% (5.29% including medical locums). Of total agency and locum spend for all staff groups, Qualified Nursing represented 1.2%, Medical 3.1% and other agency usage 0.1%. Agency Qualified Nursing spend against total Qualified Nursing spend in May was 3.3%. Agency Medical spend against total Medical spend in May was 17.6%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £57k.

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors - 28 June 2017

Progress on the Staff Survey

Purpose of Report

- Provide the board with an overview of the 2016 staff survey and quarter 1 pulse check results and the approach and actions that we are taking to improve staff engagement and involvement across the trust.

Executive Summary

- The staff survey is an annual survey and in 2016 we moved away from completing a staff sample to a full census of staff. 858 provided the trust with their view at the time and these results when received in early 2017 and have been thoroughly considered and shared with staff through the infographic outlined in Appendix 1. With the help of the Staff Engagement group we have jointly shaped the approach to take to make a step change in improving our position as a great place to work.
- We completed in quarter 1 a follow up 10 question pulse check and 516 staff took part. This quick turnaround survey which is focused on the key 10 questions that measure staff engagement, involvement and advocacy. These results have again been shared amongst staff.
- All leaders have received details of the staff survey results and where their team is of a sufficient size their pulse check results.
- We have identified four areas of focus from the Staff Survey for improvement which are being tracked for progress through the People and Culture Committee. Additionally all leaders have been asked to develop their action plans with 3 key focus areas that they will work on with their teams. Trust Management Team is tracking progress of the local development work.
- Since completing the two recent surveys DHCT has undertaken a cultural survey with EY and on receipt of the survey results we will be look to combine the findings and areas of focus into our improvement plan.

Strategic Considerations

- The turnaround time from completing the staff survey to receiving the results is long and drawn out in comparison to the time we have to make significant improvements
- The time of completing the staff survey the trust was going through a difficult time and this position has now improved
- Increasing staff engagement, involvement and advocacy is key to delivering high quality services and achieving overall success

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

Assurances

This report seeks to assure the Board that:

- We have an inclusive approach to improving staff engagement reported through the staff survey and pulse checks.

Consultation

- We have actively worked with the Staff Engagement Group to shape our development actions
- Leaders have been asked to work with their teams to develop local action plans

Governance or Legal Issues

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

From the staff survey we can retrieve detail about the staffs experience by their protected characteristics, this analysis will be carefully analysed and reviewed at the equalities forum

Recommendations

The Board of Directors is requested to:

1. Acknowledge the staff survey and pulse check results that the approach we are taking to improve staff engagement, involvement and advocacy for the trust.

Report presented by: Amanda Rawlings, Director of People and Organisational Effectiveness

Report prepared by: Amanda Rawlings, Director of People and Organisational Effectiveness

Progress since the NHS Staff Survey 2016 results
(received March 2017)

1. 2016 Staff Survey Findings

The 2016 NHS Staff survey results have been discussed at board and reviewed in detail by the People and Culture Committee. Our results in 2016 show a gradual decline in our staff engagement score from 2014. National research identifies that there is a direct correlation between staff engagement to patient safety and patient outcomes and therefore it is key that the trust focuses on staff engagement in order to deliver good patient care and experience and to create a great place to work.

Staff Engagement Scores

Scale Summary Score - the higher the score the better

Trust score 2016						3.69
Trust score 2015						3.73
Trust score 2014						3.75
National 2016 Average for combined MH/Community NHS Trusts						3.84 (2015 was 3.81)
	1	2	3	4	5	

In 2016 we had 2200 eligible employees out of 2400 who could complete the survey and 858 – 39% participated. This compares with 35.9% for the worst preforming Mental Health/Community Trusts and 55.3% for the best performing. The average response rate nationally was 46.5%. In 2015, although our response rate was slightly higher at 41%, the number of eligible staff was only 800. The 2016 staff survey results compared to 2015 show that we are:

- Significantly better on 1 question
- Significantly worse on 10 questions
- No significant difference on 77 questions

From the survey we have seen deterioration in two significant fundamentals that measure how engaged staff are in the trust:

- Recommending DHCFT as a place to work or receive treatment
- Staff motivation *the extent to which staff look forward to going to work, and enjoy and absorbed* in their jobs)

The Trust has improved significantly in one area from 31% in 2015 to 41% in 2016

- In last 3 months, have not come to work when not feeling well enough to perform duties

Findings from the NHS Staff Surveys as well as interviews with teams /staff show the following:

- Not feeling safe to raise concerns about clinical practice
- Feeling that career progression is not fair
- Quality of appraisals is poor
- Feeling that the trust is not interested in health and well -being of staff
- Feeling that managers do not appreciate staff

2. Progress

The Trust has taken the results of the Staff Survey and developed a framework to ensure we are acting at every level of the organisation. Four organisational priorities have been agreed to steer the direction and vision and then agreed actions at both service and team level to drive and embed change. They are not all quick-wins but address the cultural issues underpinning staff concerns. This will build a process of collective leadership and greater engagement. The priorities emerge from the most significant challenges in the Staff Survey results

The four organisational priorities:

- *Employee Voice*
- *Leadership engagement*
- *Staff/Resources*
- *Tools for the job*

3. Description of each of the four priorities

Employee Voice

- A core Staff Engagement Group working to introduce a new wider Staff Forum –The Voice
- A new quarterly Pulse Check to measure Staff Engagement
- Chief Executive weekly blog
- Drop in sessions with members of the Executive Team
- Bi monthly Spot Light on Leaders sessions

Tools for the job

- Hearing from staff that we need to fix the basics – phones, laptops/PC's, parking, connectivity

Leadership Engagement

- Building a leadership development framework
- Talent Management and succession planning
- Coaching conversations
- Providing support to challenged areas
- Building compassionate leadership

Staffing /Resources

- Building a workforce plan to introduce new workforce models/roles
- Focused recruitment campaigns including overseas
- Tackling retention

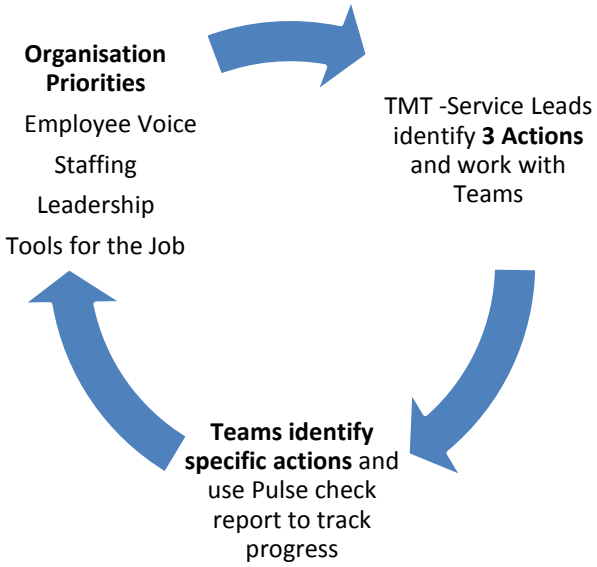
4. Service level

The Trust Management Team (TMT) brings together all service leads and is therefore a key group in driving change. Each Service Lead has received a staff survey report and now a pulse check report. From this, they have agreed three action points for their areas with rationale for their choice and a plan for monitoring progress. These will be monitored by the Trust Management Team (TMT) Teams will then work with service leaders on the actions.

5. Team level

We know that building effective and cohesive teams is crucial in terms of improving morale and changing culture. Service leaders will therefore work with team leaders on the actions. This is a significant challenge as many teams do not have regular team meetings and are feeling pressured due to shortages. At a recent Spotlight event some managers worried that this way of working was becoming the norm instead of the exception.

This is why we are offering support to teams through focus groups, coaching and team events to purposefully support the visible distribution of leadership responsibility at all levels in the organisation. Specific services have requested further support in light of their staff survey findings. This includes focus groups to help teams to gain more understanding of their results and identify solutions. This approach takes time and requires intensive work with teams who are in distress. In each session opinions of participants will be sought in relation to key areas highlighted in the team's staff survey results. Overall themes can be analysed to give a snapshot of the Trust's culture and identify trends. The approach used draws on appreciative inquiry and participatory methods.



6. Pulse Check

The Pulse check has 10 questions - including the 2 mandatory Staff Family and Friends questions. The results of the first quarterly Pulse check have now been received. The response rate was 22.4%. (516). Although this seems low in comparison to the staff survey results (39%) this is an improvement of 11% since the last full Staff Family and Friends Test in June 2016. As staff become more aware of the Pulse Check and receive reports this should increase. Reports have been circulated to 40 areas. Teams with 5 or more employees will now receive a report. This is a new approach for the Trust and will hopefully begin to build greater involvement at team level. Quarter 1 2017 is now live and results will be available early July. Teams will be able to benchmark against Staff Survey and Pulse check reports. Teams also receive any comments received from staff. We are testing a new approach to increase response rates via the use of secure boxes for people who prefer to use paper copies. This is being used at the Radbourne Unit.

7. Results of Quarter 1 Pulse Check April 2017

Comparison with previous years

- Q1 June 2016 – 258 responses, 11.14% of the Workforce *(National response rate 12.68%)*
- Q2 Staff Survey 2016 - 858 responses 39%
- Q3 *Campus only, therefore not used for comparison in this report*
- Q4 Pulse Check - 516 responses 22.4%

Staff Family and Friends questions

Question	Base	Picker Average	Trust % score	Staff Survey2016	Lowest (to date)	Highest (to date)
Q1How likely are you to recommend this organisation to friends and family if they	514	76%	70%	56%	56%	70%

needed care or treatment?						
Q2 How likely are you to recommend this organisation to friends and family as a place to work?	511	64%	51%	43%	43%%	51%

The 8 additional questions

Question	Base	% score	Staff Survey 2016	Lowest (to date)	Highest (to date)
Q5 Care of patients/service users is the trust's top priority.	494	77%	68%	68%	77%
Q6 I am able to make suggestions to improve the work of my team/department.	488	77%	74%	74%	77%
Q7 There are frequent opportunities for me to show initiative in my role.	493	70%	74%	70%	70%
Q8 I am able to make improvements happen in my area of work.	489	63%	55%	55%	63%
Q9 I think that it is safe to speak up and challenge how things are done	497	57%	New question	57%	57%
Q10 I look forward to going to work.	504	55%	53%	53%	55%
Q11 I am enthusiastic about my job.	492	67%	70%	67%	67%
Q12 Time passes quickly when I am working.	497	77%	77%	77%	77%

8. **Examples of improved engagement**

Radbourne Unit

The Radbourne Unit has a number of challenges not least staff shortages and difficulties in recruitment and retention. Response rates in the staff survey have been low and conversations with teams suggest that staff feel disconnected from the rest of the Trust and unsupported. The Staff Engagement Group held a meeting at the Unit and invited staff to attend. Two members of the Hope and Resilience Hub wanted to try out the use of staff suggestion boxes to find out what staff really thought. Within a week 133 responses had been received (compared to 33 in the Staff Survey). The responses have been collated into themes and results feedback to staff. A Senior Nurse has now been released to develop a supervision model as this was major theme and set up a staff forum within the Radbourne Unit. This will then link into the new Trust Staff Forum. .

9. The Voice

The Voice is a new staff forum suggested by the Engagement Group. Draft terms of reference have been written and ready for discussion and approval with the Chief Executive. This would be a quarterly forum with participation from every service and would build partnership working with the Executive Team. The Voice will require dedicated support and an independent Chair.

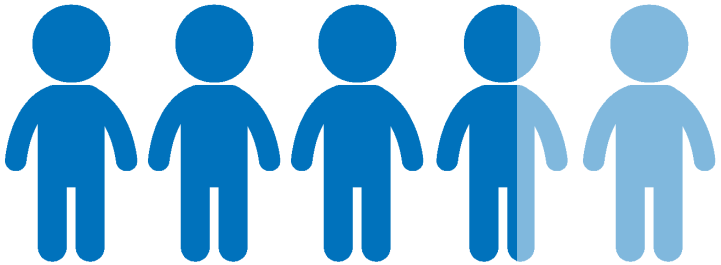
10. Next steps

Over the next couple months we will continue to work on the trust four priorities as well as supporting leaders and teams at a local level. We are waiting for the output of the cultural work we completed with EY and will look to bring the findings into our improvement plan.

Derbyshire Healthcare
NHS Foundation Trust

2016 National NHS Staff Survey: results summary

Overall staff engagement



We scored
3.69 out of 5

3.73 – our score for last year (2015)

3.80 – average score for similar trusts

77
Questions with results similar to last year
1 significantly better,
10 significantly worse

39%
Response rate
858 out of 2200 Derbyshire Healthcare employees completed the 2016 NHS staff survey

How is the staff engagement score calculated?

Staff willingness to recommend the Trust as a place to work or receive treatment
+
Staff perception of their ability to contribute towards improvement at work
+
How far staff feel motivated or engaged with their work
=
Staff engagement score

Our best areas

+ More staff know how to **report unsafe clinical practice**
+ More staff are satisfied with the opportunities for **flexible working patterns**
+ More of you are **reporting** experiences of harassment, bullying, abuse or violence
+ Fewer of you feel pressure to **attend work when unwell**
+ **Fewer experiences of physical violence** from staff in last 12 months.

Areas we need to improve on

We've heard you say…

- You want more opportunities for **career progression or promotion**
- You are reporting incidents but are not confident the Trust will **act on your concerns** and give feedback
- You are not sure the **process for reporting** is fair
- You want **appraisals** that leave you feeling valued and with a plan
- You want to see better use of patient/service receiver **feedback**.

Derbyshire Healthcare
NHS Foundation Trust

Audit & Risk Committee Summary
Council of Governors
18 July 2017

1. Introduction

Governors do not attend the Audit & Risk Committee, except on one specific occasion, and the purpose of this paper is to describe the purpose, activities and priorities of the Audit & Risk Committee so that Governors feel well informed and are able to delve deeper into any areas of interest and ask any relevant questions of the Committee members.

This document is a summary of the Committee's Annual Report for 2016/17 which was presented to the Trust Board in May 2017; this provides considerably more detail about the Committees activities.

2. Purpose of the Audit & Risk Committee

The Audit & Risk Committee is an assurance committee of the Board and is responsible for establishing and maintaining an effective system of integrated governance, risk management and internal control across the organisation, in a way that supports the organisation's objectives. This is achieved by:

- Ensuring there is an effective internal audit function that provides appropriate independent assurance to the Committee, the Chief Executive and the Board of Directors
- Reviewing the work and findings of the Trust's external auditor
- Reviewing the findings of other significant assurance functions, both internally and externally
- Reviewing the work of other committees within the organisation
- Requesting and reviewing reports and positive assurance from Directors and managers on the overall arrangements for governance, risk management and internal control
- Reviewing the annual report and annual financial statements before they are submitted to the Board
- Ensuring that the systems for financial reporting to the Board, including those around budgetary control, are subject to review in order to be sure that they are complete and accurate

3. Membership of the Audit & Risk Committee

The Audit & Risk Committee consists of three independent Non-Executive Directors, currently these are:

Name	Title	Membership Period
Barry Mellor	Committee Chair	Member from December 2016, Chair from January 2017
Julia Tabreham	Non-Executive Director	From October 2016
Margaret Gildea	Non-Executive Director	From October 2016 to November 2016 and then from January 2017

The members are supported by the Required Attendees of:

- Claire Wright, Director of Finance
- Sam Harrison, Director of Corporate Affairs & Trust Secretary
- Internal Auditors – KPMG
- Counter Fraud (quarterly) - KPMG
- External Auditors – Grant Thornton

In addition Rachel Leyland, Deputy Director of Finance and Rachel Kempster, Risk & Assurance Manager are usually in attendance to provide detailed support. Other Trust officers are requested to attend to cover specific topics.

The Lead Governor is invited to attend the meeting in May of each year which is for the prime purpose of approving the Annual Report including Quality Report, Annual Accounts including the Annual Governance Statement.

4. Key Audit & Risk Committee activities during 2016/17

4.1 Risk Management

In 2016/17 it was agreed to underpin the risk management approach with a Risk Management Strategy which was developed during the year and approved in December 2016.

4.2 Governance Improvement Plan (GIAP)

The Committee had oversight of 13 recommendations in the GIAP, it regularly reviewed evidence of progress against each of the recommendations and closed 12 of these during the year, and the final one shortly after.

4.3 Board Assurance Framework (BAF)

The BAF is a ‘live’ document and was formally reviewed quarterly by the Committee; KPMG also reviewed the Trust’s BAF and Risk Management arrangements and gave Significant Assurance, with some improvement opportunities. In addition deep dives (detailed reviews of specific risk areas) were completed by the Committee with Executive Leads for the 8 high level risks:

BAF Ref	Risk Description	Deep Dive Date
4b	Transformation	July 2016
4a	Financial Plan	October 2016
1a	Clinical Quality	December 2016
3a	Regulatory Compliance	January 2017
3b	Loss of Confidence in Leadership	January 2016
1c	Clinical Workforce	March 2017
1d	Compliance with Mental Health Act and Mental Capacity Act	March 2017
2a	Systems Wide Change	March 2017

4.4 **Counter Fraud Service**

The Trust's Counter Fraud Service is provided by an external provider. From 1 April to 30 November 20216 the service was provided by 360 Assurance and then by KPMG from 1 December. An annual plan was agreed by the Committee covering counter-fraud, bribery and corruption work of some 56.5 days in total. Each Trust is required to submit a self-review tool annually regarding the work conducted in accordance with standards set by NHS Protect and our overall level was Green – Organisation Meets Standard.

4.5 **Internal Audit**

The Trust takes a risk based approach to developing the Internal Audit programme which was approved by the Committee. The Internal Audit Service is again provided by an external provider – PWC from 1 April to 30 November and KPMG from 1 December 2016. During the year the Committee considered seven internal audit reports from PWC and one from KPMG. These identified 4 high, 16 medium and 26 low risk findings to improve weaknesses in the Trust's controls. The 4 high risk findings are being actively addressed and are in respect of:

- Section 132 (patient rights)
- Consultant job planning
- Agency controls
- Mental Capacity Act – Review of patient notes

In addition the Committee requested that the Executive Directors put in place revised arrangements to ensure that all agreed audit actions are monitored and completed by the agreed deadlines going forwards.

4.6 **External Audit**

The Trust's external auditors are Grant Thornton and in March 2017 the Committee recommended a one year extension of their contract which was approved by the Council of Governors and will run until 31 October 2018. Grant Thornton conducted a high level review of the Trust's internal audit arrangements and concluded that the work of both the previous and current internal audit service provided a satisfactory service to the Trust. Grant Thornton will be presenting their Year End conclusions at the 18 July Council of Governors meeting.

4.7 **Raising Concerns (Whistle blowing)**

The Committee received reports in May and December 2016 which mapped out the arrangements in place to address concerns within the Trust. The reports enabled the Committee to review the robustness of policy and procedures in place.

4.8 **Effectiveness of other Committees**

The Audit & Risk Committee secures its assurance of the effectiveness of other committees via each Committee's year-end report. The meeting on 27 April 2017 received the reports from the following Committees – Remuneration & Appointments, Finance & Performance, Quality, People & Culture, Mental Health Act and Safeguarding, and received significant assurance as to the effectiveness of these committees. Due to the significant changes in membership of the Mental Health Act Committee it was agreed to have an additional 6 month report on progress.

4.9 **Year End reporting**

The Committee had oversight of the year end reporting timetable and was able to see three drafts of the Annual Report and Quality Report to be able to input into these evolving documents. The Annual Report including Quality Report, Annual Accounts and Annual Governance Statement were approved at the 25 May 2017 Committee meeting and submitted according to national deadlines.

5. Priorities for 2017/18:

The five priorities for 2017/18 are:

- To promote good governance by sustaining and embedding effective Board Committee practice, building on from the successful implementation of the Governance Improvement Action Plan in 2016/17.
- To ensure that the Committee has a formal process for the interaction with Governors, including delivering an annual summary of the work of the Committee to the council of Governors and presentation of the annual accounts by the External Auditors.
- To further develop the oversight of risk within the Board committee structure, encouraging focus on the BAF, and including Deep Dives where required, to drive Board and Committee business to work towards successful delivery of the Trust's strategic objectives.

- To ensure that robust governance processes are in place to enable the Committee to seek the appropriate assurance over systems, controls and processes to inform preparation of the Annual Report and Annual Accounts including the Annual Governance Statement.
- To develop Audit & Risk Committee members to be effective in their role through training and development opportunities, thus addressing this issue as raised from the HFMA 2016/17 Audit Committee survey.

6. Conclusion

The Audit & Risk Committee members look forward to discussing this paper with the Governors on 18 July, answering their questions and hope that this paper has been informative.

Barry A Mellor
Chair, Audit & Risk Committee

Derbyshire Healthcare NHS Foundation Trust
Report to the Council of Governors – 18 July 2017

Report from Governance Committee

Purpose of Report
This paper provides an update on recent meetings of the Governance Committee.

Executive Summary
Since the last summary was provided in March, the Governance Committee has met twice, on 17 May and 3 July 2017.

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

Assurances

- The Council of Governors can receive assurance that the Committee is well established and discussing key areas of governor business
- Appropriate items for decision or approval will be brought to the full Council of Governors as appropriate
- An update of discussions at each meeting is regularly reported to the Council
- Effectiveness of the meeting is discussed regularly
- The work plan is reviewed at each meeting and changes made as and when required.

Consultation

No formal consultation is required for this update, although the Governance Committee has been established with a consultative approach and this continues to be reflected through the items discussed.

Governance or Legal Issues

The Governance Committee, as part of its work, will review key governance documents including the governors' Code of Conduct and will oversee Trust Constitution amendments prior to presenting to the Council of Governors**.**

Public Sector Equality Duty & Equality Impact Risk Analysis The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people).	
There are no adverse effects on people with protected characteristics (REGARDS).	x
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	
Actions to Mitigate/Minimise Identified Risks	

Recommendations

The Council of Governors is requested to

1. Note the discussions of the Governance Committee meeting held on 17 May 2017 and 3 July 2017

2. Review and approve the refreshed Terms of Reference for the Governance Committee.

Report presented by: **Shelley Comery**
Deputy Chair of Governance Committee

Report prepared by: **Donna Cameron, Assistant Trust Secretary**
Sam Harrison, Director of Corporate Affairs

Report from Governance Committee

The Governance Committee of the Council of Governors has met twice since its last report to the Council of Governors in May 2017 (17 May and 3 July 2017). This report provides a summary of issues discussed.

Meeting held on 17 May
8 governors attended.

Annual Review of Terms of Reference
The Committee reviewed and refreshed its Terms of Reference for clarity and to reflect more accurately the work of the Committee, including presenting the role and remit of the Committee by the themes the Committee uses to structure its agenda. The amended Terms of Reference are presented in Appendix 1 for approval by the Council of Governors.

It was agreed to produce a year-end report on the work of the Committee which will be presented to Council of Governors at the September meeting.

Membership & Engagement
Governors were updated on arrangements for the Annual Members Meeting and asked to promote the event to their constituents. Events identified as engagement opportunities for governors were promoted. Governors also shared experiences of recent engagement activities.

Recent Cyber-Attack
Governors were updated regarding the Cyber-Attack that had impacted organisations globally, including the NHS and were advised that no impact had been experienced on patient care. Governors were assured that the Trust was undertaking a full debrief and review exercise to ensure learning from the incident.

Holding to Account
Governors gave feedback on attendance at Quality Committee, where a governor observer role has recently been introduced, providing governors with a further opportunity to observe Non-Executive Directors holding the Executives to account. Governors also gave feedback on recent quality visits which were agreed to be a valuable opportunity to learn about the services provided by the Trust and to meet staff.

Merger/Acquisition Update
The Chair updated the Committee on integration work with Derbyshire Community Healthcare NHS FT (DCHS). Governors shared their experiences from attending meetings with DCHS governors to consider development of a constitution reflecting the services in the future merged organisation. A list of questions raised by governors will form part of the Confidential Council of Governors meeting, scheduled for 6 June, to discuss the integration.

Training & Development
The programme for 2017/18 was noted.

Governor Resignations
Two governor resignations had been received, resulting in vacancies in Derby City West and Chesterfield South. The Trust has written to both governors to thank them for their work in their governor role.

Meeting held on 3 July 2017
9 governors attended the meeting.

Election of Deputy Chair of Governance Committee
Shelley Comery was elected to the position of Deputy Chair of Governance Committee.

Holding to Account
An update on equality, diversity and inclusion for the first quarter of 2017/18 was delivered by Harinder Dhaliwal. A draft Public Sector Equality Duties & EDS2 Implementation Plan was also noted.

Governors fed back on their attendance in a variety of meetings across the Trust, as attendees, members and observers.

Governors sought an update on the progress being made in relation to Board appointments, following the withdrawal from the transaction process with Derbyshire Community Healthcare NHS Trust. Governors present were unanimous in their support to expedite this, following the required governance processes.

Code of Conduct
The Lead Governor shared his thoughts on the Trust's Code of Conduct for Governors. Governors were reminded that the Code is a set of expectations of behaviours. Sam Harrison undertook to clarify within the procedure when a formal non-compliance process should be triggered, that is by written notification to the Lead Governor and Trust Chair. It was also agreed that the percentage of governors voting in favour of any recommendation to remove a governor, as outlined in the Code of Conduct, should be reduced to 70%. The implications of this on the Trust Constitution will be reviewed.

Governor attendance at Council of Governors (CoG) meetings was noted. In future the Committee will also receive information on Non-Executive Director attendance at CoG.

Membership & Engagement
Governors fed back on a wide variety of engagement activities across the City and the County and on attendance at Quality Visits. Information on future engagement events was promoted.

Training & Development
The schedule of training and development opportunities was noted and further suggestions invited. Governors provided very positive feedback on the recent session on the Integrated Performance Report. Governors are keen to see better attendance at the session and encouraged colleagues to attend. It may be possible to invite governors from other Trusts to shared development sessions. A session on recruitment may be

expedited for members of Governors Nominations & Remuneration Committee over the coming weeks given the role of this Committee in forthcoming Board appointments.

Governance
The Committee received the outcome of research into a request to consider lowering the age of public members. A variety of Trusts had shared their experiences of young members. Feedback highlighted that the most successful input from younger people had been achieved through participation groups. It was agreed to discuss more broadly with the Trust's CAMHS team. Governors also received an update on the preparations for the forthcoming staff and public governor elections.

Derbyshire Healthcare
NHS Foundation Trust

Terms of Reference of the Governance Committee
Approved by Governance Committee – 17 May 2017

Authority

The Council of Governors Governance Committee is constituted as a Committee of the Council of Governors. The Governance Committee will review key governance documents including the governors' Code of Conduct and will oversee Trust Constitution amendments prior to presenting to the Council of Governors**.**

1. Role

The Council of Governors Governance Committee shall be responsible for advice and support on:

1.1 Code of Conduct

1.1.1 Maintaining an overview of governor attendance and contribution in line with the Governors' Code of Conduct and best practice, ensuring effective processes are in place to deal with any non-compliance, behaviour or conduct issues,

1.1.2 Annual review of the Governors' Code of Conduct

1.2 Membership & Engagement

1.2.1 Ensure governors have an agreed approach to member engagement and recruitment and that the Council of Governors' responsibilities are met in this respect.

1.2.2 To assist in creating opportunities to engage with governors constituents and to create new members and engage with existing members.

1.2.3 To assist in the recruitment of governors and in preparing them to fulfil their responsibilities.

1.2.4 Regularly review the Trust's membership data.

1.2.5 Maintain an oversight of governor involvement in Trust activities, ensure that those activities are coordinated and reported back to the Council of Governors.

1.2.6 Advise on arrangements for the Annual Members Meeting.

1.3 Quality

1.3.1 To consider the Trust's Quality Account and support the coordination of the governors' statement.

1.4 Holding to Account

1.4.1 Oversee engagement activities with Non-Executive Directors.

1.4.2 Make proposals for the Council's forward work programme, including items related to holding the board to account.

1.5 Training & Development

1.5.1 To consider the learning and development needs of the Council of Governors required to enable governors to undertake their role and responsibilities efficiently and effectively.

1.5.2 To reflect upon the training and development undertaken and review feedback received from governor development sessions.

1.6 Governance

1.6.1 Give due consideration to laws and regulations and the provisions of the NHS Foundation Trust Code of Governance.

1.6.2 Ensure the Council of Governors' annual effectiveness review is undertaken and outcomes presented to the Council of Governors with any required recommendations to discharge its role.

1.6.3 Review of any proposed changes to the Trust's constitution, making recommendations as required.

2. The Council of Governors shall not delegate any of its powers to the Governance Committee and the Governance Committee shall not exercise any of the powers of the Council of Governors.

3. Membership of the Committee

3.1 The Governance Committee shall comprise of elected Public Governors, Staff Governors and Appointed Governors.

3.2 The following are also invited to attend:

- Chair or Deputy Chair in the absence of the Chair.
- Director of Corporate Affairs & Trust Secretary
- Deputy Director of Communications and Involvement
- Communications & Involvement Manager
- Nominated Membership Champion.
- Assistant Trust Secretary

4. Quorum

A Quorum shall comprise:

a) Three governors
b) One member of Trust staff, aside from Staff Governors

5. Frequency of Meetings

5.1 The Committee shall meet monthly and report regularly to the Council of Governors.

6. Planning & Administration of Meetings

6.1 Yearly the Committee shall elect from its membership, a governor to serve as Chair of the Committee who will be eligible for re-election after the term has expired.

6.2 The Committee shall elect from its membership, a governor to serve as a Deputy Chair.

6.3 The Communications & Involvement Manager and the Assistant Trust Secretary will support the planning and administration of the Committee.

7. Review

7.1 The terms of reference of the Committee shall be reviewed by the Governance Committee annually and changes submitted to the Council of Governors for approval.

Derbyshire Healthcare NHS Foundation Trust
Report to the Council of Governors – 18 July 2017

Update on Governor Appointments & Resignations

Purpose of Report

Update on governor appointments and resignations since May 2017.

Executive Summary

Recent Resignations
Alan Smith, Constituency – Chesterfield South, resigned effective 2 May 2017.
Paula Lewis, Constituency – Derby City West, resigned effective 6 May 2017.
Diane Froggatt, Appointed Governor – Derby City Council, stepped down, effective 25 May 2017 (replaced by Cllr Robin Turner).
Helen Sentance, Constituency – Erewash South, resigned effective 4 July 2017.
Alexandra Hurst, Constituency – High Peak, resigned effective 10 July 2017.

Recent Appointments
Robin Turner, Appointed Governor – Derby City Council, effective 7 June 2017.
Amran Ashraf, Constituency – Derby City West, effective 1 July 2017.

Current Vacancies
Public Governors

- Bolsover
- Chesterfield South
- Erewash South
- High Peak
- North East Derbyshire

These will be taken forward in the public governor elections scheduled for the autumn.

Staff Governor
One of our Staff Governors' term of office ends on 25 September 2017 (April Saunders, Staff Governor, Nursing and Allied Professions). We will be inviting nominations for this staff governor post from 27 July – 11 August, with elections taking place in September.

Appointed Governors
Derbyshire County Council – Cllr Rob Davison, appointed governor for Derbyshire County Council was not re-elected to his seat as a local Councillor for Derbyshire County Council. This therefore means that Rob was required to step down from his role as governor representing Derbyshire County Council. The Council has nominated Councillor Linda Grooby to their appointed governor seat.

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

Assurances

The Trust works with the CoG to maintain an effective CoG and ensure appropriate steps are taken to independently recruit to governor vacancies when they arise.

Consultation

A proposal was submitted to the Governance Committee on 3 July 2017.

Governance or Legal Issues

Maintaining an effective Council of Governors with representation from all constituencies is a key element of good governance. The composition of the CoG and constituencies are outlined in the Trust constitution.

Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

There is a risk that governors are not representative of their constituencies and the diverse communities of Derby/Derbyshire. We seek to actively engage with and promote the governor role to all constituents.

The Trust is keen to encourage representation from all the communities it serves and welcomes nominations from persons of any age (16 or over), race, economic disadvantage, gender, religion, disability or sexual orientation.

Each of our governors is elected to represent their particular geographical area where they reside and has a role to engage with local members regarding their experiences of the Trust and to bring to the Council of Governors meetings issues that are of relevance to their local membership.

Recommendations

The Council of Governors is requested to:

1) To note the resignations, recent appointments and planned elections.

Report presented by:	**Anna Shaw, Deputy Director of Communications & Involvement**
Report prepared by:	**Samantha Harrison, Director of Corporate Affairs & Trust Secretary** **Denise Baxendale, Communications & Involvement Manager**

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 24 May 2017

Governance Improvement Action Plan (GIAP)

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 on the delivery of the GIAP, including the identification of tasks and recommendations that are off track.
2. To receive assurances on delivery and risk mitigation 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

This paper provides the Board with an update on the progress of delivering the GIAP.

The governance of each core area is as follows:

Core	Committee	Lead Director
Core 1 - HR and associated Functions	People and Culture	Interim Director of People and Organisational Effectiveness
Core 2 - People and Culture	People and Culture	Interim Director of People and Organisational Effectiveness
Core 3 - Clinical Governance	Quality	Director of Nursing and Patient Experience
Core 4 - Corporate Governance	Audit & Risk	Director of Corporate Affairs
Core 5 - Council of Governors	Council of Governors	Director of Corporate Affairs
Core 6 - Roles and Responsibilities of Board Members	Remuneration and Appointments	Director of Corporate Affairs
Core 7 - HR and OD	People and Culture	Interim Director of People and Organisational Effectiveness
Core 8 - Raising concerns at work	People and Culture	Director of Corporate Affairs
Core 9 - Fit and Proper	Remuneration and Appointments	Director of Corporate Affairs
Core 10 - CQC	People and Culture	Interim Director of People and Organisational Effectiveness
Core 11 - NHS improvement undertakings	Board of Directors	Director of Corporate Affairs

The summary table below provides Board members with an overview of performance against all 53 recommendations, set against each respective core area and from the

perspective of the oversight Committees.

Core	Number of Recommendations	Off Track	Some Issues	On Track	Completed
Core 1 - HR and Associated Functions	5	0	0	0	5
Core 2 - People and Culture	6	0	0	0	6
Core 3 - Clinical Governance	3	0	0	0	3
Core 4 - Corporate Governance	13	0	0	0	13
Core 5 - Council of Governors	3	0	0	0	3
Core 6 - Roles and Responsibilities of Board Members	5	0	0	0	5
Core 7 - HR and OD	8	0	0	0	8
Core 8 - Raising concerns at work	1	0	0	0	1
Core 9 - Fit and Proper	1	0	0	0	1
Core 10 - CQC	2	0	0	0	2
Core 11 - NHS improvement undertakings	6	0	0	0	6
Total	53	0	0	0	53

There are **two** blue forms to present to the Board – these are the final forms to be submitted as part of the GIAP.

Strategic considerations

Delivery of the GIAP links directly to NHS Improvement's enforcement action and associated licence undertakings

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

Board Assurances

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

3a: There is a risk that the NHSI 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
3b: Risk of a loss of confidence by staff in the leadership of the organisation at all levels

Consultation

Core areas have been discussed at respective Board Committees

Governance or Legal Issues

This paper links directly to NHSI enforcement action and associated licence undertakings

Equality Delivery System

Delivery of elements of the GIAP is likely to have a positive impact on outcomes for certain REGARDS groups

Recommendations

The Board of Directors is asked to:

1) Note the completion of all actions addressing GIAP recommendations
2) Formally approve the **two** blue forms as presented and confirm that this is provides assurance of completion, namely:

    - **M1**
    - **M3**

3) Note the full completion of the Governance Improvement Action Plan.

Report presented by:	**Kelly Sims (CQC and Governance Coordinator)**
Report prepared by:	**Samantha Harrison (Director of Corporate Affairs and Trust Secretary)**

Blue Completion Form

Recommendation	Current BRAG Rating	Recommended BRAG Rating
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 •Links to demonstrable outcomes	**Complete**	**Assurance Received**

Detail

The GIAP and governance and delivery framework were agreed by the Board in March 2016. The GIAP included the findings and recommendations from the employment tribunal investigation, Deloitte report February 2016 and the CQC focused inspection February 2016.

The GIAP delivery framework was implemented from April 2016, with updates made to the plan accordingly. The GIAP has been in operation throughout 2016/17 with progress against key tasks monitored and overseen, progress RAG rated and associated risks to delivery of actions reviewed.

Deloitte carried out a review of the implementation of the GIAP, which took place between February 2017 and April 2017. (See M3).

On 10 April 2017 verbal feedback was provided, a draft report was received on (19 April) followed by the final report on (24 April). This provided assurance that the Trust now meets the benchmark Deloitte would associate with organisations rated

amber-green against NHS Improvement's well-led framework.
Evidence
11.5 GIAP reports to Board monthly, e.g. October 2016 GIAP report to Board reporting completion of GIAP, May 2017
On-going Monitoring Arrangements Ongoing monitoring arrangements have been defined and agreed for all recommendations, as outlined in blue completion forms. Work will continue to ensure embeddedness and effectiveness of these monitoring arrangements as part of our work towards an anticipated full well-led review during 2017/18.

Executive Director Responsible	Director of Corporate Affairs	**Responsible Assurance Committee**	Board of Directors

Blue Completion Form

Recommendation **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	**Current BRAG Rating** **Complete**	**Recommended BRAG Rating** **Assurance Received**

Detail

A phase one external review was undertaken by Deloitte LLP in September 2016 to review progress and approach to implementation of the GIAP. This provided positive assurance of programme approach and informed further work on implementation and ensuring embeddedness and monitoring of actions undertaken.

Deloitte were commissioned to undertake a full review (phase two) of implementation of the GIAP between February and April 2017. During this period Board and Board Committees were observed, interviews took place with staff and Board members, focus groups were held with our governors, and information was submitted as part of their desk top review process.

On 10 April 2017 verbal feedback was provided, a draft report was received on (19 April) followed by the final report on (24 April). This gave positive assurance that significant improvement had been made across all three areas of the scope of the review, namely Board effectiveness, governance and HR associated functions, such that the Trust now meets the benchmark associated with organisations rated Amber/Green through similar well-led reviews. This Amber/Green rating reflects 'some areas of good practice, no major omissions and robust action plans to meet perceived gaps with proven track record of delivery'.

Evidence

11.6 Deloitte report phase one, September 2016
Deloitte report phase two, April 2017

On-going Monitoring Arrangements
Ongoing monitoring arrangements have been defined and agreed for all recommendations, as outlined in blue completion forms.

Work will continue to ensure embeddedness and effectiveness of these monitoring arrangements as part of our work towards an anticipated full well-led review during 2017/18.

Executive Director Responsible	Director of Corporate Affairs	**Responsible Assurance Committee**	Board of Director

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Wednesday 1 March 2017

MEETING HELD IN PUBLIC

Commenced: 1pm Closed: 4:40pm

PRESENT:	Caroline Maley	Acting Trust Chair
	Margaret Gildea	Senior Independent Director
	Dr Julia Tabreham	Deputy Trust Chair and Non-Executive Director
	Maura Teager	Non-Executive Director
	Dr Anne Wright	Non-Executive Director
	Richard Wright	Non-Executive Director
	Ifti Majid	Acting Chief Executive
	Claire Wright	Executive Director of Finance
	Carolyn Green	Executive Director of Nursing & Patient Experience
	Dr John Sykes	Executive Medical Director
	Mark Powell	Acting Chief Operating Officer
	Amanda Rawlings	Director of People & Organisational Effectiveness
	Lynn Wilmott-Shepherd	Interim Director of Strategic Development
IN ATTENDANCE:	Anna Shaw	Deputy Director of Communications & Involvement
	Sue Turner	Board Secretary (Minutes)
For item DHCFT 2017/038	Michael	Service Receiver
For item DHCFT 2017/038	Bev Green	Service Improvement / Head Nurse Hartington Unit
For item DHCFT 2017/038	Bryan Plimmer	Occupational Therapist, Cherry Tree Close
For item DHCFT 2017/038	Alex Kerry	Occupational Therapy Student
For item DHCFT 2017/038	Hannah Lister	Occupational Therapy Student
For item DHCFT 2017/038	Carol Fordham	Occupational Therapy Assistant
For item DHCFT 2017/047	Claire Biernacki	General Manager - Neighbourhoods
For item DHCFT 2017/047	Julia Lowes	Service Manager
APOLOGIES:	Barry Mellor	Non-Executive Director
	Samantha Harrison	Director of Corporate Affairs & Trust Secretary
VISITORS:	John Morrissey	Lead Governor, Public Governor, Amber Valley South
	Gillian Hough	Public Governor, Derby City East
	Linda Langley	Public Governor Chesterfield North
	Kevin Richards	Public Governor South Derbyshire
	Melissa Castledine	Derbyshire Mental Health Alliance
	Danielle Sweeney	Observer from Deloitte

DHCFT 2017/037	**ACTING CHAIR'S WELCOME, OPENING REMARKS AND APOLOGIES** Caroline Maley opened the meeting and welcomed everyone. Apologies were noted from Barry Mellor and Samantha Harrison.
DHCFT 2017/038	**SERVICE RECEIVER STORY** Bev Green introduced Michael who had entered the Trust's services through the Radbourne Unit and was then cared for by the recovery team in Cherry Tree Close. Bryan Plimmer, occupational therapist from Cherry Tree Close and Alex Kerry and

	Hannah Lister who are occupational therapy students and Carol Fordham, an occupational therapy assistant also attended the meeting as they had all been involved in Michael's recovery. Michael told the Board how he had gradually progressed over the period of one year from feeling very low when admitted to the Radbourne Unit to his current position of normality. Michael described how he had been happy at the Radbourne Unit as all his meals were provided for him but when his condition improved and he moved to Cherry Tree Close he found it difficult caring for himself, preparing his own meals and socialising with people. He also found it difficult when periods of overnight leave in his own home commenced as he felt this stage had progressed at too fast a pace for him. Despite this Michael improved and settled into periods of home leave which made him realise he could do more things for himself at home and in the community. He started to take part in voluntary charity work and participating in the photography projects run by the Occupational Therapy team. Taking part in these activities encouraged him to re-engage his interest in cricket and he now feels more confident talking to people and socialising. When asked by Carolyn Green if there were any improvements that could have been made to the service he received, Michael said that the support he received at Cherry Tree Close was good. If he had gone straight home from the Radbourne Unit he would have felt isolated and this would have caused him to have very dark days. Michael thought that the preparation for progressing to overnight leave needs improving. Patients should be told what to expect so they can be prepared for this being quite difficult to undertake and be allowed to progress at their own pace. He also thought that people need to be made aware that they will have to cater for themselves in Cherry Tree Close and be given more support to look after themselves. Michael told the Board that being at Cherry Tree Close enabled him to recover at his own pace and get to the position he is in now. He felt he could not have done this without the support that the Trust gave him and was thankful to the staff who encouraged him to give different things a try. He believes it is important that staff get to know the people in their care and understand their interests as this will help patients engage in activities. . From the perspective of the OT team at Cherry Tree Close, Michael worked very hard. Once he knew he could do things for himself he engaged in activities and social events and it was his determination that helped him recover. Activities such as the photography group helped Michael and other service receivers suffering mental health problems to communicate easier because they had something in common. The Board congratulated Michael on his recovery and thanked him for raising the need for patients' interests and passions to be discovered and to agree recovery plans and the pace of leave periods. The Board also thanked the OT team for the support they gave to Michael and the other service receivers at Cherry Tree Close. **RESOLVED: The Board of Directors noted the effort made by the Occupational Therapy Team and the need to meet the expectations of service users at Cherry Tree Close.**
DHCFT 2017/039	**<u>DECLARATIONS OF INTEREST</u>** The Declaration of Interests register was noted.
DHCFT 2017/040	**<u>MINUTES OF THE MEETING DATED 1 FEBRUARY 2017</u>** The minutes of the previous meeting, held on 1 February were agreed and accepted subject to item DHCFT 2017/030 on Suicide Prevention Briefing being amended to show that over 50% of all clinical staff have now been trained in the nationally validated suicide

	awareness training and that further response training is being planned.
DHCFT 2017/041	**MATTERS ARISING AND ACTIONS MATRIX** Ifti Majid gave an overview of the current situation regarding last month's service receiver story and confirmed that a wheelchair had now been provided for this individual. The Board recognised that improved communication with carers and the client would have resulted in a better outcome and that joint working with Derbyshire Community Health Services (DCHS) had established the next steps and learning from this particular case. The Board agreed to close all completed actions. Updates were provided by members of the Board and were noted on the actions matrix.
DHCFT 2017/042	**ACTING CHAIR'S VERBAL REPORT** Caroline Maley reported that during the last month she and other Board members had met with Southern Derbyshire Clinical Commissioning Group (SDCCG) in a 'Board to Board' meeting on 25 February when a positive exchange of views took place. A further meeting with SDCCG will be arranged so that discussions can continue. She also met with the chair of the Derby Teaching Hospitals NHS FT and with Helen Phillips from Chesterfield Royal Hospital and was pleased to hear that they have a positive opinion of our Trust. The new governor induction event took place in February and Caroline Maley was happy to see re-elected governors attending induction again. She also met with Lead Governor, John Morrissey and Gillian Hough the Chair of the governors' Governance Committee and she also attended the Governance Committee. Caroline Maley is planning to meet Dean Fathers from Nottinghamshire Healthcare next week and is looking forward to meeting a number of chairs from other trusts at meetings in London during March. **Voice of the service user community/third sector:** This discussion took place for the first time by the Board. Caroline Maley explained that she and Mark Powell had attended a public meeting at St Mary's House on 14 February when she and Mark had heard the concerns of people working in the voluntary group of services and third sector and she thought it would be good for the Board to consider how to work more closely with voluntary groups in their work; how to leverage their input and support in working for parity of esteem; and how they could support the Trust in conversations with the CCGs and discuss how to take this forward. The Board acknowledged that carer and service receiver groups have representatives that regularly attend the Quality Committee and that Derbyshire Mental Health Alliance work with people on the wards. These reciprocal relationships help the Trust to champion their voice and they do ours. Julia Tabreham asked if the Trust had a strategy for working with both the voluntary and community sector, especially as both these sectors are very different to each other. The Board discussed how these different areas require a different approach and agreed that a theme would be constructed to support both sectors that could also influence progress within our own organisation. The voice of the voluntary and community sector can be maintained through our Equality Delivery System2 (EDS2) work which will enable the Trust Strategy to connect with future service users. The Board agreed that this was a useful discussion and decided that the Executive Leadership Team (ELT) will discuss and propose the way forward for our partnerships within the voluntary sector and produce a report for the Board. It is clear that these groups welcome the Trust's involvement and Board members were urged to take part in further voluntary service meetings.

	ACTION: ELT to consider the Trust's partnership strategy with the voluntary sector prior to a report being submitted to the Trust Board. **RESOLVED: The Board of Directors noted the Acting Chair's verbal report and agreed that ELT will propose the way forward for partnerships within the voluntary sector.**
DHCFT 2017/043	**ACTING CHIEF EXECUTIVE'S REPORT** Ifti Majid, Acting Chief Executive, provided the Board of Directors with feedback on changes within the national health and social care sector as well as providing an update on developments occurring within our local Derbyshire health and social care community. The report also updated the Board on feedback from external stakeholders such as our commissioners and feedback from the Trust's staff. Ifti Majid gave an overview of the key points contained in his report. He drew attention to the Policing and Crime Bill that has since become an Act of Parliament and the Board was pleased to note that this would be considered this month at the Trust's Mental Health Act Committee. Julia Tabreham felt this was a positive direction of travel and asked how confident the Board could be that the Trust's services are ready for this act. Ifti Majid responded that evolution is taking place to ensure the right model is in place. The Trust is working closely with the police and ambulance services and the Mental Health Act Committee will escalate any concerns it might have to the Board. Ifti Majid referred to the letter he had received from NHS England (NHSE) with respect to the operational planning and contracting round 2017/19 and confirmed that the Trust had replied to NHSE stating we are not certain that we will meet the five year forward view for mental health commitments. Ifti Majid believes that the details set out in the letter from NHSE are a real indication of their commitment to ensure that the five year forward view for people with mental health problems is transparently supported. It also provides real leverage to local providers to ensure CCGs are held accountable to local people for their commissioning decisions relating to mental health funding and services. Thanks were given to the South and City Early Interventions Team at St Andrew's House for their hospitality when Ifti Majid and Mark Powell met them recently. Ifti Majid was impressed with their willingness to adopt a solution focused approach to their service and was struck by their strategies for clear two-way communication processes so that Board messages and approaches arrive at team level and helps them to make decisions locally. Ifti Majid made the Board aware of a league table that had just been issued by NHSE containing benchmarking of mental health STPs (Sustainability Transformation Plan). The Trust is ranked twelfth in the UK in terms of delivery of mental health 'must do' indicators and parity and he considered this to be a very positive result. **RESOLVED: The Board of Directors noted the Acting Chief Executive's update.**
DHCFT 2017/044	**INTEGRATED PERFORMANCE AND ACTIVITY REPORT (IPR)** Mark Powell, Acting Chief Operating Officer, opened discussions on the integrated overview of performance in workforce, finance, operational delivery and quality performance as at the end of January 2017. The Trust continued to perform well against many of its key indicators during January. The key theme continues to be one of ongoing staffing and activity pressure in many of the Trust's services. This is highlighted by the difficulty in achieving 100% Registered Nurse fill rates for day and night shifts on our inpatient wards. Although mitigated by extra nursing assistant cover this continues to be a concern which is being monitored continuously and he assured the Board that recruitment plans are being put in place to

resolve these issues.

Carolyn Green reported that quality performance focus has continued to address the issues arising from the Trust's recent Care Quality Commission (CQC) inspection report. There continues to be extensive activity across all service lines to focus on environmental, clinical, policy and organisational governance priorities and she was pleased to report that a number of the Trust's committees received assurance with regard to the CQC action plans. She also highlighted the need to improve rates in complaints responsiveness and she expects to see this improve now that increased review and performance monitoring is taking place.

Claire Wright reported a broadly similar financial situation to the previous month with the key risk being agency spend against the NHSI ceiling. The BAF (Board Assurance Framework) for next year will include cost risks associated with agency spend along with our potential inability to mitigate this risk. She emphasised that this is because decisions made on agency spend will always prioritise the interests of patient safety and always override the NHSI ceiling. Claire Wright made the Board aware of extra regulatory pressure the Trust will be under. She expects the Trust will have to absorb emerging costs associated with recruitment and she stressed the need for the Board to be mindful of further potential financial risks.

Amanda Rawlings reported that staff attendance remains a significant challenge to the Trust. Annual sickness absence rates are beginning to stabilise following a two year period of increase. Issues associated with workforce supply, along with recent actions taken to reduce agency usage were all reviewed at the February meeting of the People and Culture Committee.

Amanda Rawlings was pleased to report that the Trust's vacancy rate has reduced slightly since last month due to increased recruitment. There is an ongoing focus on clinical vacancies which is supported by a detailed action plan which was also presented at the People and Culture Committee. This action plan focusses on how to attract people to the Trust and includes campaigns across the UK, incentive schemes and introducing overseas recruitment for hard to fill posts. The recruitment process continues to improve especially now that a new e-Recruitment system (TRAC) is in place which will enable managers and candidates to utilise a streamlined, interactive and responsive process, which will reduce or eliminate paperwork and unnecessary delays.

Amanda Rawlings expressed concern about the effects of competition from other organisations that pay better rates to their staff. Caroline Maley asked if there was any indication of new supply into the market. In response Amanda Rawlings said education commissioning reductions in nursing opportunities and bursaries might have an effect but the uncertainties that BREXIT might have with workforce supply from outside of this country was also seen as a concern and she emphasised that good quality staff engagement and wellbeing of staff will be key to attracting new staff and improving staff retention.

The Board was made aware of changes that will be made with regard to the way self-employed people work within the NHS and the introduction of new taxation rates that could incur further workforce costs due to people negotiating their rates.

Mark Powell referred to the robust plans that are in place to improve recruitment and the work taking place within the People & Culture Committee to address immediate issues. He assured the Board that everything is being done to resolve staffing issues, not just in the short term but in 3 – 5 years into the future.

The Board acknowledged that the content of this report showed that a significant amount of work had been addressed through the work of the Board Committees and took assurance that these key issues are discussed particularly within the People & Culture Committee. It was agreed that a further understanding of improvements that are

	expected to be made with regard to the level of performance will form a regular part of the IPR from April onwards. **ACTION: A further understanding of improvements that are expected to be made with regard to the level of performance will form a regular part of the IPR from April onwards** **RESOLVED: The Board of Directors considered the Integrated Performance Report and obtained a good level of assurance on current performance across the areas presented.**
DHCFT 2017/045	**<u>QUALITY POSITION STATEMENT</u>** Carolyn Green provided the Board of Directors with an update on the organisation's continuing work to improve the quality of services that are provided in line with the Trust Strategy, Quality Strategy and Framework and strategic objectives. Carolyn Green informed the Board that the CQC had re-inspected secure and older adults services and was pleased to report that she had received an informal notification that the ratings of these services had improved. Carolyn Green drew attention to the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) Safety Scorecard that had been developed in response to a request from the Healthcare Quality Improvement Partnership (HQIP) for benchmarking data to support quality improvement and assured the Board that quality improvement scoring would be followed up through the Quality Committee. Julia Tabreham as Chair of the Quality Committee mentioned the need for the Quality Leadership Teams to be supported so they can improve their specific clinical reference groups. She was pleased to see that mentoring and coaching has been offered to these specific groups which will result in them being supported so they can flourish. Claire Wright referred to the sudden unexplained deaths (SUD) data incorporated in the NCISH Safety Scorecard and wanted to make sure that when scrutiny of SUD takes place that the safety aspect is reinforced. John Sykes explained that this is a very explicit term used for an unexplained death and commissioners have confirmed that these incidences are very rare. He assured the Board of the strength of the scrutiny, practice and learning that takes place within the Serious Incident and Mortality Group which is closely monitored by the Quality Committee. **RESOLVED: The Board of Directors** **1. Received and noted the Quality Position Statement** **2. Gained assurance and information on the content of the Quality Position Statement.**
DHCFT 2017/046	**<u>BOARD ASSURANCE SUMMARIES & ESCALATIONS</u>** Assurance summaries were received from the Quality Committee held on 9 February and the People & Culture Committee held on 21 February. **Quality Committee:** Julia Tabreham reported that the Committee is functioning well but is due to lose the valuable experience of its previous Chair and Non-Executive Director member Maura Teager. Her level of clinical challenge will be missed and she wanted to thank Maura for the huge contribution she has made to the work of the Committee over recent years. The Committee was assured by the Emergency Preparedness Resilience and Response (EPRR) work on disaster recovery and congratulations were made to the team for this piece of work.

	The Committee escalated the following two items to the Board, both of which were noted: • Community Health Teams - risk to delivery, emerging potential patient safety issues and significant pressure on staff in the community health teams. • CQC Actions - significant risk to delivery and lack of assurance in CQC actions outside of the Trust's control in commissioning intentions. Concerns regarding the pipeline for financial investment have been relayed to commissioners and that it is not known what effect this will have on our CQC rating. **People & Culture Committee:** Margaret Gildea felt that all issues raised from the February meeting of the Committee had been very well aired by the Board at today's meeting. The Workforce Plan will be received by the Board in April and will enable discussion to take place on future supply and funding. Since the Board decided that only the assurance summaries are to be received at each meeting Caroline Maley made the point that that the summaries should state that minutes of these meetings will be available upon request. **ACTION: Assurance summaries are to include the declaration that minutes of these meetings are available upon request.** **ACTION: Workforce Plan to be submitted to the April Board meeting.** **RESOLVED: The Board of Directors received the Board Committee Assurance Summaries and Escalations.**
DHCFT 2017/047	**<u>DEEP DIVE - NEIGHBOURHOODS</u>** Claire Biernacki and Julia Lowes from the neighbourhood team joined the meeting and provided the Board with an in depth review of the growing pressures faced by the community teams. This report set out some of the risk mitigations and end results which Claire Biernacki highlighted to the Board. She emphasised that the neighbourhood team has a strong awareness of how difficult things are and the pressure they are under. GPs are also under so much pressure they are referring anyone they believe has a mental health problem and Claire Biernacki explained how she was trying to create capacity working with primary care so people can be managed before they get to the threshold of our services. She stressed that commissioners are aware of the gap in resource to deliver appropriate levels of care co-ordination but there is no additional resource to close that gap. In 2015/16 commissioners funded a quarter of the deficit identified at that time, however the rise in rates of referral and other pressures meant that this additional resource had limited impact. The impact of pressure on the neighbourhoods impacts other services such as IAPT, CAMHS, Crisis etc. as to how they can get people flowing into our services. All these services are feeling the impact. Discussion centred on how long people are waiting to be seen. It would appear that this varied and depended on whether beds were available and in some cases there is a 3 – 5 month wait. The team is very aware of people's needs and where they are being referred from and will prioritise people on the waiting list. Amanda Rawlings asked whether people who wait 3 – 5 months deteriorate and what effect this had on carers and families and the cost to the community. Claire Biernacki explained that there are levels within the waiting lists and there is also a 'waiting well' policy which works capably but is under significant stress. The significant number of caseloads that the team has to manage was discussed. Large caseloads impact on clinical capacity to provide effective, efficient and good quality

	treatment, they also impact on the stress levels of workers and this is reflected in sickness levels, staff survey feedback and staff turnover rates. Carolyn Green proposed to work with the neighbourhood team to develop an improvement plan that will result in reducing caseloads. Mark Powell wished to assure the Board that a planning process to reduce this risk mitigation is already in place through the Contract Management Board and the Trust's Management Team (TMT). The Board committed to support the neighbourhood team to mitigate this risk and reduce bureaucracy and decided on the following actions: **1) Detailed mitigation plan to be prepared to show there are assurance mechanisms in place defined through TMT to ELT to Quality Committee and then the Board.** **2) Assurance model to be put in place around CPA, waiting lists and "waiting well" procedure which will be monitored through Quality Committee, TMT and ELT** **3) Contract team to continue to lobby commissioners for more resources for community workers linked with the STP. This will be reported through the Finance & Performance Committee** **4) Ifti Majid will write to Andy Gregory acknowledging the level of risk on the community teams and the need for improved commissioning** **5) Ifti Majid will write from the Board to the neighbourhood teams attaching the deep dive report** Carolyn Green informed the Board that the Safeguarding Committee met last week and 'red rated' the risk of the allocation of care co-coordinators to safeguard children from harm. This is a residual action that has not yet been resolved and she asked that Andy Gregory responds to this risk when he replies to Ifti Majid's letter. This was a very comprehensive report that showed the daily decisions that the teams have to take. The Board recognised the level of risk the neighbourhood team is carrying. Their work is very much valued and the Board applauded the inventive way in which the team resolves issues. **RESOLVED: The Board of Directors:** **1) Considered the content of this paper** **2) Agreed to formally address the level of risk on the community teams and the need for improved commissioning community with commissioners**
DHCFT 2017/048	**<u>GOVERNANCE IMPROVEMENT ACTION PLAN (GIAP)</u>** As described in the GIAP Governance and Delivery framework, the Board has overall responsibility for ensuring that the GIAP is delivered. In the absence of Sam Harrison, Mark Powell presented this report to provide Board members with an update on progress on the delivery of the GIAP, including the identification of tasks and recommendations that are off track. The Board noted the progress made against each recommendation and as well as issues that were raised through the Board Committee Assurance Summaries. The Board was pleased to note that there were no recommendations rated as red "off track". The recommendations that have some issues and were amber rated were reviewed and noted as follows: • **Core 3 - Clinical Governance - ClinG1 *(Refresh the role of Quality Leadership Teams to increase their effectiveness as core quality governance forums)*:**

There is still some progress to be made with this recommendation and it is hoped this can be completed before the May deadline.

- **Core 6 - Roles 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)*****:** this recommendation remains as having some issues pending assurance from Remuneration and Appointments Committee

The Board scrutinised the blue forms and the following comments were noted:

- **PC3** ***(Supplement the current mechanisms to engage with staff through the inclusion of more informal activities across both clinical and corporate areas. Develop clearer reporting of information and trends from these activities in order to triangulate with other information, for example, through the CEO report and Quality Position Statement)*****:** The Board felt satisfied with the evidence provided by the People & Culture Committee that the Board and senior management are engaging with staff and passed this recommendation.

- **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)*****:** The Revised People Plan captures actions and priorities for 2017 and was submitted to the January 2017 People & Culture Committee meeting and approved. The Board was assured that the People Plan is now embedded in the organisation and forms the basis of the agenda for the People & Culture Committee and passed this recommendation.

- **GClinG3** ***(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)*****:** The Quality Committee is now much more focussed on strategic priorities and the CQC. The Committee's forward work plan has been developed to cover all areas of the Quality Committee terms of reference and the agenda has been structured according to CQC domains and covers topics to support the delivery of the quality strategy and is cross referenced against quality priorities. The Board passed this recommendation.

- **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):*** The employment relations paper, submitted to the January People and Culture Committee provided sufficient evidence of completion of actions and provided the Board with assurance that this action could be signed off.

- **WOD1 (CQC1** ***the Trust must ensure HR policies and procedures are followed and monitored for all staff)*****:** The People & Culture Committee obtained evidence that training and adherence to procedures had taken place and passed CQC1. This resulted in the Board being assured that this action could be signed off.

- **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)*****:** The People & Culture Committee felt satisfied that all HR policies are up to date. A training programme has been rolled out and policies are being complied with. The Board passed this recommendation.

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

***concluded)*:** The People & Culture Committee was satisfied that systems are in place that focus on governance and was assured that people now understand the Whistleblowing Process. The Board passed this recommendation.

- **WOD8 *(The Trust should continue to make improvements in staff engagement and communication)*:** The Staff Engagement Group has driven the progress of this action and People & Culture Committee was satisfied that the right mechanisms are now in place. The Board passed this recommendation.

- **CQC2 *(The Trust should continue to proactively recruit staff to fill operational vacancies)*:** The Board heard that a lot of debate took place during the February meeting of the People & Culture Committee and it was agreed that this recommendation could be passed as sufficient progress had been made. The Board passed this recommendation.

- **PC2 *(Develop and undertake a clear programme of work around culture, utilising the expertise of other NHS Trusts in the Local Health Economy, and where necessary beyond, to inform the programme of activities)*:** Mark Powell informed the Board that the People & Culture Committee did not feel sufficiently assured to pass this recommendation and asked that a clear programme of work be evidenced to enable a blue form to be submitted to the next Board meeting. The Board looked forward to receiving the assurance that this action can be closed at the next meeting on 29 March.

Amanda Rawlings wished it to be recorded that six Board members attended the February meeting of the People & Culture Committee and scrutinised the GIAP recommendations the Committee has oversight for.

The report provided the Board with assurance of the delivery and risk mitigation from Board Committees and Lead Directors. Having reviewed the detail contained in the blue forms the Board felt satisfied that that strict scrutiny of all the GIAP recommendations had taken place and sufficient evidence had been provided to show that actions had been completed and that the above recommendations could now be closed and archived. The Board was also pleased to hear that a Communications programme is being developed to ensure staff are aware of the completion of the GIAP recommendations.

The pipeline of GIAP recommendations was noted and the Board acknowledged that this would be adjusted to take into account the scheduling of the Extraordinary Board Meeting that will take place in private session on 29 March.

RESOLVED: The Board of Directors:

1) Noted the progress made against addressing GIAP recommendations
2) Discussed and noted the areas rated as 'some issues'
3) Formally approved the 10 blue forms as presented and confirmed they provided assurance of completion, namely:

- **PC3**
- **PC4**
- **PC5**
- **ClinG3**
- **WOD1**
- **WOD3**
- **WOD4**
- **WOD7**
- **WOD8**
- **CQC2**

4) Noted the GIAP recommendations approval pipeline and its role in supporting effective oversight of progress
5) Agreed that no further changes are required to the GIAP following presentation of papers, outcomes of item specific discussions and/or other

	assurances provided throughout the meeting
DHCFT 2017/049	**2016/17 BOARD FORWARD PLAN** The forward plan was reviewed and will be carried forward to next year. Carolyn Green asked that the Equality Delivery System2 (EDS2) be captured in the forward plan and was assured that this was scheduled for April in the 2017/18 forward plan that will be received at the April Board meeting. **RESOLVED: The Board of Directors noted the forward plan for 2016/17.**
DHCFT 2017/050	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK OR GIAP** Level of risk on the community teams and the need for improved commissioning within community services is to be included in the BAF deep dive schedule of risks.
DHCFT 2017/051	**MEETING EFFECTIVENESS** The Board agreed there have been some good discussions on the Trust's key issues and enough time was devoted to discussions. Mark Powell was pleased that the Community Team was able to discuss the risk associated with the neighbourhoods. The level of detail contained in the report gave a good opportunity for discussion and it is clear that the team benefitted from putting the paper together. Significant progress has been made with the GIAP and this was seen through the engagement of the Board Committees in this process. Discussion on the IPR took place regarding further evolution to further enhance the triangulation. However the Board fully recognised the successful progression in integrated reporting. Today's meeting was observed by Danielle Sweeney from Deloitte who commented that the meeting was well planned; the agenda was very transparent. It was good to hear the service receiver story and she was pleased to see an effective deep dive take place in public session. There was strong governor attendance and she made positive comments with regard to Board member challenges and she observed clarity in the actions agreed and decisions made.

The next meeting of the Board held in Public Session will take place at 1pm on Wednesday, 26 April 2017.

The location will be Training Rooms 1 and 2
Research and Development Centre, Kingsway, Derby DE22 3LZ

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Wednesday 26 April 2017

MEETING HELD IN PUBLIC

Commenced: 1pm Closed: 4:45pm

PRESENT:	Caroline Maley	Acting Trust Chair
	Margaret Gildea	Senior Independent Director
	Barry Mellor	Non-Executive Director
	Dr Anne Wright	Non-Executive Director
	Richard Wright	Non-Executive Director
	Ifti Majid	Acting Chief Executive
	Claire Wright	Executive Director of Finance and Deputy Chief Executive
	Carolyn Green	Executive Director of Nursing & Patient Experience
	Dr John Sykes	Executive Medical Director
	Samantha Harrison	Director of Corporate Affairs & Trust Secretary
	Mark Powell	Acting Chief Operating Officer
	Amanda Rawlings	Director of People & Organisational Effectiveness
	Lynn Wilmott-Shepherd	Interim Director of Strategic Development
IN ATTENDANCE:	Anna Shaw	Deputy Director of Communications & Involvement
	Sue Turner	Board Secretary (Minutes)
For item DHCFT 2017/053	Jill	Service Receiver Carer
For item DHCFT 2017/053	Jenny	Service Receiver Carer
For item DHCFT 2017/053	Julie Cooper	Senior Nurse, Radbourne Unit
For item DHCFT 2017/057	Dr Beth Masterson	Junior Doctor
For item DHCFT 2017/063	Acute Inpatients Team	
APOLOGIES:	Dr Julia Tabreham	Deputy Trust Chair and Non-Executive Director
VISITORS:	John Morrissey	Lead Governor, Public Governor, Amber Valley South
	Gillian Hough	Public Governor, Derby City East
	Shelley Comery	Public Governor, Erewash North
	Kevin Richards	Public Governor, South Derbyshire
	Carole Riley	Public Governor, Derby City East
	Melissa Castledine	Derbyshire Mental Health Alliance
	Mark McKeown	Derbyshire Mental Health Alliance

DHCFT 2017/052	**ACTING CHAIR'S WELCOME, OPENING REMARKS AND APOLOGIES** Acting Trust Chair, Caroline Maley, opened the meeting and welcomed everyone. Apologies were noted from Julia Tabreham who was attending the NHSI Networking Event on Caroline Maley's behalf. Questions received from Julia Tabreham relating to the reports supporting today's agenda items would be addressed as the meeting progressed.
DHCFT	**SERVICE RECEIVER STORY**

2017/053	Nicola Fletcher introduced Jill, her daughter Jenny and Julie Cooper, Senior Nurse from the Radbourne Unit. Jill told a very moving story as the mother of a son who had experienced drugs and homelessness. She described the difficulties she and her family had experienced in locating her son and in getting help for him when he became very ill. Jill's son was eventually sectioned and admitted to the Radbourne Unit on Ward 36 which was a very distressing time for her and the family. Jill spoke very positively about the way Julie Cooper and the team worked together showing them kindness and compassion and treating them with the utmost respect. Jill and her daughter were invited to go to a carers meeting run by the ward where they were given help and reassurance from people going through the same sort of problems with their own loved ones. They found it helpful having other people to talk to and it gave them hope. Jill finished her story by telling the Board that her son has continued to improve at Audrey House and she is continuing to be involved in helping him with his journey to recovery. Carolyn Green thanked Jill for sharing her story. She explained that the Trust was aware of the impact that caring has on parent and family carers and she was pleased that support from the carers group had helped. She assured Jill that the Board would work to make people aware of the carers group and the Trust would work with other agencies to make these support services more available. Carolyn Green explained that the Trust also recognised the need to involve the family in a patient's care and patients are encouraged to have the family involved. Work is also taking place with community groups to help people understand what happens when you have to stay in hospital. The Board thanked Jill and Jenny for bringing to life their experience which emphasised the importance of carer involvement and support which had enabled thought to be given to improving the information that is made available to carers and to publicise the work of the carers group that was of great value in this case. **RESOLVED: The Board of Directors expressed thanks to Jill for sharing her experience and appreciated the opportunity to hear at first hand the service the Trust had provided.**
DHCFT 2017/054	**MINUTES OF THE MEETING DATED 1 MARCH 2017** The minutes of the previous meeting, held on 1 March were agreed and accepted.
DHCFT 2017/055	**MATTERS ARISING AND ACTIONS MATRIX** The Board agreed to close all completed actions. Updates were provided by members of the Board and were noted on the actions matrix.
DHCFT 2017/056	**QUESTIONS FROM A PUBLIC GOVERNOR** A question relating to the merger/acquisition with DCHS had been received from the public governor for Derbyshire Dales, Ruth Greaves asking if the Trust had an alternative plan to the merger by acquisition proposals. Ifti Majid responded that the Strategic Options Case (SOC) presented to governors in October set out the reasons behind improving clinical outcomes for residents of Derbyshire and clarified that if integration with DCHS proves unsustainable, the Trust is not under pressure to merge with any organisation and would continue as at present. The Trust already works in partnership with other organisations in Derbyshire for specialised services and if necessary will extend these partnerships to other organisations further. **RESOLVED: The Board of Directors noted and responded to questions raised by the public governor for Derbyshire Dales.**

DHCFT 2017/057	**ACTING CHAIR'S VERBAL REPORT** Caroline Maley reported that during the last month she had attended meetings with other chairs of organisations and providers and with Clinical Commissioning Groups and she had also met with the Chair of Nottinghamshire Healthcare. The Joint Integration Programme Committee (JIPC) met on 8 March. This project is gathering momentum as the Trust and DCHS works towards consideration of the Outline Business Case OBC at the end of July. A significant amount of work has been carried out with the Council of Governors. Additional meetings have now been established to focus on issues related to the proposed process of the acquisition. The Governance Committee continues to deliver good work and the Governors Nominations & Remuneration Committee met last week and received the annual report of the Committee as well as the appraisal for Maura Teager, Non-Executive Director on her departure from the Trust. Regular meetings have also taken place with the Lead Governor as well as other governors. National meetings have also taken place which enabled Caroline Maley to understand the progress being made in the system of mental health. This was particularly evident during a meeting that focused on the effects that BREXIT will have on the mobility of staff. During March Caroline Maley and the Non-Executive Directors attended an excellent training session facilitated by the Trust's Mental Health Act Office that covered the Mental Health Act and the Mental Capacity Act. She also attended a meeting with hospital managers which gave her a good understanding of their work. Caroline Maley also attended an excellent Board development session on equality, diversity and inclusion. Caroline Maley also attended the NHS induction for chairs and chief executives which gave her an opportunity to talk about the challenges other trusts are facing around the recruitment of medical staff. Internal meetings involved carrying out Ifti Majid's appraisal which resulted in them having a very good discussion. Caroline Maley also worked with John Sykes to recruit consultants and she also attended the TMAC (Trust Medical Advice Committee) meeting. Reference was made to the Deloitte review of well led outcomes. The final report received from Deloitte LLP reflected significant progress in all areas within the Trust's scope. The Trust now meets the NHSI (NHS Improvement) benchmark associated with organisations rated as amber-green which places the Trust alongside other well performing trusts. The Trust will continue to keep on improving and thanks were made to all staff involved in this process. **RESOLVED: The Board of Directors noted the Acting Chair's verbal report.**
DHCFT 2017/057	**ACTING CHIEF EXECUTIVE'S REPORT** The Acting Chief Executive's report provided the Board of Directors with feedback and an update on developments occurring within the local Derbyshire health and social care community. Ifti Majid gave an overview of the key points contained in his report. He drew particular attention to the work that has taken place to enter into a jointly delivered People and Organisational Effectiveness function with DCHS. It is expected that the number of other HR organisations involved in this joint venture may grow over time and will evolve into a single HR function supporting a number of organisations. Amanda Rawlings explained that as part of the management of change process staff provided input into this structure and that this has enabled a full business case to be developed into the governance

	process. This business case was received by the Finance & Performance Committee and was referred to the Board as it is an important case for the future that will support staff as well as key leaders. This is a fully inclusive process and staff will be supported by trade union colleagues throughout and the process which is expected to be completed towards the end of September. Amanda Rawlings also explained that integrating the teams of both organisations is separate to the integration work between the two Trusts and would have gone ahead regardless of that work. This is the future of the NHS working towards building a strong team for the future in Derbyshire. Amanda Rawlings told how HR team welcomed this opportunity. Margaret Gildea added that the Board can take assurance from this business case because it supports the HR function and will provide a larger and common talent pool that all stakeholders can benefit from. Caroline Maley thanked Amanda Rawlings for her excellent summarisation of the business case. She recognised that governors would be very interested to know that this business case has been scrutinised by the Finance & Performance Committee and the People & Culture Committee. The Trust is following due process in terms of steps for change and this business case will be discussed further at the meeting of the Council of Governors on 2 May. **ROYAL COLLEGE OF PSYCHIATRISTS TRAINEE-LED REVIEW INTO MORALE AND TRAINING WITHIN PSYCHIATRY** The second part of this report included a report from the Royal College of Psychiatrists. Ifti Majid introduced Beth Masterson one of the Trust's CT3 Doctors who gave a presentation on the key points contained in the Royal College of Psychiatrists trainee-led review into morale and training within psychiatry. The Board heard first-hand about the pressure that junior doctors work under and how they feel about the conditions they work in. The presentation set out the problems in recruiting to psychiatric training and Beth Masterson talked about the work of the focus groups that have taken place nationwide to establish what trainee doctors valued most about their work life and training. The presentation also provided an opportunity for the Board to acknowledge the importance of ensuring that the basic needs of trainees are met and for the Trust to become a good employer and educationalist as well as a more attractive employer for all staff. The Board thanked Dr Masterson for making the Board aware of the importance of the Royal College of Psychiatrists report and the issues psychiatric trainees are experiencing and agreed to support all the core recommendations contained in the report. Julia Tabreham's question relating to the Chief Executive's report, raised in her absence, related to how the Trust would measure the impact on estate closure on the people who are less mobile was responded to by Ifti Majid and Claire Wright who undertook to ensure that a written update on estate closure would be addressed within the next Estates Strategy report that will be brought to the Finance & Performance Committee. **RESOLVED: The Board of Directors noted the Acting Chief Executive's update and supported the recommendations contained in the report from the Royal College of Psychiatrists.**
DHCFT 2017/058	**INTEGRATED PERFORMANCE AND ACTIVITY REPORT (IPR)** Mark Powell, Acting Chief Operating Officer, opened discussions on the integrated overview of performance in workforce, finance, operational delivery and quality performance as at the end of March 2017. He drew attention to the challenge in achieving priority metric compliance by the end of the financial year around the collection of patient record data and explained that this is being worked through the Trust

Management Team meetings to see how we can best operate this metric.

The report identified a concern in the waiting time for Early Intervention in Psychosis referral to treatment. Mark Powell explained that a number of vacancies have resulted in a service capacity gap which will result in April and May being quite challenging until staff are recruited into post. This gap means that the 50% referral to treatment target has not been met and is unlikely to be met until June 2017 when new recruits start in post. In the meantime early intervention staff are being used flexibly from across the county to address these issues.

Claire Wright focussed on the outturn position for the financial year. She was pleased to report that the Trust has achieved its control total which was improved by £32k. As a result NHS Improvement (NHSI) have committed to make an incentive payment to organisations who delivered their 2016/17 control totals. This has resulted in a £906k payment that will be added to our control total during this financial year which will be used to benefit our patients.

Barry Mellor asked what assurance can be provided that the CIP (cost improvement plans) for this year will be a better plan to deliver. Mark Powell acknowledged that there is still a gap in the plan. A number of plans have been identified and internal discussions are taking place to invigorate a robust programme delivery approach that will be followed up along with any increasing risks associated with our CIP position through the Finance & Performance Committee.

Carolyn Green drew attention to bed occupancy and reported that the Trust was currently operating above the national target set by the Royal College of Practitioners. This may result in 12 hour A&E breaches and will affect people getting access to beds and work is taking place to mitigate this risk. Anne Wright asked whether the increase in bed occupancy levels was due to increasing demands or length of stay. Carolyn Green explained that length of stay has returned to average and has reduced compared to when the Trust was an outlier. The increase in bed occupancy is due to an increase in demand in the community. She assured the Board that staff make sure that patients are discharged appropriately and not too early.

Carolyn Green also referred to levels of restraint and seclusion and reported that for the first time there appears to be more restraint being applied to women and older adults, both men and women. She assured the Board that the Quality Committee is receiving a detailed breakdown of all cases in order to monitor these levels.

Amanda Rawlings was pleased to report that a slight improvement has been made in recruitment levels and in the uptake of staff appraisals. Results received for the first of the quarterly staff pulse checks has shown an improvement in participation. She felt encouraged by this trend and has shared these results with the Engagement Forum and the Executive Leadership Team (ELT).

Julia Tabreham's question, raised in her absence, related to the worrying upward trend for complaints within the Trust. She asked when the new complaints investigators were due to start work, what is the most worrying aspect of performance and how will their workload be prioritised? When can the Board expect to see an improvement in the position? Carolyn Green responded that these newly created posts will enable the team to improve the flow of mitigations and an improved performance is expected to be seen by September.

Ifti Majid referred to the ward staffing levels section of the report and asked how this information was being used to help fill rates and bed occupancy rates. Mark Powell responded that this information is used to understand fill rates and staff requirements for the coming weeks. This information was also seen as an indicator of potential safety issues and did not show the detail about the individuals working on shifts. This will be looked at further along with bed occupancy and length of stay to see if there is a link and will be captured as an enhanced narrative in the next month's report.

	ACTION: Specific areas will be investigated where bed occupancy is high to establish any links and incorporated into an enhanced narrative in the next report. **RESOLVED: The Board of Directors considered the Integrated Performance Report and obtained a good level of assurance on current performance across the areas presented.**
DHCFT 2017/059	**<u>QUALITY POSITION STATEMENT</u>** Carolyn Green provided the Board of Directors with an update on the organisation's continuing work to improve the quality of services that are provided in line with the Trust Strategy, Quality Strategy and Framework and strategic objectives. Julia Tabreham's question, raised in her absence, referred to the retrospective case record reviews following the deaths of those with severe mental illness and learning disability and asked if the Trust has modelled the impact this will have on its resources and are there plans in place to achieve what is required? John Sykes advised that the report summarised the process involved and explained that although it is not necessary to review every death in detail the Trust is required to identify and scrutinise any deaths that are connected to our services. This work will be quite intensive because some of the review systems have not yet been developed. Work is taking place to quantify the impact on staff capacity for this work and work plan is being developed. In response to Anne Wright challenging the capacity issues, John Sykes explained that a mortality technician will carry out some of this work and that reviewing individual caseloads will be substantial piece of work over and above the normal SIRI (serious investigation) work. He assured the Board that the Quality Committee has oversight of the investigation work and any issues will be escalated to the Board. John Sykes also talked about safety planning and how the Trust was now using a bespoke safety planning approach developed by our own clinicians. Training has taken place in the use of this system and feedback from the training is enabling clinicians to drive this change and this is being monitored through the Quality Committee. Carolyn Green drew attention to the Care Quality Commission Comprehensive Inspection revisit results and was very pleased to report that the Trust's warning notice has been lifted and services have been positively re-graded. **RESOLVED: The Board of Directors:** **1) Received and noted the Quality Position Statement** **2) Gained assurance in quality leadership strategy and engagement as shown in the report**
DHCFT 2017/063	**<u>DEEP DIVE – ACUTE INPATIENTS</u>** The Acute Inpatients team joined the meeting and provided the Board with an insight into some of the key achievements. The Board heard how the reinstatement of Schwartz rounds to support supervision in inpatient areas has been very beneficial especially in gaining peer support. Schwartz rounds will now be introduced in the Radbourne Unit and the Hartington Unit. A successful trip was made to Denmark to look at initiatives to develop a model on the safest way for staff to deal with conflict and aggression. This initiative is being implemented on both units and has been received very positively by both patients and staff and has helped to reduce their stresses and anxiety. A "getting to know you" folder has been introduced on each ward which has helped staff

	get to know their patients and understand what they like such as taste in music, hobbies etc. This also helps with social inclusion on the wards and helps people feel they are listened to. Refurbishment of the de-escalation rooms on the Hartington Unit has also provided a quiet space for patients to spend their time. The implementation of the Broset Violence Checklist pilot on the Enhanced Care Ward has resulted in a reduction in violence on the ward and a reduction in people who have potential for violence and aggression. This is managed through a care plan for each patient and has been very effective. The team also talked about the challenges they face and how they are continually striving to improve both quality outcomes and patients experiences in services. Staffing levels and the reliance on bank and agency staff was a particular concern and the team are focussing on plans for future improvement in staff retention. Compliance with supervision and staff appraisals was one of the elements highlighted by the CQC. The Board heard a personal experience of supervision from one of the team and was pleased to hear how this experience supported their work and how it had also been motivating and invigorating. Resulting from the CQC visit last year the team was challenged to improve their seclusion pathway and rapid tranquilisation and they have now introduced a robust management process to manage seclusion. Work is taking place to improve the standard of reporting on the Mental Capacity Act and this is being monitored through the Mental Health Act Committee. Rapid tranquilisation is being managed more efficiently and patients are being monitored correctly. The Board observed how the team has managed resources effectively and have developed themselves as a joined up service working across both the Radbourne Unit and the Hartington Unit. The Board acknowledged that staff retention is an important part of success and assured the team that Amanda Rawlings and her team are working hard to fill vacancies. **RESOLVED: The Board of Directors considered and noted the presentation made by the Acute Inpatient Team.**
DHCFT 2017/060	**<u>EQUALITY DELIVERY SYSTEM2 (EDS2)</u>** This report, presented by Amanda Rawlings provided the Board with an update against the goals of the EDS2, including actions to date, equality objectives and associated work streams. The document also set out the next steps in terms of governance and assurance to deliver the Trust's EDS2 performance grading for 2017/18, including Board Assurance Framework 3d. The report also included in Appendix 1 an update against the equality objectives, including EDS2 actions embedded in the People Plan. A Board Development Session held on 12 April focused on Equality, Diversity and Inclusion which identified specific actions to improve the Trust's equality objectives. The Board acknowledged that EDS2 is part of the Trust's governance process and approved and noted the recommendations for EDS2 2016/17. The Board also noted the steps to progress outcomes of EDS2 Goal 4 Inclusive leadership and the proposal to present to the top six priority actions and SMART implementation plan at the Board meeting in May. **ACTION: Top six priority actions and EDS2 SMART implementation plan to be received at the May 2017 Board meeting** **RESOLVED: The Board of Directors:** **1) Noted progress on equality and more specifically the undertaking of our annual EDS2 16/17 goals 1 & 2 including upward RAG improvement.** **2) Noted and approved EDS2 2016/17 external validation for goals 1 & 2 and**

	actions against the 9 outcomes (Appendix 3) and follow-up action to produce a 'You said, we did' report for publishing on website. **3) EDS2 Goal 4 Inclusive leadership – noted steps to progress outcomes and proposal to present (Draft) Board top six priority actions and SMART implementation plan at the May 2017 Board meeting.** **4) Noted BAF 3d and controls (Equality Impact, data completion rates and engagement) to deliver EDS2 2017/18 implementation plan, including formal Board approval of EDS2 2017/18 plan on the 27 September, 2017 (as per nine step EDS2 process/ methodology).**
DHCFT 2017/061	**BOARD ASSURANCE SUMMARIES & ESCALATIONS** Assurance summaries were received from the Board Committees that took place during February and March 2017. Committee Chairs summarised the escalations that had been raised and these were noted by the Board. **RESOLVED: The Board of Directors received and noted the Board Committee Assurance Summaries and Escalations.**
DHCFT 2017/062	**MEASURING THE TRUST STRATEGY** This report provided the Board with an update on year one of the Trust Strategy 2016/21 and an annual report will be received by the Board in April in the forthcoming years. The Integrated Performance Report is used for on-going monitoring of the strategy and the revised dashboard included in the report sets out the four strategic objectives and trajectory of the strategy over the next five years. Lynn Wilmott-Shepherd was pleased to report that as the Trust has achieved its financial control total the trajectory of the Trust Strategy 2016/21 is on track. A report will be submitted to the Finance & Performance Committee setting out the detail of the partnerships that will enhance service delivery and foster a system wide approach in line with the Sustainability and Transformation Plan. The Board accepted that the report was a useful snapshot of the progress that had been made during the past year and noted that an annual report on the five year Trust Strategy will be received at the April meeting in forthcoming years. **RESOLVED: The Board of Directors:** **1) Noted the achievements to date** **2) Accepted that an annual update will be received at the April Board each year**
DHCFT 2017/064	**BUSINESS PLAN 2017-18** This report provided the Board with a consolidated summary of each division and the corporate directorate's business plan for year two of the five-year Trust Strategy. The Board was satisfied that the report covered the implications for clinical and corporate areas across the Trust and approved the Business Plan 2017/18. The business plan is driven by the Trust Strategy and NHSI and is in line with feedback received from Deloitte LLP and had previously been received by the Executive Leadership Team and it will be measured through the Trust Management Team. Quarterly progress reports on the business plan are to be submitted to the Board and captured in the forward plan. **ACTION: Quarterly update reports on the Business Plan 2017 to be incorporated into the Board forward plan.** **RESOLVED: The Board of Directors:** **1) Approved the business plan for 2017-18** **2) Agreed to receive quarterly updates on progress**

DHCFT 2017/065	**ANNUAL REVIEW OF REGISTER OF INTERESTS** This report provided the Trust Board with an account of directors' interests during 2016/17. The Board reviewed the register of interests and it was noted that Ifti Majid had also declared his wife, Kate Majid's role as Assistant Chief Commissioning Officer, NHS North Derbyshire Clinical Commissioning Group. Lynn Wilmott-Shepherd's substantive role as Director of Commissioning and Delivery for NHS Erewash Clinical Commissioning Group is also to be listed. **RESOLVED: The Board of Directors:** **1) Approved and recorded the declarations of interest as disclosed and noted above. These will be recorded in the Register of Interests which is accessible to the public at the Trust Head Office and will be listed in the Trust's annual report and accounts for 2016/17.** **2) Recorded that all directors have signed to confirm compliance with the NHS Codes of Conduct and Accountability and Nolan principles; no relevant audit matters have been declared.**
DHCFT 2017/065	**ANNUAL REIVEW OF TRUST SEALINGS** This report provided the Trust Board with an account of the authorised use of the Foundation Trust Seal during 2016-17. The Board noted the three entries made to the Register of Trust Sealings for 2016/17 as shown in the report. **RESOLVED: The Board of Directors noted the authorised use of the Foundation Trust Seal during 2016-17.**
DHCFT 2017/066	**GOVERNANCE IMPROVEMENT ACTION PLAN (GIAP)** Sam Harrison presented the Governance Improvement Action Plan (GIAP) report, providing the Board with an update on progress on delivery of the GIAP. She was pleased to report that all recommendations are now complete for Core areas 2, 5, 8, 9 and 10 and asked the Board to formally approve 14 'blue forms' to confirm that the recommendation within each form had been completed. Sam Harrison pointed out that the Board approved several GIAP recommendations at extraordinary Board meeting held in confidential session on 29 March and this report would be made available on the Trust's website. The Board scrutinised the blue forms and the following comments were noted: As the recommendations contained in HR3 and HR4 were aligned these two blue forms were reviewed together: ***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. 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:*** Amanda Rawlings assured the Board that the new shared service structure for the HR/Workforce team is now in place. The Board was satisfied with the detail that supported HR3 and HR4 and approved recommendations HR3 and HR4.

	Recommendations GLING1 and CORPG7 are also aligned and these two recommendations were considered together: ***CLING1 - Refresh the role of Quality Leadership Teams to increase their effectiveness as core quality governance forums. 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:*** The Board received assurance that a very detailed effectiveness review had been carried out by the Quality Committee and approved CLING1 and CORPG7 ***WOD5 - Consider a range of development interventions for the operational HR team to ensure employment law risks are mitigated:*** The Board obtained assurance that a series of training programmes has been undertaken across the HR directorate and the team has also received updates from a variety of legal sources. The Board approved WOD5 on the understanding that the blue form would be updated with narrative to reflect this work. ***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:*** The results of the first monthly pulse checks have been received. Following the challenge that took place at the March meeting of the People & Culture Committee the blue form has been updated to reflect how staff feedback from the HR function can be captured. The Board agreed that this recommendation was now complete. ***M2 - The Governance Improvement Action Plan will be updated to reflect material matters arising from the HR investigation:*** It was acknowledged that this recommendation formed the development of the GIAP and was signed off by the Board in April 2016 and it was agreed that this recommendation was now complete. ***M4 - The Trust will implement programme management and governance arrangements to ensure the delivery of the Governance Action Plan:*** The governance and delivery framework was agreed in April 2016. The Board was satisfied that this has been effectively followed throughout 2016/17 with reporting regularly to oversight Board Committees, the Board, Council of Governors and regulators and approved recommendation M4. ***M5 - The Trust will provide regular reports to Monitor:*** The Board accepted that reports have been provided to NHSI (previously known as Monitor) as part of regular performance review meetings and approved recommendation M5. ***M6 - The Licensee will, by 18 March 2016 or such other date as agreed with Monitor, develop and submit to Monitor a timetable for making permanent appointments to all director roles which are currently vacant and/or filled on an interim basis. It will, by a date to be agreed with Monitor, revise that timetable in response to any comments made on it by Monitor:*** The Remuneration and Appointments Committee agreed the timetable for recruitment of all Board level posts outlined and these were recruited to successfully. The Board agreed closure of this recommendation at its April 2016 meeting and accepted that this recommendation was now complete. ***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.*** This was discussed at the Remuneration and Appointments Committee and it was agreed that this recommendation would be include reference to governors in their role in succession planning for Non-Executive Directors. The Board was satisfied that

	there was a process in place to develop succession planning requirements and approved recommendation RR1. ***RR2 - 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. CQC 3 - The trust should ensure that all Board members and the council of governors undertake a robust development plan:*** The Remuneration & Appointments Committee confirmed receipt of a report outlining the completed development programme for 2016/17 and agreed at the February 2017 meeting that the development of this programme for 2017/18 is to be taken forward as business as usual. The Board was satisfied that recommendation RR2 is now complete. ***RR3 - Complete the full process of 360 feedback for all Board Members and utilise the outcome to set clear objectives in relation to portfolio areas (for Executive Directors) as well as in relation to the role of the corporate director and contribution to the Board:*** The Board was assured that that appraisals for outgoing Non-Executive Director, Maura Teager and outgoing Interim Chairman, Richard Gregory had been presented to governors through the Nominations and Remunerations Committee. The Board was satisfied that work on 360 degree appraisals has been implemented and this has helped progress personal and team development and it was agreed that this recommendation RR3 is now complete. ***RR5 - The Trust should ensure that training passports for directors reflect development required for their corporate roles:*** Mandatory training will be overseen by the Executive Leadership Team and Caroline Maley will regularly review training and development with Non-Executive Directors. The Board was agreed that recommendation RR5 is now complete. The Board understood that two recommendations remain outstanding, M1 and M3, which are subject to external assurance and these will be submitted to the next meeting in May for completion. The focus will now shift to embedding and monitoring the work undertaken. **RESOLVED: The Board of Directors:** **1) Noted the progress made against addressing GIAP recommendations** **2) Formally approved the 14 blue forms as presented and confirmed that they provided assurance of completion, namely:** • **HR3** • **HR4** • **CLING1** • **CORPG7** • **WOD5** • **WOD6** • **M2** • **M4** • **M5** • **M6** • **RR1** • **RR2** • **RR3** • **RR5** **3) Agreed at the end of the Board meeting that no further changes are required to the GIAP following presentation of papers, outcomes of item specific discussions and/or other assurances provided throughout the meeting**
DHCFT 2017/067	**<u>REPORT FROM COUNCIL OF GOVERNORS MEETING</u>** Sam Harrison presented the report which provided a summary of issues discussed at the meeting of the Council of Governors held on 7 March 2017. The Board noted the report

	and was assured on the breadth of key topics presented to and discussed by the Council of Governors. **RESOLVED: The Board of Directors noted the report from the Council of Governors meeting held on 7 March 2017.**
DHCFT 2017/068	**<u>CLOSURE OF BOARD ASSURANCE FRAMEWORK 2016/17 AND ISSUE OF BOARD ASSURANCE FRAMEOWRK 2017/18</u>** Sam Harrison presented this report detailing the final issue of the Board Assurance Framework (BAF) for 2016/17 and the first issue of the 2017/18 BAF. The Board acknowledged that the BAF was very carefully scrutinised by the Audit & Risk Committee in March. The BAF was also reviewed by ELT and amendments arising from both these meetings have been incorporated into the final version of the BAF for 2016/17. Since Issue 4 of the BAF for 2016/17 was reviewed by the Board in February 2017, the risk rating of three risks has been further reduced. • Risk 1e) 'Lack of compliance with the Civil Contingencies Act as a category 2 responder. Risk identified through 2016/17 EPRR Assurance Process' has reduced from high to moderate due to mitigation in place and CCG formal notification of compliance • Risk 3b) 'Risk of a loss of confidence by staff in the leadership of the organisation at all levels' has reduced from high to moderate due to stability in senior leadership team and increased confidence of regulators, and • Risk 4a) 'Failure to deliver short term and long term financial plans could adversely affect the financial viability and sustainability of the organisation' has reduced from high to moderate due to confidence in year-end financial forecast. As a result at year-end, five risks remain graded as high risk and five as moderate risk to the achievement of the Trust's strategic objectives. The report also included the first issue of the BAF for 2017/18. Following feedback from Board Committees and KPMG this version of the BAF has been amended in terms of format and content. The risks in this first issue 2017/18 have been scrutinised by the Executive Leadership Team and Audit and Risk Committee. As a result further changes have been made and are reflected in the BAF as presented. Carolyn Green questioned whether risk 3b '*There is a risk to staff engagement and wellbeing by the Trust not having supportive and engaging leaders*' correctly articulated the risk of lack of capacity within leadership. Amanda Rawlings responded that good quality leadership staff will support the change process. This risk was concerned with working towards ensuring consistency of good leadership across the whole of the Trust. Julia Tabreham's final question, raised in her absence, referred to the risk of cyber-attack on the Trust. This was acknowledged to be an ill-understood risk and she asked if any development had been made on any further analysis into this risk. This will be the subject of a Board Development session. Mark Powell will brief the Finance & Performance Committee on the arrangements that are in place and any issues will be escalated to the Board. The Board approved the final version of the BAF for 2016/17. The content and format of the first issue of the BAF for 2017/18 was also approved and it was noted that deep dives of BAF risks will take place at various Board Committees and Audit & Risk Committee. **RESOLVED: The Board of Directors:** **1) Approved the final issue of the BAF for 2016/17** **2) Approved the content of this first issue of the BAF for 2017/18, including the revised format and additional fields**

	3) Approved ongoing reporting and monitoring arrangements as outlined
DHCFT 2017/069	**2017/18 BOARD FORWARD PLAN** The forward plan was noted by the Board. **RESOLVED: The Board of Directors noted the forward plan for 2017/18.**
DHCFT 2017/070	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK OR GIAP** It was agreed that no further changes are required to the GIAP or to be updated or included in the BAF or the GIAP.
DHCFT 2017/071	**MEETING EFFECTIVENESS** A lot of issues have been closed at today's meeting. Caroline Maley asked that the May agenda be formulated so it is more manageable so that time can be used to enable more challenge.

The next meeting of the Board held in Public Session will take place at 1pm on Wednesday, 24 May 2017.

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

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Wednesday 24 May 2017

MEETING HELD IN PUBLIC

Commenced: 1pm Closed: 4.35pm

PRESENT:	Caroline Maley	Acting Trust Chair
	Dr Julia Tabreham	Deputy Trust Chair and Non-Executive Director
	Barry Mellor	Non-Executive Director
	Richard Wright	Non-Executive Director
	Ifti Majid	Acting Chief Executive
	Claire Wright	Executive Director of Finance & Deputy Chief Executive
	Carolyn Green	Executive Director of Nursing & Patient Experience
	Dr John Sykes	Executive Medical Director
	Samantha Harrison	Director of Corporate Affairs & Trust Secretary
	Mark Powell	Acting Chief Operating Officer
	Amanda Rawlings	Director of People & Organisational Effectiveness
	Lynn Wilmott-Shepherd	Interim Director of Strategic Development
IN ATTENDANCE:	Anna Shaw	Deputy Director of Communications & Involvement
	Sue Turner	Board Secretary (Minutes)
For DHCFT 2017/073	Peter	Service User
For DHCFT 2017/073	Nicola Fletcher	Acting Assistant Director of Clinical Professional Practice
For DHCFT 2017/073	Velmer Boreland	Occupational Therapist
For DHCFT 2017/083	David Tucker	General Manager, Children & Young Peoples Services
For DHCFT 2017/083	Scott Lunn	CAMHS & IAPT Operational Lead
For DHCFT 2017/083	Aislinn Choke	Consultant Psychiatrist/Associate Medical Director
For DHCFT 2017/083	Beth Howman	Consultant Paediatrician
APOLOGIES:	Margaret Gildea	Senior Independent Director
	Dr Anne Wright	Non-Executive Director
VISITORS:	John Morrissey	Lead Governor, Public Governor, Amber Valley South
	Gillian Hough	Public Governor, Derby City East
	Carole Riley	Public Governor, Derby City East
	Rosemary Farkas	Public Governor, Surrounding Areas
	Melissa Castledine	Derbyshire Mental Health Alliance

DHCFT 2017/072	**ACTING CHAIR'S WELCOME, OPENING REMARKS AND APOLOGIES** Acting Trust Chair, Caroline Maley, opened the meeting and welcomed everyone. Apologies were noted from Margaret Gildea and Dr Anne Wright.
DHCFT 2017/073	**SERVICE RECEIVER STORY** Nicola Fletcher introduced service receiver Peter who gave an account of his experience of secure services and his time spent at the Kedleston Unit. He also talked about how he studied for a degree whilst undergoing his recovery and described his eventual progress

	into employment. Occupational Therapist, Velmer Boreland accompanied Peter and talked about how the use of community resources and peer support programmes had played a part in aiding Peter's recovery. Peter talked about how he was encouraged to take up new interests and enrolled on courses specialising in resilience training and understanding relationships which helped build his confidence. He was also encouraged to study for a teacher training qualification that he is due to complete in July which will enable him to be qualified to teach six-form students and above. The Board heard how Peter had been involved with the CQC inspection team and how this had led to him being employed by the CQC occupational therapy and clinical team. Peter is pleased that during his time with the Trust he has grown in confidence and has become more independent. He has learnt how to stay well and to spot his strengths. He has also learnt how to cope with disappointment and how to utilise his support networks. He spoke of his aspirations for the future and is currently applying for jobs. He is coming to end of his time at the Kedleston Unit and now spends five nights a week at a transition house. He hopes to secure his own flat in the near future. When asked by the Board if there was any part of the Trust's service that should change Peter described how difficult it had been accessing clarity of which advocacy service to use, and then keeping in contact with the same branch of the advocacy service. Instead he utilised the support of the clinicians on the ward and the Occupational Therapists. The Board discussed the issues raised and undertook to improve the advertising of the local authority commissioned independent advocacy service. Carolyn Green undertook to explore the service offered by the Derby city and Derbyshire services, and include this in ward information booklets and posters. Discussion also centred around how the Trust could enable Peter and others in his situation move forward in life. The Board heard of plans to develop a recovery college within the Kedleston Unit that would inspire a sense of hope and recovery for people. Although this resource is still in its infancy Peter has kindly agreed to support staff in setting up this facility which would be an important resource to have within patient centred care planning. The Board supported this initiative and it was agreed that Carolyn Green would develop a recovery and enablement strategy that will be submitted to the Quality Committee, the results of which would be reported to the through to the Board. The Board was impressed with Peter's local insight and his understanding of the choices he made and in developing his recovery. This was a truly inspirational story and the Board wished him well for the future. **ACTION: Carolyn Green will work with the Nursing and Quality team, specifically Allied Health Professionals to develop a recovery and enablement strategy that will be submitted to the Quality Committee to focus upon employment and a positive approach to recovery.** **RESOLVED: The Board of Directors expressed thanks to Peter for sharing his inspiring story and appreciated the opportunity to hear at first hand the service the Trust had provided.**
DHCFT 2017/074	**MINUTES OF THE MEETING DATED 26 APRIL 2017** The minutes of the previous meeting, held on 26 April were agreed and accepted subject to Claire Wright's title being corrected to Executive Director of Finance and Deputy Chief Executive.
DHCFT 2017/075	**MATTERS ARISING AND ACTIONS MATRIX** The Board agreed to close all completed actions. Updates were provided by members of

	the Board and were noted on the actions matrix. Carolyn Green updated the Board on the outcome from last month's Service User Story and was pleased to report that immediate financial support would be given to the carers' support group
DHCFT 2017/076	**<u>QUESTIONS FROM PUBLIC GOVERNORS</u>** Two questions were received from public governors. The first was from Gillian Hough Public Governor, Derby City East who asked what steps the Board would be taking to manage the potential risk to the quality of service delivery as the Trust moves towards the transaction with DCHS. The Chair responded that the Board has looked at clinical services and discussed the opportunity to work with DCHS to address and improve the health of our population. As regards to the quality of individual services the Board considers that integration will provide opportunities to improve quality and efficiencies and may improve the Trust's financial outlook. The Board will ensure that the CQC action plan is delivered and focus on obtaining the best clinical and effectiveness standards will continue. There were ten parts to a question received from Ruth Greaves, public governor for Derbyshire Dales. A written statement by Amanda Rawlings responding to these questions was circulated at the meeting and would be included in support of the minutes of today's meeting. **RESOLVED: The Board of Directors noted and responded to questions raised by the public governor for Derbyshire Dales and the public governor for Derby City East.**
DHCFT 2017/077	**<u>ACTING CHAIR'S VERBAL REPORT</u>** Caroline Maley firstly expressed her thanks to everyone involved in making sure safety was paramount during last week's cyber-attack. Throughout this period she was kept updated with progress and felt assured by the work being undertaken by the IT support teams who performed a sterling job under extremely difficult circumstances. During the last month Caroline Maley continued to meet with chairs of other organisations and commissioners from Erewash and Hardwick Commissioning Groups. She also met with the chair of Leicestershire Partnership Trust when they discussed the care services being offered through a pilot scheme in social care. The Council of Governors met on 2 May in public session and this meeting was observed by a number of governors from DCHS. An effective Governance Committee was held on 17 May and she also met with the Lead Governor, John Morrissey. The Non-Executive Directors met in May for their quarterly meeting and this allowed the chairs of the different Board committees to discuss how their work was progressing. Caroline Maley also attended the Audit & Risk Committee on 27 April to review the Annual Report and Accounts for 2016/17 prior to formal sign off by the Committee later in May. The Joint Integration Programme Committee (JIPC) took place on 3 May and a report of this meeting is included as part of the Acting Chief Executive's report. Cultural Assessments were held with a number of Executive Directors and Non-Executive Directors on 23 May. Caroline Maley explained that this is part of the due diligence activity being conducted by Ernst & Young in preparation for the Outline Business Case and will enable the Trust to get a deeper insight into the challenges that might be faced

	through integration. Caroline Maley attended the DAFT Conference (Derbyshire's Association for Family Therapy) and said that it was of great interest to see the work that is being carried out with families. **RESOLVED: The Board of Directors noted the activities of the Acting Chair throughout the month of May.**
DHCFT 2017/078	**<u>ACTING CHIEF EXECUTIVE'S REPORT</u>** The Acting Chief Executive's report provided the Board of Directors with feedback and an update on developments occurring within the local Derbyshire health and social care community. Ifti Majid referred to discussions held at the last Board meeting concerning public protection with regard to the number of people being released from prison. The Trust is unfortunately one of the few trusts not commissioned to provide a community forensic mental health care service. He informed the Board that he has written to commissioners and the STP expressing the Trust's serious concern regarding the risks associated with the release to Derbyshire of IPP (Indeterminate Imprisonment for Public Protection) prisoners and asked commissioners for a specific forensic stream that will help the Trust to manage the complex needs of these individuals. This risk has also been added to the Board Assurance Framework as one of our highest risks. Following on from the last meeting when the Board heard of the issues junior doctors are experiencing, Ifti Majid invited junior doctors to take part in a two-way shadowing exercise with the Board so they can understand more about the challenges junior doctors face when placed in our organisation and he urged Board members to put themselves forward to take part in this programme. Ifti Majid's report included an overview of the Trust's experiences during the recent cyber-attack and he thanked all staff who worked hard to ensure that the quality of the Trust's services was not compromised in any way. Mark Powell responded that the IT team had taken precautionary action during this period and was pleased to report that none of the Trust's systems were affected by the virus. The Trust's priorities were to make sure clinical systems were operating as quickly as possible. He was pleased to report that the Trust's PARIS disaster recovery process meant that there were no patient safety issues arising. Debriefing and lessons learnt sessions are being undertaken and will form part of a report that will be received by the Board at the next meeting in June. Mark Powell assured the Board that work had taken place to ensure that paper records that were kept during this period have been transferred to the electronic system and that wards were provided with extra staff to enable this to be carried out without staff being pulled away from clinical duties. Ifti Majid referred to the outcome of the CQC visit in February 2016 and the Deloitte Well Led exercise carried out in January 2016 which resulted in the Trust being in breach of its provider licence. He informed the Board that he had positive feedback from NHS Improvement about the Trust's progress to comply with conditions placed on the Trust with respect to its NHS provider licence. He hoped that formal notification that the Trust is free of all former licence breaches may be forthcoming shortly. Appended to this paper was a summary report from the Joint Integration Programme Committee. Ifti Majid pointed out that this did not contain the full detail of discussions that took place during the meeting and he intended to discuss with the Joint Integration Programme Director how these reports could be more detailed. **ACTION: Report on recent cyber-attack to be received at the June meeting.**

	RESOLVED: The Board of Directors noted the Acting Chief Executive's update
DHCFT 2017/079	**INTEGRATED PERFORMANCE AND ACTIVITY REPORT (IPR)** The report showed that the Trust continued to perform well against many of its key indicators during April. Owing to the IT downtime during week commencing 15 May, reporting of data was delayed which affected the level of narrative that has been able to be provided within the report. As a result, quality, workforce and operational sections were scrutinised by Board members to establish key performance issues and to gain assurance on mitigating actions being undertaken in these areas. The Board recognised that positive improvements have been made with regard to the stability around workforce metrics which showed a good start to the year. In terms of challenges, the report drew attention to a lack of staff capacity across the organisation resulting in poor performance in staff supervision and appraisals and Executive Directors were ur**g**ed to place an internal focus on these key areas. In response, Mark Powell undertook to refocus the teams on all internal performance issues, the results of which would be seen in future IPR reports. With regards to financial performance, Claire Wright reported that at month one the Trust is ahead of plan and the forecast assumes full delivery of CIP (Cost Improvement Programme), although a full set of plans to achieve the Trust's CIP of £3.85m are not yet finalised she is forecasting that the Trust will achieve its control total at the end of the year. In response to a question from Caroline Maley she clarified that there is an overspend on pay and employee expenses which is offset by over-recovery of income, both due to QIPP (Quality Improvement Prevention and Productivity) contract and service changes not yet being enacted. With regards to financial performance, Claire Wright reported that at month one the Trust is ahead of plan and plans are in place to achieve the Trust's CIP of £3.85m. She is forecasting that the Trust will achieve its control total at the end of the year despite there currently being an overspend on pay and employee expenses. The report showed that the sickness absence rate is still high and the underlying causes of stress and anxiety are one of the Trust's biggest challenges. Amanda Rawlings reported on the Trust's vacancy situation and explained that with the TRAC electronic recruitment management tool now operational the Trust's vacancy rate should improve. She was working on innovative ideas to attract staff and establishing systems that will anticipate vacancies that will arise through retirement or staff movement in order to predict immediate needs. Individuals will be recruited and retained through development opportunities. Richard Wright referred to the recent recruitment visit made to India. Mark Powell responded that he would provide the Board with a full report on his trip to India at the next meeting in June that will set out the progress made and the development of a clear partnership with India's National Institute of Mental Health which will play a significant role in improving recruitment in the longer term. The Trust is also exploring recruitment opportunities for doctors in Egypt. Concern was raised with regard to safe staffing levels in the Hartington and Radbourne Unit. Carolyn Green assured the Board that emergency planning measures were not required at this time although intensive actions were required over the summer to maintain stability. She referred to bed occupancy and pointed out that occupancy is currently quite low on the Cubley Wards and as a result some staff were transferred to other areas or skill mix reduced as bed occupancy was less than 50%. The Board requested that future IPR reports include a short summary on safer staffing, and that a report be received by the Quality Committee on safer staffing mitigation plans. **ACTION: Summary report on Safer Staffing to be regularly included in the IPR**

	ACTION: Report on safer staffing mitigation plans to be received by the Quality Committee. **RESOLVED: The Board of Directors considered the Integrated Performance Report and obtained a good level of assurance on current performance across the areas presented.**
DHCFT 2017/080	**CONTROL OF INFECTION REPORT** The Control of Infection Report summarised the activity in the safe management of Infection Prevention and Control over the preceding twelve months. The Board noted that this annual report was scrutinised by the Quality Committee and significant assurance was established. **RESOLVED: The Board of Directors accepted the Annual Control of Infection Report and received significant assurance on standards of cleanliness of clinical areas and food preparation areas**
DHCFT 2017/081	**QUALITY POSITION STATEMENT** Carolyn Green provided the Board of Directors with an update on the organisation's continuing work to improve the quality of services that are provided in line with the Trust Strategy, Quality Strategy and Framework and strategic objectives. Reference was made to the increase in drug related deaths in substance misuse. Carolyn Green assured the Board that the Quality Committee will continue to monitor the substance misuse integrated services and will maintain a monitoring brief on this national trend and challenged John Sykes and Lynn Wilmott-Shepherd to establish the learning to be had from effective governance of clinical consortium arrangements. In her support, Julia Tabreham as Chair of the Quality Committee referred to the level of intervention that the Trust's integrated service model has had across the wards and third sector organisations which had made an impression on A&E admissions and asked John Sykes and Lynn Wilmott-Shepherd to look at this clinical consortium's success criteria. John Sykes responded that this has resulted in a significant alignment of organisations within a lead provider model and he believed that an aligned strategy would be of great benefit to staff. Carolyn Green drew attention to Improving Access to Psychological Therapies services (IAPT) and informed the Board that she proposed to explore extending IAPT into walk-in centres to cope with primary care demands which would be beneficial to neighbourhoods and would also avoid activity from Accident and Emergency services. The report also included the notification of a visit by the CQC on 12 July to check compliance with the Mental Health Act and Code of Practice which was formally noted by the Board. **RESOLVED: The Board of Directors received and noted the Quality Position Statement**
DHCFT 2017/082	**BOARD ASSURANCE SUMMARIES & ESCALATIONS** Assurance summaries were received from the Board Committees that took place during April and May 2017. Committee Chairs summarised the escalations that had been raised and these were noted by the Board. **RESOLVED: The Board of Directors received and noted the Board Committee Assurance Summaries and Escalations.**

DHCFT 2017/083	**DEEP DIVE – PAEDIATRICIAN CAMHS WAIT TIMES** The Paediatrician and CAMHS services team joined the meeting and provided the Board with an insight into some of the key challenges and achievements for their services. The Board heard from David Tucker, Beth Howman, Aislinn Choke and Scott Lunn about a number of initiatives they have used to help manage the referral pressures and long waiting lists in CAMHS and Paediatrics. These initiatives included assessing job plans for each role to ensure the team had the correct processes in place for work priorities. They also held a recruitment campaign and recruited three new doctors and managed to secure some locum cover that provided extra capacity. The team have also made use of funding identified for consultant paediatricians and utilised nurses to carry out work previously carried out by paediatricians. This has enabled the team to recruit a psychologist to help with additional demand. The team also entered joint recruitment with Derby Teaching Hospital to make posts more attractive to applicants. Despite this effort, there is an ongoing strain on services. The trajectory for paediatrics patients waiting over 52 weeks showed significant demand. The Board was informed that 'waiting well' checks take place during this wait time and this process is working effectively. The team considered that the recent addition of a waiting list care co-ordinator will help with the flow of appointments. One of the key challenges for the team is that appointments are not kept. Families are reminded of the importance of notifying the team when cancelling appointments and the Board heard how DNAs (Did Not Attend) were checked on a case by case basis for issues relating to safeguarding or neglect. Support services also work with families to help them attend. The Board was concerned to hear that the number of appointments lost each week equates to three whole time staff. A great deal of work has taken place within the team to improve waiting times. The team gave an overview of their plans for future improvement. A speciality doctor is due to start in June. The Board was informed that consultant paediatricians are in great demand and is also a very difficult post to recruit to. The team is trying to be as flexible as possible with the work plans to attract consultant paediatricians. The current CAMHS service performance shows a resource gap. The Trust receives a certain amount of funding but not enough funding to provide the right scale of services for the population of children. Community paediatricians are commissioned to work with young people up to the age of 16 years unless in they are in attendance at special schools or subject to child protection. This is a known commissioning gap and the Board heard that Lynn Wilmott-Shepherd is working towards addressing this issue. The Board understood that there is an increasing complexity of cases and consistent demand on resources. The current wait list assessment showed a number of reasons for the longest wait times. CAMHS and Learning Disabilities see three times their commissioned referral rate. The service is operating at two thirds capacity for paediatric consultants. Plans for future improvement involve implementing a new service model with a pathway that is clinically led with assessment function consultants who will work on getting people referred to the correct treatment pathway to help with flow. The implementation of an assessment intervention team has improved access and has decreased both the internal and external waits by 16%. The team described how CAMHS has seen a huge increase in referrals from A&E which was considered to be a good indication that young people are accessing the service. The Board considered this to be a useful summary of the intervention by the CAMHS and Paediatric Team and they were commended for their positive and creative thinking. Despite all their good work too many children have to wait a considerable amount of time. The Board was assured that the team was doing everything possible to improve the waiting time. There is a need to reinforce the decision making across the Trust and balance the clinical services needs with the financial position and work with

	Commissioners to ensure appropriately contracted services. **RESOLVED: The Board of Directors considered and noted the presentation made by the Paediatrician and CAMHS services team**
DHCFT 2017/084	**<u>GOVERNANCE IMPROVEMENT ACTION PLAN (GIAP)</u>** Sam Harrison presented the Board with the final Governance Improvement Action Plan (GIAP) report. This report provided Board members with an update on progress on the delivery of the two remaining recommendations from the GIAP. ***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:*** The Board acknowledged that Deloitte carried out a review of the implementation of the GIAP, which took place between February 2017 and April 2017. A final report received from Deloitte on (24 April) provided assurance that the all findings from the GIAP have been completed and that the Trust now meets the benchmark Deloitte would associate with organisations rated amber-green against NHS Improvement's well-led framework. ***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:*** This recommendation relates to external assurance received from Deloitte and enabled the Board to be satisfied that the GIAP has been implemented in full. The Board passed and approved both recommendations M1 and M3. The outcome of the Deloitte report will now be submitted to NHS Improvement. In terms of reporting and embeddedness Sam Harrison informed the Board that she is waiting for feedback from NHSI on the Deloitte report. This will be monitored through the Executive Leadership Team to ensure embeddedness and continuation of governance evidence, working towards an anticipated full well-led review during 2017/18. **RESOLVED: The Board of Directors:** **1) Noted the completion of all actions addressing GIAP recommendations** **2) Formally approved the two blue forms as presented and confirm that this is provides assurance of completion, namely M1 and M3** **3) Noted the full completion of the Governance Improvement Action Plan.**
DHCFT 2017/085	**<u>INFORMATION GOVERNANCE UPDATE</u>** This report provided the Board with a performance update on the Trust's Quarter 4 progress towards meeting the requirements of the 2016-17 Version 14 Information Governance Toolkit as well as the work of the Information Governance Committee and Information Governance breach monitoring. The report assured the Board of the successful completion of Information Governance monitoring. The Board noted the good governance around IG training compliance that will be reinforced throughout this year. Sam Harrison highlighted the IG bulletin that had been published several times during the year which served to ensure organisational learning and implementation of best IG practice across the organisation. **RESOLVED: The Board of Directors:** **1) Acknowledged the successful completion of the IG Toolkit** **2) Acknowledged the progress made with the IG work plan and** **3) Acknowledged the risk to the organisation of failing to meet the requirements of the IG Toolkit particularly with regards to the mandatory IG Training**

	requirement.
DHCFT 2017/086	**FIT AND PROPER PERSON DECLARATION** The purpose of the paper was to support the Chair's responsibility to declare that all Trust Board Directors meet the fitness test and do not meet any of the 'unfit' criteria as per the Fit and Person's Test regulations (Health and Social Care Act 2008 Regulation 2014) and in line with the Trust's Fit and Proper Persons Test Policy. The Board approved the Trust's Fit and Proper Persons Test Policy in 2016 and acknowledged that this policy has been maintained and applied throughout the year. Appropriate checks have been made on appointment of Director level posts made during 2016/17 and relevant checks and supporting information relating to existing post holders has been provided, including ongoing review and monitoring of the recording system for all Directors. In addition, self-declarations have been made by all Directors as at 31 March 2017. Comprehensive files containing evidence to support the elements of the fitness test have been retained and regularly reviewed to ensure contents are updated as required. The Board was satisfied that this declaration evidences the embeddedness of processes set in place as part of the Governance Improvement Action Plan (recommendations FF1 (4) and FF (5)) relating to compliance with the Fit and Proper Persons Test. Caroline Maley declared that appropriate checks have been undertaken in reaching her judgment that she was satisfied that all Directors of the Trust, including Non-Executive Directors, and Executive Directors (including voting, non-voting and Acting) are deemed to be fit and that none meet any of the 'unfit' criteria. Specified information about Board Directors is available to regulators on request. **RESOLVED: The Board of Directors received full assurance from the Chair's declaration that that all Directors meet the fitness test and do not meet any of the 'unfit' criteria**
DHCFT 2017/087	**REPORT FROM THE AUDIT & RISK COMMITTEE ON THE EFFECTIVENESS OF BOARD COMMITTEES** Sam Harrison provided a report to the Board on the activity and effectiveness of the Audit and Risk Committee for 2016/17, comparing the work of the Committee to its Terms of Reference. The report was considered by the Audit and Risk Committee at its meeting on 26 April 2017 where the Committee received significant assurance on the effectiveness of the Committee. Although there has been a significant change in membership of the Committee the annual effectiveness survey showed that the Committee was satisfied that it had fulfilled its remit in line with its terms of reference. In addition to this KMPG had provided external clarification that the Committee was effective and had suggested some areas for development for new Committee members. The report provided the Board with assurance on the effectiveness of the Audit and Risk Committee and all other Board Committees, which the Audit and Risk Committee had reviewed at their April meeting in its role of overseeing Board Committee effectiveness. It was noted that a further update on progress is to be provided by the Mental Health Act Committee to the Audit and Risk Committee in October 2017 given the ongoing development of this Committee that is underway. It was also noted that the terms of reference of all the committees will be presented to the Trust Board as part of the annual review of the Corporate Governance Framework in July. **RESOLVED: The Board of Directors:** **1) Received full assurance on the effectiveness of the Audit and Risk Committee**

	during 2016/17 **2) Received significant assurance regarding the discharge of the remit of all other Board committees, as considered by the Audit and Risk Committee.**
DHCFT 2017/088	**REPORT FROM COUNCIL OF GOVERNORS MEETING** Sam Harrison presented the report which provided a summary of issues discussed at the meeting of the Council of Governors held on 6 April and 2 May 2017. The Board noted the report and was assured on the range of key topics presented to and discussed by the Council of Governors. **RESOLVED: The Board of Directors noted the report from the Council of Governors meeting held on 6 April and 2 May 2017.**
DHCFT 2017/089	**NHS IMPROVEMENT YEAR-END SELF-CERTIFICATION** Samantha Harrison presented the NHS Improvement year-end self-certification which providers are required to complete after the financial year-end relating to compliance with the following NHS provider licence conditions: • The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3)) • The provider has complied with required governance arrangements (Condition FT4(8)) • If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service (Condition CoS7(3) The aim of self-certification is for providers to carry out assurance that they are in compliance with the conditions and providers may carry out this process as they see fit. DHCFT proposes to present the proposed relevant declarations to the Trust Board. The Board of Directors: • Confirmed it had met the criteria for holding a licence (condition G6) • Declared that the licensee has a reasonable expectation that the licensee will have the required resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. • Confirmed that it complies with all elements of the Corporate Governance Statement (condition FT4) • Was satisfied that during the financial year ended 31 March 2017 the Trust had provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they were equipped with the skills and knowledge they need to undertake their role. **RESOLVED: The Board of Directors:** **1) Confirmed agreement with the proposed declarations for signature by the Chair and Chief Executive.** **2) Agreed to the publication of the self-declarations within one month of the declaration by the Trust Board.**
DHCFT	**ANY OTHER BUSINESS**

2017/090	Carolyn Green pointed out that she was mindful of the need to plan for changes to the Mental Health Act that might arise from the Government's manifesto. In response, the Board proposed discussing this further outside of the meeting.
DHCFT 2017/091	**2017/18 BOARD FORWARD PLAN** The forward plan was noted by the Board. **RESOLVED: The Board of Directors noted the forward plan for 2017/18.**
DHCFT 2017/092	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK** A full report on the BAF will be presented at the meeting to be held in July. The Board discussed the issue of capacity and demand within the Trust as exemplified in the Deep Dive for paediatrics and CAMHS services. Ifti Majid is to review the relevant risks within the BAF with a view to proposing an increase in risk rating to reflect the operational pressures and related risks faced by the Trust.
DHCFT 2017/093	**MEETING EFFECTIVENESS** The Board agreed that sufficient time was allowed to discuss the IPR report and requested that thirty minutes be devoted to the Deep Dives in future meetings.

The next meeting of the Board held in Public Session will take place at 1pm on Wednesday, 28 June 2017.

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

Governor questions to 24 May 2017 Trust Board Meeting

1) Please can we have clarification on exactly what has happened to the HR departments in DHcFT and DCHS?

On 22nd May we closed the first stage consultation with the senior staff across DHCT and DCHS regarding future senior roles for a joint HR/Workforce/OD team. The feedback is being reviewed and outcome will be discussed with the senior team over the next week before confirming who will be in what senior roles in the future. The next stage is for Amanda Rawlings to work with the senior team to develop the business case for stage 2 which will cover the wider HR/Workforce/OD teams across both trusts.

2) What was the justification for this change?

The direction came from NHSI in June 2016 asking STP's to collaborate on back office functions. DHCT and DCHS have agreed to work together and we have started with HR/Workforce/OD and Estates.

The Carter Review, and indeed Lord Carter's review of pathology services some 15 years ago, demonstrated that there is still a significant potential saving if back office services and pathology services are consolidated on a regional basis. Indeed, back office services in the NHS have not consolidated in the way they have in many other sectors and I know that many STP areas are already developing plans in this area. We will therefore be asking all STP leads to develop proposals to consolidate back office and pathology services with outline plans, initially on an STP footprint basis but with a mind to consolidate across larger areas over time, to be agreed before the end of July. Jeremy Marlow, Director of Operational Productivity and lead director for Carter Implementation will be heading this work, working closely with STP leads.

JIM MACKEY **ED SMITH**
Chief Executive NHSI **Chairman NHSI**

3) What were the perceived risks, and the perceived advantages?

As with all service changes there is a period of uncertainty for staff and the challenge of embedding a new structure and service. The positive is that a new larger team will provide more capacity and resilience to DHCT than we have today and some efficiencies.

4) Was NHSI informed prior to the changes taking place?

NHSI are not required to approve or agree with this arrangement, but are aware from our regular meetings with them about the work we are doing back office and our approach is in response to their national directive.

5) Relating to Question 4, when and why did you inform/not inform NHSI?

As above

6) Why did you not inform governors?

We have approached this change like we do with other service changes and discussed at the relevant Board Committees. The full business case is yet to be developed and approved. The Council of Governors will up dated as we progress further with the back office work programme.

7) Why did you choose to implement this re-structuring prior to completion of the OBC and the crucial decision on whether to proceed to FBC?

The sharing of back office functions is separate to the OBC/FBC and we are working on separate timetable.

8) How does this re-structuring change the viability of Collaboration, rather than Acquisition?

The approach we are taking with back office is about increasing our collaboration and partnership working and is not related to the acquisition.

9) What other departments are you considering re-structuring prior to April 2018?

We are currently working together on HR/Workforce/OD and Estates.

10) Will you be informing governors, so that they can perform their task of 'holding to account' during the process, rather than when it is a 'fait accompli'?

The Non-Executive Directors through the governance process will scrutinise and hold the Executives to account on this work programme.

Derbyshire Healthcare
NHS Foundation Trust

SUMMARY OF
CONFIDENTIAL MEETING OF COUNCIL OF GOVERNORS
HELD IN PRIVATE SESSION

TUESDAY 6 JUNE 2017

Background
Governors had requested additional Council of Governors meetings to specifically discuss the merger by acquisition. As a result on a bi-monthly basis confidential meetings were arranged to discuss this subject in private.

Summary of Meeting
The second confidential meeting of the Council of Governors was held, as scheduled, on Tuesday 6 June 2017. The Trust's Board of Directors relayed their decision not to proceed with the proposed merger of the Trust with Derbyshire Community Health Services NHS Foundation Trust (DCHS) at this time. The reasons for the decision were outlined and discussed. The governors present unanimously supported the Board's decision.

Governors were thanked for their contribution to the discussions to date on the potential merger and for their ongoing support throughout this process.

Details on how the Trust is to utilise the valuable feedback obtained through the process to date and the planned focus on the development of an Accountable Care System for the whole of Derbyshire were outlined. Plans for staff engagement relating to the withdrawal from the transaction were discussed and governors invited to raise queries and questions.

The Board will move to consider its structure. The Senior Independent Director had been asked to initiate conversations with the Governors Nominations & Remuneration Committee regarding the recruitment process for a substantive Trust Chair. The appointment for the other Acting board roles will follow.

A request was received to consider lowering the age of eligibility for membership of the Trust to age 12. This will be discussed at the Governance Committee.

It was highlighted that meetings that had been scheduled to further discuss aspects of the proposed merger would now be cancelled and a new meetings timetable will be circulated to governors shortly.

Governor Meeting Timetable 2017/18

DATE	TIME	EVENT	LOCATION
20/7/17	2.00 – 4.00pm	Governor development session – Finance	Meeting Room 1, Albany House
26/7/17	2.30 – 6.00pm	Annual Members Meeting Meeting starts at 4pm	Conference Room A&B, Research and Development Centre
27/7/17	1.00pm – 4.00pm	Trust Board Meeting	Conference Room A&B, Research and Development Centre
15/8/17	2.00 – 4.30pm	Governance Committee	Rooms 1 & 2, Research and Development Centre
13/9/17	10.00am – 12.30pm	Governance Committee	Meeting Room 1, Albany House
21/9/17	2.00 – 4.00pm	Governor development session – Research & Development / Mental Health Act (including Process of Serious Incidents)	Meeting Room 1, Albany House
26/9/17	12.00 – 1.00pm	Governors and NEDs – lunch and network	Winding Wheel, Chesterfield
26/9/17	1.00pm onwards	Council of Governors meeting	Winding Wheel, Chesterfield
27/9/17	1.00pm onwards	Trust Board Meeting	Conference Room A&B, Research & Development Centre
17/10/17	10am – 12 noon	Governor development session – Crisis Care Concordat	Meeting Room 1, Albany House
18/10/17	10.00am – 12.30pm	Governance Committee	Meeting Room 1, Albany House
1/11/17	1.00pm onwards	Trust Board Meeting	Conference Room A&B, Research & Development Centre
8/11/17	1.00pm – 4.00pm	CoG to Board	Training rooms 1&2, Research and Development Centre
15/11/17	10.00am – 12.30pm	Governance Committee	Meeting Room 1, Albany House
22/11/17	2.00 – 4.00pm	Governor development session – Recruitment training	Meeting Room 1, Albany House
28/11/17	12.00 – 1.00pm	Governors and NEDs – lunch and network	Conference Room A&B, Research and Development Centre
28/11/17	1.00pm onwards	Council of Governors meeting	Conference Room A&B, Research and Development Centre
29/11/17	1.00pm onwards	Trust Board Meeting	Conference Room A&B, Research & Development Centre
06/12/17	10.00am – 12.30pm	Governance Committee	Meeting Room 1, Albany House

14/12/17	10am – 12 noon	Governor development session – TBC	Meeting Room 1, Albany House
22/1/18	10.00am – 12.30pm	Governance Committee	Meeting Room 1, Albany House
24/1/18	12.00 – 1.00pm	Governors and NEDs – lunch and network	Post Mill Centre, South Normanton
24/1/18	1.00pm onwards	Council of Governors meeting	Post Mill Centre, South Normanton
31/1/18	1.00pm onwards	Trust Board Meeting	Conference Room A&B, Research & Development Centre
27/2/18	10.00am – 12.30pm	Governance Committee	Meeting Room 1, Albany House
28/2/18	1.00pm onwards	Trust Board Meeting	Conference Room A&B, Research & Development Centre
20/3/18	10.00am – 12.30pm	Governance Committee	Meeting Room 1, Albany House
21/3/18	12.00 – 1.00pm	Governors and NEDs – lunch and network	Conference Room A&B, Research and Development Centre
21/3/18	1.00pm onwards	Council of Governors meeting	Conference Room A&B, Research and Development Centre
28/3/18	1.00pm onwards	Trust Board Meeting	Conference Room A&B, Research & Development Centre

GLOSSARY OF NHS TERMS	
NHS Terms of Abbreviations	**Terms in Full**
A	
A&E	Accident & Emergency
ACCT	Assessment, Care in Custody & Teamwork
AfC	Agenda for Change
AHP	Allied Health Professional
AMHP	Approved Mental Health Professional
AP	Assistant Practitioner
B	
BAF	Board Assurance Framework
BMA	British Medical Association
BME	Black & Minority Ethic
C	
CAMHS	Child and Adolescent Mental Health Services
CASSH	Care & Support Specialised Housing
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CCT	Community Care Team
CDIM	Clinical Digital Maturity Index
CEO	Chief Executive Officer
CES	Care Episode Statistics
CFH	Connecting for Health
CIP	Cost Improvement Programme
CMHT	Community Mental Health Team
CNST	Clinical Negligence Scheme for Trusts
COF	Commissioning Outcomes Framework
COG	Council of Governors
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPR	Child Protection Register
CQC	Care Quality Commission
CQUIN	Commissioning for Quality Innovation
CRB	Criminal Records Bureau
CRG	Clinical Reference Group
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services
CTO	Community Treatment Order
D	
DAT	Drug Action Team
DBS	Disclosure and Barring Service
DfE	Department for Education
DoH	Department of Health
DHCFT	Derbyshire Healthcare NHS Foundation Trust
DIT	Dynamic Interpersonal Therapy
DNA	Did Not Attend
DPA	Data Protection Act
DTOC	Delayed Transfer of Care
DWP	Department for Work and Pensions
E	

GLOSSARY OF NHS TERMS	
NHS Terms of Abbreviations	**Terms in Full**
ECT	Enhanced Care Team
ECW	Enhanced Care Ward
ED	Emergency Department
EHIC	European Health Insurance Card
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
EMDR	Eye Movement Desensitising & Reprocessing Therapy
EMR	Electronic Medical Record
EPR	Electronic Patient Record
ERIC	Estates Return Information Collection
ESR	Electronic Staff Record
EWTD	European Working Time Directive
F	
FBC	Full Business Case
FOI	Freedom of Information
FFT	Friends and Family Test
FT	Foundation Trust
FTN	Foundation Trust Network
F&P	Finance and Performance
G	
GMC	General Medical Council
GP	General Practitioner
H	
HEE	Health Education England
HES	Hospital Episode Statistics
HoNOS	Health of the Nation Outcome Scores
HSCIC	Health & Social Care Information Centre
HSE	Health and Safety Executive
HWB	Health and Wellbeing Board
I	
IAPT	Improving Access to Psychological Therapies
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IDVAs	Independent Domestic Violence Advisors
IG	Information Governance
IM&T	Information Management and Technology
IPR	Individual Performance Review
IPT	Interpersonal Psychotherapy
J	
JNCC	Joint Negotiating Consultative Committee
K	
KPI	Key Performance Indicator
KSF	Knowledge and Skills Framework
L	
LA	Local Authority
LCFS	Local Counter Fraud Specialist
LHP	Local Health Plan
LHWB	Local Health and Wellbeing Board

GLOSSARY OF NHS TERMS	
NHS Terms of Abbreviations	**Terms in Full**
M	
MARS	Mutually Agreed Resignation Scheme
MAU	Medical Assessment Unit
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference (meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.
MCA	Mental Capacity Act
MDA	Medical Device Alert
MDT	Multi-Disciplinary Team
MFF	Market Forces Factor
MHA	Mental Health Act
MHIN	Mental Health Intelligence Network
MHRT	Mental Health Review Tribunal
N	
NCRS	National Cancer Registration Service
NED	Non-Executive Director
NICE	National Institute for Health and Care Excellence
NHS	National Health Service
NHSI	National Health Improvement
NOM	Network Operation Manager
O	
OBC	Outline Business Case
ODG	Operational Delivery Group
OP	Out Patient
OSC	Overview and Scrutiny Committee
P	
PAB	Programme Assurance Board
PAG	Programme Advisory Group
PALS	Patient Advice and Liaison Service
PCC	Police & Crime Commissioner
PCOG	Performance and Contract Operational Group
PHE	Public Health England
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PLIC	Patient Level Information Costs
PPT	Partnership and Pathway Team
PREM	Patient Reported Experience Measure
PROMS	Patient Reported Outcome Measure
Q	
QAG	Quality Assurance Group
QC	Quality Committee
QIPP	Quality, Innovation, Productivity
QLT	Quality Leadership Team
QOF	Quality and Outcomes Framework

GLOSSARY OF NHS TERMS	
NHS Terms of Abbreviations	**Terms in Full**
R	
RAID	Rapid Assessment, Interface and Discharge
RCGP	Royal College of General Practitioners
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
RoCR	Review of Central Returns
S	
SAAF	Safeguarding Adults Assurance Framework
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SEN	Special Educational Needs
SLA	Service Level Agreement
SLR	Service Line Reporting
SOC	Strategic Options Case
SOF	Single Operating Framework
SPOR	Single Point of Referral
STP	Sustainability Transformation Plan
S(U)I	Serious (Untoward) Incident
T	
TARN	Trauma Audit and Research Network
TCS	Transforming Community Services
TDA	Trust Development Authority
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
TMAC	Trust Medical Advisory committee
W	
WTE	Whole Time Equivalent