Derbyshire Healthcare NHS
NHS Foundation Trust

# Meeting of the Council of Governors

# 6 September 2016

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

Better together

# MEETING OF THE COUNCIL OF GOVERNORS

## Tuesday 6 September 2016 commencing at 1.00 pm

## St Thomas Centre, Chatsworth Drive, Brampton, Derbyshire S40 3AW

## AGENDA

| | SUBJECT MATTER | Enc | Led by | Time |
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| **1.** | Welcome, introductions and Chairman's Opening Remarks Apologies and Declaration of Interests | | Richard Gregory | 1:00 |
| **2.** | Minutes of meeting held 21 July 2016 and 12 July 2016 | **A** | Richard Gregory | 1:05 |
| **3.** | Matters arising and Actions Matrix | **B** | Richard Gregory | 1:10 |
| **4.** | Acting Chief Executive's Report (includes an update on Derbyshire Sustainability and Transformation Plan) | **C** | Ifti Majid | 1:20 |
| **5.** | 21C Proposals – Presentation on Better Care Closer to Home | **-** | Beverley Smith (North Derbyshire CCG) | 1:35 |
| **HOLDING TO ACCOUNT** | | | | |
| **6.** | Strategy Implementation | **D** | Mark Powell | 2:00 |
| **7.** | Integrated Performance Report | **E** | Claire Wright | 2:15 |
| **8.** | Non-Executive Director Updates | **Verbal** | NEDs | 2:30 |
| **9.** | Governance Improvement Action Plan | **F** | Mark Powell Sam Harrison | 2:45 |
| **10.** | Actions and learnings from patient stories presented to public Board Meetings | **-** | Carolyn Green | 3:00 |
| **3:15 B R E A K** | | | | |
| **11.** | Ratified Minutes of Board Meeting held 30 June | **G** | Richard Gregory | 3:30 |
| **12.** | Updated Terms of Reference and Report of Nominations and Remunerations Committee | **H** | Sam Harrison | 3:35 |
| **13.** | Revision of Engagement with the Board of Directors and Council of Governors Policy | **I** | Sam Harrison | 3:45 |
| **14.** | Any Other Business | | Richard Gregory | 3:55 |
| **15.** | Close – at 4:00pm | - | Chair | 4:00 |
| **FOR INFORMATION** | | | | |
| I. Governor Meeting Timetable<br>II. Governor Development Training Programme<br>III. Glossary of NHS Terms | | **J** | - | |

***Next Meeting:-1:00 pm –Thursday 24 November, 2016, Conference Rooms A&B, R&D Centre, Kingsway***

Derbyshire Healthcare NHS
NHS Foundation Trust

# MEETING OF COUNCIL OF GOVERNORS

## Thursday 21 July 2016, commencing at 1pm

### Clinical Suite 1, 2nd Floor, R&D Centre, Kingsway

The meeting opened at 1pm and closed at 3.50pm

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| **PRESENT:** | Richard Gregory | Interim Chairman |
| **GOVERNORS:** | Shelley Comery | Public Erewash North |
| | Rosemary Farkas | Public Surrounding Areas |
| | Diane Froggatt | Appointed, Derby City Council |
| | Ruth Greaves | Public Derbyshire Dales |
| | Gillian Hough | Public Erewash North |
| | John Morrissey | Public Amber Valley South and Lead Governor |
| | Carole Riley | Public Derby City West |
| | Kelly Sims | Staff (Admin and Allied Support) |
| **IN ATTENDANCE:** | Jim Dixon | Non-Executive Director |
| | Caroline Maley | Senior Independent Director & Non-Executive Director |
| | Maura Teager | Non-Executive Director |
| | Claire Wright | Executive Director of Finance |
| | Samantha Harrison | Director of Corporate Affairs and Trust Secretary |
| | Anna Shaw | Deputy Director of Communications & Involvement |
| | Shirley Houston | Engagement Officer |
| For item DHCFT/Gov/2016/040 | Jenna Davies | GIAP Programme Manager |
| For item DHCFT/Gov/2016/041 | Owen Fulton | Principal Employee Relations Manager |
| For item DHCFT/Gov/2016/043 | Helen MacMahon | Service Line Manager – CAMHS |
| For item DHCFT/Gov/2016/043 | Scott Lunn | Clinical IAPT Lead - CAMHS |
| For item DHCFT/Gov/2016/043 | Laura McAra | Acting Area Service Manager - CAMHS |
| **APOLOGIES:** | Barry Appleby | Public, South Derbyshire |
| | Paul Crawford | Appointed, University of Nottingham |
| | Dr Paula Crick | Appointed, University of Derby |
| | Rob Davison | Appointed, Derbyshire County Council |
| | Sarah Gray | Staff (Nursing and Allied Professions) |
| | Moira Kerr | Public Derby City West |
| | John Jeffrey | Public Bolsover |
| | Alexandra Hurst | Public High Peak |
| | Lynda Langley | Public Chesterfield North |
| | Nitesh Painuly | Staff (Medical and Dental) |
| | April Saunders | Staff (Nursing and Allied Professions) |

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| **DHCFT/Gov/ 2016/034** | **INTERIM CHAIRMAN'S WELCOME**<br><br>Richard Gregory, the Interim Chairman, opened the meeting and welcomed everyone. Apologies were duly noted and listed as above. It was pointed out that Claire Wright was acting today as deputy for Ifti Majid who was attending the Health & Wellbeing Board and Jenna Davies was present at the meeting to discuss the Governance Improvement Action Plan item.<br><br>Richard Gregory introduced and welcomed Joan Barnett from Grant Thornton who would present the Annual Report and Accounts Report from our external auditors.<br><br>The Board's Integrated Performance Report was presented to governors for the first time. Governors were asked to feed back whether this information is useful and whether it is considered a valuable report for Council.<br><br>Changes to the Trust's Board of Directors were contained in the CEO Report and were highlighted by Richard Gregory. Jayne Storey had resigned from her role and leaves the Trust at the end of August. The Remuneration and Appointments Committee would meet next week to agree to the process for appointing a successor as quickly as possible and governors will be kept informed of progress. After a long career with the NHS Carolyn Gilby has decided to retire and will step down at the end of September from her role of Acting Director of Operations. The Remuneration and Appointments Committee are to consider succession arrangements at their next meeting.<br><br>Richard Gregory gave thanks to Amie Elliot and Robert Quick for their significant contribution to the Council of Governors. He explained that Amie Elliott had decided to stand down as a governor and Robert Quick is required to stand down because he is moving out of his constituency. Richard Gregory referred to the recent resignation from Michael Walsh and gave thanks to him for his time as a governor, and for his contribution as Chair of the Governance Committee. Elections to fill these vacancies will be carried out with as part of scheduled forthcoming elections. .<br><br>Richard Gregory took the opportunity to thank governors for their valuable contribution to the recent CQC inspection which took place at the beginning of June. He informed governors that no formal report had so far been received from the CQC although it was understood that a response would not normally be expected until six weeks post inspection and that governors would be kept informed of any developments. The CQC had raised several issues following the inspection and the Trust was responding appropriately with data requests and in some cases compliance improvements on points raised. He said there would undoubtedly be learnings for the Trust following the inspection but it was too early to identify the scale of issues raised. |
| **DHCFT/Gov/ 2016/035** | **MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD ON 1 JUNE 2016**<br><br>The minutes of the meeting held on 1 June were accepted and agreed subject to the list of apologies being amended to show apologies received from Dianne Froggatt. The constituency details would also be corrected to show Gillian Hough as public governor for Derby City East and Carole Riley public governor also for Derby City East. |
| **DHCFT/Gov/ 2016/036** | **REVIEW OF ACTIONS MATRIX**<br><br>Updates on progress with actions and confirmation of those listed as completed were agreed. |

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| | **DHCFT/Gov/2016/026 The exploration of potential secondary school representatives/appointed partner governor:** Governors discussed the need to support mental health issues in secondary and primary schools and establish a relationship with representatives of the education sector. Jim Dixon agreed to speak to Carolyn Green to take this forward.<br><br>**DHCFT/Gov/2016/030 Governor Visits:** Richard Gregory summarised the very useful discussions in the earlier informal Non-Executive Director/governor meeting and the agreement to improve the governance feedback from quality visits. Clare Grainger, Head of Quality and Performance, had agreed to review the feedback from governor quality visits on a quarterly basis which would be reported to the Council of Governors and create a record which would be used to help inform the Council's annual contribution to the Trust's Quality Account. The Board would also improve governance feedback from the visits by receiving reports through the Quality Committee which would then inform the Council.<br><br>The meeting had also discussed the Council's need to demonstrate actions/learnings from patient stories at Board meetings and it had been agreed that the following Board would contain a follow up report which could also be reported to Council.<br><br>**ACTION: Carolyn Green to be asked to coordinate production of actions/learnings from patient stories presented to public Board Meetings.** |
| **DHCFT/Gov/ 2016/037** | **<u>ACTING CHIEF EXECUTIVE'S REPORT</u>**<br><br>In Ifti Majid's absence Claire Wright presented the report which provided the Council of Governors with feedback on changes within the national health and social care sector as well as providing local updates within the health and social care community. The report is aimed to support the Council in its duty of holding the Board to account by way of informing governors of feedback from external stakeholders such as our commissioners and feedback from our staff.<br><br>Claire Wright outlined the key points contained in Ifti Majid's Report:<br><br>1. The NHS Equality and Diversity Council had published the inaugural report of the NHS Workforce Race Equality Standard (WRES), showing results of the experiences of BME and white staff from the staff survey 2015 at every NHS trust across England. This would be taken forward on behalf of the Trust through the People & Culture Committee to compare our results with the average for similar trusts and to understand how we can improve learning from the best in class.<br><br>2. The Nuffield Trust was commissioned by NHS Employers to examine how best NHS staffing can be reorganised to support new ways of delivering care to patients and had published 'Reshaping the workforce to deliver the care patients need'. The report found that equipping the existing non-medical workforce – NHS nursing, community and support staff – with additional skills is the best way to develop the capacity of the health service workforce. This report was also being considered by the enabling workforce work stream as part of the Sustainability Transformation Plan (STP).<br><br>3. Public consultation on 21st Century 'Better Care Closer to Home' continues with many events being held across North Derbyshire and governor participation is actively encouraged.<br><br>4. The Trust has instigated emergency procedures to enable rapid action to be taken in the Adult Acute Service at the Radbourne Unit. The senior leadership |

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| | team is meeting daily to address staffing levels to ensure safe and effective services continue to be delivered.<br><br>5. Claire Wright was pleased to inform governors that the Trust has been successful in winning the contract for integrated Adult Substance Misuse Service which will commence on 1 April 2017.<br><br>6. The roll out of the 'lean' programme has commenced and training sessions have started for key clinical and operational leaders. This programme is key to delivering more efficient services of clinical pathways and support services.<br><br>Ifti Majid's report also included the Listen, Learn and Lead matrix which set out the latest round of team visits by Directors.<br><br>**Derbyshire Sustainability and Transformation Plan:** The STP for Derbyshire outlined a county-wide approach to show how the local NHS will cope with a number of challenges over the next five years. This work brings together all local NHS providers and commissioners, local authorities and the voluntary sector to develop a comprehensive – joined-up – local plan.<br><br>At the special Council of Governors meetings held on 12 July both Derbyshire Healthcare NHS FT and Derbyshire Community Health NHS Foundation Trust (DCHS) discussed initial ideas about how closer working between the two trusts could have a significant positive impact and support the system to meet these challenges. Richard Gregory informed governors that he, Ifti Majid, Claire Wright and John Sykes met this week with the opposite members of the Board of DCHS to discuss the work streams that will map out which type of collaboration the Trust would favour. He was pleased that governors at last week's meeting on 12 July very rightly were concerned that mental health services are protected and received confirmation of the Trust's absolute commitment to its mental health services. The Board will keep governors regularly updated with the discussions with DCHS and Richard Gregory also anticipated that any future model of proposed collaboration will require governor approval. While we are at the very early stages of this work, staff are aware of these initial conversations and how the Trust is starting to explore the potential for further collaboration with DCHS.<br><br>As part of the Derbyshire submission team, Ifti Majid will be taking part in a very high level STP submission review meeting on 25 July with NHS England and NHS Improvement (NHSI).<br><br>Richard Gregory informed governors that the STP would be a standing agenda item for discussion at each meeting of the Council of Governors and an update would be made at the next meeting on 6 September.<br><br>**RESOLVED: The Council of Governors noted the Acting Chief Executive's report.** |
| **DHCFT/Gov/ 2016/038** | **<u>APPOINTMENT OF NON-EXECUTIVE DIRECTORS</u>**<br><br>Samantha Harrison presented her report to the Council of Governors to consider the recommendation of the Nominations and Remuneration Committee to appoint two Non-Executive Directors (NEDs).<br><br>The Nominations and Remuneration Committee had agreed after debate to recommend that two candidates would be offered posts for the HR and general NED roles, but that the NED post with clinical/operational skills and experience would not be offered. Governors considered it important that there was an NED on the Trust Board with clinical and/or operational skills and experience to reflect this as the major |

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| | focus of the Trust's activities. This 'clinical' NED role is currently held by Maura Teager who is not due to finish her term of office until March 2017 so all agreed that this allowed sufficient time to carry out a further recruitment process.<br><br>A competitive process had taken place for the recruitment of the NED posts. Governors were satisfied that all candidates had gone through a robust selection and appointment process and agreed and approved the nominations of the two new Non-Executive Directors, Julia Tabreham and Margaret Gildea.<br><br>Samantha Harrison informed governors that she would ensure that pre-employment checks would be carried out on the two newly appointed NEDs and they would also go through the fit and proper persons requirement process.<br><br>Richard Gregory said the quality of the candidates was exceptionally high from his experience demonstrating commitment and support to mental health services and this Trust. He extended his thanks to Phil Harris who had wanted to stand down as a NED some time ago but had kindly remained in post until a successor was appointed. Phil Harris would now be asked to attend an exit interview and John Morrissey as Lead Governor would take part in this interview with Richard Gregory.<br><br>**ACTION: Richard Gregory and John Morrissey to conduct an exit interview with Phil Harris.**<br><br>**ACTION: Samantha Harrison to arrange for pre-employment checks to be carried out on the newly appointed NEDs and for them to undergo the fit and proper persons test.**<br><br>**RESOLVED: The governors agreed and approved the nominations of the two new Non-Executive Directors, Julia Tabreham and Margaret Gildea.** |
| **DHCFT/Gov/ 2016/039** | **<u>CODE OF CONDUCT</u>**<br><br>The Code of Conduct for the Council of Governors has been under review for a period of time. Its content has been discussed at two meetings of the Governance Committee (on 12 April 2016 and 6 June 2016) and this final version has been recommended to the full Council of Governors for approval.<br><br>Samantha Harrison advised that compliance with the Code of Conduct is an important requirement for all governors and she invited further comments from governors who were present at the meeting. John Morrissey pointed out that governors agreed with the Code of Conduct but absolute unanimity was not obtained regarding the section that states that governors should only speak to the media in their capacity as a governor and with the prior agreement of the Chairman of the Council of Governors. He and some governors felt that receiving prior authorisation from the Trust when dealing with the media was a restrictive practice.<br><br>Richard Gregory responded that he would work with governors so they can be as open as possible and would only advise governors not to speak to the media if he thought that the Trust might be unfairly represented. He stressed his commitment to openness and transparency and gave examples from a previous trust which demonstrated he was happy for governors to air their views about the Trust. He also felt that this section of the Code of Conduct was intended to protect individual governors as well as the organisation, for example in any legal issues/risks.<br><br>Ruth Greaves talked about her experience in dealing with the media when she had been unable to contact the Chairman to gain approval to speak to the media. She had sought advice from Philip Farrar, the independent lawyer who had recently supported governors and reflected that she had changed what she had intended to say to the |

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| | media following his guidance. Richard Gregory advised that it would be too expensive to supply governors with access to legal advice on an ongoing basis but that advice and support was availability via himself and the Communication team. Governors need to ensure that any press or social media activities are in line with the communications guidance outlined in the Code of Conduct and associated Trust policies. Anna Shaw and her team are experts in handling the media and should be contacted to obtain advice, Samantha Harrison can also be approached for help and support.<br><br>Diane Froggatt was happy to support the Code of Conduct and asked if the Communications team could provide a list of contact numbers who could be approached for guidance. Kelly Simms did not feel the Code of Conduct stops governors expressing their opinions. She acknowledged that the Code was a protective document that she already signed up to as a member of staff and reflected that if she were to talk to the media, she would want the Communications team to provide their support. Gill Hough also agreed with the Code of Conduct and did not consider it was too strong or restrictive.<br><br>Diane Froggatt felt data protection could be an issue of legality in the Code of Conduct and asked if there was any information governance training that governors could participate in. Sam Harrison confirmed that there was an online programme available for staff and that she would look into whether this could be made available to governors for inclusion in the governor induction programme. . Anna Shaw stressed that in line with this guidance, there are responsibilities relating to individual cases and patient confidentiality and any governor speaking on behalf of the Trust and its membership would need to ensure guidance was followed in this respect. This is part of the advice the Communications team discuss with any spokespeople talking with the media.<br><br>Following this discussion, governors approved the Code of Conduct which in line with good practice will be reviewed on an annual basis. The Code of Conduct will be circulated to all governors who will be requested to sign it to declare that they agree to uphold the Code of Conduct. New governors will also be asked to sign the Code of Conduct on appointment.<br><br>Richard Gregory advised governors that as Michael Walsh had resigned the position of Chair of the Governance Committee was now vacant. It was agreed that Anna Shaw and her team will send an email to all governors along with the Committee's terms of reference for names to be put forward to fill this position.<br><br>**ACTION: Anna Shaw to email governors and collect nominees for the Chair of the Governance Committee**<br><br>**ACTION: Anna Shaw to share the communication team's contact details to governors.**<br><br>**ACTION: Information Governance to be included in the governors training programme**<br><br>**ACTION: Code of Conduct to be circulated to all governors for the declarations to be signed.**<br><br>**RESOLVED: The Council of Governors received and approved the Code of Conduct** |
| **DHCFT/Gov/ 2016/040** | **<u>GIAP UPDATE</u>**<br><br>Jenna Davies presented governors with an update on progress of all tasks within the |

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| | GIAP, including the identification of tasks that are off track, and those that the Council of Governors has responsibility for oversight.<br><br>Considerable work had taken place on the governor-related GIAP actions. Under wider GIAP progress significant work had taken place with Human Resources (HR) and Organisational Development related actions. Since the GIAP paper had been circulated to governors the People & Culture Committee had approved the HR model and the Trust's People Plan. This had now taken forward the culture and change and organisation development aspects of the GIAP as well as other areas around the training and development programme for staff.<br><br>Richard Gregory had chaired the People & Culture Committee on 15 July and informed governors that Sue Walters, the Trust's Staff Engagement Project Lead had brought some good ideas on staff engagement to the Committee and he would ask her to attend the next meeting of the Council of Governors meeting to present the engagement agenda.<br><br>It was recognised that a lot of elements of the GIAP are now complete. Richard Gregory pointed out that the Board is under the scrutiny of NHSI and has to demonstrate that processes are embedded.<br><br>Sam Harrison's paper for the second part of this item provided an update on tasks which are assigned to the Council of Governors for oversight. A progress report against these actions is discussed at each Governance Committee and the paper outlined the discussions held at the latest meeting held on 7 July and progress made on individual actions.<br><br>It was recognised that a lot of this work has been carried out by the Governance Committee and has enabled progress to be made in the GIAP. Governors confirmed that they were content with the status of actions outlined in the paper for which they have responsibility for oversight.<br><br>**ACTION: Staff Engagement Project Lead to attend the next meeting of the Council of Governors meeting to present the engagement agenda.**<br><br>**RESOLVED: The Council of Governors reviewed the GIAP and was assured by the progress of actions for which they have responsibility for oversight.** |
| **DHCFT/Gov/ 2016/041** | **<u>EQUALITY AND DIVERSITY WORKFORCE 2016/17</u>**<br><br>Owen Fulton, Principal Employee Relations Manager presented governors with an update on the Equality and Diversity Workforce approach for 2016 /17.<br><br>Owen Fulton explained that the Trust was positively re-engaging in the equality duty in order to extend it across protected characteristics. It consists of a general equality duty, supported by specific duties which are imposed by secondary legislation. In summary, those subject to the equality duty must, in the exercise of their functions, have due regard to the need to:<br><br>• Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.<br><br>• Advance equality of opportunity between people who share a protected characteristic and those who do not.<br><br>• Foster good relations between people who share a protected characteristic and those who do not. |

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| | It was noted that the CQC welcomed this strategy which works towards best practice. A consultation process will make sure the Trust is compliant with legislation.<br><br>Richard Gregory thanked Owen Fulton for the progress made so far. He asked how long it would take to progress undeveloped areas to achieving completion and understood that key milestones will indicate progress.<br><br>Maura Teager considered this was a good piece of work. It was recognised that a lot of good practice takes place in this organisation but there are pockets of resistance about engagement and changing behaviour and it will take a while to change this. Governors were pleased to note that there was no evidence to show that this resistance in engagement is having an impact on patient experience.<br><br>It was noted that progress reports from the 4Es and the BME Group would be received by the People & Culture Committee. Assurance was obtained that progress was being made with equality and governors would be kept updated on progress.<br><br>**RESOLVED: The Council of Governors acknowledged the Equality and Diversity Workforce approach for 2016/17** |
| **DHCFT/Gov/ 2016/042** | **PRESENTATION OF THE ANNUAL REPORT AND ACCOUNTS AND REPORT FROM EXTERNAL AUDITORS (GRANT THORNTON)**<br><br>A requirement under the Trust's constitution requires governors to be presented with the Trust's annual accounts. Claire Wright provided governors with a high level presentation that outlined the process and outputs of the annual accounts for 2015/16.<br><br>It was noted that financial performance during the year has been reported to Council of Governors and in public session of the Trust Board. The accounts are audited by our independent external auditors, Grant Thornton.<br><br>Claire Wright pointed out that the surplus achieved shown on the Statement of Comprehensive Income for 2015/16 is £1.1m after CIP had been achieved. This figure is adjusted by the regulator for impairments of £0.7m. This created a surplus of £1.8m as measured by Monitor (now NHS Improvement) and shows a good performance against plan of £1.3m.<br><br>The surplus achieved for the year translates to a healthy risk rating of 4, which is the best score achievable<br><br>Claire Wright explained that she would describe in more detail the financial position including balance sheet elements in the governors' financial training. She asked governors to let her know if they wanted any other financial factors included in their training.<br><br>**Report from External Auditors (Grant Thornton)**<br><br>Joan Barnett provided governors with an Annual Audit Letter presentation which summarised key findings arising from work that Grant Thornton carried out for the Trust for the year ended 31 March 2016.<br><br>Joan Barnett praised the work that Anna Shaw, Jenna Davies and the Finance Team in pulling together the annual accounts and annual report and thanked them for contributing to the efficient audit which resulted in Grant Thornton's opinion on the financial statements being issued ahead of the national deadline.<br><br>Joan Barnett pointed out that the most significant issue arising from the audit was with regard to the valuation of buildings. During the audit Grant Thornton identified a |

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| | number of differences between the Trust's internal data for building areas and the information previously provided by the Trust to the external valuer. This resulted in a potential overstatement of asset values of £1.147m which was below materiality. Joan Barnett confirmed that specific representation from the Trust's management resulted in this uncertainty not being material to the financial statements.<br><br>It was emphasised that the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the period ending 31 March 2016.<br><br>The Annual Audit Letter reflected the good working being undertaken with the Trust and that the Trust has been very proactive in working in partnership to support the delivery of strategic priorities. The Trust also has adequate arrangements in place to secure financial resilience.<br><br>**RESOLVED: The Council of Governors received the financial update report and Annual Audit Letter from Grant Thornton.** |
| **DHCFT/Gov/ 2016/043** | **INTER-SERVICE DEPARTMENT WAITING TIMES**<br><br>Laura McAra, Helen MacMahon and Scott Lunn from the Derby City neighbourhood team attended the meeting to discuss inter-service department waiting times as this had been requested by the Governance Committee at a recent meeting. The waiting times and action plan to improve the service was summarised.<br><br>Demand far outstrips capacity:<br>• Numbers waiting are high<br>• Length of wait can be significant<br>• Neighbourhoods are recognised to be under-resourced to tune of 60 care co-ordinators<br><br>Waiting List Management:<br>• In line with Trust Policy<br>• Several cohorts of referrals are prioritised – high and urgent clinical risk, people discharged from wards, veterans, children transitioning<br>• The only time a child transitioning to adult services has to wait is when the competing priorities dictate – this is not often but the impact for the individual, those close to them and the CAMHS service is considerable and Neighbourhood services respond as soon as possible<br>• There is a new policy related to transfer between the services in process, which will replace the previous one.<br><br>Action:<br>• Negotiations with commissioners has led to new resource to address under-resourcing, of about a third of what is agreed as required<br>• Recruitment has been in process to get these posts filled as soon as possible<br>• Neighbourhood transformation is planned to improve capacity; these new ways of working have commenced but need to be modelled through, governance assured and rolled out<br>• Neighbourhood managers liaise with other services referring to ensure priority of service is managed to the best possible outcome.<br><br>Scott Lunn explained that in CAMHS (Child and Adolescent Mental Health Services) there have been 2,600 referrals a year and about 5% of these referrals are transferred into adult services. A transition policy has been agreed which looks at appropriate transition plans which enables CAMHS to hold on to and treat young people as long as possible. This is because it is recognised that a lot of children prefer to remain in CAMHS until treatment has been completed rather than transfer to adult services mid- |

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| | way through treatment. Scott Lunn emphasised that if they receive a child who needs treatment the team assess their individual needs. The CAMHS team do not always believe that transition age should be 18 to enter adult services because so many are not ready to transfer to adult services. The Trust is commissioned up to age 18 but in practice works as flexibly as possible.<br><br>It was recognised that early intervention can make an enormous difference to recovery and huge strides have been made in treating cases on an individual basis which has resulted in some patients preferring to stay within CAMHS as they are not ready to go into adult services. It was recognised that this is how the service operates but it is not necessarily how the service was commissioned.<br><br>Gillian Hough asked if it would be possible to meet with commissioners to discuss extending the CAMHS service to an appropriate age limit and what impact this would have on commissioning and finance. It was proposed that commissioners be invited to a Council of Governors meeting to discuss this and Sam Harrison will liaise with Scott and Gillian Hough and Carole Riley to address the issues discussed and draft a letter to commissioners to invite them to talk to governors. Claire Wright suggested that Mark Powell would be key to understanding the ripple effect this would have on other services and would give way to informed debate with commissioners. Carolyn Green would also be asked to progress discussions with commissioners.<br><br>**ACTION: Samantha Harrison to engage with Scott Lunn, Carolyn Green, Gillian Hough and Carole Riley to draft a letter to invite commissioners to discuss extending the CAMHS service to an appropriate age limit.**<br><br>**RESOLVED: The Council of Governors received and noted the verbal inter-service department waiting times.** |
| **DHCFT/Gov/ 2016/044** | **INTEGRATED PERFORMANCE REPORT**<br><br>This was the first time governors have received the integrated report and Claire Wright highlighted key areas contained in the report which gave governors an overview of performance as at the end of May 2016 with regard to workforce, finance and operational delivery and quality performance.<br><br>Richard Gregory considered this report to be a significant step forward which clearly showed performance across all areas, enabled an overview to be easily understood, supported by detail which also usefully highlighted evidence from different perspectives. Governors were asked if the report was of value and whether it contained a suitable level of detail and all responded that the report was a valuable source of reference<br><br>**RESOLVED: The Council of Governors received and noted the Integrated Performance Report** |
| **DHCFT/Gov/ 2016/045** | **NON-EXECUTIVE DIRECTOR UPDATE**<br><br>Caroline Maley, the Senior Independent Director, reported that she had agreed with John Morrissey the Lead Governor, that today's Non-Executive Director update was to be verbal rather than written to enable discussion.<br><br>As Chair of the Audit and Risk Committee Caroline Maley described key activities of the Committee. Useful discussions were held on the Board Assurance Framework which enabled the Committee to have a good understanding of how risk is acknowledged within the Trust. Other main points of business centred around the Corporate Governance Framework which will be further developed as the framework evolves. The Trust is about to go out to tender for its internal audit and counter fraud |

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| | services and this is a big part of the assurance model that affects how we work. During the last few weeks Caroline also carried out a quality visit to Tansley Ward and she was also working with the Governor Task and Finish Group on the Employment Tribunal issues.<br><br>In response to Caroline Maley's update John Morrissey was pleased to point out that the final report containing the conclusions of the Task and Finish Group was due to be presented to the Council of Governors.<br><br>Maura Teager, Chair of the Quality Committee and Safeguarding Committee informed governors that times were very challenging dealing with rapid follow up on areas identified from the CQC visit which included areas of seclusion. She talked through items the Committee had discussed at the July meeting such as the early warning system for ILS (?) training and work plan. The Committee also looked at consultant paediatrics performance and waiting times for children. Different levels of care are being looked at and the Committee also discussed recovery and wellbeing and difficulties in the Radbourne Unit. The Committee scrutinised the detail contained in the Serious Incident reports and looked at complaints and compliments that had been received from service users. Maura Teager said that she tries to carry out at least one informal visit to a team or a site per month and this month she visited the Hartington Unit where workforce issues were uppermost in everyone's minds. A new cohort of qualified nurses will start in September and Maura Teager was encouraged by the willingness of staff to cover rotas in the meantime over the holiday period. In addition to this Maura also carried out a number of quality visits. The impact of the No Smoking policy will soon be reviewed and it is hoped that staff can be given more confidence to help patients receive treatment in a non-smoking environment.<br><br>Ruth Greaves was interested to know about diagnosis in the autism pathway. This is a life-long condition and she wanted to know what guidance was in place for people to cope with the situation they find themselves in. Maura Teager informed her that this is a very valuable service and there are specialised nurses in this area. Teams work with families to help them learn to care for family members with autism and teach them coping mechanisms.<br><br>**RESOLVED: The Council of Governors noted the verbal reports from the Non-Executive Directors who were present at the meeting.** |
| **DHCFT/Gov/ 2016/046** | **RATIFIED MINUTES OF THE BOARD MEETINGS HELD ON 25 MAY 2016**<br><br>The ratified minutes of the Board meetings held on 25 May were received and noted.<br><br>**RESOLVED: The Council of Governors received the minutes of the Trust's Public Board meeting held on 25 May 2016.** |
| **DHCFT/Gov/ 2016/047** | **REPORT FROM GOVERNANCE COMMITTEE**<br><br>The report from the Governance Committee highlighting issues discussed at meetings held on 7 July was received and noted.<br><br>**RESOLVED: The Council of Governors received the report from the Governance Committee meeting held on 7 July 2016.** |
| **DHCFT/Gov/ 2016/048** | **MEETING CLOSE**<br><br>There being no other matters to discuss, Richard Gregory thanked governors for attending and closed the meeting at 3.50pm. |
| **DHCFT/Gov/** | **DATE OF NEXT MEETING** |

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| **2016/049** | Tuesday, 6 September 2016 at 1pm, St Thomas Centre, Chatsworth Drive, Brampton, Derbyshire S40 3AW. |

# EXTRAORDINARY MEETING OF COUNCIL OF GOVERNORS

## Held in Private

**Tuesday, 12 July 2016**
**Meeting Room 1, Albany House,**
**Kingsway, Derby DE22 3LZ**

The meeting opened at 1pm and closed at 3:45pm

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| **PRESENT:** | Richard Gregory | Interim Chairman |
| **GOVERNORS:** | | |
| | Rosemary Farkas | Public Surrounding Areas |
| | Sarah Gray | Staff Nursing and Allied Professions |
| | Ruth Greaves | Public Derbyshire Dales |
| | Gillian Hough | Public Derby City East |
| | Alexandra Hurst | Public High Peak |
| | Moira Kerr | Public Derby City West |
| | John Morrissey | Public Amber Valley South |
| | Robert Quick | Public North East Derbyshire |
| | April Saunders | Staff Nursing and Allied Professions |
| **IN ATTENDANCE:** | Caroline Maley | Senior Independent Director & Non-Executive Director |
| | Maura Teager | Non-Executive Director |
| | Phil Harris | Non-Executive Director |
| | Ifti Majid | Acting Chief Executive |
| | Claire Wright | Executive Director of Finance |
| | Carolyn Green | Executive Director of Nursing & Patient Experience |
| | Richard Eaton | Communications Manager |
| | Shirley Houston | Engagement Officer |
| | Sue Turner | Board Secretary and Minute Taker |
| **APOLOGIES:** | Barry Appleby | Public South Derbyshire |
| | Shelley Comery | Public Erewash North |
| | Dr Paula Crick | University of Derby |
| | Cllr Rob Davison | Derbyshire County Council |
| | Prof Paul Crawford | University of Nottingham |
| | Dr Nitesh Painuly | Staff (Medical and Dental) |
| | Diane Froggat | Derby City Council |
| | John Jeffrey | Public Bolsover |
| | Lynda Langley | Public Chesterfield North |
| | Carole Riley | Public Derby City East |
| | Kelly Sims | Staff Administration and Allied Support Staff |

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| **1.** | **INTERIM CHAIRMAN'S WELCOME**<br><br>Richard Gregory, the Interim Chairman, opened the meeting and welcomed everyone. He explained that the purpose of today's meeting is to set out the process for partnership and collaboration as part of the Sustainability and Transformation Planning (STP) within Derbyshire.<br><br>This plan was considered at today's confidential extraordinary meeting of the Trust's Council of Governors and took place on the same day as the Council of Governors of Derbyshire Community Health Services NHS Foundation Trust (DCHS) - after which a briefing would be made to all staff within the organisation so they would be aware of how the Trust was starting to explore the potential for further collaboration with DCHS. There are a variety of options to define the level of collaboration and the Trust was at the very early stages of considering these. Both Boards have agreed to work in partnership to develop a 'strategic options case' which considers the pros and cons of each option. It is anticipated that this work will then be presented to both Boards towards the end of the calendar year for consideration.<br><br>At today's meeting governors would hear some specific proposals that are being made nationally and the presentation to be made by Gareth Harry from the Hardwick Clinical Commissioning Group would set the scene.<br><br>As it was Rob Quick's final meeting as a governor, Richard Gregory thanked him for the significant contribution he had made to the effectiveness of the Council. |
| **2.** | **ACTING CEO UPDATE ON PARTNERSHIP AND COLLABORATION**<br><br>Ifti Majid explained the reasons behind the proposal to work collaboratively with DCHS for the benefits of the patients and carers of Derby and Derbyshire. Both trusts offer a range of different services and his report set out how the Trust could collaborate more efficiently and formally with DCHS and provided information for governors to consider with regard to exploring strategic options for collaboration. He explained that he had proposed to the Board of Directors that time and resource be approved in order for a Strategic Options Case (SOC) to be prepared for consideration by the Trust Board in the autumn and this was agreed at the June confidential meeting.<br><br>A range of options would be considered, from informal collaboration to a full merger. Ifti Majid talked about the main system challenges for the Derbyshire health and social care system which have arisen mainly as a result of NHS funding challenges, rising demand and marked health inequality across the county and city, workforce shortages and the shape of NHS provision across the county. He also highlighted the opportunities that would arise through closer working with DCHS and how increased collaboration would enable the transformation of our services to support the system.<br><br>A wide variety of options that could exist between our two organisations was pointed out and work would take place between now and October to specify how we might work differently. The next step would be to form a formal partnership-based programme to create a SOC that would consist of:<br><br>• Current strategy, strategic issues and challenges<br>• Strategic options analysis and evaluation for all spectrum options including strategy fit, quantified risks and benefits, deliverability and risks to delivery, return in terms of supporting the closure of the STP gaps<br>• Clarity around how any proposed collaboration fits with the health economy (STP) strategy |

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| | • Alignment of priorities/goals for both organisations and any other collaboration partner<br>• Impact of proposed collaboration on:<br>o Patients<br>o Trusts and other organisations<br>o Local Health Economy<br><br>• Working with NHS Improvement (NHSI) to understand:<br>o What type of risk assessment is needed<br>o Clarity on assessing customer benefits<br><br>It is anticipated that the creation of the SOC and associated engagement would require a minimum of four months to develop and a draft paper is expected to be presented to both Boards in October setting out the next steps.<br><br>Ifti Majid explained that a project team had already been set up to form our SOC. Governors will be in the centre of engagement as well as other stakeholders that we will engage with such as clinicians, colleagues in the CCGs, people who use our services and other colleagues in the wider provider organisations. Richard Gregory added that the most important principle of collaboration is maintaining and developing the quality of mental health services for patients in Derbyshire. The Board intends to make sure that future collaboration has an absolute commitment to mental health. Any formal collaboration will be agreed between governors and the Board and will be part of our long term strategy.<br><br>Gillian Hough was disappointed to see only one strand, namely DCHS. She would have liked to have seen many other organisations involved as she believes there is power in numbers. Ifti Majid considered this was a valid point and would be part of the first stage of the SOC.<br><br>John Morrissey was concerned that the best way forward might involve a number of legal challenges that will have a big impact on any savings that might be incurred. Ifti Majid explained there is already a legal framework in place which has a strict process to follow and the coming together of two organisations is currently covered in legislative framework.<br><br>Moira Kerr was of the opinion that analysis of closer collaboration between the two trusts would not be a surprise given the history of provision in the county and views expressed in recent years.<br><br>Rob Quick was very pleased to hear that staff would be briefed on the plan and that staff and service receivers would be involved in the wider service provision.<br><br>**RESOLVED: The Council of Governors:**<br>**1) Noted the strategic options for closer working between the Trust and Derbyshire Community Health Services**<br>**2) Agreed to have involvement in the development of the Strategic Outcome Case**<br>**3) Agreed to receive updates at all future Council meetings** |
| **3.** | **<u>THE WIDER SUSTAINABILITY AND TRANSFORMATION PLAN (STP)</u>**<br><br>To understand how the SOC for our Trust and DCHS fitted into the developing system strategy, Ifti Majid introduced Gareth Harry, Chief Commissioning Officer from the Hardwick Clinical Commissioning Group (CCG) who presented an update to governors on Parity of Esteem, 21st Century Joined Up Care proposals and consultation and the Derbyshire Sustainability and Transformation Plan (STP). He talked about the advantages of integrating mental health services and physical health services.<br><br>Governors acknowledged that more funding is required for mental health services and Moira |

Kerr made the point that if the trusts merge a higher level of mental health care funding could be obtained. Gareth Harry and Ifti Majid responded that if the Derbyshire system does not change models of care or improve the integration of services there would be a gap of £240m by 2020/21.

Governors questioned the exact meaning of 'parity of esteem'. Gareth Harry confirmed that it was the growth in mental health expenditure matching or exceeding total commissioner allocation growth. It was not parity with acute providers as was generally thought. Governors hoped that as the plan develops tangible figures would be made available to assess the impact of parity of esteem on mental health services.

Gareth Harry highlighted how the Derbyshire STP will address the gaps across Derbyshire and identify the levers for closing gaps in health and wellbeing, care quality and finance and efficiency.

Ruth Greaves was concerned about who would be responsible for the confidentiality of care for patients and how information would be shared in teams from different trusts working together in the community. Gareth Harry explained that this would be managed as part of clinical governance within the integrated teams and is yet to be discussed and agreed. Who takes control of governance is an important issue and would be addressed very carefully as well as how staff are trained to comply with requirements.

Governors understood that STP will make a big difference in the treatment and care of patients and Gareth Harry's presentation set out how the STP mental health work stream would work with all partners represented on the work stream. Partners include all CCGs, the Trust, DCHS, Public Health and Adult Care. The work stream would focus on prevention and achieving parity in terms of closing the mortality and morbidity gap for people with mental health problems.

April Saunders was concerned that there would be ward closures in community areas when these should be utilised to increase services working in the community rather than losing them. She also pointed out that so far there was no mention of how carers would be supported within the community.

Moira Kerr produced a list of concerns she had received from carers regarding difficulties in providing mental health care to people waiting for treatment in ED (Emergency Department) which she handed out during the meeting. She stressed the importance of people feeling safe in ED especially if they have been sectioned but not admitted and need to be cared for by a mental health professional during that time. Carolyn Green pointed out that many people are admitted from ED and a different system needs to be put in place to resolve the problem. The answer would be to have acute nurses working in ED looking at psychological mindedness but support investment does not meet demand. Concern was also raised about access to autism pathways. Gareth Harry hoped this service will be developed to meet demand as investment is improved and offered to discuss these issues further with Carolyn Green outside of the meeting.

Other points to consider raised by governors included:

- Could service users/staff help design the new integrated services?
- How will parity of esteem work in a merged organisation?
- The plan needs to demonstrate extra resourcing of mental health, and identify how investment in mental health saves money in physical acute provision
- Training requirements for merged teams and IT issues
- Could the Finland community team model be considered?
- Consideration of the need for Tier 4 beds for children

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| | • How can carers be better supported?<br>• Should we have a Derbyshire health and social care board to enable social care integration?<br>• Consideration of how more robust community services could avoid A&E admissions.<br><br>Richard Gregory said it was important to capture all of these points and he reiterated that the future collaboration with DCHS and system development needed to demonstrate how improvements to mental health services would be achieved.<br><br>Ifti Majid pointed out that while the STP develops, two systems will need to operate and this will mean significant investment to provide the head room to invest in the services that would produce benefits in time. It was reiterated that Gareth Harry's presentation today was an update on STP. The plan will take time to develop and it was expected that a draft paper would be presented to governors in the Autumn. In the meantime STP would be a standing agenda item for discussion at each meeting of the Council of Governors.<br><br>**RESOLVED: The Council of Governors received an update on Parity of Esteem and the Derbyshire Sustainability and Transformation Plan (STP).** |
| **5.** | **CLOSURE OF MEETING**<br><br>There were no further items for discussion, Richard Gregory thanked all those present for their contributions and closed the meeting at 3:40pm. |

| COUNCIL OF GOVERNORS ACTION MATRIX - SEPTEMBER 2016 | | | | | |
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| **Date of Minutes** | **Minute Reference** | **Heading** | **Lead** | **Status of Action** | **Current Position** |
| 15.3.2016 | DHCFT/Gov/2016/014 | External Investigation Reports | Jayne Storey | Joint Board and Council of Governors training programme to be put in place | Training identified in Governor Training Development Programme |
| 15.3.2016 | DHCFT/Gov/2016/014 | External Investigation Reports | John Sykes | John Sykes to involve governors and staff groups to discuss the psychology around the effects of personal / inappropriate relationships | Personal relationships policy has been updated and reissued to staff and was circulated to governors on 6 June. This also falls under the remit of the Trust's Raising Concerns (Whistleblowing) policy. Sam Harrison has made arrangements to meet with Moira Kerr to discuss the above policy. ACTION COMPLETE |
| 15.3.2016 | DHCFT/Gov/2016/014 | External Investigation Reports | Jayne Davies | Opportunities for staff to meet governors prior to council meetings will be looked at. A proper policy will be put in place for governors to follow when visiting staff and will be developed by Jayne Davies | Future meetings would where possible take place at other Trust locations and local staff will be invited to meet governors. September meeting is taking place in Chesterfield. Venues for all meetings are shown in the governor magazine. |
| 1.6.2016 | DHCFT/Gov/2016/021 | Matters Arising | Jayne Storey | Jayne Storey to update governors on day to day Lead for Equality and Diversity issues | Owen Fulton is lead for Equality and Diversity and presented the Equality Diversity and Workforce paper at July COG meeting. ACTION COMPLETE |
| 1.6.2016 | DHCFT/Gov/2016/024 | People Strategy | Jayne Storey | Jayne Storey undertook to make minor amendments as outlined by Gill Hough on page 3 of the strategy | To be followed up by Jayne Storey |
| 1.6.2016 | DHCFT/Gov/2016/026 | GIAP | Carole Riley Jim Dixon | Carole Riley to liaise with Jim Dixon and explore potential secondary school representative contacts/appointed governors. | Schools to be guided in mental health issues. This approach is to be extended to primary schools also. It was suggested that a Trust representative could work with schools to provide guidance in mental health issues and a presentation made to a head teachers group to show how early intervention could work. Jim Dixon agreed to speak to Carolyn Green to take this forward. |
| 1.6.2016 | DHCFT/Gov/2016/026 | GIAP | Sam Harrison | Samantha Harrison to review timelines for elections for the forthcoming year | In development. |
| 1.6.2016 | DHCFT/Gov/2016/030 | Any other business - Quality Visits | Carolyn Green | Feedback from quality visits to be reported back to Council of Governors and Trust Board to evidence learning from visits | Feedback from quality visits should be provided on a quarterly basis. Maura Teager will progress this as Chair of the Quality Committee. This is also relevant to patient stories to Board about how we hear first-hand from service users and staff. We need to consider how we capture the issues that the Board should be learning from patient experiences and report these back to COG. |

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| 1.6.2016 | DHCFT/Gov/2016/030 | Any other business - Governor Visits | Carolyn Green | Carolyn Green to develop a protocol for governor visits within the Trust | A first draft has been developed but requires further work from governors and will be circulated week commencing 19 July. Sam Harrison and Carolyn Green are holding discussions to develop appropriate protocol. |
| 21.7.2016 | DHCFT/Gov/2016/030 | Matters Arising from June meeting | Carolyn Green | Carolyn Green to be asked to coordinate production of actions/learnings from patient stories presented to public Board Meetings | This will be a standing agenda item for COG. |
| 21.7.2016 | DHCFT/Gov/2016/038 | Appointment of Non-Executive Directors | Richard Gregory<br>John Morrissey | Richard Gregory and John Morrissey to conduct an exit interview with Phil Harris | Exit interview took place 24 August. ACTION COMPLETE |
| 21.7.2016 | DHCFT/Gov/2016/038 | Appointment of Non-Executive Directors | Sam Harrison | Samantha Harrison to arrange for pre-employment checks to be carried out on the newly appointed NEDs and for them to undergo the fit and proper persons test | Currently in progress - awaiting results of fit and proper persons test. |
| 21.7.2016 | DHCFT/Gov/2016/039 | Code of Conduct | Anna Shaw | Anna Shaw to email governors and collect nominees for the Chair of the Governance Committee<br><br>Anna Shaw to share the communication team's contact details to governors.<br><br>Information Governance to be included in the governors training programme<br><br>Code of Conduct to be circulated to all governors for the declarations to be signed. | This process has been undertaken, two governors expressed interest to be Chair of the Governance Committee. All governors have been asked to express a preference from the two candidates and the new Chair will be announced w/c 30 August<br><br>The communications team contact details are included in the Governor Connect issued on 1 September<br><br>Information Governance training will be offered on 5 December (please see revised Governor Training Development Programme for further details).<br><br>Code of Conduct circulated to all governors and six signed copies have been returned to date. Governors who have not yet returned their signed Code of Conduct are asked to do so asap, prior to the Council of Governors meeting on 6 September. |
| 21.7.2016 | DHCFT/Gov/2016/040 | GIAP | Sam Harrison | Staff Engagement Project Lead to be invited to attend the next meeting of the Council of Governors meeting to present the engagement agenda. | Scheduled for November meeting. |

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| 21.7.2016 | DHCFT/Gov/2016/044 | Inter-Service Department Waiting Times | Sam Harrison | Samantha Harrison to engage with Scott Lunn, Carolyn Green, Gillian Hough and Carole Riley to draft a letter to invite commissioners to discuss extending the CAMHS service to an appropriate age limit | This is currently in development |

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

**Derbyshire Healthcare NHS Foundation Trust**
Report to Council of Governors 6 September 2016

## Acting Chief Executives Report to the Council of Governors

**Purpose of Report:**

This report provides the Council of Governors 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.

**National Context**

1. NHSI continue to drive provider collaboration and have issued their first priority areas for back office collaboration against which they will benchmark providers. These are Finance, HR, IM&T, Procurement, Payroll, Governance and Risk, Estates and Facilities and Legal services. There is a strong direction from the centre for as much collaboration as possible, as soon as possible, in back office and pathology functions. There is also strong focus in the acute sector on the delivery of Carter acute productivity and efficiency programme. Providers and STPs will be required to produce STP wide back office consolidation business plans to return to NHSI by the end of September. NHSI have signalled that in time they wish to expand this work to all corporate and administrative costs.

2. NHSI have put the 2017/18 and 2018/19 tariff out to consultation, within that is the guidance to move away from block contracts for Mental Health service and use either episodic or capitation methods or other local contractual agreements.

3. NHS England have said they will take action in areas where funding pledged for mental health services is not reaching the front line: if commissioners and providers are not investing in services as set out in NHS England's implementation plan or hitting key performance targets, the NHSE have said they will step in.

4. NHS England has announced a £5m perinatal community services development fund whereby STPs, commissioners and providers can bid for money to expand services for women with mental health problems during or after pregnancy. The fund is part of £365m plan to expand perinatal support to an extra 30,000 women a year by 2020/21. The £5m pot for 2016/17 is the first of three payments pledged to the scheme in last month's implementation plan, with £15m due in 2017/18 and £40m the year after.

**Local Context**

5. The consultation in the north of the county is progressing well with lots of stakeholder consultation events taking place around the north of Derbyshire. It is now entering its second round of consultation events. We have provided responses to questions particularly with regard to the development of a Dementia Rapid Response Team in the north of the county

6. The Derbyshire STP progressed has now been assessed by The National Team, I was part of the representation that attended. We received positive feedback about our level of ambition and the structure we have in place with respect to STP Governance. There

were three specific areas of improvement that were requested:

- Be more granular and specific in regards to setting out how the footprint will collaboratively strengthen primary care to support the shift in care from hospitals.

- Ensure there is sufficient evidence behind the activity modelling and savings assumptions to further demonstrate ability to deliver the anticipated clinical benefits.

- Include stronger plans for mental health drawing on the recent publication of the Forward View for Mental Health. This is a really positive comment and demonstrates the increasing commitment and focus on improving mental health services. In Derbyshire we have very clear plans for delivering the mental health five year forward view, closely aligned to our Trusts Strategy that will now be included in the core document rather than an appendix

In addition NHS England have increased scrutiny on all STPs nationally with two weekly checkpoint meetings to monitor progress against performance. Two key areas of focus over the next month include workforce planning and engagement both with staff and our wider communities.

7. HSJ reported that Chesterfield Royal FT has won a 15 year contract to provide services at three GP practices it was previously running as an "emergency caretaker". The trust's primary care arm – Royal Primary Care – will be providing services to 20,000 patients from three practices in Grangewood, Staveley and Inkersall. The contract was awarded by North Derbyshire Clinical Commissioning Group following a competitive tender process

**Within our Trust**

6. Building on my last briefing to the Board we are continuing the work to explore the optimal degree of organisational collaboration with DCHS. The preparation of the strategic outcomes case continues on track to deliver a recommendation to the Trust Board in October. As part of the development of this case an engagement event was held for key stakeholders on the 31 August that was well attended by Board members, Governors, clinical leaders and representatives from other Derbyshire Organisations.

7. We continue to work closely with other Organisations in Derbyshire around developing plans for closer collaboration between support services, (back office functions as described by NHSI). I am hopeful of being able to present initial options to the Board of Directors by the end of October

8. On 23 August the Trust received the draft report following the CQC visit during June. We are currently completing factual accuracy check on the reports and will return these to the CQC by 7 September. There will then be a period of time where the CQC review our comments before the public release of the final documents.

9. Of the past few months we have seen increased pressure on bed availability for adults with mental health problems resulting in increasing numbers of adults needing to be treated outside of Derbyshire. One knock on impact of this is that patients presenting at Emergency Departments have had to wait longer for a bed whilst one was sourced. This has led to an increasing number of people waiting longer than 12 hours. We

recognise that this is not an acceptable experience for those individuals and the clinical teams have been working closely with counterparts in both Acute Trusts in order to improve this situation. In addition NHS England has called a meeting to review this situation and receive assurance from ourselves and other providers about actions we are taking.

10. You will be aware from recent articles in the press that junior doctors remain dissatisfied with the revised contract they have been offered and remain in discussions with the BMA. Along with all other Trusts we are implementing the revised contract and as part of that I am delighted we have appointed Dr Sugato Sarkar as the Junior Doctor Guardian who will be the designated person for junior doctors to raise concerns with about their hours.

11. Listen, Learn, Lead – Due to the holiday season there has only been one visit this month. These can be seen on the actions tracker in appendix 1. Some of the key themes emerging from visits this month included:

    - Uncertainty around the collaborative work with DCHS, what it might mean for frontline staff
    - Mixed feelings around the process/early draft findings associated with CQC visit
    - Positive feedback around staff feeling able to raise difficult issues with very senior managers in open forums and that this was a significant shift from how it has been in the past

The Executive Team continue to work to clean up and close actions on the tracker and the document presented at the next Board will incorporate all updates available.

**Strategic considerations**

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

**Consultation**

None

**Governance or Legal Issues**

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

**Equality Delivery System**

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

**Recommendations**

Council of Governors are requested to:

1) Note the contents of the update

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| **Report presented by:** | **Ifti Majid**<br>**Acting Chief Executive** |
| **Report prepared by:** | **Ifti Majid (supported by Claire Wright, Director of Finance)**<br>**Acting Chief Executive** |

**Derbyshire Healthcare NHS Foundation Trust**
Report to Council of Governors 6 September 2016

## Strategy Implementation Update

**Purpose of Report:**
The Trust Board approved the Trust Strategy 2016-21 in May of this year. At that time a brief outline of the strategy implementation process was presented. This report is to apprise the Council of Governors of the progress of the implementation process and any current risks to delivery.

**Executive Summary**

The report received by the Board in May gave a brief outline of the strategy implementation process which commenced on the 15th June. The key stages undertaken to-date include:

| Milestones | Date | Update |
|---|---|---|
| 'Strategy Implementation' Event – this gave greater explanation of the process, the objectives and the parameters to ensure everyone knew what was expected, what was required, timescales etc | 15/06/16 | Attended by 30+ managers and clinicians |
| Clinical Service Areas (Neighbourhood, Campus and Central Services) - initial scoping and analysis and develop of Business Plans throughout the whole process | 15/06/16 to 19/09/16 | This is being led by Contracting and Business Planning – process underway and linked to other workstreams |
| Teams working on the 7 Sustainability Transformation Plan areas and Corporate Services submitted 'Outline Solutions' (options considered) to a panel consisting of Executive Directors, Senior Managers, commissioners etc (Gateway 1) | w/c 11/07/16 | 'Gateway 1' - a panel of Directors, Senior Managers, Governor representation and Commissioners received presentations of initial ideas. Feedback was given to all groups and agreement was given to continue further scoping. |
| Pathway Workshop – this was convened following feedback from groups post Gateway 1 | 02/08/16 | A workshop was held to review all workstreams, share outputs, look at synergies and agree the way forward |
| Alignment to the Sustainability and Transformation Plan – following discussions with the 'Engine Room' it was necessary to reframe the requirements of groups | 19/08/16 | Owing to STP requirements it was necessary to reframe the requirements of our process. Timescales and areas of work remained. However, the business case and other outputs were simplified. |
| Deadline for receipt of 'Proposed Solution' for each STP area | 05/09/16 | This remains an initial deadline as it is in-line with STP requirements. Corporate area plans have been superseded by the 'back-office' work so this area is not being held to internal deadlines |

The process is progressing according to plan and is aligned with the Sustainability and Transformation Plan. Our internal process has been cognisant of the wider health and care economy from the beginning, involving key people from other organisations, particularly Adult Care, DCHS and commissioners.

There remain some key risks to delivery such as links to the system wide planning agenda and the competing priorities of both clinical and operational teams owing to the recent CQC inspection and subsequent actions. These risks are being mitigated by ensuring close alignment to the 'Engine Room' (the central team driving the process) and the Commissioner Leads. Where appropriate we are linking to structures which are already in place, such as the Dementia Board and the CAMHs Transformation Group, by integrating the projects into core business we reduce complexity and demand on staff time.

The next stage for the process is 'Gateway 2' on 16th and 23rd September, where proposals will be discussed with a panel consisting of Directors, a representative from the Non-Executive Directors, a staff and public Governor representative, Senior Managers and Commissioners.

A Business Case and a two year timeline for implementation will be submitted for 'confirm and challenge' these will form the basis for inclusion within the current management structure Business Plans. All areas will have a clear view of the direction of travel over the next two years.

This will be in-line with STP timelines as the final Business Plan for Mental Health, Learning Disabilities and Children/CAMHS has got to be submitted on 14th October.

**Strategic considerations**

The key strategic consideration is the need for a clear link to the wider system transformation and the Sustainability and Transformation Plan (STP).

The strategy implementation process is fully cognisant of STP themes and any potential interdependencies. This is a dynamic environment and key links are made via workstream leads.

**Board Assurances**

The Board Assurance Framework for 2016/17 has been updated to include the strategy implementation process

**Consultation**

The strategy implementation process has involved a wide group of staff as appropriate to the particular area of work. This has included Associate Clinical Directors, other clinical staff, Managers, Staff Side and team members who are able to contribute service specific expertise. The Council of Governors and Trust Board are also engaged in the process via representation on the Strategy Panels.

**Consultation (Cont…)**

External organisations including Adult Care, Commissioners and DCHS have been represented either directly or virtually.

As the process progresses the workstream groups are continuing to include a wider audience of staff, service users and external agencies including the voluntary sector.

The 'Gateway Panels' have included representatives from the Board and Council of Governors.

**Governance or Legal Issues**

There are currently no governance or legal issues identified at this initial planning stage as business cases are developed. However, as the implementation process progresses governance and legal issues are likely to arise and will be reported accordingly.

**Equality Delivery System**

Increasing collaborative working with charity sector organisations that have specific positive relationships with certain communities is likely to positively impact on outcomes for certain REGARDS groups.

**Recommendations**

The Council of Governors is requested to:

1. Note the contents of this report
2. Receive assurance that the strategy implementation process is progressing and that appropriate measures are in place to ensure that it is in-line with the system wide STP process

| | |
|---|---|
| **Report presented by:** | **Mark Powell**<br>**Director of Strategic Development** |
| **Report prepared by:** | **Lynn Wilmott-Shepherd**<br>**Associate Director of Strategy and Business Development** |

**Derbyshire Healthcare NHS Foundation Trust**
Report to Board of Directors – 7 September 2016

# Integrated Performance Report Month 4

## Purpose of Report

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

## Recommendations

The Board of Directors is requested to:

1) Consider the content of the paper and consider their level of assurance on the current performance across the areas presented.

## Executive Summary

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

This month's report continues to develop the integrated reporting, with Quality baselines being established.

This month the data has been triangulated and a key theme drawn out from the information in the report.

The report continues to be modified to reflect changes requested by the Board.

## Strategic considerations

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

## Board Assurances

This report should be considered in relation to the relevant risks in the Board Assurance Framework.
As an integrated performance report the content of provides assurance across several BAF risks related to workforce, operational performance, quality performance, financial performance and regulatory compliance.

**Consultation**

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

**Governance or Legal issues**

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

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

**Equality Delivery System**

This report reflects performance related to our whole staff and service receiver population and therefore includes members of those populations with protected characteristics in the REGARDS groups.
Any specific impact on members of the REGARDS groups is described in the report itself.

| | |
|---|---|
| **Report presented by:** | **Carolyn Gilby, Acting Director of Operations**<br>**Claire Wright, Director of Finance**<br>**Jayne Storey, Director of Workforce**<br>**Carolyn Green, Director of Nursing** |
| **Report prepared by:** | **Peter Charlton, General Manager, Information Management**<br>**Rachel Leyland, Deputy Director of Finance**<br>**Liam Carrier, Workforce Systems & Information Manager**<br>**Hayley Darn, Nurse Consultant** |


Highlights

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

Challenges

- CIP forecast to deliver further but not to full target
- Mitigations of Financial risks during 16/17

Highlights

- 28 Day readmission compliance has improved
- Outpatient Letters have seen a full quarters sustained achievement of both targets

Challenges

- 18 week incomplete RTT compliance
- Initial cluster of patients
- % 6-8 Week Breastfeeding coverage
- Early Intervention is showing a significant decline in performance

Highlights

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

Challenges

- Monthly and annual sickness absence rates continue to rise.
- Budgeted Fte vacancies remain high.
- Appraisal compliance rates have decreased.

This is a report section in phased development.

Highlights

- Safety Planning training has increased and is close to the 90% target.

Challenges

- Supervision rates have improved slightly with work still to be done
- Flu vaccinations for staff – planning is underway for a programme to commence October 2016

# FINANCIAL OVERVIEW – JULY 2016

Enc E

| Category | Sub-set | Metric | Period | Plan | Actual | Variance | Trend | Key Points |
|---|---|---|---|---|---|---|---|---|
| Governance | FSRR | Overall Financial Sustainability Risk rating | YTD | 3 | 4 | G | | As at the end of July the FSRR is 4 which is better than plan and is forecast to be a 4 at the end of the year. Each of the quarters are also forecast to be a 4. |
| | | | Forecast | 4 | 4 | G | | |
| | | Debt Service Cover | YTD | 3 | 3 | G | | |
| | | | Forecast | 3 | 3 | G | | |
| | | Liquidity | YTD | 3 | 4 | G | | |
| | | | Forecast | 4 | 4 | G | | |
| | | Income and Expenditure Margin | YTD | 3 | 4 | G | | |
| | | | Forecast | 4 | 4 | G | | |
| | | Income and Expenditure Margin Variance | YTD | 4 | 4 | G | | |
| | | | Forecast | 4 | 4 | G | | |
| I&E and profitability | Income and Expenditure | Control Total position £'000 | In-Month | 223 | 355 | G | | The Control Total shows the position including the Sustainability Transformation Fund (STF) and the Underlying Income and Expenditure position excludes the STF. Surplus is better than plan in the month and due to changes in the run rate is forecast to achieve plan at the end of the financial year.<br><br>The Normalised Income and Expenditure shows the financial performance adjusting for any non-recurrent costs or benefits that will not continue. |
| | | | YTD | 364 | 1,006 | G | | |
| | | | Forecast | 2,531 | 2,531 | G | | |
| | | Underlying Income and Expenditure position £'000 | In-Month | 154 | 286 | G | | |
| | | | YTD | 88 | 729 | G | | |
| | | | Forecast | 1,701 | 1,701 | G | | |
| | | Normalised Income and Expenditure position £'000 | In-Month | 154 | 301 | G | | |
| | | | YTD | 88 | 832 | G | | |
| | | | Forecast | 1,701 | 1,618 | R | | |
| | Profitability | Profitability - EBITDA £'000 | In-Month | 826 | 964 | G | | |
| | | | YTD | 2,815 | 3,480 | G | | |
| | | | Forecast | 9,806 | 9,677 | R | | |
| | | Profitability - EBITDA % | In-Month | 7.3% | 8.6% | G | | |
| | | | YTD | 6.2% | 7.8% | G | | |
| | | | Forecast | 7.1% | 7.2% | G | | |
| Liquidity | Cash | Cash £m | YTD | 10.392 | 11.513 | G | | Cash is currently above plan but is forecast to be below plan at year end due to the forecast release of some provisions. |
| | | | Forecast | 13.153 | 12.355 | R | | |
| | Net Current Assets | Net Current Assets £m | YTD | 4.065 | 6.314 | G | | |
| | | | Forecast | 7.570 | 5.587 | R | | |
| | Capex | Capital expenditure £m | YTD | 0.841 | 0.757 | R | | |
| | | | Forecast | 3.450 | 3.450 | G | | |
| Efficiency | CIP | CIP achievement £m | In-Month | 0.358 | 0.187 | R | | CIP is currently behind plan and is forecast not to deliver the full plan at the end of the financial year. |
| | | | YTD | 1.433 | 0.718 | R | | |
| | | | Forecast | 4.300 | 2.900 | R | | |
| | | | Recurrent | 4.300 | 1.998 | 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

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

# OPERATIONAL OVERVIEW – JULY 2016

Enc E

| Category | Sub-set | Metric | Period | Plan | Actual | Variance | Trend | Key Points |
|---|---|---|---|---|---|---|---|---|
| Performance Dashboard | NHSI | CPA 7 Day Follow-up | Month | 95.00% | 96.15% | G | ↓ | Compliant with NHSI targets except incomplete RTT where demand appears greater than our ability to meet using current processes. |
| | | | Quarter | 95.00% | 97.35% | G | → | |
| | | CPA Reviews in Last 12 months | Month | 95.00% | 95.79% | G | → | |
| | | | Quarter | 95.00% | 95.79% | G | → | |
| | | Delayed Transfers of Care | Month | 7.50% | 2.31% | G | → | |
| | | | Quarter | 7.50% | 2.35% | G | → | |
| | | Data completeness - Identifiers | Month | 97.00% | 99.42% | G | → | |
| | | | Quarter | 97.00% | 99.42% | G | → | |
| | | Data completeness - Outcomes | Month | 50.00% | 93.89% | G | → | |
| | | | Quarter | 50.00% | 93.89% | G | → | |
| | | Community Care Data Activity - Completeness | Month | 50.00% | 93.22% | G | → | |
| | | | Quarter | 50.00% | 93.22% | G | → | |
| | | Community Care Data - RTT Completeness | Month | 50.00% | 92.31% | G | → | |
| | | | Quarter | 50.00% | 92.31% | G | → | |
| | | Community Care Data - Referral Completeness | Month | 50.00% | 75.91% | G | → | |
| | | | Quarter | 50.00% | 75.28% | G | ↓ | |
| | | 18 Week RTT incomplete | Month | 92.00% | 89.84% | R | ↓ | |
| | | | Quarter | 92.00% | 89.74% | R | ↓ | |
| | | Early Interventions New Caseload | Month | 95.00% | 167.40% | G | ↓ | |
| | | | Quarter | 95.00% | 167.40% | G | ↓ | |
| | | Clostridium Difficile Incidents | Month | 7 | 0 | G | → | |
| | | | Quarter | 7 | 0 | G | → | |
| | | Crisis Gatekeeping | Month | 95.00% | 100.00% | G | → | |
| | | | Quarter | 95.00% | 100.00% | G | → | |
| | | IAPT RTT within 18 weeks | Month | 95.00% | 99.78% | G | → | |
| | | | Quarter | 95.00% | 99.85% | G | → | |
| | | IAPT RTT within 6 weeks | Month | 75.00% | 88.22% | G | ↓ | |
| | | | Quarter | 75.00% | 88.31% | G | ↓ | |
| | | Early Intervention in Psychosis RTT Within 14 Days | Month | 50.00% | 57.14% | G | ↓ | |
| | | | Quarter | 50.00% | 55.10% | G | ↓ | |

Key:

**Period**

Month Current Month

Quarter Current Quarter

Achieving target

Not achieving target

↑ → ↓ Trend compared to previous month/quarter

# OPERATIONAL OVERVIEW – JULY 2016

Enc E

| Category | Sub-set | Metric | Period | Plan | Actual | Variance | Trend | Key Points |
|---|---|---|---|---|---|---|---|---|
| Performance Dashboard | Locally Agreed | CPA Settled Accommodation | Month | 90.00% | 96.50% | G | → | The majority of clinicians now successfully manage their PbR caseloads either independently or through positive engagement with available support. |
| | | | Quarter | 90.00% | 96.50% | G | → | |
| | | CPA Employment Status | Month | 90.00% | 97.41% | G | → | |
| | | | Quarter | 90.00% | 97.41% | G | → | |
| | | Data completeness - Identifiers | Month | 99.00% | 99.42% | G | → | |
| | | | Quarter | 99.00% | 99.42% | G | → | |
| | | Data completeness - Outcomes | Month | 90.00% | 93.89% | G | → | |
| | | | Quarter | 90.00% | 93.89% | G | → | |
| | | Patients Clustered not Breaching Today | Month | 80.00% | 81.32% | G | → | |
| | | | Quarter | 80.00% | 80.84% | G | → | |
| | | Patients Clustered regardless of review dates | Month | 96.00% | 94.75% | R | → | |
| | | | Quarter | 96.00% | 94.63% | R | → | |
| | | 7 Day Follow-up - all inpatients | Month | 95.00% | 95.51% | G | ↓ | |
| | | | Quarter | 95.00% | 96.95% | G | → | |
| | | Ethnicity coding | Month | 90.00% | 90.89% | G | ↓ | |
| | | | Quarter | 90.00% | 90.89% | G | ↓ | |
| | | NHS Number | Month | 99.00% | 99.97% | G | → | |
| | | | Quarter | 99.00% | 99.97% | G | → | |
| | Schedule 4 | Consultant Outpatient Trust Cancellations | Month | 5.00% | 6.45% | R | → | The main reasons given for cancellation were clinician absence from work and clinician on annual leave. |
| | | | Quarter | 5.00% | 6.38% | R | → | |
| | | Consultant Outpatient DNAs | Month | 15.00% | 16.20% | R | ↓ | |
| | | | Quarter | 15.00% | 15.84% | 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% | 91.06% | G | ↑ | |
| | | | Quarter | 90.00% | 92.26% | G | ↑ | |
| | | Outpatient letters sent in 15 working days | Month | 95.00% | 95.76% | G | → | |
| | | | Quarter | 95.00% | 96.58% | G | ↑ | |
| | | Inpatient 28 day readmissions | Month | 10.00% | 8.20% | G | ↑ | |
| | | | Quarter | 10.00% | 5.21% | G | ↑ | |
| | | MRSA - Blood stream infection | Month | 0 | 0 | G | → | |
| | | | Quarter | 0 | 0 | G | → | |
| | | Mixed Sex accommodation breaches | Month | 0 | 0 | G | → | |
| | | | Quarter | 0 | 0 | G | → | |
| | | 18 weeks RTT greater than 52 weeks | Month | 0 | 0 | G | → | |
| | | | Quarter | 0 | 0 | G | → | |
| | | Discharge Fax sent in 2 working days | Month | 98.00% | 100.00% | G | ↑ | |
| | | | Quarter | 98.00% | 100.00% | G | → | |

# OPERATIONAL OVERVIEW – JULY 2016

Enc E

| Category | Sub-set | Metric | Period | Plan | Actual | Variance | Trend | Key Points |
|---|---|---|---|---|---|---|---|---|
| Performance Dashboard | Fixed Submitted Returns | 18 weeks RTT greater than 52 weeks | Month | 0 | 0 | G | → | Compliant with Fixed Targets except incomplete RTT where demand appears greater than our ability to meet using current processes. |
| | | | Quarter | 0 | 0 | G | → | |
| | | 18 Week RTT incomplete | Month | 92.00% | 89.81% | R | ↓ | |
| | | | Quarter | 92.00% | 89.81% | R | ↓ | |
| | | Mixed Sex accommodation breaches | Month | 0 | 0 | G | → | |
| | | | Quarter | 0 | 0 | G | → | |
| | | Completion of IAPT Data Outcomes | Month | 90.00% | 94.80% | G | → | |
| | | | Quarter | 90.00% | 94.80% | G | ↓ | |
| | | Ethnicity coding | Month | 90.00% | 90.81% | G | ↓ | |
| | | | Quarter | 90.00% | 90.81% | G | → | |
| | | NHS Number | Month | 99.00% | 99.99% | G | → | |
| | | | Quarter | 99.00% | 99.99% | G | → | |
| Other Dashboards | Health Visiting | % 10-14 Day Breastfeeding coverage | Month | 98.00% | 100.00% | G | → | 6-8 week coverage target has been missed by 6 Health Visitor teams due to mobilisation, workforce factors and organisational change |
| | | | Quarter | 98.00% | 100.00% | G | → | |
| | | % 6-8 Week Breastfeeding coverage | Month | 98.00% | 95.90% | R | ↓ | |
| | | | Quarter | 98.00% | 95.90% | R | ↓ | |
| | IAPT | Recovery Rates | Month | 50.00% | 54.35% | G | ↓ | |
| | | | Quarter | 50.00% | 54.35% | G | → | |
| | | Reliable & Recovery Rates | Month | 65.00% | 73.50% | G | → | |
| | | | Quarter | 65.00% | 73.50% | G | ↑ | |
| | Safer Staffing | Inpatient Safer Staffing Fill Rates | Month | 90.00% | 104.8% | G | ↓ | Detailed ward level information shows specific variances |
| | | | Quarter | 90.00% | 104.8% | G | ↓ | |

# WORKFORCE OVERVIEW – JULY 2016

Enc E

| Category | Sub-set | Metric | Period | Plan | Actual | Variance | | Trend | Key Points |
|---|---|---|---|---|---|---|---|---|---|
| Workforce Dashboard | NHSI Key Performance Indicator (KPI) | **Turnover** (annual) | **Jul-16** | 10% | **10.86%** | → | G | ↑ | Annual turnover remains within the Trust target parameters and is below the regional Mental Health & Learning Disability average of 12.58% (as at May 2016 latest available data). Monthly sickness absence rates continue to increase at 6.32% for July 2016. Compared to the same period last year the monthly sickness absence rate is 0.66% higher. The annual sickness absence rate continues to increase running at 5.80% as at July 2016. The regional average annual sickness absence rate for Mental Health & Learning Disability Trusts is 5.05% (as at April 2016 latest available data). Anxiety/stress/depression/other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 26.05% of all sickness absence, followed by Surgery at 14.66% and Injury/Fracture 8.74%. Vacancy rates have increased by 0.35% compared to the previous month. The number of employees who have received an appraisal within the last 12 months has decreased this month by 4.10% to 67.19%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £656k of which £410k related to Medical staff. Compulsory training compliance has decreased slightly this month by 0.18% but still remains above the 85% main contract non CQUIN. |
| | | | Jun-16 | | 10.86% | | G | | |
| | | **Sickness Absence** (monthly) | **Jul-16** | 3.9% | **6.32%** | ↗ | R | ↑ | |
| | | | Jun-16 | | 6.20% | | R | | |
| | | **Vacancies** (including 10% funded fte cover) | **Jul-16** | 10% | **17.83%** | ↗ | A | ↑ | |
| | | | Jun-16 | | 17.48% | | A | | |
| | | **Vacancies** (actual) | **Jul-16** | 0% | **7.83%** | ↗ | A | ↑ | |
| | | | Jun-16 | | 7.48% | | A | | |
| | | **Appraisals** (all staff - number of employees who have received an appraisal in the previous 12 months) | **Jul-16** | 90% | **67.19%** | ↘ | R | ↓ | |
| | | | Jun-16 | | 71.29% | | R | | |
| | | **Appraisals** (medical staff only - number of employees who have received an appraisal in the previous 12 months) | **Jul-16** | 90% | **82.24%** | ↘ | R | ↑ | |
| | | | Jun-16 | | 83.96% | | R | | |
| | | **Qualified Nurses** (to total nurses, midwives, health visitors and healthcare assistants) | **Jul-16** | 65% | **67.52%** | ↘ | G | ↑ | |
| | | | Jun-16 | | 68.31% | | G | | |
| | | **Agency Usage** (£ year to date level of agency expenditure exceeding the ceiling set by NHSI) | **Jul-16** | £0 | **656k** | ↗ | R | ↑ | |
| | | | Jun-16 | | 445k | | R | | |
| | | **Agency Usage** (% year to date level of agency expenditure exceeding the ceiling set by NHSI) | **Jul-16** | 0% | **65.00%** | ↗ | R | ↑ | |
| | | | Jun-16 | | 58.00% | | R | | |
| | Other KPI | **Compulsory Training** (staff in-date) | **Jul-16** | 95% | **90.31%** | ↘ | A | ↑ | |
| | | | Jun-16 | | 90.49% | | A | | |

Key:

**Period** Current month and previous month

**Plan** Trust target

↗ Variance to previous month

Achieving target/within target parameters

Approaching target/approaching target parameters

Not achieving target/outside target parameters

Trend based on previous 4 months

Turnover parameters (8% to 12%)

Vacancy parameters (10% to 20%)

# QUALITY OVERVIEW – JULY 2016

Enc E

| Category | Sub-set | Metric | Period | Plan | Actual | Variance | Trend | Key Points |
|---|---|---|---|---|---|---|---|---|
| Quality | Quality Strategy | Percentage of current Inpatients with a recorded Capacity Assessment | Month | 100.00% | | R | ↓ | Awaiting FSR roll out (data from PARIS), Capacity assessments now recorded on PARIS as per 'Blue Light' June 2016. Monitoring underway on this indicator in advance of full FSR. Awaiting further development of FSR amd reporting capability to demonstrate care planning. |
| | | | Quarter | 100.00% | | R | ↓ | |
| | | Percentage of all patients with a care plan in place which has been reviewed with 12 months | Month | 90.00% | N/A | | → | |
| | | | Quarter | 90.00% | N/A | | → | |
| | | Seclusion incidents | Month | 20 | 25 | G | → | |
| | | | Quarter | 60 | 32 | G | → | |
| | | Physical Restraint incidents | Month | 55 | 62 | G | ↑ | |
| | | | Quarter | 165 | 78 | G | ↓ | |
| | | Clinical Supervision | Month | 90 | 52.60% | A | ↑ | Sampling audit of care planning undertaken July 2016. |
| | | Management Supervision | Month | 90 | 68.70% | A | → | Supervision continues to increase. |
| | | Safeguarding Supervision | Month | 90 | 47.90% | R | ↑ | Metric for safeguarding supervision requires refinement as frequency is less. |
| | | Professional Supervision | Month | 90 | 19.70% | R | ↑ | Exploring combing with managerial. 3 per year |
| | CQUINs or contractual levy | Flu Jab Up-take | Month | 45.00% | N/A | | → | Flu remains unchanged. Think Family training increased by 2.5%, Safety Planning increased by 8%, now almost at target. New data collection system for CTR commenced August 2016 |
| | | | Quarter | 45.00% | N/A | | → | |
| | | Think Family Training | Month | 90.00% | 66.43% | A | ↑ | |
| | | | Quarter | 90.00% | N/A | A | → | |
| | | The safety plan training | Month | 90.00% | 89.93% | A | ↑ | |
| | | | Quarter | 90.00% | N/A | A | → | |
| | | The number of LD or Autism admissions without a CTR before admission | Month | 0 | | | → | |
| | | | Quarter | 0 | | | → | |

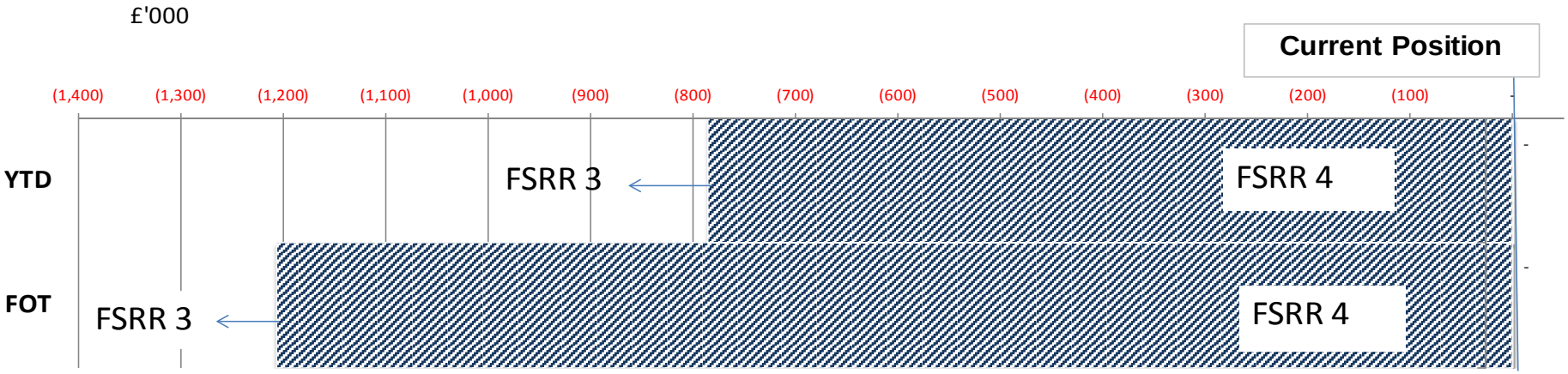
# Financial Section

## Governance – Financial Sustainability Risk Rating (FSRR)

Enc E

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

The headroom down to a FSRR of 3 year to date and forecast is £0.8m and £1.2m respectively. The headroom is shown in the graph below:




The year to date FSRR at the end of each of the quarters is shown in the table below:

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

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

# Income and Expenditure

Enc E

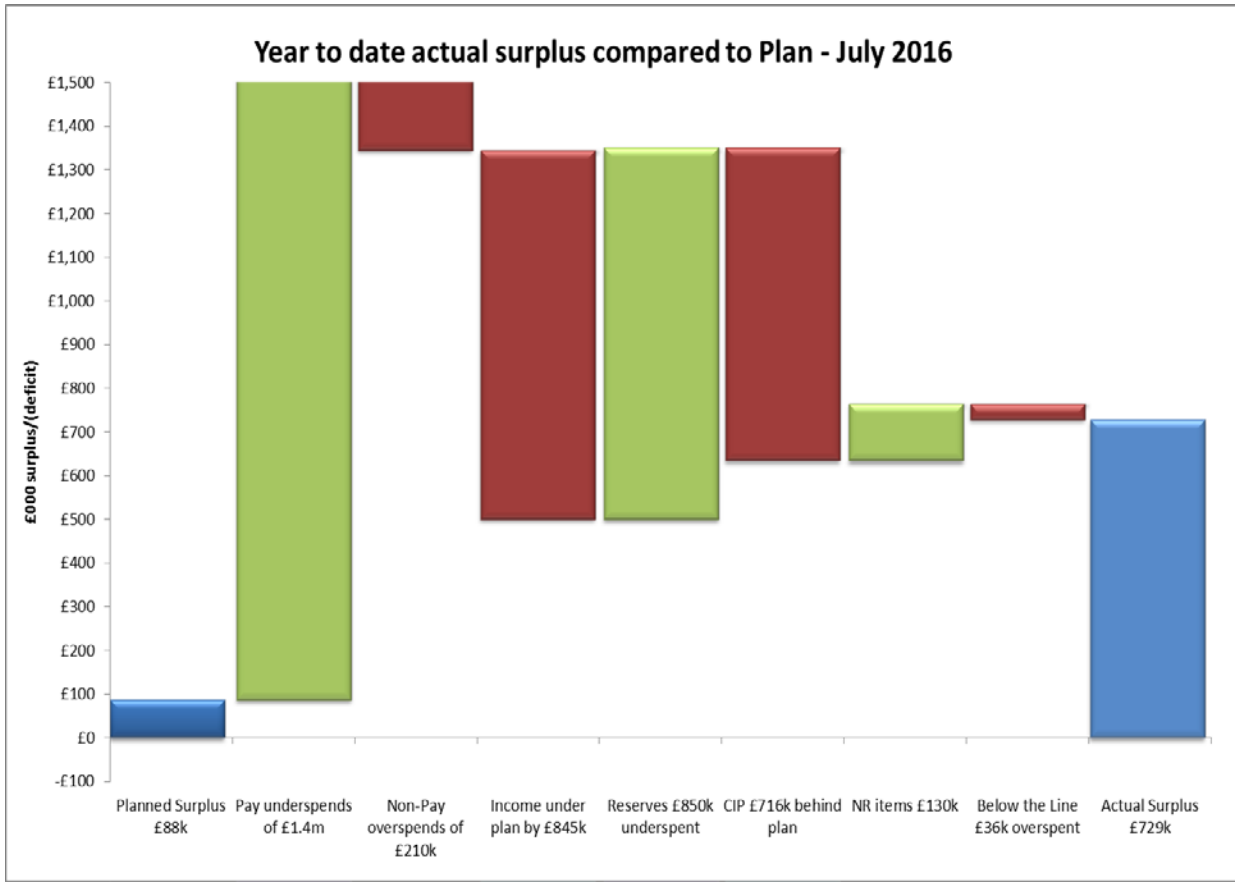
## Statement of Comprehensive Income — July 2016

| | Current Month | | | Year to Date | | | Forecast | | |
|---|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | Variance Fav (+) / Adv (-) | Plan | Actual | Variance Fav (+) / Adv (-) | Plan | Actual | Variance Fav (+) / Adv (-) |
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Clinical Income | 10,520 | 10,419 | (101) | 42,357 | 41,306 | (1,051) | 127,406 | 124,183 | (3,223) |
| Non Clinical Income | 849 | 826 | (23) | 3,397 | 3,103 | (293) | 10,190 | 9,450 | (740) |
| Employee Expenses | (8,376) | (8,003) | 372 | (34,197) | (32,001) | 2,196 | (101,492) | (96,915) | 4,577 |
| Non Pay | (2,167) | (2,279) | (111) | (8,742) | (8,929) | (187) | (26,298) | (27,040) | (741) |
| **EBITDA** | **826** | **964** | **137** | **2,815** | **3,480** | **665** | **9,806** | **9,677** | **(128)** |
| Depreciation | (295) | (301) | (6) | (1,178) | (1,215) | (37) | (3,534) | (3,448) | 86 |
| 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 | (175) | (175) | 1 | (740) | (726) | 14 | (2,141) | (2,099) | 41 |
| Dividend | (133) | (133) | (0) | (533) | (533) | 0 | (1,600) | (1,600) | 0 |
| **Net Surplus / (Deficit)** | **223** | **355** | **132** | **364** | **1,006** | **642** | **2,231** | **2,230** | **(0)** |
| Technical adjustment - Impairment | 0 | 0 | 0 | 0 | 0 | 0 | (300) | (300) | 0 |
| **Control Total Surplus / (Deficit)** | **223** | **355** | **132** | **364** | **1,006** | **642** | **2,531** | **2,530** | **(0)** |
| Technical adjustment - STF Allocation | 69 | 69 | 0 | 277 | 277 | 0 | 830 | 830 | 0 |
| **Underlying Net Surplus / (Deficit)** | **154** | **286** | **132** | **88** | **729** | **642** | **1,701** | **1,700** | **(0)** |

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

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

Clinical Income is £101k less than plan in month and is forecast to be £3.2m worse by the end of the year of which a significant proportion is due to differences in planning assumptions with offsetting expenditure reductions. There is however forecast underperformances on activity related income.
Non Clinical income is ahead of plan in the month by £23k but has a forecast outturn of £0.7m behind plan. £0.4m relates to a miscellaneous income target with no income forecast against it.
Pay expenditure is £372k less than the plan in the month and the year end position is £4.6m more favourable than plan which is due to planning assumptions (with offsetting income reductions) but also vacancies and recruitment.
Non Pay is overspent in the month by £111k which mainly relates to Drugs and PICU expenditure which is also driving the forecast overspend.




## Summary of key points Enc E

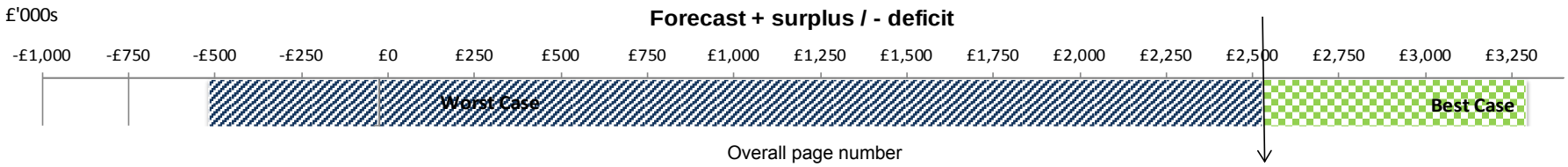
Overall favourable variance to plan year to date which is driven by the following:

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

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

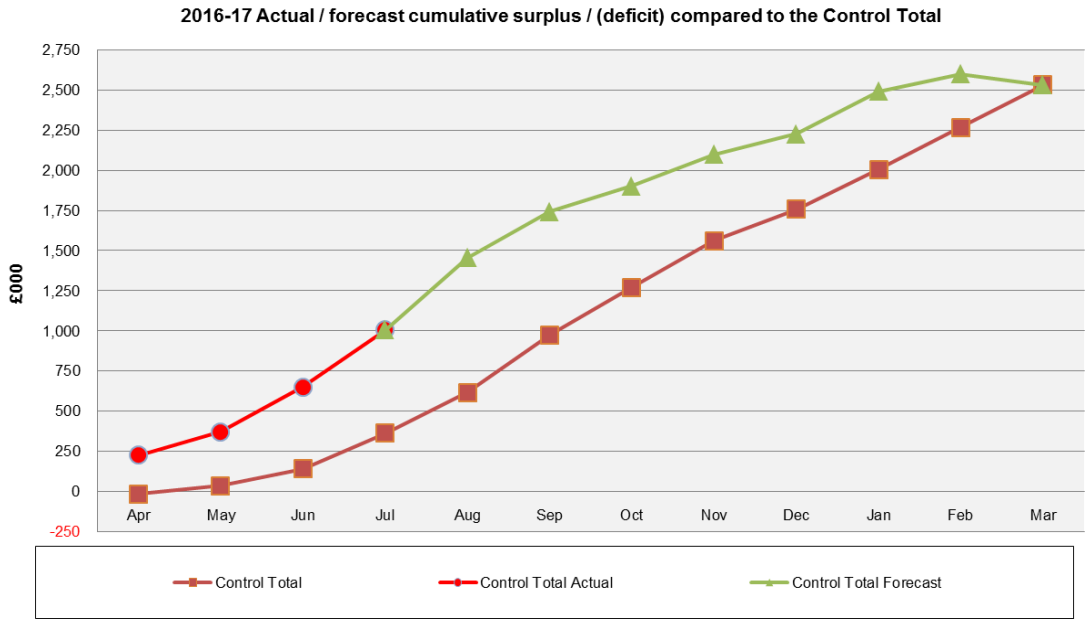
## Forecast Range

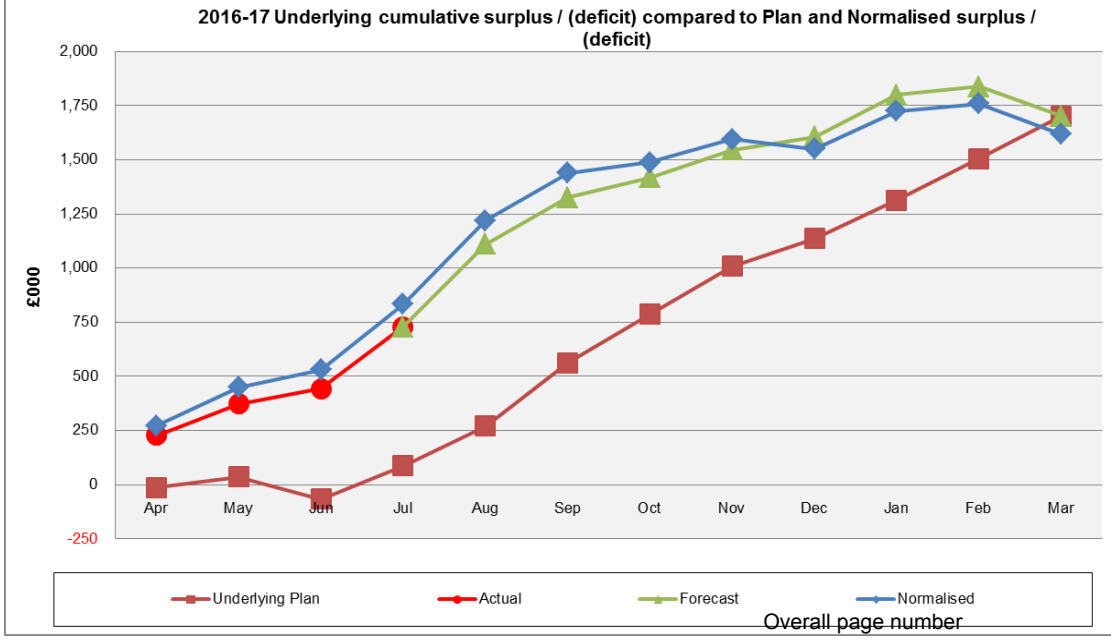
| Best Case | Likely Case | Worst Case |
|---|---|---|
| £3.3m Surplus | £2.5m surplus | £0.5m deficit |



# Normalised Income and Expenditure position

Enc E



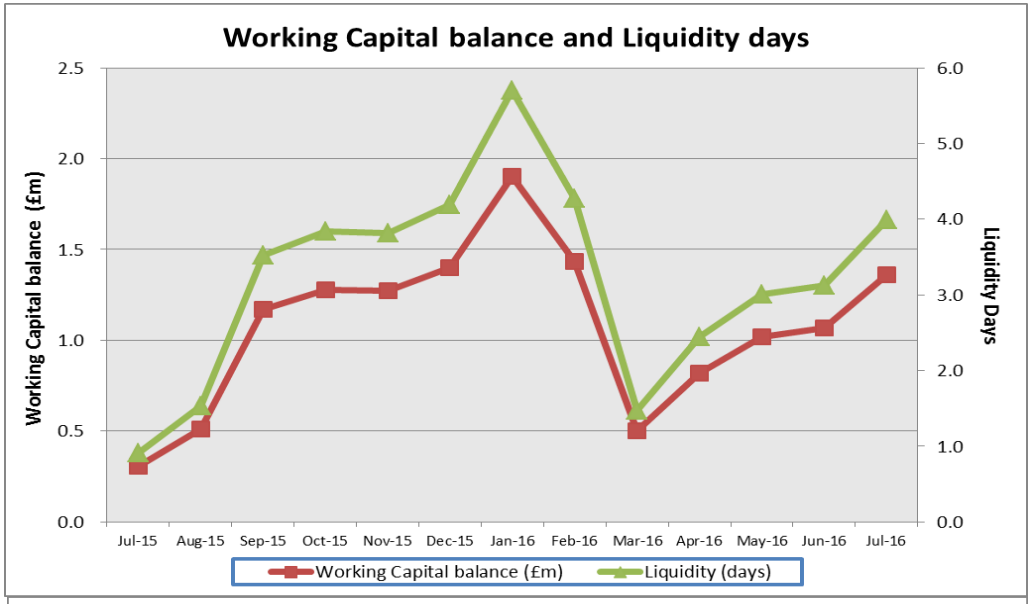

The first graph shows the actual and forecast cumulative surplus against the control total (including the Sustainability Transformation Fund (STF). The surplus is forecast to remain ahead of plan in the first part of the financial year and then slowly reduce back down to the planned control total.

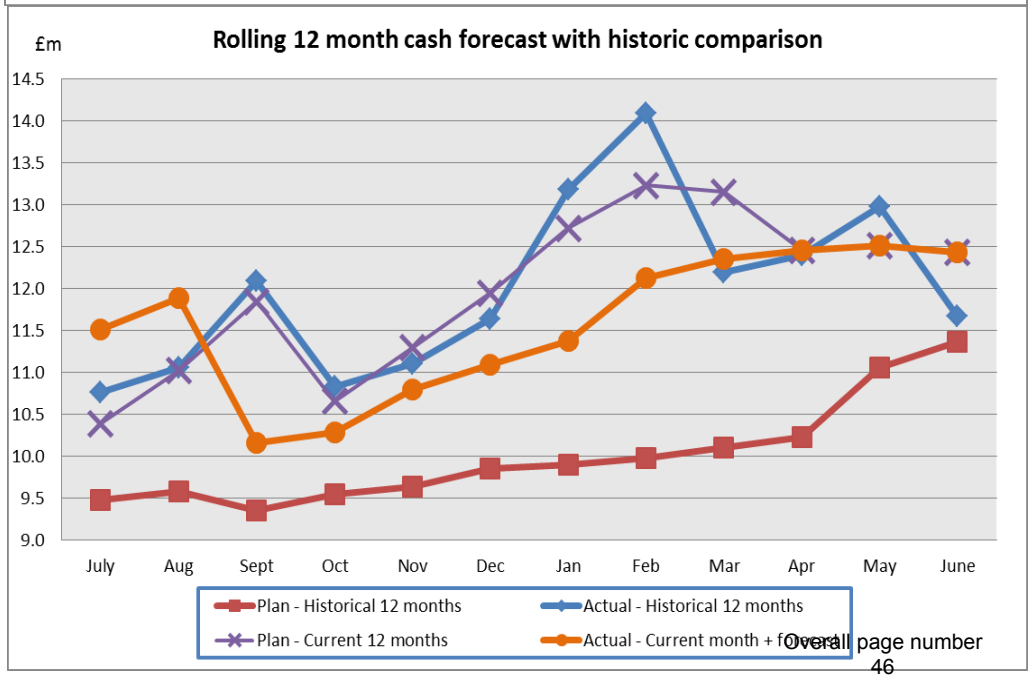
The second graph shows the underlying actual and forecast surplus against the underlying plan excluding the STF.

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

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

# Liquidity



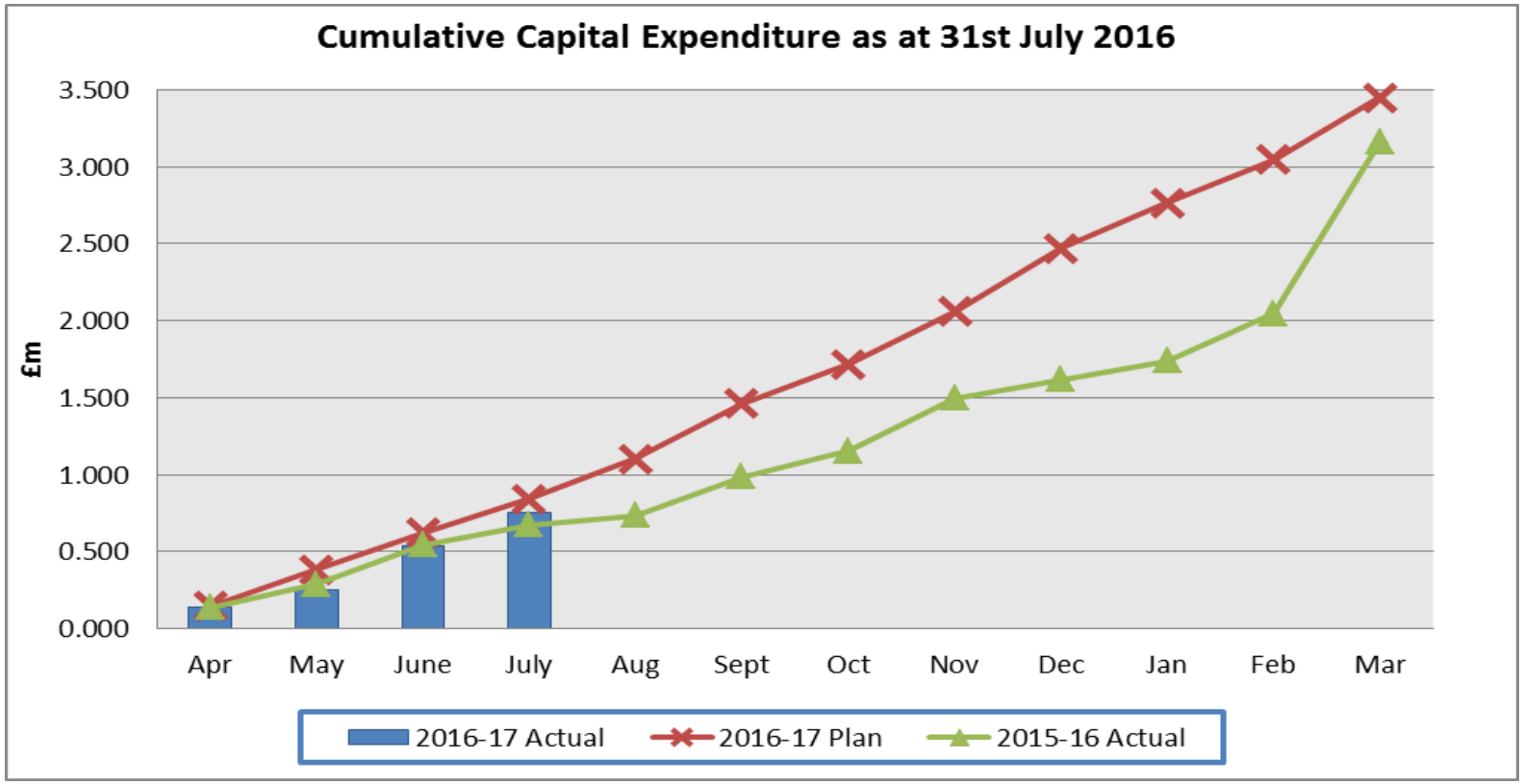




The first graph shows the working capital balance (net current assets less net current liabilities adjusted for assets held for sale and inventories) and how many days of operating expenses that balance provides.

During last financial year working capital continued to improve due to improved cash levels. The downward trend at the end of last financial year is reflective of the reduction in cash due to year end transactions. July continues to show a further improvement up to 4 days which still gives a rating of 4 on that metric (-7days drops to a rating of 3).

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

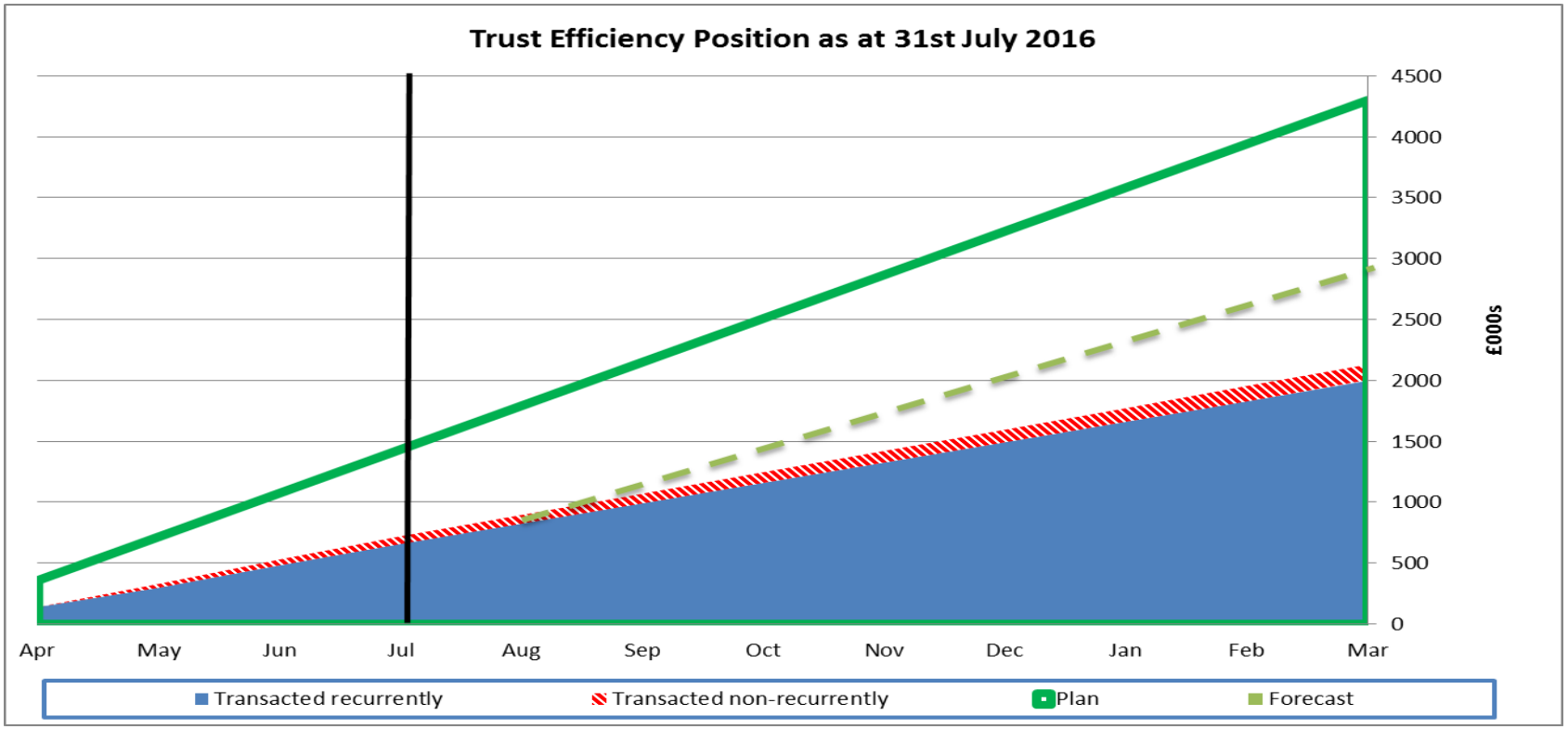
Cash is currently at £11.5m which was £1.1m better than the plan at the end of July. This is mainly driven by the Income and Expenditure surplus.




Capital Expenditure is £84k behind plan year to date but is forecast to spend to the plan of £3.45m by year end.

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

## Cost Improvement Programme (CIP)



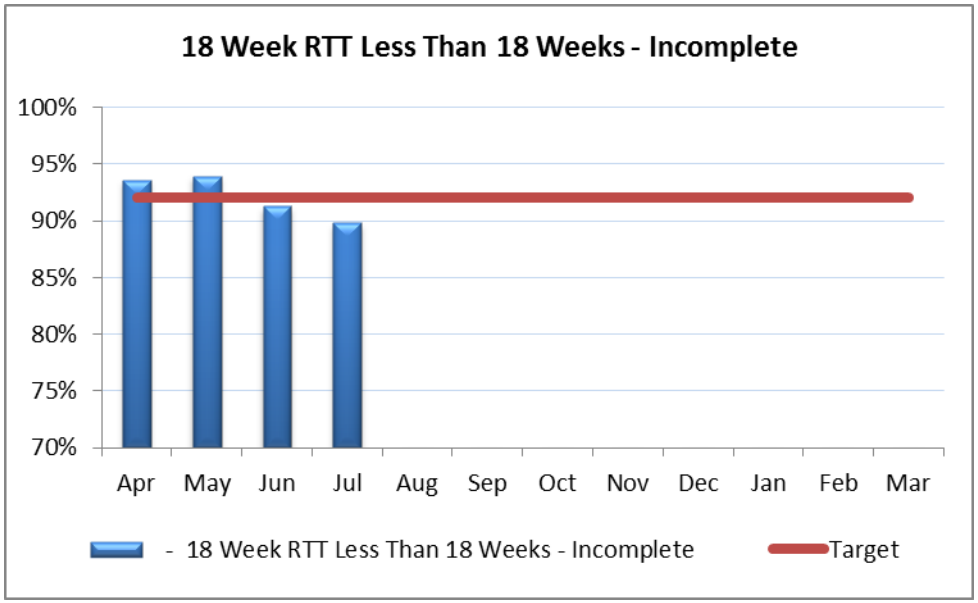

At the end of July there was a shortfall against the year to date plan of £716k. The full year amount of savings identified at the end of July reporting is £2.1m leaving a gap of £2.2m.

The forecast assumes that a further £0.8m will be achieved by the end of the financial year leaving unfound CIP of £1.4m.

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

# Operational Section

# 18 Week RTT Less Than 18 Weeks - Incomplete

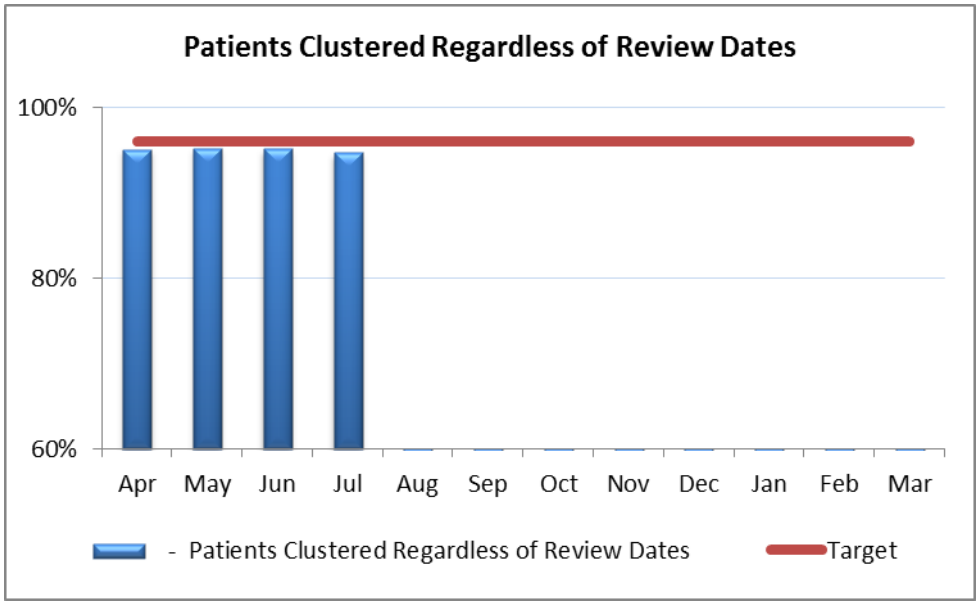



Analysis of first outpatient appointment referral and activity data for the period April 2014 to date suggests that the number of new referrals received per week outweighs the number of number of available new outpatient appointment slots.

Actions being taken:

- Review of job planning.
- Investigation is underway to establish whether any treatment has been provided during contacts with the Trust's interface services prior to onward referral to outpatients. Records will be corrected if applicable.
- To propose that assessment appointments with interface services should always include a form of treatment

# Clustering

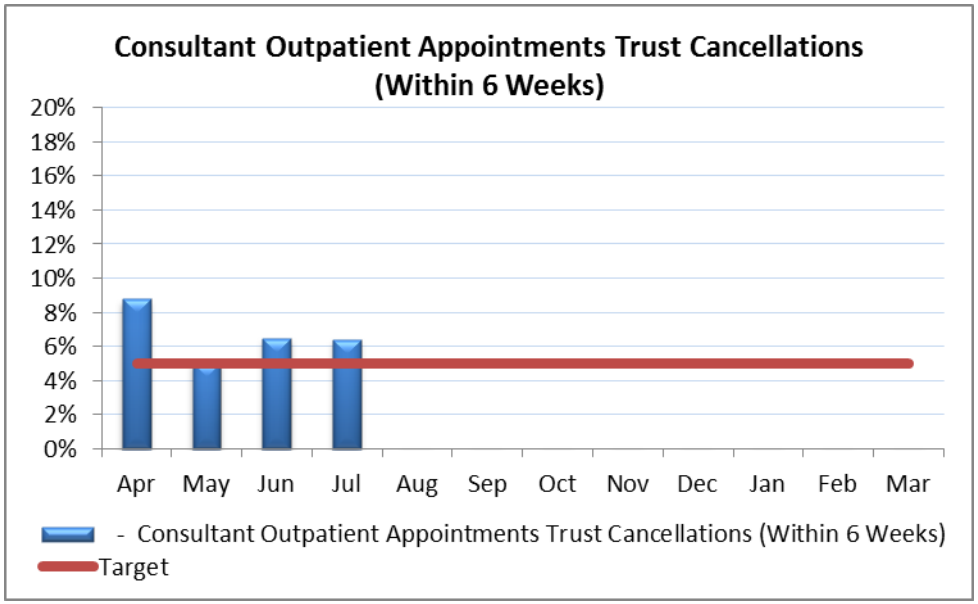



The majority of clinicians now successfully manage their PbR caseloads either independently or through positive engagement with available support.

Solutions being deployed on an ongoing basis:

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

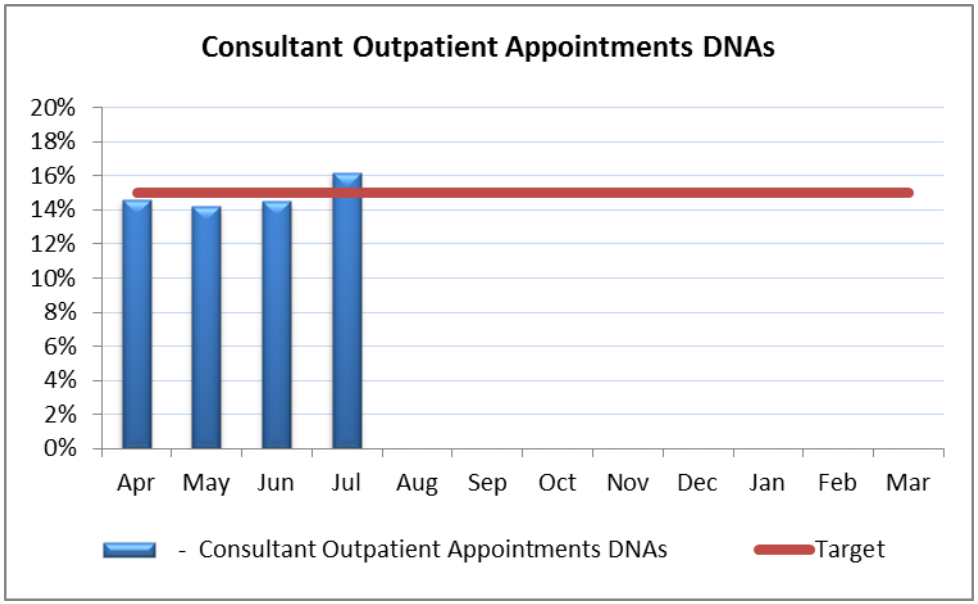
## Consultant Outpatient Appointments Trust Cancelations (within 6 weeks)




The main reasons given for cancellation were clinician absence from work and clinician on annual leave.

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

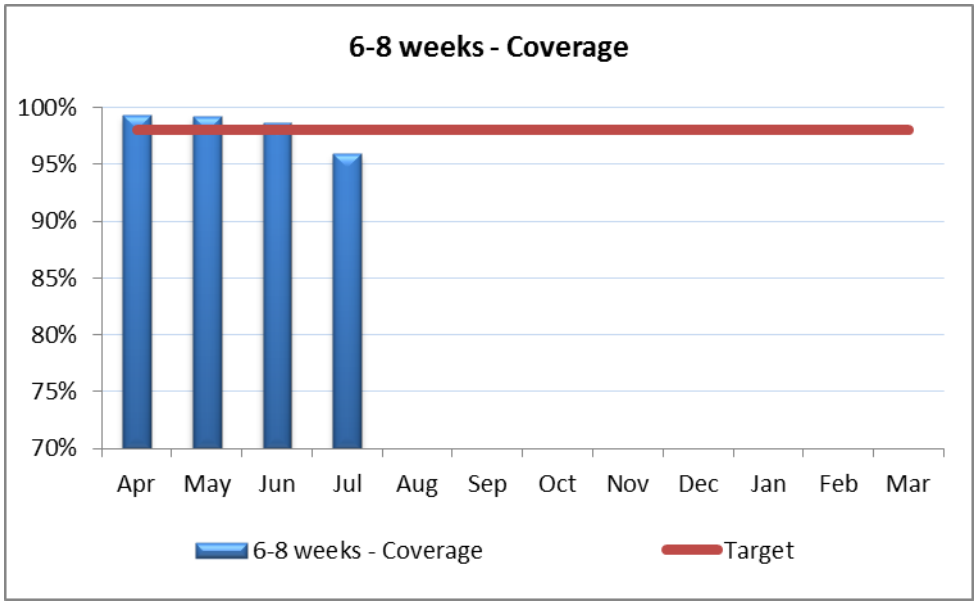
# Consultant Outpatient Appointments DNAs




The rate of DNAs was above the target threshold for the first time in 6 months. In August to date it has dropped below threshold once more.

- The Divisional Admin Coordinator and Professional Lead has been requested to review outpatient administration processes.
- To continue to monitor

# 6-8 weeks - Coverage



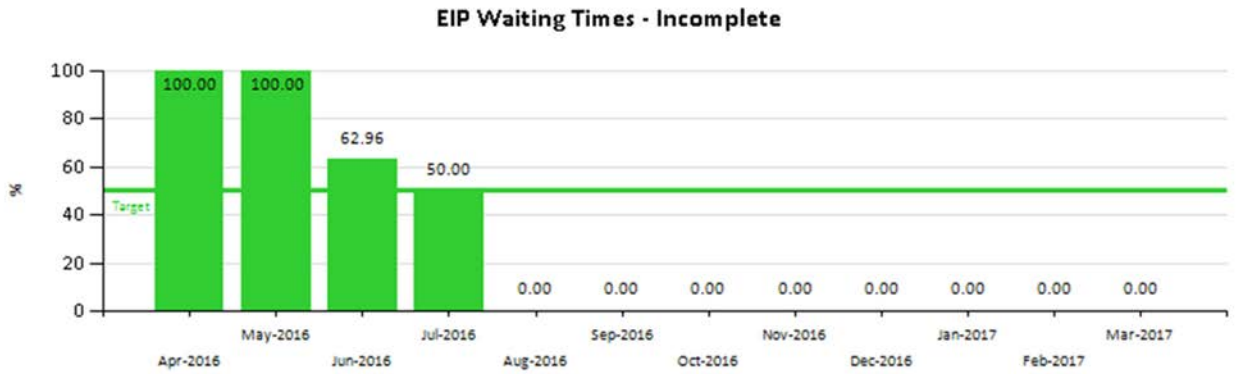

The coverage targets for July 2016 were not met in six HV teams. This has been attributed to several factors these being:

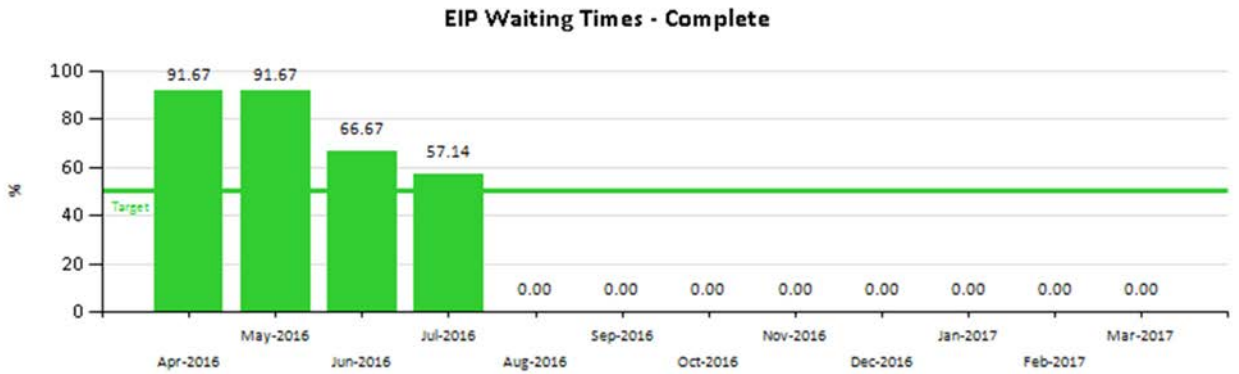
- The impact the mobilisation plan is having on staffs moral
- Reduced workforce – annual leave, sickness, under recruitment
- Change of responsibility from administrators providing the exceptions to HV teams to the HV teams. Some staff did not have authorisation to access to the data

Action:

- An email has been sent to all staff from Sue Earnshaw recognising staffs hard work in such a changing environment and will be sending out progress emails each month
- There will be a significant reduction in holidays as the summer comes to a close. Out for advert to recruit HVs in October. Staff are returning from extended sick leave
- All HV teams have now been informed again it is their responsibility to identify their own data. Also, teams have identified of two members of staff to review their reports at each allocation /team meeting to ensure the targets are met. Staff aware of how to access the data via IT.

# EIP Performance Monitoring Downward Trajectory




We implemented the new access and waiting time standards from 1st April 2016 and we have experienced a greater than expected increase in referrals. All of the analysis prior to launch, supported by national and regional analysis indicated a 20% uplift due to the increase in age range beyond 35 yrs. We have experienced 100% increase in referrals. This has naturally created a challenge to see patients within the 2 week timeframe and has caused compliance to drop when previously we achieved 100% compliance.

We received additional funding to increase capacity in support of the new standards and this is underway with 3 of the 4 additional care coordinator posts recruited to (started or with start dates planned). Recruitment is continuing and has unexpectedly been added to with 2 new resignations. Factoring in 2 additional long-term absences and we have a situation where referrals have doubled and capacity is short by at least 4 whole time equivalents.

We have introduced a daily monitoring of waiting times in order that we can identify potential breaches before they happen and we are working to improve our capacity position with some short-term and longer-term actions. Both of these actions will have the effect of improving waiting time compliance.

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# WARD STAFFING

| Ward name | Day | | Night | | Comments Required | Analysis and Action Plan for 'Average fill rate' above 125% and below 90% |
|---|---|---|---|---|---|---|
| | Average fill rate - registered nurses / midwives (%) | Average fill rate - care staff (%) | Average fill rate - registered nurses / midwives (%) | Average fill rate - care staff (%) | | |
| AUDREY HOUSE RESIDENTIAL REHABILITATION | 163.3% | 67.5% | 112.9% | 87.1% | Yes | No comment received |
| CHILD BEARING INPATIENT | 115.6% | 125.0% | 100.0% | 115.0% | No | |
| CTC RESIDENTIAL REHABILITATION | 110.8% | 93.3% | 100.0% | 106.5% | No | |
| ENHANCED CARE WARD | 87.7% | 101.6% | 71.4% | 113.7% | Yes | We continue to carry 3 RG vacancies one of which has been recruited into with a start date of December. All shifts have trust NIC with appropriate competencies. Shortfalls in RGs backfilled with NA cover from bank. |
| HARTINGTON UNIT - MORTON WARD ADULT | 101.5% | 100.0% | 59.3% | 195.7% | Yes | Morton ward we are currently carrying a number of Band 5 vacancies – at the point of these figures it was 5.36 WTE. We also have a band 5 acting up into the Band 6 position. It is therefore not possible to allocate x2 staff nurses on the night shift. |
| HARTINGTON UNIT - PLEASLEY WARD ADULT | 107.0% | 74.8% | 90.6% | 102.4% | Yes | The ward currently has only 7 HCA's, one of whom is on long term sick. As a result day shifts quite often have more than the planned registered staff on duty in place of HCA's which reflects the low percentage of care staff 74.8% against the 107.o% of registered staff being used on day shifts. |

Enc E

# WARD STAFFING

| Ward name | Day | | Night | | Comments Required | Analysis and Action Plan for 'Average fill rate' above 125% and below 90% |
|---|---|---|---|---|---|---|
| | Average fill rate - registered nurses / midwives (%) | Average fill rate - care staff (%) | Average fill rate - registered nurses / midwives (%) | Average fill rate - care staff (%) | | |
| HARTINGTON UNIT - TANSLEY WARD ADULT | 67.8% | 143.8% | 54.1% | 212.5% | Yes | Tansley Ward is currently running with a high level of Band 5 vacancies against funded posts. In June there are 10.2 whole time equivalent (wte) Band 5 vacancies and only 8.7 wte Band 5 nurses in post.<br>Of those 8.7 wte Band 5 nurses in post 1 full time nurse was removed from clinical duty at the end of February pending investigation into concerns who has no potential return date. The part time Band 5 nurse having just had surgery is recovering well with a favourable prognosis and will hopefully commence a phased return in early September. I have maintained regular support and we have discussed a positive plan to support her return to duty. The impact of the vacancies and absence has been significant on our ability to maintain even minimum numbers of Band 5 nurses on shift at 2/2/1.<br>Many actions are being taken to address. some of which are:<br>• Rotas are written approximately 3 months in advance via the e-roster to allow for staff to plan their time and to identify any potential qualified bank shifts they can do to bring us up to minimum numbers of 2 registered nurses on early and late duties and 1 qualified nurse on night duty.<br>• Lead and Senior nurses working clinically in the numbers and on bank to bring numbers up to minimum and provide leadership.<br>• Block booking Bank HCA to bring overall staffing numbers up to 5/5/3 |
| KEDLESTON LOW SECURE UNIT | 116.6% | 84.9% | 106.5% | 100.0% | Yes | |

Enc E

# WARD STAFFING

| Ward name | Day | | Night | | Comments Required | Analysis and Action Plan for 'Average fill rate' above 125% and below 90% |
|---|---|---|---|---|---|---|
| | Average fill rate - registered nurses / midwives (%) | Average fill rate - care staff (%) | Average fill rate - registered nurses / midwives (%) | Average fill rate - care staff (%) | | |
| KINGSWAY CUBLEY COURT - FEMALE | 87.4% | 107.1% | 72.6% | 121.5% | Yes | We have had high levels of Registered Nurse sickness, which is beginning to ease in August |
| KINGSWAY CUBLEY COURT - MALE | 88.6% | 125.2% | 85.5% | 197.9% | Yes | We currently have registered nurse vacancies which may be reflected in the figures. We are also experiencing a high level of clinical need for patients on the ward so staffing establishment is increased each shift |
| LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP | 127.2% | 99.8% | 64.5% | 228.9% | Yes | No comment received |
| LONDON ROAD COMMUNITY HOSPITAL - WARD 2 OP | 104.0% | 90.1% | 119.3% | 133.9% | Yes | No comment received |
| RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT | 97.5% | 97.7% | 82.9% | 108.8% | Yes | the % for night shift is correct and due to current ward Registered Nurse vacancies we are not able to meet fill rate, hence the over filling of Nursing Assistant's on nights |
| RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT | 87.2% | 114.6% | 62.3% | 347.1% | Yes | Ward 34 continues to carry a large number of vacancies which is being addressed via recruitment, also ward 34 have had a high number of increased engagement levels and on going high clinical activity which has increased the number of bank staff used. |
| RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT | 61.5% | 122.9% | 56.7% | 174.2% | Yes | No comment received |
| RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT | 93.6% | 106.1% | 97.0% | 117.7% | No | |

# Workforce Section

Enc E

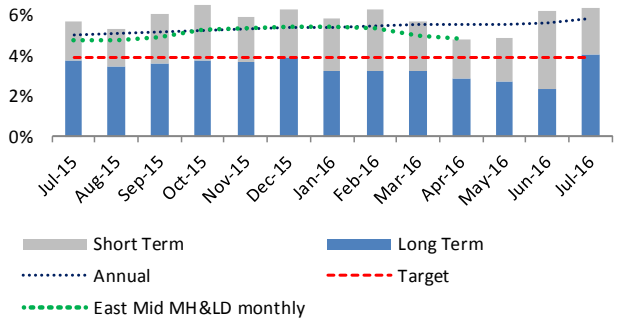
Wellbeing

## Sickness Absence

(Monthly)

| May-16 | Jun-16 | Jul-16 |
|---|---|---|
| 4.87% | 6.20% | **6.32%** |

Target 3.9%



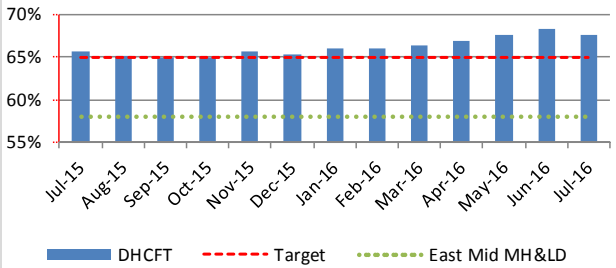

The Trust annual sickness absence rate is currently 5.80%. Monthly sickness absence rates have increased again this month by 0.12% to 6.32%. In June 2016 there was a large increase in short term absence caused by traditional long term absence reasons which has now developed into long term sickness. Anxiety/stress/depression/other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 26.05% of all sickness absence, followed by surgery at 14.66% and injury/fracture at 8.74%.

## Qualified Nurses

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

| May-16 | Jun-16 | Jul-16 |
|---|---|---|
| 67.50% | 68.31% | **67.52%** |

Target 65%



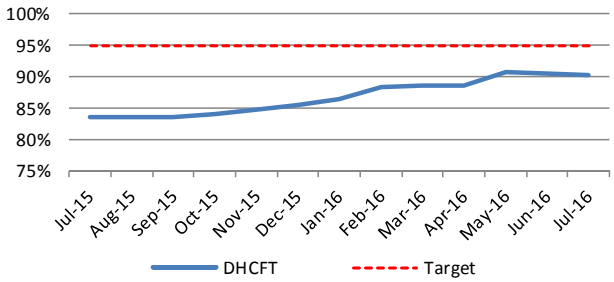

Contracted staff in post qualified nurses to total nurses, midwives, health visitors and healthcare assistants remains within target at 67.52%. Vacancy rates can impact on this measure. The NHS average is 61.38% and the East Midlands Mental Health & Learning Disability average is 58.04%.

## Compulsory Training

(Staff in-date)

| May-16 | Jun-16 | Jul-16 |
|---|---|---|
| 90.87% | 90.49% | **90.31%** |

Target 95%




Compulsory training compliance continues to remain high running at 90.31%, a slight decrease of 0.18% compared to the previous month. Compared to the same period last year compliance rates are 6.90% higher. Compulsory training compliance remains above the 85% main contract commissioning for quality and innovation (CQUIN) target.

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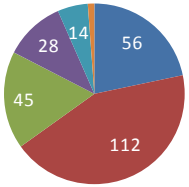
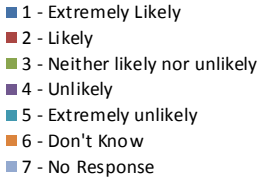
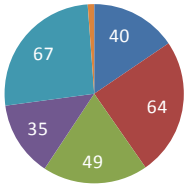
## Staff FFT Q1 2016/17 & Staff Survey 2015

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




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

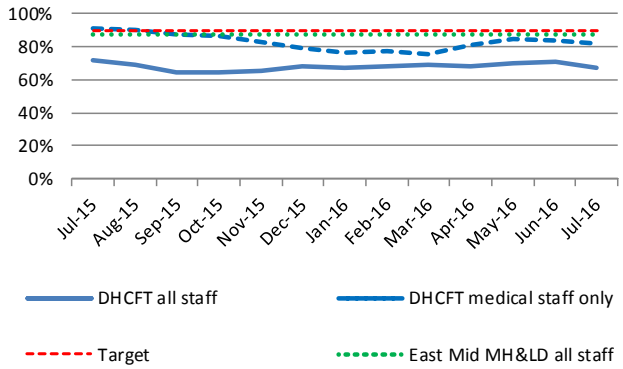



| | 2014 | **2015** | National Average |
|---|---|---|---|
| Overall staff engagement | 3.75 | **3.73** | 3.81 |

## Appraisals

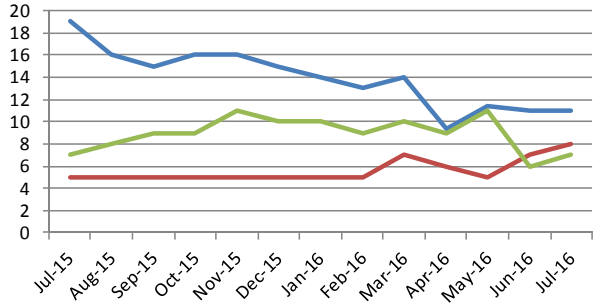
| | May-16 | Jun-16 | **Jul-16** |
|---|---|---|---|
| (All staff) | 69.59% | 71.29% | **67.19%** |

Target 90%

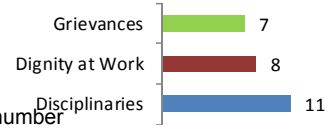



The number of employees who have received an appraisal within the last 12 months has decreased by 4.10% during July 2016 to 67.19%. Compared to the same period last year, compliance rates are 4.29% lower. Medical staff appraisal compliance rates are running at 82.24%. According to the latest staff survey results, the national average for Mental Health & Learning Disability Trusts is 91%.

## Grievances/Dignity at Work/Disciplinaries as at 31/07/16




7 grievances currently lodged at the formal stage, 1 new case received regarding job banding and responsibilities of the role. 8 dignity at work cases currently lodged, 1 new case involving allegations of a racist nature. 11 disciplinaries in progress, 3 cases have been resolved and 3 new cases reported which includes allegations of information governance breach and patient complaints.



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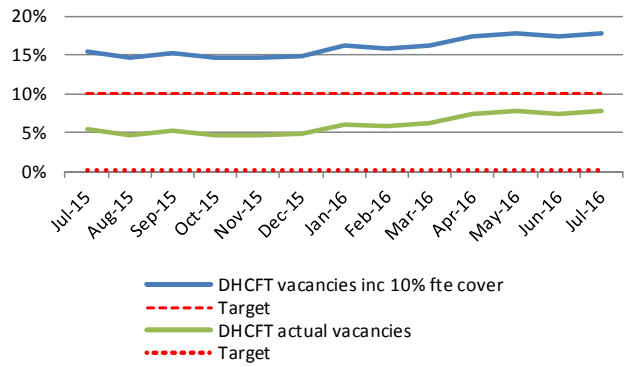
## Vacancy

| (Budgeted full time equivalent) | May-16 | Jun-16 | **Jul-16** |
|---|---|---|---|
| Including 10% funded fte cover | 17.75% | 17.48% | **17.83%** |
| Actual | 7.75% | 7.48% | **7.83%** |

Target 10%/0%

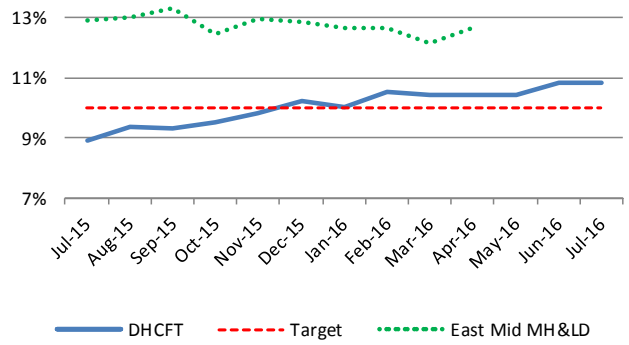



The Trust target for contracted staff in post is 90% which allows 10% funded full time equivalent (fte) surplus for sickness and annual leave cover in In-Patient areas. The budgeted fte vacancy rate has increased by 0.35%. April 2016 included additional full time equivalent investment for 2016/17. New recruitment activity during July 2016 was for 70 posts. 69% were for qualified nursing, 20% admin & clerical, 4% additional clinical services, 4% medical and 3% scientific & technical.

## Turnover

| (Annual) | May-16 | Jun-16 | **Jul-16** |
|---|---|---|---|
| | 10.44% | 10.86% | **10.86%** |

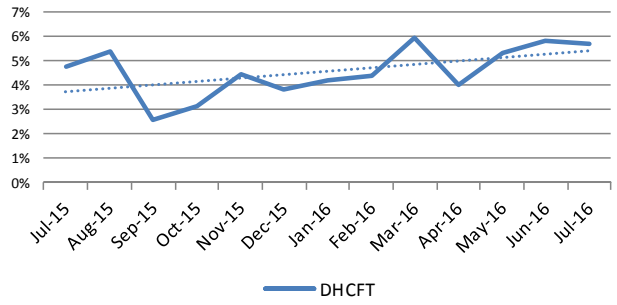
Target 10%




Annual turnover remains within Trust target parameters at 10.86% and is below the average for East Midlands Mental Health & Learning Disability Trusts. The average number of employees leaving each month remains static at 22. During July 2016 12 employees left the Trust which included 4 retirements. A key factor still remains for the increase in recent turnover rates, which is a reduction in overall contracted staff in post caused by unfilled vacancies.

## Agency Usage

| (Spend) | May-16 | Jun-16 | **Jul-16** |
|---|---|---|---|
| | 5.29% | 5.79% | **5.71%** |




Total agency spend in July 2016 was 5.71% (6.18% including medical locums). Of total agency and locum spend for all staff groups, Qualified Nursing represented 1.2%, Medical 3.5% and other agency usage 1.5%. Agency Qualified Nursing spend against total Qualified Nursing spend in July was 3.3%. Agency Medical spend against total Medical spend in July was 17.0%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £656k of which £410k related to Medical staff.

# Workforce Key Performance Indicator (KPI) Triangulation July 2016

Enc E

The triangulation focus list for key Workforce metrics identifies Wards/Teams that are most in need of attention and support. The table below list Wards/Teams that are in need of attention and support in more than one Workforce KPI. Please note that all figures relate to July 2016 and to fall into the focus list a Ward/Team must have at least 10 employees/funded fte.

**Teams requiring attention and support in more than one Workforce KPI:**

| Ward/Team July 2016 | HC | KPI | % |
|---|---|---|---|
| County North Early Intervention | 15 | Appraisal | 40.00% |
| County North Early Intervention | 15 | Sickness Absence | 8.87% |
| County South Early Intervention | 10 | Appraisal | 20.00% |
| County South Early Intervention | 10 | Compulsory Training | 85.39% |
| Derby City Early Intervention | 14 | Appraisal | 7.14% |
| Derby City Early Intervention | 14 | Compulsory Training | 81.75% |
| Derby City Neighbourhood - Team C | 22 | Appraisal | 45.45% |
| Derby City Neighbourhood - Team C | 22 | Compulsory Training | 80.77% |
| Derby City Neighbourhood - Team C | 22 | Sickness Absence | 11.74% |
| Derbyshire County Substance Misuse - High Intensity | 33 | Appraisal | 24.24% |
| Derbyshire County Substance Misuse - High Intensity | 33 | Compulsory Training | 73.50% |
| Hope & Resilience Hub | 24 | Appraisal | 41.67% |
| Hope & Resilience Hub | 24 | Sickness Absence | 16.39% |
| HP+NthDales Neighbourhood - Team A | 16 | Appraisal | 50.00% |
| HP+NthDales Neighbourhood - Team A | 16 | Sickness Absence | 10.76% |
| **HP+NthDales Neighbourhood - Team B** | 28 | Appraisal | 50.00% |
| **HP+NthDales Neighbourhood - Team B** | 28 | Compulsory Training | 84.10% |
| RDH Ward 35 Adult Acute Inpatient IP | 29 | Appraisal | 34.48% |
| RDH Ward 35 Adult Acute Inpatient 'IP' | 29 | Sickness Absence | 23.14% |
| Rykneld CBT | 13 | Appraisal | 7.69% |
| Rykneld CBT | 13 | Compulsory Training | 85.19% |
| Rykneld CBT | 13 | Sickness Absence | 12.02% |
| Young Persons CAMHS | 10 | Appraisal | 40.00% |
| Young Persons CAMHS | 10 | Compulsory Training | 80.00% |

# Quality Section

## Strategic Risks (Board Assurance Framework)

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

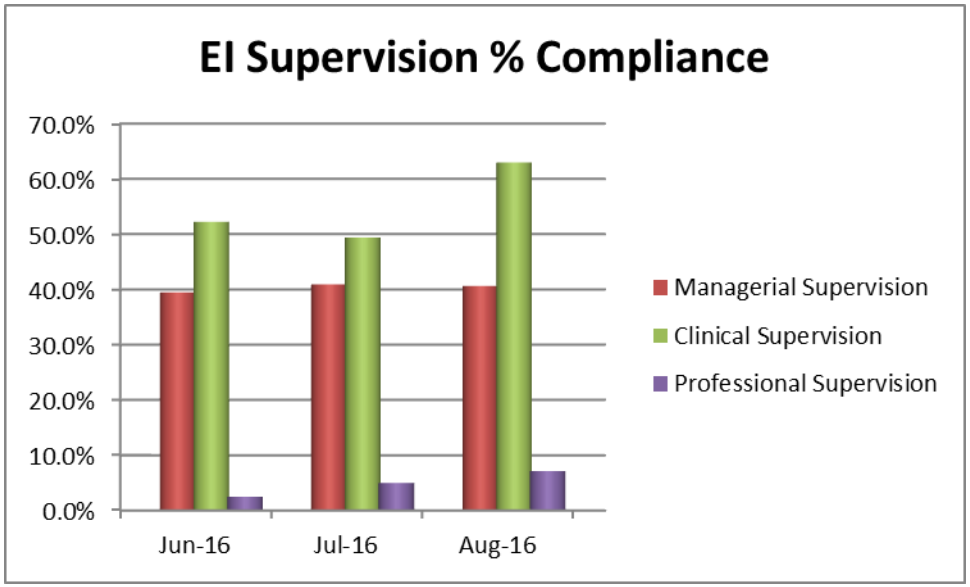
No changes to the current risk ratings identified this month.

## Clinical Risks (Significant)

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

Themes include:
Significant staffing level risks across a number of service areas;
Associated increases in work related stress;
Increased risks of violence and aggression identified on Radbourne Wards in relation to the number of staff vacancies;
Increased risk of fire identified on some inpatient wards associated with the smoking ban

**EI Supervision % Compliance**




A review of the Early Interventions in Psychosis Performance data, alongside the Workforce & OD indicators demonstrated the reduction in compliance with key indicators. As a key feature of integrated performance reporting is triangulation and identification of themes, this prompted a review of supervision data for that service to see if this was perhaps contributing to a dip in quality of service provision, and staff experience.

Supervision rates in the team are low, compared to the target of >90%.

Future plans for the development of the supervision aspect of the report are to consider how this may be reported in the future and what  other aspects of quality could demonstrate this.

**Derbyshire Healthcare NHS Foundation Trust**
Report to Council of Governors 6 September 2016

# Governance Improvement Action Plan

## Purpose of Report

The paper provides a brief update on the delivery of the GIAP and an overview of the actions that CoG is responsible for seeking assurance on delivery.

## Executive Summary

The Board summary report has been amended to provide an overview of the entire programme of work.

There are currently 136 actions over 11 Core areas. Good progress continues to be made to deliver the plan.

Following one to one meetings with lead directors and discussion at Board Committees since the end of July, there are 97 (71%) actions complete, 28 (21%) actions remain on track to be completed as planned; there are 'some issues' with the delivery of 2 actions (1%) and 9 actions (7%) are rated as 'off track'.

| Core | Number of Actions | Off Track | Some Issues | On track | Completed |
|---|---|---|---|---|---|
| Core 1 - HR and associated Functions | 12 | | | | 12 |
| Core 2 - People and Culture | 19 | 4 | | | 15 |
| Core 3 - Clinical Governance | 9 | | | 2 | 7 |
| Core 4 - Corporate Governance | 29 | 4 | | 2 | 23 |
| Core 5 - Council of Governors | 10 | | 1 | 1 | 8 |
| Core 6 - Roles and Responsibilities of Board Members | 14 | | | 10 | 4 |
| Core 7 - HR and OD | 20 | 1 | 1 | 9 | 9 |
| Core 8 - Raising concerns at work | 2 | | | 1 | 1 |
| Core 9 - Fit and Proper | 6 | | | | 6 |
| Core 10 - CQC | 4 | | | | 4 |
| Core 11 - NHS improvement undertakings | 11 | | | 3 | 8 |
| **Total** | 136 | 9 | 2 | 28 | 97 |

The CoG has oversight of 10 Actions, these risks are currently rated as;

| Action Rag Rating | |
|---|---|
| Completed | 8 |
| On track | 1 |
| Some Issues | 1 |
| Off Track | 0 |

The accompanying paper on this agenda provided by the Director of Corporate Affairs outlines further detail on each of the actions that CoG has oversight for.

Since the last meeting of the Council of Governors, Trust representatives have met with the enforcement team from NHSI where progress against the GIAP was discussed in detail. NHSI confirmed that it felt the Trust had made good progress across the plan and was satisfied with the underpinning process being adopted by the Trust which supports delivery of the planned actions.

It was agreed with NHSI as part of the next phase of delivery that the Trust would seek peer support in two specific areas of the plan, these being Culture and Engagement and Committee Effectiveness. Two Trusts have been approached who are deemed to be delivering best practice to ascertain how DHcFT could be supported and learn in these specific areas. Dudley and Walsall Mental Health Trust have been approached for Culture and Engagement and Hertfordshire Partnership Trust for Committee Effectiveness.

Progress in these areas will be reported through future reports to the Board of Directors and Council of Governors.

**Strategic considerations**

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

**Assurances**

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

**Consultation**

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

**Governance or Legal issues**

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

**Recommendations**

The Council of Governors is requested to;

- Review the content of this paper, alongside the paper produced by the Director of Corporate Affairs and seek assurance where required

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

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

**Council of Governors 21 July 2016**

**Governance Improvement Action Plan (GIAP)**

**Tasks relating to the Council of Governors**

The following report provides an update on those tasks within the Governance Improvement Action Plan which are assigned to the Council of Governors for oversight. A progress report against these actions is discussed at each Governance Committee and the detail below reflects discussion at the latest meeting (held on 7 July) and as reported to the Council of Governors meeting on 21 July, with further update on progress on specific tasks as relevant.

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

**CG1: The relationship between the Board of Directors and the Council of Governors is poor. Both parties should adopt a conciliatory approach rather than continuing with the antagonism which inflicts the current relationship.**

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

1) The Board and Council of Governors will co-write a policy on how the Board and Council of Governors will work in partnership.

   Target date: 30 June – **SOME ISSUES** – although a policy has been written and discussed in depth by the Governance Committee in June and July, it is awaiting final sign off at the Council of Governors on 6 September, following further amendments suggested at the Governance Committee on 7 July.

   Key principles and a draft policy was identified from best practice and discussed at the Governance Committee on 6 June and further at the meeting on 7 July. This encompasses arrangements already set in place including the twice yearly Council of Governors and Board session and the regular Non-Executive Director and Council of Governor sessions. Agreed governor representatives have also been invited to attend Board Committee meetings to observe the work of Committees, further understand their role and to hold Non-Executive Directors to account. Comments were raised and incorporated into a further draft of the policy for discussion at the Governance Committee on 7 July, where additional comments were raised following discussion. Subject to agreement by the full Council of Governors, the policy will be presented for approval at the Trust Board meeting in October 2016.

   Equality Impact – none.

   Financial impact – no direct financial or resource impact.

2) The Trust will expand the role of Lead governor to ensure greater collaborative working with the Chairman and SID.

**ACTION COMPLETE** - The Lead Governor role has been reviewed and agreed at the Council of Governors in January 2016 to reflect best practice that the role of the lead governor should be expanded to include greater responsibility and accountability. John Morrissey has been appointed to the role.

Equality impact – none.

Financial impact – no direct financial or resource impact.

3) Development and implement a process for the assessment of the effectiveness of Council of Governors.

30 September – **ON TRACK**

A proposal for evaluation of the effectiveness of the Council of Governors was drawn up and discussed at the Governance Committee on 6 June 2016. Following discussion and approval, governors agreed that this should be undertaken in September 2016, to allow meaningful input from recently appointed governors. The results are to be reviewed by the Governance Committee and the findings used to develop an action plan for the governors to take forwards. Discussion at the Governance Committee on 7 July confirmed that this could be made available to governors in electronic format and paper copy according to governor preference. Results of the evaluation are scheduled to be discussed at the Governance Committee in October 2016.

Equality impact – none.

Financial impact – no direct financial or resource impact.

4) Council of Governors to review and embed a new governance structure which will focus on more joined up working between Council of Governors and the Board of Directors.

**ACTION COMPLETE** - a Governance Committee has been established which incorporates the remit of the previous governor sub-committees. It is hoped that this ensures that governors can attend one committee to cover the key areas covered by the previous committees including membership, quality and performance. A work programme for the committee has been developed to ensure that key elements are included in the committee's business going forwards.

Equality impact – none.

Financial impact – no direct financial or resource impact.

5) Implement a Code of Conduct for all Governors

**ACTION COMPLETE** – Code of Conduct written and approved at Council of Governors meeting on 21 July 2016. Implementation is underway with all governors requested to sign and return agreement with the Code.

Equality impact – none.

Financial impact – no direct financial or resource impact.

**CG2: Deloitte 12 – Formal training should be required for all current members of the Council of Governors and to future members as they join. This training should include the role of the Governors, the context of organisational governance and the personal conduct expected of Governors.**

1) Develop a new induction programme for the Council of Governors and roll out its delivery.

**ACTION COMPLETE** - the planned induction event took place on 31 May to cover the areas of the role of governors, their context within the organisation and personal conduct as outlined by the Code of Conduct. The Chair, chief executive and wider Board members attended to present at the event. New governors were invited to attend along with existing governors to refresh knowledge and to meet new governors. Those new governors unable to attend the session had bespoke 1:1 induction sessions with the Director of Corporate Affairs and the Trust Chairman. The Governance Committee on 7 July reviewed the collated evaluation from the induction and noted this to be very positive. A further induction session is being arranged once current elections are completed.

Equality impact – none.

Financial impact – no direct financial or resource impact.

2) Develop a Council of Governors development plan for 2016/2017 to include Govern Well and other external training.

**ACTION COMPLETE** - a broad development programme has been drawn up which includes regular sessions for governors to attend to learn more about the Trust's activities and their role. Feedback from the first five sessions has been positive although we would encourage as many as possible of our governors to attend. Sessions in April, May, June and July have covered the Trust's Strategy, the Governance Improvement Action Plan, CQC preparation, the role of Audit and Finance overview, where Trust directors have attended to present and receive feedback on these areas. The programme is owned by governors and can be flexed to accommodate future requirements.

External training opportunities, via Governwell and other providers are circulated to Governors and the Lead Governor and other governors have

attended external training events and fed back to governor colleagues through the Governance Committee.

Equality impact – none.

Financial impact – no direct financial or resource impact, although there are costs to attending externally run courses which are covered by established budgets.

3) Ensure that a schedule of the plans are made available to all Board members and members of the Council of Governors and the plan is delivered.

**ACTION COMPLETE** - all governors have received a copy of the development plan and future events are also publicised via Governor Connect. The programme is being delivered and evaluated on an ongoing basis with feedback to the Governance Committee. Feedback to date has been extremely positive with the opportunity to discuss complex topics in an informal setting being valued by governors.

Equality impact – none.

Financial impact – no direct financial or resource impact.

**CG3: Prioritise the recruitment to the Council of Governors, ensuring that the role of the Governor and vacancies are publicised.**

1) Chairman will engage stakeholders to ensure representation on the Council of Governors

**ACTION COMPLETE** - the Chair has written to stakeholders to confirm representation. The police constabulary has declined to participate as an appointed governor in future and the Trust's Constitution will be amended accordingly.

Equality impact – none.

Financial impact – no direct financial or resource impact.

2) Hold Governor elections.

**ACTION COMPLETE** - nominations and elections were held for vacant public and staff governor roles in Spring 2016. We were pleased to welcome nine new governors for the following constituencies:

Public –
Bolsover
Chesterfield North
Derby City East (two governors elected)
Erewash North
High Peak
Surrounding areas

Staff –
Nursing and Allied
Admin and Allied Support Staff.

It was not possible to elect governors to represent Chesterfield South and Amber Valley North constituencies and these remain vacant at present. Two additional seats are now available due to resignation of a governor and a move out of area. The Governance Committee on 7 July reviewed future plans for elections during 2016/17 and agreed to go ahead with two rounds of elections during 2016/17, commencing July and November.

Equality impact – none.

Financial impact – no direct financial or resource impact.

**DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST**

**MINUTES OF A MEETING OF THE BOARD OF DIRECTORS**

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

**Thursday, 30 June 2016**

**MEETING HELD IN PUBLIC**

Commenced: 1pm Closed: 4:40pm

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

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

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| | well as rescue medication. Max is also non-verbal, he has had a tracheotomy and is fed via gastrostomy, he also has brittle bones and uses a wheelchair.<br><br>Max has had several operations and cannot do much for himself and is prescribed considerable medication that needs to be administered correctly. Jackie has three other children and since receiving support from the Lighthouse when Max was eight, Jackie and her family are now managing to live a fuller life and are far happier.<br><br>Louise explained that the Lighthouse's main priority is to keep Max safe and provide family respite. He has complex needs which are quite difficult to manage. To stabilise Max's care Louise set up training sessions for all the staff to learn how to meet Max's needs and this has provided Jackie and her family with comfort knowing that Max and other children like him can receive respite care which enables families to spend time together to function normally. Max is always happy at the Lighthouse and has access to sensory rooms and fun equipment.<br><br>Carolyn Green asked Jackie what improvements in the support and care for Max she and her family could have received. Jackie wished Max could have accessed the Lighthouse at a much earlier age as caring for him has been very difficult. Staff at the Lighthouse know Max very well and Louise makes sure that any new staff are trained to care for his needs. Jackie suggested that photographs showing how Max likes to sleep or sit could be used as useful guidance to staff who care for children like Max. Carolyn Green pledged to supply the Lighthouse with a camera so photographs can used to inform staff of not just Max's needs, but those of other children in the Lighthouse's care as a patient safety improvement under the Trust's innovation network.<br><br>The Board asked to know more about staff training for children with such complex needs. Louise described the enormous element of care involved looking after children like Max and stressed that the complex needs of these children is ever increasing. Tracheotomy and rhesus training is something that needs to be looked at to enable the right level of training to be continuous with the staff who join the Lighthouse team on an ongoing basis. Training has been concentrated on nursing staff and Louise has set up a system to ensure staff undergo training so they are compliant, but she has noticed there has been reluctance / as well as skills competence and the ability to retain this skill set from social care staff to take on training within their roles. Louise was keen for the training packages to be completed and ratified and Carolyn Green suggested that Louise be invited to attend the Physical Care Committee which would help and support her in her endeavours.<br><br>The Board considered Jackie's story to be truly inspirational and felt gratified to hear how Louise and the Lighthouse team cared for Max had responded to Jackie's and her family's needs.<br><br>**ACTION: Bev Green and Carolyn Green to arrange for a camera to be provided for use at the Lighthouse through the Trust innovation network.**<br><br>**RESOLVED: The Board of Directors expressed thanks to Jackie for sharing her experience and appreciated the opportunity to hear at first hand the service the Trust had provided.** |
| **DHCFT 2016/091** | **MINUTES OF THE MEETING DATED 25 MAY 2016**<br><br>The minutes of the meeting held on 25 May were accepted and agreed subject to the list of attendees being amended to record apologies received by Jayne Storey. |
| **DHCFT 2016/092** | **MATTERS ARISING AND ACTIONS MATRIX**<br><br>The Board agreed to close all completed actions. Updates were provided by members of the Board and were noted directly on the actions matrix. |

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| **DHCFT 2016/093** | **CHAIRMAN'S VERBAL REPORT**<br><br>Richard Gregory updated the Board on progress made in Derbyshire on the Sustainability and Transformation Plan (STP) which involves the Trust heading towards a more integrated service which will improve quality of patient care across all providers including health and social care. He explained that because this is a national initiative and the Trust was being encouraged to move at pace, a special meeting of the Trust's Council of Governors and Derbyshire Community Health Services NHS Foundation Trust's (DCHS) Council of Governors will take place to update governors on the work that will bring together all local NHS providers, commissioners, local authorities and the voluntary sector, to develop a comprehensive and joined-up plan for the future.<br><br>**RESOLVED: The Board of Directors noted the Interim Chairman's verbal update.** |
| **DHCFT 2016/094** | **ACTING CHIEF EXECUTIVE'S REPORT**<br><br>Ifti Majid presented his report which provided the Board with feedback on changes within the national health and social care sector as well as providing an update on developments occurring within the local Derbyshire health and social care community. The report also updated the Board on feedback from external stakeholders such as commissioners and the Trust's staff. The report was also used to support strategic discussion on the delivery of the Trust strategy.<br><br>Ifti Majid informed the Board that the 21C Joined Up Care Public Consultation went live on 29 July the proposals of which were contained in the publication of the consultation document that was circulated at the meeting.<br><br>Attention was drawn to the inaugural report of the NHS Workforce Race Equality Standard (WRES) that had been published by the NHS Equality and Diversity Council which he thought gave interesting reading. This is the first time WRES data has been published nationally and Ifti was pleased to report that the Trust is rated higher than the national average. He was also pleased to report that an update on the Trust's Equality and Diversity Workforce approach for 2016 - 17 would be presented to the Trust Board at the next meeting in July.<br><br>Following the referendum last week, Ifti Majid made a public statement which acknowledged the contribution of staff from ethnic areas which was fully supported by the Board.<br><br>*"In common with other senior healthcare leaders, I want to take this opportunity to recognise the vital contribution made to the delivery of our services by staff who are not UK nationals.*<br><br>*"Their skill, commitment and dedication are key to ensuring the ongoing quality of our services.*<br><br>*"I am saddened by reports over the last week about the increase in abuse towards non-UK nationals following last week's referendum. I would like to make it absolutely clear that within our Trust we will not accept this sort of behaviour and I would urge all of our staff to use existing mechanisms to alert us to any such incidents.*<br><br>*"As a Trust, I am confident that we can demonstrate our belief in tolerance and respect by valuing and supporting individuals regardless of their background or nationality."*<br><br>Ifti Majid reported that formal feedback following the CQC inspection visit at the beginning of June was still awaited and initial issues raised at the time are being dealt with immediately. Carolyn Green added that some high level areas were around quality |

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| | priorities. Improvements have been made but there are still some areas that need to reach full 100% compliance. There is work to be carried out within the positive and safe risk reduction strategy to ensure our data is accurate and work is also being carried out on seclusion and segregation compliance as this had been raised as a concern by the CQC. At this point Richard Gregory took the opportunity to thank governors for contributing to the CQC inspection which had proved extremely valuable.<br><br>Ifti Majid's report also included the Listen, Learn and Lead matrix which set out the latest round of team visits by Directors.<br><br>**RESOLVED: The Board of Directors noted the contents of the Acting Chief Executive's report** |
| **DHCFT 2016/095** | **INTEGRATED PERFORMANCE AND ACTIVITY REPORT**<br><br>This report provided the Trust Board with an integrated overview of performance as at the end of May 2016 with regard to workforce, finance and operational delivery and quality performance.<br><br>Claire Wright pointed out key points emerging from the report relating to Finance. She explained how IAPT performance income had deteriorated which was mainly due to sickness and vacancy aspects. She also highlighted the work currently taking place to progress gaps in the Cost Improvement Programme (CIP) which will be assessed further in July.<br><br>Claire Wright informed the public and visitors to the meeting that the Board had agreed during its confidential session this morning to accept NHSI's offer of £0.83m sustainability and transformation funding. This would create a £2.5m surplus control total in place of the currently agreed £1.7m surplus.<br><br>Carolyn Gilby highlighted key points relating to operational functions and was pleased to point out that the Trust was fully compliant with NHSI targets. Discussion took place on whether there was more demand for early intervention work and it was agreed that this would be raised with commissioners. Carolyn Gilby added that new NICE guidance is being adhered to which the Trust has not measured against before and this was being reviewed with commissioners within the terms of new monitoring within contract management.<br><br>It was noted that Workforce KPIs were looking more favourable although sickness absence remains a concern. Specific action has been taken in this area and staff have been asked if they would like to work extra hours. Jayne Storey pointed out that a recent report from BUPA showed that 60% of stress issues reported by staff were home related issues, not work related. Stress management training for managers has been offered and is being actively encouraged. Meetings had also taken place with First Care who manage the Trust's absence system to help develop best practice and learning and there is some really proactive information in this area. Caroline Maley was concerned about the level of vacancies and it was pointed out that the majority of vacancies had arisen due to staff moving to other areas of the organisation rather than from staff leaving the Trust.<br><br>Carolyn Green provided a brief overview of quality issues and explained that quality measures were currently being developed further with redesign of clinical record keeping. She was also working with the Quality Leadership Teams to improve standards of compliance on areas such as seclusion and segregation. Specific work will also take place to improve monitoring of seclusion and segregation recording rates which will be cross referenced against DATIX incidents through the Mental Health Act Committee. Some of the Trust's feedback with regard to the recording of segregation was related to when the Radbourne unit was closed to admissions and the 136 suite was closed due to an incident involving a very dangerous service user. This was a particularly difficult issue |

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

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| | **1) Considered the report**<br>**2) Scrutinise the contents**<br>**3) Sought additional assurance regarding the number of doctors suspected/excluded from practice that would be dealt without outside of the meeting.** |
| **DHCFT 2016/099** | **COMPLIANCE RETURN – GOVERNANCE STATEMENTS 4, 5 AND 6 INCLUDING DELEGATED AUTHORITY**<br><br>Sam Harrison presented her paper which supported the requirement for the Board to submit Governance Statements four, five and six to NHS Improvement (NHSI) by 30 June (statements one, two and three were previously submitted in May).<br><br>Members of the Board confirmed their agreement with Statement 6: "*The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.".* This enabled Sam Harrison to return Statement 6 to NHSI by 5pm in line with requirements and would also be uploaded onto the Trust's website.<br><br>Due to the notified changes in the phasing of the submission of compliance returns to NHSI for 2016/17 which no longer fit with the Trust's governance arrangements, the Board approved delegated authority to the Chair of the Audit and Risk Committee, and the Chair of the Finance and Performance Committee for the sign off of future submissions. Once submitted, these will be circulated to the Board for information at the next Public Trust Board meeting.<br><br>**RESOLVED: The Board of Directors:**<br>**1) Gave agreement for Governance Statement 6 to be returned to NHSI by 5pm, 30 June 2016**<br>**2) Approved delegated authority to the Chair of the Audit and Risk Committee and Chair of the Finance and Performance Committee for the sign off of compliance returns.** |
| **DHCFT 2016/100** | **BOARD COMMITTEE ESCALATIONS**<br><br>Short assurance summaries were received from committee chairs which identified key risks, successes and decisions made. Each summary was scrutinised and escalations were noted. The ratified minutes of meetings held in May were received for information and no issues were raised.<br><br>**RESOLVED: The Board of Directors received the Board Committee escalations and ratified minutes of meetings held in May.** |
| **DHCFT 2016/101** | **DEEP DIVE – VACANCIES, SICKNESS AND RECRUITMENT**<br><br>A "deep dive" into the Trust's Sickness Absence information and links to other employee relations activity was presented to the Board in September 2015 and was subsequently updated and presented to the Finance & Performance Committee in January 2016.<br><br>Kath Lane, Acting Deputy Director of Operations, presented today's "deep dive" which was generated in response to the Board's request for a further deep dive into the number of vacancies, sickness levels, and recruitment undertaken within the Trust. The report highlighted the 20 teams on the KPI Hot Spot Triangulation within the Workforce Dashboard for May 2016, and a focus on the top 6 teams within the Trust on the Board Dashboard for May 2016. This approach involved joint analysis between Workforce and Organisational Development functions together with Operational Management to develop action plans against the KPIs. The trajectory for recruitment in the updated Operational Recruitment Plan previously presented to the People and Culture Committee was also |

taken into account.

Kath Lane, Tim Slater, Garry Southall and Susan Team Spray from both the Operational and Workforce functions attended the meeting and drew attention to the action plan that had been formulated to stabilise the situation. They described the work taking place to establish how this model was functioning and how an analysis was being carried out to see how deep routed issues impacted on staff attendance. It was clear that sickness absence is symptom of what is happening within the teams. This has influenced the model and this evidence will be used to inform current and future ways of working.

High levels of stress have been experienced in the Enhanced Care Ward (ECW) due to significant incidents that have occurred over the last six months. The impact these incidents have had on ECW cannot be under estimated and stronger working relationships are being are being developed across port folios in order to deliver a more integrated approach to bring together combined objectives to achieve secure care plans. At this point the team took the opportunity to thank John Sykes and the Board for their support in seeing them through the difficult times they experienced in the case of a particular patient.

It was understood that the main reason for absence is due to stress. It was pointed out that 60% of stress related absence is due to stress in people's home life and is not work related. Analysis of case load sizes did not show correlation with stress levels. The Workforce team has been working very closely with managers to provide them with coaching so they are aware of the health and attendance policy to encourage people back into the workplace. In addition to this, stress management courses are being run throughout the county and managers are being encouraged to attend. Evidence now shows that mangers are feeling more confident to tackle issues at an earlier stage.

The report also showed that absence is linked with high levels of activity. Enormous strides are being made to recruit more staff but staff retention is the real challenge, although vacancies in neighbourhood posts were showing an improvement. Targets were highlighted in the report and the Board was interested to know how challenging these targets would be. It was acknowledged that there would be always be seasonal variances in sickness absence; statistics show when these will be spiked and work would take place to pre-empt this as much as possible. Richard Gregory stressed the importance of setting aspirational targets that can be achieved the need to be confident in the plans and processes. He also added that the People & Culture Committee recently agreed these targets should be revised and a benchmarking exercise is taking place and will be submitted to the People &Culture Committee in September to show what has been achieved.

Richard Gregory asked how the Board could support the teams. Tim Slater wished for the Board authorise the process to speed up the development of the electronic recruitment system which is currently being developed within IM&T. It was recognised that a strong business partner model is required (the HR and Operations model needs enhancement) and the capacity/resource within the Workforce Team needs to improve all and all these issues will be progressed through the People & Culture Committee.

The Board was pleased to see Operations and Workforce functions working together to face the challenges they have been presented with. The Board supported promoting different ways of thinking and creating an open minded staff culture and asked to be kept informed so progress can be measured.

**RESOLVED: The Board of Directors:**

1) **Acknowledged the report and noted the progress that is taking place to recruit staff and support areas with staffing challenges.**
2) **Acknowledged the work taking place to consider those areas that trigger more than one KPI on the Workforce Dashboard, and following analysis by Operational Management and the Workforce & OD Department be assured that**

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| | **appropriate support and assistance are provided to those teams.**<br>**3) Considered incorporating data / KPIs against teams that demonstrate excellence in order to encourage the sharing of best practice and supporting other teams who may require assistance** |
| **DHCFT 2016/102** | **REPORT FROM COUNCIL OF GOVERNORS MEETING**<br><br>Sam Harrison presented her report which updated the Board on discussions held at the Council of Governors meeting held on 1 June.<br><br>The Board noted the issues discussed with governors during the meeting.<br><br>**RESOLVED: The Board of Directors noted the discussions at the Council of Governors meeting held on 1 June 2016** |
| **DHCFT 2016/103** | **GOVERNANCE IMPROVEMENT ACTION PLAN**<br><br>Mark Powell presented his report which provided Board members with an update on progress of all tasks within the GIAP, including the identification of tasks that are off track, including those that the Board has responsibility for oversight.<br><br>Members of the Board recognised that the main focus of attention during the last four weeks had been on tasks with a delivery deadline up to, and including the end of June. It was understood there had been limited opportunity to look beyond this in any great detail due to significant resource being directed towards the Trust's recent CQQ inspection. In addition, due to the timing of the Board Committee meetings only the People and Culture Committee had met to discuss and receive assurance on the tasks that they have oversight for on behalf of the Board, the outcome of which was indicated in the 'comments on progress' and in the updated RAG ratings sections in the GIAP. This resulted in issues being mainly to do with actions around the People Plan, Engagement and Corporate Governance.<br><br>Mark Powell explained that to progress these issues he, Jayne Storey and members of the HR team would build emphasis behind individual issues that need to be improved as quickly as possible and he was confident that significant progress would be seen to have been made on specific tasks by the July meeting of the People & Culture Committee.<br><br>Mark Powell also informed the Board on progress made on the development of KPIs and associated assurance mechanisms which were areas that NHSI had asked the Trust to focus on and to consider as part of the GIAP. These areas will be discussed and finalised at the Board Development Session on 13 July and will be submitted to the July Board for approval.<br><br>Members of the Board understood that whilst the HR resource plan was fully recruited to, the HR team had been further challenged by a number of other requests on their time during June which had resulted in reduced capacity to focus on the GIAP. However, following further discussion, Board members were satisfied that corrective action was being taken to address the development of specific tasks and actions and looked forward to receiving evidence that significant progress has been made with the GIAP at the July Board meeting.<br><br>**RESOLVED: The Board of Directors:**<br>**1) Reviewed the content of the full GIAP**<br>**2) Discussed the recommendations rated as 'off track' or 'some issues' and was assured by the mitigation provided from the responsible Director, individual Directors or Committee Chairs.** |
| **DHCFT 2016/104** | **BOARD FORWARD PLAN** |

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| | The forward plan was noted and would be updated in line with today's discussions.<br><br>**RESOLVED: The Board of Directors noted the forward plan for 2016/17** |
| **DHCFT 2016/105** | **IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK OR GIAP**<br><br>The BAF would be influenced by information received on the Sustainability and Transformation Plan and would be linked to the BAF submission to be received at the July Board. |
| **DHCFT 2016/106** | **BOARD PERFORMANCE AND CONTENT OF MEETING**<br><br>The Board felt that good discussions were held during the meeting. It was reiterated that any questions applicable to the agenda and at the Chair's discretion should be received by the Board Secretary up to 48 hours prior to the meeting for a response to be provided by the Board at each meeting. |

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

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

**Derbyshire Healthcare NHS Foundation Trust**
Report to Council of Governors 6 September 2016

## Governors Nominations & Remuneration Committee

### Purpose of Report

The paper provides an update on the meeting of the Nominations and Remuneration Committee, held on 3 August 2016 and seeks approval from the Council of Governors for the revised Terms of Reference for the Committee.

### Executive Summary

The Governors Nominations & Remuneration Committee met on 3 August 2016. The Committee:

- Reviewed the Non-Executive Director (NED) appraisals for 2015/16
- Supported objectives for NEDs for 2016/17
- Agreed feedback via the Chair for consideration of NED portfolios and development
- Agreed that a job description for the role of Trust Chair would be developed
- Reviewed the revised Terms of Reference (TOR)
- Discussed the requirements for a 'clinical' NED, requested a revised job description for the role and authorised the Director of Corporate Affairs & Trust Secretary to initiate a recruitment campaign for the 'clinical' NED
- Requested feedback from the NED candidates in the recent recruitment process on the Trust's services and process.

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

### Strategic considerations

- By delivering to its TOR the Committee is held in line with and according to the Corporate Governance Framework.

### Assurances

- The TOR have been updated to reflect and comply with good governance arrangements. Changes include clarifying the membership and quorum. The TOR will be used by the Committee to populate the year work plan for the Committee and the Committee will report against its effectiveness in terms of complying with the Terms of Reference in an end of year report to Council of Governors (CoG).

- The Council of Governors can be assured from the updates provided that the Committee is meeting its requirements as set out in the TOR.

**Consultation**

- Terms of Reference have been reviewed by the Committee.

**Governance or Legal issues**

- By following its TOR the Committee is following and practicing good governance.

**Recommendations**

The Council of Governors is asked to:

- Receive the report of the meeting of 3 August.
- Ratify the Terms of Reference for the Governors Nominations & Remuneration Committee.
- Note the approach taken for the recruitment of the 'clinical' Non-Executive Director.

**Report prepared by:** **Donna Cameron (Corporate Services Officer)**

**Report presented by:** **Sam Harrison (Director of Corporate Services & Trust Secretary)**

**Draft 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.

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).

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.

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.

- Three Public Governors (including Lead Governor)
- Two Appointed Governors
- One Staff Governor
- Chair of the Trust
- The Director of Corporate Affairs & Trust Secretary may attend as a non-member.

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.

3.4 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.

## 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 and Director of Corporate Affairs & Trust Secretary.

5.3 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.

## 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 Council of Governors 6 September 2016

# Revision of Engagement with the Board of Directors and Council of Governors Policy

## Purpose of Report

This report sets out a revised draft policy that has been developed from reviewing best practice and incorporates comments arising from discussion at the Governance Committee at its 6 June and 7 July meeting.

## Executive Summary

The policy covers a range of important areas including:

- Relationship between the Trust Board and the Council of Governors
- Handling of concerns
- Powers & duties, roles and responsibilities of the Trust Board and the Council of Governors
- Role of the Senior Independent Director
- Grounds and procedure for the removal of the Chair or a Non-Executive Director
- Dispute Resolution Procedure

The policy also encompasses those activities which we have developed within the Trust such as the twice yearly Board/Council of Governor sessions and Governor/NED informal sessions. Also referenced are the opportunities recently offered to representative governors to attend Board Committees to observe discussions.

The purpose of this policy is therefore to:

- Set out the systems and structures to promote a constructive working relationship between the Council of Governors and the Trust Board
- Set out a process for dealing with problems that may arise, as recommended by NHS Improvement's Code of Governance

**Strategic considerations and assurances**

- This Policy for Engagement clarifies the respective roles and responsibilities of the Board and the Council of Governors
- This policy outlines the assurance of the Board and the Council of Governors to maintain commitment to the Nolan principles which are a foundation of our roles

**Consultation**

- This policy was discussed at the Governance Committee at its 6 June and 7 July meeting

**Governance or Legal issues**

- This policy outlines the commitment by the Board of Directors and governors to developing engagement and two-way communication to carry out their respective roles effectively

**Recommendations**

The Council of Governors is asked to:

- Receive and note the revised Engagement with the Board of Directors and Council of Governors Policy

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| **Report prepared and presented by:** | **Sam Harrison**<br>**Director of Corporate Services & Trust Secretary** |

**Policy for Engagement between the Trust Board and the Council of Governors**

The following updated draft policy has been developed from reviewing best practice and incorporates comments arising from discussion at the Governance Committee at its 6 June and 7 July meeting.

The policy covers a range of important areas including:

- Relationship between the Trust Board and the Council of Governors
- Handling of concerns
- Powers & duties, roles and responsibilities of the Trust Board and the Council of Governors
- Role of the Senior Independent Director
- Grounds and procedure for the removal of the Chair or a Non-Executive Director
- Dispute Resolution Procedure

The policy also encompasses those activities which we have developed within the Trust such as the twice yearly Board/Council of Governor sessions and Governor/NED informal sessions. Also referenced are the opportunities recently offered to representative governors to attend Board Committees to observe discussions.

In developing this policy both the Board and the Council of Governors are keen to maintain commitment to the Nolan principles which are a foundation of our roles:

**The Nolan Principles - The Seven Principles of Public Life**

**Selflessness**
Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

**Integrity**
Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

**Objectivity**
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

**Accountability**
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

**Openness**
Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

**Honesty**
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

**Leadership**
Holders of public office should promote and support these principles by leadership and example.

**POLICY FOR ENGAGEMENT BETWEEN THE TRUST BOARD AND THE COUNCIL OF GOVERNORS**

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## EXECUTIVE SUMMARY

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

The Board leads the Trust by undertaking four key roles:

- setting strategy
- supervising the work of the executive in the delivery of the strategy and through seeking assurance that systems of control are robust and reliable
- setting and leading a positive culture for the board and the organisation;
- giving account and answering to key stakeholders, particularly Councils of Governors.

The statutory general duties of the council of governors are:

- to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and
- to represent the interests of the members of the corporation as a whole and the interests of the public.

The Trust Board recognises that it needs to enable the Council to hold it to account, in the first instance through the Non-Executive Directors. The Trust Board commits to consult governors on all strategic issues and material service developments before decisions are made, recognising that governor feedback enables a better informed and more effective Board.

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

This policy outlines the commitment by the Board of Directors and governors to developing engagement and two-way communication to carry out their respective roles effectively.

### Introduction

i. The Trust Board and Council of Governors are committed to building and maintaining an open and constructive working relationship. Under-pinning such a relationship is the need for clarity on the respective roles and responsibilities.

ii. NHS Improvement's Code of Governance recommends that each Foundation Trust should have a Policy for Engagement between the Trust Board and the Council of Governors, which clearly sets out how the two bodies will interact with one another for the benefit of the Trust.

iii. This Policy for Engagement clarifies the respective roles and responsibilities of the Board and the Council of Governors, and describes the information flow between the two groups. The policy describes the involvement of governors in forward planning, and the role they plan in respect of holding the Trust Board to account.

iv. The Policy for Engagement also sets out a process should the governors have a concern about the performance of the Board, compliance with the licence or the welfare of the Trust. It also describes the process should the governors have significant concerns about the performance of the Chair or Non-Executive Directors.

v. This policy is intended to provide clear guidance and a useful framework for both the Trust Board and Council of Governors and has been approved by each respectively. [dates to be added when this has happened]

## 1. INTRODUCTION

### 1.1 Purpose

1.1.1 The Board is committed to building and maintaining an open and constructive working relationship with the Council of Governors. The Board believes that it is important that the respective powers and roles of the Trust Board and the Council of Governors are clear, and are followed in practice.

1.1.2 There may be times where the Council of Governors has concerns about the running of the Trust. NHS Improvement's Code of Governance recommends that the Council of Governors should establish a Policy for Engagement with the Trust Board for those circumstances when they have concerns about the performance of the Trust Board, compliance with its licence or the welfare of the Trust.

1.1.3 The purpose of this policy is therefore to:

- set out the systems and structures to promote a constructive working relationship between the Council of Governors and the Trust Board
- set out a process for dealing with problems that may arise, as recommended by NHS Improvement's Code of Governance.

1.1.4 This policy complements the Trust's arrangements for governor communication with NHS Improvement and the Care Quality Commission (CQC) where governors have concluded that a Trust has failed, or is failing, to act in accordance with its constitution, or Chapter 5 of the Health and Social Care Act (2006) and where it is considered that the intervention of NHS Improvement or the Care Quality Commission may be appropriate. That is, it is the role of the Lead Governor to contact regulators in this instance.

## 2. RELATIONSHIP BETWEEN THE TRUST BOARD AND THE COUNCIL OF GOVERNORS

### 2.1 Powers and Duties, Roles and Responsibilities

2.1.1 The respective powers and roles of the Trust Board and the Council of Governors are set out in their Standing Orders and the Trust Constitution.

2.1.2 The Trust Board and the Council of Governors should understand their respective roles and seek to follow them in practice. Any concerns or queries should be raised with the Chair, Director of Corporate Affairs/Trust Secretary or Lead Governor.

2.1.3 The Trust will provide induction and ongoing training regarding roles and responsibilities.

### 2.2 Trust Board and Council of Governors

2.2.1 In order to facilitate communication between the Trust Board and Council of Governors, there will be an opportunity for governors to raise questions linked to the agenda of each public Trust Board meeting. As per established arrangements for questions to the Trust Board, these should be submitted to Board Secretary at least 48 hours prior to the Board meeting.

2.2.2 The Council of Governors will have the opportunity to submit formal questions/concerns to the Trust Board, and will receive a response within seven working days of the meeting.

2.2.3 Governors may, by informing the Chair, request an item to be added to the agenda of the Council of Governors for discussion, or via the Governance Committee, or raise as 'any other business' at the Council of Governors meeting.

2.2.4 Governors will have the opportunity to raise questions about the affairs of the Trust

with any Director present at a meeting of the Council of Governors. Wherever possible, questions should be submitted to the Chair in advance of the meeting, to enable a reasonable time to be allocated during the meeting. Where this is not possible, a written response will be provided within seven days of the meeting.

2.2.5 Whilst a confidential part of Board of Director meetings will be held in private the agenda from these meetings will be made available for governors. The public Trust Board papers will be sent to governors electronically and are also available from the Trust website prior to the meeting.

**2.3 Role of the Chair**

2.3.1 The Chair is responsible for leadership of the Trust Board and the Council of Governors, ensuring their effectiveness on all aspects of the role and setting their agenda. The Chair is responsible for ensuring that the two groups work together effectively, and that they receive the information they require to carry out their duties.

2.3.2 In the Chairman's absence meetings of the Council of Governors will be chaired by the Deputy Chair of the Trust Board.

2.3.3 The Chair will ensure that the views of governors and members are communicated to the Trust Board and that the Council of Governors is informed of key Trust Board decisions.

2.3.4 The Chair will meet with the Lead Governor, and will have 1:1 meetings with individual governors as reasonably requested.

**2.4 Role of the Trust Board**

2.4.1 The Trust Board will formally meet with the Council of Governors twice a year to review the Trust's performance against the annual objectives, the Quality Accounts and compliance with the Monitor licence.

**2.5 Role of Non-Executive Directors and the Senior Independent Director**

2.5.1 Non-Executive Directors will be invited to attend meetings of the Council of Governors, make presentations and answer questions as appropriate.

2.5.2 Non-Executive Directors will commit time to build effective relationships with governors and governors and Non-Executive Directors will agree to spend time together to understand each other's perspectives and build good levels of mutual understanding. Non-Executive Directors will schedule to meet informally with governors on a regular basis.

2.5.2 The Senior Independent Director will be available to the Council of Governors and individual governors if they have concerns which contact through the normal channels of Chair has failed to resolve or for which such contact is inappropriate. The Senior Independent Director should attend sufficient meetings of the Council of Governors Council to listen to their views in order to help develop a balanced understanding of the issues and concerns of the governors and members.

2.5.3 The role of the Senior Independent Director is set out in Appendix B.

2.5.4 The process to be followed in dealing with concerns is set out in Section 3.

**2.6 Role of Executive Directors**

2.6.1 Executive directors (including the Chief Executive or deputy) will be invited to attend Council of Governors meetings, and be asked to facilitate discussions and answer questions as appropriate.

**2.7 Role of the Governors**

2.7.1 Governors are required to meet the statutory duties as set out in Appendix A.

**2.8 Role of the Lead Governor of the Council of Governors**

2.8.2 **As Lead Governor:**

a. Act as a direct link between the governors and NHS Improvement in situations where it would be inappropriate to go through the Chair
b. Act as the point of contact between the Council of Governors and the Care Quality Commission
c. Prioritise agenda items for the Council of Governors and ensure action plans are followed
d. Maintain regular communication with the Chair, conducting regular reviews of the performance of the Trust
e. Member of the Nominations and Remuneration Committee
f. Member of the Governance Committee
g. Represent concerns that governors may have (either as a body, or individually) to the Chair
h. Together with the Chair address inappropriate action by any governor subject to Nominations and Remuneration Committee approval
i. Lead the appraisal process for the Council of Governors, and facilitate the Council of Governors review of effectiveness
j. Maintain a close working relationship with the Senior Independent Director (SID) of the Board of Directors
k. Together with the SID carry out the appraisal of the Chair
l. Agree the format of regular Council of Governor/Non-Executive Director meetings
m. As representative of the Trust's Council of Governors establish and maintain working relationships with NEDs, the Board of Directors and forge links with external bodies such as CQC, Health and Wellbeing Board and Council of Governors of other foundation trusts.

**2.9 Council of Governors involvement in forward planning**

When the Trust Board is engaged in strategic planning (eg annual planning, strategic direction) governors will be involved in the process so that the views of members can be properly canvassed and fed into the process.

**2.10 Accountability**

2.10.1 The Council of Governors has a role to hold the Non-Executive Directors individually and collectively to account for the performance of the Trust Board, including ensuring the Trust Board acts so that the Trust does not breach its licence. In order to carry out this role, the Council of Governors will be provided with high quality information that is relevant to the decisions they have to make. The information needs of the Council of Governors will be discussed as part of the induction process and subject to ongoing review, and the governors will be consulted in the planning of agendas of Council of Governors Council meetings.

2.10.2 NHS Improvement's Code of Governance provides that the Trust Board will notify the Council of Governors of any major new developments or changes to the Trust's financial condition, performance of its business or expectations as to its performance, that if made public would be likely to lead to a substantial change to the financial well-being, healthcare delivery performance or reputational standing of the Trust.

2.10.3 The Health & Social Care Act 2012 places a mandatory duty on the Board of Directors to consult with and seek the agreement of the Council of Governors on 'significant transactions' including mergers, acquisition, dissolution, separation, raising additional services from activities other than via its principal purpose and raising the threshold of funds raised from private patients as outlined in the Trust's Constitution.

2.10.4 The Council of Governors have the powers to call an Executive Director to the Council of Governors for the purpose of obtaining information about the Trust's performance of its functions or the Director's performance of their duties.

## 3. HANDLING OF CONCERNS

**3.1** A concern, in the meaning of this policy, must be directly related to either:

- The performance of the Trust Board, or
- Compliance with the licence, or
- The welfare of the Trust

Other matters that do not constitute a concern can be raised with the Chair to be discussed at the appropriate forum (see para 2.2.2-2.2.4).

### 3.2 Stage 1 – Informal

3.2.1 In the event that the Council of Governors has a concern of the type described above, every attempt should be made to resolve the matter firstly by discussion with the Chair. Where it affects financial matters, the Director of Finance should be involved. The Lead Governor should normally represent the Council of Governors in these matters, and they will consider whether additional representation is required.

3.2.2 Every attempt should be made to resolve concerns in an appropriate way, and as quickly as possible. This may involve the Chair convening a meeting with governors, and/or requesting reports from the Chief Executive, Director of Finance or another director or officer of the Trust, or a report from the Audit and Risk Committee or other committee, and providing comments on any proposed remedial action.

3.2.3 The outcome of the matter will be reported to the next formal meeting of the Council of Governors, who will consider whether the matter has been resolved satisfactorily.

### 3.3 Stage 2 – Formal

3.3.1 This is the formal stage where stage 1 has failed to produce a resolution and the services of an independent person are required. In this case the Senior Independent Director assumes the role of mediator, as recommended by the Code of Governance, and conducts an investigation.

3.3.2 The decision to proceed to Stage 2 and beyond will always be considered by the full Council of Governors, at an extraordinary, private meeting. This is to ensure that any decision is a collective Council of Governors decision. The decision to proceed to Stage 2 must be collectively agreed by a majority of the Council of Governors present at a meeting which is quorate. In the event that the Council of Governors does not agree to proceed to Stage 2, that decision is final.

3.3.3 Evidence requirements

Any concern should be supported by relevant evidence. It cannot be based on hearsay alone, and should meet the following criteria:

a. Any written statement must be from an identifiable person(s) who must sign the statement and be willing to be interviewed under either stage of this process.
b. Other documentation must originate from a *bona fide* organisation and the source must be clearly identifiable. Newspaper articles will not be accepted as *prima facie* evidence but may be admitted as supporting evidence.
c. Where the concern includes hearsay, eg media reports, the Council of Governors may require the Trust Board to provide explanations and, if necessary, evidence to show that the hearsay reports are untrue.

3.3.4 Investigation and Decision of the Senior Independent Director

3.3.4.1 The Senior Independent Director's role is to seek to resolve the matter in the best interests of the Trust.

3.3.4.2 The Senior Independent Director will produce a written report of their findings and recommendations and present it to the Council of Governors and Trust Board. The report will address the issues raised by the Council of Governors, and will also consider whether action is required to repair any breakdown in the relationship between the Trust Board and the Council of Governors.

3.3.4.3 The decision of the Senior Independent Director will be final in resolving the matter in the best interests of the Trust.

3.3.4.4 In the event that the Council of Governors' remain dissatisfied with the Senior Independent Director's decision, the options in paragraph 3.4 may be considered.

**3.4 Action in event of Stage 2 failing to achieve resolution**

3.4.1 If the Council of Governors does not consider that the matter has been adequately resolved, they have four options:

a. Accept the failure to reach a resolution of the matter and consider the matter closed; or
b. Seek the intervention of another independent mediator (ie a Chair or Senior Independent Director from another NHS Foundation Trust) in order to seek resolution of the matter, or
c. Inform NHS Improvement if the Trust is at risk of breaching its licence.
d. Follow the Dispute Resolution Procedure (as outlined at Appendix D).

**3.5 Removal of the Chair or any Non-Executive Director**

3.5.1 In relation to concerns raised in accordance with this policy, the Council of Governors should only exercise its power to remove the Chair or any Non-Executive Directors after exhausting all other means of engagement with the Trust Board.

3.5.2 The procedure for removing the Chair or a Non-Executive Director is set out in Appendix C.

**APPENDIX A**

**POWERS AND DUTIES OF THE TRUST BOARD AND THE COUNCIL OF GOVERNORS**

| **Trust Board:** | **Council of Governors:** |
|---|---|
| All the powers of the Trust are to be exercised by the Trust Board. The Trust Board may do anything which appears to it to be necessary or desirable for the purposes of or in connection with the functions of the Trust, subject to any restrictions in its licence. The powers of the Trust Board include, but are not limited to, the ability to borrow and invest money, acquire and dispose of property, enter into contracts, accept gifts of property (including property to be held on Trust for the purposes of the Foundation Trust or for any purposes relating to the health service), and employ staff. | The Council of Governors cannot veto decisions made by the Trust Board. |
| The Trust Board must submit forward planning information and annual reports and accounts to NHS Improvement, after consulting with the Council of Governors and having regard to their views. | The Council of Governors is to be consulted on forward planning by the Trust Board, and the Trust Board must have regard to their views. |
| The Trust Board will present the annual report and accounts and the auditors report to the Council of Governors and will lay a copy of the annual accounts, and any report of the auditor on them before Parliament, and once it has done so, send copies of these documents to NHS Improvement, along with the annual report. | The Council of Governors is to be presented with the annual report and accounts and the report of the auditor on them, at a general meeting of the Council of Governors. |
| It is for the non-executive directors to appoint and remove the Chief Executive. The appointment of the Chief Executive requires the approval of the Council of Governors. | The Council of Governors is to approve the appointment of the Chief Executive by the non-executive directors. The appointment requires the approval of a majority of the Council of Governors. |
| It is for a committee consisting of the chairman, the chief executive and the other non-executive directors to appoint or remove the executive directors | The Council of Governors is to appoint the chair and other non-executive directors of the NHS Foundation Trust at a general meeting of the Council of Governors. The appointment requires the approval of a majority of the members of the Council of Governors.<br><br>If the Council of Governors is to remove the chair or non- executive directors of the NHS Foundation Trust, such removal must occur at a general meeting of the Council of Governors and it requires the approval of three quarters of the members of the Council of Governors. |
| The Trust Board must establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors | The Council of Governors is to decide the remuneration and allowances, and the other terms and conditions of office, of the non-executive directors. The decision requires the approval of a majority of the members of the Council of Governors. |
| The Trust Board must establish a committee of non-executive directors to act as an Audit Committee | The Council of Governors is to appoint or remove the external auditor at a general meeting of the Council of Governors. The appointment and removal requires the approval of a majority of the members of the Council of Governors. |
| Provide active leadership of the Trust within a framework of prudent and effective controls which enable risk to be assessed and managed. | Represent the interests of the Trust's members and partner organisations in the local health economy. |

| Trust Board: | Council of Governors: |
|---|---|
| Set the Trust's strategic aims, taking into consideration the views of the Council of Governors, ensuring that the financial and human resources are in place for the Trust to meet its objectives, and review management performance. | Regularly feedback information about the Trust, its vision and its performance to the constituencies and the stakeholder organisations that either elected or appointed them. |
| Ensure compliance by the Trust with its licence, its Constitution, mandatory guidance issued by regulators, relevant statutory requirements and contractual obligations. | Act in the best interests of the Trust and adhere to its values and governor Code of Conduct. |
| Ensure the quality and safety of healthcare services, education, training and research delivered by the Trust and apply the principles and standards of clinical governance set out by relevant NHS bodies. | Hold the Non-Executive Directors individually and collectively to account for the performance of the Trust Board including ensuring the Trust Board acts so that the Trust does not breach its licence. |
| Ensure that adequate systems and processes are maintained to measure and monitor the Trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery. | Acknowledge the overall responsibility of the Trust Board for running the Trust and should not try to use the powers of the Council of Governors to veto decisions of the Trust Board. |
| Regularly review the performance of the Trust in these areas against regulatory requirements and approved plans and objectives. | Establish a policy for engagement with the Trust Board for those circumstances when they have concerns about the performance of the Trust Board, compliance with its licence or the welfare of the Trust. |
| Establish the values and standards of conduct for the Trust and its staff in accordance with NHS values and accepted standards of behaviour in public life, and operate a Code of Conduct that builds on the values of the Trust and reflects high standards of probity and responsibility. | Inform the Independent Regulator if the Trust is at risk of breaching its licence if these concerns cannot be resolved at a local level. |
| Ensure that there is a formal, rigorous and transparent procedure for the appointment or election of new members to the Trust Board, and satisfy itself that plans are in place for orderly succession of appointments to the Trust Board so as to maintain an appropriate balance of skills and experience within the Trust and on the Trust Board, and ensure planned and progressive refreshing of the Trust Board. | Agree a process for the evaluation of the Chair and the non-executive directors, with the Chair and the non-executive directors, and agree the outcomes of the evaluations. |
| Present a balanced and understandable assessment of the Trust's position and prospects. | Agree with the Audit and Risk Committee of the Trust Board the criteria for appointing, reappointing and removing external auditors. |
| Maintain a sound system of internal control to safeguard public and private investment, the Trust's assets, patient safety and service quality. | Work with the Trust Board on such other matters for the benefit of the Trust as may be agreed between them. |
| Establish formal and transparent arrangements for considering how they should apply the financial reporting and internal control principles and for maintaining an appropriate relationship with the Trust's auditors. | Assess its own collective performance and its impact on the Trust, and communicate this to the members of the Trust. |
| Consult and involve members, patients, clients and the local community, and monitor how representative the Trust's membership is and the level of effectiveness of member engagement. | Hold constituency meetings to ensure Member's interests are represented and Trust information is fed back. |
| Ensure that the Trust co-operates with other NHS bodies, local authorities and other relevant organisations with an interest in the local health economy. | |

| **Trust Board:** | **Council of Governors:** |
|---|---|
| Work with the Council of Governors on such other matters for the benefit of the Trust as may be agreed between them. | Raise issues and matters for discussion:<br>Contact Chair/Involvement Manager to identify an appropriate forum and to submit items for meetings, eg<br>☐ Request items to be included in the Council of Governors (or Governance Committee) agenda or raise matters under Any Other Business<br>☐ Raise formal questions for response by the Trust Board<br>☐ Ask questions of the Chief Executive at Council of Governors meetings. |
| Follow the principles of openness and transparency in its proceedings and decision making unless this conflicts with a need to protect the wider interests of the public or the Trust (including commercial in confidence matters) and make clear how potential conflicts of interests are dealt with. | |
| Undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors. | |

**Role of the Senior Independent Director**

The Senior Independent Director (SID) will be a Non-Executive Director of the Trust Board.

**The SID's role will be:**

- ☐ To be available to the Trust Directors if they have concerns which cannot be resolved through the normal channels (or is inappropriate) of the Chair or Chief Executive.
- ☐ To support the Chair in resolving disputes between individual Trust Board members in respect of their role as a director of the Trust.

**In respect of the Council of Governors**

- ☐ To be available to members and governors if they have concerns which cannot be resolved through the normal channels (or is inappropriate) of the Chair or Chief Executive. To maintain sufficient contact with governors to understand their issues and concerns, including building an effective relationship with the Lead Governor.
- ☐ To help resolving disagreements between the Council of Governors and Trust Board in accordance with the policy setting out the approach to be taken in these circumstances
- ☐ To agree a process for evaluating the performance of the Chair and to agree appropriate processes for reporting such evaluation annually to the governor Nominations and Remuneration Committee.
- ☐ To work with the Chair to establish a policy for engagement of the Council of Governors with the Trust Board.

## Grounds and Procedure for the Removal of the Chair or any Non-Executive Director

### Introduction

The Council of Governors has the power to remove the Chair and any Non-Executive Director of the Trust. Such removal must occur at a general meeting of the Council of Governors and requires the approval of three quarters of the members of the Council of Governors.

In relation to concerns raised under the Policy for Engagement, the Council of Governors should only exercise its power to remove a Non-Executive Director after exhausting all other means of engagement with the Trust Board, as set out in that policy.

### Grounds for removal

The removal of a Non-Executive Director should be based on the following criteria. Grounds for removal can include the following:

a) s/he is not qualified, or is disqualified, from becoming or continuing as a Non-Executive Director under the Constitution
b) s/he has failed to attend meetings of the Trust Board for a period of six months
c) s/he has failed to discharge his duties as a Non-Executive Director
d) s/he has knowingly or recklessly made a false declaration for any purpose provided for under the Constitution or in the 2006 Act
e) s/he has knowingly or recklessly failed to declare a conflict of interest
f) his/her continuing as a Non-Executive Director would be likely to:
    I. prejudice the ability of the Trust to fulfill its principal purpose or other of its purposes under the Constitution or otherwise to discharge its duties or functions
    II. harm the Trust's work with other persons or bodies with whom it is engaged or may be engaged in the provisions of goods or services
    III. adversely affect public confidence in the goods and services provided by the Trust; or otherwise bring the Trust into disrepute
g) s/he has failed or refused to comply with the regulatory framework, the Standing Orders, or any Code of Conduct which the Trust shall have published from time to time
h) s/he has refused without reasonable cause to undertake any training which the Trust requires all Non-Executive Directors to undertake
i) s/he purports to represent the views of any professional body, political party or trade union of which he is a member
j) it is not in the interests of the Trust for the Non-Executive Director to continue to hold office
k) s/he does meet the criteria as outlined in the Trust Fit and Proper Persons Test policy.

The following list provides examples of matters which may indicate to the Council of Governors that it is no longer in the interests of the Trust that a Non-Executive Director continues in office. The list is not intended to be exhaustive or definitive; the Council of Governors will consider each case on its merits, taking account of all relevant factors.

a) If an annual appraisal or sequence of appraisals is unsatisfactory
b) If the Non-Executive Director loses the confidence of the Trust Board
c) If the Non-Executive Director loses the confidence of the public or local community in a substantial way
d) If the Non-Executive Director fails to monitor the performance of the Trust in an effective way
e) If the Non-Executive Director fails to deliver work against pre- agreed targets incorporated within their annual objectives
f) If there is a terminal breakdown in essential relationships, eg between a Chair and a Chief Executive or between a Non-Executive Director and the Chair or the rest of the Trust Board.

### Procedure

a) Any proposal to remove a Non-Executive Director can be proposed by a Council member, the Chair, or the Trust Board.
b) The Non-Executive Director will be notified in writing of the allegations, and be invited to submit a response.
c) The Non-Executive Director is entitled to address the Council of Governors at the meeting considering the proposal to remove him.

d) The Trust Board may make representations to the Council of Governors whether they are for, or against the resolution, or even if they are divided.

e) The Council of Governors may consider any relevant evidence, eg appraisal documentation or witness statements.

f) The Council of Governors should take professional advice, via the Director of Corporate Affairs/Trust Secretary, prior to removing a Non-Executive Director.

g) In relation to concerns raised in accordance with the Policy for Engagement, the Council of Governors should only exercise its power to remove a Non-Executive Director after exhausting all other means of engagement with the Trust Board.

**Chair of meetings:**

The Chair may normally express an opinion on the appointment and removal of a Non-Executive Director, but does not have formal voting rights at the Council of Governors.

The Chair should also consider, however, whether **in particular circumstances** a conflict of interest arises in dealing with the removal of a Non-Executive Director, and if so, stand aside for that part of the meeting.

For the removal of the Chair, the Senior Independent Director will preside at meetings of the Council of Governors.

**Removal and disqualification of governors:** the process for the removal and disqualification of governors is covered in Annex 5 of the Trust's constitution.

**Appendix D**

**Dispute Resolution Procedure**

In the event of dispute between the Council of Governors and the Trust Board, where the above policy has been followed as appropriate through informal (Stage 1) and formal (Stage 2) procedures at outlined at 3.2 and 3.3, the dispute resolution procedure can be considered as a further option should Stage 2 procedures fail to achieve a resolution:

1. In the first instance the Chairman on the advice of the Director of Corporate Affairs/Trust Secretary, and such other advice as the Chairman may see fit to obtain, shall seek to resolve the dispute.

2. If the Chairman is unable to resolve the dispute he shall appoint a special committee comprising equal numbers of Directors and Governors to consider the circumstances and to make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute.

3. If the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the Chairman may refer the dispute back to the Trust Board who shall make the final decision.

4. Under the 2006 Act, as amended, NHS Improvement has appointed a Panel for Advising Governors (the Panel) to which governors of NHS foundation trusts may refer a question concerning whether their trust has failed, or is failing, to act in accordance with its constitution, or Chapter 5 of the 2006 Act.

# Governor Meeting Timetable 2016
# 24 August 2016

| DATE | TIME | EVENT | LOCATION |
|---|---|---|---|
| **06/09/16** | 11am – 12.30pm | Meet staff | St Thomas Centre, Chatsworth Drive, Brampton, S40 3AW |
| **06/09/16** | 1pm onwards | Council of Governors Meeting | St Thomas Centre , Chatsworth Drive, Brampton, S40 3AW |
| **07/09/16** | 1pm onwards | Trust Board Meeting | Conference Room A&B, Research and Development Centre |
| **13/09/16** | 1pm – 4pm | Public accountability and engaging with members | Meeting Room 1, Albany House |
| **20/09/16** | 10am – 12.30 | Governance Committee | Meeting Room 1, Albany House |
| **22/09/16** | 2.30pm – 6.30pm | Annual Members Meeting | Ilkeston Resource Centre |
| **4/10/16** | 1pm – 4pm | Governor Training – Quality Priorities CQC update | Meeting Room 1, Albany House |
| **05/10/16** | 1pm onwards | Trust Board meeting | Conference Room A&B, Research and Development Centre |
| **11/10/16** | 10am – 12.30pm | Governance Committee | Meeting Room 2, Albany House |
| **20/10/16** | 1pm onwards | CoG to Board | Conference Rooms A&B, Research and Development Centre |
| **02/11/16** | 1pm onwards | Trust Board meeting | Conference Room A&B, Research and Development Centre |
| **9/11/16** | 10am – 12.30pm | Governance Committee | Meeting Room 1, Albany House |
| **15/11/16** | 1pm – 4pm | Meeting Skills and working in line with the code of conduct | Meeting Room 1, Albany House |
| **24/11/16** | 11am – 12.30pm | Governors to NEDS | Conference Room A&B, Research and Development Centre |
| **24/11/16** | 1pm onwards | Council of Governors meeting | Conference Room A&B, Research and Development Centre |
| **5/12/16** | 1pm – 4pm | Governor Training – IG and Social Media Training | Meeting Room 1, Albany House |
| **07/12/16** | 1pm onwards | Trust Board Meeting | Conference Room A&B, Research and Development Centre |
| **21/12/16** | 10am – 12.30pm | Governance Committee | Meeting Room 2, Albany House |
| **11/01/17** | 1pm onwards | Trust Board Meeting | Conference Room A&B, Research and Development Centre |
| **19/01/17** | 11am – 12.30pm | Governors to NEDS | TBC |
| **19/01/17** | 1pm onwards | Council of Governors meeting | TBC |
| **01/02/17** | 1pm onwards | Trust Board Meeting | Conference Room A&B, Research and Development Centre |
| **01/03/17** | 1pm onwards | Trust Board Meeting | Conference Room A&B, Research and Development Centre |
| **07/03/17** | 11am – 12.30pm | Governors to NEDS | Conference Room A&B, Research and Development Centre |
| **07/03/17** | 1pm onwards | Council of Governors meeting | Conference Room A&B, Research and Development Centre |

**Governor Development Training Programme 2016/2017** **Enc J**

| Date | Time | Training | Presenter | Venue |
|---|---|---|---|---|
| | | | | |
| Friday 22 April 2016 | 1pm - 5pm | Trust Strategy and Governance Improvement Action Plan | Mark Powell and Jenna Davies | Meeting room one, Albany House, Kingsway Site, Derby, DE22 3LZ |
| Monday 9 May 2016 | 9am - 1pm | Trust Strategy and CQC Preparations | Carolyn Green | Meeting room one, Albany House, Kingsway Site, Derby, DE22 3LZ |
| Tuesday 31 May 2016 | 9am - 4pm | Governor Induction | Sam Harrison | Conference Room A&B, Research & Development Centre |
| Monday 4 July 2016 | 10am - 1pm | Nominations & Remuneration Committee members - The Governor role in recruiting NEDS | Sam Harrison/Emma Pickup, Gatenby Sanderson Recruitment | Meeting Room two, Albany House, Kingsway Site, Derby |
| Tuesday 5 July 2016 | 2pm - 5pm | NHS Audit | Mark Stocks (Grant Thornton) and Caroline Maley | Meeting room one, Albany House, Kingsway Site, Derby, DE22 3LZ |
| Wednesday 20 July 2016 | 9am - 12 noon | TBC | | Meeting room one, Albany House, Kingsway Site, Derby, DE22 3LZ |
| Friday 19 August 2016 | 1pm - 4pm | NHS Finance | Claire Wright/Rachel Leyland | Meeting room one, Albany House, Kingsway Site, Derby, DE22 3LZ |
| Tuesday 13 September 2016 | 1pm - 4pm | Public Accountability and Engaging with Members | Richard Gregory | Meeting room one, Albany House, Kingsway Site, Derby, DE22 3LZ |
| Tuesday 4 October 2016 | 1pm - 4pm | Quality Priorities and CQC update | Carolyn Green | Meeting room one, Albany House, Kingsway Site, Derby, DE22 3LZ |
| Tuesday 15 November 2016 | 1pm - 4pm | Meeting Skills and working in line with the code of conduct | Sam Harrison / Sue Walters | Meeting room one, Albany House, Kingsway Site, Derby, DE22 3LZ |
| Monday 5 December 2016 | 1pm - 4pm | IG / Social Media | Richard Eaton / Andrew Preston | Meeting room one, Albany House, Kingsway Site, Derby, DE22 3LZ |
| January | TBC | Commissioners | TBC | TBC |
| February | TBC | Mental Health Act | TBC | TBC |
| March | TBC | Research and Development | TBC | TBC |

| 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 |
| 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 |
| DWP | Department for Work and Pensions |
| **E** | |
| ECT | Enhanced Care Team |
| ECW | Enhanced Care Ward |

| GLOSSARY OF NHS TERMS | |
|---|---|
| **NHS Terms of Abbreviations** | **Terms in Full** |
| 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** | |
| FOI | Freedom of Information |
| 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 |
| IG | Information Governance |
| IM&T | Information Management and Technology |
| IPR | Individual Performance Review |
| IPT | Interpersonal Psychotherapy |
| **J** | |
| JNC | Joint Negotiating 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 |
| **M** | |
| MARS | Mutually Agreed Resignation Scheme |
| MAU | Medical Assessment Unit |
| MDA | Medical Device Alert |
| MDT | Multi-Disciplinary Team |

| GLOSSARY OF NHS TERMS | |
|---|---|
| **NHS Terms of Abbreviations** | **Terms in Full** |
| 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 |
| 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** | |
| QC | Quality Committee |
| QLT | Quality Leadership Team |
| QOF | Quality and Outcomes Framework |
| **R** | |
| RAID | Rapid Assessment, Interface and Discharge |
| RCGP | Royal College of General Practitioners |
| RoCR | Review of Central Returns |
| **S** | |
| SBS | Shared Business Services |
| SEN | Special Educational Needs |
| SLA | Service Level Agreement |
| SLR | Service Line Reporting |
| SPOR | Single Point of Referral |
| S(U)I | Serious (Untoward) Incident |
| **T** | |
| TARN | Trauma Audit and Research Network |
| TDA | Trust Development Authority |
| TUPE | Transfer of Undertakings (Protection of Employment) Regulations 1981 |

| GLOSSARY OF NHS TERMS | |
|---|---|
| **NHS Terms of Abbreviations** | **Terms in Full** |
| TMAC | Trust Medical Advisory committee |
| **W** | |
| WTE | Whole Time Equivalent |