Derbyshire Healthcare NHS
NHS Foundation Trust

Meeting of the Board of Directors

11 January 2017

Trust Headquarters, Ashbourne Centre, Kingsway Site, Derby, DE22 3LZ
Tel: (01332) 623700
Acting Chief Executive: Ifti Majid Acting Trust Chair: Caroline Maley

Better together

Derbyshire Healthcare NHS
NHS Foundation Trust

NOTICE OF BOARD MEETING - WEDNESDAY 11 JANUARY 2017
TO COMMENCE AT 1.00 PM IN CONFERENCE ROOMS A&B, FIRST FLOOR,
RESEARCH & DEVELOPMENT CENTRE, KINGSWAY, DERBY DE22 3LZ

	TIME	AGENDA	ENC	LED BY
1.	1:00	Chair's welcome, opening remarks and apologies for absence	**-**	Caroline Maley
2.	1:05	Service Receiver Story	**-**	Caroline Maley
3.	1:30	Declarations of Interest	**A**	Caroline Maley
4.	1:30	Minutes of Board of Directors meeting held on 7 December 2016	**B**	Caroline Maley
5.	1:35	Matters arising – Actions Matrix	**C**	Caroline Maley
6.	1:40	Chair's Update	**-**	Caroline Maley
7.	1:50	Acting Chief Executive's Update	**D**	Ifti Majid
OPERATIONAL PERFORMANCE, QUALITY AND STRATEGY				
8.	2:05	Integrated Performance and Activity Report	**E**	Mark Powell Claire Wright Amanda Rawlings Carolyn Green
9.	2:20	Position Statement on Quality	**F**	Carolyn Green
10.	2:35	Board Committee Assurance Summaries and Escalations: Audit & Risk Committee 13 December, Assurance Summary Quality Committee 15 December 2016 Ratified Minutes: Quality Committee 10 November, Audit & Risk Committee 11 October 2016	**G**	Committee Chairs
GOVERNANCE				
11.	2:45	Governance Improvement Action Plan	**H**	Sam Harrison
3:00 B R E A K				
12.	3:15	Deep Dive Presentation – Kedleston Unit – *will be circulated at the meeting*	**I**	Mark Powell
13.	3:35	Report from Council of Governors meeting held 14 December 2016	**J**	Sam Harrison
CLOSING MATTERS				
14.	3:45	Any Other Business	**-**	Caroline Maley
15.	3:55	2016/17 Board Forward Plan	**K**	Caroline Maley
16.	4:00	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Meeting effectiveness	**-**	Caroline Maley

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

The Trust Chair may, under the Foundation Trust's Constitution, request members of the public to withdraw for the Board to conduct its remaining business in confidence as special reasons apply or because of information which is likely to reveal the identities of an individual or commercial bodies.

The next meeting will be held at 1.00 pm on 1 February 2017
in Conference Rooms A & B, Centre for Research and Development, Kingsway, Derby DE22 3LZ
Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.
Participation in meetings is at the Chairman's discretion.

Declaration of Interests Register 2016-17

NAME	INTEREST DISCLOSED	TYPE
Margaret Gildea Non-Executive Director	Director, Organisation Change Solutions Limited Non-Executive Director, Derwent Living	(a, b)
Ifti Majid **Acting Chief Executive**	Board Member, North East Midlands Leadership Academy Board	(a)
Caroline Maley Acting Trust Chair	Director – C D Maley Ltd Trustee – Vocaleyes Ltd.	(a) (a, d)
Barry Mellor Non-Executive Director	Non-Executive Director, Rotherham NHS Foundation Trust Trustee, Rotherham Hospital Charity Mrs Mellor is a befriender with Age UK	(a, d)
Amanda Rawlings Director of People and Organisational Effectiveness (DHcFT)	Director of People and Organisational Effectiveness, Derbyshire Community Healthcare Services (DCHS) Co-optee Cross Keys Homes, Peterborough	(a, d)
Dr John Sykes Medical Director	Independent Deprivation of Liberty mental Health Assessor undertaking assessments on BGHS patients at the request of Derbyshire County Council via my medical secretary	(b)
Dr Julia Tabreham Deputy Trust Chair and Non-Executive Director	Non-Executive Director, Parliamentary and Health Service Ombudsman Director of Research and Ambassador Carers Federation Board member, RESTORE (supporting older offenders in the criminal justice system) Lay Member - National Institute for Health and Care Excellence, Guideline Development Group, National Collaborating Centre for mental Health of Adults in the Criminal Justice System Julia Tabreham is also assisting NICE (National Institute for Health and Care Excellence) to write training programmes for people providing lay advice to its Guideline Development Groups	(a, d)
Lynn Wilmott-Shepherd Acting Director of Strategic Development	Director of Commissioning at Erewash CCG	(a)
Richard Wright Non-Executive Director	Director, Sheffield Chamber of Commerce Chair, The Sheffield College Chair Sheffield University Technical College Member of Advisory Board of Sheffield National Centre for Sport and Exercise Medicine	(a)

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

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

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Wednesday 7 December 2016

MEETING HELD IN PUBLIC

Commenced: 1pm Closed: 4:20pm

PRESENT:	Richard Gregory	Interim Trust Chair
	Julia Tabreham	Deputy Trust Chair and Non-Executive Director
	Caroline Maley	Senior Independent Director
	Maura Teager	Non-Executive Director
	Margaret Gildea	Non-Executive Director
	Richard Wright	Non-Executive Director
	Ifti Majid	Acting Chief Executive
	Claire Wright	Executive Director of Finance
	Carolyn Green	Executive Director of Nursing & Patient Experience
	John Sykes	Executive Medical Director
	Mark Powell	Acting Chief Operating Officer
	Amanda Rawlings	Director of People & Organisational Effectiveness
	Samantha Harrison	Director of Corporate Affairs & Trust Secretary
	Lynn Wilmott-Shepherd	Interim Director of Strategic Development
IN ATTENDANCE:	Anna Shaw	Deputy Director of Communications & Involvement
	Donna Cameron	Corporate Services Officer and Minute Taker
	Anne Wright	Incoming Non-Executive Director
	Melanie Curd	Deputy Trust Secretary, DCHS
	Zoe Kwan	Registrar, Observer
For Item DHCFT/2016/202	Lucia Whitney	Consultant Psychiatrist
For Item DHCFT/2016/202	Joanna Miatt	Consultant Clinical Psychologist
For Item DHCFT/2016/202	Helen Crowson	Service Manager, Lead CBT Therapist
APOLOGIES:	Barry Mellor	Non-Executive Director
VISITORS:	John Morrissey	Lead Governor, Public Governor, Amber Valley South
	Mark McKeown	Derbyshire Mental Health Alliance
	Gillian Hough	Public Governor, Derby City East
	Shelley Comery	Public Governor, Erewash North
	Carole Riley	Public Governor, Derby City East
	Bernard Thorpe	Lead Governor, DCHS

DHCFT 2016/187	**INTERIM CHAIRMAN'S WELCOME, OPENING REMARKS AND APOLOGIES** Interim Chair, Richard Gregory, opened the meeting and welcomed everyone. Apologies were noted as above.
DHCFT 2016/188	**SERVICE RECEIVER STORY** Carolyn Green offered apologies to the Board for the absence of a patient story, due to ill health. However, a 'deep dive' on eating disorders will be presented later in the meeting and asked the Board if it could take into account the needs of service users with anorexia nervosa when receiving the item.

DHCFT 2016/189	**DECLARATIONS OF INTEREST** The Declaration of Interests register was noted. An additional declaration was registered for Dr Julia Tabreham who been asked by the Department of Health to lead on the Parliamentary and Health Service Ombudsman's contribution to establishing NHS complaints support in Ireland. Ifti Majid advised he had been invited to sit on the North East Midlands Leadership Academy Board. Lynn Wilmott-Shepherd advised that her substantive post is as Director of Commissioning at Erewash CCG. Maura Teager's position as Non-Executive Director of Ripplez had concluded at the end of September 2016 and so can be removed from the register. **ACTION: The declaration of interests register to be updated.**
DHCFT 2016/190	**MINUTES OF THE MEETING DATED 2 NOVEMBER 2016** The minutes of the previous meeting, held on 2 November 2016, were reviewed. The following amendments were requested: **2016/189 Service User Story – Page 3 in the minutes** Caroline Maley recalled that it had been agreed that the Trust would review its position regarding spent convictions to allow people to work in the Trust. Jo Downing had been asked to work with HR to review this. It was agreed that this should be reflected in the minutes and added to the actions matrix. **2016/174 Acting Chief Executive's Report – final line above the resolution** Caroline Maley requested that this line be expanded to explain the reason for Ifti Majid's departure from the Public Board Meeting. He had left to attend a meeting with NHS Improvement. It was agreed that the minutes should be amended to reflect this. **2016/175 Integrated Performance & Activity Report – Page 5, Para 6** Caroline Maley requested the minutes to be amended to clarify that the transaction costs, anticipated to be £650k would be shared proportionately with the Trust assuming 40% of the costs, and DCHS assuming 60%. **Page 6, Para 7 to be amended as below:** Claire Wright reminded the Board that NHSI's additional reporting requirements for agency expenditure will be discussed further at the Board Development session on 16 November. At that same session, the Board will also be discussing the new NHSI control total as part of the operational plan update. Progress with delivery of current and future year financial plans including agency expenditure will also be discussed in the Finance and Performance Committee at the end of November. **2016/181 Governance Improvement Action Plan** To be amended as follows 6. Core 3 (Clinical Governance): This action remains rated as still having issues to resolve and will be brought back to the Quality Committee *(not Remuneration & Appointments Committee).*
DHCFT 2016/191	**MATTERS ARISING AND ACTIONS MATRIX**

	Matters Arising **2016/182 Board Assurance Framework** Claire Wright updated the Board on discussions held at Finance & Performance Committee on 28 November. It had been agreed that the risk associated with the back office collaboration and business continuity should not be a separate risk, but that it should be incorporated into the existing Change risk, 4b, - Failure to deliver the agreed transformational change, at the required pace could result in reduced outcomes for service users, failure to deliver financial requirements and negative reputational risk. **Actions Matrix** The Board agreed to close all completed actions. Updates were provided by members of the Board and were noted directly on the actions matrix.
DHCFT 2016/192	**INTERIM CHAIRMAN'S VERBAL REPORT** Richard Gregory, Interim Chair, was pleased to report to the Public Board that, following a meeting of the Trust's Remuneration & Appointments Committee earlier in the day, Ifti Majid has been confirmed in post as Acting Chief Operating Officer for a period until the formal decision is made on whether to go ahead with the acquisition arrangements with DCHS and this decision is transacted. If the acquisition does not progress the Trust would return to an open, substantive recruitment process. Ifti Majid has formally withdrawn from the secondment to the Sustainability & Transformation Plan (STP) Managing Director post. The Board thanked Ifti Majid for his commitment to the Trust. In the same meeting, acting arrangements were confirmed for the Chief Operating Officer role (Mark Powell) and the Director of Strategy role (Lynn Wilmott-Shepherd). The Remuneration & Appointments Committee also approved the Voluntary Redundancy Programme and the Executive Director remuneration scheme. A full report had been given at the Confidential Trust Board meeting earlier in the day. The Governors' Nominations & Remuneration Committee on 13 December will meet with two internal candidates for the Acting Trust Chair post. A recommendation will be brought to an Extraordinary Council of Governors Meeting on 14 December. The Chairman paid tribute to Jim Dixon, who had stepped down from the Trust Board on 17 November. Richard Gregory will write to thank Jim Dixon for his significant contribution to the Trust. An exit interview will be scheduled. The Confidential Trust Board had received updates on contracts and the operational plan. A meeting is scheduled with NHS Improvement (NHSI) on Monday 12 December, which is the routine Performance Review Meeting. . **ACTION: Chairman to write a letter of thanks to Jim Dixon.** **ACTION: Exit interview with Jim Dixon to be scheduled.** **RESOLVED: The Board of Directors noted the Interim Chairman's verbal report.**
DHCFT 2016/193	**ACTING CHIEF EXECUTIVE'S REPORT** Ifti Majid, Acting Chief Executive, shared information on the latest correspondence from the Chief Executive of NHSI. There are on-going concerns regarding the use of interims in the NHS. Development of internal staff, particularly around leadership positions, is a requirement, and this is the journey the Trust has been on over the last year. This week has been 'contract mediation week' in the NHS. Trusts were required to notify NHS England (NHSE) or NHSI if they were in or needed to be in mediation. Mediation is if a Trust is not in a position to sign off on contracts. The majority of Trusts have

	signalled they are not ready to do that, including this Trust. However, final sign off is by 23 December and the Trust expects to be ready by this time. STP work is paused for an eight week period, as requested by NHSE and NHSI, in order for Trusts to deal with contracting. The contracting will reflect STP moves away from CCG/Provider to understanding system risks and dealing with contracts as an investment plan to deliver the STP over the length of the contract. Ifti Majid assured the Board that the Trust is looking for achievable targets to promote and provide mental health services. Ifti Majid reported that he had attended several meetings with the Chief Executive at Derbyshire Community Health Services (DCHS) to reaffirm this Trust's commitment to the on-going collaboration and journey towards acquisition. A Terms of Reference for the joint programme board to lead the collaboration journey has been agreed. A Board to Board meeting will be arranged for the New Year to enable those conversations. Ifti Majid also reported that he had attended a meeting with DCHS senior leaders where the impact on both organisations was discussed. More events will be planned as the journey continues. The Communications & Involvement Team were congratulated for delivering a fantastic Staff Award Ceremony recently. Team Awards are scheduled for later in the month. Caroline Maley enquired if NHSI had responded to the Strategic Options Case (SOC). Ifti Majid advised the SOC had been acknowledged and the Trust had been advised to proceed with the next phase. Both sets of governors can expect to be updated regularly throughout. Julia Tabreham expressed her support for the SOC but was anxious regarding closure of services and increased risk to patients; she asked that the Acting Chief Executive share his impressions of the biggest risk to provision locally. Ifti Majid considered that risks exist in a number of areas in trying to shift the locus of care from being too reliant on acute providers delivering services. Mark Powell added that much work is required to manage public expectation around where it is perceived to be the best place to receive services and help people understand the benefits of the new proposals. **RESOLVED: The Board of Directors noted the verbal report from the Acting Chief Executive Officer.**
DHCFT 2016/194	**<u>INTEGRATED PERFORMANCE AND ACTIVITY REPORT</u>** Mark Powell, Acting Chief Operating Officer, led the presentation of the integrated overview of performance as at the end of October 2016. The focus of the report was on workforce, finance, operational delivery and quality performance, all of which had been discussed in detail at various Board committees over the last few weeks as evidenced in the board assurance summaries. **Quality Performance** Actions taken to address the CQC warning notice had delivered assurance to the Quality Committee. The target group for Fire Warden Training was noted to have expanded but a sustained improvement was observed. Improved performance was highlighted against the Positive & Safe Strategy. Maura Teager sought assurance that changes in levels of reporting were not as a result of under-reporting. Carolyn Green, Executive Director of Nursing & Patient Experience, confirmed that regular checks are carried out and the Trust benchmarks well as a 'good reporter'. Mark Powell added that information used in reporting is triangulated and queried to provide additional assurance of accuracy. Julia Tabreham queried the Trust's confidence in achieving the quality trajectory for prone restraint. Carolyn Green responded that the Trust had agreed to retain this target, whereas many others had not. A nationally validated training programme is being utilised to assist with this.

	Caroline Maley observed the increase in concerns raised. Carolyn Green reflected on the strategy to reduce complex complaints which can result in an increase in concerns as they are addressed through an informal complaints process, as demonstrated in the Trust. No new themes have been observed. **Operational Delivery** This remains relatively stable with all NHSI indicators being achieved. Robust plans are in place in areas which are challenged and assurance is required. **Finance** Key risks were noted, including the on-going non-delivery of the full Cost Improvement Programme (CIP). However the Board noted the on-going actions in respect of this. Claire Wright highlighted the change to the Single Oversight Framework ratings with regard to changes in expected agency expenditure in Q4 and the impact of a resulting metric of 4 for agency costs, triggering an overrule that resulted in a maximum Use of Resources metric of 3 for the year end. In the Finance & Performance Committee on 28 November the Committee had been advised to expect that at year end. Headway is being made with the CIP and cost avoidance programme. Claire Wright shared with the Board that at STP level there had been discussion around treating the Derbyshire system cash reserves as a whole for utilisation by another provider; the Trust had made it clear this was not a position supported by its Board. Julia Tabreham sought further information on pressures related to drug spend. Mark Powell agreed to arrange a meeting to discuss. Carolyn Green agreed to share a previously presented paper on medicines management. **People Performance/Workforce** The People & Culture Committee had received a number of plans on recruitment and health and wellbeing. Actions continue to be reviewed by the Committee. Amanda Rawlings advised that the new TRAC Recruitment System is due to come on line imminently and this will improve the time taken to recruit. **ACTION: Mark Powell to meet with Julia Tabreham to discuss pressures on drug spend.** **ACTION: Carolyn Green to forward a paper on Medicines Management to Julia Tabreham.** **RESOLVED: The Board of Directors noted the content of the report and Noted the assurance being received by the Board via the assurance summaries,**
DHCFT 2016/195	**<u>POSITION STATEMENT ON QUALITY</u>** Carolyn Green presented the statement to provide the Board of Directors with an update on the organisation's continuing work to improve the quality of services provided in line with the Trust's Strategy, Quality Strategy and Framework and strategic objectives. The Appleby Homicide and Suicide study, expected in January 2017, will provide benchmark data for comparison with national trends. The Trust continues to work on security aspects and has submitted its latest self-assessment to NHS Protect. Feedback has been received on the Security Action Plan and a briefing will be provided. The December Quality Committee will be receiving feedback on complaints from Healthwatch Derby The CQC Community Mental Health Survey results have been published. The Trust is benchmarked against outstanding NHS Trusts, with a solid performance rated as good. Quality visits have been excellent but the Board should expect to note disappointment

	expressed by staff regarding outcomes which may have been impacted by their supervision and appraisal rates. Carolyn Green assured the Board that these are being reviewed and addressed. Visit participation is being reviewed and a suggestion considered that newer Non-Executive Directors (NEDs) are accompanied by more experienced NEDs initially and that clinical presence forms part of each visit. **RESOLVED: The Board of Directors** **1. Received and noted the Quality Position Statement.** **2. Gained assurance and information on the content of the statement.**
DHCFT 2016/196	**<u>BOARD ASSURANCE SUMMARIES & ESCALATIONS</u>** Assurance summaries were received from Safeguarding Committee held on 4 November 2016, Quality Committee held on 10 November 2016, People & Culture Committee held on 17 November 2016 and Mental Health Act Committee held on 18 November 2016. The following points were noted: **Quality Committee** No escalations from Quality Committee. However, Julia Tabreham advised that, as discussed at Committee Chairs, the NEDs feel there is repetition in the reporting mechanisms used. Sam Harrison emphasised the importance of an audit trail and that assurance summaries were a recommendation from the Deloitte's review to enable clear identification and escalation of issues. The Board agreed that the summaries will continue. **People & Culture Committee** Margaret Gildea reported on the focus on recruitment, processes and the staff survey. There seems very clear leadership in the HR function and a very clear agenda. **Mental Health Act Committee** Maura Teager highlighted the escalation identified regarding evidencing consents and compliance reports from PARIS, which the Acting Chief Operating Officer is looking into. The additional resource in the Mental Health Team is having a positive impact but PARIS is impacting on delivery. It was noted Mark Powell is to review the PARIS business case for delivery against original objectives and to set out a plan for the next 18 months to address the needs of the Trust. Ratified minutes of the meetings of Quality Committee held on 13 October 2016, People & Culture Committee held on 19 October 2016, Safeguarding Committee held on 7 October 2016 and Mental Health Act Committee held on 26 August 2016 were included for information. **RESOLVED: The Board of Directors received the Board Committee Assurance Summaries and Escalations.**
DHCFT 2016/197	**<u>SAFEGUARDING ADULTS ANNUAL REPORT</u>** Carolyn Green presented the Safeguarding Adults Annual Report 2015/16 and Programme of Work. The report provides an update of progress towards safeguarding adults, including a description of systems and processes to protect adults and the result of the Trust's plans to strengthen work in this area. The Safeguarding Committee has received this report which provides the Board with good assurance that the Trust has improved substantially over the last three years. Maura Teager, Chair of the Safeguarding Committee echoed this and likewise assured the Board of the growth in confidence on the adult safeguarding agenda and an increase in assurance. Julia Tabreham mentioned the consistent lack of attendance of key partners, which has been taken forward. The emergence of adult modern slavery will

	continue to be a focus going forward. Carolyn Green assured the Board that the Trust is meeting its requirements locally and a national assurance checks that the trust is active in this work, can confirm its attendance and commitment to PREVENT and assures all those aspects are in place. **RESOLVED: The Board of Directors accepted and received the annual report and agreed the recommendations as outlined in the section work plans.**
DHCFT 2016/198	**LOOKED AFTER CHILDREN ANNUAL REPORT** Carolyn Green presented the Looked After Children Annual Report, summarising the year 2015/16 to provide assurance to the Trust Board that the Trust is fully discharging its statutory duties in this area of practice. The report demonstrates another good year for the service with good performance. Richard Gregory sought an update on the resource gap identified. Carolyn Green advised that there had been no further update on the commissioning gap but noted that it is identified on the Trust's risk register. Maura Teager shared her concerns regarding the impact on skills in the current team due to leavers and retirements, as identified on the Board Assurance Framework, Carolyn Green assured the Board that mitigation plans are in place to maintain team performance while it is developed. Maura Teager acknowledged the contribution of Lesley Smales, Designed Nurse, Looked After Children, who has recently resigned. **RESOLVED: The Board of Directors received and agreed the annual report and recommendations as outlined in it.**
DHCFT 2016/199	**ENGAGEMENT & CULTURE PLAN** Amanda Rawlings presented the Board with an approach to deliver change in culture and improvement in staff engagement. The approach has been developed through consultation with staff, by accessing resource and support from NHSI and talking to colleagues in Dudley & Walsall Mental Health Partnership NHS Trust about their experiences in driving up engagement. The key themes identified and used to form a platform for approach are: • Leadership, values and behaviours • Trust and credibility • Systems and processes There will also be an on-going programme with DCHS around engagement. The People & Culture Committee will oversee performance and manage the implementation of the plan. The Board discussed the importance of leaders in engagement. Amanda Rawlings emphasised the need to recruit and develop a diverse pool of leaders and the requirement to equip them for their roles with access to mechanisms to support them in their leadership development journey. The Board was unanimously supportive of the plan. **RESOLVED: The Board of Directors** **1. Agreed the approach and direction recommended in the report.** **2. Noted the investment required to take the approach forward and expects a paper to outline the required investment at a later date.**

DHCFT 2016/200	**REPORT FROM COUNCIL OF GOVERNORS MEETING HELD ON 24 NOVEMBER 2016** Sam Harrison presented the regular summary from recent meetings, which had covered discussions on the Strategic Options Case and the Deputy Trust Chair Post. The November meeting had included an update on the SOC and had updated the governors on the performance report. **RESOLVED: The Board of Directors noted the report and the regular updates to governors.**
DHCFT 2016/201	**GOVERNANCE IMPROVEMENT ACTION PLAN** Sam Harrison presented the GIAP report to provide Board members with an update on progress on the delivery of the GIAP. In summarising, the number of actions 'on track' was noted to be 34. Six actions were 'off track' in November; this has been reduced to two in December. Core 1 and Core 4 have been reviewed and will be presented to the relevant Board Committee for sign off of recommendation as complete in December and subject to agreement, be presented to the Trust Board in January. Core 5 recommendations were agreed as being completed at the CoG on 24 November and the blue completion forms are presented to the Board today for formal sign off of CoG1, 2 and 3. Each Board Committee has reviewed its GIAP actions and recommendations against the context of the original Deloitte governance review. The Trust will be highlighting this review in the Performance Review Meeting with NHSI in December to provide assurance on progress and robustness of process. Ifti Majid thanked Sam Harrison for the momentum in addressing the actions and recommendations. **RESOLVED: The Board of Directors** **1. Noted the progress made against GIAP recommendations.** **2. Noted the areas rated 'off track' and with 'some issues'.** **3. Formally approved the blue completion forms as presented and confirmed CoG 1, 3 and 3 as now complete.** .
DHCFT 2016/202	**DEEP DIVE – EATING DISORDERS SERVICE** Lucia Whitney, Consultant Psychiatrist, Joanna Miatt, Consultant Clinical Psychologist and Helen Crowson, Service Manager, Lead CBT Therapist from the Eating Disorders Service, joined the meeting to present a 'Deep Dive' into the service. The service provides care for adults in Derby City and County with anorexia nervosa with a BMI of 16.9 and under. The team works from Belper but travels across the city and county offering a range of interventions. Beds are commissioned and paid for by NHS England. The local, preferred provider is Leicester's Eating Disorder Unit, which has 13-15 beds to serve five surrounding counties. Private sector beds may be utilised if NHS beds are unavailable. Entry level criteria to the service is based on significant weight loss and BMI which can prevent the team from dealing with early onset and intervention; the likelihood of successful recovery is higher when treated earlier. The Trust has a lower death rate than the national average but the Board was asked to note that the client group is high risk and has the highest mortality of any psychiatric disorder. Partnership working takes place across primary and acute care. Relationships are strong with voluntary sector organisations, such as First Steps, which supports carers and families. Despite this, little information is available to the public on help for eating

	disorders and unfortunately the help that can be provided is restricted. The key challenge for the team is its capacity to provide a comprehensive service for Derby and Derbyshire and the challenge of not being able to treat clients with a BMI above 16.9; however if they did, referrals would significantly increase and the service would not be able to manage this volume operationally.. Carolyn Green advised that the team will be putting together modelling for investment, including a potential pilot for next year's contracting round. The need for earlier intervention is a research and evidence-based recommendation which the team believe would lead to improved recovery rates. The model will go to the Quality Assurance Group and then to Commissioners. Margaret Gildea offered to assist in the delivery of the model to the Commissioners, to share her personal experience of services for eating disorders in the county. The Board unanimously supported this work and agreed that in order to extend the issues with BMI criteria this would be addressed through the Quality Assurance Group where all the CCGs are present. In addition to this Ifti Majid committed to include information on the service in a scheduled presentation to the Health & Wellbeing Board in January. The Chair thanked the Team for their powerful presentation and valuable involvement. **ACTION:** **1. BMI criteria to be addressed through the Quality Assurance Group** **2. Ifti Majid to include information on the Eating Disorders Service in a scheduled presentation to the Health & Wellbeing Board in January** **RESOLVED: The Board of Directors received and noted the deep dive into the Eating Disorders Service**
DHCFT 2016/203	**2016/17 BOARD FORWARD PLAN** The forward plan was noted. **RESOLVED: The Board of Directors noted the forward plan for 2016/17.**
DHCFT 2016/204	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK OR GIAP** Richard Gregory reported that Remuneration and Appointments Committee had discussed the Board Assurance Framework (BAF) Risk 3C – There is a risk that turnover of the Board members could adversely affect delivery of the organisational strategy due to loss of specialist organisational knowledge, capacity and stability. It is proposed, on behalf of Committee, that this risk has been mitigated with the recent appointments and therefore the risk should be removed from the BAF. **RESOLVED: The Board of Directors agreed to remove Risk 3C from the BAF.**
DHCFT 2016/205	**MEETING EFFECTIVENESS** The Board agreed the meeting had been effective. There had been much detailed progress reporting and discussion. The Integrated Performance Report was noted to be working well.
DHCFT 2016/206	**ANY OTHER BUSINESS** On behalf of the Board, Caroline Maley thanked Richard Gregory for his enormous

	contribution and effort. During his time as Interim Chairman he had navigated the Trust through challenging times, never losing his passion for the Trust and the services it provides for its users. The Board thanked Richard Gregory for leaving the Trust in a much stronger position and for establishing strong relationships with the Board and Governors, a sentiment echoed by John Morrissey, Lead Governor. Richard thanked the Board for its support. He had enjoyed his time working in a great Trust and wished all a successful future. It had been a difficult year to be Chair but he had been humbled by those he had worked with and hoped for a steady progression to improvement.

The next meeting of the Board held in Public Session will take place at 1pm on Wednesday, 11January 2017.

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

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - JANUARY 2017			Enc C
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
25.5.2016	**DHCFT 2016/080**	Deep Dive - Neighbourhoods	Claire Wright	Building requirements of Neighbourhood teams in STP developments and as part of the Estates strategy to be considered by Claire Wright.	2.11.2016	The next 6 monthly progress update of the Estates Strategy will be received by the Finance and Performance Committee on 23 January and will cover neighbourhood estate requirements and will also include a section summarising progress with the Derbyshire STP estates workstream.	Green
7.9.2016	**DHCFT 2016/143**	Security and Safety (under AOB)	Sam Harrison	Sam Harrison is to liaise with the chairman and Non-Executive Directors to assign a lead director to the security and safety NED lead role	5.10.2016	Richard Wright has agreed to assume the Safety NED Role. A meeting has been arranged with Carolyn Green and Richard Wright to discuss the role.	Green
02.11.16 AND 07.12.16	**DHCFT 2016/169**	Service Receiver Story	Amanda Rawlings	The Trust will review its position regarding recruitment of people with spent convictions to allow people to work in the Trust safely.	11.01 2017	HR Team will incorporate the recruitment of people with spent convictions as part of their recruitment review.	Green
07.12.16	**DHCFT 2016/189**	Declaration of Interests	Sam Harrison	Julia Tabreham, Lynn Wilmott-Shepherd and Maura Teager declarations to be updated .	11.01.17	Declarations of Interest has been updated	Green
07.12.06	**DHCFT 2016/192**	Interim Chairman's Report	Richard Gregory	Chairman to write thanks to Jim Dixon following his departuer from the Trust. Exit interview with Jim Dixon to be scheduled.	31.12.2016	Exit interview has been undertaken and outcome will be discusssed at Governors Nominations and Remuneration Committee on 10 January 2017	Green
07.12.16	**DHCFT 2016/194**	Integrated Performance And Activity Report	Mark Powell/ Carolyn Green	Information regarding drug spend and medicines management to be shared with Julia Tabreham	11.01.2016	Information provided to Julia Tabreham by Mark Powell.	Green
07.12.16	**DHCFT 2016/202**	Deep Dive – Eating Disorders Service	Carolyn Green	BMI criteria to be addressed through the Quality Assurance Group	11.01.2016	This risk has been flagged to the Quality Assurance Group and will be explored further at the QAG meeting at the end of January.	Green
07.12.16	**DHCFT 2016/202**	Deep Dive – Eating Disorders Service	Ifti Majid	Ifti Majid to include information on the Eating Disorders Service in a scheduled presentation to the Health & Wellbeing Board in January.	11.01.2016	This will form part of a presentation being given to the Health and Wellbeing Board in January	Green

Resolved	**GREEN**	8	100%
Action Overdue	**RED**		
Agenda item for future meeting	**YELLOW**		

Derbyshire Healthcare NHS Foundation Trust
Report to Public Board of Directors 11 January 2017

Acting Chief Executive's Report to the Public Board of Directors

Purpose of Report:

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

National Context

1. NHS Improvement have reminded organisations of their duty to comply with the ongoing commitment that patients admitted as an emergency will receive services that meet the 4 priority clinical standards detailed below, 7 days a week:

    - Standard 2: Time to Consultant Review
    - Standard 5: Access to Diagnostics
    - Standard 6: Access to Consultant-directed Interventions
    - Standard 8: On-going Review

    At present it does not seem that these standards are to be monitored in mental health and/or community based organisations, however as the NHS Mandate states the total population of England will have access to 7 day services by 2020 it is essential that we begin to give some consideration to these issues within our Trust and services.

2. Half way through the financial year it is useful to review the performance of the NHS, enabling us to then think about the information contained in our integrated performance report in the context of NHS performance as a whole. The following are points of note:

    - 89 per cent attainment of 4 hours A&E performance target. Attendances over the last year have increased by 4.5%.

    - 200,000 DTOC (Delayed Transfers of Care) cases in October 2016, up from 160,100 at the same time last year. The 200,000 delayed days represents the highest figure since monthly data was first collected in August 2010. Our position in October was a DTOC of 2.39% significantly below our target of 7.5%.

    - 67.3% of category A calls received an 8 minute ambulance response rate, 90.4% received a response within 19 minutes. There were 839,724 emergency calls handled in October 2016, up 4.8% on the previous year.

    - 90.4 % of RTT (Referral to Treatment) patients were waiting up to 18 weeks to start treatment in October 2016. 3.8m patients were waiting to start elective

treatment at the end of the month, of which 1,427 were waiting more than 52 weeks. By comparison in October we had nobody with an RTT greater than 52 weeks and our in month performance was 92.31% within 18 weeks and 99.44% for IAPT services.

- 39 CCGs have plans that show a cumulative deficit by the end of 2016/17, and 93 CCGs reporting year to date overspends

3. In December 2016 the CQC (Care Quality Commission) published their review of the way NHS trusts review and investigate deaths of patients in England called Learning, Candour and Accountability. A year after the NHS England commissioned review at Southern Health, the CQC have now completed their national review. To support the findings the CQC:
4.

- Carried out a national survey of all NHS trusts and visited 12 acute, community healthcare and mental health trusts

- Engaged with over 100 families, holding interviews and events, as well as seeking views through an online form, online community and social media

- Consulted with charities and NHS professionals

The general themes covered 5 key areas, due to the importance I have included more detail than I routinely do in this report and I would expect the Quality Committee to complete a review against each of the findings for our Trust:

- **Involvement of families and carers**
  Families and carers often have a poor experience of reviews and investigations, and are not always treated with kindness, respect and sensitivity. The CQC found that the extent of their involvement in reviews and investigations varies and they are not always listened to.

- **Identification and reporting**
  The CQC found inconsistency in the way organisations became aware of the deaths of people in their care, with no clear systems for a provider that identifies a death to tell commissioners or other providers involved in the person's care. Other issues include the lack of a consistent way of recording the deaths of patients that have recently been discharged. We also found that electronic systems don't always support the sharing of information between NHS trusts and other services involved in someone's care.

- **Decision to review or investigate**
  Healthcare staff use the Serious Incident Framework to help them decide whether a review or investigation is needed. But this can mean investigations only happen if a serious incident has been reported, and the criteria for deciding to report an incident and the application of the framework both vary. Clinicians are using different methods to record their decisions, definitions used to identify and report deaths are used inconsistently, and sharing information between providers is often difficult.

- **Reviews and investigations**

The quality of investigations is often poor and methods set out in the Serious Incident Framework aren't applied consistently. Specialised training and support aren't given to all staff carrying out investigations. There are problems with the timeliness of investigations and confusion about standards and timelines set out in the guidance. Where a number of agencies are involved, their ability to work together is restricted by a lack of clarity over which agency is responsible for leading the investigation and they often work in isolation.

- **Governance and learning**
  There are no consistent frameworks or guidance requiring boards to keep all deaths under review, and boards only receive limited information about the deaths of people using their services. When they do receive information, they often don't challenge the data effectively. Where investigations take place, there are no consistent systems to make sure recommendations are acted on or learning is shared. There's a lack of robust mechanisms to disseminate learning from investigations or benchmark beyond a single trust.

The CQC detailed eight recommendations that the Quality Committee should monitor our compliance against as a Trust:

1. Learning from deaths needs much greater priority within the NHS to avoid missing opportunities to improve care.
2. Bereaved relatives and carers must receive an honest and caring response from health and social care providers and the NHS should support their right to be meaningfully involved.
3. Healthcare providers should have a consistent approach to identifying and reporting the deaths of people using their services and share this information with other services involved in a patient's care.
4. There needs to be a clear approach to support healthcare professionals' decisions to review and/or investigate a death, informed by timely access to information.
5. Reviews and investigations need to be high quality and focus on system analysis rather than individual errors. Staff should have specialist training and protected time to undertake investigations.
6. Greater clarity is needed to support agencies working together to investigate deaths and to identify improvements needed across services and commissioning.
7. Learning from reviews and investigations needs to be better disseminated across trusts and other health and social care agencies, ensuring that appropriate actions are implemented and reviewed.
8. More work is needed to ensure the deaths of people with a mental health or learning disability diagnosis receive the attention they need.

Local Context

5. On 21 December a group of Board members comprising of the Board Chair, Chair of Audit and Risk Committee, Chair of Finance and Performance Committee, Acting CEO, Director of Finance and Acting Director of Strategic Development met to review the latest contract offer. The Board members present in the meeting were in agreement with signing the contract and believe that any potential benefits of going to contractual arbitration were outweighed by the risk and costs of doing so. We

recognised that whilst a stretching requirement for us as a Trust with a number of significant risks that it is not possible to fully mitigate at this point in time, given the NHS operating environment, this would be seen as a favourable settlement.

Prior to indicating our formal acceptance all Board members were given sight of contract details and had the opportunity to make comments. The deadline for contract signing passed on 23 December 2016 with our Trust having agreed an initial contract position subject to a number of caveats detailed as formal side letters to the contract.

The gap between the total contractual income in the contract and the control total is £6.9m. This will be met by a combination of Trust CIP of £3.85m (at our risk) and commissioner disinvestment, income and cost out, of £3.05m (at commissioner risk). This is challenging but deliverable and CIP (Cost Improvement Programme) plans have already been drafted for the majority of the £3.85m, subject to detailed work up and quality impact assessment.

It should be noted that with respect to the disinvestment £3.05m :

- This will be a reduction in service with equivalent costs out to match the lost income
- The CCGs (Clinical Commissioning Groups) have not currently shared any plans for disinvestment
- Plans to be developed by 31 January 2017 for £2.2m of it and 31 March for £850K; if plans are not in place the money will be paid back into the contract and we will receive the income
- We have agreed to work collaboratively
- Plans will be rigorously quality impact assessed and would require consultation in many cases.

There are a number of areas where further discussion is required ahead of the commencement of the contract, most noticeable of those is the need for investment to support both the requirements of the CQC comprehensive inspection, ie staffed 136 suites and increased availability of psychological therapies and historical underfunding such as the recognised shortfall in community care coordinators. Without further investment it is unclear how the CCGs will meet the requirements detailed by Claire Murdoch (NHS England's National Mental Health Director) around parity of esteem.

6. During January 2017 there will be a stock take of the Derbyshire STP, (Sustainability Transformation Plan) organisations' ongoing commitment to the submitted plan and agreement around how to start to implement the business cases agreed as part of the development process. This is essential for our organisation as our own strategy relies on the implementation of both the Children's and Mental Health business cases to achieve the transformed pathways that deliver better outcomes for people using our services. I will be strongly supporting the ongoing implementation of the STP transformational business cases but will be clear in my belief that we have to break the cycle of investing in acute (physical) bedded care at the expense of developing community services if we are going to support people to receive credible, evidenced

care closer to home.

7. Over the next month there will be a number of key meetings in relation to the outline Business Case for our acquisition/merger with DCHS. We will have a four way CEO/Chairs meeting, a full Board to Board meeting and commence our Joint Programme Board approved at the December Board meeting.

Within our Trust

8. On 15 December it was our Parisian themed Team Awards evening. It was a well-attended event, which saw the Ashbourne Centre transformed into a French café! Congratulations to all those who won awards and were shortlisted, the quality, innovation and commitment showed by all present was outstanding. Congratulations to our CAMHS Service who won the Team of the Year award recognising several years of work in difficult and challenging circumstances.

9. My thanks to Sara Johnson and the staff and patients at Audrey House who were so welcoming when I called in for a visit the week before Christmas. It was great to see how much the staff and patients value the improved environment, even though, as it was pointed out to me, people have further to travel into town. I would also like to recognise the staff team for their innovation in developing a checklist of vital information for staff that are sent to Audrey House for a single shift.

10. On 23 December I was fortunate to visit each ward in our Trust. Whilst great to see how much effort staff had put into making the ward environments as festive as possible it was a great opportunity to hear the issues and daily changes staff were facing. Recruitment was the issue mentioned most often, particularly band 5 nurses, but other issues included an increasing challenge to discharge people in a timely manner due to delays with housing, noticed pressure on community care coordinators due to their workload and vitally the importance of ensuring we engage with staff when there are changes in how we deliver services, recognising that change even if it is seen positively can be stressful.

11. Whilst I was attending the East Midlands Leadership Academy Board I spoke to the Chair of Nottinghamshire Healthcare Foundation Trust and was impressed with the fact they have a staff innovation slot at the end of their Board meetings – they start with a patient story and end with a staff story – I know we do this via the deep dive on occasions but wondered if it was something the Board may like to consider.

Strategic considerations

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

Board Assurances

- Our strategic thinking is beginning to include national issues that are not immediately in the health or care sector but that could be of high impact.

- The Board can take assurance that Trust level of engagement and influence is high in the health and social care community
- Feedback from staff is being reported into the Board

Consultation
None

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

Equality Delivery System
There are no issues raised in this paper that would have a negative impact on any REGARDs groups

Recommendations

The Board of Directors is requested to:

1) Note the contents of the update
2) Consider closing the Public Board sessions with a 'staff story'

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

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 11 January 2017

Integrated Performance Report Month 8

Purpose of Report

This paper provides the Trust's Board of Directors with an integrated overview of performance as at the end of November 2016. The focus of the report is on 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 current performance across the areas presented.
2) Consider whether it wishes to make any further amendments to the Integrated Performance Report to align it more clearly to the Single Oversight Framework and/or high risk areas contained in the Board Assurance Framework.

Executive Summary

The key theme for month 8, which also progressed into month 9 relate to ongoing staffing pressures in many of the Trust services. Particularly affected were many of our inpatient areas and Community Mental Health teams. Vacancy and sickness are contributing factors, with November's sickness absence figure much high than Trust expectations. Whilst the majority of this relates to nursing staff, there has been further sickness within medical teams too. This trend continued into December with an increase in requests for short term medical agency cover and this has had an effect on clinic cancellations in both November and December. Whilst not directly correlated to overall sickness absence, the Trust's flu vaccination uptake still remains relatively low.

Set against these pressures is a lower than expected patient occupancy at wards 1 and 2 at London Road Hospital. This has been the case for a few months and has enabled both wards to support other areas of the Trust with staff, when it has been safe to do so. Given the continued staffing issues across many service areas, plans are being considered to temporarily close one of wards 1 or 2 to enable a more structured and managed approach to redeploying staff into both inpatient and community teams to alleviate these pressures.

This report also includes more targets from the NHS Improvement Single Oversight Framework, which came into effect from 1st October 2016 replacing the Monitor Risk Assessment Framework and the NHS Trust Development Authority Accountability Framework.

The framework has introduced a number of operational challenges:

- Cardio-metabolic assessment and treatment for people with psychosis – work is ongoing to capture all the information needed to calculate the position. Until this work is completed we will not know the size of the challenge.

- Early intervention referral to treatment – work is in progress to resolve issues relating to how the position is calculated in order to ensure an accurate position is reported.

- Data completeness priority metrics – this target is to be achieved by financial year end. This requires the collection and recording of almost 15000 pieces of information which will be extremely challenging. Further clarification has been sought from NHSI regarding the actual construction of this new indicator.

The framework also includes a number of quality of care monitoring metrics some of which are, and some of which are not currently reported in the Trust's NHSI dashboard: staff sickness; staff turnover; executive team turnover; NHS staff survey; proportion of temporary staff; aggressive cost reduction plans; written complaints – rate; staff friends and family test % recommended – care; occurrence of any never event; NHS England/NHS Improvement patient safety alerts outstanding; CQC inpatient/mental health and community survey; mental health scores from friends and family test - % positive; potential under-reporting of patient safety incidents.

Overall performance

In general, the Trust continued to deliver good overall performance against many of its key indicators across November. This summary provides an overview of the some of the key issues during the month, assurance in a number of challenged areas and a forward look of some future risks and/or issues Board members need to be aware of.

Quality Performance

During the month quality performance focus has remained on addressing the issues arising from the Trust's recent Care Quality Commission (CQC) inspection report. Clinical and operational teams, led by the Director of Nursing and Patient Experience have been working on delivering the actions resulting from the CQC warning notice, CQC comprehensive report, as well as the on-going improvements required to improve patient care. In addition the Trusts Quality committee and Audit and Risk committee have received extended information on quality performance and a deep dive into Quality as outlined in the Board assurance framework BAF1a.

A number of the Trust's Committees received assurance on CQC plans.

Some of the key areas of focus have been on:

- Maintaining Fire warden training compliance, with Campus teams improving back to over 75% following the change in the eligible group.

- Safeguarding children's training at Level 3 which has increased and is now over 70%.

- Ensuring that supervision and appraisals are recorded. This continues to be challenging with the Deputy Director of Operations taking oversight of the mitigation plan. Quality teams and other services have offered supervision and support time to the campus areas to provide more time to support staff but the picture is improving.

- Reports on the capacity of teams such as Care co-ordination in mental health community teams has been reviewed and pressure on the teams remains significant.

The use of CQC portal 1 and CQC portal 2 action tracker has enabled an integrated approach to managing competing priorities and there continues to be extensive activity across all service lines to focus on environmental, clinical, policy and organisational governance priorities. These data requests are already being used in assurance reports to reflect upon clinical practice and develop and or redefine improvement plans. Over 40 actions have now been completed and an additional twenty actions completed in the November and December period

The number of prone restraints has increased; this is not unusual to have changes in this area when considering a high use of restraint and some key incidents relating to patient profiles. The quality committee has received up-dates on the Positive and safe training review and further information on the new training programme will be provided in Q4.

The number of concerns has increased, at this time; we are viewing this as a positive indicator and the ability to resolve complaints at a lower level of intervention.

This month sees the inclusion of complaints response time performance data and although the immediate acknowledgement letters have significantly improved from last year's response times there are performance improvement requirements with regards to completing complaints investigations and finalising the full complaint. This performance has slipped and has been identified by the Executive Leadership team as an area that requires investment in a small team of investigators both for serious incidents and complaints to improve this performance.

<u>Operational Performance</u>

Overall performance remains relatively stable, with all of the new activity based Single Oversight Framework indicators being achieved. There are a number of areas where performance remains variable, with further detail provided in the main body of the report.

In summary, the Trust's Performance, Contract and Operational Group (PCOG) received and approved actions plans in a number of key performance areas. These plans are actively monitored at each months meeting and reviewed to ensure they are on schedule to deliver the required improvement in performance. This responsibility will move to the Trust Management Team from mid-January 2017.

All under-performing targets identified in this report will be reviewed by TMT during January to ensure that the agreed action plans are on track to deliver improvements in performance. These will include;

- Outpatient Clinic Trust Cancellations
- Outpatient letters
- PbR Clustering
- Breastfeeding rates

Financial Performance

The year to date score from the Use of Resources (UoR) metrics is unchanged from last month: our overall UoR is a 3. Four of the five metrics are relatively strong at 2, 1, 1 and 1, but the fifth metric, agency spend against ceiling, remains at 4, and that triggers an override that restricts the overall rating to a 3.

This month the forecast for agency expenditure has increased and the level of agency expenditure in the final quarter of the year will cross the threshold to score of 4 which means the overall year-end rating would be restricted to 3, as currently.

Our NHS segment is now officially 3 (and is no longer a shadow rating).

In surplus terms, the Trust remains ahead of plan cumulatively for the year to date, with a trajectory to return to planned control total by year end as costs increase and income reduces.

In forecasting the achievement of the control total surplus, the Board is aware that it assumes the mitigation of some significant risks, that have not all as yet been mitigated; the unmet CIP and cost avoidance requirements (this gap has improved since last month however), the risk of income clawback by commissioners (as yet unresolved), the as-yet unquantified potential for backdated pay (related to outstanding job evaluations), ongoing pressures in agency costs and out of area Psychiatric Intensive Care Unit costs. Some less significant risks have now been moved from worse case to most likely case which is why the overall worst case is less of a deficit than previously.

During December the Trust reached agreement on contracts for next year and submitted an operational plan to NHS Improvement as per national requirements. Early planning has started on action required to reach 2017/18 and 2018/19 control total surplus levels required by NHSI. As a result of contractual negotiations, 2017/18 will require Trust CIP of £3.85m (at our risk) and commissioner-driven QIPP (Quality, Innovation, Productivity and Prevention) disinvestment of £3.05m (at commissioner risk).

People Performance

Whilst a number of indicators in the People and Workforce dashboard remain off track, there continues to be progress in a number of areas that are intended to impact on Trust performance in the short and medium term.

Staff attendance rate remains a challenge at 6.65% against a target of 5.04% and is 0.78% higher than this time last year. Compulsory training remains below the 90% target at 86.94% but is above our CQUIN (Commissioning for Quality Innovation) target of 85%. There has been an improvement in appraisal completions to 72.24% but this is still below the target of 90%

In recognition of the need to recruit and retain high calibre of staff in all fields, particularly AHPs (Allied Health Professionals), medics and nursing, there is continued effort to enable swift and effective recruitment procedures which draw on appropriate talent pools and ensure that resources are deployed in the most appropriate way. Once implemented in March 2017, E-Recruitment, using TRAC system, will enable managers and potential employees to utilise a streamlined, interactive and responsive process, which would reduce or eliminate paperwork and unnecessary delays.

The future positioning of our Trust is also partly dependent on our ability to attract and recruit from a wider talent pool, more so when recruiting to 'hard to fill' clinical vacancies/posts. Hence, our recent achievement of Tier 2 Sponsorship Licence through the UK Visas & Immigration (UKVI) in December 2016 will facilitate the Trust's ability to recruit from an international/worldwide pool of talent.

In addition, since December 2016, 'hard to recruit' vacancies are being advertised on social media platforms - LinkedIn and Facebook.

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 (BAF).

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

Consultation

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

Governance or Legal issues

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: **Mark Powell**
Acting Chief Operating Officer

Claire Wright
Director of Finance

Amanda Rawlings
Director of People and Organisational Effectiveness

Carolyn Green
Director of Nursing and Patient Experience

Report prepared by: **Peter Charlton**
General Manager, Information Management

Rachel Leyland
Deputy Director of Finance

Liam Carrier
Workforce Systems & Information Manager

Hayley Darn
Nurse Consultant

Highlights

- Surplus better than plan YTD. Forecast to achieve plan at year end
- Cash better than plan at the end of November

Challenges

- CIP forecast to deliver further but not to full target
- Containment of agency expenditure which is currently triggering an override on the new Use of Resources Rating
- Mitigations of Financial risks during 16/17

Highlights

- NHSi Single Oversight Framework has been implemented

Challenges

- 10 day outpatient letter target has been breached due to a software upgrade
- Clustering of patients
- Outpatient Cancellations have breached
- 6-8 week coverage has fallen below target

Highlights

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

Challenges

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

Highlights

- No of incidents involving patients held in seclusion has decreased compared to the previous month.
- Although at an early stage of implementation, % of patients with a Safety Plan has increased
- % of staff compliant with Fire Warden training has increased
- % of in patient older adults rights forms received by MHA Office has increased
- % of staff receiving clinical and management supervision has increased
- The position re outstanding actions following serious Incident investigations has improved, but continues to be pressured

Challenges

- No of incidents of moderate to catastrophic incidents has continued to increase compared to the previous month.
- No of incidents of physical assault (patient on patient) has increased slightly
- No of concerns continues to increase
- A new indicator regarding response rates to complaints has been included this month and indicates significant delays in the operational response

FINANCIAL OVERVIEW – NOVEMBER 2016

Category	Sub-set	Metric	Period	Actual	Rating	Trend	Key Points
Governance	Use of Resources (UoR) Metric	Overall Use of Resources Metric	YTD	3	A	→	As at the end of November the Use of Resources Rating is 3 and is now also forecast to be a 3 at the end of the year, due to triggering an override on the agency. The agency forecast has got worse this month compared to last month and now triggers an override at the end of the financial year driven by the agency metric. We have been segmented in segment 3.
			Forecast	3	A	↘	
		Capital Service Cover	YTD	2	Y	→	
			Forecast	2	Y	→	
		Liquidity	YTD	1	G	→	
			Forecast	1	G	→	
		Income and Expenditure Margin	YTD	1	G	→	
			Forecast	1	G	→	
		Income and Expenditure variance to plan	YTD	1	G	→	
			Forecast	1	G	→	
		Agency variance to ceiling	YTD	4	R	→	
			Forecast	4	R	↘	
	Single Oversight Framework	NHS I Segment	YTD	3	n/a	n/a	

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
I&E and profitability	Income and Expenditure	Control Total position £'000	In-Month	290	256	R	↓	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. The Normalised Income and Expenditure shows the financial performance adjusting for any non-recurrent costs or benefits that will not continue.
			YTD	1,562	2,232	G	↑	
			Forecast	2,531	2,531	G	→	
		Underlying Income and Expenditure position £'000	In-Month	221	187	R	↓	
			YTD	1,008	1,679	G	↑	
			Forecast	1,701	1,701	G	→	
		Normalised Income and Expenditure position £'000	In-Month	221	222	G	↓	
			YTD	1,008	1,577	G	↑	
			Forecast	1,701	1,797	G	→	
	Profitability	Profitability - EBITDA £'000	In-Month	893	830	R	↓	
			YTD	6,425	6,901	G	↑	
			Forecast	9,806	9,699	R	→	
		Profitability - EBITDA %	In-Month	7.8%	7.3%	R	↘	
			YTD	7.0%	7.7%	G	→	
			Forecast	7.1%	7.2%	G	→	
Liquidity	Cash	Cash £m	YTD	11.295	13.915	G	↑	Cash is currently above plan but is forecast to be below plan at year end due to the forecast release of some provisions. Capital is slightly behind plan YTD but is forecast to fully spend by the end of the financial year.
			Forecast	13.153	12.711	R	→	
	Net Current Assets	Net Current Assets £m	YTD	5.964	8.060	G	↑	
			Forecast	7.570	6.505	R	→	
	Capex	Capital expenditure £m	YTD	2.060	1.535	R	↑	
			Forecast	3.450	3.450	G	→	
Efficiency	CIP	CIP achievement £m	In-Month	0.358	0.226	R	↑	CIP is currently behind plan and is forecast not to deliver the full plan at the end of the financial year. This is compensated for by other cost avoidance and underspends in the overall position.
			YTD	2.867	1.520	R	↓	
			Forecast	4.300	2.694	R	↓	
			Recurrent	4.300	1.645	R	↘	

Key:

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

Plan In-month or Year end Trust plan

Achieving plan
Not achieving plan

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

OPERATIONAL OVERVIEW – NOVEMBER 2016

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	NHSI	CPA 7 Day Follow-up (M)	Month	95.00%	96.39%	G	↓	NHSi have introduced a new Single Oversight Framework to monitor Trusts Performance. The dashboard has been updated to reflect all the new activity based indicators. The Trust is compliant with all NHSI targets where they have been set except Physical Health where work is required to capture all the information needed to calculate the indicators. Until that work has been concluded Physical Health compliance will be assessed via a quarterly audit. The Priority Metrics indicator - the Trust is awaiting clarification from NHSi regarding the derivation of this indictor. The compliance target is 85% by the end of the financial year. Early intervention referral to treatment – work is in progress to resolve issues relating to how the position is calculated in order to ensure an accurate position is reported. For each metric we have indicated if it is monitored by NHSi Quarterly (Q) or Monthly (M).
			Quarter	95.00%	97.88%	G	↑	
		Data completeness - Identifiers (M)	Month	95.00%	99.45%	G	→	
			Quarter	95.00%	99.56%	G	→	
		Data completeness - Priority Metrics (M)	Month	N/A	71.13%		→	
			Quarter	N/A	69.19%		→	
		Crisis Gatekeeping (Q)	Month	95.00%	97.65%	G	→	
			Quarter	95.00%	97.40%	G	↑	
		IAPT RTT within 18 weeks (Q)	Month	95.00%	99.70%	G	→	
			Quarter	95.00%	99.63%	G	→	
		IAPT RTT within 6 weeks (Q)	Month	75.00%	88.41%	G	↑	
			Quarter	75.00%	87.35%	G	↓	
		Early Intervention in Psychosis RTT Within 14 Days - Complete (Q)	Month	50.00%	68.00%	G	↑	
			Quarter	50.00%	65.00%	G	↑	
		Early Intervention in Psychosis RTT Within 14 Days - Incomplete (Q)	Month	50.00%	51.39%	G	↑	
			Quarter	50.00%	50.00%	G	↓	
		Patients Open to Trust In Employment (M)	Month	N/A	8.91%		→	
			Quarter	N/A	8.67%		→	
		Patients Open to Trust In Settled Accommodation (M)	Month	N/A	59.70%		→	
			Quarter	N/A	57.19%		↓	
		Under 16 Admissions To Adult Inpatient Facilities (M)	Month	0	0	G	→	
			Quarter	0	0	G	→	
		IAPT People Completing Treatment Who Move To Recovery (Q)	Month	50.00%	53.13%	G	→	
			Quarter	50.00%	53.52%	G	→	
		Physical Health - Cardio-Metabolic - Inpatient (Q)	Month					
			Quarter					
		Physical Health - Cardio-Metabolic - EI (Q)	Month					
			Quarter					
		Physical Health - Cardio-Metabolic - on CPA (Community) (Q)	Month					
			Quarter					

Key:

Period

Month Current Month

Quarter Current Quarter

Achieving target

Not achieving target

↑ → ↓ Trend compared to previous month/quarter

OPERATIONAL OVERVIEW – NOVEMBER 2016

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Locally Agreed	CPA Settled Accommodation	Month	90.00%	96.54%	G	→	The majority of clinicians now successfully manage their PbR caseloads either independently or through positive engagement with available support.
			Quarter	90.00%	96.72%	G	→	
		CPA Employment Status	Month	90.00%	97.21%	G	→	
			Quarter	90.00%	97.27%	G	→	
		Data completeness - Identifiers	Month	99.00%	99.45%	G	→	
			Quarter	99.00%	99.56%	G	→	
		Data completeness - Outcomes	Month	90.00%	93.73%	G	→	
			Quarter	90.00%	93.80%	G	→	
		Patients Clustered not Breaching Today	Month	80.00%	77.26%	R	→	
			Quarter	80.00%	77.61%	R	↓	
		Patients Clustered regardless of review dates	Month	96.00%	94.65%	R	→	
			Quarter	96.00%	94.61%	R	→	
		7 Day Follow-up - all inpatients	Month	95.00%	96.04%	G	→	
			Quarter	95.00%	96.85%	G	↑	
		Ethnicity coding	Month	90.00%	91.64%	G	→	
			Quarter	90.00%	91.30%	G	↓	
		NHS Number	Month	99.00%	99.98%	G	→	
			Quarter	99.00%	99.98%	G	→	
		CPA Review in last 12 Months (on CPA > 12 Months)	Month	95.00%	95.20%	G	→	
			Quarter	95.00%	95.35%	G	→	
		Community Care Data - Activity Information Completeness	Month	50.00%	93.79%	G	→	
			Quarter	50.00%	94.01%	G	→	
		Community Care Data - RTT Information Completeness	Month	50.00%	92.31%	G	→	
			Quarter	50.00%	92.31%	G	→	
		Community Care Data - Referral Information Completeness	Month	50.00%	74.46%	G	↓	
			Quarter	50.00%	74.75%	G	↓	
		Early Interventions New Caseloads	Month	95.00%	148.90%	G	↓	
			Quarter	95.00%	148.90%	G	↓	
		Clostridium Difficile Incidents	Month	7	0	G	→	
			Quarter	7	0	G	→	
		18 Week RTT Greater Than 52 weeks	Month	0	0	G	→	
			Quarter	0	0	G	→	

OPERATIONAL OVERVIEW – NOVEMBER 2016

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Schedule 6	Consultant Outpatient Trust Cancellations	Month	5.00%	6.25%	R	→	Associate Clinical Directors to continue to review cancellation reasons and discuss with consultant(s) concerned where reasons do not appear valid, if applicable. IM&T have now adapted Paris to enable the recording of cancellation reasons for individual appointments, not just whole clinics, has started to have a positive impact in terms of monitoring. There was some disruption to service whilst the digital dictation software was upgraded. Normal service has now been resumed. A review of 28 day readmissions, to be undertaken by the Associate Clinical Director and Head of Nursing, has been commissioned. The findings will be reported to PCOG in January 2017.
			Quarter	5.00%	6.03%	R	→	
		Consultant Outpatient DNAs	Month	15.00%	14.23%	G	↑	
			Quarter	15.00%	15.08%	R	↑	
		Under 18 admissions to Adult inpatients	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Outpatient letters sent in 10 working days	Month	90.00%	88.77%	R	↑	
			Quarter	90.00%	87.89%	R	→	
		Outpatient letters sent in 15 working days	Month	95.00%	95.82%	G	↑	
			Quarter	95.00%	94.80%	R	→	
		Inpatient 28 day readmissions	Month	10.00%	13.82%	R	↓	
			Quarter	10.00%	9.20%	G	↓	
		MRSA - Blood stream infection	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Mixed Sex accommodation breaches	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Discharge Fax sent in 2 working days	Month	98.00%	98.47%	G	→	
			Quarter	98.00%	98.99%	G	→	
		Delayed Transfers of Care	Month	7.50%	1.79%	G	→	
			Quarter	7.50%	1.88%	G	→	
		18 Week RTT Less Than 18 Weeks - Incomplete	Month	92.00%	94.15%	G	→	
			Quarter	92.00%	94.15%	G	→	

OPERATIONAL OVERVIEW – NOVEMBER 2016

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Fixed Submitted Returns	18 weeks RTT greater than 52 weeks	Month	0	0	G	→	Compliant with Fixed Targets
			Quarter	0	0	G	→	
		18 Week RTT incomplete	Month	92.00%	94.44%	G	→	
			Quarter	92.00%	94.55%	G	↑	
		Mixed Sex accommodation breaches	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Completion of IAPT Data Outcomes	Month	90.00%	95.87%	G	→	
			Quarter	90.00%	95.70%	G	→	
		Ethnicity coding	Month	90.00%	92.22%	G	↑	
			Quarter	90.00%	91.18%	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%	98.52%	G	↓	Vacancies have impacted on compliance
			Quarter	98.00%	98.84%	G	→	
		% 6-8 Week Breastfeeding coverage	Month	98.00%	96.76%	R	↓	
			Quarter	98.00%	97.83%	R	↓	
	IAPT	Recovery Rates	Month	50.00%	52.74%	G	→	Compliant with IAPT Targets
			Quarter	50.00%	52.91%	G	→	
		Reliable & Recovery Rates	Month	65.00%	69.68%	G	→	
			Quarter	65.00%	69.69%	G	↓	
	Safer Staffing	Inpatient Safer Staffing Fill Rates	Month	90.00%	101.4%	G	→	Detailed ward level information shows specific variances
			Quarter	90.00%	101.2%	G	↑	

WORKFORCE OVERVIEW – NOVEMBER 2016

Category	Sub-set	Metric	Period	Plan	Actual	Variance		Trend	Key Points
Workforce Dashboard	NHSI Key Performance Indicator (KPI)	**Turnover** (annual)	**Nov-16**	10%	**11.71%**	↘	G	↑	Annual turnover remains within the Trust target parameters and is below the regional Mental Health & Learning Disability average of 12.65% (as at June 2016 latest available data). The monthly sickness absence rate is 0.80% higher compared to the previous month and it is also 0.58% higher than in the same period last year (November 2015). The annual sickness absence rate is running at 5.60%. The regional average annual sickness absence rate for Mental Health & Learning Disability Trusts is 5.09% (as at July 2016 latest available data). Anxiety/stress/depression/other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 27.97% of all sickness absence, followed Surgery at 13.17% and cold, cough, flu - infuenza at 9.65%. Vacancy rates have decreased by 0.42% compared to the previous month. The number of employees who have received an appraisal within the last 12 months has increased by 3.58% to 72.24%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £1.332m of which £726k related to Medical staff. Compulsory training compliance has decreased this month by 1.28% but still remains above the 85% main contract non CQUIN.
			Oct-16		11.79%		G		
		Sickness Absence (monthly)	**Nov-16**	5.04%	**6.65%**	↗	R	↓	
			Oct-16		5.85%		R		
		Vacancies (including 10% funded fte cover)	**Nov-16**	10%	**16.40%**	↘	A	↓	
			Oct-16		16.82%		A		
		Vacancies (actual)	**Nov-16**	0%	**6.40%**	↘	A	↓	
			Oct-16		6.82%		A		
		Appraisals (all staff - number of employees who have received an appraisal in the previous 12 months)	**Nov-16**	90%	**72.24%**	↗	R	↑	
			Oct-16		68.66%		R		
		Appraisals (medical staff only - number of employees who have received an appraisal in the previous 12 months)	**Nov-16**	90%	**85.59%**	↘	R	↑	
			Oct-16		87.74%		R		
		Qualified Nurses (to total nurses, midwives, health visitors and healthcare assistants)	**Nov-16**	65%	**68.09%**	↘	G	↓	
			Oct-16		68.75%		G		
		Agency Usage (£ year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Nov-16**	£0	**£1.332m**	↗	R	↑	
			Oct-16		£1.194m		R		
		Agency Usage (% year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Nov-16**	0%	**65.89%**	↘	R	↑	
			Oct-16		67.40%		R		
	Other KPI	**Compulsory Training** (staff in-date)	**Nov-16**	90%	**86.94%**	↘	G	↓	
			Oct-16		88.22%		G		

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 – NOVEMBER 2016

Category	Sub-set	Metric	Period	Plan	Actua	Varianc	Trend	Key Points
Quality	Safe	No of incidents of moderate to catastrophic actual harm	Month	24	43			Plan: average last fin yr (month)
			Quarter	73	83		NA	Plan: average last fin yr (Qtr). Actual: Q2. Inclusion of trend data to commence Q3
		No of episodes of patients held in seclusion	Month	8	6			Plan: previous month. Actual: Current month.
			Quarter	35	59			Plan: Q1 data. Actual: Q2 data
		No of incidents involving patients held in seclusion	Month	20	6			
			Quarter	61	60			Q2 data
		No of incidents involving physical restraint	Month	55	41			
			Quarter	165	211			Q2 data
		No of incidents involving prone restraint	Month	5	10			Plan: Mth Qtr, average from 1/4/16 when prone restraint collected on Datix as defined field.
			Quarter	15	30			Q2 data
		No of incidents of physical assault - patient on patient	Month	15	12			
			Quarter	44	42		NA	Q2 data. Inclusion of trend data to commence Q3
		No of incidents of physical assault - patient on staff	Month	20	11			
			Quarter	61	81		NA	Q2 data. Inclusion of trend data to commence Q3
		No of falls on in-patient wards	Month	38	29			
			Quarter	113	84		NA	Q2 data. Inclusion of trend data to commence Q3
		No of incidents of absconsion	Month	43	28			
			Quarter	130	85		NA	Q2 data. Inclusion of trend data to commence Q3
		No of patients with a clinical risk plan (FACE or Safety Plan)	Month	100%	79.81%			
			Quarter	100%	80.20%			
		Of above, no of patients with a Safety Plan	Month	90%	1.17%			Early stage of implementation. Go live from 1/11/16.
			Quarter	90%	0.80%			
		% of staff compliant with Level 3 Safeguarding Children training	Month	95%	70.07%			
			Quarter	95%	NA			Qtr comparison not available
		% of staff compliant with Think Family training	Month	95%	72.40%			
			Quarter	95%	NA			Qtr comparison not available
		% of staff compliant with Clinical Safety Planning eLearning	Month	95%	92.58%			
			Quarter	95%	NA			Qtr comparison not available
		% of staff compliant with Fire Warden training	Month	90%	75.7%			As of 31/10/16 cohort increased 3x due to change in policy. The figure respresent staff within in-patient areas.
			Quarter	90%	NA			Qtr comparison not available
		No of people with LD or Autism admitted without a CTR (Care & Treatment Review)	Month	0	3			
			Quarter	0	7			

QUALITY OVERVIEW – NOVEMBER 2016

Category	Sub-set	Metric	Period	Plan	Actua	Varianc	Trend	Key Points
Quality	Caring	No of complaints received	Month	9	10			
			Quarter	26	39			Q2 data. Inclusion of trend data to commence Q3
		No of concerns received	Month	18	42			
			Quarter	53	121			
		No of compliments received	Month	72	85			
			Quarter	217	292			
		No of incidents requiring Duty of Candour	Month	2	0			These figures will fluctuate based on the outcome of investigations.
			Quarter	8	1		NA	
	Effective	% of in-patients with a recorded capacity assessment	Month	100%	88.35%			
			Quarter	100%	NA	NA	NA	Qtr comparison not available
		% of patients who have had their care plan reviewed and have been on CPA > 12months	Month	90%	95.14%			
			Quarter	90%	95.79%			
		No of seclusion forms not received by MHA Office	Month	0	3			1 form from Oct 16 nort received and 3 from Nov. Being actively chased by MHA office with support of ASM/HoN
			Quarter	0	10		NA	Q2 data. Inclusion of trend data to commence Q3
		% of CTO rights forms received by MHA Office	Month	100%	84%			Relates to whole cohort of patients
			Quarter	NA	NA	NA	NA	
		% of in patient older adults rights forms received by MHA Office	Month	100%	85%			Relates to Cubley Ct and Wards 1&2
			Quarter	100%	100%		NA	Relates to Cubley Ct only
	Responsive	% of staff uptake of Flu Jabs	Month	45%	32.9%			Data to end of 30/11/16
			Year	45%	22.7%			Relates to 2015.16 compaign
		% of policies in date	Month	95%	96.0%			
			Quarter	NA	NA	NA	NA	
	Well Led	% of staff who have received Clinical Supervision, within defined timescales	Month	90%	52.75%			
			Quarter	90%	NA	NA	NA	
		% of staff who have received Management Supervision, within defined timescales	Month	90%	63.1%			
			Quarter	90%	NA	NA	NA	
		No of outstanding actions following serious Incident investigations	Month	0	19			16 only became overdue as of 30/11/16
			Quarter	0	7		NA	Average for Q2. Comparison to Q1 not analysed
		No of outstanding actions following complaint investigations	Month	0	44			With operational teams to resolve
			Quarter	0	NA	NA	NA	
		% of responded to (orange) complaint investigations completed within 40 working days	Year	100%	36%			From 1/4/16 to 30/11/16. 24 of the 93 'orange rated complaints were not responded to within 40 working days. 26 complaints are still ongoing
		% of responded to (red) complaints investigations completed within 60 working days	Year	100%	0%			From 1/4/16 to 30/11/16. 3 of the 4 'red' rated complaints were not responded to within 60 working days. 1 complaint is still ongoing.
		No of outstanding actions following CQC comprehensive review report	Month	0	170			82% of all the actions are either complete or in progress and on target 08/12/2016 UPDATE: A full review of all actions will be undertaken by the end of December. The status of each action will be agreed by the Action Lead and the Director of Nursing. Updated statistics will be produced following the review

Financial Section

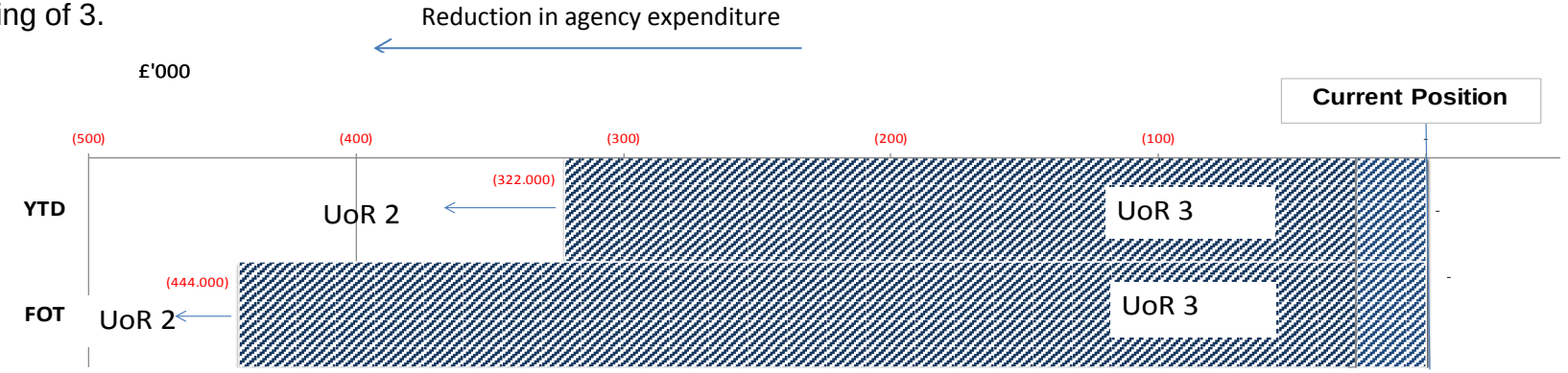
Governance – Use of Resources (UoR) Rating

The Use of Resources rating at the end of November is a 3 which is due to triggering a 4 on the agency metric. Due to agency expenditure being above the ceiling in excess of 50% and therefore continuing to trigger a 4, the forecast UoR is also a rating of 3 at the end of the financial year.

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

To note some of the metrics including the overall rating does not have a plan set by NHS Improvement, so the plan on the Distance from Plan and the overall rating is based on an internal plan.

As four of the metrics are in a healthy position and it is the agency metric that is driving the lower rating and the trigger this is the area of focus from a headroom perspective, which is shown in the chart below. YTD if agency expenditure was £0.3m less we would have not triggered an override and remained at a rating of 2. From a forecast perspective we would need to reduce expenditure by £0.4m in order avoid triggering an override and remain at a rating of 3.



Income and Expenditure

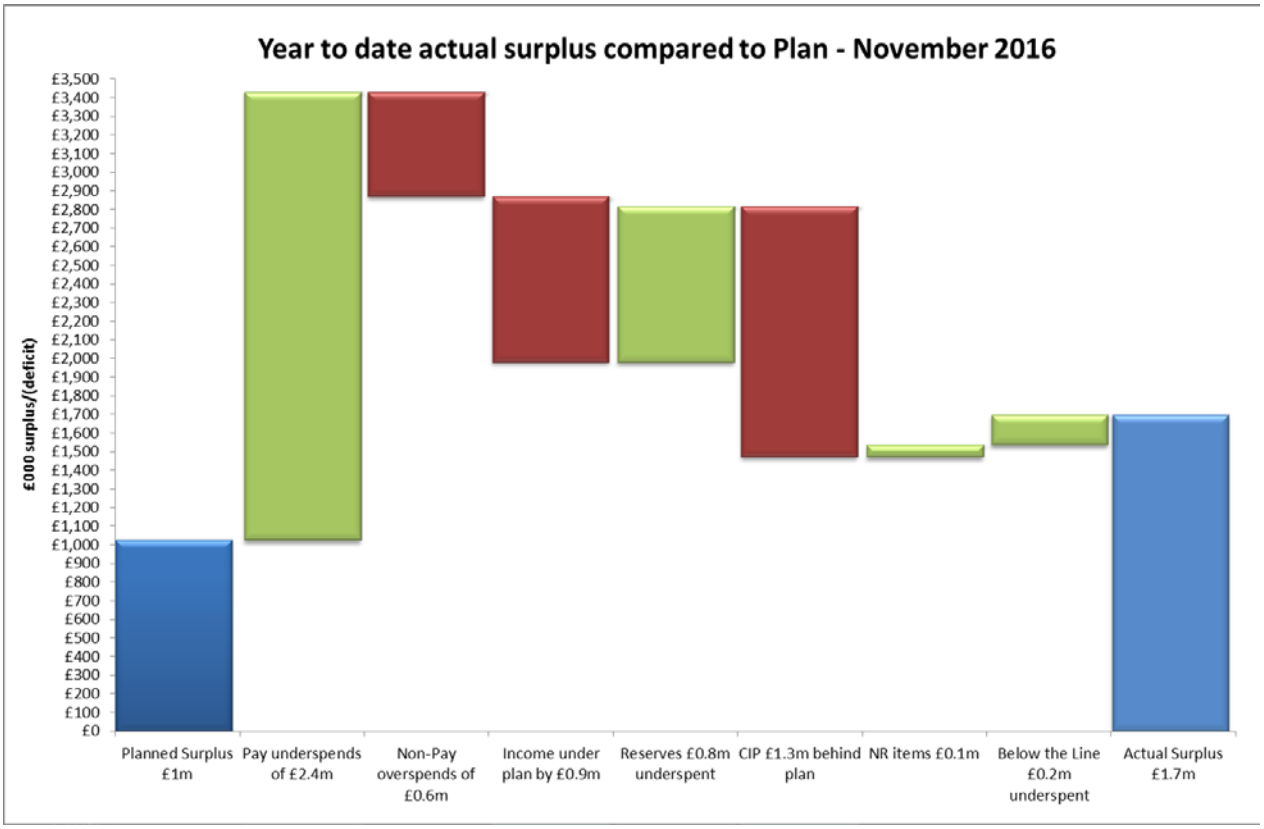
Statement of Comprehensive Income — November 2016

	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	10,654	10,555	(98)	84,866	82,957	(1,909)	127,406	124,632	(2,774)
Non Clinical Income	849	836	(13)	6,793	6,322	(471)	10,190	9,371	(819)
Employee Expenses	(8,426)	(8,152)	274	(67,800)	(64,356)	3,444	(101,492)	(96,535)	4,958
Non Pay	(2,183)	(2,409)	(226)	(17,435)	(18,022)	(587)	(26,298)	(27,770)	(1,472)
EBITDA	**893**	**830**	**(63)**	**6,425**	**6,901**	**476**	**9,806**	**9,699**	**(107)**
Depreciation	(295)	(271)	23	(2,356)	(2,173)	183	(3,534)	(3,451)	83
Impairment	0	0	0	0	(36)	(36)	(300)	(300)	0
Profit (loss) on asset disposals	0	0	0	0	0	0	0	0	0
Interest/Financing	(175)	(170)	5	(1,440)	(1,416)	24	(2,141)	(2,105)	36
Dividend	(133)	(133)	(0)	(1,067)	(1,079)	(13)	(1,600)	(1,613)	(13)
Net Surplus / (Deficit)	**290**	**256**	**(35)**	**1,562**	**2,196**	**635**	**2,231**	**2,231**	**0**
Technical adjustment - Impairment	0	0	0	0	(36)	(36)	(300)	(300)	0
Control Total Surplus / (Deficit)	**290**	**256**	**(35)**	**1,562**	**2,232**	**671**	**2,531**	**2,531**	**0**
Technical adjustment - STF Allocation	69	69	0	553	553	0	830	830	0
Underlying Net Surplus / (Deficit)	**221**	**187**	**(35)**	**1,008**	**1,679**	**671**	**1,701**	**1,701**	**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 overall.

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 £0.1m less than plan in month and is forecast to be £2.8m less than plan by the end of the year of which a significant proportion is due to differences in planning assumptions with offsetting expenditure reductions. There is however forecast underperformances on activity related income.
Non Clinical income is less than plan in the month by £13k and has a forecast outturn of £0.8m behind plan. £0.4m relates to a miscellaneous income target with no income forecast against it.
Pay expenditure is £0.3m less than the plan in the month and the year end forecast position is £4.9m 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 £226k and has a forecast outturn of £1.5m worse than plan which mainly relates to Drugs and PICU expenditure.



Summary of key points

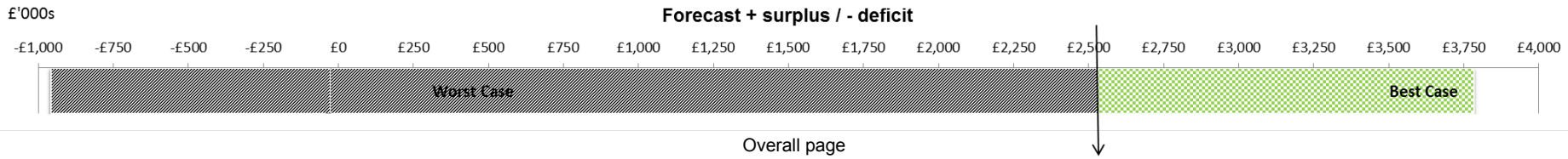
Overall favourable variance to plan year to date which is driven by the following:

- 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.

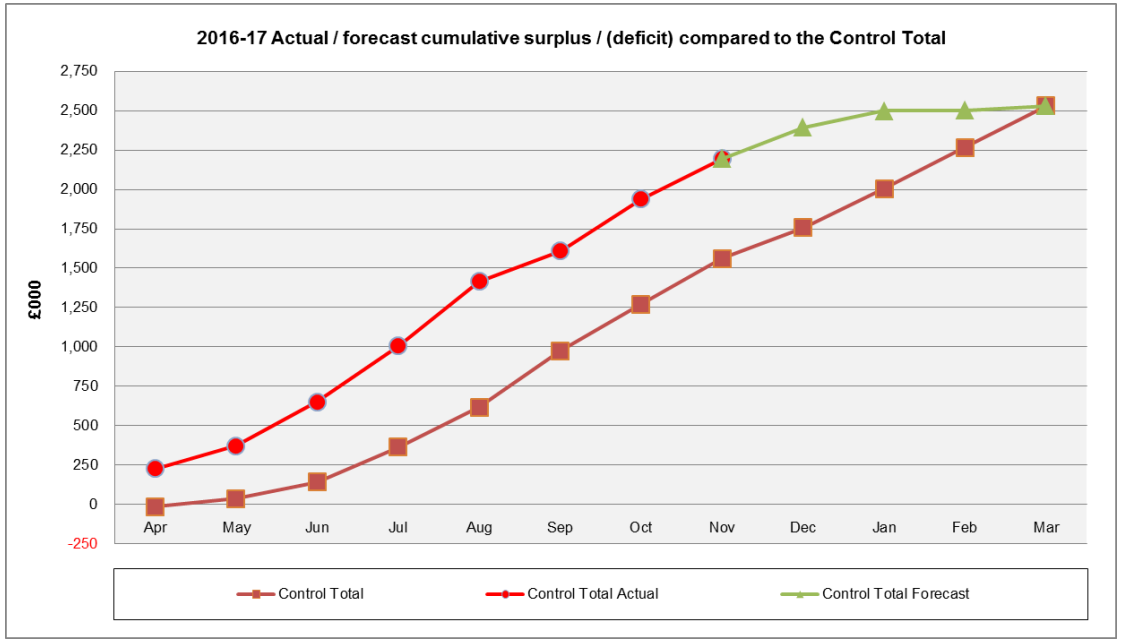
The main variables in the forecast range are: CIP assumptions, STF income, income claw back, agency expenditure, AfC backlog claims, PICU, IAPT, CPC income and other unexpected non-pay costs.

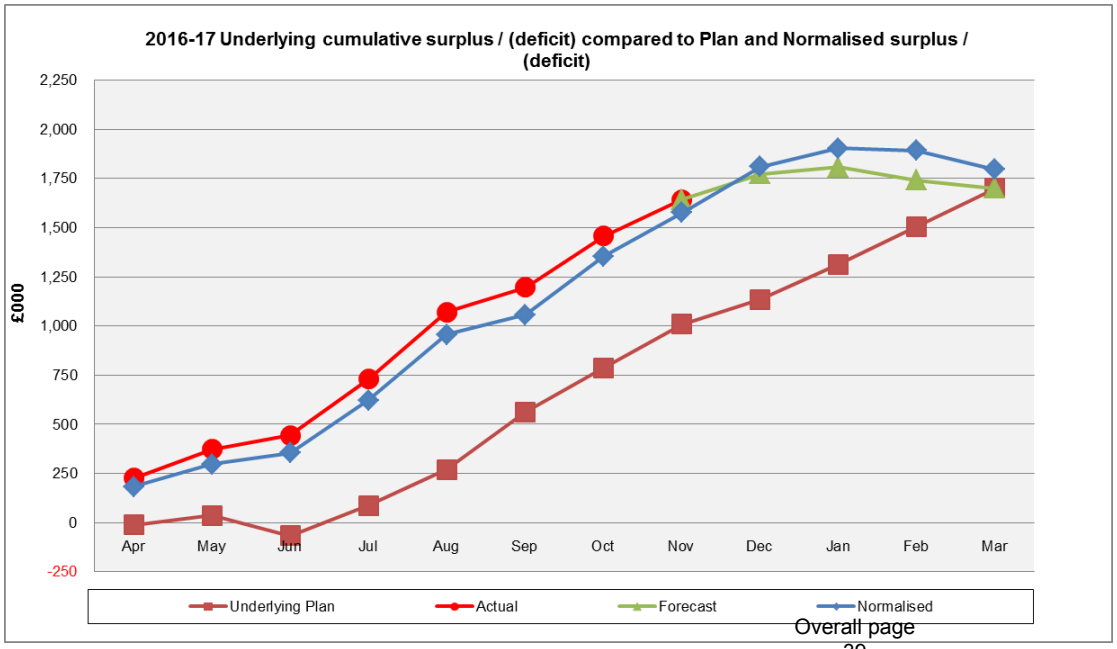
Forecast Range

Best Case	Likely Case	Worst Case
£3.8m Surplus	£2.5m surplus	£1.0m deficit



Normalised Income and Expenditure position





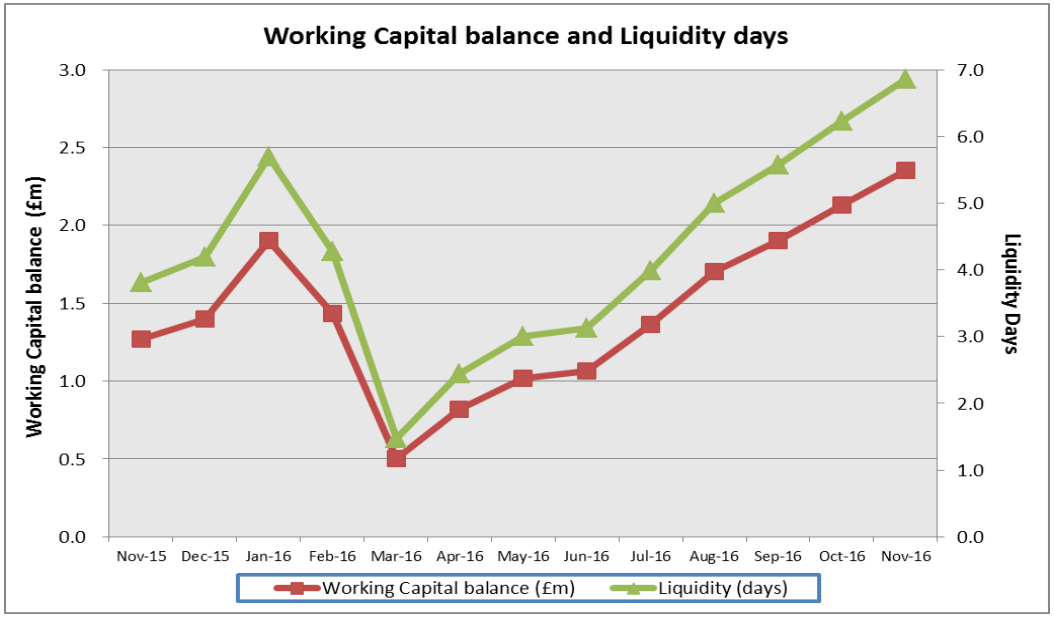
The first graph shows the actual and forecast cumulative surplus against the control total (including the Sustainability Transformation Fund (STF). The surplus is forecast to remain ahead of plan until the latter part of the financial year when it will reduce back down to the planned control total.

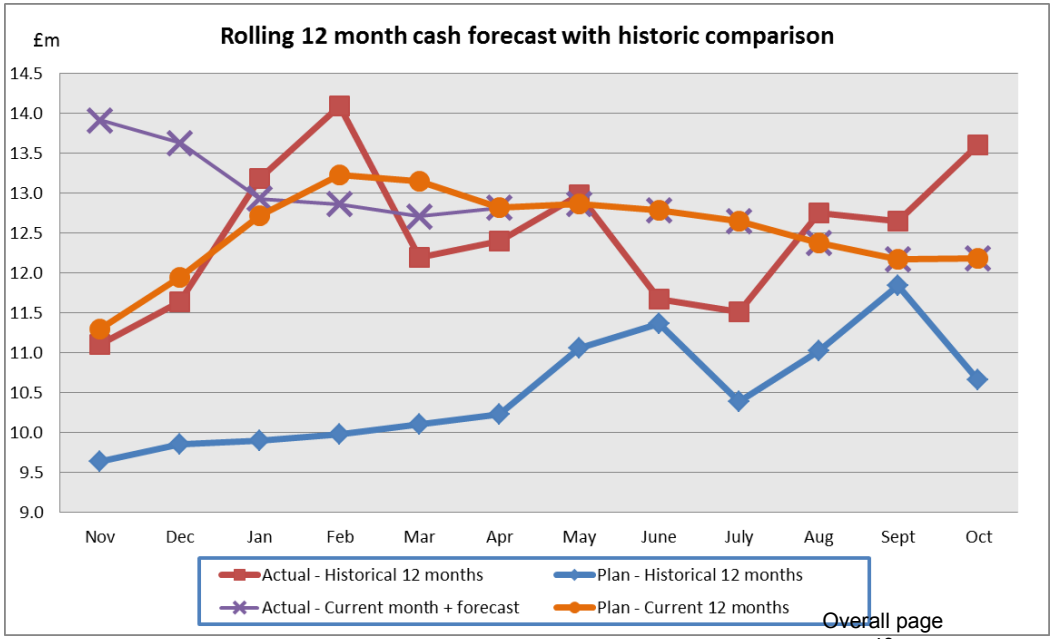
The second graph shows the underlying actual and forecast surplus against the underlying plan excluding the STF.

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 and additional resources. In the normalised position these have been removed.

Liquidity





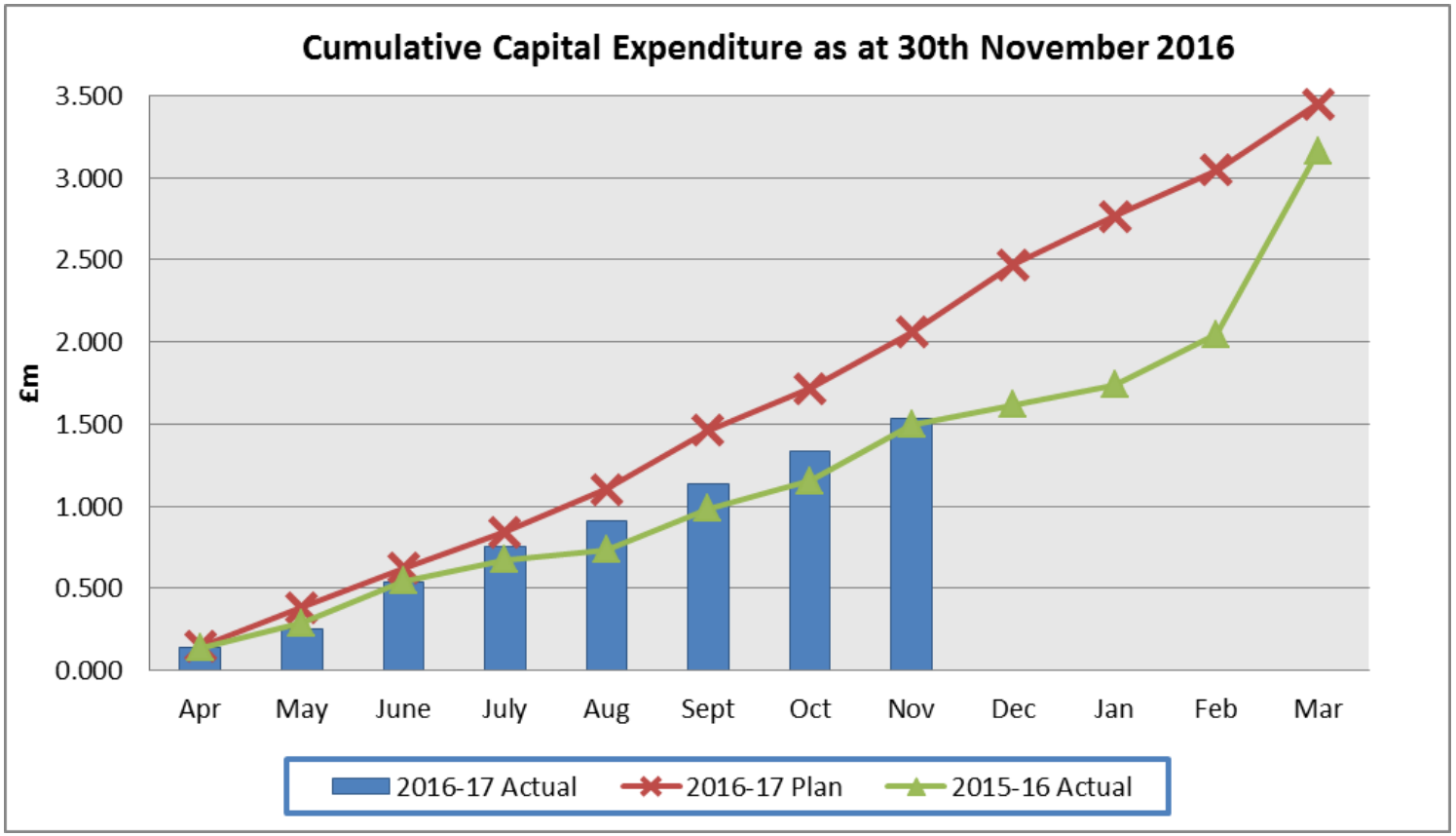
The first graph shows the working capital balance for the last 12 months (net current assets less net current liabilities adjusted for assets held for sale and inventories) and how many days of operating expenses that balance provides.

During 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. November continues to show a further improvement up to 6.86 days which still gives a rating of 1 (the best) on that metric (-7days drops to a rating of 2).

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

Cash is currently at £13.9m which was £2.6m better than the plan at the end of November. This is mainly driven by the Income and Expenditure surplus and capital being slightly behind plan.

Capital Expenditure

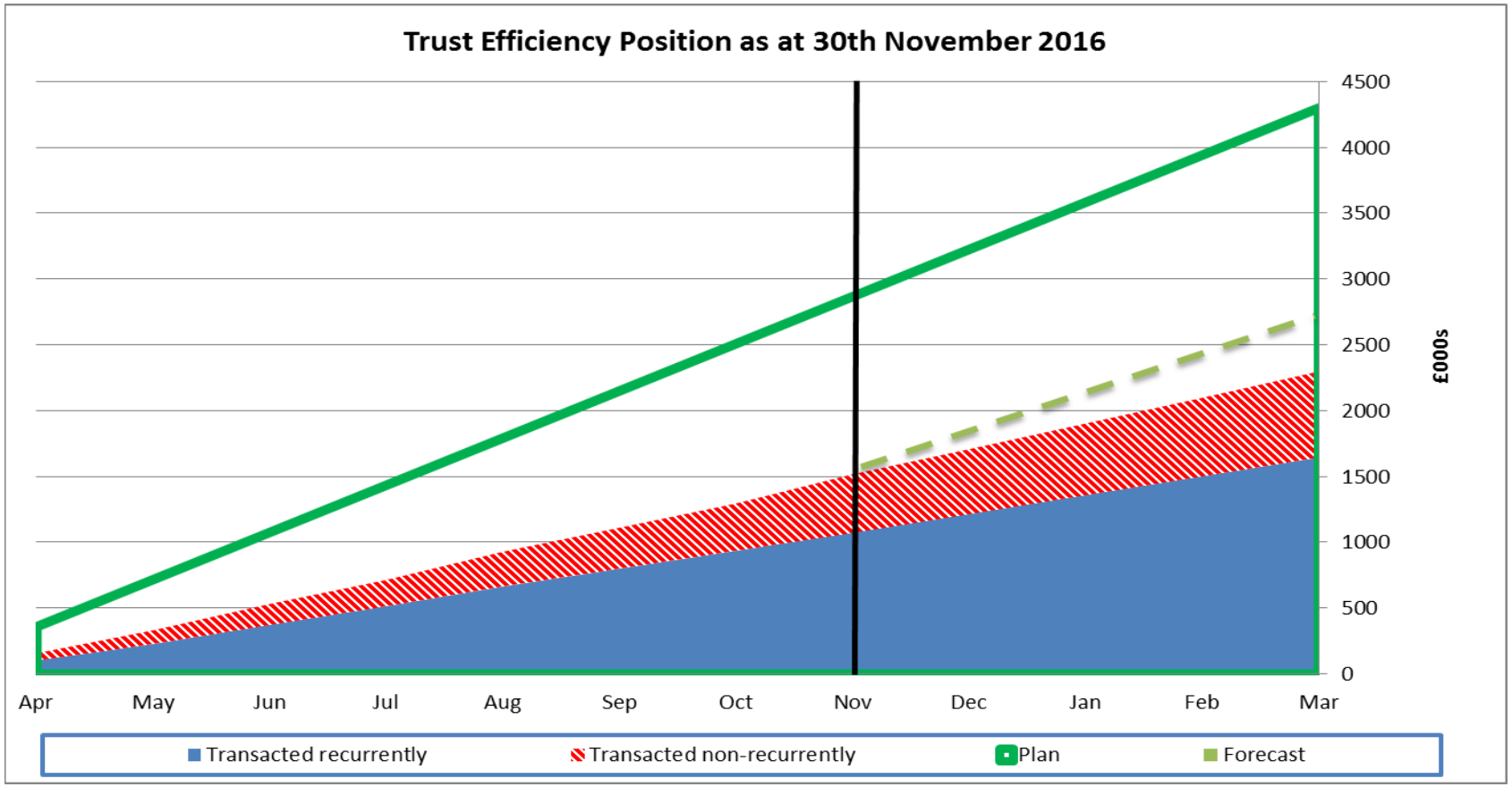


Capital Expenditure is £525k behind plan year to date but is forecast to spend to the plan of £3.45m by year end.

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 already taken place to date this year in order to fund more urgent schemes. Capital Action Team members are overseeing the delivery of CQC-related capital requirements related to environment.

Efficiency

Cost Improvement Programme (CIP)



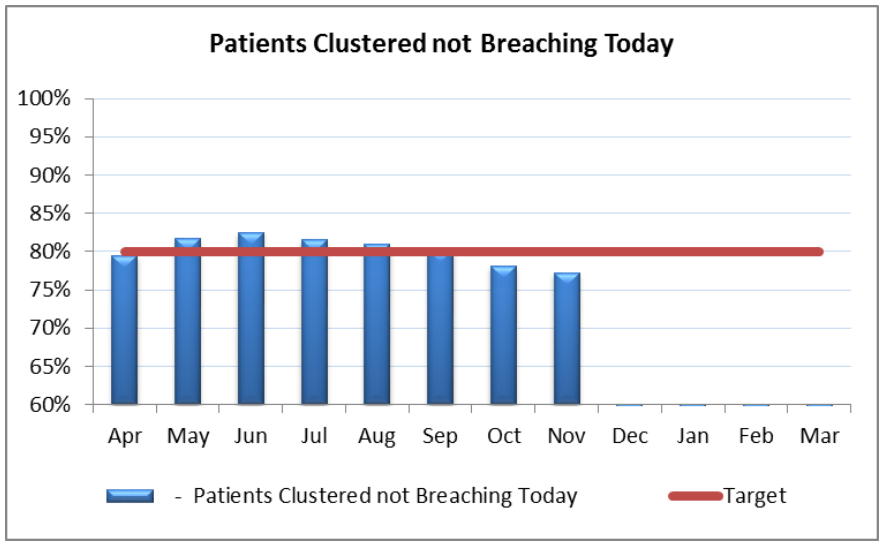
At the end of November there was a shortfall against the year to date plan of £1.346m. The full year amount of savings identified at the end of November reporting is £2.3m leaving a gap of £2.0m.

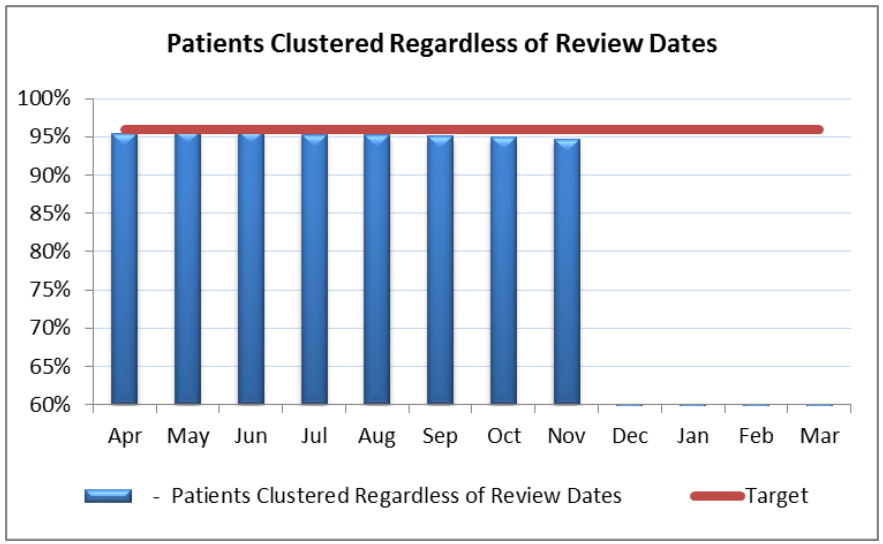
The forecast assumes that a further £0.4m will be achieved by the end of the financial year leaving unfound CIP of £1.6m. This underachievement is compensated for by cost avoidance and other underspends in the overall position.

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

Operational Section

Clustering



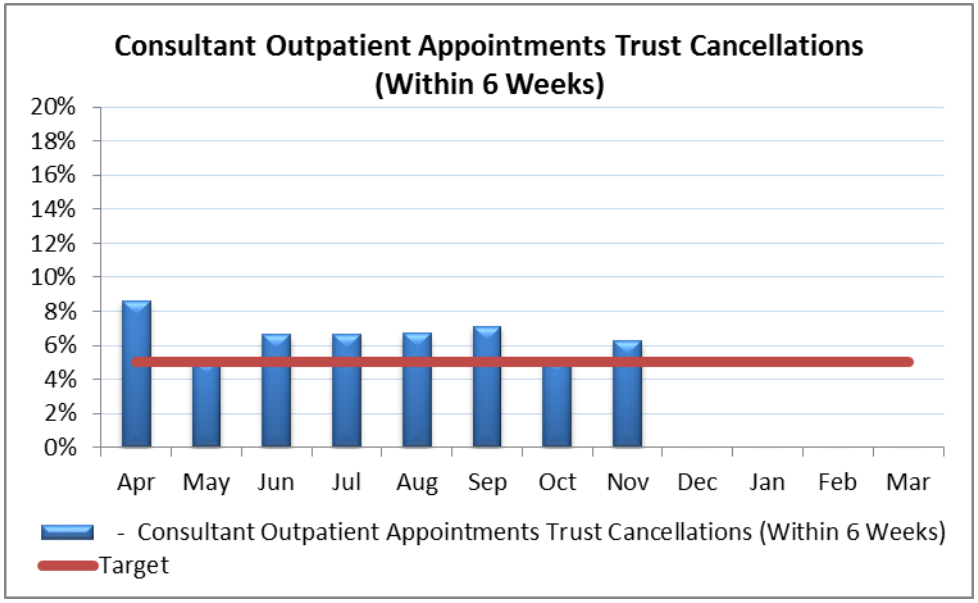


An action plan is being implemented. The actions relate to staff support and improvements to the IT system. Actions are due to conclude at the end of February (3), March (1) and April (4). The impact of these actions will be monitored by the Performance and Contract Overview Group (PCOG).

Other solutions being deployed on an ongoing basis:

- Associate Clinical Directors are reviewing at medical management meetings and being requested to raise with individual medics
- 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?” continues.

Consultant Outpatient Appointments Trust Cancellations (within 6 weeks)



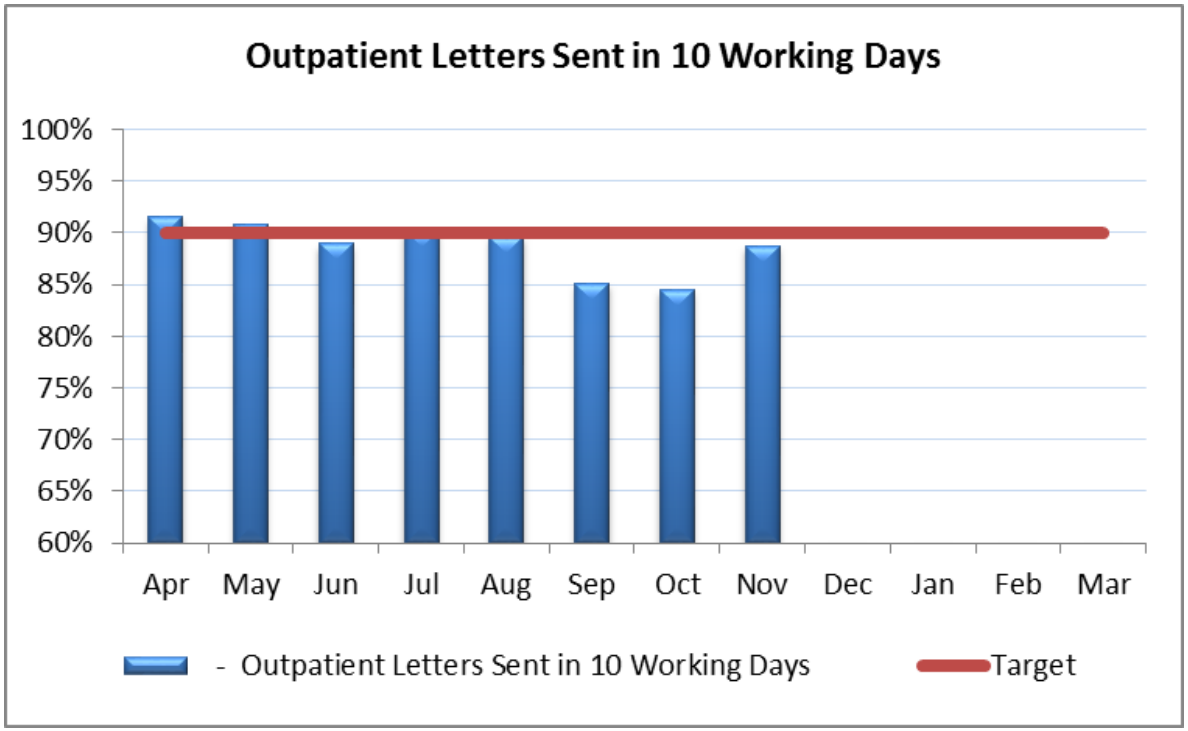
The main reasons given for cancellation in November were consultants being absent from work through sickness (44%), clinics being rescheduled to create capacity to see more urgent appointments (15%) and clinics booked in error (6%). 144 appointments had to be cancelled through consultant sickness absence. Wherever possible these appointments would be picked up by other consultants, however there is very limited capacity in the system to do so.

IM&T have now adapted Paris to enable the recording of cancellation reasons for individual appointments, not just whole clinics. We have started using this new reporting functionality to monitor reasons and minimise avoidable cancellations.

The rate of cancellations has continued to increase in December, the vast majority of which have been unavoidable (96%), however there were also 11 appointments cancelled for reasons of consultant annual leave.

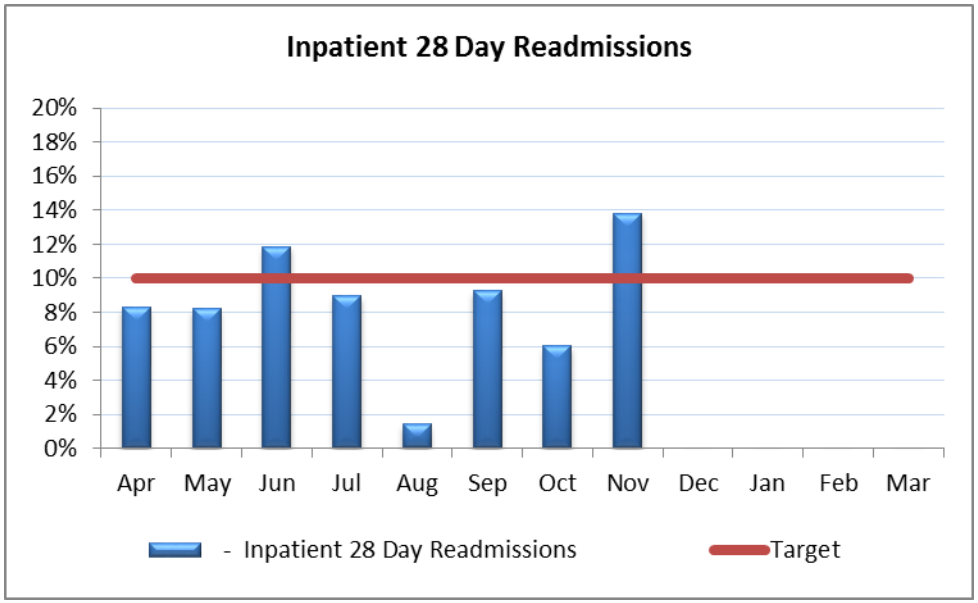
- Associate Clinical Directors to review cancellation reasons monthly and discuss with consultant(s) concerned where reasons do not appear valid, if applicable.
- Medical Director to re-brief all medics by 31/1/2017 of the requirement to book annual leave giving at least 6 weeks' notice to ensure patients are not inconvenienced.

Outpatient Letters Sent in 10 Working Days



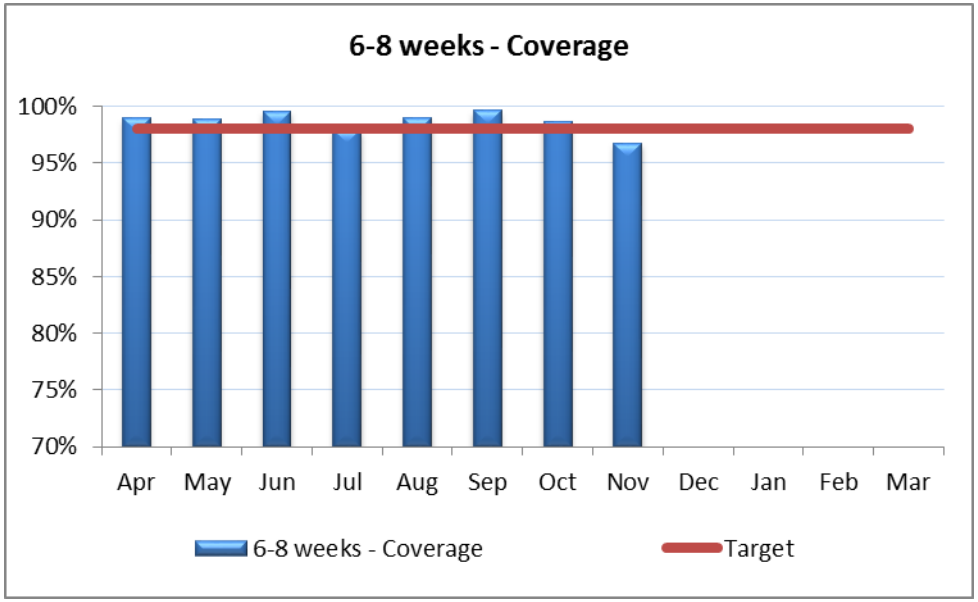
Following the upgrade of the Dictate.IT software in October we experienced quite a few residual issues which extended into November. These issues have now been resolved and the system is working properly, however it is likely we will also fall below target in December owing to sickness and annual leave having a significant impact on capacity. There is an expectation that performance improves from January 2017 onwards.

Inpatient 28 Day Readmissions



A review of the 28 day readmissions, to be undertaken by the Associate Clinical Director and Head of Nursing, has been commissioned. The detailed findings will be reported in January 2017. Pending the full report, initial verbal feedback would indicate that around a quarter of the readmissions in November were patients being transferred back from placements in Psychiatric Intensive Care Units, so were not specific 28 day readmissions against agreed criteria. The readmission rate in December is likely to be well below the target ceiling at around 4.5%.

6-8 weeks - Coverage



Low staffing levels continue to impact on achievement of the 6-8 week target. The funded establishment is 57.17 wte (work time equivalent) Health Visitors, compared with 47.16 wte staff in post. In addition there are 3.9 wte Health Visitors on maternity leave.

1.9 wte Health Visitors are currently working their notice to leave. 1.6 wte Health Visitors are on long-term sick and 1.4 wte Health Visitors are on a career break until May 17 and July 18 respectively.

Some progress is being made with recruitment, with 5 wte new starters expected to be in post by the end of March following a recruitment fair which proved successful. Another recruitment fair is planned for February.

WARD STAFFING

Ward name		Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Occupancy % Rate	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
AUDREY HOUSE RESIDENTIAL REHABILITATION	94.67%	158.9%	69.1%	186.7%	20.0%	Yes	We now work on 2RN staff to work a night shift. RN staff compared to NA staff we have more RN staff to ensure where possible we are working to 2RN at night and during the early and late shifts. Our establishment as been uplifted by 2 additional RN posts which means we loose 2NA posts – 1 as recently retired and 1 moved to the Beeches so we have not replaced these posts. Please note through November I had redeployed 2 NA staff to support Kedleston Unit for 3 weeks each which did have a knock on effect due to then having some sickness with annual leave previously granted and so some shifts may not have been filled by the bank and some covered by RN staff to ensure safe staffing across the unit.
CHILD BEARING INPATIENT	74.44%	112.2%	108.3%	113.3%	182.8%	Yes	Current fill rate tolerances for care staff on nights were broken due to long term sickness and engagement levels, particularly with regards to infant care.
CTC RESIDENTIAL REHABILITATION	86.52%	111.3%	94.0%	100.0%	100.0%	No	
ENHANCED CARE WARD	98.33%	86.7%	101.1%	68.3%	163.3%	Yes	We have at present outstanding RN Vacancies which we have ongoing adverts to recruit into. Have total of 1.2 RNs starting in January but have a 1.0 leaving. Also have 5.6 NA Vacancies out to advert. All shifts covered by trust employed RN.
HARTINGTON UNIT - MORTON WARD ADULT	96.81%	98.9%	126.1%	56.9%	202.8%	Yes	We are currently carrying some Band 5 vacancies and therefore cannot always roster x2 qualified staff on night shift. These vacancies are also often covered by unqualified staff. We are also carrying Band 3 vacancies on the ward.

WARD STAFFING

Ward name		Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Occupancy % Rate	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
HARTINGTON UNIT - PLEASLEY WARD ADULT	94.50%	113.1%	82.9%	81.5%	122.0%	Yes	A HCA remains removed from duty, the ward skill mix is also biased towards registered staff in light of the population the ward serves i.e. 12 older adult beds/8 adult. Our O/A population often requiring more intensive nursing. This accounts for the 84% cited for care staff on days. The ward also continues to carry x1 Registered nurse vacancy (identified staff member to commence at start of January 2017), and x1 band 5 who is currently seconded into a lead nurse (Band 6) role. This shortfall, again with the usual pressures of A/L, training, sickness etc. have meant the ward has not been able to place x2 registered nurses on every night shift, this has inevitably been covered by the use of HCA staff resulting in the breach of night figures.
HARTINGTON UNIT - TANSLEY WARD ADULT	98.06%	101.1%	100.8%	50.0%	200.0%	Yes	Tansley Ward has broken the fill rate rules on skill mix on night duty for the month of November. The planned number of registered staff on night duty is 2 however throughout November there was only ever 1 registered nurse on duty. Rationale for deficits on night duty: • There are currently 4.4 wte vacancies at Band 5 and 1 x Band 5 on special leave with no provisional date for return. • All posts are open to the rolling recruitment programme and we are actively looking for staff to fill the vacancies. One nurse was recruited at the recent recruitment fayre in Derby last month however she is still a student and will not qualify until September 2017 and as such unavailable until that time. • Of the staff currently in post 5 registered nurses are under preceptorship having recently commenced in post and are working predominantly day duty as part of their induction to the ward and role. From December onwards they have had periods of rotation onto night duty bringing some of the night shifts in December up to the required numbers. • Although the skill mix did not meet the planned requirements registered nurse deficits were covered by Bank HCAs and minimum staffing numbers were met. Going forward there will be scope to plan to increase the number of registered nurses on night duty taking into account remaining vacancies sickness, training and annual leave to be more in line with requirements.

WARD STAFFING

Ward name		Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Occupancy % Rate	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
KEDLESTON LOW SECURE UNIT	82.33%	102.3%	101.8%	103.3%	100.0%	No	
KINGSWAY CUBLEY COURT - FEMALE	65.93%	80.3%	109.3%	70.0%	114.4%	Yes	R/N tolerances rates have been broken due to current R/N vacancies. We are actively recruiting, and have some new starters in the New Year.
KINGSWAY CUBLEY COURT - MALE	71.30%	64.9%	118.0%	63.3%	137.8%	Yes	R/N tolerances rates have been broken due to current R/N vacancies. We are actively recruiting, and have some new starters in the New Year.
LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP	86.04%	108.3%	72.1%	78.3%	159.9%	Yes	Registered staff have been moved due to short term sickness/vacancy days and nights x 13 over the course of the month Additional RN band 5 seconded to CCM for 6 months to cover vacancy Additional LN band 6 to support audit other ward x 3 shifts Bank shift requested unfilled No agency use Bleep shifts Band 6/7 off site x 10 shifts this month Training commitments 13 RN band 5 and 5 NA band 3 shifts
LONDON ROAD COMMUNITY HOSPITAL - WARD 2 OP	61.88%	103.3%	84.3%	100.0%	108.3%	Yes	The reason why the day staff nursing assistants are showing at red is because the ward has had low patient numbers so we have sent staff to support other areas on a regular basis
RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT	103.67%	97.0%	96.3%	93.5%	98.9%	No	
RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT	101.50%	100.0%	97.6%	65.2%	164.6%	Yes	Ward 34 continue to carry a large number of vacancies and currently have an increase number of nurse under preceptorship, we are currently unable to facilitate 2 qualifier nurse on nights but is constantly being reviewed.
RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT	100.33%	90.5%	108.3%	76.5%	126.7%	Yes	We have fallen below required level of qualified due to maternity leave and vacancies. These shifts have been covered by unqualified.
RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT	100.50%	97.2%	97.7%	100.0%	108.1%	No	

Workforce Section

WORKFORCE DASHBOARD

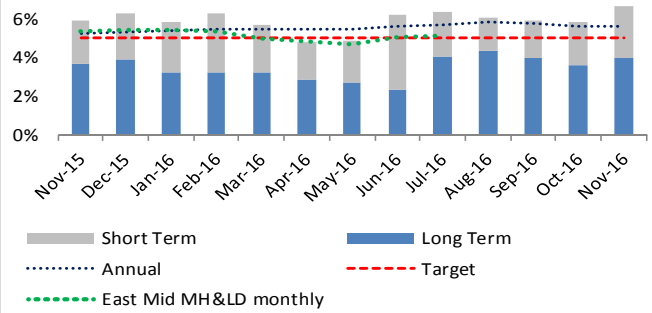
Wellbeing

Sickness Absence

(Monthly)

Sep-16	Oct-16	Nov-16
5.89%	5.85%	**6.65%**

Target 5.04%



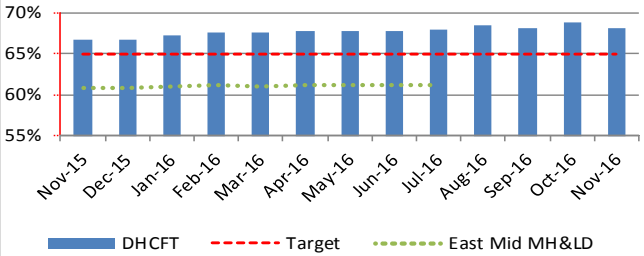
The Trust annual sickness absence rate is currently 5.60%. The monthly sickness absence rate is 6.65% which is 0.80% higher than in the previous month (an increase of 0.35% in long term absence, notably surgery, and 0.45% increase in short term, notably cold, cough, flu - influenza) and it is also 0.78% higher than in the same period last year (November 2015). Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 27.97% of all sickness absence, followed by Surgery at 13.17% and cold, cough, flu - influenza at 9.65%.

Qualified Nurses

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

Sep-16	Oct-16	Nov-16
68.07%	68.75%	**68.09%**

Target 65%



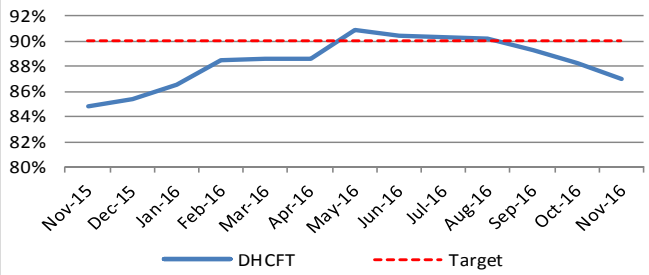
Contracted staff in post qualified nurses to total nurses, midwives, health visitors and healthcare assistants is running at 68.09%. Vacancy rates can impact on this measure. The average for East Midlands Mental Health & Learning Disability Trusts is 61.19%. Health Visitors represent 5.36% of the Trust total and are not included in the Qualified Nurses calculation. Healthcare Assistants and Nursing Support staff represent 26.55% of the total.

Compulsory Training

(Staff in-date)

Sep-16	Oct-16	Nov-16
89.26%	88.22%	**86.94%**

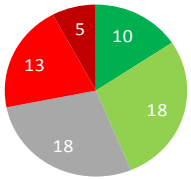
90%

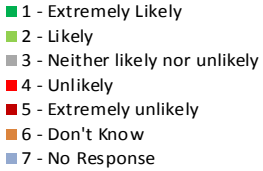


Compulsory training compliance continues to remain high running at 86.94%, although a decrease of 1.28% compared to the previous month. Compared to the same period last year compliance rates are 2.51% higher. Compulsory training compliance remains above the 85% main contract commissioning for quality and innovation (CQUIN) target and is slightly below the Trust target.

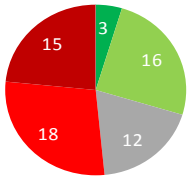
Staff FFT Q2 2016/17 (In-Patient campus focus; 64 responses, 10.08% response rate) & Staff Survey 2015

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.

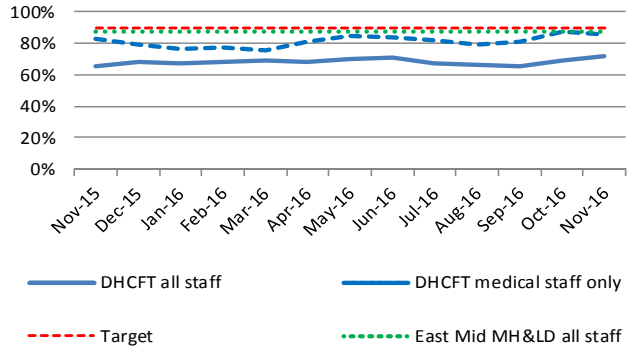


	2014	**2015**	National Average
Overall staff engagement	3.75	**3.73**	3.81

Appraisals

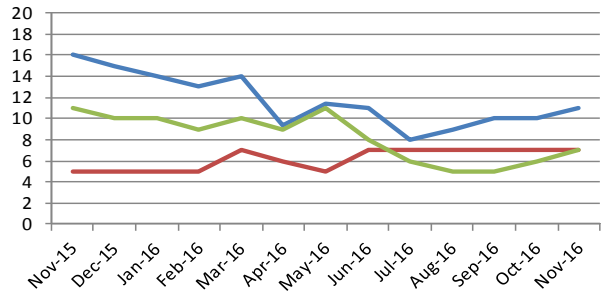
(All staff)	Sep-16	Oct-16	**Nov-16**
	65.88%	68.66%	**72.24%**

Target 90%

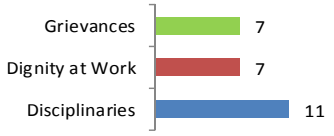


The number of employees who have received an appraisal within the last 12 months has increased by 3.58% during November 2016 to 72.24%. Compared to the same period last year, compliance rates are 6.70% higher. Medical staff appraisal compliance rates are running at 85.59%. According to the 2015 staff survey results, the national average for Mental Health & Learning Disability Trusts is 91%. Local benchmarking data for a range of Trusts in the East Midlands shows an average completion rate of 82.86%.

Grievances/Dignity at Work/Disciplinaries as at 30/11/16



There are 7 grievances currently lodged at the formal stage, 1 new grievance has been lodged and efforts continue to resolve the issues. There are 7 dignity at work cases currently lodged, no new cases and efforts continue to bring existing cases to a conclusion. There are 11 disciplinaries in progress, no further cases have been resolved and 1 new case have been received.

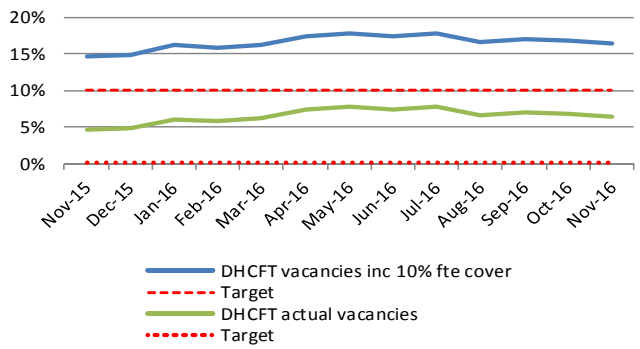


WORKFORCE DASHBOARD

Attendance

Vacancy

	Sep-16	Oct-16	Nov-16
(Budgeted full time equivalent) Including 10% funded fte flexibility/cover	16.92%	16.82%	**16.40%**
Actual	6.92%	6.82%	**6.40%**

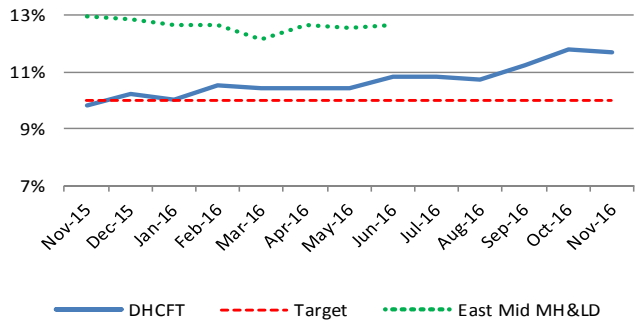


Target 10%/0%

The Trust target for contracted staff in post is 90% which allows 10% funded full time equivalent (fte) surplus for flexibility including sickness and annual leave cover in In-Patient areas. The budgeted fte vacancy rate has decreased by 0.42%. April 2016 included additional full time equivalent investment for 2016/17. New recruitment activity during November 2016 was for 94 posts. 57% were for qualified nursing, 16% admin & clerical, 15% additional clinical services, 6% prof / scientific / technical, 4% allied health professionals and 2% medical.

Turnover

	Sep-16	Oct-16	Nov-16
(Annual)	11.25%	11.79%	**11.71%**

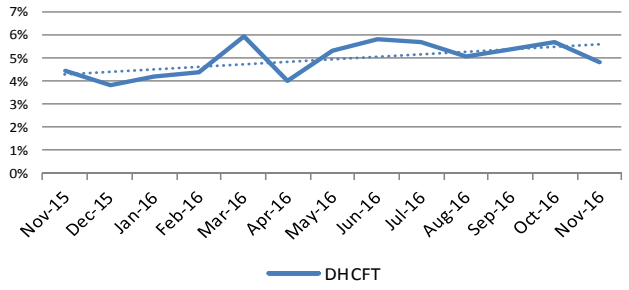


Target 10%

Annual turnover remains within Trust target parameters at 11.71% and is below the average for East Midlands Mental Health & Learning Disability Trusts. The number of employees leaving the Trust has risen in previous months to an average of 22.9. During November 2016 18 employees left the Trust which included 3 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

	Sep-16	Oct-16	Nov-16
(Spend)	5.39%	5.65%	**4.79%**



Total agency spend in November was 4.79% (5.52% including medical locums). Of total agency and locum spend for all staff groups, Qualified Nursing represented 1.6%, Medical 2.2% and other agency usage 1.0%. Agency Qualified Nursing spend against total Qualified Nursing spend in November was 4.1%. Agency Medical spend against total Medical spend in November was 13.5%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £1.332m of which £726k related to Medical staff.

Quality Section

Strategic Risks (Board Assurance Framework)

Risk Description	Risk rating	Trend
1a) Failure to achieve clinical quality standards	HIGH	⟷
1b) Lack of compliance with equality legislation	HIGH	NEW
1c) Risk to delivery of care due to being unable to source sufficient clinical staff	HIGH	NEW
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	⟷
3c) Risk that turnover of the Board members could adversely affect delivery of the organisational strategy	MED	⟷
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 significant change. V4 of BAF in process of update for Audit and Risk Committee Jan 2017.

Clinical Risks (Significant). *The list below relates to themes from across a number of risk assessments recorded on Datix*

Risk Description	Risk rating	Trend
Significant staffing level risks across a number of service areas remain: Radbourne Unit, pharmacy, paediatricians, psychology, neighbourhood teams., Memory Assessment Service Since last reported Children in Care have identified a high staffing level risk . A number of risks associated remain with exceeding of the agency cap for reasons of patient safety	HIGH	⟷
Associated with the number of staff vacancies, risks related to work related stress and increased risks of violence and aggression on the Radbourne Wards remain	HIGH	⟷
Increased risk of fire identified on some inpatient wards associated with the smoking ban continues to be raised, although currently no increases in actual fires	HIGH	⟷
Risks with respect to discharge from the DRH and transfer across neighbourhood boundaries. remain	HIGH	⟷
Recent high level risks have been identified in relation: patient transport to out of area beds; and access to e-learning within the Trust.	HIGH	⟷

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 11 January 2017

Quality Position Statement

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

Executive Summary

This position statement sets out:

1. Care Quality Commission (CQC) report, family liaison, access to psychological therapies and suicide prevention. Influencing the system and monitoring
2. Quality leadership engagement
3. Quality visits and methodology
4. Quality leadership teams and CQUIN (Commissioning for Quality Innovation) developments and leadership and engagement strategy
5. action planning

Strategic considerations

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

(Board) Assurances

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

Consultation

This paper has not been previously presented but does reference information available to the Quality Leadership Teams and quality governance structures

Governance or Legal issues

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

Equality Delivery System

Any impacts or potential impacts on equality have been considered as part of all our quality work, the risks to older men of working age remains a focus of the suicide prevention strategy and work plan. There are no significant changes too this data to change the plans from an equalities perspective. The national CQUINs are included there is a potential risk that in this work to reduce non-essential attendances at Accident and Emergency there may be unexpected consequences to patients with mental health problems if this has the

unexpected consequence of diagnostic over shadowing, that patients with complex health conditions miss the opportunity to have a full physical healthcare screening as they are deemed to have a primary mental health condition. The Trust clinical team will take into account a full physical healthcare triage in ensuring the safest and most appropriate use of resources.

The report details the direct equalities work planned as part of our PSED (Public Sector Equality Duty) in the planning of this event, key equality challenges have been included. Although the transgender community is a small community group, this is a group with significant stigma and challenge. Experiencing the world as a different gender than the one assigned to you at birth can take a toll. Nearly all research into transgender individuals' mental health shows poorer outcomes. A study looking specifically at transgender women, predominantly women of colour, only further confirms that reality.

What is less clear, however, is whether trans individuals experience more mental distress due to external factors, such as discrimination and lack of support, or internal factors, such as gender dysphoria, the tension resulting from having a gender identity that differs from the one assigned at birth.

Transgender people are often treated extremely poorly by their parents, by their schools, by society at large, and that can lead to problems in school and at work, as well as poverty and increased risk of substance use. This makes this community a key group to consider that their rights and access to appropriate and effective services are protected.

Recommendations

The Board of Directors is requested to:

1) Receive this quality position statement.
2) Gain assurance, be advised on quality leadership strategy and engagement and information on its content and seek clarity or challenge on any aspect of the report.

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

QUALITY POSITION STATEMENT
December 2016

1. SAFE SERVICES

1.1 The CQC (Care Quality Commission) published its review of learning, candour and accountability

The Trust is completing a review of this paper which will be led by the Quality Committee, the Medical Director and the Lead professional for Patient Safety and will also involve a review with Commissioners at the joint quality assurance meeting in January.

The Trust has historically struggled with Family Liaison and investigation. There is evidence that in 2013 and 2014, there were incidences where involvement in investigations and Family Liaison would have been a positive service offer in 2014. The service gradually developed and in 2015 and 2016, the Family Liaison service has become more defined in its service offer. This includes support in directing and influencing investigations, direct information support, support at Coroner's court, offers for family psychological support or psychological support to children.

Our Family Liaison team does offer access to key materials and voluntary groups such as survivors of bereavement by suicide.

Bereavement by suicide shares characteristics with other bereavements and it is also different. Understanding how and why it differs is helpful when you are supporting people who have been bereaved. The grieving process is often complicated and typically lasts longer than other types of bereavement – significant effects may still be felt for many years after the death. We are all individuals and each person will have had a unique relationship with the person who died – there is no single or correct way to experience bereavement. However there are many common reactions and factors in bereavements by suicide.

Aspects of the experience of bereavement by suicide which make it different can include:

- Circumstances of the loss
- Emotional and physical reactions
- Post traumatic stress
- The survivors questions – "why?" and "what could I have done?"
- Stigma and isolation
- Family and community tensions
- Other prejudices
- Lack of privacy
- Investigations
- A key risk to the person is through their own elevated risk of suicide, as death of loved one can add significant risks to the person themselves

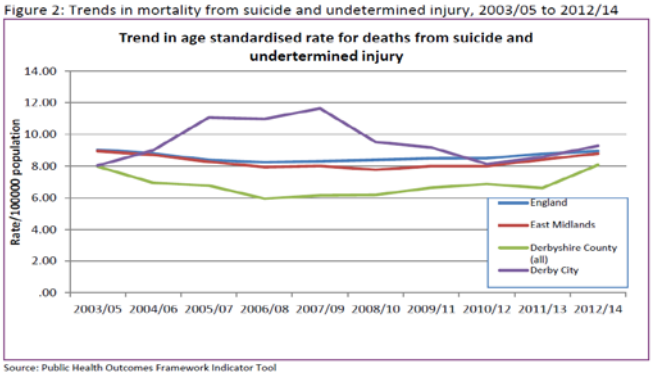
The majority of individuals who commit suicide do not have a diagnosable mental illness. They are people who at a particular time are feeling isolated, desperately unhappy and alone. Suicidal thoughts and actions may be the result of life's stresses and losses that the individual feels they just can't cope with. This places family and friends bereaved through loss, through physical health or suicide at higher risk.

The Derbyshire completed suicide rate is rising significantly and the last published information stated that
https://observatory.derbyshire.gov.uk/IAS/Custom/Resources/HealthandWellbeing/Suicides_in_Derby_and_Derbyshire_report_2014.pdf

Executive Summary

- This report provides analysis on the deaths from suicide and undetermined injury of residents of Derbyshire County and Derby City that were registered in 2014. Additional information on deaths from suicide and undetermined injury registered in 2013 is included in the Appendix.
- The number of deaths from suicide and undetermined injury has risen in both Derby City (from 20 in 2013 to 25 in 2014, a 25% increase) and Derbyshire County (from 46 in 2013 to 86 in 2014, an 87% increase).
- The age-standardised rates of deaths from suicide and undetermined injury in Derby City and Derbyshire County are statistically similar to the England rate.
- Approximately three-quarters of the deaths registered in Derbyshire in 2014 were men.
- The highest age-specific rate of death from suicide was in those aged 40-49 years, with a similar pattern observed in males and females.
- At a district level, Chesterfield had the highest rate of deaths from suicide and undetermined injury, and was the only district that observed a statistically significant change in rates between 2013 and 2014.

Figure 2: Trends in mortality from suicide and undetermined injury, 2003/05 to 2012/14



Source: Public Health Outcomes Framework Indicator Tool

Table 3: Age-standardised rates of deaths from suicide and undetermined injury per 100,000 population, 2003/05 to 2012/14

A problem that is developing is the Trust's own clinical capacity to offer psychological support proactively to families of those bereaved by suicide or in serious incidents. Most

family members or children would be placed upon a waiting list for psychological therapy or family support. This will be raised with both Derbyshire and regional commissioners on any ideas how support could be offered in these types of families and cases.

Action:

1. The Quality Committee to lead the review of this published paper on publication of the revised investigation framework in 2017. The Lead Professional for Patient Safety will adopt this into Trust practice.
2. The Executive Director of Nursing and Patient Experience to explore ideas with both Derbyshire and regional Commissioners, on how to implement this psychological support to families.
3. The increases in the suicide rate for our community not open to Mental Health services will be carefully monitored by the Trust and the Derbyshire public health led interagency suicide reduction plan.

4. WELL LED

4.1 Quality Leadership

The Executive Director of Nursing and Patient Experience attended a Quality governance CPD (Continuing Professional Development) event with the Quality Leads in the services. The events explored Quality Governance and models of how this has developed over the years. Also discussed, was the new Trust management group, streamlining of meeting structures to integrate the senior management team and QLT (Quality Leadership Team) structures. There was good attendance and debate and future events will be considering bottom up approaches to quality governance, ideas for communications, developing share understanding on collective leadership and learning from the Kings Fund and other organisations in quality improvement.

4.2 Findings From Quality Visits

The Quality visit programme was completed and the Quality visits awards were presented in December 2016. This was a well-received event and positive for our staff in recognising their achievements.

- **Effectiveness Award: Liaison Team South, based within Royal Derby Hospital**
  The team provides advice, support and a signposting service where potential mental health and/or drug and alcohol issues are identified. Following referral from a health professional in the emergency department or an inpatient ward within the Royal Derby Hospital. The team offer an intervention, assessment and discharge process that covers all aspects of mental health - including drug and alcohol use and self-harming. The team won an award at Derby Teaching Hospitals annual awards ceremony earlier this year, in recognition of the value that they bring to the Royal Derby Hospital.

- **Patient Experience Award: Killamarsh and North Chesterfield Neighbourhood Team**
  This service has a long tradition of working closely with local community centres, farms and leisure centres to provide creative and constructive opportunities for service receivers in non-stigmatising environments. The team have an inclusive approach and work closely with a peer support worker to provide those they care for with hope.

- **Patient Safety Award: Criminal Justice Mental Health Liaison Team, Derby**
  This team provides an innovative screening service at several points within the Criminal Justice system. This allows early detection and assessment of offenders with mental health problems to ensure the most appropriate and effective outcomes.

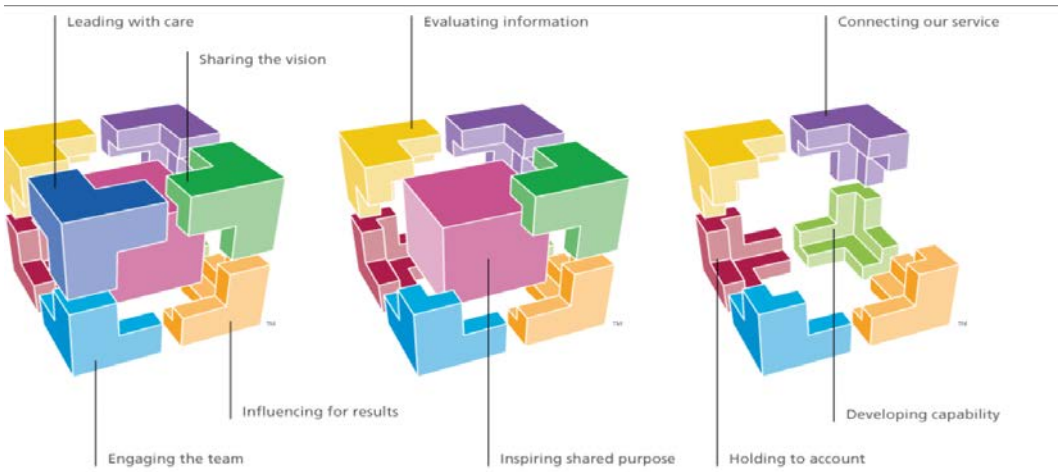
- **Team of the Year Award: Child and Adolescent Mental Health Services (CAMHS)**
  The CAMHS team were rated 'outstanding' by the CQC inspectors earlier this year, and received this award for introducing new services – including a new eating disorders service – and for developing a single point of access, to speed up referrals.

- **DEED of the Year Award: Andrea Anthony and Tina Daly, Derbyshire Substance Misuse Service**
  Andrea and Tina witnessed an individual known to the team (but not an open client) collapsed outside public toilets in Ilkeston. Being aware that the person was at high risk of overdose, they went to check on him and decided he was likely experiencing a Heroin overdose. They called an ambulance but also made the decision to administer Naloxone to him immediately, to block the effects of the heroin. Their quick response and action brought the individual round from the overdose and almost certainly saved a life.

Our amazing flu peer vaccinators were also recognised as part of the ceremony for their work in enabling colleagues to get the flu jab. Collecting the award on their behalf was Julie Carvin, who organised the flu peer vaccinator scheme.

The methodology behind quality visits is to inspire innovation, enable and the celebration of good practice and sharing good practice across the organisation to cross fertilise innovation, which is a key component of inspiring shared purpose and our Trust strategy and vision.

Leadership academy, the Healthcare Leadership model (2016)



4.3 CQUIN for 2017/2018

As part of the 2017/18 CQUIN (Commissioning for Quality Innovation) requirements, there is a focus on the following CQUINs as set nationally

Staff Wellbeing and Catering, Wellbeing and Flu inoculations - Liz Bates and a named Dietician - oversight by People and Culture and led by Julie-Ann Trembling and the flu team with Julie Carvin and Hayley Darn in support.

Mental Health Liaison and a 20 per cent reduction and to explore the potential to reduce and offer more effective alternatives to reduce avoidable A&E presentations – Bob Gardner, Lesley Fitzpatrick, Dr Simon Thacker, Brenda Rhule and Karen Wheeler.

Severe Mental Illness and Improving Physical Health - Hayley Darn, Dr Mahendra Kumar, Bill Rollings

Transitions out of Children and Young People's Mental Health Services - Improving the Patient Experience and Enabling Safe and Effective Transition - Scott Lunn, Richard Morrow, Brenda Rhule, Karen Wheeler, Lead professional for Children's and CAMHS on appointment, Tina Ndili and Anne Cox.

The teams will be requested to model a collective leadership model to across pathways and actively communication with their clinical teams on their ideas to deliver the CQUIN.

The methodology will include:-

1. Hold a meeting and brainstorm
2. An outline plan
3. A presentation for the Quality Leadership Teams and SMT's on what they need to do and how they will contribute to achieving this in January
4. A presentation to Executive Leadership Team on the plan and trajectory for achievement in January
5. A paper to the Quality Leadership Team on the CQUINs and a summary of the developed plans and ideas in February
6. A schedule for reporting with timescales against the plan for the teams and ensuring this includes clinical team briefings and explicit requirements for them to be involved and share ideas
7. An outline of any resources needed to implement the CQUIN
8. An outline risk review- any risks to delivery

Involving Service receivers and carers in Trust developments and briefing on Trust wider system developments

Planning for our equalities events in March 2017

The Trust will be submitting presentation for scrutiny for its equalities developments and formal submissions and key quality aspects from all areas of the Trust will be submitted.

1. Quality strategy and policy
2. REGARDS (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual Orientation) case studies and stories to show good practice and service user involvement
3. Health promotion and stigma - Substance Misuse
4. Feedback, Complaints and Compliments FFT (Friends and Family Test), etc (triangulated)
5. Incidents
6. Care planning
7. Trans-gender policy developments
8. Childrens services adapting to meet the needs of children with disabilities
9. Suicide prevention strategy group

4.4 Care Quality Commission Comprehensive Inspection

The CQC full inspection report was published on 29 September 2016. We continue to work on our action plan. December has been a busy month with continued progress in all areas of the CQC portal and progress on actions in all areas.

In addition, in December 2016 we submitted additional evidence and the Trust also received an unannounced inspection of the Kedleston unit. We look forward to receiving our re-inspection report in January 2017 for factual accuracy checks and publication in January to February 2017.

Report prepared and presented by
Carolyn Green, Executive Director of Nursing and Patient Experience

Board Committee Summary Report to Trust Board
Audit & Risk Committee – 13 December 2016

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Draft Minutes of the Audit & Risk Committee meeting 11 October 2016	Minutes of the previous meeting	Agreed as an accurate record	-	Agreed for inclusion in next Public Board papers	-
Actions Matrix **Matters Arising**	Updates noted	Completed actions agreed	-	-	-
Overview of complaints and themes (for assurance)	Carolyn Green presented the report on Complaints, Concerns and Compliments which focussed on process, systems and balances as per the oversight role of the Audit and Risk Committee	Partial assurance was received as performance was not fully complaint with timelines. There was assurance relating to 100% of acknowledgements issued within the 3 day target. Trust response times for complaints benchmark well with other organisations and there is significantly improved performance compared to last year. The CQC inspection raised no concerns. The increasing number of patient concerns was noted as positive as this reflects informal resolution. Investigators have been approved to help improve performance.	There is a risk to maintaining performance levels – this is monitored through the Quality Leadership Teams.	In-reach visit to patient experience team to be offered to NEDs.	-

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Update on Raising Concerns (Whistleblowing) arrangements	Sam Harrison outlined details of the Raising Concerns process and cases raised with the Freedom to Speak Up Guardian since April 2016.	Details of the cases were presented. No themes were emerging as yet but it was noted that several cases had been redirected to be resolved through HR processes. Raising concerns awareness is to be promoted through the Trust's Engagement Forum. Timescales to be included in future reports to allow effective oversight of process. CQC data as received by Carolyn Green to be incorporated into future reporting.	FSU Guardian is moving on from the role. New NED (Margaret Gildea) has been identified following departure of Jim Dixon.	It was agreed that a remedy approach be explored and that staff support should be provided when allegations are not upheld.	-
Draft Risk Management Strategy	Rachel Kempster presented the final draft of the Risk Management Strategy which has been developed over recent committees and through working with the Committee chair and Director of Corporate Affairs	Updated detail was noted on risk management, risk tolerance and risk appetite. Agreed as effective and comprehensive document. There was assurance given in relation to team training, guidance and 1:1 training provided on risk management processes within the Trust.	None	2017/18 objectives were agreed. The focus on Risk Management/BAF at the Board Development Session on 8 Feb 2016 was noted. Strategy approved subject to amendments to reflect perception of impact of risk. To be disseminated to all staff.	-

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Deep Dive BAF Risk 1a Clinical Quality	Carolyn Green outlined progress in the management of this BAF risk.	CQC feedback from their inspection indicated that there were no areas of harm. Clinical controls are in place to mitigate this risk. Actions agreed to include focus on commissioners, quality improvements and investment.	Risks and mitigating factors were outlined as part of the report. Quality Leadership Team effectiveness is a risk due to the importance of their role. Gaps in control to be addressed.	Agreed to support the risk to remain at 16 (4x4)	**-**
GIAP Update against Core 4 Recommendations	Sam Harrison presented the update on GIAP actions that fall to the Audit and Risk Committee (Core 4). This included presentation of five blue completion forms for approval for onward referral to the Trust Board.	Assurance received with evidence as outlined – blue forms agreed.	-	Agreed to be forwarded to January Trust Board for sign-off.	As part of regular GIAP report
GIAP Progress report against ClinG2	Rachel Kempster and Susan Spray presented details of the work undertaken to address this GIAP recommendation	There was noted to be good progress in the number of policies reviewed as fit for purpose. Assurance was received that the policy review group has been re-established and is working effectively. Management development programme is now underway to ensure staff are aware of key HR policies.	Systems and processes in place that keep up to date and scrutiny and challenge for fit for purpose.	Agreed that this is a completed GIAP recommendation.	To be included as part of GIAP Board report

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
EXTERNAL AUDIT					
Indicative Audit Plan	Mark Stocks presented the indicative audit plan. 2016 Value statement	Details of audit approach and standard significant and other risks were noted. Performance against KPIs and added value report provided assurance of good performance of external auditors.	-	Sector emerging issues and developments to be shared with ELT. Client satisfaction review to be arranged by Grant Thornton.	**-**
INTERNAL AUDIT					
Update on previous audit recommendations	Ali Breadon gave an overview of the reports noting that these had focussed on areas of known concern for the Trust.	Limited assurance received due to lack of compliance with identified audit findings.	Internal monitoring of updates was not reflected in internal audit findings	Oversight of actions to be determined by Executive Director leadership. To be discussed at Executive Leadership Team.	To be escalated to Board as a potential area of concern
Consultant Job Planning	Ali Breadon outlined key high risk issues and areas for action	Limited assurance received – high risk audit. John Sykes to work with Associate Clinical Directors to ensure job plans are completed by the end of the year.	-	Potential to develop job planning framework.	**-**
S.132 Patient Rights	This audit focussed upon follow up on one of CQC issues raised.	Limited assurance (medium). Carolyn Green provided assurance that recent checks indicated 87% compliance. Ongoing oversight by Mental Health Act Committee to ensure compliance, with assurance reported to Audit and Risk	-	To be reported back to Mental Health Act Committee.	Referral to MHAC

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
		Committee.			
Data Security	Medium risks had been found regarding lack of formal process for information classification.	Partial assurance received. Issues raised around supplier due diligence regarding compliance with our policies.	-	Actions required noted.	**-**
Agency controls	Details of the audit findings were outlined. Mark Powell provided further evidence in response to the audit given the high risk findings.	Weekly agency meetings are now held, overseeing these actions and wider areas. Assurance was provided that action is being taken and regular review and reporting is underway.	Ongoing risk of agency spend above set thresholds (impacting on Single Operating Framework ratings)	Noted.	Agency controls is reported monthly to Trust Board.
Key Financial Systems (data)	This was outlined to be a low risk findings report.	Partial assurance was provided. There are low levels of overtime - some housekeeping areas have overtime arrangements in place relating to income generating events.	-	-	**-**
Head of Internal Audit Opinion (to date)	Interim Head of Internal Audit Opinion	The opinion has dropped a category from the previous year. Details will be used to inform the Trust's Annual Governance Statement. Thanks were given to PWC for their internal audit work with the Trust	-	Head of Internal Audit Opinion to be used in drawing up of the Trust's Annual Governance Statement.	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
INTERNAL AUDITORS – KMPG					
Progress report and draft plan for remainder of 2016/17	Sophie Jenkins presented the draft report for internal audit activity for the remainder of 2016/17	Assurance was received that plans are being developed for Internal Audit for the remainder of the financial year and for the ongoing programme for 2017/18	-	Work relating to conflicts of interest was noted and Caroline Maley and Sam Harrison are to review. The draft plan was noted	**-**
Counter Fraud – verbal update and technical update	Laura Weaver gave a verbal update on progress to implement a full fraud risk assessment in January 2017.	The technical update was noted. A self-review tool is to be completed for the Trust against the standards in January for submission by April.	-	Self-review to be presented to March Audit And Risk Committee. Carolyn Green to forward recently undertaken security risk assessment to KPMG.	**-**
Interim Counter Fraud report to end of contract (Penny Gee)	Penny Gee presented the interim annual report on Counter Fraud activity.	There has been a handover to KPMG for ongoing counter fraud services. There is one outstanding issue where 360 Assurance will retain a file. KPMG and 360 Assurance are to liaise to complete the standard self-assessment. The report provides assurance of demonstrable embracement of anticrime strategy within the Trust. Assurance was also provided that a robust handover is being undertaken. KPMG are to undertake a full fraud risk assessment and identify	-	Agreed this report to inform work by internal A verbal update will be provided to the January meeting and a written report provided for the March Audit and Risk Committee meeting.	**-**

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
		areas for focus of ongoing work.			
Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework	Updates noted as per agenda items. Sam Harrison updated that the BAF had been presented to NHSI as part of the Trust's routine Performance Review Meeting on 12 December 2016.	Suggestions for development of BAF reporting were noted.	It was noted that compliance issues were emerging across audit areas.	-	The emerging theme of compliance is to be escalated to the Trust Board.
2016/17 Forward Plan	Rachel Kempster requested that the regular update on internal audit recommendations progress be reported quarterly to the Committee.	Annual work plan of the Committee to be amended to reflect quarterly update on the implementation of internal audit recommendations.	More regular updates scheduled due to risk of non compliance	Quarterly reports to be scheduled	**-**
Meeting Effectiveness	Meeting noted to be effective although extended longer than planned.	**-**	**-**	**-**	**-**

Board Committee Summary Report to Trust Board
Quality Committee - meeting held on 15 December 2016

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Minutes and Actions	Agreed and ratified	Good assurance			
Quality Dashboard	Significant improvement Detailed discussion on the information and actions already in place, demonstrating progress.	Good assurance on planning	Clinical and management performance of supervision	Additional weekly monitoring by COO remains in place.	
CQC Action Plan	Significant improvement and good assurance on progress. Terms of reference reviewed with review and challenge.	Good assurance partial assurance due to being a work in progress	None currently identified	Evidence presented and agreed Quality Committee Group to have additional detail and agreed	
Healthwatch complaints report	Listening to the voice of the community through Healthwatch Derby Patient experience an negative experiences of complainants in a 2015 survey Expectations and commissioning specifications Responsiveness of investigators Verbal feedback on	Partial assurance Risk and audit committee have evidence of improved performance on acknowledgment but still below standard performance in complex investigation responsiveness Development work with service receivers group on mutual expectations and exploring service offer	Complaints responsiveness is a known concern and requires investment in an investigators model Risks to delivery in outline business case, if contract settlement requires significant disinvestment there is a risk to delivery	Evidence presented and received a further follow up meeting to explore operational detail and concerns To add complaints response times to the integrated dashboard	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
	operational experience and performance not in report Concerns expressed re recurrent themes of the crisis team and learning An example of a front door presentation and the subsequent responsiveness of the investigation team An example that a service manager has informed Healthwatch that complaints responsiveness are not supported by central services	Exploration with ASM on expectations of their role in complaints handling feedback through operational managers on this feedback. Feedback to the crisis team on Concerns expressed re recurrent themes of the crisis team and their learning			
Healthwatch Crisis report	Listening to the voice of the community through Healthwatch Derbyshire. A sample size of 40 respondents, and feedback on both Trust and non-Trust services and an associated action plan	All recommendations accepted Action plan accepted	Trust recommendations can be implemented however concerns were expressed about non-Trust services and change	Action plan to be delivered and led by Consultant nurse Sam Kelly, operational feedback on delivery to the CAMPUS QLT	
Current waits for mental health co-ordinators	A detailed report was received on community activity, increase in referrals 217 per cent and caseload size Waiting well initiatives which were recognised in the CQC comprehensive	Partial assurance Mitigation plans in place Lack of investment in community offer may significantly exacerbate this structural capacity gap Triangulates with gap in	Community capacity and standards could impact upon patient experience and potentially patient safety. Significant increase in the pressure in	Bi-monthly monitoring at QLT and Quality committee.	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
	report are in place but are pressured.	psychological therapy in neighbourhoods known risk as re confirmed in CQC June inspection and action plan Paper to be discussed with QAG in January meeting	neighbourhood services Detailed on DATIX and BAF At Quality summit (2016) commissioners confirmed their intentions to support the Trust with community investment, there may be significant risks to delivery		
Quality indicators and outcomes	The review and findings have a detailed action plan.	A quality indicator and improvement plan was confirmed For development into EPR and to support Recovery quality priority	Risks weighed up between clinical choices and clinical strategy defined	Paper adjusted to confirm decision Briefings to QLT on decision	
Suicide and self-harm	Up-date on the action plan	Partial assurance Monitoring of community data and Trust data	Increase in public health suicide rate and data	Improvement plan agreed Include changes in public health data in the January Quality position statement in line with openness, transparency with the public and to influence the system	
Positive and Safe	Up-date on the action plan	Partial and increasing assurance	Reducing risks	Improvement plan agreed, full written report in January 2017	
Person centred care planning and assurance	Position statement Some direction of travel	Partial assurance until an improvement plan with trajectory for key delivery is	A SMART delivery plan	To be rescheduled for January or February 2017. nb early Quality Committee	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
		submitted		meeting in January	
Serious incident monthly report	Paper presented and discussed Detailed review of incidents and themes No immediate cluster or concerns	January report to continue to report trend and include the new CQC paper and the trust response and improvement plan	Remains a medium risk Close monitoring of serious incidents and death rate, particularly with a changing county picture	Additional actions agreed.	
Annual Clinical research plan	Report presented Significant research activity and the positive impacts of being involved in research.	Increasing assurance	None at this time.	None	
Emergency preparedness Resilience and response	Gap in assurance Reduced performance, due to capacity issues Additional technical advice and support requested from partners	Limited assurance Increasing assurance on improvement plan Significant work in development and in delivery phase	Continues as a risk to service delivery	Monthly reporting	
Governance Improvement Action plan	Verbal report received and blue form to be tabled for January	Increasing assurance. Improved performance	None at this time.		
Childrens and Central services	A report was presented	Increasing assurance.	None at this time.		
Neighbourhood and Campus QLT	Verbal report	Continues to require additional development	None at this time.		

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Governors Governance Committee	Verbal report Starting to design the quality account, choice of indicator to be proposed to the governors in line with their requirements	DDN and QG to request information from both QLTs on information for this year's quality account	None at this time.		
Consideration of BAF risk related to Quality	Meeting issues are already logged on risk register and BAF To separate MHAC, MCA assurance from BAF1a and add a new risk to be led by MHAC	Assurance that risks reported are reflected in the risk register and BAF	On-going concerns re increasing pressure and capacity.	Adjustments of QC risk 1a to separate quality issues surround mental health and capacity legislation	
Any other business and effectiveness	Group discussion Effective Meeting over ran but large agenda was confirmed				
Confidential section	Reflection on the meeting Minutes agreed				

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE QUALITY COMMITTEE

HELD ON THURSDAY 10 NOVEMBER 2016
AT 2.00 PM IN MEETING ROOM 1, ALBANY HOUSE

PRESENT	Julia Tabreham	Chair & Non-Executive Director
	Maura Teager	Non-Executive Director
	Carolyn Green	Executive Director of Nursing & Patient Experience
	John Sykes	Executive Medical Director
	Mark Powell	Acting Chief Operating Officer
ATTENDEES (A)	Rachel Kempster	Risk & Assurance Manager
	Sandra Austin	Derby City & South Derbyshire MH Carers Forum
	Rubina Reza	Research & Clinical Audit Manager
	Sangeeta Bassi	Chief Pharmacist
	Deepak Sirur	Clinical Director
	Petrina Brown	Lead Psychologist
	Richard Morrow	Children's Services QLT Lead
	Simon Thacker	Neighbourhood & Campus Services QLT Lead
	Rob Morgan	Health & Safety Adviser (Item 197 Only)
APOLOGIES	Margaret Gildea	Non-Executive Director
	Sarah Butt (A)	Associate Director of Clinical Practice
	Emma Flanders (A)	Lead Professional for Patient Safety

QC/2016/187	**SERVICE USER REP AND CARER REP FEEDBACK** The Chair invited Sandra Austin to update the Committee on the issue of data protection, as recently discussed at the Carers Forum. Sandra advised that the Forum had discussed the issue of misdirected patient information which had led to, in one case, a member of a patient's family incorrectly receiving a letter regarding a relative's care. There had also been a case of a care plan being read by the wrong patient. John Sykes, as Chair of the Information Governance Committee, advised that these incidents are reviewed and a severity rating given depending on number of people involved and sensitivity of information. Harm is also taken into consideration. As per the Duty of Candour, feedback is given on actions taken and those affected are invited to share the impact. Julia Tabreham extended an invitation to John Sykes, or a representative of the IG Group, to attend the Carers Forum to update on IG matters.
QC/2016/188	**WELCOME & APOLOGIES FOR ABSENCE** The Chair welcomed attendees to the meeting. Apologies were noted as above.
QC/2016/189	**MINUTES OF THE MEETING HELD ON 13 OCTOBER 2016** The minutes of the previous meeting, held on Thursday 13 October 2016, were accepted as a correct record.
QC/2016/190	**MATTERS ARISING, ACTIONS MATRIX & POLICY STATUS MATRIX** The committee reviewed the Actions Matrix and agreed updates and amendments.

	The Policy Status Matrix was reviewed. The one outstanding policy (Equality Impact Risk Analysis) was noted. Rachel Kempster advised this will be ready for the December Quality Committee and will ensure it is circulated ahead of the papers to ensure time for thorough review. **ACTION** **Equality Risk Impact Risk Analysis Policy to be distributed prior to the meeting papers for consideration.**
QC/2016/191	**QUALITY DASHBOARD** Carolyn Green presented the Quality Dashboard to provide the Quality Committee with summary of highlights and challenges through the use of high level quality indicators identified in line with the quality elements of the Trust strategy and the quality priorities. The dashboard reflects data for September 2016 and was previously presented to the October Trust Board meeting. A subset of the dashboard had also been presented to the Mental Health Act Committee. The Chair had shared the Dashboard with Frances Steele of NHSI at the recent Quality Summit who was impressed with it. Carolyn Green advised she had sought further intelligence reporting to verify if levels of violence were linked. Links to levels of violence relating to smoking cessation has been found to be anecdotal and in respect to a request from Maura Teager the data on this will be reviewed further to minimise perceptions. Carolyn highlighted the recovery plan for CQC on supervision for nursing and allied professions. A model has been proposed for the Radbourne Unit. Maura Teager requested an update on models being used which Carolyn will provide to the January Quality Committee. A report on the 15 worst affected areas for supervision will be produced from January onwards. The committee discussed further measures for future iterations but Rachel Kempster requested that the Committee agree to retain the format as presented for an initial period in order to produce embedded data and for trend information to be developed before considering any changes. The time and resource required to provide the dashboard has been flagged as a risk and reported to the Medical Director. The Chair noted the significant level of work involved in producing the dashboard and asked that it be appropriately and properly resourced as a vital reporting mechanism. **ACTION** **An update on models used to recover supervision levels to be provided to the January meeting. The report will also highlight the 15 worst affected areas.** **RESOLVED: Quality Committee noted the report and agreed to future reporting requirements.**
QC/2016/192	**CQC PLANNING** Carolyn Green presented the report to brief the Quality Committee on CQC regulations and comprehensive inspection of key aspects of regulation breaches. The committee was assured by the action plan update and noted the

	significant improvements made in the 14 weeks since the inspection. **RESOLVED: Quality Committee noted the CQC update on current plans and on planning and engagement with staff, confirming it received assurance from the report.**
QC/2016/193	**COMMUNITY PAEDIATRICS PERFORMANCE REPORT** John Sykes presented the report, prepared by David Tucker, General Manager, CAMHS and Childrens , this report is specifically focusing upon Paediatricians. The report outlines the challenges in recruiting community paediatricians and resultant impact on waiting lists. The issue of community paediatrician access is longstanding and has been exacerbated by an ageing workforce. Ways to improve recruitment are being considered, including the use of head-hunters and overseas recruitment. However, the issues with recruitment are reflective of a national picture and shortage of candidates. The service is heavily reliable on agency staff, which is not sustainable to the public purse, may not lead to the most optimal quality offer and is in breach of the NHS Improvement regulations. This additional investment for a waiting list initiative to support children is being funded by the commissioner. Initiatives to reduce waiting lists include follow ups for children and young people on the ADHD pathway being undertaken by non-medical staff. By utilising this transformational change there is a trajectory to reach waiting list target for this service by March 2017, but the Committee is asked to note that demand outstrips resource so its work in progress. Quality Committee requested a report to its February meeting on the impact and assurance on the initiatives listed in the report. Maura Teager requested information on the impact increased waiting times on young people and families in distress; further information on safeguarding risks, risk assessment and impact will be reported back by John Sykes at the next meeting. The information will also include an analysis on priorities of waiting list and any early warnings which Quality Committee should be aware of if safeguarding issues exist in the family. Discussion regarding paediatricians from the Royal Derby participating in the community rota are on-going. Mark Powell confirmed he is meeting with the Chief Operating Officer at the Royal shortly and will raise the benefits of closer working between acute and community paediatrics. **ACTION** **1. John Sykes to update the December Quality Committee on impact of waiting list on children and families.** **2. Update report on impact of waiting list initiatives requested for February Quality Committee.** **RESOLVED: Quality Committee** **Noted the report and agreed that assurance is limited. Regular reporting is essential as this is a high risk area.**
QC/2016/194	**PATIENT EXPERIENCE REPORT** Richard Morrow presented the report on behalf of Sarah Butt. The report updates the committee, using a range of data, to demonstrate how the Trust is learning and improving services and patient experience. The report

	provides an annual narrative position on themes identified. Key data have been critically reviewed to identify any notable issues or themes divisionally. Key themes across all areas are medicines management, safe staffing and mental health compliance and person centred care. Significant work has been undertaken over the last few weeks in mental health act compliance to address issues in care planning. Further details will be provided in the next report. **RESOLVED: Quality Committee noted the report.**
QC/2016/195	**POSITIVE & SAFE – MONTHLY PROGRESS** Carolyn Green advised that progress had been covered through discussion of the Quality Dashboard. In responding to a request for an update from Maura Teager, Rachel Kempster advised that the revised policy for segregation and seclusion is scheduled for discussion at the Mental Health Act Committee.
QC/2016/196	**SAFETY PLAN** John Sykes presented an update on the safety plan. Just under 92% of staff have completed e-learning training for risk/safety assessment for the Safety Plan system. FACE assessment will be turned off on 31 March 2017 and the Trust is on target to hit trajectory of 100% by that date. It has been noted that there are currently six places where safety is recorded. The PARIS developers are working to identify ways of linking/automatically populating that information. **RESOLVED: Quality Committee noted the risks involved in currently having two methods of assessing risk/safety until 31 March 2017. Quality Committee also noted the deadline for full compliance of staff training in order to Safety Plan by 31 March 2017.**
QC/2016/197	**LIGATURE RISK REDUCTION** Rob Morgan, Health & Safety Advisor, attended to present Quality Committee with an update in relation to Ligature Risk Reduction, an area of high priority. Ligature reduction work is on-going for Hartington and Radbourne Unit but both are scheduled for completion by the end of the financial year. Works are complete in the Kedleston Unit with the exception of replacement windows. Risk assessments have been audited to ensure consistency within the units. Environmental handover work is being trialled in ECW and feedback will be provided on that at a later stage. **RESOLVED: Quality Committee noted the update and the position of the Trust in its programme of ligature risk reduction.**
QC/2016/198	**PHYSICAL HEALTHCARE – UPDATE** Carolyn Green presented the report, prepared by Hayley Darn to update Quality Committee on the standards for physical healthcare, current challenges and direction. Physical healthcare is a Trust quality priority and is likely to continue into 2017/18 as the current CQUINS are out to consultation

	nationally and a further repeat of the Royal College of Psychiatrists audit is being suggested as a key area. In considering the effects of workforce planning on strategic developments, Maura Teager sought an opinion of confidence in RGN recruitment. Carolyn Green advised that a recruitment event is scheduled for Friday 11 November with seven candidates scheduled. **RESOLVED: Quality Committee noted the position and on-going work in physical healthcare will be reported by the standard reporting structures of the Physical healthcare committee.**
QC/2016/199	**SERIOUS INCIDENT MONTHLY REPORT** Rachel Kempster presented the report on behalf of Emma Flanders, to update Quality Committee regarding all Serious Incidents (SIs) in October 2016). Highlighted to the committee was a reduction from three to two externally reported incidents. Catastrophic incidents are down from ten to nine. No specific patterns were observed in incidents reported in October. At the time of producing the report there were 27 overdue actions from SIRI investigations. Themes from investigations in August have been identified and communicated to staff. Of the 71 live investigations when this was produced, 38 were overdue. The Committee is asked to note that the number of investigations have doubled from 2013 to 2015. This pressure on the clinical services and the governance team, has been submitted as part of the business planning process to consider the expansion of this work. Rachel updated the Committee on the status of overdue actions; as of 10 November there are ten with six becoming overdue on 31 October. Maura Teager noted her concern that a large number of actions became overdue at the end of October, suggesting that an opportunity had been missed to escalate these earlier. Advice on an early warning system was requested for Quality Committee in order to assist in identifying peaks and consideration of the feasibility of this. Rachel Kempster confirmed that a DNA Policy had been completed. The route for approval will be verified to ensure clinical and quality group sign off. **ACTION** **1. Early warning system for alerting Quality Committee to large number of expected overdue actions to be incorporated into the December SIRI report.** **2. Rachel Kempster to feedback on approval route of DNA policy.** **RESOLVED: Quality Committee evaluated and received assurance from the SIRI report.**
QC/2016/200	**CARE PLANNING/PERSON CENTRED CARE** The item was deferred to the December meeting due to late provision of the paper.

QC/2016/201	**ANNUAL CLINICAL RESEARCH PLAN** Rubina Reza presented the report to provide Quality Committee with a view of the Research Programme during 2016-17. In noting the work to recruit participants to studies, Maura Teager asked how easy it was to recruit from minority groups. Rubina advised that while some groups may be harder to recruit to than others, recruitment is not a particular issue. The Chair thanked Rubina Reza for the report; noting the draft research programme and a good depth and breadth of work, enquiring about plans for collaboration. Rubina confirmed most studies are works with other centres. Simon Thacker added that a study is being undertaken with Nottingham in preventing frailty through dementia. **RESOLVED: Quality Committee noted the content of the report and programme of research activity.**
QC/2016/202	**GOVERNANCE IMPROVEMENT ACTION PLAN (GIAP)** Carolyn Green presented the Quality Committee with an update against Core 3 of the GIAP. Carolyn confirmed she has continued with unannounced visits to Quality Leadership Teams (QLTs). QLT governance structures continue to be developed and embedded but assurance is still required that work plans and action plans are being followed. Recent visits confirm that the right information is being discussed at QLT level but more proactive decision making is required. Further work is required to tighten up process and the function of inquisitive inquiry at the QLT level, use of the risk governance system, noting actions and risk mitigation. The new Deputy Director and additional Lead professionals will help with this. While QLTs are still on target to make significant progress by January, more headway on clinical performance management and scrutiny is required and the status of this therefore remains unchanged.
QC/2016/203	**NEIGHBOURHOOD & CAMPUS QLT QUARTERLY REPORT** Simon Thacker shared he had submitted his QLT report experience and the situation is alarming. He is concerned that channels of communication are not operating effectively. There are administrative problems with the flow and coherence of information. The ability of the QLT to achieve so much with a finite resource is impacting on the time clinicians can spend on patient care. In addition Simon Thacker raised concerns re clinical capacity in the older Adults service and psychiatry job plans in the Cubley wards. Simon Thacker and John Sykes to discuss this medical management issue and provide assurance that this operational matter has a DATIX risk assessment, a mitigation plan. The Chair noted the issue with resource as having been repeatedly flagged; more assurance is required on this matter, which is to be picked up outside the meeting, by Dr John Sykes Simon was challenged to consider the infrastructure required to put deliver on the assurances required. Carolyn Green urged that a proposal is developed with the Executive Medical Director that can be reviewed to consider as a clinical risk and also to allow this issue to be managed through

	the commissioners risk / issues log.. The Chair reminded colleagues that QLTs are a key part of the infrastructure of assurance and would welcome a future update. To give assurance, Quality Committee is looking for three months consistency in agreed levels of performance. **ACTION: A verbal update will come to the next meeting via John Sykes and Mark Powell** Sandra Austin offered apologies and left the meeting at this point.
QC/2016/204	**QUALITY ASSURANCE GROUP SUMMARY REPORT** Carolyn Green presented the report of the regular Quality Assurance Group meeting with Commissioners. Quality Committee was asked to note the concerns raised by the Trust, capacity required to undertake it and the complexity involved as summarised in the QAG report. **RESOLVED: Quality Committee noted the report.**
QC/2016/205	**ITEMS ESCALATED TO THE BOARD OR OTHER COMMITTEES** Quality Committee noted that Mental Health Act Committee will be reviewing the Quality Dashboard. Should a resolution to the concerns in Neighbourhood & Campus QLT not have been found this may be escalated to the Board.
QC/2016/207	**FORWARD PLAN 2016/17** The forward plan was noted.
QC/2016/208	**MEETING EFFECTIVENESS** The Chair apologised for the meeting running over time although colleagues had welcomed the opportunity to debate and discuss items in full. The dashboard had been positively received. Conversations with QLT were difficult but important to have.

MINUTES OF THE AUDIT & RISK COMMITTEE

HELD ON
TUESDAY, 11 OCTOBER, 2016 AT 1PM
HELD IN MEETING ROOM 1, ALBANY HOUSE,
KINGSWAY, DERBY DE22 3LZ

MEMBERS PRESENT:	Caroline Maley	Committee Chair and Senior Independent Director
	Margaret Gildea	Non-Executive Director
	Julia Tabreham	Non-Executive Director
IN ATTENDANCE:	Claire Wright	Executive Director of Finance
	Sam Harrison	Director of Corporate Affairs & Trust Secretary
	Rachel Kempster	Assurance and Risk Manager
	Mark Stocks	Partner, Grant Thornton
	Alison Breadon	Partner, PwC
	Sue Turner	Board Secretary and Minute Taker

WELCOME AND APOLOGIES

The Chair, Caroline Maley opened the meeting, welcomed everyone present and introduced Margaret Gildea and Julia Tabreham as the new Non-Executive Director members of the Committee.

AUD 2016/086	**MINUTES OF THE AUDIT & RISK COMMITTEE MEETING DATED 19 JULY 2016** The minutes of the meeting held on 19 July were accepted and approved as an accurate record of the meeting.
AUD 2016/087	**ACTION MATRIX** All updates provided by members of the Committee were noted directly to the matrix.
AUD 2016/088	**QUARTERLY REVIEW OF BOARD ASSURANCE FRAMEWORK 2016/17** Sam Harrison made the formal presentation of the Board Assurance Framework (BAF) to the Audit & Risk Committee for 2016/17. This report detailed the third issue of the BAF for 2016/17. Sam Harrison drew the Committee's attention to the three additional risks that have been added to the BAF this quarter which were noted as follows: 1b) The Trust is not compliant with equality legislation. There is therefore a risk that the Trust does not operate inclusivity and may be unable to deliver equity of outcomes for staff and service users. (Currently assessed as high risk.) 1c) Risk to delivery of safe, effective and person centred care due to the Trust being unable to source sufficient permanent and temporary clinical staff. (Currently assessed as high risk.) 3c) There is a risk that turnover of Board members could adversely affect delivery of the organisational strategy due to loss of specialist organisational knowledge, capacity and stability. (Currently assessed as moderate risk.)

	The Committee acknowledged that the addition of these three additional risks reflected how the BAF is an active live document. There are now a total of nine risks contained in the BAF and this was considered to be a manageable number of risks for the Trust. The programme of deep dives that have become embedded into the BAF process was reviewed and it was noted that risk 3c on Board turnover would be scrutinised at the Remuneration and Appointments Committee. Rachel Kempster pointed out that the BAF had recently been significantly reviewed and the updated sections were shown in blue type. She drew attention to the cross reference of operational/high/extreme risk. Margaret Gildea thought that the risks were very clearly shown and that the extreme risks were well highlighted. Julia Tabreham felt that the document could be reformatted to make it easier to read and it was agreed that Rachel Kempster would consider how to improve the format of presentation of the BAF. It was explained that Risk 3b (Risk of fundamental loss of confidence by staff in the leadership of the organisation at all levels) referred to the loss of specialised Mental Health knowledge that could arise on the departure of Ifti Majid and Carolyn Gilby. Sam Harrison informed the Committee that succession planning is an ongoing risk and is being reviewed by the Remuneration and Appointments Committee. At the last meeting of the Committee it had been suggested that risks 2a and 4b could be merged. Sam Harrison advised that Mark Powell felt that at this moment in time it would be sensible to keep these two risks separate as considered and adopted by the Executive Leadership Team outside of the Audit and Risk Committee. It was agreed that the comment in the positive assurances column for risk 3c (2016/17 compliance with HR policies and procedures (planned Q1)) will be moved across into the gaps in assurance column. The Committee agreed that the BAF would be further updated where required and submitted to 2 November Trust Board as part of established programme of reporting. **ACTION: Rachel Kempster to consider how to improve the format of the BAF to make it easier to read and to move the information as outlined within risk 3c as presented** **RESOLVED: The Audit and Risk Committee:** **1) Approved this third issue of the BAF for 2016/17, agreeing the three new risks added to the BAF** **2) Agreed for this third issue of the BAF for 2016/17 to be considered by Board in November**
AUD 2016/089	**RISK MANAGEMENT STRATEGY AND OVERVIEW OF RISK MANAGEMENT CONTROLS AND ASSURANCE** The Committee received the proposed new Risk Management Strategy for the Trust. This was presented by Sam Harrison in a draft format for initial consultation and discussion. Key points were highlighted during the meeting and it was decided to discuss the proposal in more detail in order to finalise the strategy in a separate meeting with Caroline Maley, Sam Harrison and Rachel Kempster.

	The Committee discussed the different risk responsibilities of the Quality Committee and the Audit and Risk Committee and agreed that the responsibility for ensuring areas of significant risk are escalated from clinical/operational leadership teams and groups to the Board and vice versa and the effective management of clinical and non-clinical risks is the responsibility of both the Quality Committee and the Audit and Risk Committee. The Chair acknowledged that a lot of work had gone into the draft strategy and she felt that the Trust's risk appetite should be identified in the form of a chart/diagram. Sam Harrison pointed out that Rachel Kempster had checked best practice and they both considered there is a comprehensive and robust risk management system in place within the Trust which now only requires the strategy to underpin the risk management process. Alison Breadon made the point that risk appetite is not mentioned in the BAF and Rachel Kempster and Sam Harrison agreed to consider including risk appetite within the strategy and the BAF and proposed that the Board Development Session in February 2017 will be used to review the Risk Management Strategy along with the risk appetite of the Board. It was agreed that the next draft version of the Risk Management Strategy will include more charts and diagrams and will be submitted to the December meeting of the Committee. **ACTION: Rachel Kempster and Sam Harrison to produce of further draft Risk Management Strategy containing charts/diagrams and would reflect the risk appetite of the Board.** **RESOLVED: The Audit and Risk Committee considered the draft Risk Management Strategy and agreed to discuss to discuss the proposal in a separate meeting. (COMPLETE)**
AUD 2016/090	**<u>DEEP DIVE RISK 4a FINANCIAL PLAN</u>** Claire Wright delivered a presentation that set out the key control processes that are in place to deliver Risk 4a 'Failure to deliver short term and long term financial plans could adversely affect the financial viability and sustainability of the organisation'. Claire Wright drew attention to Finance and Performance Committee reporting and how these papers and minutes provide evidence of the financial performance at a granular level. She also explained how performance of the Finance and Performance Committee and PCOG (Performance and Contract Operational Group) contributes to the oversight of management and contractual performance and that the process for accepting the control total and building the required CIP (Cost Improvement Programme) is discussed further at Board level. She also explained the ongoing work that takes place during weekly agency staff use meetings held with Amanda Rawlings, Mark Powell and John Sykes in order to increase resource and improve recruitment and retention which the Finance and Performance Committee has oversight for. She also highlighted the fact that CIP/cost avoidance is also reported through the Finance and Performance Committee, Programme Assurance Board and is regularly monitored by the Board. These processes/controls were all noted as evidence of key controls, and assurances. Claire Wright concluded that following today's deep dive it remains appropriate for the post-mitigation score for the finance BAF risk for non-delivery of financial plans to be 20 (5x4). It remains true that financial performance could in aggregate worsen by more than £1m and therefore warrants an impact score of 5. In terms of likelihood it is still 'probable' (more than 50% likely to worsen by £1m) hence the final score of 4.

	The Chair felt this was a thorough and useful deep dive which showed evidence of the cross reference with the Finance and Performance Committee which made the Committee aware of the depth and challenge taking place to mitigate this risk. Julia Tabreham asked what control mechanisms should be in place that would prevent any inappropriate booking of agency spend. Claire Wright responded that documentation is in place to gain approval. Bank and overtime work is always looked at first before agency spend is considered. Alison Breadon confirmed these processes had been strengthened and revised recently. The Committee agreed high level of assurance had been obtained from the actions and controls to mitigate this risk on the evidence presented by Claire Wright. **RESOLVED: The Audit & Risk Committee was assured by the controls that are in place to mitigate risk 4a Financial Plan.**
AUD 2016/091	**<u>GOVERNANCE IMPROVEMENT ACTION PLAN</u>** At the Audit and Risk Committee meeting on the 19 July, members of the Committee did not get the opportunity to be assured on the progress of the GIAP actions for which Audit and Risk Committee has oversight. Sam Harrison's paper set out to provide assurance and evidence of progress against each of the actions which the Committee has oversight responsibility. It was agreed practice as part of the GIAP programme that each Board Committee would take ownership of core areas of the GIAP. Sam Harrison explained that she had followed the agreed process to present to the Committee all actions on Core 4 and she also gave an update on other risks that the Audit and Risk Committee has oversight responsibility for. In addition to this the Trust has also recently received the Deloitte Phase 1 report (October 2016) which had looked at the project management and work to date the Trust has undertaken on the GIAP. Sam Harrison had taken steps to review actions taken to date in the context of the original recommendations within the GIAP which had been a requested action within the recent Deloitte report. It was pointed out that this is an exercise the Board has agreed each Committee will carry out during October - December. The Committee acknowledged it had been successful in progressing its actions. In April, May and July the Committee assessed its actions as complete and these are reflected in the rag and BRAG rating in the report. The Committee would now be asked to challenge whether actions are completely embedded within the organisation to ensure it is satisfied that the action is complete at the end of the process. This will be a significant exercise and will require a reassessment of the source documentation in order to build on what has been achieved so far to substantiate the facts and provide evidence of completion. The Committee commissioned Sam Harrison to scrutinise this further with other executive colleagues and to present the GIAP back to the Committee at the next meeting. Each Committee chair will be asked to provide evidence of having reassessed their Committee's actions and provide evidence that the actions are complete. **ACTION: Sam Harrison to review actions already completed and present proposals for any additional work or review of status to December Audit and Risk Committee meeting.**

	RESOLVED: The Audit & Risk Committee: **1) Received this report and noted the update of the actions.** **2) Noted those actions outlined as 'off track' with mitigations noted** **3) Discussed and agreed the process by which further review of all actions for which the Audit and Risk Committee has oversight should be undertaken**
AUD 2016/092	**COMMITTEE ASSURANCE SUMMARY REPORTS** Assurance summary reports were received from the Audit and Risk Committee held on 19 July, Quality Committee held on 11 August and 8 September, Mental Health Act Committee held on 26 August as well as the draft minutes of the meeting of the People and Culture Committee held on 20 September. It was agreed that in future assurance summary reports are to be submitted directly to the Board. Sam Harrison will work with executives to ensure summaries are completed consistently. It was agreed that the Audit and Risk Committee does not require assurance summaries to be submitted to each meeting as these reports are received by the Board on a monthly basis and provide the Board with oversight of assurance and any need for escalation. Assurance of committee effectiveness will continue to be sought through the year end reports from Committees to the Audit and Risk Committee. **RESOLVED: The Audit & Risk Committee noted the Assurance Summaries received from the Quality Committee Mental Health Act Committee and the draft minutes of the meeting of the People and Culture Committee.**
AUD 2016/093	**STANDING FINANCIAL INSTRUCTIONS WAIVER REGISTER** In accordance with the Trust's Standing Financial Instructions the Waiver Register granted from 1 April - 30 September 2016 was presented by Sam Harrison to the Audit and Risk Committee for review. Julia Tabreham queried the number of waivers contained in the register. Claire Wright assured her that a consistent approach is applied to the assessment of the percentage of spend which allows a trend to be analysed. The reliance on sole providers and preferred suppliers was discussed between Claire Wright and Sam Harrison and it was agreed that reliance on single supplier will be addressed as part of future reporting. The Chair recognised that this process has been reviewed and it was agreed that the report will be developed to include a trend analysis on the use of waivers, including details on category of spend and suppliers and will be presented to the Committee three times a year. **RESOLVED: The Audit & Risk Committee reviewed and received the Register.**
AUD 2016/094	**IMPLEMENTATION OF INTERNAL AND EXTERNAL AUDIT RECOMMENDATIONS PROGRESS UPDATE** Rachel Kempster's paper identified progress of actions resulting from internal and external audit reports. This follow up of progress is undertaken to ensure the actions identified are completed in a timely manner and if overdue, the risks associated with the

	delay in completion are identified. Rachel Kempster gave an overview of the process she had undertaken for collecting the data and providing evidence that the process that had been followed. The Committee recognised that consistency had been applied in the process but was concerned that the narrative contained in the progress columns was not always complete. Caroline Maley also raised the point that the Mental Capacity Act action ratings in the PWC report did not match the ratings shown in the progress report and this disconnect was noted by the Committee. The Committee noted the report and requested that individuals be asked to provide further narrative in future reports to allow the Committee to obtain assurance/evidence of completion of progress. **ACTION: Rachel Kempster to ensure further narrative is captured in future reports that will provide the Committee with assurance on completion of progress.** **RESOLVED: The Audit & Risk Committee received and noted the report and agreed it would continue to be submitted twice a year as previously agreed**
AUD 2016/095	**<u>UPDATE REPORT ON EXTERNAL AUDIT PLAN PROGRESS</u>** Mark Stocks of Grant Thornton outlined the progress made in delivering Grant Thornton's responsibilities as the Trust's external auditors. Mark Stocks informed the Committee that work on the external audit plan has commenced for 2016/17 and an outline plan will be received by the Committee in December. It was noted that the accounts for this year are being worked on by Joan Barnett and the Trust's Finance Team and work is also taking place to understand emerging accounting issues and the Trust's proposed response; and to plan for an efficient audit in the spring. The Committee noted that Grant Thornton will be reviewing the action the Trust is taking in response to the Governance Improvement Action Plan as part of their value for money work and that this will be a continued area of focus within the external audit plan. Mark Stocks highlighted the recent activity undertaken by Grant Thornton as set out in the report. The Committee discussed how BREXIT might have an effect on research priorities and recognised the period of radical change that will take place in the Trust especially in back office functions with regards to the SOC (Strategic Options Case) and STP (Sustainability and Transformation Plan). Despite the changes that lie ahead the Committee looks forward to a good audit process for the forthcoming year. **RESOLVED: The Audit and Risk Committee noted the progress made on External the Audit Plan**
AUD 2016/096	**<u>UPDATE REPORT ON INTERNAL AUDIT PLAN PROGRESS</u>** Alison Breadon ran through the activities and progress in delivering the 2016/17 audit plan which is currently on track. The Committee noted that the Committee Effectiveness review has been removed from the internal audit plan due to the duplication with follow up work that Deloitte have been asked to carry out on the Trust.

	Alison Breadon confirmed that PWC will provide the next meeting with the report on Data Security and handling information to discuss the asset framework to record sensitive and highly confidential data as this was considered a medium risk area. PWC will also provide a follow up report on previous audit findings in their progress report that will be received at the December meeting. Alison Breadon advised that the current level of non-compliance regarding agency spend ceiling and the forecast improvements needed must be viewed as realistic by the Board. PWC are therefore highlighting the risk of non-achievement of forecast improvement and the significant financial impact that could have. A report on agency spend has been drafted and issued to the responsible Executive Directors and it has been agreed that it would be presented to the Trust Board. She appreciated that work is taking place to make recruitment more effective and this is being assessed by the Finance and Performance Committee and People and Culture Committee. The sector updates and publications were referred to and noted and Sam Harrison confirmed that relevant Caldicott matters have been addressed within the Information Governance Committee and the New Security Standards will be reported to the Quality Committee. The Mental Capacity Act (MCA) awareness report received from PWC was noted and it was confirmed that this will be addressed at the Mental Health Act Committee in November as well as the Quality Committee for cross referral. The Chair did not obtain assurance from the report. She considered this to be a medium to high risk area and would expect the Mental Health Act Committee to address this concern at the November meeting. The HR Policies report was also reviewed by the Committee. Margaret Gildea was of the opinion that if Amanda Rawlings had reviewed the report, she would have taken a harder view and suggested that a re-audit takes place on HR policies in order to make progress on policy alignment. **RESOLVED: The Audit and Risk Committee received and noted the Internal Audit progress report**
AUD 2016/097	**ANTI CRIME CIRCULAR FROM NHS PROTECT** This circular discusses the role of audit committee chairs of NHS providers and CCG chief officers in ensuring that there are proper anti-crime arrangements in place at NHS provider organisations. The Circular was provided for awareness and the Committee noted that 'anticrime' is the term that is now used to refer to counter fraud and security management. The Committee was also made aware by Claire Wright that the Trust completes an annual counter fraud self-assessment and submits a compliance response to NHS Protect. **RESOLVED: The Audit and Risk Committee noted and was assured that anti-crime arrangements are in place within the Trust.**
AUD 2016/098	**2016/17 FORWARD PLAN** The forward work plan was noted and will be further reviewed by Sam Harrison and the Chair on an ongoing basis.

AUD 2016/099	**MEETING EFFECTIVENESS** The Chair thanked all those present for their attention and attendance and closed the meeting at 4:30pm. The Committee reviewed the overall effectiveness of discussions which included positive comments from PWC that recurring issues were arising across agenda items. The meeting was well chaired and strategic issues were discussed.
AUD 2016/091	**DATE AND TIME OF NEXT MEETING** The next meeting of the Audit and Risk Committee is due to take place at 10:30 on Tuesday, 13 December, and will be held in Meeting Room 1, Albany House, Kingsway.

Blue Completion Form

Recommendation **HR1 –** The HR and OD departments should be under the management of one Executive Director	**Current BRAG Rating**	**Recommended BRAG Rating**
	On Track	**Assurance Received**

Detail

As part of the investigation into the issues surrounding the recent employment tribunal the panel recommended that the HR, Workforce and OD functions should be placed under the management of one Executive Director. This was further emphasised by Deliotte as part of their review who highlighted the importance for 'drawing together the various strands of HR and its related functions'.

Jayne Storey was appointed as the Director of Workforce and OD in January 2016 and in September Amanda Rawlings became the successor. All functions of HR, workforce development and OD are under one Director. The team is working successfully together with clear focus, objectives and structured team meetings.

Evidence

Appointment of Jayne Storey and then Amanda Rawlings – Minutes of Remuneration and Appointments Committee held on 27 July 2016

Organisational Structure highlighting combined function.

Shared post of Amanda Rawlings as Director of People and Organisation Effectiveness, with the remit as part of the national direction of back office consolidation an integrated People and Organisational Effectiveness team is being developed for the two Trusts. Inside DHCT there is a fully functioning team with weekly team meetings – Minutes of meetings evidence this.

On-going Monitoring Arrangements
Will be further reviewed by CQC and also monitored on an annual basis by the Board.

Executive Director Responsible	Interim Director of People and Organisational Effectiveness	**Responsible Assurance Committee**	People and Culture Committee

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 11 January 2017

Governance Improvement Action Plan (GIAP)

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

Therefore, the purpose of this paper is as follows:

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

2. To receive assurances on delivery and risk mitigation from Board Committees and Lead Directors.

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

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

Executive Summary

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

The governance of each core area is as follows:

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

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

Core	Number of Recommendations	Off Track	Some Issues	On Track	Completed
Core 1 - HR and Associated Functions	5	0	0	2	3
Core 2 - People and Culture	6	0	0	4	2
Core 3 - Clinical Governance	3	0	2	0	1
Core 4 - Corporate Governance	13	0	0	8	5
Core 5 - Council of Governors	3	0	0	0	3
Core 6 - Roles and Responsibilities of Board Members	5	1	0	4	0
Core 7 - HR and OD	8	0	1	7	0
Core 8 - Raising concerns at work	1	0	0	1	0
Core 9 - Fit and Proper	1	0	0	0	1
Core 10 - CQC	2	1	0	0	1
Core 11 - NHS improvement undertakings	6	0	0	3	3
Total	53	2	3	29	19

Since the last Board meeting there have been changes in Board RAG ratings for Core 1 – HR and Associated Functions, Core 2 – People and Culture, Core 6 – Roles and Responsibilities of the Board Members – Core 10 – CQC.

Executive Leadership Team
At their meeting on 19 December ELT reviewed a report which highlighted the pipeline of planned completion of blue action forms for all GIAP recommendations. This report will be presented monthly to ELT to ensure oversight of progress and escalation and management of any issues arising.

Overall, Board RAG ratings have improved and progress has been made in the areas that are currently rated as 'off track' or 'some issues'. The body of the report provides more detail on this.

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

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

3a: There is a risk that the NHSI enforcement actions and CQC requirement notice, coupled with adverse media attention may lead to significant loss of public confidence in our services and in the trust of staff as a place to work

3b: Risk of a fundamental loss of confidence by staff in the leadership of the organisation at all levels

Consultation
Core areas have been discussed at respective Board Committees.

Governance or Legal Issues
This paper links directly to NHSI enforcement action and associated licence Undertakings.

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

Recommendations

The Board of Directors is asked to:

1) Note the progress made against addressing GIAP recommendations
2) Discuss the areas rated as 'off track' and 'some issues', seeking assurance where necessary on the mitigation provided
3) Formally approve the 11 blue forms as presented and confirm that these are now complete namely:
   - HR1
   - HR2
   - HR5
   - PC1
   - PC6
   - CorpG2
   - CorpG9
   - CorpG10
   - CorpG12
   - CorpG13
   - CQC1
4) Agree at the end of the Public Board meeting whether any further changes are required to the GIAP following presentation of papers, outcomes of item specific discussions and/or other assurances provided throughout the meeting.

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

Report prepared by: **Kelly Sims (Project Support Officer)**

1. Introduction

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

Detailed below are updates against Core areas where there have been changes in Board RAG ratings:

Core 1 – HR and Associated Functions
It was agreed at the extraordinary meeting of the People and Culture Committee, held on 14 December, that blue completion forms for recommendations HR1, HR2 and HR5 (following review of the evidence and narrative) should be forwarded to the January Trust Board for sign-off (see attached). It was also agreed that recommendation HR3 would be ready for review by the People and Culture Committee in April 2017.

Core 2 – People and Culture
At the extraordinary meeting of the People and Culture Committee held on 14 December, it was agreed that blue forms related to recommendations PC1 and PC6 are complete and should be forwarded to Trust Board for sign-off (see attached).

At the GIAP planning meeting, held on 11 November it was agreed that the status of recommendation PC5 should be changed to 'on track'. The Trust values have been refreshed and work on embedding them is ongoing. It was further agreed that the concept of the behavioural framework is not being progressed at present and will be reviewed as part of the joint development work with DCHS.

Core 3 – Clinical Governance
Following discussion at the Quality Committee, held on 15 December, it was agreed that a blue form could be prepared for ClinG2 for presentation to the January Committee meeting. This followed assurance also received at the Audit &Risk Committee held on 12 December, as this Committee also has an oversight role of this recommendation. There are still some issues with recommendations with ClinG1 and ClinG3, with plans to complete actions and embed activity. ClinG1 is scheduled for Committee review in March 2017, with potential sign-off. ClinG3 is scheduled for further review at January's Quality Committee meeting.

Core 4 – Corporate Governance
At the Audit & Risk Committee on 13 December blue forms for five recommendations were agreed. These related to four completed recommendations: CorpG2, CorpG10, CorpG12 and CorpG13, and for one recommendation that was agreed to be no-longer applicable, CorpG9 (see attached).

Core 6 – Roles and Responsibilities of Board Members
It was agreed at the November Remuneration and Appointments Committee that three further recommendations could be designated as 'on track' following presentation and scrutiny of reports relating to RR2 (Board Development Programme), RR3 (360
appraisal process for Board members) and RR5 (Board member mandatory and professional development).

Following discussion at the Committee held on 7 December, Board Development activity was reviewed and actions agreed that would provide assurance that activity was embedded as business as usual. It was agreed to move the status of recommendation RR2 to 'on track' for delivery by an April 2017 deadline.

Core 10 – CQC

Recommendation CQC1 states that 'the Trust should ensure that the outcome of this focused inspection impacts directly upon the organisational strategy'. Following discussion at the People & Culture Committee GIAP Planning Meeting held on 11 November it was confirmed that a blue completion form should be completed for this recommendation. This was supported at the Executive Leadership Team (ELT) held on 19 December 2016 (see attached).

2. **Red Rated 'Off Track' recommendations**
   There are 2 recommendations rated as Red as detailed in the table below (2 last month):

Core Area	Recommendation	Action(s)	Mitigation
Core 6 - Roles and Responsibilities of Board Members	RR1 - Implement proposals to improve succession planning at Board level, including ensuring that Governors are adequately engaged in this process. Alongside this, develop processes for succession planning for Senior Leader positions	Develop and approve Board level, key divisional and corporate leaders succession plan	A mitigation plan was agreed at October's Remuneration & Appointments Committee, with succession planning process being led by Amanda Rawlings and Ifti Majid. Further development of the succession plan was discussed at the November and December Remuneration and Appointments Committee and proposed to be deferred until the new year due to priorities of other work areas. Further discussion at December's Remuneration and Appointments Committee confirms this position is unchanged
Core 10 - CQC	CQC 2 - The Trust should continue to proactively recruit staff to fill operational vacancies	Implement the recruitment plan and monitor effectiveness against an agreed vacancy rate trajectory	A revised recruitment plan has not yet been fully developed. However, two posts have been appointed to within the HR team to add capacity to speed up the recruitment process. Discussion at ELT on 19.12.16 clarified actions required to complete this recommendation and embed in ongoing Trust work. Further discussion with Interim Chief Operating Officer on 22.12.16 has identified proposed evidence of actions to address this recommendation to include: Recruitment Plan as presented to the PCC, evidence of weekly agency meetings with attendance by Executive Directors. Assurance to be provided through completion of internal audit recommendations on agency controls. Monthly reporting is in place to the confidential Trust Board to highlight progress and impact on actions. A relocation expenses policy was approved by ELT on 19.12.16. A specific recruitment plan for each staff group is to be developed. Evidence to be presented to People & Culture Committee February meeting for proposed sign-off with blue completion form planned for March Board (subject to Committee approval).

3. Amber rated 'some issues' rated recommendations

There are 3 recommendations rated as Amber as detailed below (7 last month):

Core Area	Recommendation	Action(s)	Mitigation
Core 3 - Clinical Governance	ClinG1 - Refresh the role of Quality Leadership Teams to increase their effectiveness as core quality governance forums	1) Agree and implement a QLT forward plan process to ensure all required papers are received at each meeting 2) Develop and implement a standard escalation template to be used by QLTs 3) For a 6 month period DoN and MD to attend QLTs to provide coaching and oversight of meeting effectiveness	QC agreed that in order to progress this recommendation to completion it would need to see evidence of escalation templates, minutes of meetings, work plans linked to the Quality Committee forward plan, attendance embedded on the minutes and risk register. QLT leads will need to attend QC on a rotational monthly basis but detailed QLT updates from each Team will be provided monthly. When the Committee has received all this information from each QLT consistently on a monthly basis for four months the Committee indicated they would be prepared to sign off this recommendation. Reviewed at December Quality Committee – confirmed that this remains 'some issues' pending evidence to be received over further months.
	ClinG3 - Increase the effectiveness of the Quality Committee by ensuring clear alignment of the committee with the quality strategy and associated objectives, and ensuring a clear focus on seeking assurance	Ensure that Quality Committee agenda is structured so that it focuses on topics to deliver quality strategy and goals	QC agreed that there needed to be more focus on revising the agenda template to confirm how papers supported delivery of the Trust Strategy, in ensuring completion of actions and having a clear forward plan At October's meeting QC agreed that the Action Log required richer narrative when capturing actions and accountabilities. Overall, the Committee expects to sign off this recommendation off by the end of the calendar year Reviewed at December Quality Committee – confirmed that this remains 'some issues'.
Core 7 - HR and OD	WOD7 - The Trust should monitor the adherence to the grievance, disciplinary, whistle-blowing policies and the current backlog of cases concluded	The backlog of cases made known to the CQC at the time of the inspection are concluded	Progress continues to be made resolving all cases in line with Trust policy. Robust review undertaken and regular review by Executive Leadership Team. Status to be reviewed at December PCC with a view to status becoming 'on track'. To be reviewed at January PCC as there was no formal December PCC meeting.

Blue Completion Form

Recommendation **HR2 –** Ensure external resources for the newly appointed Director of Workforce, OD and Culture are obtained in order to drive the transformation of HR and related functions through a combination of coaching, buddying, and mentoring support	**Current BRAG Rating**	**Recommended BRAG Rating**
	On Track	**Assurance Received**

Detail

Owing to operational pressures and leave, it was agreed that additional capacity and support would need to be brought into the existing team to support the delivery of the GIAP whilst the existing team focused on embedding new ways of working.

A plan setting out resource requirements to deliver the GIAP was agreed by ELT in April and staff were recruited to additional roles. Process updates were given to the People and Culture Committee on a regular basis throughout the recruitment process. ELT and People and Culture Committee and the Board in October approved revised resource requirement plan for the remainder of 2016 and into 2017 to support the new Interim Director of People and Organisational Effectiveness to pull together the revised integrated structure and to deliver the key priorities.

Evidence

1.4 Revised Workforce Resource plan approved by ELT, further revision in October 2016

On-going Monitoring Arrangements
Will be monitored by ELT/PCC and Board

Executive Director Responsible	**Interim Director of People and Organisational Effectiveness**	**Responsible Assurance Committee**	People and Culture Committee

Blue Completion Form

Recommendation	**Current BRAG Rating**	**Recommended BRAG Rating**
HR5 - As part of the development of the People strategy and developing the model for HR, the function should define how it measures and evaluates the impact of HR, particularly around securing organisational development. A clear set of metrics demonstrating the impact of the function should be a focus on the newly created People and Culture committee	**On Track**	**Assurance Received**

Detail

A revised HR model based on the one suggested by Deloitte was presented to the People and Culture Committee in June. The Committee acknowledged the current capacity issues in HR and noted the progress but agreed that the proposal only gave partial assurance and that further detail about the model and how it would work in practice was required before the Committee could be assured. It was agreed that a further paper would be presented to the Committee which set out this detail.

The further paper was discussed and approved by the People and Culture Committee in July, with an agreement that the team would progress as quickly as possible to embed the new way of working.

At the GIAP planning meeting on 11 November it was agreed that the structure had been realigned to manage current priorities. The People Plan is being refreshed to meet the priorities of the next 6-9 months. The refreshed plan is being submitted to the People and Culture Committee for review in January 2016.

The board receives monthly progress reports on a range of key people metrics and the People and Culture Committee receives monthly a detailed People performance report which tracks the effectiveness of how the trust and the workforce directorate are performing with the people agenda.

Evidence

Report to PCC in October regarding the future direction for the Workforce and OD team

People metrics report (part of the People Performance report presented and tracked at the People and Culture Committee e.g. report to November meeting of People and Culture Committee)

Top level performance metrics including Integrated Performance Report statistics report to Board e.g. October Board papers

On-going Monitoring Arrangements
PCC will oversee the approval and delivery of the People Plan

Executive Director Responsible	Interim Director of People and Organisational Effectiveness	**Responsible Assurance Committee**	People and Culture Committee

Blue Completion Form

Recommendation **PC1 –** The Trust should adopt an Organisational Development and Workforce Committee	**Current BRAG Rating**	**Recommended BRAG Rating**
	On Track	**Assurance Received**

Detail

The Terms of Reference for the People and Culture Committee was agreed in February 2016 and the Committee operates on a monthly basis and has an established agenda, Terms of Reference and annual Work Plan. The Committee membership comprises of Non-Executive and Executive Directors, Staff Governor and Trade Union colleagues.

The Terms of Reference for the People and Culture Committee sub-committees were presented in March but not approved and were revised and approved at April's Committee meeting. The Terms of Reference and sub-committees have been further refined during September and October 2016. The changes to the Terms of Reference for the People and Culture Committee and sub-committees have been minuted through and tracked at the People and Culture Committee.

At the GIAP review meeting on 11 November it was agreed that a blue form should be completed as this People and Culture Committee is now well established and functioning.

Effectiveness of the Committee, as for all Board Committees, is reviewed on an annual basis and reported to the Audit and Risk Committee.

Evidence

Terms of Reference (latest People and Culture Committee version approved at October 2016 People and Culture Committee meeting

Annual People and Culture Committee Work Plan

On-going Monitoring Arrangements
At least annually the Terms of Reference will be reviewed and refreshed.

Executive Director Responsible	Interim Director of People and Organisational Effectiveness	**Responsible Assurance Committee**	People and Culture Committee

Blue Completion Form

Recommendation **PC6 –** Expand the current Chair and CEO reports to provide a greater depth of information regarding key priorities for stakeholder engagement, feedback provided and any barriers to progress	**Current BRAG Rating**	**Recommended BRAG Rating**
	Completed	**Assurance Received**

Detail

Board and Council of Governors receive updated from the Chair and Chief Executive at each meeting. Staff receive regular updates on strategic issues, i.e. STP, Strategic Options Case with DCHS and operational matters.

The CEO report to the Board has been enhanced to include more detailed information about stakeholder engagement. This summarises feedback from staff and provides evidence of where action has been taken in response to this feedback.

The Trust Board confirmed its assurance on the delivery of Chair and CEO reports at the 27 April 2016 Board meeting and agreed closure of this recommendation.

On 11 November the GIAP planning meeting agreed that this action is complete and that evidence is available in Board minutes.

Evidence

July 2016 CEO report to Board.

Minutes capturing Chair's verbal feedback to Board – September 2016.

On-going Monitoring Arrangements
Routine reporting by chair and CEO to each Board meeting – standing agenda items on annual work plan.

Executive Director Responsible	Interim People and Organisational Effectiveness	**Responsible Assurance Committee**	People and Culture Committee

Blue Completion Form

Recommendation **Corp G2 –** The Governance Framework should be updated to give greater clarity regarding roles of key individuals and governance forums, including all EDs, the SID and Vice Chair, PCOG, QLTs and the Safeguarding Committee	**Current BRAG Rating**	**Recommended BRAG Rating**
	Completed	**Assurance Received**

Detail

The Corporate Governance Framework was discussed at the Board Development Session held on 11 May 2016 and further iterations of the document were discussed at the Audit and Risk Committee on the 24 May and 19 July 2016. This action was signed off as complete by the Board of Directors in the public session of the Board meeting held on 27 July 2016. The Corporate Governance Framework itemises the roles of key individuals and the main committees of the Board. However the role of Quality Leadership Teams and Performance and Contract Operational Group is considered no longer relevant for this action as their role will be encompassed in the revised Accountability Framework which was approved at the confidential session of the Board meeting held on 2 November 2016.

The Accountability Framework is subject to a separate GIAP action (CorpG7).

Evidence

4.1 Corporate Governance Framework report to Board 27 July 2016

4.2 Accountability Framework report to Board 02 November 2016

On-going Monitoring Arrangements
Terms of Reference within the Corporate Governance Framework are subject to annual review

Work plans are a standing agenda item at each Board Committee meeting

Executive Director Responsible	Director of Corporate Affairs	**Responsible Assurance Committee**	Audit and Risk Committee

Link to CorpG7

Blue Completion Form

Recommendation **Corp G9 –** Formalise the role of PCOG as a key forum in the Trust governance structure	**Current BRAG Rating**	**Recommended BRAG Rating**
	Off Track	**No Longer Applicable**

Detail

This relates to the alignment of the Trust's Accountability Framework to the Trust's revised Corporate Governance Framework.

An Accountability Framework has been developed and approved in the confidential session of the Trust Board meeting held on 2 November 2016.

The new structure will be implemented from January 2017, however it has been agreed that this forum is no longer required and does not form part of the new Accountability Framework. The Accountability Framework is subject to a separate GIAP action (CorpG7).

Recommendation no longer applicable

Evidence

N/A

On-going Monitoring Arrangements
N/A

Executive Director Responsible	Director of Corporate Affairs	**Responsible Assurance Committee**	Audit and Risk Committee

Link to Corp G7

Blue Completion Form

Recommendation **Corp G10 –** Further improve the function of the ELT by improving the timeliness of papers and quality of debate	**Current BRAG Rating** **Completed**	**Recommended BRAG Rating** **Assurance Received**

Detail

The Board of Directors have signed this action off as complete. Good progress has been made in terms of focussing debate on key priorities, administration and recording actions. Key priorities for ELT agendas have been identified as follows; Control Total Delivery, CIP Delivery, GIAP, CQC Comprehensive Visit and Recommended Implementation, Connecting with the Organisation, STP, Trust Strategy Implementation and Escalated Issues.

Executive Team Principles have been agreed and implemented since April 2016.

ELT papers are issued routinely on the Thursday prior to the Monday meeting.

Evidence

4.3 Corporate Governance Framework

4.4 Action log of ELT

4.5 Example agenda from ELT

4.6 Executive Team Principles

On-going Monitoring Arrangements
Annual review of effectiveness of ELT

Executive Director Responsible	Director of Corporate Affairs	**Responsible Assurance Committee**	Audit and Risk Committee

Blue Completion Form

Recommendation **Corp G12 –** Reintroduce short summary reports from Committee Chairs to the Board to supplement Minutes. These should identify key risks, successes and decisions made / escalated from the meeting	**Current BRAG Rating**	**Recommended BRAG Rating**
	Completed	**Assurance Received**

Detail
Assurance Summary Report - this action was signed off by the Board as complete, but after the Board meeting in April it was agreed further changes were required to the summary reports to improve their consistency. These were duly made and agreed at the June Board meeting. The amended summary report template was further approved by Audit and Risk Committee as part of the Corporate Governance Framework and subsequently Board in July 2016. Board Committee Chairs at their meeting on 16 November 2016 discussed the use and effectiveness of the Committee Assurance Summaries and agreed these were helpful to identify assurance, risk and escalations to the Board. Assurance Summary Reports will be considered as part of the audit and informal observation of the Board meeting.

Evidence
4.3 Corporate Governance Framework
4.7a,b,c Examples of Assurance Summary Reports
4.8a,b Minutes of the NED Chairs meeting held 16 November 2016
On-going Monitoring Arrangements Director of Corporate Affairs to work on an ongoing basis with Executive colleagues to refine and review. Scheduled agenda item on Board Committee Chairs quarterly meetings

Executive Director Responsible	Director of Corporate Affairs	**Responsible Assurance Committee**	Audit and Risk Committee

Blue Completion Form

Recommendation	**Current BRAG Rating**	**Recommended BRAG Rating**
Corp G13 – The Board should re-establish the Board Assurance Framework as one for all risks including risks which it is involved in and when that risk has an element of confidentiality how it is handled. It should write and implement a plan for BoD development which includes these objectives	**Completed**	**Assurance Received**

Detail

The Board Assurance Framework (BAF) was agreed in March following a Board Development Session held in February 2016 and considers all risks relating to the delivery of the Trust Strategy. The BAF has been presented quarterly to the Audit and Risk Committee and the Trust Board. Executive Directors review regularly and Board meetings reflect at each meeting whether items have been raised that either affect existing BAF risk ratings or which require the BAF to be updated.

BAF Deep dives **-** these have been scheduled for relevant Board Committees, but subject to the rule that should the risk be red rated then the Audit and Risk Committee undertake the deep dive.

A Board Development Session on the BAF is scheduled for February 2017, to be attended by internal auditors, KPMG. This is to include discussion on how risks with element of confidentiality are managed.

Review of BAF risks is a standing item on all Committee Forward Plans.

Evidence
4.9a,b Board Assurance Framework
4.10a,b Minutes of meetings reviewing the BAF, e.g. Finance & Performance Committee October 2016
4.11 Committee forward plans
On-going Monitoring Arrangements BAF is standing item on all Board and Committee Forward Plans

Executive Director Responsible	Director of Corporate Affairs	**Responsible Assurance Committee**	Audit and Risk Committee

Blue Completion Form

Recommendation CQC1 – The Trust should ensure that the outcome of this focused inspection impacts directly upon the organisational strategy – February 2016	Current BRAG Rating	Recommended BRAG Rating
	Completed	Assurance Received

Detail

During its development the new Trust Strategy has considered the outcome of the CQC inspection as part of the development of strategic priorities, particularly with reference to 'our people'.

11.11.16: The GIAP Planning meeting agreed that the action should be signed off as evidence of compliance is available. This was confirmed at the Executive Leadership Team meeting held on 19.12.16.

Evidence

Trust Strategy 2017-21

On-going Monitoring Arrangements
To be monitored as part of strategy implementation.

Executive Director Responsible	Interim Director of Strategy	**Responsible Assurance Committee**	Board of Directors

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 11 January 2017

Report from Council of Governors
14 December 2016

The Council of Governors met on 14 December 2016 at the Ashbourne Centre, Kingsway, Derby. This report provides a summary of issues discussed for noting by the Trust Board.

14 DECEMBER 2016 - EXTRAORDINARY CONFIDENTIAL MEETING

The meeting was chaired by Richard Gregory, Interim Trust Chair. Eleven governors were in attendance. The Council of Governors discussed arrangements and recommendations from the Nominations & Remuneration Committee regarding appointment of the Acting Trust Chair.

14 DECEMBER 2016 – EXTRAORDINARY PUBLIC MEETING

The Council of Governors was convened in public session, and joined by members of the Board. The Council of Governors discussed agenda items, including:

APPOINTMENT OF ACTING TRUST CHAIR

A ballot was held to determine the outcome of the recommendation of the Nominations and Remuneration Committee to appoint Caroline Maley as Acting Trust Chair. The Interim Trust Chair announced that the recommendation had been accepted. The appointment will be effective from 1 January 2017 on an Acting basis for the period until the transaction arrangements with Derbyshire Community Healthcare NHS Foundation Trust are agreed and enacted.

LEAD GOVERNOR AND DEPUTY LEAD GOVERNOR ARRANGEMENTS

The Lead Governor role and proposals for a Deputy Lead Governor role were discussed. Council of Governors agreed that expressions of interest would be sought for a Deputy Lead Governor on a temporary basis pending a full election process for both the Lead and Deputy Lead Governor posts which would commence on 1 February, following the conclusion of current governor elections. The outcome would be formally approved at a Council of Governors meeting on 7 March 2017.

Terms of office for two public governors were extended to align with wider public governor terms of office (from 22 January to 1 February 2017). The current Lead Governor's role, John Morrissey, was agreed to be extended to 7 March 2017 subject to his reappointment as public governor for Amber Valley South.

ANY OTHER BUSINESS

Richard Gregory thanked the Council of Governors for its support during his tenure as Interim Chairman.

RECOMMENDATION

The Board is asked to note the summary report from the Council of Governors.

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

2016-17 Board Annual Forward Plan

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

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	Apr-16	May-16	Jun-16	Jul-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
SH	Committee Assurance Summaries (following every meeting) - Audit & Risk - Finance & Performance (Confidential) - Mental Health Act - Quality Committee - Safeguarding - People & Culture	Strategic Outcome 3	X	X	X	X	X	X	X	X	X	X	X
MP	Governance Improvement Action Plan	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X	X
SH	Fit and Proper Person Declaration	Licence Condition FT4		X									X
MP	Emergency Planning Report								X				
SH	Board Effectiveness Survey											X	
SH	Report from Council of Governors Meeting		X				X	X		X		X	
LWS	Measuring the Trust Strategy											X	
OPERATIONAL PERFORMANCE													
CG, CW, AR, MP	Integrated performance and activity report to include Finance, Workforce, performance and Quality Dashboard	Licence Condition FT 4 Strategic outcome 1 Strategic Outcome 3	X	X	X	X	X	X	X	X	X	X	X
MP	Agency Controls									X	X	X	X
QUALITY GOVERNANCE													
CG	Position Statement on Quality (Incorporates Strategy and assurance aspects of Quality management) Includes Annual Review of Recovery Outcomes in October and Annual Looked After Children Report in December	Strategic Outcome 1 CQC and Monitor	X	X	X	X	X	X	X	X	X	X	X
CG/JS	Safeguarding Children Annual Report	Children Act Mental Health Standard Contract							X				
CG/JS	Safeguarding Adults Annual Report	CQC Mental Health Standard Contract								X			
CG	Control of Infection Report	Health Act Hygiene Code		X									

2016-17 Board Annual Forward Plan

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	Apr-16	May-16	Jun-16	Jul-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
CG/JS	Integrated Clinical Governance Annual Report including MHA/Governance/Complaints and Compliments/SIRIs/Patient Safety/NHS Protect (LSMS) and Emergency Preparedness/H&S (including H&S and Fire Compliance and Associated Training)	CQC and H&S Act							X				
CG	Annual Community Patient Survey	Clinical Practice CQC							X				
JS	Re-validation of Doctors	Strategic Outcome 3			X								
CG	Progress from Quality Visits				X					X			X
CG	Annual Review of Recovery Outcomes *							X					
CG	Annual Looked After Children Report *									X			

* Incorporated in Quality Position Statement