Derbyshire Healthcare
NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust
Public Trust Board Meeting

Conference Rooms A and B, Centre for Research and Development, Kingsway Hospital, Derby DE22 3LZ
1 November 2017 13:00 - 1 November 2017 16:30

INDEX

Derbyshire Healthcare
NHS Foundation Trust

NOTICE OF PUBLIC BOARD MEETING –WEDNESDAY 1 NOVEMBER 2017
TO COMMENCE AT 1.00 PM IN CONFERENCE ROOMS A&B
FIRST FLOOR, CENTRE FOR RESEARCH & DEVELOMENT, KINGSWAY HOSPITAL

	TIME	AGENDA	ENC	LED BY
1.	1:00	Chair's welcome, opening remarks, apologies for absence and Declarations of Interest Register	**A**	Caroline Maley
2.		Minutes of Board of Directors meeting held on 27 September 2017	**B**	Caroline Maley
3.		Matters arising – Actions Matrix	**C**	Caroline Maley
4.		Questions from governors or members of the public	**-**	Caroline Maley
5.	1:15	Chair's Update	**-**	Caroline Maley
6.	1:25	Chief Executive's Update	**D**	Ifti Majid
7.	1:35	STP Update	**D1**	Ifti Majid
OPERATIONAL PERFORMANCE, QUALITY AND STRATEGY				
8.	2:00	Integrated Performance and Activity Report - Outpatient Model Report	**E**	Mark Powell/Claire Wright/Amanda Rawlings/Carolyn Green/ John Sykes
9.	2:40	Position Statement on Quality	**F**	Carolyn Green
10.	2:50	Board Committee Assurance Summaries and Escalations: Safeguarding Committee held on 7 September, Audit & Risk Committee held on 3 October, Quality Committee held on 12 October, 2017 *(minutes of these meetings are available upon request)*	**G**	Committee Chairs
3:00 B R E A K				
11.	3:15	Deep Dive – Nutritional Care and Catering across Mental Health Inpatient	**H**	Claire Wright
12.	3:35	Board Assurance Framework Update 2017/18 Third Issue	**I**	Sam Harrison
13.	3:45	Corporate Governance Framework Refresh 2017	**J**	Sam Harrison
14.	4:55	Governance Improvement Action Plan – six month update Response to Deloitte Phase 2 external assurance recommendations	**K**	Sam Harrison
CLOSING MATTERS				
15.	4:05	Any Other Business	**-**	Caroline Maley
16.	4:10	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Meeting effectiveness	**-**	Caroline Maley
FOR INFORMATION				
Report from Council of Governors Meeting held 26 September 2017-			**L**	-
2017/18 Board Forward Plan			**M**	-

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 29 November 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 Chair's discretion

Declaration of Interests Register 2017-18

NAME	INTEREST DISCLOSED	TYPE
Margaret Gildea Non-Executive Director	Director, Organisation Change Solutions Limited Non-Executive Director, Derwent Living	(a, b)
Ifti Majid Chief Executive	Board member, North East Midlands Leadership Academy Board Kate Majid (spouse) Assistant Chief Commissioning Officer, NHS North Derbyshire CCG	(a, d)
Caroline Maley 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 Julia Tabreham Deputy Trust Chair and Non-Executive Director	Non-Executive Director, Parliamentary and Health Service Ombudsman Director of Research and Ambassador Carers Federation Leads the Parliamentary and Health Service Ombudsman's contribution to establishing NHS complaints advocacy support in Ireland	(a, d)
Lynn Wilmott-Shepherd Interim Director of Strategic Development	Substantive post – Director of Commissioning and Delivery, NHS Erewash CCG	(d)
Richard Wright Non-Executive Director	Director, Sheffield Chamber of Commerce Chair, The Sheffield College Multi Academy Trust Chair Sheffield University Technical College Member of Advisory Board of Sheffield National Centre for Sport and Exercise Medicine	(a, d)

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 27 September 2017

MEETING HELD IN PUBLIC

Commenced: 1pm Closed: 4.30pm

PRESENT:	Caroline Maley	Trust Chair
	Dr Julia Tabreham	Deputy Trust Chair and Non-Executive Director
	Margaret Gildea	Senior Independent Director
	Barry Mellor	Non-Executive Director
	Dr Anne Wright	Non-Executive Director
	Richard Wright	Non-Executive Director
	Ifti Majid	Acting Chief Executive
	Claire Wright	Director of Finance & Deputy Chief Executive
	Dr John Sykes	Medical Director
	Carolyn Green	Director of Nursing & Patient Experience
	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
	Sue Turner	Board Secretary (minutes)
	Dr Matthew Joseph	Consultant Psychiatrist (shadowing Director of Nursing & Patient Experience)
	Katie Keys	Senior Occupational Therapist (shadowing Director of Nursing & Patient Experience)
For DHCFT 2017/133	Nicola Fletcher	Acting Assistant Director of Clinical Professional Practice
For DHCFT 2017/141	Petrina Brown	Lead Clinical Psychologist
For DHCFT 2017/141	Graham Wilkes	Lead Clinical Psychologist
VISITORS:	John Morrissey	Lead Governor and Public Governor, Amber Valley South
	Carole Riley	Deputy Lead Governor and Public Governor, Derby City East

DHCFT 2017/132	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST** Trust Chair, Caroline Maley, opened the meeting and welcomed everyone. No apologies for absence or declarations of interests were received. Following confirmation of Caroline Maley's post as Trust Chair by the Council of Governors at their meeting held on 13 September, Acting Chief Executive, Ifti Majid took the opportunity on behalf of the Board and the Trust's staff to congratulate her on her appointment. Caroline Maley responded that she was delighted to be able to carry on the work she commenced in her previous acting role and very much looked forward to leading the Board, Council of Governors and staff to deliver great care for the people of Derbyshire who use the services of the Trust.
DHCFT	**SERVICE RECEIVER STORY**

2017/133	Acting Assistant Director of Clinical Professional Practice, Nicola Fletcher, introduced Jonathon Sanderson, a fellow chief nurse currently on a placement with the Trust who talked about his substantive role in operating theatres, and the Emergency Department (ED) and the ethos displayed by staff when dealing with tragic events. He described how staff usually showed no emotions at the time of these incidents and they did not discuss how they felt which he felt had led to high levels of mental health problems and had even led to suicide. Jonathon recalled a tragic case involving the death of a young child and the effect this had on the ED team who worked tirelessly to save the child's life. He described how distressing it was observing the anguish felt by the family and that members of the team could not help but show their emotion at the time. He felt that although the team received a de-brief after this distressing event it is clear that this approach does not properly support or prepare staff to deal with events like this on a personal level and they work in a robust atmosphere with senior staff who are often reluctant to share their feelings. This had urged Jonathon to think about staff support and wellbeing and suicide prevention while undertaking his placement here at the Trust and he asked the Board what kind of provision was made to staff when they are affected by traumatic events and whether there is a policy within the Trust to ensure the wellbeing of staff. The Board discussed the trauma medical staff experience through deaths that occur at work and acknowledged that clinical staff talk to people who feel suicidal on a day to day basis and work to prevent people from taking their own lives while supporting their families. The Trust is committed to helping staff succeed dealing with the day to day trauma they face. Ifti Majid explained that a staff Health and Wellbeing Strategy was developed to support staff when they are challenged by stress, anxiety or depression. The Trust's strengthened approach for supporting staff is being taken forward by the Director of People and Organisational Development, Amanda Rawlings through the People & Culture Committee to ensure staff have the support networks they need to deal with any incident. Caroline Maley thanked Jonathon for sharing his experience with the Board. **RESOLVED: The Board of Directors expressed thanks to Jonathon for sharing his story which enabled the Board to focus on the wellbeing of its staff and give clear insight into a service that the Trust provides for its staff.**
DHCFT 2017/134	**MINUTES OF THE MEETING DATED 27JULY 2017** The minutes of the previous meeting, held on 27 July were agreed and accepted as an accurate record, subject to the word 'prototype' being replaced with 'initial' in the first sentence of the sixth paragraph of the Acting Chief Executive's report item DHCFT 2017/119. The first sentence of the final paragraph of this item would be corrected to read *'Caroline Maley responded that The Trust and DCHS had been asked by the STP Board to present at the next STP Board meeting on why transaction did not go ahead.'* The seventh paragraph of DHCFT 2017/120 Integrated Performance and Activity Report would be corrected to show that Deputy Medical Director, Mark Broadhurst and not Acting Chief Operating Officer, Mark Powell undertook to improve the outpatient experience.
DHCFT 2017/135	**ACTIONS MATRIX AND MATTERS ARISING** The Board agreed to close all completed actions. Updates were provided by members of the Board and were noted on the actions matrix. All completed 'green' actions were scrutinised to ensure that they were fully complete and actions that were not complete were challenged with Executive Director leads.
DHCFT	**CHAIR'S VERBAL REPORT**

2017/0136	Over the summer Caroline Maley had spent time meeting teams. As a non-clinician she felt that her visit to Ward 35 was quite challenging and it gave her a good insight into the day to day work of clinical staff. She also met with the Patient Experience Team and attended the Mortality Group and Serious Incident meetings with them which enabled her to see how the team operates. An interesting quality visit to the Radbourne Unit's Hope and Resilience Team enabled Caroline to see how patients are supported through this important initiative. The governors' Governance Committee took place on 18 August. Caroline continues to regularly meet with the lead and deputy lead governors when open and frank discussions take place. She was pleased to report that a particularly effective Council of Governors meeting took place on 26 September where she observed effective interaction between governors and Non-Executive Directors. She was also pleased to welcome a new governor for Erewash South to the meeting. Caroline met with Paul Wood of the Southern Derbyshire Clinical Commissioning Group who is also the Sustainability and Transformation Partnership (STP) Chair and discussed the detail behind why the merger transaction did not go ahead with Derbyshire Community Health Services NHS Foundation Trust (DCHS). Caroline attended the Health and Wellbeing Board which focussed on the work being carried out throughout Derbyshire on Learning Disabilities. She also attended a meeting of the Trust's Mental Health Act Committee on 26 August. Both Ifti Majid and Caroline Maley attended the STP Board meeting last week. Caroline was pleased to report that good discussions took place around the table with NHS Improvement (NHSI) and NHS England (NHSE) on how to operate as a sovereign entity. As a result of Caroline Maley's update John Sykes asked how overall savings can be offset within the STP that will work towards delivering the Trust's control total. This enabled the Board to discuss the progress being made within the STP and agree that more time is to be spent at Board meetings to discuss what impact STP developments will have on mental health work streams and how this will be cascaded through the organisation. **RESOLVED: The Board of Directors noted the activities of the Trust Chair throughout the month of September.**
DHCFT 2017/137	**<u>ACTING CHIEF EXECUTIVE'S REPORT</u>** The Acting Chief Executive's report provided the Board of Directors with an update on developments occurring within the local Derbyshire health and social care community. The report also updated the Board on feedback from external stakeholders such commissioners and feedback from staff. The report was used to support strategic discussion on the delivery of the Trust strategy. Ifti Majid noted that his report had also been presented to governors at yesterday's Council of Governors meeting. His report covered on a national level the NHSI and NHSE publication on winter 2016/17 and the Royal Society for Public Health's report which looked at the positive and negative effects of social media on young people's mental health. From a local context the report outlined the Trust's continued involvement in the Erewash Vanguard and that it is was one of the providers involved in delivering care as part of Wellbeing Erewash which is now known as 'Erewash Alliance'. Ifti Majid was pleased to report that the STP had held their first board meeting and had agreed to prioritise and speed up the implementation of plans set out in Joined Up Care Derbyshire and focus their organisations on the main projects, or 'work streams'. This

	will help all the eleven organisations involved in the STP start working together as a whole system and move away from functioning as separate entities which will provide better patient care and services. Following the announcement by senior health leaders that the NHS is putting £325 million into new projects in fifteen areas across the country, Ifti Majid's report outlined how Derbyshire would receive up to £30m for two local projects which will allow Derby Teaching Hospitals Foundation NHS Trust to implement plans for an 'Urgent Care Village' which will incorporate GP services, a frailty clinic and mental health services to ensure patients receive the right care in the right place, first time, and avoid going to A&E unnecessarily which will lead to improved outcomes for these people. Ifti Majid's report also commended the work of colleagues who led two large scale World Suicide Prevention Day events on 10 September 2017. These events meant the Trust was able to make positive links with partners in Derbyshire County Council, Public Health, Network Rail, Samaritans and Cruse. Ifti Majid also thanked local leaders and members of the operations and nursing/quality teams who worked hard to prepare for the visit from James Mullins, Head of Hospital Inspections, Mental Health CQC (Care Quality Commission) when he met staff and reviewed the progress and improvements the Trust has made since the comprehensive inspection in June last year. Although this was an informal visit he was pleased with what he saw and gave positive feedback from his visit. Julia Tabreham thanked Ifti Majid for his report and referred to the recommendations made by NHSI and NHSE in their review of winter 2016/17 and drew attention to the need for the Trust to be ready for hidden factors and the inevitable rise in demand for the forthcoming winter. Ifti Majid assured her that the operational teams were focussing on prevention and are working in parallel with community services supporting people who are also waiting for treatment for acute services. **RESOLVED: The Board of Directors noted the Acting Chief Executive's update**
DHCFT 2017/138	**<u>INTEGRATED PERFORMANCE AND ACTIVITY REPORT (IPR)</u>** The IPR provided the Trust Board with an integrated overview of performance as at the end of August 2017 that focussed on workforce, finance, operational delivery and quality performance. The report showed that the Trust continues to perform well against many of its key indicators with improvement continuing across many services. Caroline Maley raised the issue of the pressure placed on staff when they were moved into areas such as the Radbourne Unit to fill staffing gaps. Director of Nursing & Patient Experience, Carolyn Green responded that staff are moved to other areas to ensure that no members of staff are left in an unsafe environment. In order to comply with safety standards, we ensure that staff who are moved to different areas have obtained minimum core competences and have completed mandated training and are safe to practice. Mark Powell assured the Board that there is now a more planned approach to moving staff. A number of Occupational Therapists (OTs) have been recruited and more OTs will be recruited to work on inpatient wards in October. He was pleased to report that there are signs of improvement across some of the community teams and staff have been recruited into the Crisis teams. Although the recruitment of qualified professionals to wards has not increased at the rate he would have hoped, improvements are being made in terms of the workforce plan. He drew attention to the number of registered nurses in band 5 positions working in inpatient wards running at 50% - 60% establishment who are supplemented with bank and agency staff. He acknowledged this is an ongoing risk which he and Director of People & Organisational Effectiveness, Amanda Rawlings are working towards resolving. Mark Powell reported that agency staffing levels are still high but are lower than other

	organisations. Agency expenditure on inpatient areas is minimal which is due to staff flexibility in carrying out additional shifts. Ifti Majid observed some benefits from triangulating the information contained in the IPR. Although staffing fill rates are problematic, agency levels continue on a high trajectory due to sickness levels remaining high. However, catastrophic harm has fallen as have episodes of seclusion and so have incidents involving patients held in seclusion. Also the number of incidents of physical assault and incidents involving physical restraint have reduced in campus areas. Ifti Majid considered this was a clear testament to the Trust's staff who have achieved these results whilst working under extreme pressure. Mark Powell agreed and assured the Board that over the last few months staffing levels have been met and maintained but recognised that these arrangements are not sustainable in the long term. Proactive work is taking place to recruit and retain staff and maintain sustainability such as the return to practice initiative being developed. Caroline Maley was concerned about the risks associated with people being released from prison and the impact this has on non-commissioned community forensic services and asked how this can be addressed with commissioners. Carolyn Green informed her that part of the issue is that we are unable to identify how many people will be released and this risk is included in the Board Assurance Framework (BAF) risk 1a and remains a high risk to clinical quality standards. She assured the Board that she has requested a meeting with commissioners to explore immediate risks and mitigations and make sure direct action takes place and she will brief the Executive Leadership Team on the outcome of her discussions. She will be submitting a briefing paper to the next Quality Committee and this matter will also be addressed through the Safeguarding Committee. This was also a concern for Non-Executive Director, Anne Wright who had observed this trend over the last 12 months and agreed this is a significant risk to the organisation's clinical quality standards. Ifti Majid drew attention to the financial position which is currently being aided by non-recurring benefits. Claire Wright assured the Board that the Finance & Performance Committee is managing the Trust's financial risks. However, not all these risks are under the Trust's direct control such as the risk around the QIPP (Quality, Innovation, Productivity) programme where commissioners contribute to our income. She reported that estates disposal has improved the financial position but this is masking the underlying key element of risks. It is important to continue to improve efficiencies and improve the Trust's Cost Improvement Programme (CIP). She also referred to the regulatory impact which influences financial risks and assured the Board that this too is regularly monitored by the Finance & Performance Committee. Julia Tabreham referred to the need to achieve our control total which she understood would not be easily reached and was concerned that this could lead to a slip in quality provision. Claire Wright assured her that this would be controlled by thoroughly managing financial risks in order to make the right decisions for our patients. The Board considered the risks associated with the key four areas of quality, operations, workforce and finance. It was agreed that an approach to understand what the impact this has on people, workforce supply and finance will be addressed by the Executive Leadership Team so that new ways of working can be focussed upon to provide the Board with the assurance that proactive work to explore creative models is taking place. **RESOLVED: The Board of Directors considered the Integrated Performance Report and obtained significant assurance on current performance across the areas presented.**
DHCFT 2017/139	**<u>QUALITY POSITION STATEMENT</u>** Carolyn Green provided the Board of Directors with an update on the organisation's continuing work to improve the quality of services that are provided in line with the Trust Strategy, Quality Strategy and Framework and strategic objectives.

	This report also contained the procedure for learning from deaths which sets out how the new process will work and how cases will be reviewed going forward. Rachel Williams, Lead for Patient Safety and Patient Experience joined the meeting and assured the Board that the Trust has complied with the CQC's requirement to have a procedure in place for learning from deaths. The Board was informed that learning from deaths will enable the Trust to deliver better end of life care, providing patients and their families and carers with a good experience. It was suggested by Barry Mellor that a two page summary of the procedure be communicated to staff which Rachel Williams undertook to cascade to staff through the Trust's Policy Bulletin. Anne Wright as Non-Executive Director responsible for Mortality and Learning from Deaths welcomed this procedure which will help in investigating the cause of death of every patient within the Trust's care and thanked Rachel Williams on behalf of the Board for the work she undertook in implementing this procedure. Lynn Willmott-Shepherd referred to the importance of maintaining a smoke free environment within the Trust and the effect this has in terms of the Trust's CQUIN (Commissioning for Quality Innovation) and was pleased to see that work is taking place to refresh the strategic direction of the smoke free initiative across all Trust sites. Having reviewed the Quality Position Statement the Board confirmed it was satisfied with the current trajectory of the CQC action plan and obtained significant assurance with regard to patient safety. **RESOLVED: The Board of Directors:** **1) Received and noted the Quality Position Statement** **2) Gained significant assurance with regard to safety** **3) Gained significant assurance with regard to the completion of CQC actions** **4) Gained significant assurance on the Trust's arrangements for learning from deaths**
DHCFT 2017/140	**<u>BOARD ASSURANCE SUMMARIES & ESCALATIONS</u>** Assurance summaries were received from the meetings of the Quality Committee held on 10 August, Mental Health Act Committee held on 24 August and People & Culture Committee held on 21 September 2017. Committee Chairs summarised the escalations that had been raised and these were noted by the Board as follows: **Mental Health Act Committee:** Anne Wright highlighted the work dedicated to completing actions related to issues raised by the CQC and the work being undertaken to embed the required changes. She looked forward to seeing a significant improvement in the performance of the Committee now that its sub-group has begun operating which will focus on operational activity and will enable the Committee to focus on strategic and assurance matters. **Quality Committee:** Julia Tabreham drew the Board's attention to the potential loss of carer and service user representatives on the Committee which will leave it exposed due to the loss of this valuable area of expertise. **People & Culture Committee:** Margaret Gildea had no issues to raise. The Committee is continuing to focus on exploring alternative models and solutions to improve recruitment and approved a process that will encourage staff who have retired to return to work. **RESOLVED: The Board of Directors received and noted the Board Committee Assurance Summaries and Escalations**
DHCFT 2017/141	**<u>DEEP DIVE – CLINICAL PSYCHOLOGY</u>**

Lead Clinical Psychologists Graham Wilkes and Petrina Brown joined the meeting and provided the Board with an insight into some of the key challenges and achievements experienced by the service team. They welcomed the opportunity to give the Board an understanding of clinical psychology services as it helped them reflect on issues and challenges raised by the CQC and realise opportunities that the service can move forward with.

The Board heard how the team is structured throughout the county and was impressed with the low staff turnover rate. The team is working hard developing evidence based specialist interventions for people identified as having a personality disorder. The Board was pleased to note that a lot of skill sharing takes place within the team and that staff can develop into other specialist areas.

Graham Wilkes and Petrina Brown were particularly proud to have developed expertise working alongside investigations into historical abuse and looking at people's needs and psychological therapies as well as areas of need for staff support. They are now working with senior managers to offer clinical expertise to other areas within the Trust in areas under investigation.

The Board was informed of the Post Incident Peer Support Network (PIPS) initiative which involves different types of working within the Trust and includes support provided to staff. This covers debriefing sessions after serious incidents which allows people to gain an understanding of the event that occurred and is a valuable support network. Unfortunately this is under-utilised and a lot of staff feel they know how to absorb their experience. This was noted to have clear links to the patient story as presented at the beginning of the Board meeting.

Petrina Brown and Graham Wilkes made the Board aware of the challenges they face due to waiting list pressures and their concern that without more resource the team will not be able to make any inroads into psychological recovery. Although their capacity is challenging due to covering long term absences and maternity leave they always prioritise cases that carry the most risk and make sure people are aware they are waiting and are working with GPs to help mitigate these risks. They find it hard to find time with high caseloads to progress and it is difficult to find time and space to develop innovative practice.

Margaret Gildea was interested to know how the team established whether a patient should see a psychologist or a psychiatrist. Petrina Brown explained that each person is assessed to see what their primary needs are to determine the appropriate therapy for each situation and that medication is reviewed by working closely alongside medics.

Medical Director, John Sykes had noticed that consultant caseloads include many people with personality disorders and asked if there could be a new style of personality disorder that has developed as a result of the move away from medical therapy. Petrina Brown responded that a lead psychologist is looking at psychology interventions. Although medication is sometimes useful in times of crisis the service provides therapies and psychological interventions at all different levels. The spectrum of support they provide ensures people have enough resilience to be able to engage in quite challenging therapies.

The Board noted the plans the team has for future improvement and agreed to the implementation of a clinical psychology bank made up of people who want to work part time, might want extra hours. People who want to work on particular projects and also people who might be working other organisations. The team are keen to develop a bank for long term flexible working and see this as a way of mobilising staff models in clinical psychology which will also help cover absence due to maternity leave. The Board recognised that some plans for future improvement are incorporated in the Workforce Plan. Recruitment to assistant psychologist roles and personality disorder activity needs to progress and the Board supported Petrina Brown and Graham Wilkes in pushing forward these services.

	RESOLVED: The Board of Directors considered and noted the presentation made by the Clinical Psychology team and agreed to the plans for future improvement outlined above.
DHCFT 2017/142	**SAFEGUARDING CHILDREN AND ADULTS AT RISK ANNUAL REPORT** This annual report summarised the year 2016 to 2017 and included the Safeguarding Children and Adults Board Strategic Plans. The Chair of the Safeguarding Committee, Anne Wright, informed the Board that whilst the Committee accepted the recommendations contained in the report the Committee also expressed concern regarding the general increase in safeguarding work both in adults and children's areas which is having a substantial impact on CAMHS (Child and Adolescent Mental Health Services) and health visitor services. This included increased levels of domestic violence and radicalisation as well as risks related to new and emerging communities. The Board accepted the Safeguarding Children and Adults At Risk Annual Report and was significantly assured that the Safeguarding Committee is monitoring the issues raised in the report and is seeking assurance on mitigation actions. The report will now be submitted to NHSI on 28 September to comply with SAAF (Safeguarding Assessment and Analysis Framework) and S11 of the Children's Act 2004. The Board also obtained significant assurance that the Derbyshire Safeguarding Children Board was reviewed and found to be outstanding. **RESOLVED: The Board of Directors:** **1) Noted the performance and complexity of this report and the findings of the annual report, model and recommendations** **2) Received assurance on the Trust's position and interconnectivity with the Safeguarding Children's and Adults Board for the City and County** **3) Received assurance on the breadth and depth of safeguarding activity to both prevent and respond to the needs of our community and being assured of an effective work plan for the Trust** **4) Acknowledged that the Executive lead provides this report, with the knowledge that there is limited benchmarking information to confirm safeguarding data at a national level in the public domain** **5) Obtained assurance that the Derbyshire Safeguarding Children Board was externally reviewed in 2017 and achieved a rating of outstanding.**
DHCFT 2017/143	**EQUALITY DELIVERY SYSTEM 2 (EDS2) 2017/18 UPDATE AND DRAFT WORKFORCE RACE EQUALITY STANDARD (WRES) ACTION PLAN AND DRAFT INTERIM EQUALITY, DIVERSITY AND INCLUSION STRATEGY OVERVIEW 2017** The report presented by Amanda Rawlings provided the Board with an update on the Equality Delivery System (EDS2) and included the draft Workforce Race Equality 2017 action plan which sets out how the Trust will to act on the findings following its annual WRES submission (approved by the Board of Directors on the 27 July 2017). The report also sought the Board's approval of the draft Interim Equality, Diversity & Inclusion Strategy overview which sets out how the Trust will deliver its equality objectives and embed equality, diversity and inclusion. The Board was made aware by Amanda Rawlings of the work progressing in accordance with EDS2. She was pleased to report that the Trust was the leading organisation in EDS2 performance and thanks were made to Harinder Dhaliwal for engaging staff in this process and for her work in developing the EDS2 annual grading progress delivery event taking place on 23 November. It was recognised that the draft Equality Diversity & Inclusion Strategy was developed through a Board Development Session held in April 2017. The Board fully supported the strategy and was committed to its further development through a follow up Board

	Development session on equality diversity and inclusion taking place in February 2018. The Board also noted that the WRES action plan was scrutinised by the People & Culture Committee on 21 September 2017 and fully supported its implementation. Claire Wright, Deputy Chief Executive and Director of Finance and the appointed LGBTQ Board Champion, informed the Board that she intends to submit a report to a forthcoming Board meeting proposing that the Board signs up as an ally in its approach to supporting REGARDS groups which will enable members of staff to be confident that the Board has an interest in all aspects of equal rights, sexual orientation and gender. **RESOLVED: The Board of Directors:** **1) Noted the annual EDS2 Grading event taking place 23 November 2017** **2) Noted and approved the Draft WRES 2017 action plan** **3) Noted the importance of holding officers to account to ensure workforce diversity and our BME talent pipeline is 'succession ready' through existing performance management mechanisms and quality visits** **4) Approved the DRAFT Interim Equality, Diversity & Inclusion Strategy overview and next steps.**
DHCFT 2017/144	**PULSE CHECK FINDINGS** This report updated the Board of Directors on the latest Pulse Check Results and informed the Board on the Staff Survey Plan for 2017. Amanda Rawlings hoped that this report would provide the Board with assurance that a significant improvement has been achieved in staff response rate and also an improvement in the results received from the two main questions: • How likely are you to recommend this organisation to friends and family if they needed care or treatment – results showed that 73% of respondents would likely or extremely likely to recommend. • How likely are you to recommend this organisation to friends and family as a place to work – results showed that 57% of respondents would likely or extremely likely to recommend. All other questions showed an increase in response as well as positive comments that described the commitment of staff. The overriding themes centred around staff resource and capacity. Claire Wright was interested to know if it was difficult to triangulate areas of focus such as gender, diversity and equality in the pulse check. Amanda Rawlings informed her that it is the Staff Survey that is designed to reflect these areas. The Pulse Check focussed mainly on what it is like to work in any particular area within the Trust. The Staff Survey will show the number of staff the Trust will need to focus on for REGARDS characteristics. The Board was encouraged to see signs of improvement and that it identified teams that needed more support and noted the improvement achieved in the quarterly pulse check. **RESOLVED: The Board of Directors:** **1) Noted the improvement can be seen from the continued quarterly pulse check.** **2) Noted the 2017 staff survey plan**
DHCFT 2017/145	**BOARD EFFECTIVENESS SUMMARY** This report provided the Trust Board with the results of the Board Effectiveness Survey conducted in March 2017. Director of Corporate Affairs & Trust Secretary, Sam Harrison reported that significant

	assurance could be obtained relating to the perception of the effectiveness of the Board across a broad range of areas and results were very positive, especially around questions 1, 3, 4 and 9 which were well articulated in the report. She drew attention to the results relating to succession planning which have been discussed at the Remuneration & Appointments Committee as part of GIAP (Governance Improvement Action Plan) Action RR1 embeddedness review. Quarterly updates are in train for the Executive Leadership Team with regular updates scheduled to be submitted to the Remuneration & Appointments Committee. Sam Harrison was also pleased to report that the Board felt that it is more visible and focused upon being more approachable. Activities undertaken since March 2017 have included continued deep dive presentations to the Board and increased Board member participation in quality visits, as well as a range of engagement events with the Executive Team and Chief Executive where concerns and issues are encouraged to be raised. The results also reinforced the importance of ongoing work to promote staff to raise concerns (to line management, Freedom to Speak up Guardian and Board members alike) with the confidence that these will be listened to and acted upon. Ifti Majid thanked Sam Harrison for producing the report that set out the results of the survey and was keen for the survey to be repeated. Following feedback from Board members it was suggested that the wording of some of the questions be adapted slightly for clarity without destroying any comparability of the previous survey and hoped that the work undertaken by the Board on the cultural agenda will show a positive impact on results. **RESOLVED: The Board of Directors:** **1) Note the outcome of the Board Effectiveness Survey March 2017** **2) Considered the responses including how further improvements are being taken forward as part of planned action by either the Board itself, Board Committees or the wider Trust** **3) Agreed that the survey should be completed again in October 2017**
DHCFT 2017/146	**ANY OTHER BUSINESS** None was discussed.
DHCFT 2017/147	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK** It was agreed that no further changes are required to be updated or included in the BAF as a result of today's discussions.
DHCFT 2017/148	**2017/18 BOARD FORWARD PLAN** The forward plan was noted by the Board.
DHCFT 2017/149	**MEETING EFFECTIVENESS** Good discussions focused on staff wellbeing were noted to be a theme on today's agenda. The Board agreed that the impact of the STP is to be addressed in more detail and more time will be devoted to discussing this item.
DHCFT 2017/150	**REPORT FROM THE CONFIDENTIAL COUNCIL OF GOVERNORS MEETING** This report was provided for information and was noted by the Board. **RESOLVED: The Board of Directors noted the report from the Confidential Council of Governors meeting held on 13 September 2017.**

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

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

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - OCTOBER 2017			Enc C
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
24.5.17	DHCFT 2017/073	Service Receiver Story	Carolyn Green	**ACTION TRANSFERRED TO THE QUALITY COMMITTEE** Carolyn Green will work with the Nursing and Quality team specifically Allied Health professionals to develop a recovery and enablement strategy that will be submitted to the Quality Committee to focus upon employment and a positive approach to recovery	1.11.2017	The Recovery and Enablement Strategy was received and agreed by the Quality Committee at the October meeting.	Green
26.6.17	DHCFT 2017/104	Equality, Diversity and Inclusion Update	Amanda Rawlings	Harinder Dhaliwal to develop the initiative of representatives from the BME network joining trust boards	27.7.2017	Work is progressing on this NHS Improvement initiative to improve BME representation on trust boards. There is a good balance of representation on the Board. Caroline Maley is engaged in this programme which aims to help people take the next step to being recruited to boards from the REGARDS community.	Green
27.7.17	DHCFT 2017/120	Integrated Performance Report	Mark Broadhurst Carolyn Green	Quality Leadership Team, Trust Management Team and Quality Committee to assess how to change the practice of Outpatient Clinics to allow an Outpatient Model Report to be brought to the Board on 1 November setting out causes of cancellations and the solutions	1.11.2017	Outpatient Model Report submitted to 1 November 2017 meeting	Green
27.7.17	DHCFT 2017/120	Integrated Performance Report	Mark Broadhurst John Sykes Green	Report identifying patient measures through IT solutions developed with clinicians to be received by the Quality Committee and Finance & Performance Committee prior to a report setting out the solutions being submitted to the Board on 29 November	29.11.2017	Agenda item for 29 November Board	Yellow
27.7.17	DHCFT 2017/122	Board Assurance Summaries & Escalations	John Sykes Carolyn Green	Quality Committee to receive a report quantifying the full benefits of Clinical Audit	12.10.2017	Clinical Audit Report received by the Audit Committee on 3 October 2017. Report timeline to Quality Committee being agreed between Medical Director and Director of Nursing & Patient Experience. In the meantime value of clinical audit is being monitored by the Quality Committee. Accepted by the Quality Committee and scheduled on the work plan	Green

Resolved	**GREEN**	4	80%
Action Ongoing/Update Required	**AMBER**	0	
Action Overdue	**RED**	0	
Agenda item for future meeting	**YELLOW**	1	20%
		5	100%

Derbyshire Healthcare NHS Foundation Trust
Report to Public Board of Directors 1 November 2017

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. October 2017 saw the release of the Race Disparity Audit, commissioned last year to review how public services treat different ethnicities across the UK. The results are mixed. There are disparities between ethnic groups in all areas of life affected by public organisations. Some are more pronounced than others or have a greater impact on people's life chances and quality of life. In some areas, disparities are reducing, while in others, they are static or increasing. With respect to the Health sector the following key points should be noted:

    - More than half of adults in all ethnic groups other than the Chinese group were overweight (having a Body Mass Index of 25 and over), and this was particularly so among the white and black ethnic groups, affecting two out of three white and black adults. Adults in the mixed group were the most likely to be physically active but also the most likely to smoke.

    - Most Asian groups express lower levels of satisfaction and less positive experiences of NHS General Practice services

    - In the general adult population, black women were the most likely to have experienced a common mental disorder such as anxiety or depression in the last week, and black men were the most likely to have experienced a psychotic disorder in the past year. However, white British adults were more likely to be receiving treatment for a mental or emotional problem than adults in other ethnic groups.

    - Black adults were more likely than adults in other ethnic groups to have been sectioned under the Mental Health Act

    - The public sector workforce is a major employer, but ethnic minority employees are concentrated in the lower grades or ranks, and among younger employees.

    - In 2016, 18% of the non-medical NHS workforce (all staff excluding doctors and dentists) were from an ethnic minority group (excluding White minorities).Only 7% of very senior managers and 11% of senior managers were from an ethnic minority group

    - 93% of NHS board members in England are white (which includes white ethnic

minority backgrounds)

2. The Care Quality Commission (CQC) has published *The state of health and adult social care in England 2016/17*, an annual assessment of quality performance, trends, and themes amongst all providers that are registered with the CQC. All providers that are registered with the CQC have now been inspected therefore providing a baseline view of quality across health and social care. The CQC concludes that most people are still receiving high quality care. While some providers have been successful at improving care despite the mounting pressures, there are signs quality is deteriorating in some services and staff are showing signs of strain. Key themes include:

   - Increasing complexity of demand means that the entire health and social care system is at full stretch, with pressures especially noticeable where sectors connect and people transition between services.

   - NHS staff have worked hard to protect and maintain quality, and many services originally rated as inadequate have used their CQC inspection reports to improve. However, too much care still needs improving and some providers have seen quality deteriorate including acute hospitals and mental health services.

   - Staff resilience is a growing concern given sustained pressures from rising demand and workforce shortages.

   - Significant risks remain in adult social care, where deterioration in quality would outpace improvement and gaps between need and provision would widen

   - Fines for delayed transfers of care levied by the NHS on local authorities are causing tensions that are impeding more collaborative working to resolve problems.

   - Better care requires more joined up services and better partnership working to address fragmentation of services and build care more seamlessly around people's needs. Cultures of safety, openness and transparency, with a leadership approach that applies equality and human rights thinking to quality improvement and actively involve patients, carers and families in these processes, are leading the development of new ways to deliver care more effectively

Local Context

3. NHS England and NHS Improvement held a national event for STP (Sustainability Transformation Plan) SROs on 26 September 2017. The emphasis of the event was that the STP focus now needs to be on implementation. David Behan from the CQC identified that STPs are at different levels of development with many displaying strong and positive leadership – however he emphasized that the task does not just require leadership but also required good management as well. In terms of delivery the greatest emphasis was on successfully managing 'winter'. It is likely that many requests for reporting may be via the STP. The Derbyshire system has agreed a winter plan and currently we are clarifying the various roles of the STP Board, STP PAG (Provider Alliance Group), A&E Delivery Board and Derbyshire Urgent Care Strategic Development Board with respect to plan delivery. Other issues that were discussed requiring continued focus were:

   - Requirement to hit the national priority targets (Mental health, cancer and primary

care)

- Workforce planning at a system level
- Financial pressures

An interim review of the progress against the Derbyshire STP plan that was published in October 2016 has been completed. Key points to note are:

- For some work streams the plan for 2017/18 does not reflect the plan that was submitted last year
- Several work streams are still in the set up phase.
- We have had success in reduced referrals, outpatient attendances, and non-elective admissions; excellent performance against the RTT (Referral to Treatment Targets) for early intervention in psychosis; with greater system working, and all work streams fully operational, could we achieve transformation at greater scale and pace?
- There remain some hotspots where performance is not at the level required – for example increased A&E attendances, performance against the 4 hour A&E target at Derby, cancer waits

The interim review has been discussed by the PAG and at the Board to ensure that the system leaders are sighted on the progress against the original STP plan. Furthermore, PAG recommended that the work being taken forward by Finance Directors to identify suggested priority areas which require system working to contribute to financial recovery should consider the current performance challenges as highlighted in this review.

4. On 19 November we held the second joint City/County Health and Wellbeing Board session facilitated by the Local Government Association. The focus of the event was integration, learning from other areas that perhaps are further ahead than Derbyshire and importantly looking at what actions we need to be taking that will support the system delivery.

5. A Derbyshire wide adult autism strategy was agreed in 2015 across the four CCGs and two Local Authorities. A refresh of the strategy has been undertaken to incorporate the requirements of the 2015 statutory guidance, findings from the 2016 Autism self-assessment return, Transforming care programme requirements and implications of the Building the Right Support national plan regarding development of community services and closure of inpatient facilities for people living with LD (Learning Disability) and/or autism.

   The system wide strategy refresh details the priority areas based on the national requirements and local findings, the actions required to achieve the priorities, the system breakdown showing responsible organisations and the expected outcomes and benefits to be realised.

   Through the transforming care programme it is recognised that autism is a stronger factor in many more individual cases than was previously known, with two thirds of all

transforming care cases having CTRs (Care and Treatment Reviews) having an element of autism. Forty per cent are people being supported within the TCP (Transforming Care Partnerships) programme have autism and no learning disability. Sixty per cent of readmissions are people with autism, again many with autism and no learning disability.

Progress has been made in Derbyshire to increase awareness around autism and from 2017/18 all NHS key providers have a quality requirement regarding access to training and support for all staff to ensure reasonable adjustments and adaptations are made.

The Derbyshire Adult Autism Strategy aims to build on that good work and support all areas of the system to deliver changes as detailed in the 2015 statutory guidance to deliver the requirements of the 2009 Autism Act.

The strategy is going to be presented at the December Health and Wellbeing Boards and we are required to:

- Note the Derbyshire wide Adult Autism Strategy refresh (2017-2020)
- Note the linkages to the delivery of the requirements of the transforming care programme
- Approve the specific actions required for our Trust

The strategy is attached in appendix 1.

6. During October both Health and Wellbeing Boards received the Futures in Mind (Children's) Local Transformation Plan (LTP) refresh. The vision of the single shared LTP is that, 'children and young people are able to achieve positive emotional health by having access to high quality, local provision, appropriate to their need, as well as a range of support enabling self-help, recovery and wellbeing. A health Needs Assessment has been carried out as part of the process that suggested the following:

    - As a system we are likely only to be engaging and supporting one in every four children and young people with a mental illness
    - Evidence suggests that one in every ten school-aged children will suffer a mental illness, but that this will vary across vulnerable groups. For example, prevalence of mental illness in looked after children will be as much as 45%, and in the youth justice system as many as 1 in 5
    - An estimated 13,000 CYP (Children and Young People) are currently experiencing mental ill health across Derby and Derbyshire
    - Bullying remains a significant issue for CYP, with appearance, race, culture and religion dominating reasons behind it
    - Schools are an important setting for CYP, but teachers do not always feel trained and able to support individuals with issues of emotional wellbeing
    - Eligibility for 'Pupil Premium' is associated with deprivation, which is associated with poor outcomes for CYP. So in knowing which schools have

greatest uptake of the premium we have a means of targeting interventions effectively

- There is inequity in referrals into and waits for Child & Adolescent Mental Health Services (CAMHS) services by geography, though the services themselves, including CAMHS RISE (Rapid Intervention, Support and Empowerment) in the south of Derbyshire, continue to support good outcomes

- Parents of adolescents are the most unsupported of all groups of parents, yet they are likely to play one of the more significant roles from crisis through to recovery.

The Health needs assessment has suggested that the plan needs to be amended by:

- Developing further the support offer to parents, to empower families to become more aware of and resilient to mental ill health in CYP, with a particular focus on conduct disorders.

- Developing further a whole-school approach to prevention and early intervention, including training for teachers and opportunities for CYP to comfortably and confidently talk about mental health during the school day.

- Transforming care of CYP with complex and comorbid needs, such as those who have a learning disability coupled with self-harm and behavioural difficulties, or eating disorder with autism, through intensive home-treatment.

- Developing the workforce, both in breadth of number and depth of skill, aligned to national FiM (Functional Independence Measure) targets. This will be underpinned by the principles of Improving Access to Psychological Therapies (IAPT). Building community capacity, specifically in the voluntary and community sector (VCS), which should be coherent and Derbyshire-wide. A peer support, befriending scheme, online and telephone based provision for CYP needs to be embedded in the VCS offer.

- Continuing to work with NHSE to develop new and alternative models of care to respond to need differently, with a focus on enhanced community provision, the development of safe places and avoidance of higher cost CAMHS hospital and Tier 4 admission where less appropriate.

- To work alongside the development of 'place-based' commissioning to strengthen our support to CYP in their local area, including through Primary care, Public Health Nursing, Early Help and Schools.

The Trust is fully engaged with the developments proposed in the plan and more details will be presented to the Board as the plan is finalised.

Within our Trust

7. 10 October was World Mental Health Day and this year the focus was on the mental health of workforce. In our Trust we held two events on 10 and 12 October that attracted large numbers of staff where they were able to look at home made goods stalls, get health and wellbeing advice and try out new activities. Many thanks to all

those who worked so hard to pull together the events.

8. On 6 October our Trust hosted the National Forum for Mental Health Coding and Information. The event was organised by our own Helen Chapman (Helen is one of only two nationally accredited mental health coders) with her counterpart in Leicestershire Partnership Trust. It was the second national forum they have organised and it was very well attended. There were some great examples of how MH coding supports clinicians to provide and evidence the right clinical care at the right time, its use for audits and research, for regulators, commissioners, as well as internally for Trusts in supporting transformation. It was a thought provoking broad-ranging day that included foresight on technical updates like ICD11 and SNOMED (Systematized Nomenclature of Medicine (electronic exchange of clinical health information)) as well as sessions from services receivers and clinicians on schizophrenia. There was really positive feedback from the day including from NHS Digital who had five people attending.

9. Since our last Board meeting in September I have met with/visited our Healthcare Assistants as part of their practice development forum, staff at the Kedleston Unit, nurses, doctors and healthcare assistants on Cubley Male and our Consultants at the Trust Medical Advisory Group. Common themes that emerge from these meetings include:

    - Staff tell me that they can see and appreciate our focus on our people, some of the initiatives are beginning to be recognised and are welcome.

    - We are too slow as a Trust to respond to initiatives generated on the front line and it feels like there is still too few people at a very senior level who can give the go ahead to do something different.

    - The messages and approaches we share at the most senior level in the Trust are not always filtering down to front line staff.

    - Stability of leadership is key to strong team functioning and staff told me that they find it unsettling when we move managers around at short notice.

    - The burden of paperwork remains a tension for frontline staff, CPA (Care Programme Approach), connectivity to access Paris (though most people appreciated the benefits of an electronic system)

    I would ask the Board to note that the Executive Team are focussed on actions from this feedback and importantly will ensure feedback is given directly to teams.

10. The Emergency Care Improvement Program (ECIP) were invited by our Trust and Royal Derby Hospitals trust to provide a mental health review as it is a regional outlier for 12-hour mental health delays. This took place In May 2017. ECIP reviewed a proportion of the current mental health urgent care pathway against agreed acute and mental health standards and evidence base for best practice including:

    - Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults –

Guidance

- Five year forward view for mental health (FYFV) including the need to expand Crisis Resolution and Home Treatment Teams (CRHTTs)
- Crisp Commission- Old problems, new solutions
- CQC thematic review- Right here right now

One of the main outcomes of the review was for ECIP to deliver a facilitated health economy wide workshop to support all partners to develop an integrated mental health urgent care work plan, with a focusing on avoiding twelve hour trolley breaches, but to also seek to resolve the underlying factors that contribute to these. The workshop took place on 29 September and was attended by a range of partners including, Royal Derby Acute Hospital, Social Care, East Midlands Ambulance Service, Commissioners and members from many of the Trust's own teams. A draft action plan has been agreed and will be presented for approval by all partners at an upcoming A&E Board meeting

11. After a period of planning the use of the Red2Green tool in the acute adult inpatient wards was introduced on Monday 9 October 2017. This introductory phase is expected to last six weeks, which will be followed by a review session on the 16th November 2017. 'Red and Green Bed Days' are a visual management system to assist in the identification of wasted time in a patient's journey. Applicable to in-patient wards in both acute and community settings, this approach is used to reduce internal and external delays as part of the SAFER patient flow bundle. At the centre of the system is the person receiving the acute care whose experience should be one of involvement and personal control, with an expectation of what will be happening.

    During the next two months the clinical and operational leadership teams will be reviewing impact on length of stay and early discharges

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

Assurances

- Our strategic thinking includes national issues that are not immediately in the health or care sector but that could be of high impact.
- The 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

- The report has not been to any other group or committee though content has been discussed in various Executive meetings

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis	
The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people) (Public Sector Equality Duty & Equality Impact Risk Analysis) The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).	
There are no adverse effects on people with protected characteristics (REGARDS).	
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	x
Actions to Mitigate/Minimise Identified Risks This document is a mixture of a strategic scan of key policy changes nationally and locally that could have an impact on our Trust and the reporting of internal actions and feedback I have received relating to the strategy delivery. Any implementation of national policy in our Trust would include a repeat Equality	

Impact Assessment even though this will have been completed nationally.

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

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

That equality impact assessment carried out will determine a response to the three aims of the general equality duty:

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

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

The work being carried out in relation to the needs assessment for children's services is a good example of how understanding the detailed risks and opportunities for different parts of our communities can have an impact on service provision.

Recommendations

The Board of Directors is requested to:

1) Scrutinise the report, noting the risks and actions being taken
2) Seek further assurance around any key issues raised.
3) Note the Derbyshire wide Adult Autism Strategy refresh (2017-2020)
   a. Note the linkages to the delivery of the requirements of the transforming care programme
   b. Approve the specific actions required for our Trust

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

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

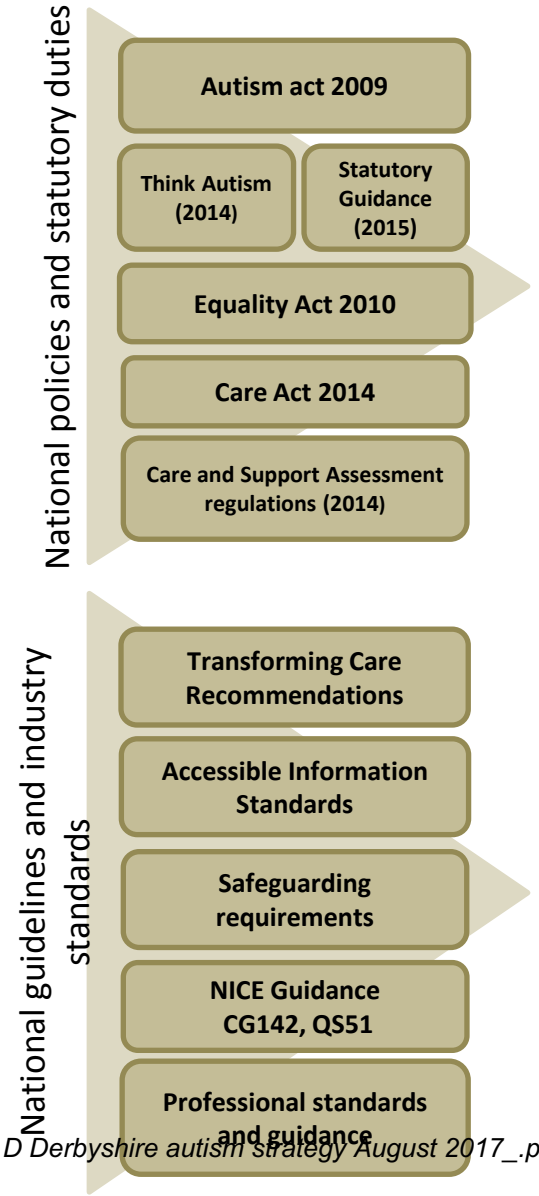
Derbyshire
Adult Autism Strategy Refresh
2017-2020

DERBYSHIRE County Council
Improving life for local people

Erewash CCG
Hardwick CCG
North Derbyshire CCG
Southern Derbyshire CCG
NHS

Derby City Council

1. What are the things we need to achieve?



The Autism act[1], Department of Health national strategy[2,3] and associated statutory guidance[4,5]; provides the strategic framework for improvement across all services to support people with an autistic spectrum condition. Whilst the statutory guidance is clear on the requirements that both NHS bodies and Local Authorities *must* achieve, it also specifies what NHS bodies and Local authorities should achieve and how public sector bodies should work in partnership to support people with an autistic spectrum condition to lead a fulfilling and rewarding life.

The rights of people with autistic spectrum conditions are enshrined within the Equality Act 2010[6]and the Human Rights Act (1998)[7].

The Care Act (2014)[8] places a duty on Local Authorities to prevent, reduce or delay the need for care and support and to ensure that anybody, including a carer, who appears to need care or support is entitled to an assessment, which must focus on outcomes important to the individual as detailed within statutory regulations.

The transforming care programme[9] has been established to improve the quality of support provided to people with a learning disability and/or autism who display behaviour that challenges.

The accessible communication standards (2016)[10] aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily understand and receive support so they can communicate effectively with health and social care services

All Local Authorities have overarching duties to safeguard both children and vulnerable adults from abuse[11].

NICE have produced clinical guidance and quality standards relating to the assessment and management of autistic spectrum conditions in adults[12,13].

Many professional bodies have created an published standards with which their members should abide. These include the Royal College of Psychiatrists, British Psychology society, Royal College of General Practitioner, Royal College of Nursing and the Social Care Institute of Excellence.

2. What do we know about how well we are progressing?

Local findings

Autism Self-Assessment Returns (SAF)
Gap analysis return to PHE
2013 2014 2016

Derbyshire Autism Health and Social Care Needs Assessment (2011)

Derbyshire survey of adults living with Autism (2013)

Regular engagement with self advocates

Findings from CTR reviews

Increased awareness across society

Derbyshire Autism Partnership Board

The Autism Act[1] requires the Department of Health to undertake regular assessment of the progress of local areas in implementing the actions required. This is achieved through a Self-Assessment return co-ordinated by Local Authorities but including NHS and public sector partners. A summary of the local findings are provided on the following page

The Derbyshire Autism needs assessment [14] recommended that the local system look to develop a joint care pathway across health and social care; the pathway should take account of training needs of staff and carers, ensure services make reasonable adjustments and adaptations and effectively plan capacity levels to meet the expected rise in demand. It also recommended that an action plan and monitoring mechanisms are developed to support the delivery.

The results of the survey identified the following priorities for people with autism living in Derbyshire; help with meeting friends, communication, managing behaviour, getting a buddy or volunteering, finding groups and joining activities.

The Autism leads in Derbyshire and co-chair of the Autism Partnership Board regularly meet self-advocates and collate the themes including good practice and areas for improvement. The main themes relate to length of time between referral and diagnosis and lack of post diagnostic support.

Care and Treatment reviews of people admitted for mental health acute care or receiving crisis services in the community has highlighted the need for more effective pro-active care planning enhanced workforce skills, reasonable adjustments and housing support needs.

National awareness campaigns and media focus has had a positive effect on reducing stigma relating to ASD, this has encouraged more people to seek both a diagnosis and support services to meet their needs. Since 2012 the number of adults referred for an ASD assessment has increased substantially (>50% increase) and the number of people meeting social care eligibility criteria with an autistic spectrum condition has in creased 25% since 2014[15]

The Derbyshire Autism Partnership Board have highlighted the need for further work with Department of Work and Pensions and Job Centre colleagues to enable an increase in people getting into and maintaining employment.

3. How well have we done in meeting the requirements of the Autism Statutory Guidance?

The table below provides a summary of the submissions made for the populations of Derbyshire County and Derby City. The table is a quick visual guide of the responses provided to the questions which included a self-assessed RAG rating. The self assessment reports provide much greater detail relating to all of the sections detailed below and the progress made by each Local authority area in achieving the requirements of the Autism Act and subsequent strategic requirements and statutory guidance. The full report can be found at https://www.gov.uk/government/publications/autism-self-assessment-framework-exercise[15]

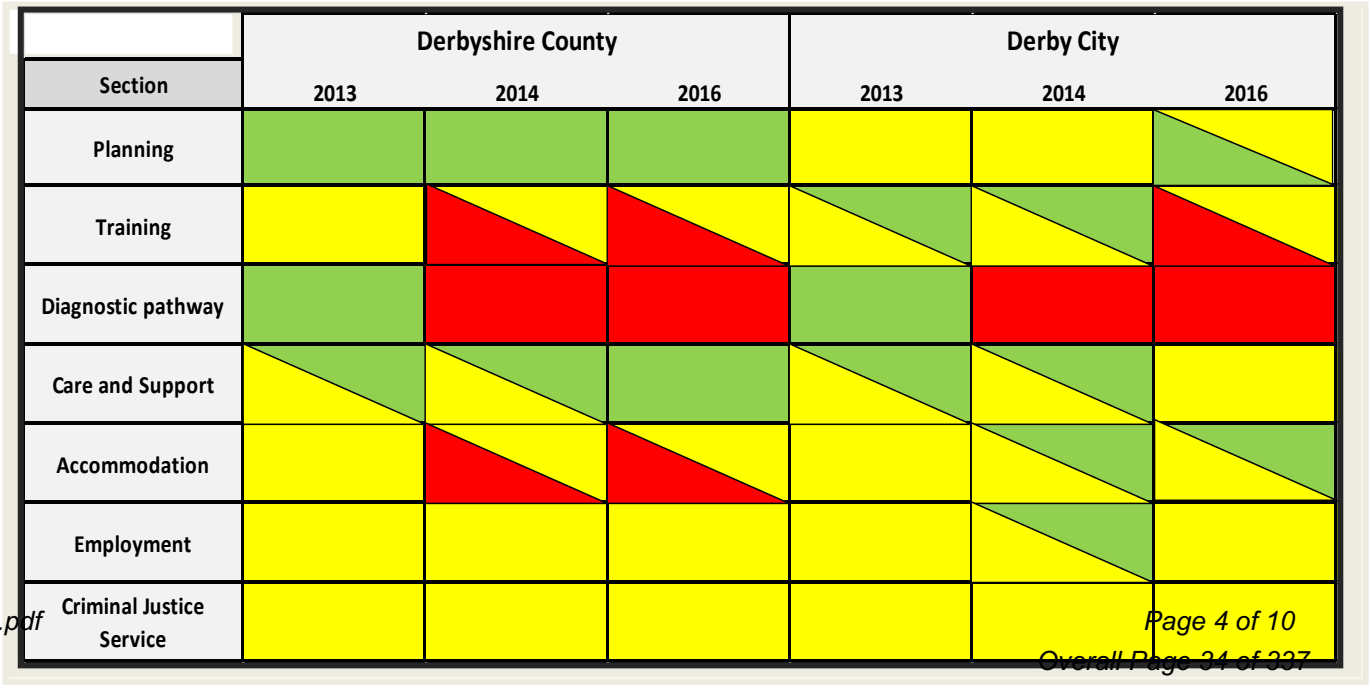
The Self Assessment return highlights the need for improvement on access to training for both specialist staff (social workers and specialist health care) and mainstream services (all care provision including healthcare providers, partner organisations including DWP (Job Centre+), Borough Council departments (housing and leisure services) courts and probation service and Derbyshire Constabulary). The report also highlights that improvements are required in the delivery of the diagnostic pathway in relation to reduction in waiting times and provision of post-diagnostic specialist support.

Further work is required in relation to the provision of care and support and ensuring equitable access to care assessments, raising awareness across care agencies to ensure that reasonable adjustments and adaptations are made and stimulating the market to provide greater levels of choice over specialist support.

Improvement in accommodation support is required from Derbyshire County Council which is based on the partnership between the Local Authority and Borough Councils.

Both local authorities have dedicated employment support for people with disabilities however further work is required to improve support for people with autism.

Working relationships have been established with partner agencies across the Criminal Justice System however further work is required to support increased understanding and reasonable adjustments/adaptations to support people.



4. What are our priorities for the next 3 years?

- Improve access to advice, information and training
- Enable people to live well
- Improve access to specialist support
- Improve access to diagnostics
- Preparing for adulthood

Collating the requirements from the statutory guidance and the themes from the local findings the following areas have been highlighted as a priority for the Derbyshire Adult Autism Programme.

For both individuals with an autistic spectrum condition; and their immediate support network, along with paid carers and health providers there is a need to **improve access to advice information and training across Derbyshire.** The communication methods and information needs will vary from one person to the next so we need to develop many different ways of providing the information including booklets, videos, on-line learning modules and face to face learning.

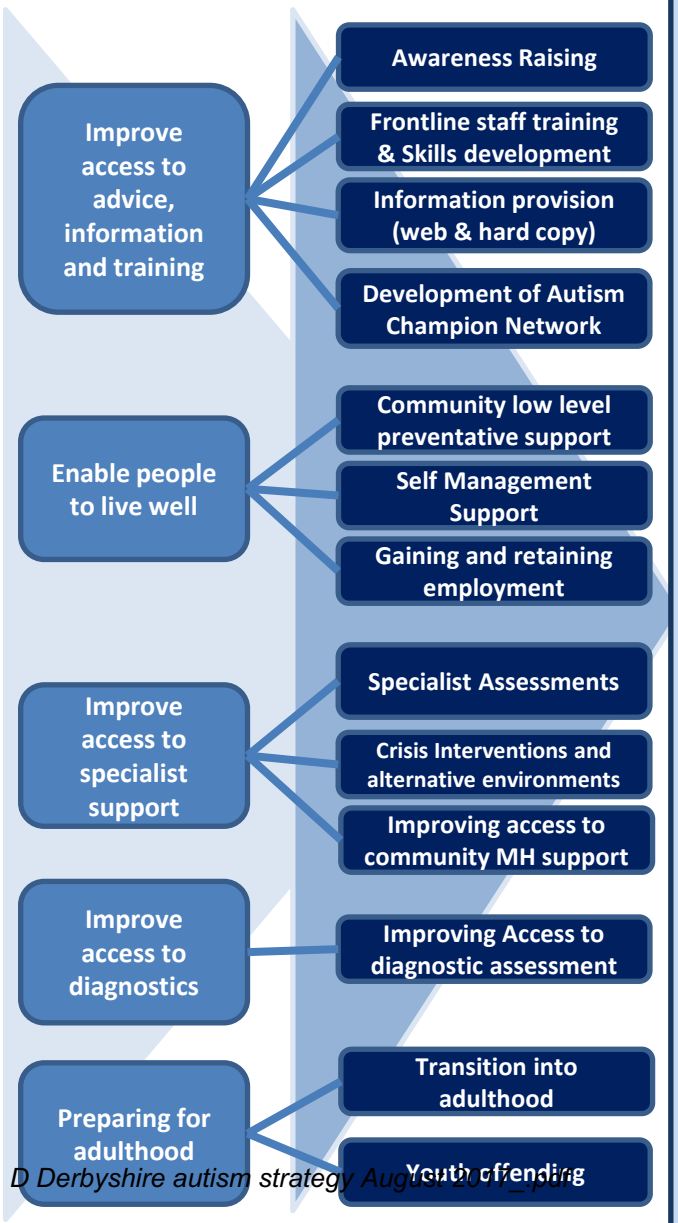
Both the Derbyshire survey and Self-Assessment results highlight a need to increase access to support to **enable people to live well** within their homes and communities. We want to create a system that promotes empowerment and self-management at it's core and provides rapid access to advice, guidance and care provision when needed.

We know that there are times when some people need expert advice from people with greater levels of knowledge and skills therefore we want to **improve access to specialist support**. We understand that this needs to be available not only in times of crisis (when things are going wrong and support is required urgently) but also to assist with development of personal strategies to help people cope with challenging situations, and to support the development of effective care plans which capture what is important to people and how services will work together.

In Derbyshire there are two Adult Autism Assessment services able to provide a diagnosis however the waiting times are longer than we would like. We know we need to **improve access to diagnostics** to ensure that people get help to understand themselves and their condition better, that access routes are opened up to ensure reasonable adjustments are made and interventions are adapted as required.

We know that life's transitions are hard for everyone but can be extremely difficult for people with an autistic spectrum condition. We want to help prepare individuals, families and services for the unique challenges that **preparing for adulthood** can bring for people, which includes navigating relationships and sexuality, moving into a home of your own, seeking further skills and employment, becoming financially independent and how to build a network of support to enable people to cope with these challenges.

5. How are we going to achieve them?



1) We will ensure that all organisations are aware of their duties to provide autism awareness training to all staff and we will work with national and local campaigns to increase awareness across our communities.

2) We will work with health and social care organisations to ensure that staff receive the relevant training and skills to deliver their role.

3) We will develop and publish information booklets and support packs .

4) We will work across the system to link people together and develop networks of support .

5) We will review care and support provision to ensure that the interventions offered are evidence based and provide good value for the individual and the Derbyshire £.

6) We will provide advice and guidance to individuals and their immediate support network to promote and encourage self-management strategies and techniques.

7) We will work with partner agencies to promote employment support for both the potential employee and employer.

8) We will support the development of specialist assessment skills across the relevant agencies and organisations.

9) We will work with our crisis response services to develop specialist skills to support people with ASD and ensure that rapid access to appropriate environments for assessment and treatment is provided.

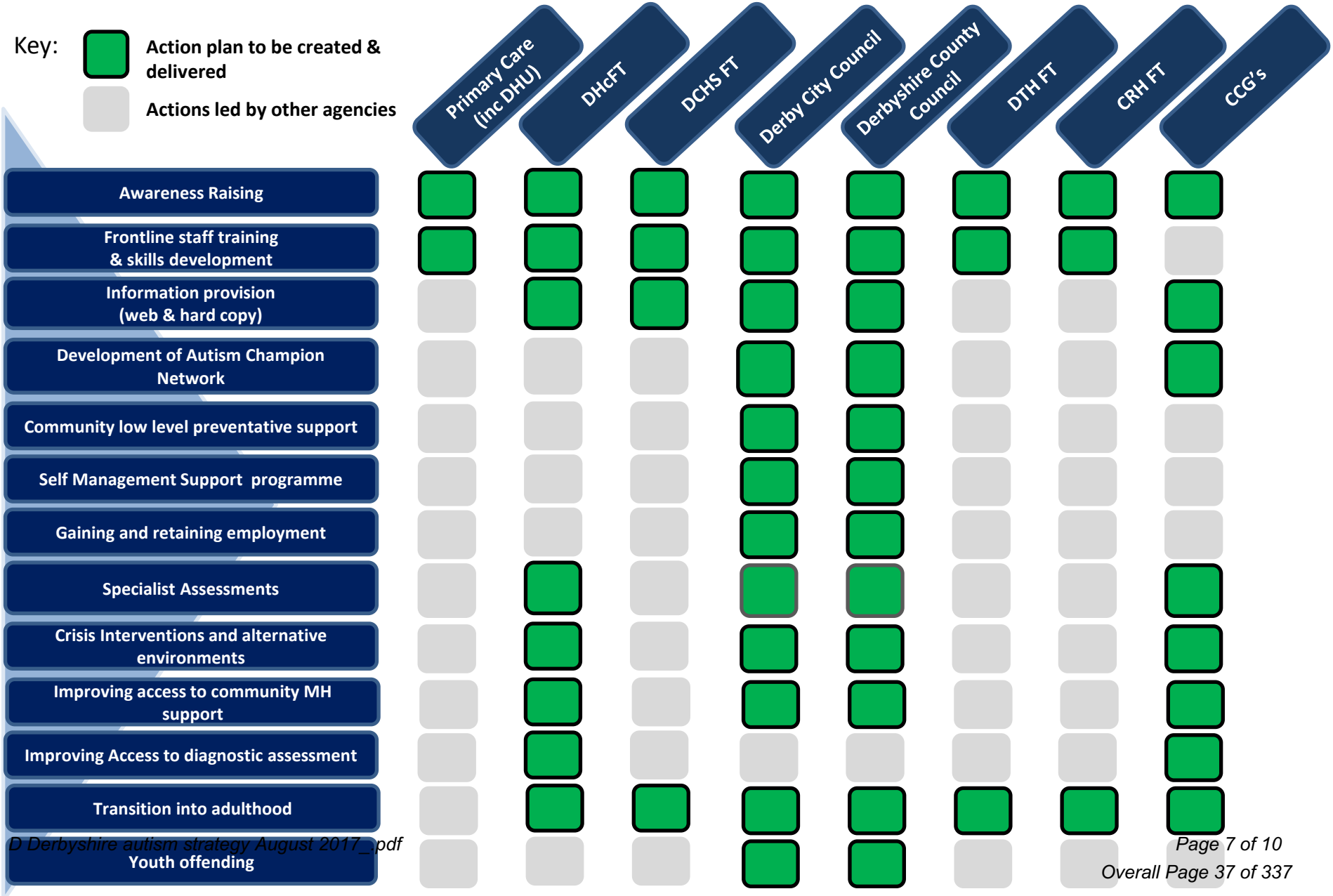
10) We will work with the providers of community mental health support (including IAPT services) to ensure the interventions provided are adapted and that reasonable adjustments are made to the physical environment and communication methods.

11) We will work with our providers of adult autism assessment to reduce the waiting times between referral and assessment.

12) We will smooth the transition between children's and adult services for those individuals receiving care and support and provide advice and guidance for those individuals whose needs are not as complex however may find the transition challenging.

13) We will work across agencies to support people who have offended and reduce re-offending rates.

6. What are the responsibilities for key health and social care organisations?



7. How will we know when we have achieved them?

- **Timely information and advice from one single point of access**
- **Improved access to community care assessments**
- **Increased social skills and understanding of behaviours**
- **Increased independence and self-directed support**
- **Increased understanding and management of risk**
- **Improved access to education and employment**
- **Improved pre-assessment and post diagnostic support**
- **Reduced levels of anxiety and depression**
- **Reduced assessment times**
- **Improved understanding of meltdown triggers**

People will know where to go to get access to advice and information and it will be provided 24/7.

People will be informed of their rights to receive a community care assessment and the assessment process will be sensitive to identify the social as well as care needs.

People will be supported to understand the impact of their behaviour on others (this will include supporting people with autism understanding the impact their behaviour has on people without autism as much as people without autism understanding the impact of their behaviours on people living with autism).

People will be supported to live the life they want to lead, in their community with knowledge and skills to enable them to build personal resilience a strong support network.

People will have a better understanding of the risks (both in their community, wider society and on-line), and will know how to avoid or reduce their personal exposure.

People will be able to access training courses and apprenticeships that have made reasonable adjustments to take account of their environmental and communication needs.

Employers will make reasonable adjustments and adaptations to the recruitment process and will ensure appropriate support is provided within the work place.

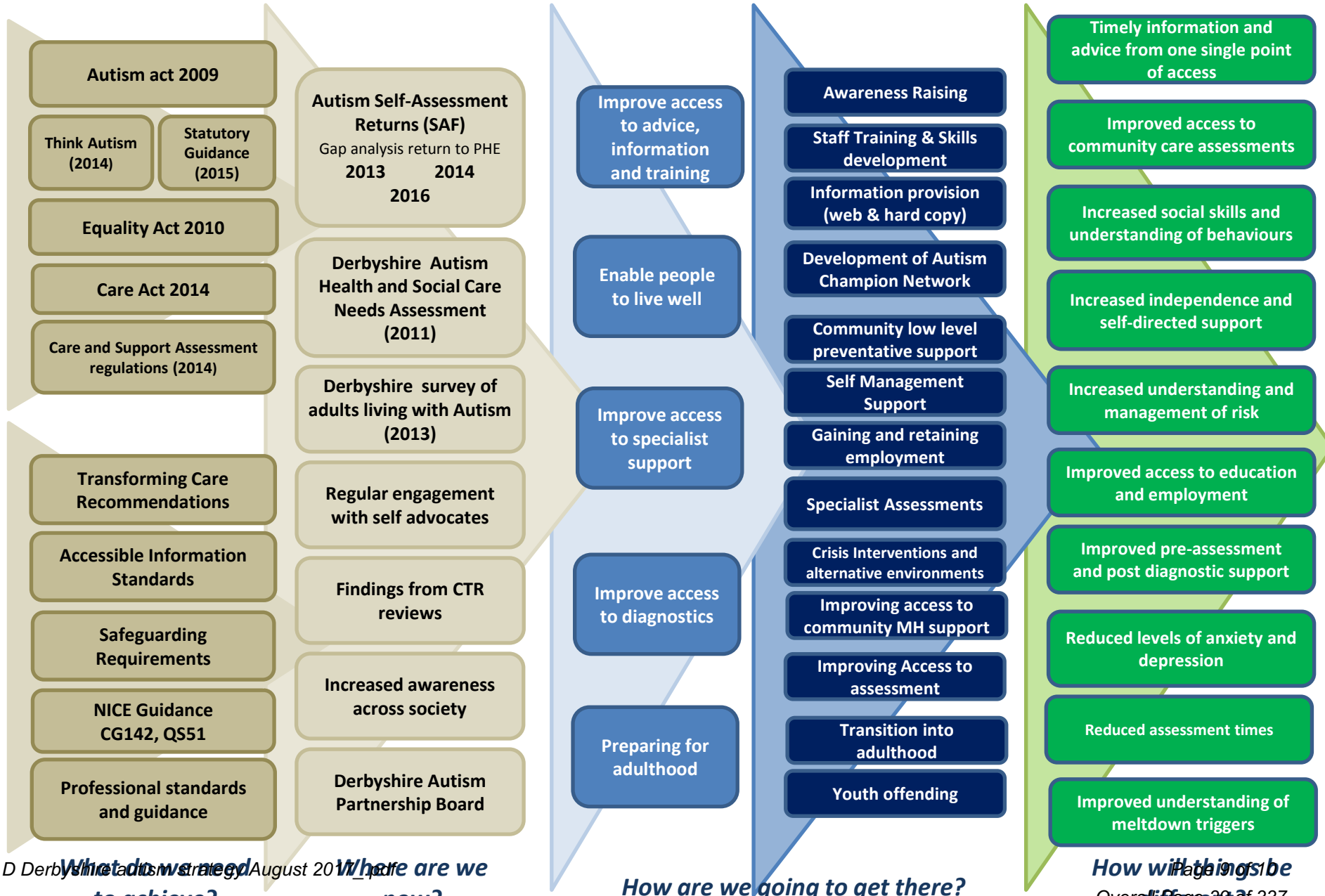
People will have access to specialist advice and support to help them understand and manage their condition.

People will be supported to improve their emotional and mental health resilience and will recognise personal triggers and have strategies in place to manage the effects.

People will have timely access to assessments and will be kept fully informed of the process and associated timescales.

People will feel safe to share with their immediate support network and others, the conditions (environment, physical and emotional) which could lead to a feeling of being overwhelmed or 'meltdown' and will feel confident that if that situation arises appropriate actions will be taken to reduce the intensity and length of the response.

Derbyshire (County & City) Adult Autism Programme 2017–20



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Update on the STP

2017

NHS Five Year Forward View 2014

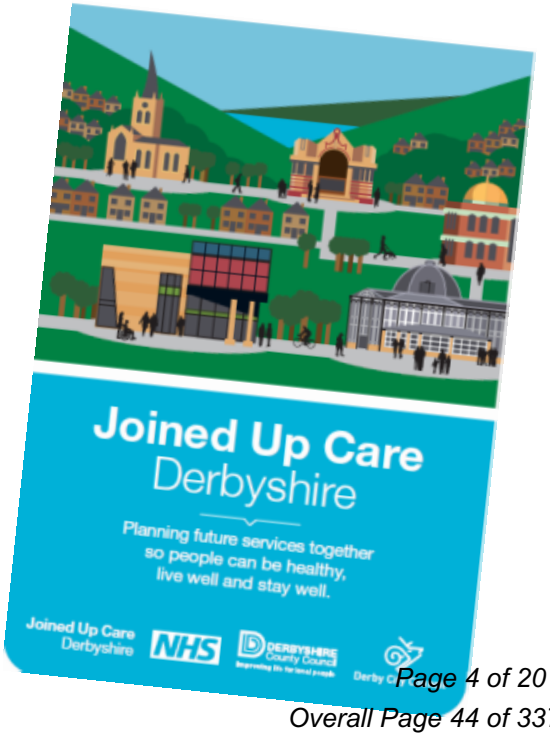
- *The traditional divide between primary care, community services, and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and coordinated health services patients need."*

Why bring services together?

- We need to treat long term conditions better and provide care in the right place, when they need it, at the right time.
- Health and social care need to work seamlessly together
- We need to be as efficient as possible
- We need to make sure services are tailored and targeted to people and their communities
- Preventing physical and mental ill health and helping people to make better lifestyle choices

How the NHS and local authorities are integrating care?

2016 – NHS sets up 44 sustainability and transformation partnerships (STP) covering all England - last October each STP published their plans.



Derbyshire's STP, is called Joined Up Care Derbyshire. Business cases supporting the priority areas are all online

So what is the plan?

- For the NHS to meet patients' needs better in future, there are three gaps that need to close which were all set out in the Five Year Forward View.
- To do this, every part of the NHS needs to understand:
  - local priorities and challenges related to the three gaps
  - how these are likely to evolve over the next five years

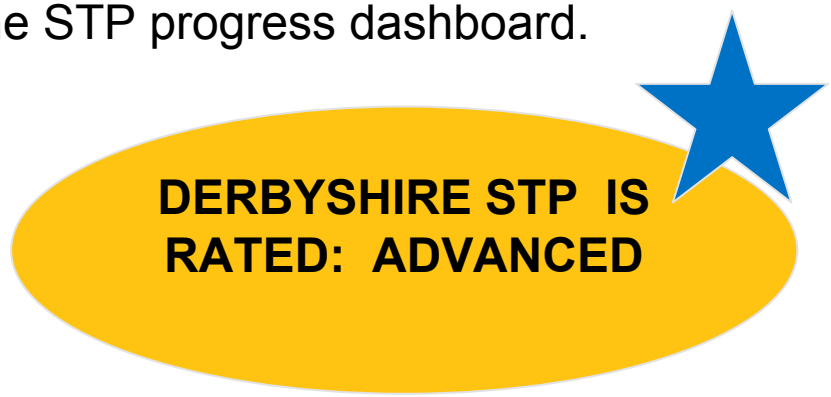
Measuring progress

- In November 2016 NHSE said that the Derbyshire plans for health and social care was "*a credible base for operational planning"* and leadership and governance was considered to be strong.

- However, some nervousness was expressed to the speed of how expected changes were to be delivered and further work was suggested in relation to some of the financial assumptions made.

- Overall, the plan was felt to represent a good starting position and work began on developing the plans to the next stage

- In July 2017 NHS England published the STP progress dashboard.



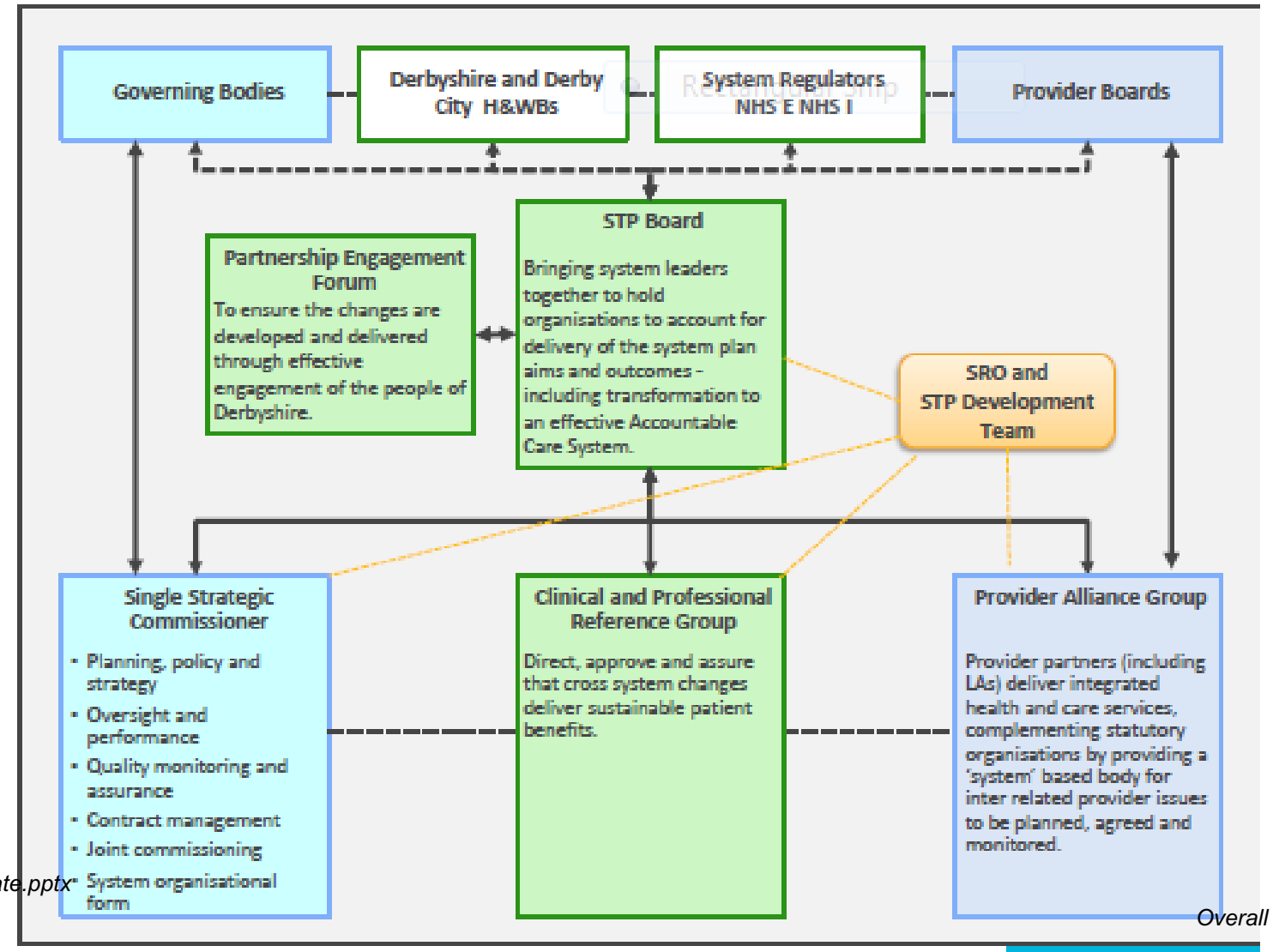
Financially – how are we shaping up

The financial gap does not go away and continues to be a challenge:

We have an estimated funding gap of £240m in our health system and £136m in our local authority over the next three years if we don't change the way we work

How is the Partnership moving forward?

All partners agreed a Governance structure which will help and support the system to make the changes it needs.



How is the Partnership moving forward?

The work we are doing in partnership, supports the national direction to move towards Accountable Care Systems.

What is an ACS?

NHS organisations (commissioners and providers) in partnership with local authorities, take on collective responsibility for resources and population health, providing joined up, better coordinated care.

- Acting on national priorities - taking strain off A&E, making it easier to see a GP, improving access to cancer and mental health services.
- More control over funding available supporting transformation.
- Accountability for improving health and wellbeing of population.

Joined Up Care Derbyshire

So what's in the plan?

Our priorities:

1.To do more to prevent ill health and help people take good care of themselves.

2.To tailor services so they look after and focus on people in their communities, so people get better, more targeted care and support.

3.To make it easy for people to access the right care, whenever it is needed, so everyone gets better quality, quicker support across the system. This would help keep Accident & Emergency, Minor Injury Units and Urgent Care Centres free for patients who really need them.

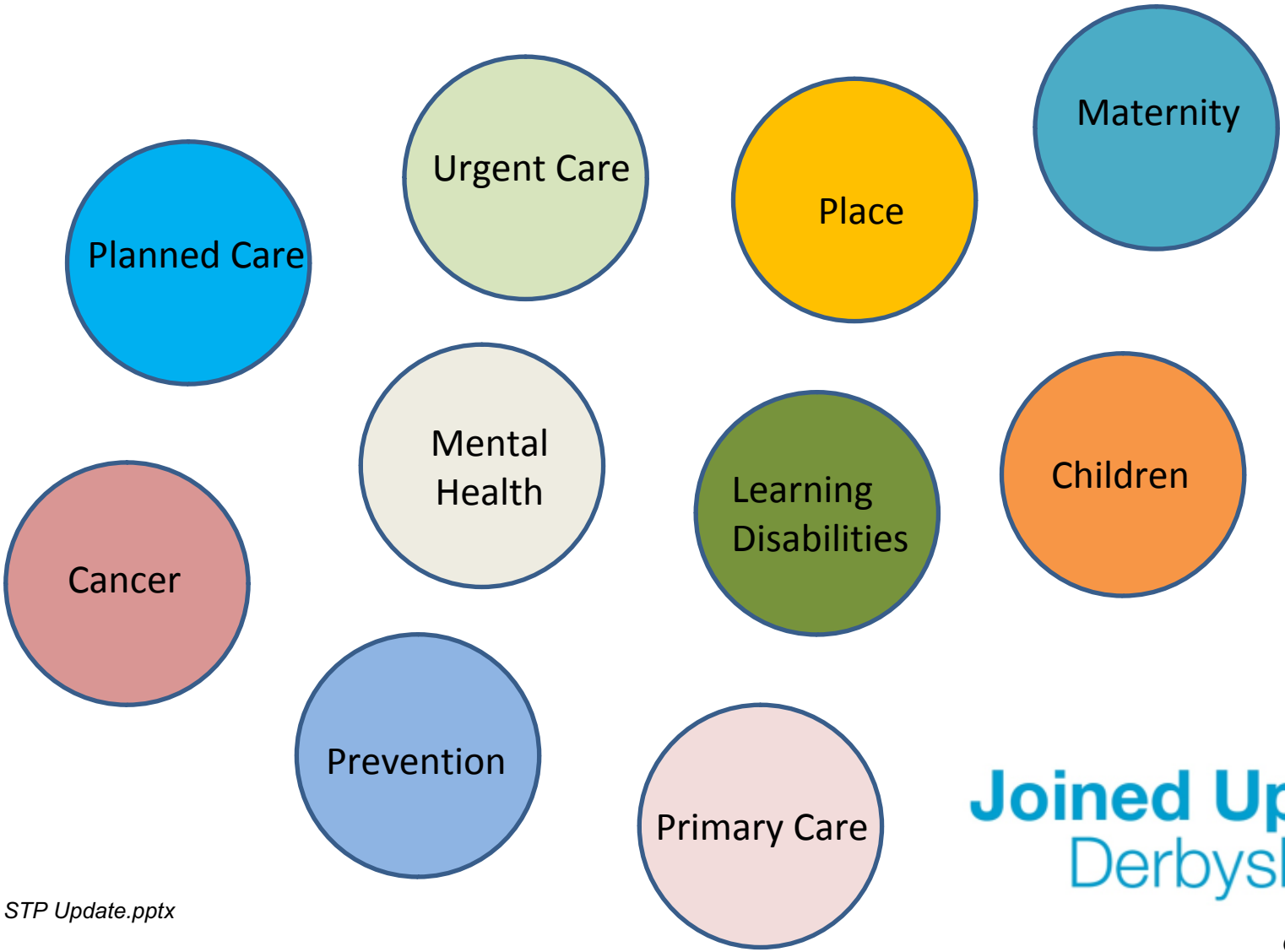
4.To get health and social care working seamlessly together so people get consistently high quality, efficient, coordinated services, without gaps or duplication.

5.To make organisations as efficient as possible so money is pumped into services and care, with running costs kept low.

Joined Up Care Derbyshire

So what's in the plan?

To deliver the priorities there are 10 work areas



Joined Up Care Derbyshire

Mental Health Workstream

Why = The Purpose

What is your cause? What do you believe?

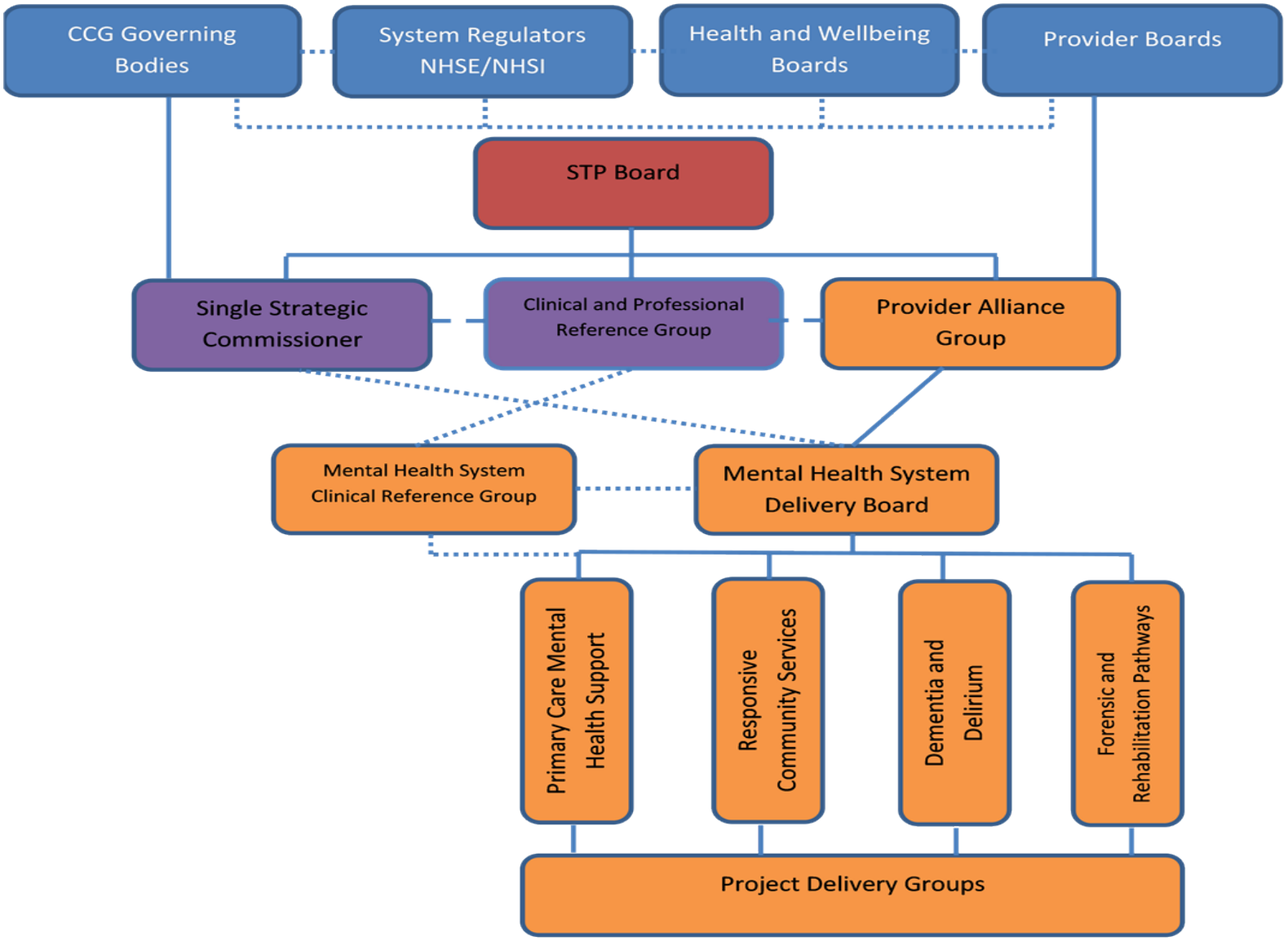
How = The Process

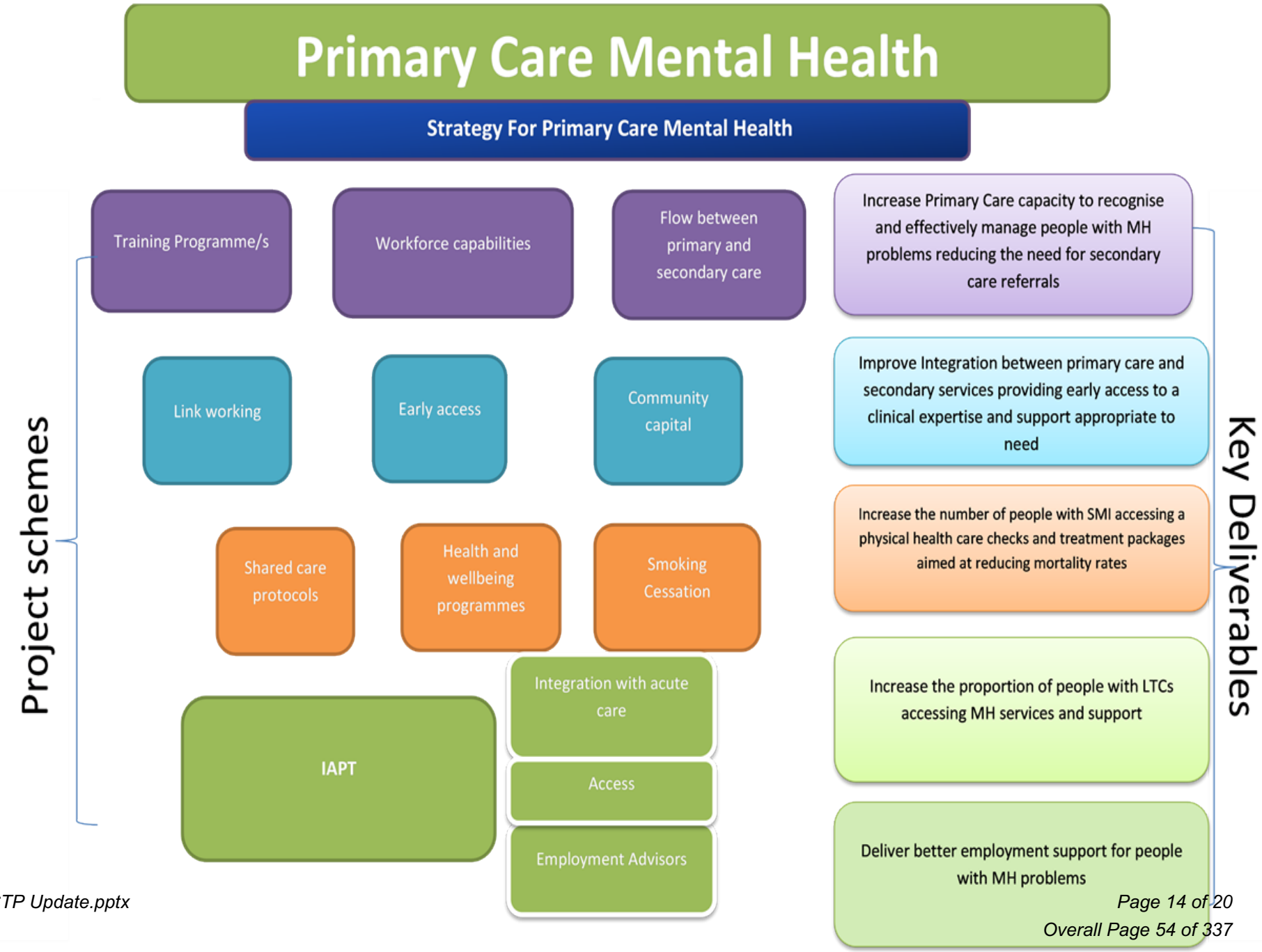
Specific actions taken to realize the Why.

What = The Result

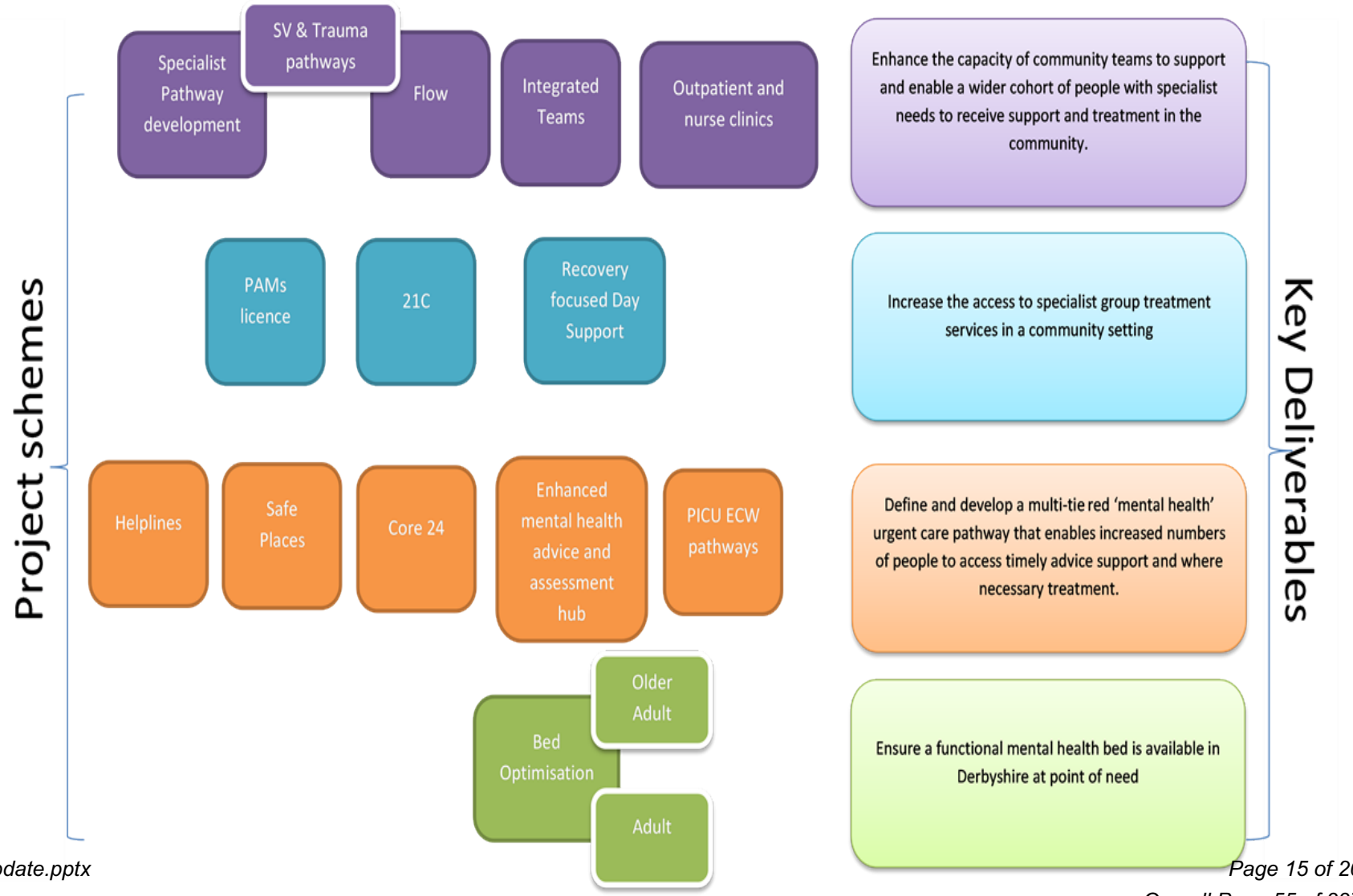
What do you do? The result of Why. Proof.

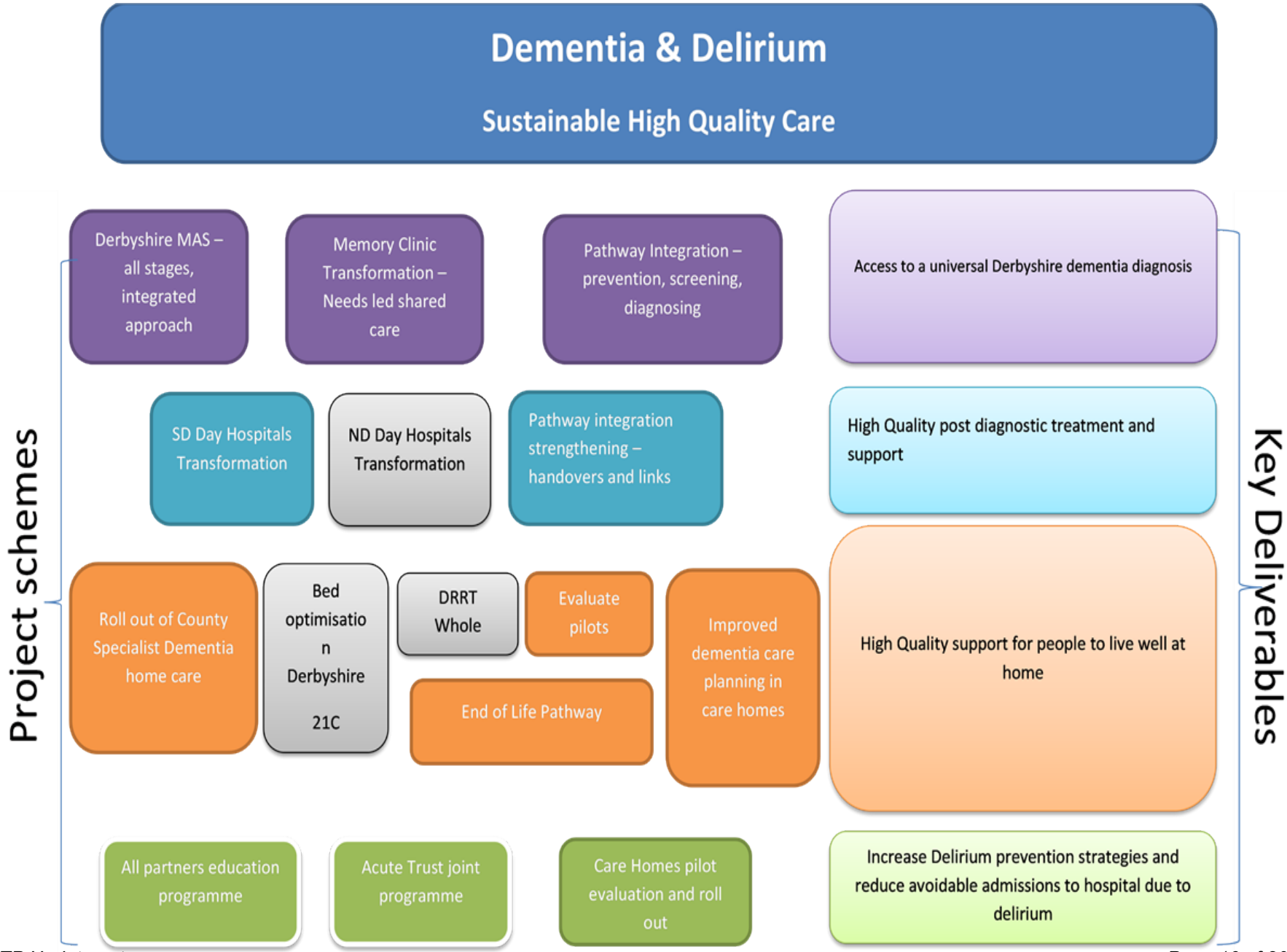
Mental Health System Delivery Board Governance Chart



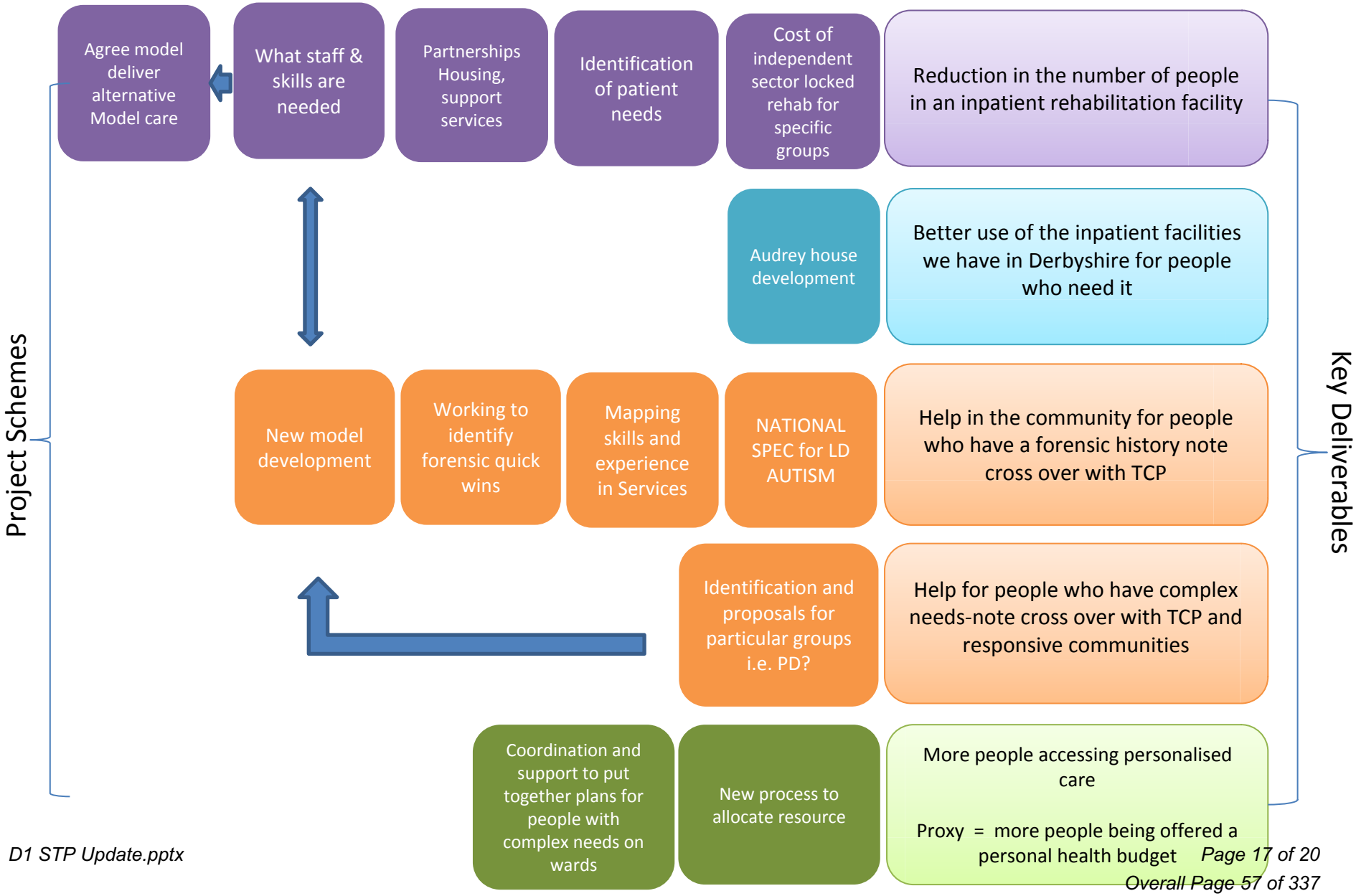

Primary Care Mental Health
Strategy For Primary Care Mental Health
Project schemes
Training Programme/s
Workforce capabilities
Flow between primary and secondary care
Link working
Early access
Community capital
Shared care protocols
Health and wellbeing programmes
Smoking Cessation
IAPT
Integration with acute care
Access
Employment Advisors
Key Deliverables
Increase Primary Care capacity to recognise and effectively manage people with MH problems reducing the need for secondary care referrals
Improve Integration between primary care and secondary services providing early access to a clinical expertise and support appropriate to need
Increase the number of people with SMI accessing a physical health care checks and treatment packages aimed at reducing mortality rates
Increase the proportion of people with LTCs accessing MH services and support
Deliver better employment support for people with MH problems

Responsive Communities




Dementia & Delirium
Sustainable High Quality Care
Project schemes
Key Deliverables
Derbyshire MAS – all stages, integrated approach
Memory Clinic Transformation – Needs led shared care
Pathway Integration – prevention, screening, diagnosing
Access to a universal Derbyshire dementia diagnosis
SD Day Hospitals Transformation
ND Day Hospitals Transformation
Pathway integration strengthening – handovers and links
High Quality post diagnostic treatment and support
Roll out of County Specialist Dementia home care
Bed optimisation Derbyshire 21C
DRRT Whole
Evaluate pilots
End of Life Pathway
Improved dementia care planning in care homes
High Quality support for people to live well at home
All partners education programme
Acute Trust joint programme
Care Homes pilot evaluation and roll out
Increase Delirium prevention strategies and reduce avoidable admissions to hospital due to delirium

Rehabilitation and Forensic



Getting out and talking to people

2017

Starting the conversation

Working in partnership with Healthwatch Derby and Derbyshire and the voluntary sector we have visited markets, meetings, and events across Derbyshire and spoken to approximately 1,000 people about the future of health and social care.

More than 200 carers have given us their thoughts on the ideas set out for the future of health and care

Starting the conversation

More than 200 people have answered our questionnaire

Please get in touch and have your say:
http://www.southernderbyshireccg.nhs
cations/joinedupcarederbyshire/

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 November 2017

Integrated Performance Report Month 7

Purpose of Report

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

Executive Summary

The Trust continues to perform well against many of its key indicators, with maintenance or improvements continuing across many of the Trust's services. These can be seen within the body of this report.

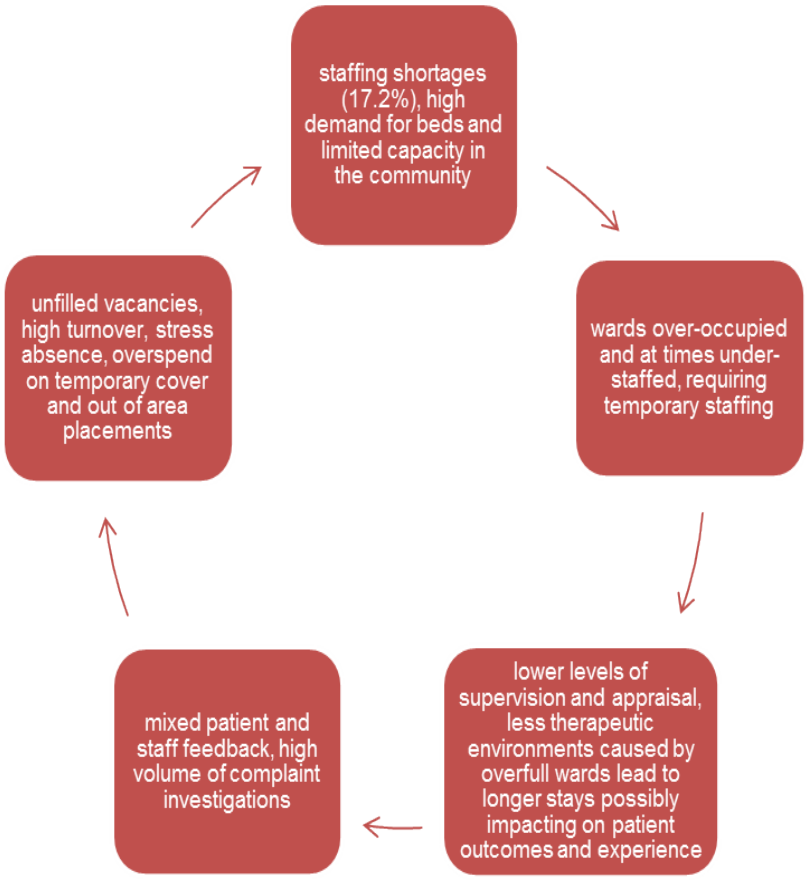
The Quality dashboard has been enhanced this month to include graphs to identify trends over the past six months and the past two quarters. Currently only data for the last two quarters is available, but this will build to present a rolling four quarters position.

Board members will also note that a level of operational detail has been taken out of this report. This will be presented and used to inform decisions and actions at Divisional Performance reviews and Trust Management Team. Where Board members require further assurance regarding performance greater detail on the actions being undertaken by Trust teams will be provided through the Board Committee structure, via the Executive Leadership or Trust Management Teams.

In addition, colleagues will note that the executive summary has been presented in a slightly different way with a focus on the main inter-relationships between current performance concerns along with actions and mitigation that the Executive team are taking forward.

Regarding month 7 performance there are a number of key issues that remain a challenge both within our inpatient and community services. The focus of this summary is on these two broad areas.

Inpatient Services



There are specific action plans or programmes of work in place to mitigate the risks and issues set out above.

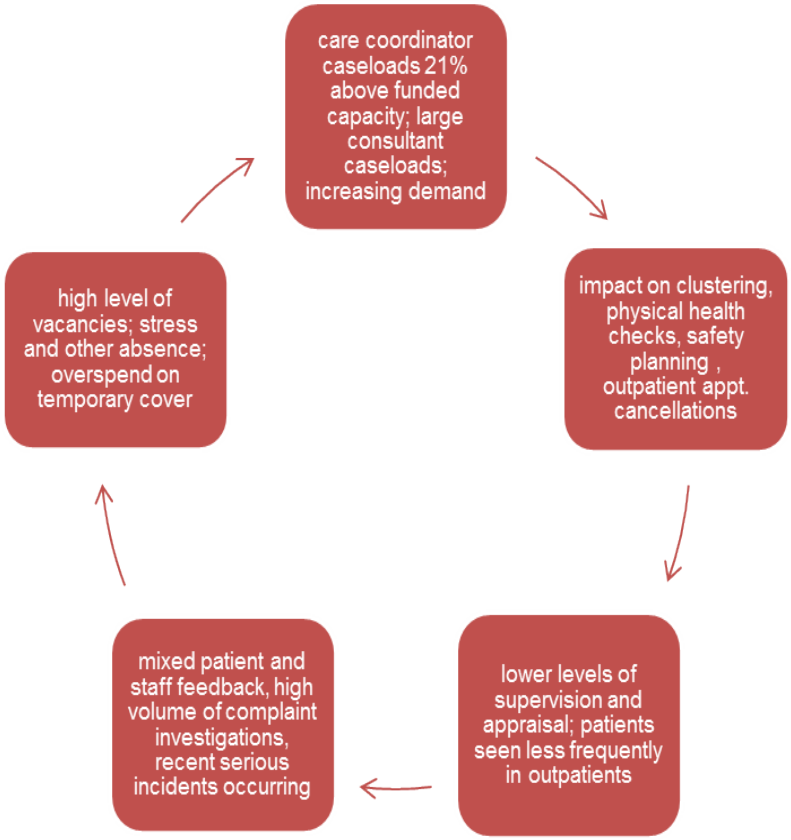
1. Introduced Red2Green programme which focuses on most efficient use of the resource available to reduce length of stay, therefore impacting positively on bed occupancy and the need for placing patients out of area. Trust Management Team has oversight of this programme.
2. Emergency Care Improvement Programme (ECIP) facilitated health economy wide workshop to support all partners to develop an integrated mental health urgent care work plan, with a focusing on avoiding 12 hour trolley breaches, but to also seek to resolve the underlying factors that contribute to these. Action plan has been agreed and presented to A&E Board and will continue to be reported there by DHcFT and will be overseen by Trust Management Team.
3. Inpatient staffing and recruitment plan focusing on recruitment and retention strategies, for example recruitment fairs, overseas employment, return from retirement schemes, advance recruitment of students from universities, rotation schemes, development of internal bank.

4. Continued implementation of the Trust's workforce plan, introducing Occupational Therapists and a Pharmacy Technician in inpatient

establishments.

5. Continued review of all agency staffing requests to ensure tight grip over both quality and finances. Bi-weekly meetings in place to review this.
6. Owing to Band 7 ward managers remaining in staffing numbers the provision of formal supervision sessions remains a challenge but by having senior clinicians operating in the numbers this offers a higher level of clinical support to junior staff. Clinical practice facilitators have been introduced to assist with supervision of students to ensure positive placements thus reducing the supervisory burden on ward staff and enhancing the likelihood of students wanting to return to ward areas for permanent employment.
7. Currently scoping a formal review of the Trust's adult acute inpatient services, similar to the recent review of Crisis Resolution Home Treatment service.

Community Services



There are specific action plans or programmes of work in place to mitigate the risks and issues set out above.

1. A review of Neighbourhood model is being undertaken focusing upon the clinical model and how more capacity could be created from limited resources. Trust Management Team will have oversight of this work.

2. Community capacity shortfall has been raised continually with commissioners and is risk-registered. There are ongoing actions to mitigate risks by the introduction of new initiatives, e.g. nurse-led clinics, pre-discharge groups,

rapid access in need and introduction of non-medical prescribers.

3. A number of changes have been introduced in relation to clustering deficits, e.g. electronic flag not to use clusters 0-3.
4. A review has been undertaken by the Deputy Medical Director to review clinic cancellations and Did Not Attend (DNAs), with a separate report provided to Board members for further discussion.
5. Supervision and appraisal action plans are in place and monitored and are showing some improvement.
6. There is emphasis on the staff survey feedback, with clear plans to communicate “you said, we did” actions.
7. Continued implementation of the Trust’s workforce plan, introducing new roles into community teams. Over recruitment into specific community teams in key hotspot areas such as Derby City Neighbourhood remains in place.
8. Continued review of all agency staffing requests to ensure tight grip over both quality and finances. Bi-weekly meetings in place to review this.

The cumulative financial effect of the issues identified in this report is the same as last month. In surplus terms, the Trust is ahead of plan year to date by £1.1m. The forecast remains to achieve the control total at the end of the financial year.

With regard to other financial performance factors, the Use of Resources (UoR) metrics is a 2 year to date and is forecast to be a 2 at the end of the financial year. Current performance is strong in most measures. Forecast-wise four of the five metrics remain strong at 2, 1, 1 and 2, but the agency spend against ceiling is forecast to be a 3 by year end. This is, however, still better than last year and would meet our objective of being less than 50% above the ceiling. Currently the forecast for agency medical expenditure is above the required reduction by £504k. However it is important to note that the forecast includes a contingency for unforeseen medical agency requirements of £160k.

Planning continues for additional cost improvement action required to achieve 17/18 control total financial plan and to seek to address the level of non-recurrent CIP in preparation for 2018/19. The residual Commissioner-driven QIPP disinvestment schemes are not agreed and discussions with Commissioners about this are ongoing.

The numbers reported in the attached finance report are consistent with the numbers reported in the monthly finance return sent to NHS Improvement on 16th October 2017.

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

Assurances

- This paper relates directly to the delivery of the Trust's strategy by summarising performance across the four key performance measurement areas.
- This report should be considered in relation to the relevant risks in the Board Assurance Framework.
- As an integrated performance report the content provides assurance across several BAF risks related to workforce, operational performance, quality performance, financial performance and regulatory compliance.

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people) (Public Sector Equality Duty & Equality Impact Risk Analysis)

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).

There are no adverse effects on people with protected characteristics (REGARDS).	X

There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	

Actions to Mitigate/Minimise Identified Risks

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

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

Recommendations

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

Report presented by:	**Mark Powell, Acting Chief Operating Officer**
	Claire Wright, Director of Finance
	Amanda Rawlings, Director of People and Organisational Effectiveness
	Carolyn Green, Director of Nursing and Patient Experience
Report prepared by:	**Peter Charlton, General Manager, Information Management**
	Rachel Leyland, Deputy Director of Finance
	Liam Carrier, Workforce Systems & Information Manager
	Rachel Kempster, Risk and Assurance Manager
	Peter Henson, Performance Manager

Financial Perspective

Highlights
- Surplus ahead of plan year to date
- Forecast achievement of control total
- Cash better than plan
- Delivery of Cost Improvement Programme

Challenges
- Containment of agency expenditure within ceiling set by NHSI
- Receipt of full CQUIN income assumed in forecast
- Reduction in Out of Area costs
- High level of non-recurrent CIP
- Additional action required to achieve forecast control total

Operational Perspective

Highlights
- Delayed Transfers has not breached the target
- Inpatient 28 day readmissions not breached.

Challenges
- Data completeness - Priority Metrics
- Clustering continues to be a challenge
- Cancellations and DNAs in outpatients
- The process of monitoring discharge emails sent in 2 working days is under review

People Perspective

Highlights
- Compulsory training compliance remains high and is above the 85% target.

Challenges
- Monthly and annual sickness absence rates remain high, but are reducing.
- Budgeted Fte vacancies remain high, but continue to reduce.
- Appraisal compliance rates remain low, but have increased.

Quality Perspective

Highlights

The dashboard has been improved this month to include graphs to identify trends over the past 6 months and the past 2 quarters. Currently only data for the last 2 quarters is available, but this will build to present a rolling 4 quarters position going forward.

- After an increase in serious incidents in May 2017, the number has stabilised
- Incidents of prone restraint has reduced following an increase in July 2017
- Patient on staff physical assaults has reduced
- No of absconsions has reduced significantly this month
- No of patients on a safety plan is steadily increasing
- No of outstanding actions following complaint investigations has decreased. The target has been amended from 0 to 5 to allow comparison

Challenges
- Incidents and episodes of seclusion has increased again, following a reduction in August, but remain stable overall
- No of outstanding actions following serious incident investigations has increased this month, The target has been amended from 0 to 5 to allow comparison

FINANCIAL OVERVIEW – September 2017

Category	Sub-set	Metric	Period	Plan	Actual	Rating	Trend	Key Points
Governance	Use of Resources (UoR) Metric	**Overall Use of Resources Metric**	YTD	1	2	Y	↓	At the end of September the Use of Resources Rating is an overall '2'. Forecast is a rating of '2' which is slightly worse than the plan of '1'. This is mainly driven by the agency metric which is forecast at a '3' for the end of the financial year.
			Forecast	1	2	Y	→	
		Capital Service Cover	YTD	2	2	Y	→	
			Forecast	2	2	Y	→	
		Liquidity	YTD	1	1	G	→	
			Forecast	1	1	G	→	
		Income and Expenditure Margin	YTD	1	1	G	→	
			Forecast	1	1	G	→	
		Income and Expenditure variance to plan	YTD	1	1	G	→	
			Forecast	1	2	Y	→	
		Agency variance to ceiling	YTD	1	3	A	↓	
			Forecast	1	3	A	→	
	Single Oversight Framework	NHS I Segment	YTD		2	n/a	n/a	

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
I&E and profitability	Income and Expenditure	Control Total position £'000	In-Month	273	259	R	↑	At the end of September the surplus is ahead of plan by £1.1m. This is due to additional non-recurrent income related to an overage on a previous asset sale being received in a previous month. The forecast is to achieve the control total at the end of the financial year. The normalised forecast takes out the non-recurrent income and expenditure. Without the non-recurrent income mentioned we would have a gap to the control total. EBITDA is forecast £1.2m behind plan. This is offset by below the line items such as profit on disposal, small underspends on depreciation and Public Dividend Capital payments.
			YTD	1,633	2,699	G	↑	
			Forecast	2,765	2,765	G	→	
		Control Total position ex STF £'000	In-Month	220	206	R	↑	
			YTD	1,355	2,421	G	↑	
			Forecast	1,971	1,971	G	→	
		Normalised Income and Expenditure position £'000	In-Month	220	224	G	↑	
			YTD	1,355	1,655	G	↑	
			Forecast	1,971	1,256	R	↑	
	Profitability	Profitability - EBITDA £'000	In-Month	886	851	R	↑	
			YTD	5,350	5,299	R	↑	
			Forecast	10,159	8,939	R	↘	
		Profitability - EBITDA %	In-Month	7.9%	7.4%	R	↗	
			YTD	8.0%	7.7%	R	→	
			Forecast	7.6%	6.5%	R	→	

Category	Sub-set	Metric	Period	Plan	Actual	Rating	Trend	Key Points
Liquidity	Cash	Cash £m	YTD	12.864	16.516	G	↓	Cash is ahead of plan year to date due to the overage income and the additional STF income from 2016/17. The forecast cash is ahead of plan by £3.85m which is due to the current cash balance plus forecast cash receipts from asset disposals. Capital expenditure is behind plan year to date but is forecast to achieve full spend.
			Forecast	12.193	16.046	G	→	
	Net Current Assets	Net Current Assets £m	YTD	8.158	8.422	G	↑	
			Forecast	8.345	7.161	R	→	
	Capex	Capital expenditure £m	YTD	1.390	0.647	R	↓	
			Forecast	3.338	3.338	G	→	

Category	Sub-set	Metric	Period	Plan	Actual	Rating	Trend	Key Points
Efficiency	CIP	CIP achievement £m	In-Month	0.321	0.316	R	↑	CIP is ahead of plan YTD and the forecast assumes an overachievement of £1m by the end of the financial year. A significant amount of CIP is non-recurrent in nature.
			YTD	1.925	2.890	G	↘	
			Forecast	3.850	4.809	G	↑	
			Recurrent	3.850	1.719	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 – SEPTEMBER 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	Key Points
Performance Dashboard	NHSI	CPA 7 Day Follow-up (M)	Month	95.00%	100.00%	G	↑		All NHS metrics are all compliant except "Priority Metrics" which is a new indicator since April 2017. See detailed slide for actions in place to address the under performance. For each metric we have indicated if it is monitored by NHS Quarterly (Q) or Monthly (M).
			Quarter	95.00%	97.53%	G	→		
		Data completeness - Identifiers (M)	Month	95.00%	99.44%	G	→		
			Quarter	95.00%	99.44%	G	→		
		Data completeness - Priority Metrics (M)	Month	85.00%	72.01%	R	→		
			Quarter	85.00%	69.90%	R	↓		
		Crisis Gatekeeping (Q)	Month	95.00%	100.00%	G	↑		
			Quarter	95.00%	99.52%	G	→		
		IAPT RTT within 18 weeks (Q)	Month	95.00%	100.00%	G	→		
			Quarter	95.00%	99.90%	G	→		
		IAPT RTT within 6 weeks (Q)	Month	75.00%	92.03%	G	→		
			Quarter	75.00%	93.34%	G	↓		
		Early Intervention in Psychosis RTT Within 14 Days - Complete (Q)	Month	50.00%	100.00%	G	↑		
			Quarter	50.00%	91.78%	G	↑		
		Early Intervention in Psychosis RTT Within 14 Days - Incomplete (Q)	Month	50.00%	86.67%	G	↑		
			Quarter	50.00%	85.19%	G	↑		
		Patients Open to Trust In Employment (M)	Month	N/A	9.33%		→		
			Quarter	N/A	8.98%		→		
		Patients Open to Trust In Settled Accommodation (M)	Month	N/A	59.73%		→		
			Quarter	N/A	56.94%		↓		
		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%	55.21%	G	↑		
			Quarter	50.00%	52.02%	G	↓		
		Physical Health - Cardio-Metabolic - Inpatient (Q)	Month	N/A					
			Quarter	N/A					
		Physical Health - Cardio-Metabolic - EI (Q)	Month	N/A					
			Quarter	N/A					
		Physical Health - Cardio-Metabolic - on CPA (Community) (Q)	Month	N/A					
			Quarter	N/A					

Key:

Period Month Current Month

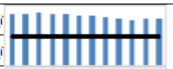
Quarter Current Quarter

Achieving target

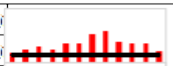
Not achieving target

Trend compared to previous month/quarter

OPERATIONAL OVERVIEW – SEPTEMBER 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	Key Points
Performance Dashboard	Locally Agreed	CPA Settled Accommodation	Month	90.00%	95.28%	G			An action plan has been implemented. We should be able to start evaluating the impact of the actions as each is completed over the next few months.
			Quarter	90.00%	95.28%	G			
		CPA Employment Status	Month	90.00%	96.85%	G			
			Quarter	90.00%	96.85%	G			
		Data completeness - Identifiers	Month	99.00%	99.44%	G			
			Quarter	99.00%	99.44%	G			
		Data completeness - Outcomes	Month	90.00%	93.30%	G			
			Quarter	90.00%	93.30%	G			
		Patients Clustered not Breaching Today	Month	80.00%	75.31%	R			
			Quarter	80.00%	75.86%	R			
		Patients Clustered regardless of review dates	Month	96.00%	94.10%	R			
			Quarter	96.00%	94.19%	R			
		7 Day Follow-up - all inpatients	Month	95.00%	97.37%	G			
			Quarter	95.00%	95.57%	G			
		Ethnicity coding	Month	90.00%	91.61%	G			
			Quarter	90.00%	91.61%	G			
		NHS Number	Month	99.00%	100.00%	G			
			Quarter	99.00%	100.00%	G			
		CPA Review in last 12 Months (on CPA > 12 Months)	Month	95.00%	96.49%	G			
			Quarter	95.00%	96.49%	G			
		Community Care Data - Activity Information Completeness	Month	50.00%	93.43%	G			
			Quarter	50.00%	93.88%	G			
		Community Care Data - RTT Information Completeness	Month	50.00%	92.31%	G			
			Quarter	50.00%	92.31%	G			
		Community Care Data - Referral Information Completeness	Month	50.00%	73.90%	G			
			Quarter	50.00%	74.83%	G			
		Early Interventions New Caseloads	Month	95.00%	100.00%	G			
			Quarter	95.00%	100.00%	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 – SEPTEMBER 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	Key Points
Performance Dashboard	Schedule 6	Consultant Outpatient Trust Cancellations	Month	5.00%	6.12%	R			The most common reason was "consultant absent from work". Alternative approaches to outpatient appointment booking are being piloted.
			Quarter	5.00%	7.66%	R			
		Consultant Outpatient DNAs	Month	15.00%	15.84%	R			
			Quarter	15.00%	16.14%	R			
		Under 18 admissions to Adult inpatients	Month	0	0	G			
			Quarter	0	1	G			
		Outpatient letters sent in 10 working days	Month	90.00%	92.33%	G			
			Quarter	90.00%	91.64%	G			
		Outpatient letters sent in 15 working days	Month	95.00%	96.93%	G			
			Quarter	95.00%	96.46%	G			
		Inpatient 28 day readmissions	Month	10.00%	8.13%	G			
			Quarter	10.00%	9.63%	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 Emails sent in 2 working days	Month						Process under review
			Quarter						
		Delayed Transfers of Care	Month	0.80%	0.57%	G			
			Quarter	0.80%	1.22%	R			
		18 Week RTT Less Than 18 Weeks - Incomplete	Month	92.00%	96.60%	G			
			Quarter	92.00%	97.07%	G			

OPERATIONAL OVERVIEW – SEPTEMBER 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	Key Points
Performance Dashboard	Fixed Submitted Returns	18 weeks RTT greater than 52 weeks	Month	0	0	G	⇨		Compliant with Fixed Targets
			Quarter	0	0	G	⇨		
		18 Week RTT incomplete	Month	92.00%	95.32%	G	⇩		
			Quarter	92.00%	95.91%	G	⇨		
		Mixed Sex accommodation breaches	Month	0	0	G	⇨		
			Quarter	0	0	G	⇨		
		Completion of IAPT Data Outcomes	Month	90.00%	96.80%	G	⇨		
			Quarter	90.00%	96.34%	G	⇨		
		Ethnicity coding	Month	90.00%	92.57%	G	⇨		
			Quarter	90.00%	91.95%	G	⇨		
		NHS Number	Month	99.00%	100.00%	G	⇨		
			Quarter	99.00%	100.00%	G	⇨		
Other Dashboards	Health Visiting	% 10-14 Day Breastfeeding coverage	Month	98.00%	100.36%	G	⇧		Compliant with Targets.
			Quarter	98.00%	99.76%	G	⇨		
		% 6-8 Week Breastfeeding coverage	Month	98.00%	99.61%	G	⇨		
			Quarter	98.00%	100.00%	G	⇨		
	IAPT	Recovery Rates	Month	50.00%	55.29%	G	⇧		Compliant with Targets.
			Quarter	50.00%	52.02%	G	⇩		
		Reliable Improvement Rates	Month	65.00%	70.87%	G	⇧		
			Quarter	65.00%	68.14%	G	⇩		
	Safer Staffing	Inpatient Safer Staffing Fill Rates	Month	100.00%	104.1%	R	⇨		Detailed ward level information shows specific variances
			Quarter	100.00%	104.4%	R	⇩		

WORKFORCE OVERVIEW – September 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance		Trend	Key Points
Workforce Dashboard	NHSI Key Performance Indicator (KPI)	**Turnover** (annual)	**Sep-17**	10%	**10.17%**	μ	G	↓	Annual turnover remains within the Trust target parameters and is below the regional Mental Health & Learning Disability average of 12.41% (as at July 2017 latest available data). The monthly sickness absence rate is 0.50% lower than the previous month and compared to the same period last year (September 2016) it is 0.55% lower. The annual sickness absence rate continues to reduce running at 5.35% (as at August 2017 latest available data). The regional average annual sickness absence rate for Mental Health & Learning Disability Trusts is 5.18% (as at June 2017 latest available data). Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 32.35% of all sickness absence, followed by surgery at 11.58% and other musculoskeletal problems at 9.82%. The Funded Fte vacancy rate has decreased by 0.82% to 7.86%. The number of employees who have received an appraisal within the last 12 months has increased by 3.15% to 76.18%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £728k. Compulsory training compliance has decreased by 0.81% to 86.88%.
			Aug-17		10.64%		G		
		Sickness Absence (monthly)	**Sep-17**	5.04%	**5.34%**	μ	R	↓	
			Aug-17		5.84%		R		
		Sickness Absence (annual)	**Aug-17**	5.04%	**5.35%**	μ	R	↓	
			Jul-17		5.39%		R		
		Vacancies (including funded fte flexibility / cover)	**Sep-17**		**7.86%**	μ		↓	
			Aug-17		8.68%				
		Appraisals (**all staff** - number of employees who have received an appraisal in the previous 12 months)	**Sep-17**	90%	**76.18%**	κ	R	↑	
			Aug-17		73.03%		R		
		Appraisals (**agenda for change staff only** - number of employees who have received an appraisal in the previous 12 months)	**Sep-17**	90%	**75.88%**	κ	R	↑	
			Aug-17		72.82%		R		
		Appraisals (**medical staff only** - number of employees who have received an appraisal in the previous 12 months)	**Sep-17**	90%	**82.47%**	κ	A	↓	
			Aug-17		78.22%		R		
		Agency Usage (£ year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Sep-17**	£0	**£0.728m**	κ	R	↑	
			Aug-17		£0.610m		R		
		Agency Usage (% year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Sep-17**	0%	**44.64%**	κ	R	↑	
			Aug-17		44.17%		R		
	Other KPI	**Compulsory Training** (staff in-date)	**Sep-17**	90%	**86.88%**	μ	A	↓	
			Aug-17		87.69%		A		

Key:

Period Current month and previous month

Plan Trust target

κ Variance to previous month

Achieving target/within target parameters

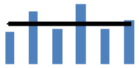
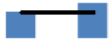
Approaching target/approaching target parameters

Not achieving target/outside target parameters

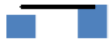
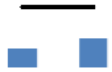
Trend based on previous 4 months

Turnover parameters (8% to 12%)

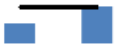
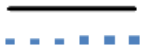
QUALITY OVERVIEW – OCTOBER 2017

Sub-set	Metric	Period	Plan	Actual	Trend graph by month (rolling 6 months: April - September 2017)	Trend graph by quarter (last 2 qtrs: April - September 2017)	Key Points
Safe	No of incidents of moderate to catastrophic actual harm	Month	29	32			Plan: average last fin yr 2016/17 (month).
		Quarter	88	102			Plan: average last fin yr (Qtr) 2016/17. Actual: 2017/18 Q2 data
	No of deaths of patients who have died within 12 months of their last contact with DHcFT	No of deaths of	104	109			Note, data as at 04/10/2017
		Quarter	312	370			Plan: average last fin yr (Qtr).Actual: 2017/18 Q2 data
	No of serious incidents reported to the CCG	Month	5	7			Plan - average last fin yr (month)
		Quarter	16	23			Plan: average last fin yr (Qtr). Actual: 2017/18 Q2 data
	No of episodes of patients held in seclusion	Month	10	15			
		Quarter	30	45			Plan: average last fin yr (Qtr). Actual: 2017/18 Q2 data
	No of incidents involving patients held in seclusion	Month	16	16			
		Quarter	47	46			Plan: average last fin yr (Qtr). Actual: 2017/18 Q2 data
	No of incidents involving physical restraint	Month	48	53			
		Quarter	143	145			Plan: average last fin yr (Qtr). Actual: 2017/18 Q2 data
	No of incidents involving prone restraint	Month	10	8			Month plan based on average from 1/7/16 when prone restraint collected on Datix as defined field
		Quarter	29	44			Qtr plan based on average for Q2/Q3/Q4. Actual 2017/18 Q2 data
	No of incidents of physical assault - patient on patient	Month	12	9			
		Quarter	37	41			Actual: 2017/18 Q2 data
	No of incidents of physical assault - patient on staff	Month	19	8			
		Quarter	56	61			Actual: 2017/18 Q2 data

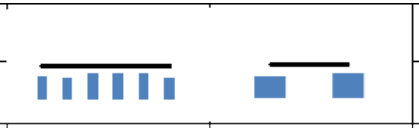
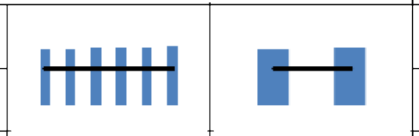
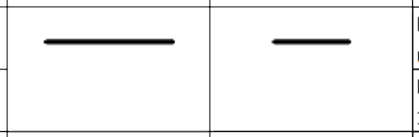
QUALITY OVERVIEW – OCTOBER 2017

Safe	No of falls on in-patient wards	Month	32	32			
		Quarter	96	99			Actual: 2017/18 Q2 data
	No of incidents of absconsion	Month	33	14			
		Quarter	99	90			Actual: 2017/18 Q2 data
	No of patients with a clinical risk plan (FACE or Safety Plan)	Month	100%	75.31%			
		Quarter	100%	75.39%			
	Of above, no of patients with a Safety Plan	Month	90%	37.66%			Safety Plan replaced FACE from 1/4/2017
		Quarter	90%	27.64%			
	% of staff compliant with combined Level 3 Safeguarding Children and Think Family training	Month	85%	95.30%			
		Quarter	85%	NA			Qtr comparison not available
	% of staff compliant with Clinical Safety Planning eLearning	Month	95%	95.40%			
		Quarter	95%	NA			Qtr comparison not available
	% of CTRs (Care & Treatment Reviews) completed	Month	100%	100%			All patients requiring CTR's identified. Responsibility to complete CTR is with CCG
		Quarter	NA	NA			
	% of compliance with inpatients VTE assessment	Month	95%	81.74%			
		Quarter	95%	NA			
	HCR20 assessment completed (Low Secure)	Month	100%	100.0%			Indicator relates to % of patients with HCR20 assessment completed in time this month. All other assessments are completed, but some were not within the timescale.
		Quarter	100%	NA			

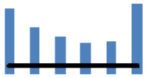
QUALITY OVERVIEW – OCTOBER 2017

Caring	No of complaints opened for investigation	Month	12	11			
		Quarter	37	43			Actual: 2017/18 Q2 data
	No of concerns received	Month	35	33			
		Quarter	104	121			
	No of compliments received	Month	100	94			
		Quarter	300	266			
	No of investigations by the Parliamentary Ombudsman	2016/17	NA	6			Data is provided cumulatively from 1st April each year
		2017/18	NA	1			Data is provided cumulatively from 1st April each year
	% of complaints upheld (full or in part) by the Parliamentary Ombudsman	2016/17	NA	0			1 ongoing and 5 no further action
		2017/18	NA	0			1 ongoing
	% of responded to (orange) complaint investigations completed within 40 working days, opened after 01/04/2016	Year	100%	25%			As at 05/10/2017, 229 (orange) complaints. 128 not responded within 40 working days. 58
	% of responded to (red) complaints investigations completed within 60 working days, opened after 01/04/2016	Year	100%	0%			As at 05/10/2017, 10 (red) complaints. 5 not responded within 60 working days. 5 ongoing.
	No of incidents requiring Duty of Candour	Month	1	1			These figures will fluctuate based on the outcome of investigations.
		Quarter	2	7			

QUALITY OVERVIEW – OCTOBER 2017

Effective	% of in-patients with a recorded capacity assessment	Month	100%	92.70%			
		Quarter	100%	94.94%			
	% of patients who have had their care plan reviewed and have been on CPA > 12months	Month	90%	96.45%			
		Quarter	90%	96.07%			
	No of seclusion forms not received by MHA Office	Month	0	3			Seclusion pathway moved to PARIS. Seclusion end date and time not yet automated to inform
		Quarter	0	7			
	% of CTO rights forms received by MHA Office	Month	100%	93.0%			As at 04/10/2017
		Quarter	NA	NA			
	% of in patient older adults rights forms received by MHA Office	Month	100%	79.0%			
		Quarter	NA	NA			
Responsive	% of staff uptake of Flu Jabs	Month	45%	NA			Data to end of 30/11/16. New campaign for 2017 underway.
		Year	45%	38.40%			Relates to 2016 campaign. Final data as shown in 16/17 Quality Account
	% of policies in date	Month	95%	96.01%			As at 04/10/2017
		Quarter	NA	NA			

QUALITY OVERVIEW – OCTOBER 2017

Well Led	% of staff who have received Clinical Supervision, within defined timescales	Month	100%	61.38%			
		Quarter	100%	NA			
	% of staff who have received Management Supervision, within defined timescales	Month	100%	72.00%			
		Quarter	100%	NA			
	No of outstanding actions following serious incident investigations	Month	5	46			Total overdue actions as at 02/10/2017
		Quarter	0	NA			
	No of outstanding actions following complaint investigations	Month	5	30			Total overdue actions as at 06/10/2017
		Quarter	NA	NA			
	No of outstanding actions following CQC comprehensive review report (2016)	Month	0	21			Figure as at 04/10/2017

Financial Section

Governance – Use of Resources (UoR) Rating

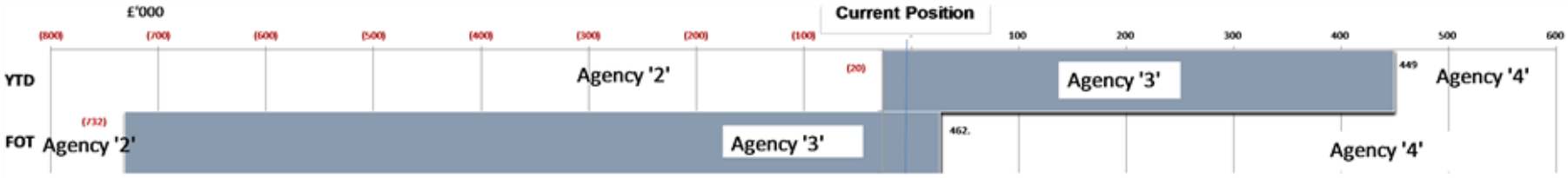
The Use of Resources rating at the end of September is a ‘2’ as the agency metric has moved to a ‘3’.

The ratings for each of the future quarters are forecast to be a ‘2’ which is mainly driven by the agency metric remaining at a 3.

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

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

The agency metric is currently forecast at a ‘3’ for the end of the financial year. In order to reduce that metric down to a ‘2’ by the end of March then we need to reduce agency expenditure by £732k. **However if we spend an additional £27k above the current forecasted levels then this would move the metric to a 4 and trigger an override.**



Income and Expenditure

Statement of Comprehensive Income — September 2017

	Current Month			Year to Date			Forecast		
	Plan	Actual	Variance Fav (+) / Adv (-)	Plan	Actual	Variance Fav (+) / Adv (-)	Plan	Actual	Variance Fav (+) / Adv (-)
	£000	0	£000	£000	£000	£000	£000	£000	£000
Clinical Income	10,373	10,661	288	62,201	63,918	1,717	124,378	127,722	3,344
Non Clinical Income	805	888	83	4,792	5,202	411	9,822	9,309	(513)
Employee Expenses	(7,992)	(8,219)	(227)	(47,731)	(49,059)	(1,328)	(95,932)	(99,656)	(3,724)
Non Pay	(2,299)	(2,480)	(180)	(13,912)	(14,763)	(851)	(28,108)	(28,436)	(328)
EBITDA	**886**	**850**	**(36)**	**5,350**	**5,299**	**(51)**	**10,159**	**8,939**	**(1,221)**
Depreciation	(278)	(277)	2	(1,669)	(1,645)	24	(3,338)	(3,333)	6
Impairment	0	0	0	0	(685)	(685)	(300)	(685)	(385)
Profit (loss) on asset disposals	0	0	0	0	950	950	0	950	950
Interest/Financing	(176)	(176)	(0)	(1,093)	(1,068)	24	(2,146)	(2,119)	28
Dividend	(159)	(139)	20	(955)	(837)	118	(1,910)	(1,673)	237
Net Surplus / (Deficit)	**273**	**258**	**(15)**	**1,633**	**2,014**	**380**	**2,465**	**2,080**	**(385)**
Technical adjustment - Impairment	0	0	0	0	(685)	(685)	(300)	(685)	(385)
Control Total Surplus / (Deficit)	**273**	**258**	**(15)**	**1,633**	**2,699**	**1,066**	**2,765**	**2,765**	**0**
Technical adjustment - STF Allocation	53	53	0	278	278	0	794	794	0
Underlying Net Surplus / (Deficit)	**220**	**205**	**(15)**	**1,355**	**2,421**	**1,066**	**1,971**	**1,971**	**0**

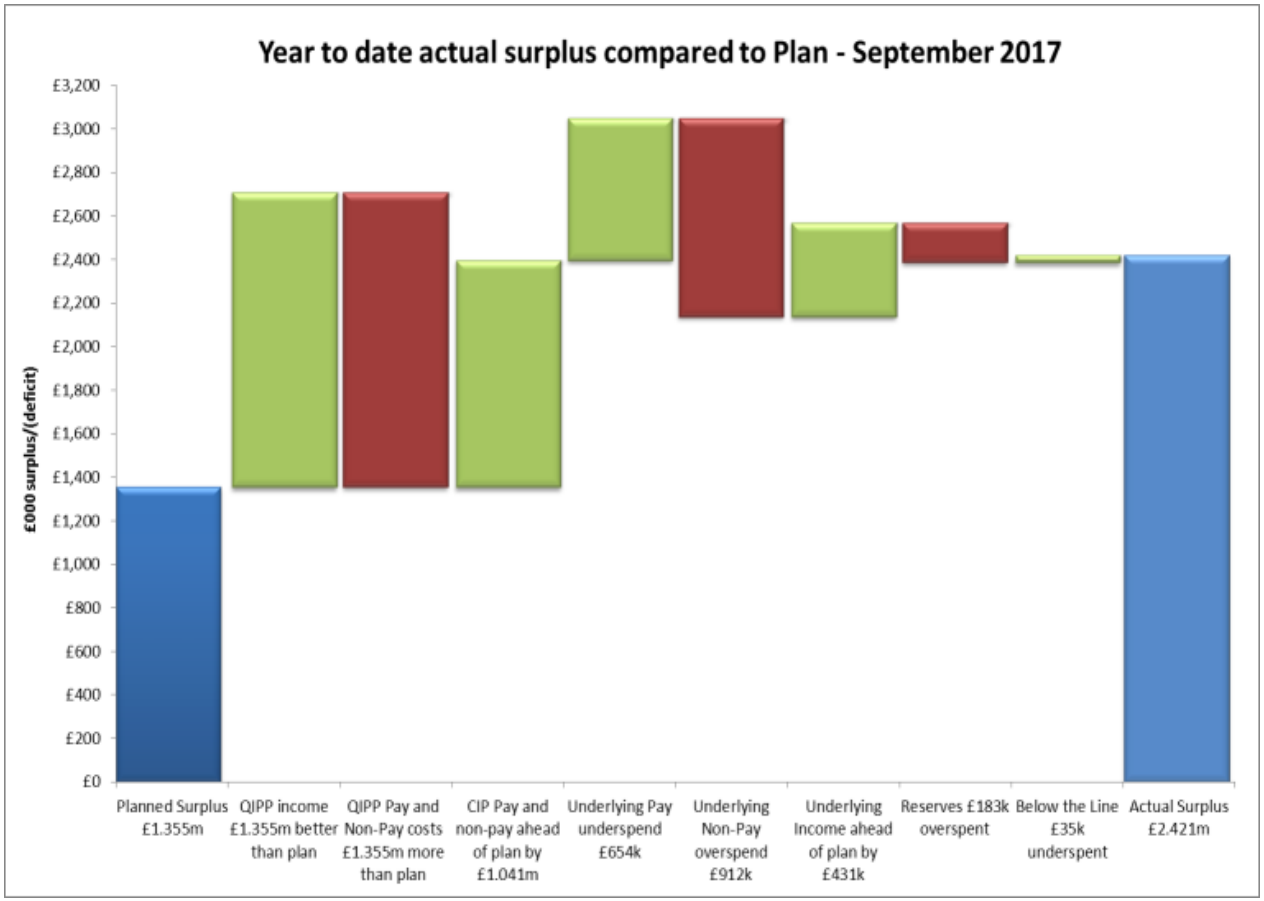
The Statement of Comprehensive Income shows the financial performance against both the control total surplus of £2.77m which includes the Sustainability Transformation Fund (STF) income and the surplus / (deficit) against the plan with the STF income excluded £1.97m.

Clinical Income is £1.72m more than plan year to date and at the end of the year is forecast to be £3.3m ahead of plan. This is mainly due to the income related to QIPP disinvestments not being removed from the contract as currently no further disinvestments have been identified (offsetting expenditure).

Non Clinical income is ahead of plan year to date by £0.4m but is forecast to underachieve plan by £0.5m. This mainly relates to Pharmacy recharge income being lower than planned (with corresponding expenditure reductions).

Pay expenditure is £1.3m more than the plan at the end of September and forecast £3.7m more than plan. This relates to costs not yet being released relating to QIPP disinvestments (offsetting income) and CIP forecast to be delivered in a different way to the plan.

Non Pay is overspent year to date by £0.9m and is forecast to be £0.3m overspent by the end of the year which mainly relates to the overspend on the Acute Out of Area budget partly offset by other underspends.



Summary of key points for YTD variances

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

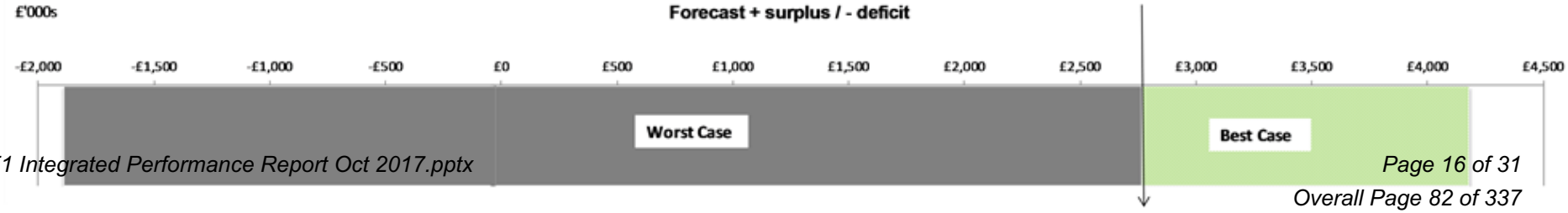
- QIPP income is more than plan which is equally offset by pay and non-pay expenditure being more than plan. This is due to the disinvestment not yet being fully agreed with Commissioners.
- CIP is currently ahead of plan mainly due to the non recurrent allocation of income benefits in a previous month.
- Underlying pay underspends (exc. QIPP/CIP) due to various vacancies across the Trust, partially offset by bank and agency expenditure.
- Underlying non-pay overspend (exc. QIPP/CIP) mainly driven by out of area expenditure higher than plan.

Forecast Range

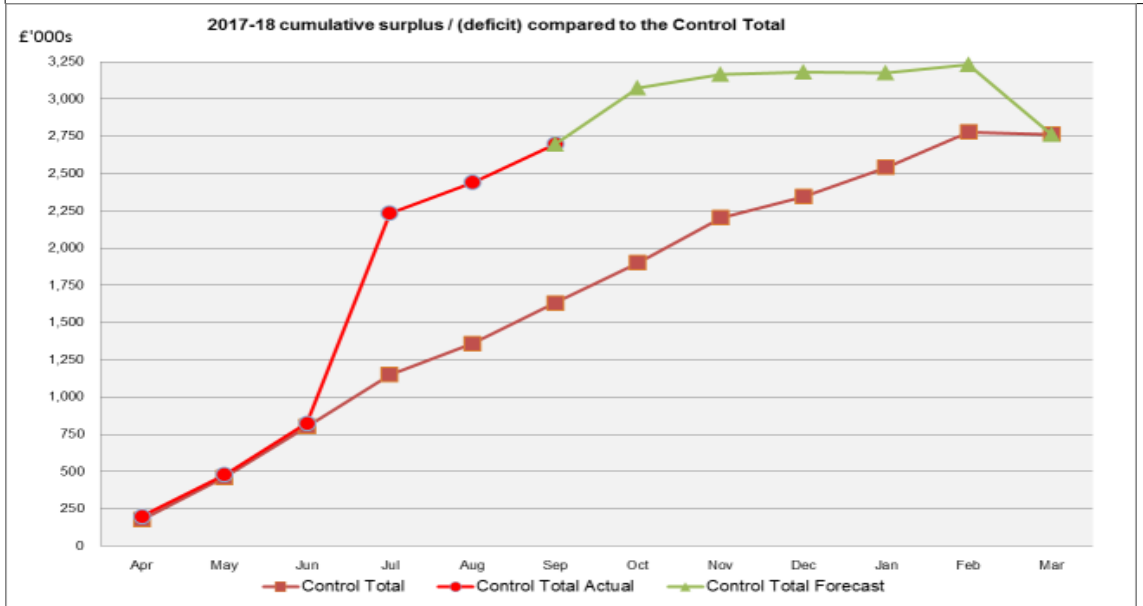
The main variables in the forecast range are: STF income loss, CIP forecast not fully realised, agency expenditure, CPC income, CQUIN income not received and other unexpected pay and non-pay costs.

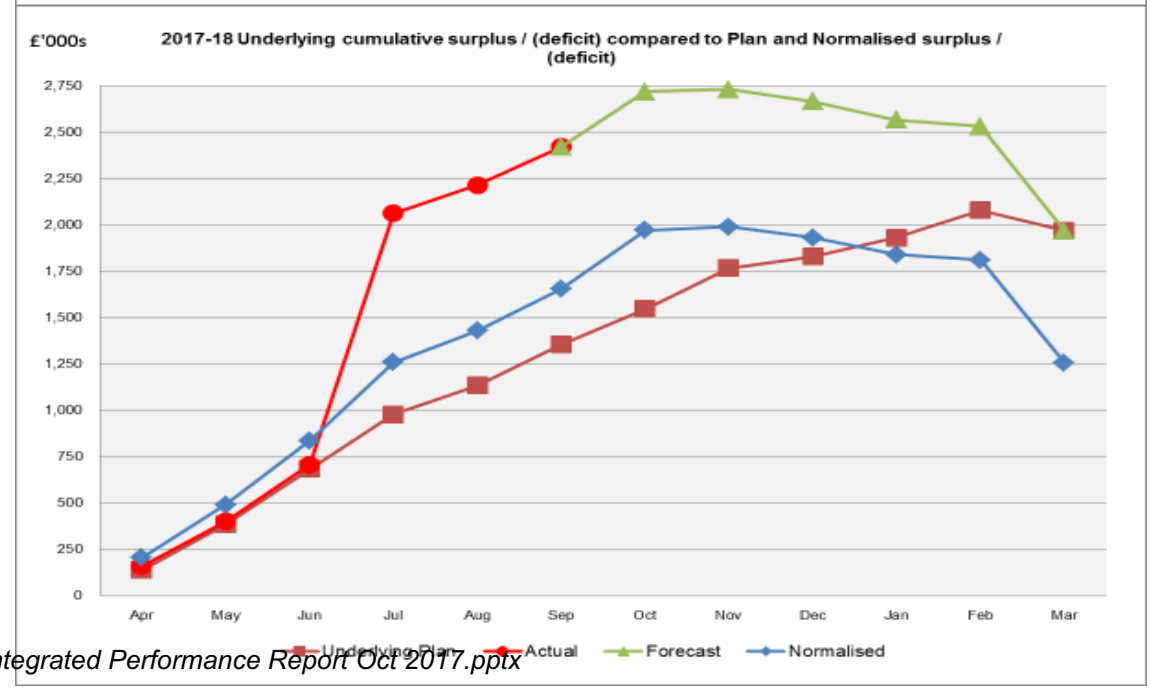
Forecast Range

Best Case	Likely Case	Worst Case
£4.2m surplus	£2.8m surplus	£1.9m deficit



Normalised Income and Expenditure position





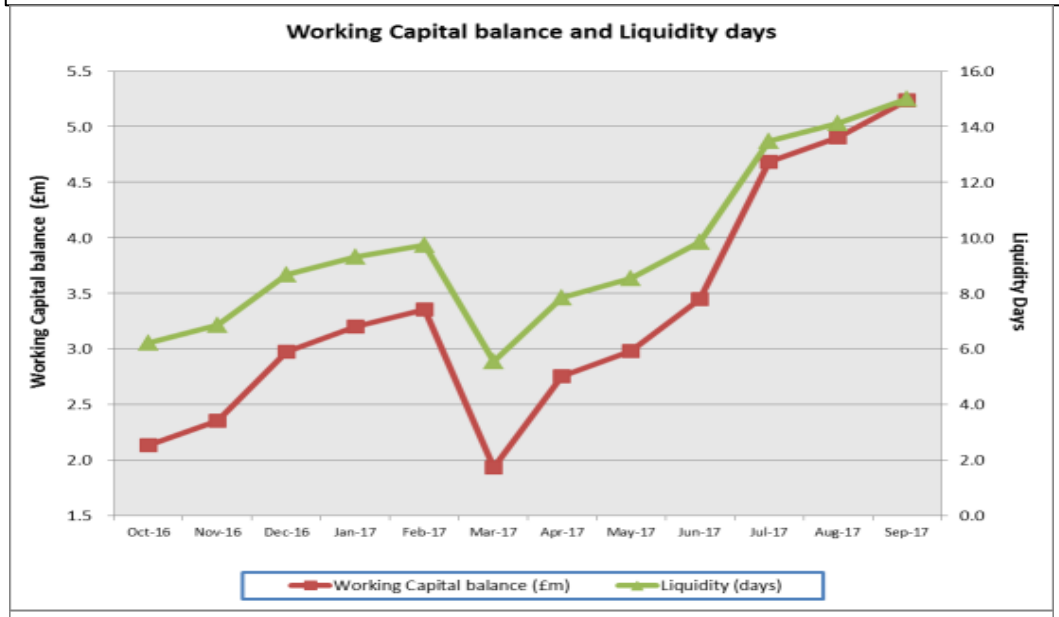
The first graph shows the actual cumulative surplus against the control total (including the Sustainability Transformation Fund (STF).

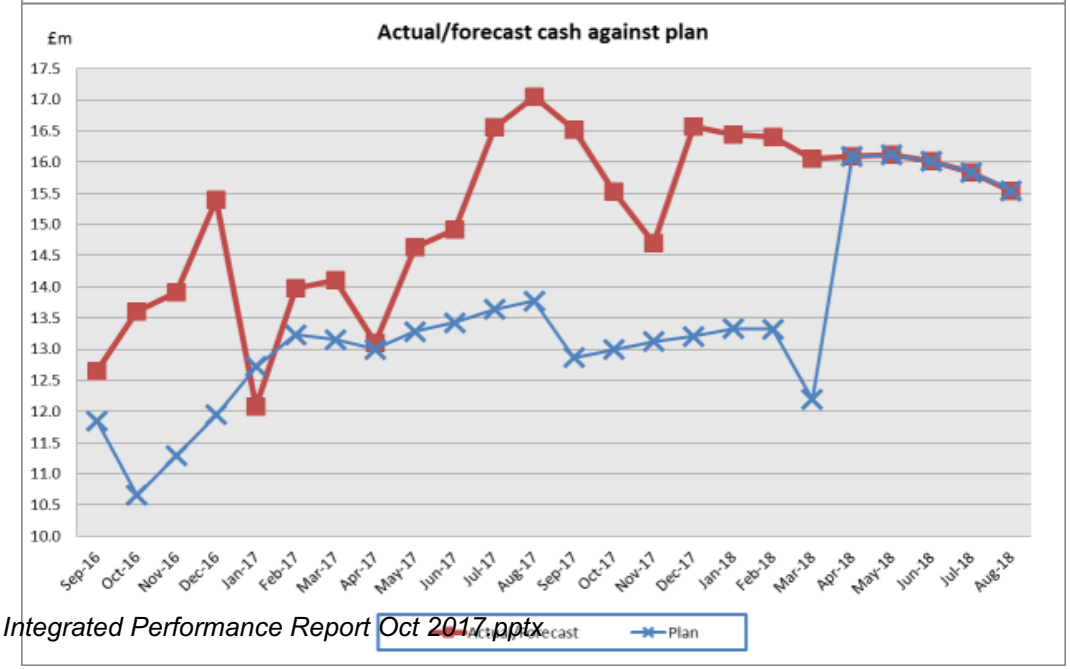
The peak in July (on both graphs) relates to overage income from a previous asset disposal.

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

There is some additional non-recurrent expenditure in the position related to temporary staff posts for part of the financial year and non-recurrent transaction costs. There is also some non-recurrent income from the overage related to a previous asset disposal. In the normalised position these have been removed.
As shown in the graph if these non-recurrent items were not incurred then the forecast outturn would be below the plan and would require additional management action to achieve the control total.

Liquidity





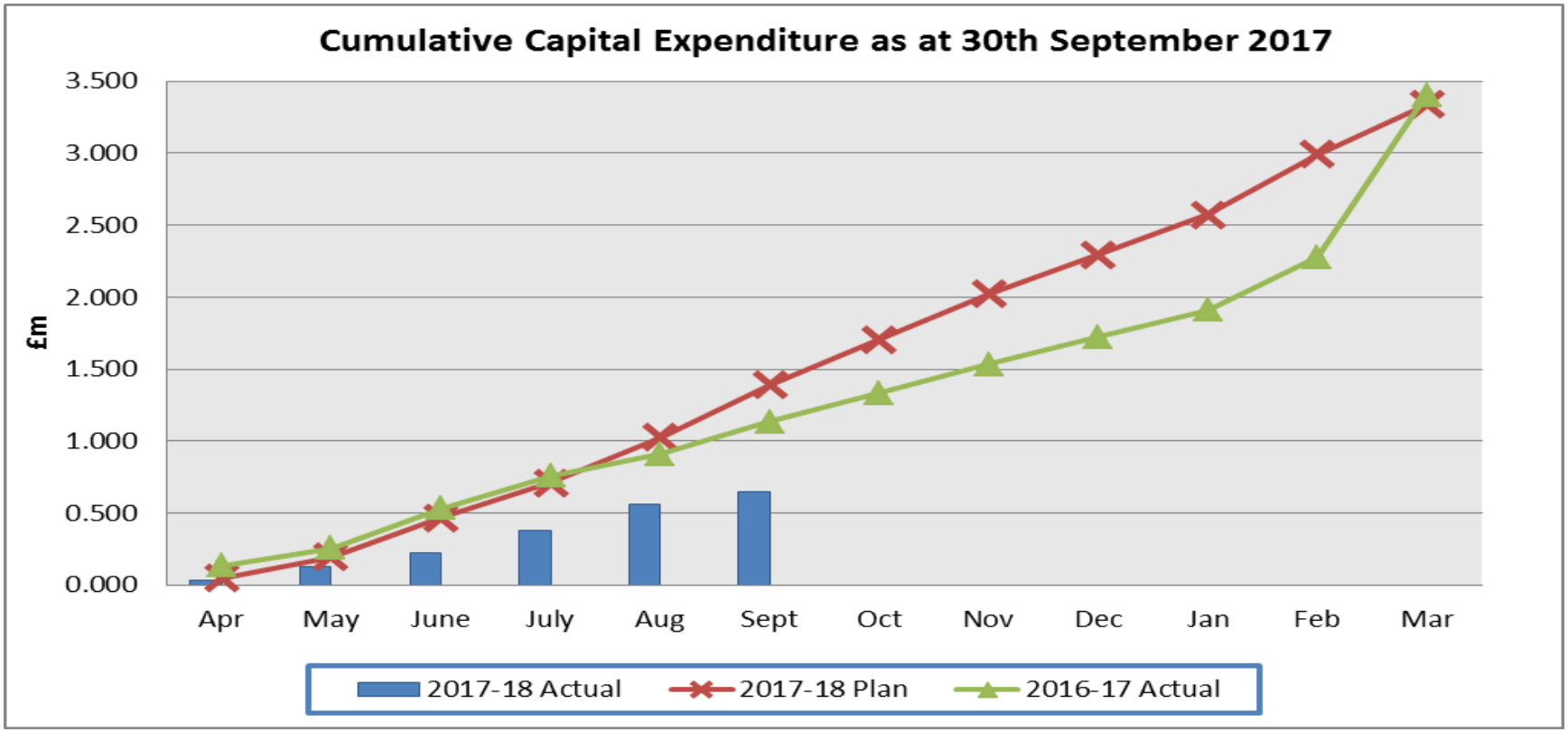
The first graph shows the working capital balance for the last 12 months (net current assets less net current liabilities adjusted for assets held for sale and inventories) and how many days of operating expenses that balance provides.

During the last 12 months working capital and liquidity continues to improve due to higher cash levels. The downturn in March 2017 is reflective of the increase in year end transactions such as provisions, along with an increase in payables mainly related to capital as works have concluded at the end of March.
The liquidity at the end of September is just over 15 days which 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 provided by external auditors illustrates that the peer average continues to be around +19 days, therefore our liquidity must remain a strategic priority for us to continue to improve and protect.

Cash is currently at £16.5m which is £3.6m better than the plan at the end of September and is forecast to be above plan by £3.9m. This is mainly due to sale proceeds and additional STF income related to 2016/17.

Capital Expenditure

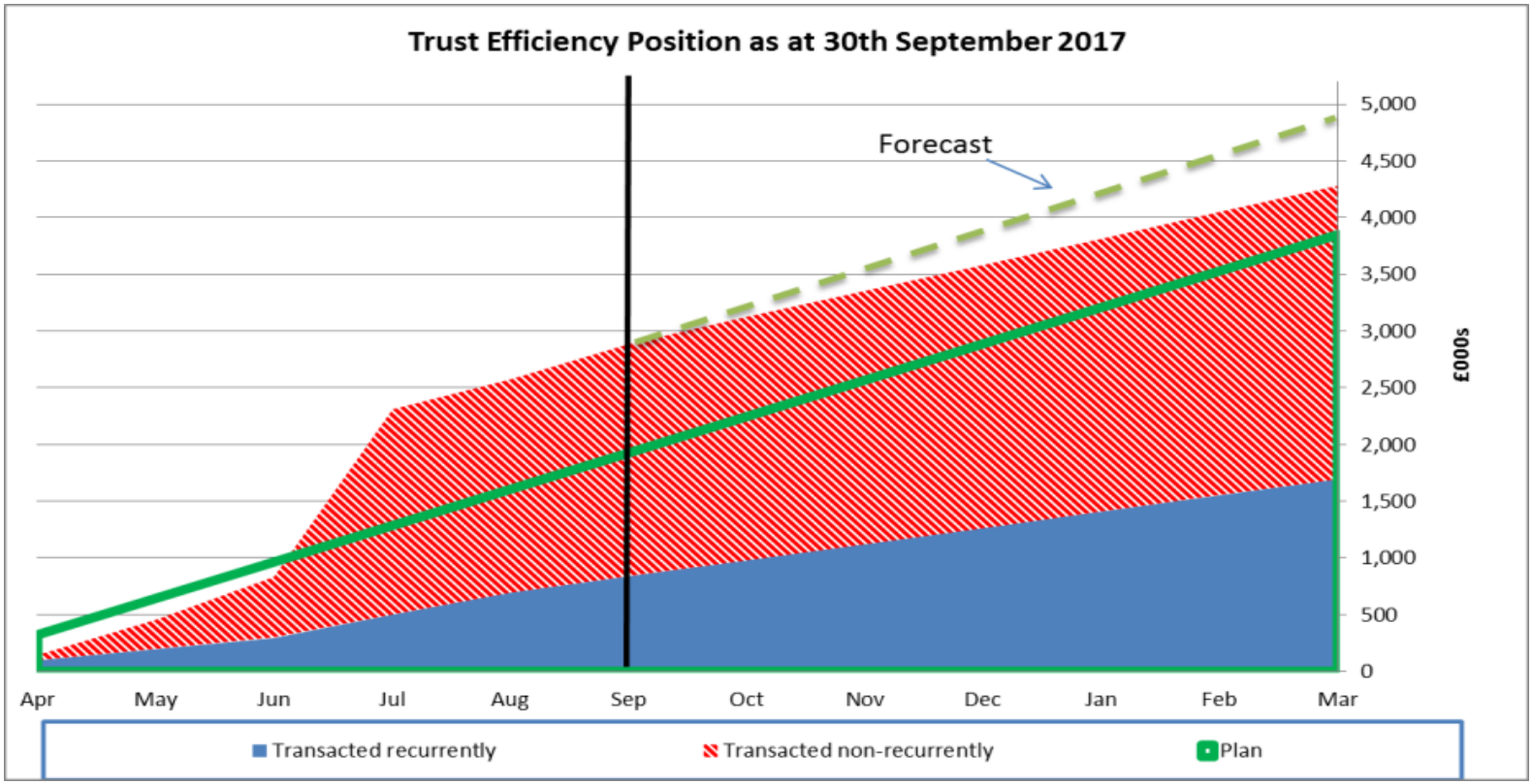


Capital Expenditure is behind plan by £743k at the end of September. There is a fully committed plan which may need to be re-prioritised in year to take into account any urgent bids that arise, which will be monitored by the Capital Action Team.

Additional STF income which was notified to us in 2016/17 and will be paid in this financial year is expected to be added to the capital plan. This could be invested in schemes that will drive further efficiencies across the Trust and to benefit staff well being. This is currently not included in the forecast.

Efficiency

Cost Improvement Programme (CIP)



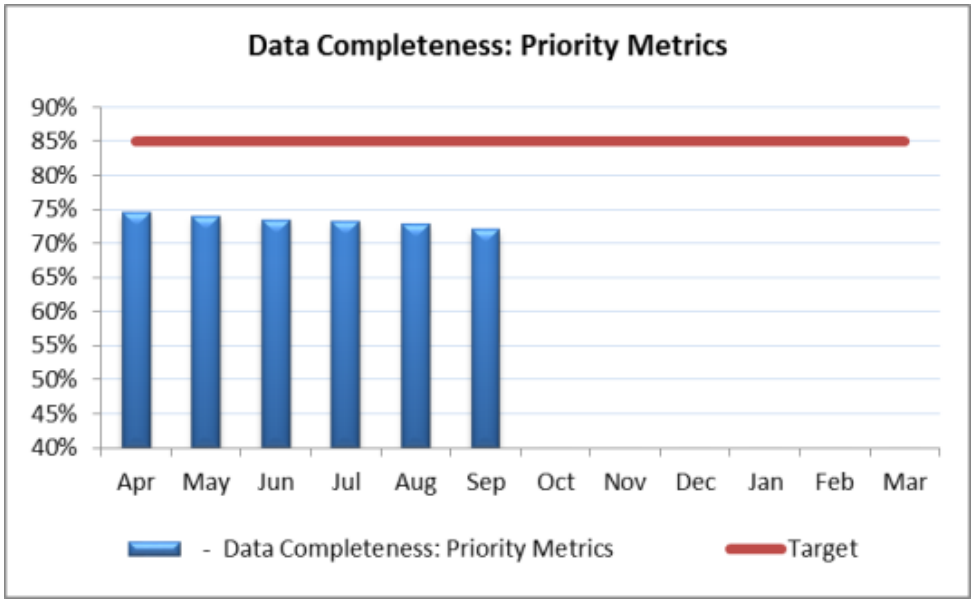
At the end of September there was £4.3m of assured CIP against a plan of £3.85m, making an overachievement of £438k. Of the £4.3m assured, £2.6m was assured non-recurrently.

The forecast assumes a further delivery of £0.5m of which almost all is non-recurrent. The total CIP forecast to be delivered is £4.8m which is an overachievement of £1m against the target of £3.8m. Of the forecast £4.9m, £3.1m is non-recurrent in nature.

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

Operational Section

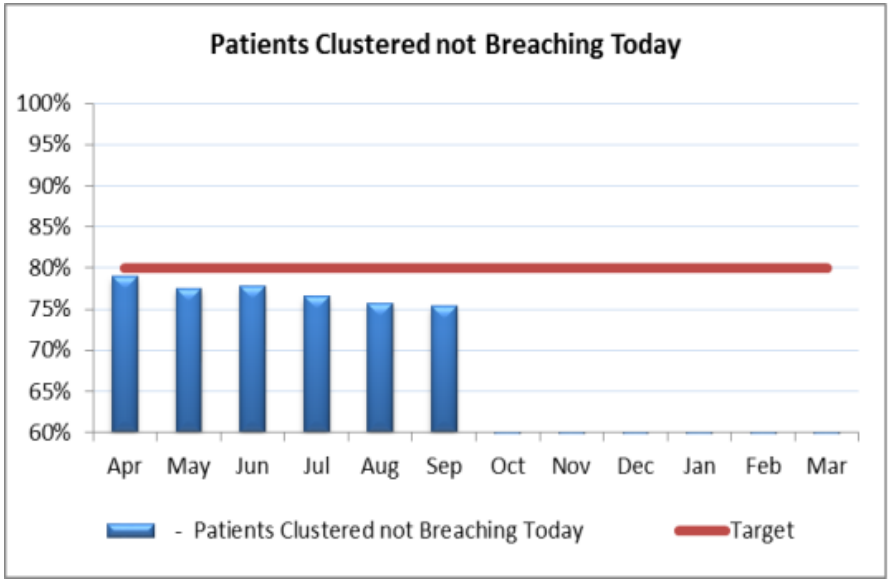
Data Completeness: Priority Metrics

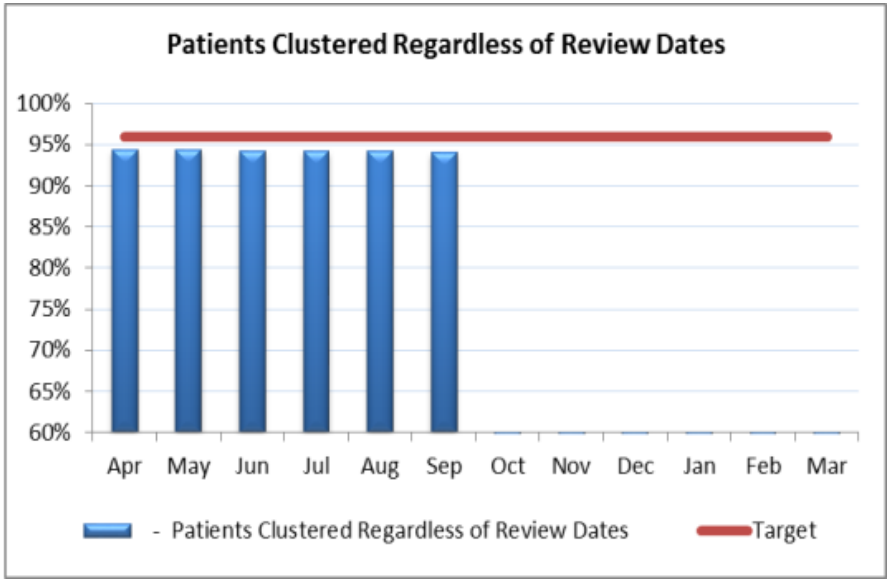


This is an NHS Improvement Single Oversight Framework (SOF) target which came into force from 1st October 2016. The national requirement is to achieve the priority metrics target of 85%. Achieving this target would be extremely challenging without additional resource. It is acknowledged there are capacity issues.

A proposal to revise the SOF is currently out for consultation. NHS Improvement are proposing to replace the "data completeness priorities metrics" and "data completeness identifiers metrics" indicators with a single "data quality maturity index – mental health services data set score" indicator. The proposed target is 95%. In the latest published national data the Trust scored 98.9% therefore if this change comes into effect we should be able to achieve the revised target.

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



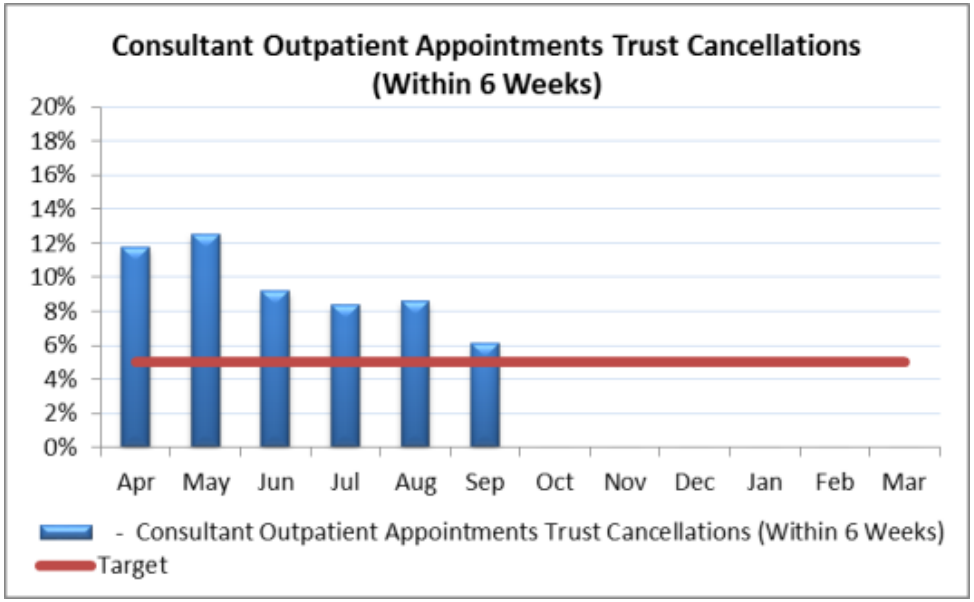


A paper was presented to the Finance and Performance Committee on 22nd May 2017. The Committee stated that it was important to achieve the identified performance standards and commissioned an action plan to address the requirements:

- The 2 performance targets should be complemented by the approved quality indicators not replaced by them
- Clusters to be used to help analyse caseloads and case flow.
- Audit to understand why there is a discrepancy with the red rule adherence
- Multi-disciplinary reference group to be established
- Target teams or individuals where clustering seems out of kilter with the performance and red rules

A follow up to May's report will be provided to the next F&P Committee

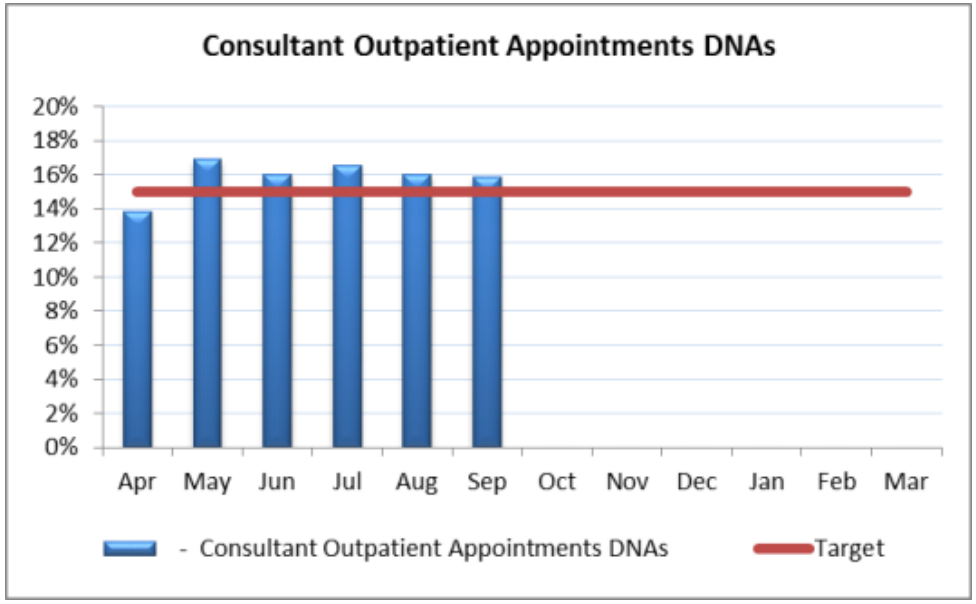
Consultant Outpatient Appointments Trust Cancellations (within 6 weeks)



Board members are directed towards a separate report on the agenda covering this issue.

Att Type	Total	%
Clinician Absent From Work	164	44%
Moved - Trust Rescheduled	75	20%
Moved - Clinic Cancelled	39	11%
Moved - Staff Issue	22	6%
Virtual Clinic	18	5%
No Consultant	14	4%
Clinician On Annual Leave	13	4%
Moved - Location Issue	13	4%
Clinic Booked In Error	10	3%
Trust Rescheduled	1	0%
Clinician Must Attend Training	1	0%
Paris System Issue	1	0%
Grand Total	371	100%

Consultant Outpatient DNAs



Board members are directed towards a separate report on the agenda covering this issue.

WARD STAFFING

Ward name	Occupancy % Rate	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
		Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
AUDREY HOUSE RESIDENTIAL REHABILITATION	81.33%	172.5%	67.4%	83.3%	0.0%	Yes	Please be advised that through September we had a number of NA staff on leave and due to increased levels of observations additional shifts were covered by both bank staff and Registered staff to ensure safety. We are aiming for 2 qualified for each night shift, staff have however been moved to other wards with low RN staffing in which this as been replaced with bank NA staff.
CHILD BEARING INPATIENT	85.00%	76.6%	92.9%	96.7%	186.7%	Yes	Current fill rate tolerances have been broken for registered nurses in the day to cover a member of staff on a career break, carers leave and clinical activity when there was no unqualified bank staff available. Care staff on nights due to two long term sickness absences and high observation levels.
CTC RESIDENTIAL REHABILITATION	80.00%	116.0%	87.8%	136.7%	80.0%	Yes	The registered day figure is higher and the unregistered lower due to having a registered nurse on duty who is not counted in the registered numbers (but showing as registered) We have endeavoured to cover the nights with 2 registered and 1 unregistered (in line with trust policy) this is reflected in the night shift figures.
KEDLESTON LOW SECURE UNIT	45.00%	88.7%	54.7%	98.3%	71.7%	Yes	We have a nursing assistant on long term sick, several nursing assistant vacancies and also reduced staffing levels at present in preparation for the refurbishment. Bleep holder also working in the numbers with the bleep to support where necessary
KINGSWAY CUBLEY COURT - FEMALE	55.74%	111.4%	97.8%	50.0%	131.1%	Yes	Figures are correct apart from the 4th late shift – table indicate one RN on duty however the bleep holder worked in numbers. On the 18th table recorded no RN cover however a RN was moved from another ward but recorded on the system. We have broken the staffing level expectation due to Maternity leave, career break, sickness, training and vacancies. We were over staffed on night with NAs due to shortfall of RNs on nights.
KINGSWAY CUBLEY COURT - MALE	70.93%	77.1%	122.0%	88.3%	172.2%	Yes	There is one incorrect entry, for 9/9/17 on the night shift there were 4 unqualified staff on duty not 3, so that would equate to 41.67hrs not 31.25 which is showing, all the other entries are correct.
LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP	87.22%	82.7%	104.9%	90.0%	130.0%	Yes	The percentage of RN use is lower as we had 1 retire and 2 new starters were awaiting their registration to come through. Due to this the 2 new nurses were paid as Nursing assistants which has raised the care staff ratio.

WARD STAFFING

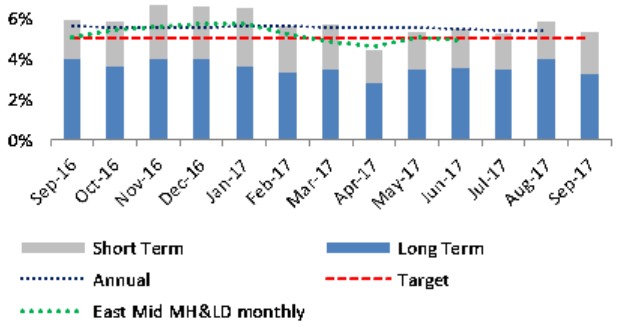
Ward name	Occupancy % Rate	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
		Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
HARTINGTON UNIT - MORTON WARD ADULT	91.11%	98.6%	123.0%	48.3%	236.7%	Yes	In response to the unavailability of registered staff on the Radbourne and Hartington Units during July, August and September the following mitigation has been put in place: • Recruitment of registered nurse agency staff where possible • Recruitment of bank registered nurse where possible • Safe offers of additional hours at appropriate rates to both inpatient and community based registered staff • Request for corporate staff who have a registered nursing qualification to be redeployed for 1 day a week to the units • Utilisation of additional nursing assistants to cover gaps in registered nurse availability [within agreed safe parameters] • Review of all secondments • Inpatient Band 7 Registered Nurses to be included in the numbers • Cease training unless essential for safety of the unit • Pilots developing regarding Pharmacy technicians within the skill mix • Pilots developing regarding OTs within the skill mix The situation remains fragile despite the mitigation in place and the units remain vulnerable in terms of the ability to cover for any further unanticipated absence. The situation is being closely monitored and ASMs and Divisional Nurses will escalate situations of heightened risk on a day to day basis.
HARTINGTON UNIT - PLEASLEY WARD ADULT	84.33%	95.0%	96.6%	51.7%	200.0%	Yes	
HARTINGTON UNIT - TANSLEY WARD ADULT	100.14%	82.0%	128.3%	58.3%	186.7%	Yes	
ENHANCED CARE WARD	97.00%	68.9%	135.4%	48.3%	195.0%	Yes	
RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT	100.50%	72.6%	157.3%	56.7%	223.3%	Yes	
RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT	103.17%	82.0%	136.7%	56.7%	266.7%	Yes	
RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT	98.00%	80.6%	169.6%	51.7%	178.3%	Yes	
RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT	104.00%	100.5%	162.0%	53.3%	330.0%	Yes	

Workforce Section

WORKFORCE DASHBOARD

Sickness Absence	Jul-17	Aug-17	Sep-17
(Monthly)	5.27%	5.84%	**5.34%**
(Annual)	5.39%	5.35%	**tbc**

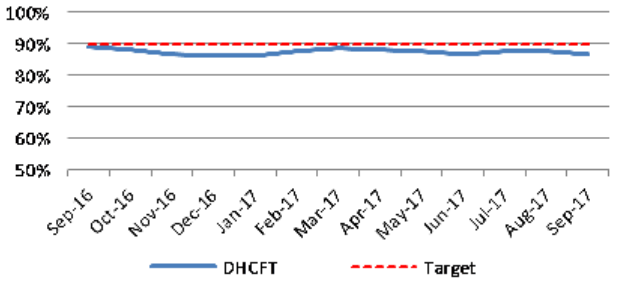
Target 5.04%



The monthly sickness absence rate is 0.50% lower than the previous month and compared to the same period last year (September 2016) it is 0.55% lower. The Trust annual sickness absence rate continues to reduce and is running at 5.35% (as at August 2017 latest available data). Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 32.35% of all sickness absence, followed by surgery at 11.58% and other musculoskeletal problems at 9.82%. Compared to the previous month short term sickness absence has increased by 0.25% and long term sickness absence has decreased by 0.75%.

Compulsory Training	Jul-17	Aug-17	Sep-17
(Staff in-date)	87.90%	87.69%	**86.88%**

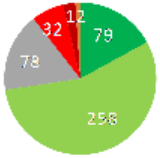
Target 90%

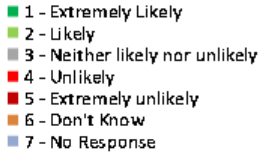


Compulsory training compliance continues to remain high running at 86.88%, a decrease of 0.81% compared to the previous month. Compared to the same period last year compliance rates are 2.38% lower.

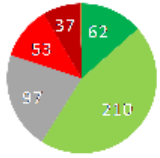
Staff FFT Q2 2017/18 (465 responses, 20.5% response rate) **& Staff Survey** 2016

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





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



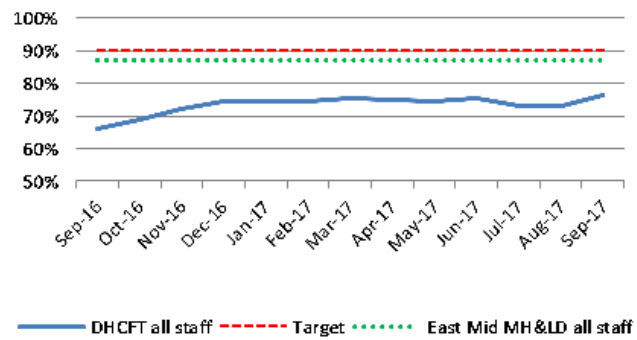
	2016	National average 2016	2015	National average 2015
Overall staff engagement:	**3.69**	3.84	3.73	3.81

Appraisals (All staff)

Jul-17	Aug-17	Sep-17
73.15%	73.03%	**76.18%**

K

Target 90%



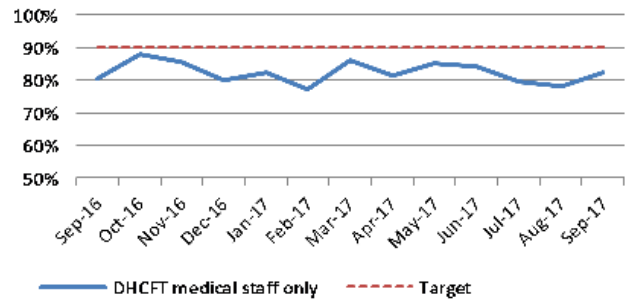
The number of employees who have received an appraisal within the last 12 months has increased by 3.15% during September 2017 to 76.18%. Compared to the same period last year, compliance rates are 10.30% higher. According to the 2016 staff survey results, the national average for Mental Health & Learning Disability Trusts is 88.79%. Local benchmarking data for a range of Trusts in the East Midlands shows an average completion rate of 83.57%.

Appraisals (Medical staff only)

Jul-17	Aug-17	Sep-17
79.61%	78.22%	**82.47%**

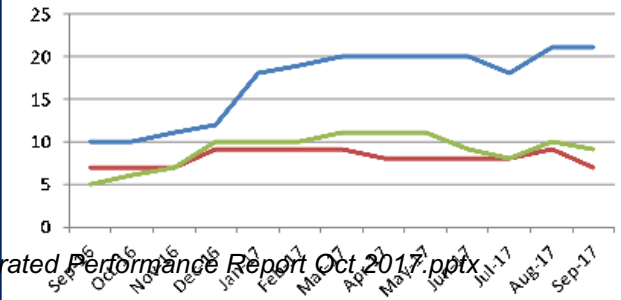
K

Target 90%

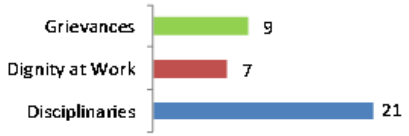


The number of Medical staff who have received an appraisal within the last 12 months has increased by 4.25% to 82.47%. Compared to the same period last year, compliance rates are 1.74% higher. Junior Doctors on rotational training are excluded from the figures.

Grievances/Dignity at Work/Disciplinaries as at 30/09/2017

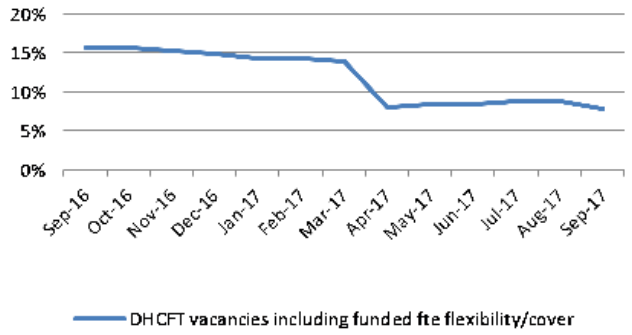


There are 9 grievance cases lodged at the formal stage, no new cases and 1 resolved. There are 7 Dignity at Work cases, no new cases and 2 have been resolved. There are 21 Disciplinary cases, no new cases and it is anticipated that a further two will be resolved in the next period.



Vacancy

(Funded full time equivalent) Including funded fte flexibility/cover	Jul-17	Aug-17	Sep-17
	8.73%	8.68%	**7.86%**

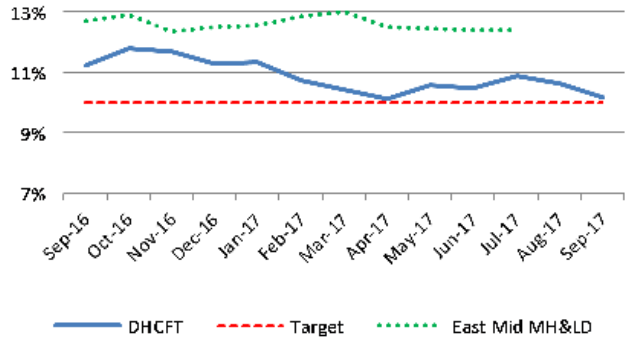


The Trust vacancy rate includes funded Fte surplus for flexibility including sickness and annual leave cover. Funded vacancy rates have decreased to 7.86% in September 2017. 2017/18 budget changes included a large reduction in Fte from 2016/17 investment not materialising and Cost Improvement Programmes. During the period January 2017 to September 2017, 184 employees have left the Trust and 247 employees have joined the Trust.

Turnover

(Annual)	Jul-17	Aug-17	Sep-17
	10.89%	10.64%	**10.17%**

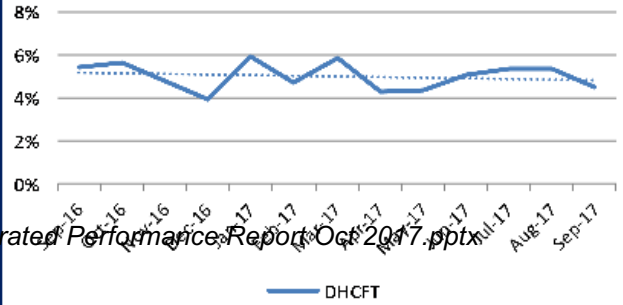
Target 10%



Annual turnover remains within Trust target parameters at 10.17% and remains below the average for East Midlands Mental Health & Learning Disability Trusts (12.41%). The average number of employees leaving over the last 12 months has decreased by 1.58 to 19.5. During September 2017 18 employees left the Trust which included 5 retirements.

Agency Usage

(Spend)	Jul-17	Aug-17	Sep-17
	5.32%	5.34%	**4.48%**



Total agency spend in September was 4.48% (4.92% including medical locums). Of total agency and locum spend for all staff groups, Qualified Nursing represented 0.9%, Medical 3.1% and other agency usage 0.5%. Agency Qualified Nursing spend against total Qualified Nursing spend in September was 2.6%. Agency Medical spend against total Medical spend in September was 17.3%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £728k.

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 1 November 2017

Outpatient Clinics

Purpose of Report:

The purpose of this report is to provide the Board with an understanding of the importance of the "outpatient clinic" model of working and the challenges of the model as well as actions proposed to address these challenges.

Executive Summary

- Outpatient clinics are an efficient means of providing care to patients and are effective for many but not all patients referred to DHCFT
- Concerns exist over the patient experience of the outpatient clinic due to appointment cancellations, and the efficiency of clinics due to failed attendance. In addition the experience of patients attending appointments is not uniformly good and a recent concern has been raised about the accessibility of the care record to all doctors providing clinic appointments
- A number of challenges are identified for the smooth running of clinics from administrative, to clinician and care pathway related factors.
- This report suggests actions to improve clinic performance while acknowledging that some factors such as recruitment are a national problem and are largely out of our control

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

(Board) Assurances

- The Board can be assured that significant work is being undertaken to improve performance against this challenging objective

Consultation

- The action plan has been discussed in TMT

Equality Delivery System

- The legal requirement on the NHS to promote equality is promoted by the provision of development opportunities for all staff

Recommendations

The Board of Directors is requested to:

1) Note the importance of outpatient clinics as an efficient means of providing care to our patients in a way that is largely positively received by patients
2) Note the challenges faced in providing clinics in the current climate of recruitment difficulties of both medical and nursing staff and ever increasing demand on services.
3) Note the actions being taken to improve the position
4) Review and agree to the proposed action plan to improve the patient experience of outpatient clinics through improved clinic performance.

Report presented by: **John Sykes, Medical Director**

Report prepared by: **Mark Broadhurst, Deputy Medical Director**

The Outpatient Clinic

1. Introduction

The outpatient clinic in Derbyshire Healthcare Foundation Trust is utilised as an efficient means of providing care to patients open to the Trust.
The vast majority of such clinics are provided by Consultants and trainee doctors although innovations in some areas have seen Non Medical Precribers carrying out similar clinics under the supervision of Consultants.

It should be noted that the model of outpatient clinic provision within the Trust is one that aims to be rooted within the neighbourhood teams rather than working in isolation. This is achieved through attendance of clinic providers at MDT meetings, joint appointments with the Care Programme Co-ordinators if possible and the use of the Electronic Care Record (PARIS) to enable clinicians to have access to real time updates about care provision outside the clinic. However, there is a group of patients who are seen only in the outpatient clinic and who have no other support from within the Trust.

The cancellation of patient appointments by the Trust and the non-attendance of patients at clinics presents a direct concern for clinicians and patients and a wider concern for the Trust and those who commission our services

2. Outpatient Clinic Challenges Highlighted at Trust Board

This financial year to date (2 Oct 2017), 31,025 outpatient appointments have been offered to patients. The majority of non-completed appointments are due to patient cancellation (7,153 appointments). There have been 2,894 Trust cancellations and 3,220 “DNAs” (Did Not Attend) representing 9.33% and 15.54% of appointments respectively.

Therefore 17,758 completed outpatient clinic appointments occurred between April and October 2017. During the same time period, 45 complaints, concerns and incidents relating to outpatient clinics were received. Even allowing for likely under-reporting, this suggests that the overwhelming majority of appointments are regarded positively.

Patient Cancellations

It is important that patients are enabled to have appointments that are as convenient as possible for them and therefore the ability to cancel and reschedule appointments is important for them.

Did Not Attend

There are a number of reasons that patients do not attend their appointments. These may include administrative, geographical or clinical factors among others. Administrative factors may include appointment letters or reminders not being received by patients. Geographical factors may include difficulties getting to appointments, for example in rural areas. Clinical factors may include co-morbid physical health problems, a lack of acceptance that mental health support is required

or improvement in the patient's health such that appointments are no longer needed. Other factors may include dissatisfaction with previous experience of the service.

Trust Cancellations

Trust Cancelled Outpatient Appointments April – September 2017 with "Reasons"

	Total	
Reason	**n**	**%**
Clinician Absent From Work	719	28%
No Consultant	431	17%
Moved - Trust Rescheduled	312	12%
Moved - Staff Issue	307	12%
Virtual Clinic	244	9%
Moved - Clinic Cancelled	224	9%
Clinician On Annual Leave	107	4%
Clinic Booked In Error	90	3%
Moved - Location Issue	82	3%
Clinician Must Attend Meeting	22	1%
Clinician Must Attend Tribunal	15	1%
Clinician Must Attend Training	14	1%
Paris System Issue	7	0%
MHA Assessment Urgent Work	1	0%
Grand Total	**2575**	**100%**

This refers to appointments cancelled by DHCFT.

In order to avoid this occurring routinely, a policy of "virtual clinics" exists within the Trust. This allows for advance appointments to be booked but to remain alterable until 6 weeks before the date of the appointment. Appointment letters are sent to patients at the 6 week point. Planned leave (e.g. annual leave or study leave) for doctors running clinics must be arranged at least 6 weeks in advance. Thereby, only "virtual" clinic appointments, of which the patient is not aware, can be cancelled for reasons of planned absence. This system reduces inconvenience to patients whose appointments are changed by reducing the risk of clinic cancellation due to doctors being unavailable. However Trust cancellations can occur for unforeseen reasons such as sickness or sudden vacant posts in the case of locum doctors who have to give only 1 week notice to leave. Virtual clinic cancellations should not appear in monitoring data as they do not affect the patient's experience.

Monitoring of Trust cancellations is designed to allow action to be taken around specific clinic difficulties by assigning the cancellation to one of a number of reasons. However, the "Reason" categories are not used uniformly leading to a lack of clarity. Scrutiny of Trust cancellations in August revealed 4 consultants for whom clinics were cancelled under the category "clinician absent from work". In fact this single category represented a mixture of absence of a locum, sickness and failure to cancel a clinic for planned annual leave. It is important that the categorisation of clinic cancellations is accurate so that clinicians and those organising the clinics can be supported to avoid future cancellations as far as possible.

Furthermore, a proportion of Trust cancellations appear in monitoring data despite having been cancelled appropriately in advance and patients not having been inconvenienced.

Doctors not having access to patient's notes in clinic

A further difficulty highlighted recently by a presentation at Trust Board is that in some clinic appointments, doctors have not had access to patient's notes. DHCFT has moved to an Electronic Patient Record, PARIS, the roll out of which was completed in 2017. An electronic care record has the advantage that all clinicians with access to the record of a patient can access information on care provided to that patient from any location where PARIS can be accessed (i.e. Trust computers). There are 2 instances where access to patient information is not possible on PARIS:

- On arrival, locum doctors do not have access to PARIS until they have been trained. There is limited access to PARIS trainers in the Trust such that it may be a few days before PARIS access can be granted. In such cases, the balance of cancelling clinics has to be weighed against the limited information (usually print out of the last 2 letters) that will be available in the appointment.

- For longer term review of patients' condition or treatment, clinical information on PARIS is limited to the years that the system has been used. Paper notes with older clinical information are available from storage but access is subject to a delay and usually the requirement for the old paper notes leads to a delay in treatment.

3. Difficulties with Current Outpatient Provision

Consultants have very large caseloads of up to around 600 patients. The outpatient clinic allows very efficient provision of care to such large numbers of patients. There is marked variation in caseload size among consultants within the Trust. This depends on factors including the clinical characteristics of the patient population in different geographical areas, the consistency of medical staff in the area because there is a tendency for locum doctors not to discharge patients even when discharge is appropriate, different styles of working among consultants and the availability of other services which could aid patients' recovery and allow discharge from clinic.

The most important factors affecting outpatient clinics at present appear to be:

- the presence of locum staff – while every effort is made to ensure that appropriately qualified locum staff fill consultant vacancies, clinics are often cancelled at a time of changeover due to the lack of availability of locums and the need to train them to use PARIS before they can perform effectively in a clinic. Delays in training locums who are already being paid to work for us leads to poor patient outcomes and is extremely expensive. Furthermore, locums tend not to discharge patients from the clinic even when that would be an appropriate step. This leads to accelerated growth of the consultant caseload where we have locum cover.

Over the last year the Trust has redoubled its efforts to recruit substantive consultants and medical staff with a degree of success despite national recruitment difficulties in psychiatry and paediatrics. A far more strategic approach to recruiting locums has been developed although wider NHS strategy has not improved our ability to recruit and retain locum staff.

- The lack of alternatives to the outpatient clinic. Outpatient clinics are only beneficial for a proportion of patients referred to secondary care mental health services. The principal of outpatient clinics working in isolation has been challenged over the years and in many places only patients on CPA are seen in clinics. In DHCFT a custom of discharging patients from CPA to the outpatient clinic has evolved. While efficient, outpatient clinics employ the most expensive resource in the organisation and are inflexible. Thus patients with arguably the lowest level of need are in a very efficient but inflexible and expensive resource. At the same time, patients with greater need may be discharged to the clinic because of pressures on nursing caseloads. A significant group of patients in the outpatient clinic are those with chaotic lifestyles, risky behaviour and who have few medical needs – those patients with personality disorders. Such patients clearly require support that cannot be provided by the inflexibility of an outpatient clinic alone but many do not receive additional support.

  Innovative approaches to reduce the burden on consultants of high caseloads and assist in areas with medical vacancy are being trialled in the Trust. For example:

  - Non Medical Prescriber pilot in Killamarsh where one day of NMP input has supported a day of consultant vacancy per week,

  - The use of non-medical staff to support consultant vacancies/workload in children's services – In the paediatric service, the neurodevelopmental team of nurses provide assessments and follow up appointments for children with ADHD. They monitor medication and provide parenting courses to support behavioural management. Nonmedical prescribers have only recently incorporated in the team and will also be able to do their own prescribing including titration of medication for ADHD which can be very time intensive with regular reviews although medical staff will continue to be needed to initiate medication.

    Paediatric services also have nurses in the continence service who have taken on work which was previously done by doctors. Also assessments for conditions such as possible dyspraxia are now done in the first place by physiotherapists and referred for medical assessment if appropriate.

  - Memory Assessment Services are moving towards nurse led diagnosis of specific difficulties.

- In the High Peak and Dales and Bolsover and Clay Cross Neighbourhoods, OT led recovery clinics are being established to promote the use of non-mental health community support to aid recovery of our patients allowing appropriate discharge from secondary care. In this model, partnership working with other agencies and 3rd sector support enables our patients to move forward in their recovery. The recovery approach includes workshops and resilience training and development of an understanding and awareness of strategies to maintain wellbeing, recognition of relapse indicators and a plan of action in the event of relapse. Providing this recovery approach creates a safe discharge pathway within service delivery.

- These factors are intertwined since they present a challenge to the consultant workforce and make consultant posts unattractive thus presenting a barrier to recruitment and ultimately perpetuating the problem

4. Recommended Actions

The suggested changes aim to give patients a better outpatient clinic experience and one that is tailored to their needs. In addition, the appropriate discharge of patients not requiring CPA and the use of alternatives to clinics as appropriate will lead to an increase in the capacity of doctors to work at the their licence with patients who are complex and risky. The suggested changes are as follows:

- The reason for clinic cancellations must be classified correctly and in a way that allows monitoring and remedial action to be taken if necessary

- Contact details for all patients should be checked and updated on as regular a basis as possible in order that appointment letters and reminder texts can be received by patients. In addition, if patients do not attend appointments, medical staff telephone them to establish the reason for non-attendance and conduct a telephone appointment with the agreement of the patient. This should lead to a reduction in future DNA rate but is only possible with accurate contact details

- Ensure that appointment letters are sent and that this is in a timely manner that gives patients the opportunity to rearrange appointments if necessary

- In areas of high turnover of locum staff it is essential that patients are allocated to the current doctor responsible for their care. This does not always occur and leads to difficulty in interpreting reporting data and giving support appropriately in areas of need

- The monitoring of clinic cancellation data will be reviewed monthly in the medical management meeting and Clinical Directors will assist in investigating and supporting areas where rates of cancellations and DNAs are high.

- Medical and clinic administrators will be reminded of the process of virtual clinics and the need to ensure that all planned leave is arranged at least 6 weeks in advance. The 6 week rule will be monitored through rates of clinic cancellations. It is likely that clinicians with medical management roles will breach this rule and it is requested that the board supports the need to adhere to this rule when requesting medical managers to attend meetings.

- All consultant staff and medical secretaries will be reminded of the need to telephone patients who have not attended a clinic appointment as a means of identifying reasons for non-attendance, carrying out a telephone consultation and preventing future non-attendance. The correct documentation of such contacts is important.

- Innovative quality improvement projects to improve care pathways and increase the capacity in clinics in neighbourhoods should be encouraged and where effective rolled out to other areas eg non-medical prescriber clinics, use of non-medical staff to support outpatient activity, the use of physicians associates etc. It should be noted however that such innovative approaches is unlikely to lead to significant short term improvements due to the difficulties nationally in recruiting nursing staff.

- The development of nurse led clinics and step down programmes according to local need to support (respectively) longer term CPA management of patients with psychosis and a recovery based OT approach for patients progressing towards discharge from mental health services. These developments would lead to increased capacity required to allow rapid access back into our services at times of need

- It is vital that patients receive appropriate care such that if those being supported with personality disorders or forensic needs are seen in clinics by doctors with the appropriate expertise and with an additional support system that ensures they are able to engage in that care pathway. Consideration should be given to the development of specific personality disorder services and community forensic services. It is highly likely that such services would have far wider benefits including a reduction in bed use by patients with personality disorder for whom that intervention is often unhelpful. Furthermore, without changes in such services that will support clinics it is unlikely that the clinic experience will change.

- Ongoing work to improve recruitment to vacant consultant posts and to improve the efficiency of locums once in post by expediting training in systems including PARIS to enable them to begin to work clinically sooner.

Outpatient Action Plan

Ref	Recommendation	Action	Responsible Officer	Due date/Priority	Completion Date	Progress
1	Inaccurate classification of reason for cancellation by medical secretaries	Deputy Director to meet with Pro Head of Admin in order to plan intervention	Kathryn Lane	2/10/17	28/9/17	Complete
2	Inaccurate classification of reason for cancellation by medical secretaries	Prof Head of Admin to meet with Medical Secretary Managers and Performance team to disseminate correct classification information and to plan cascade to areas in need of improvement/support	Julie Scattergood	2/11/17		Date set for meeting
3	To ensure that medical secretaries or outpatient admin are sending out appointment letters in a timely manner and are not missing letters	To audit and follow up findings To cascade that in event of a late letter being sent med secs accompany with a TC	Julie Scattergood	2/11/17		Audit in motion
4	To improve contact detail information for patients	KL to raise with GMs, Performance Manager and Admin lead and review plans	Kathryn Lane	2/11/17		
5	Data cleanse regarding change of consultants /locum cover etc	HR /Temporary Staffing Lead to include Julie Scattergood in email confirmation of arrangements Dep Director of Ops to discuss with all	Kathryn Lane	2/10/17		Agreed
6	Clinic Cancellation data monitoring	To maintain monitoring and action planning via medical management meeting	Dr Mark Broadhurst	2/10/17		Ongoing
7	Management of 6 week cancellation of clinic rule to be reviewed	Re launch by reinforcing the rule and check process adherence	Dr M Broadhurst Kathryn Lane	2/11/17		
8	Reminder to Consultants regarding the	Briefing to all medical staffing	Dr Mark		26/9/17	

Ref	Recommendation	Action	Responsible Officer	Due date/Priority	Completion Date	Progress
	need to telephone patients who have DNAd		Broadhurst			
9	Review process relating to data entry when telephone contact made	Dr Mark Broadhurst to review universal application of the process with Julie Scattergood and subsequently brief all medical secretaries and consultants	Dr Mark Broadhurst Julie Scattergood	2/11/17		Consultants briefing in place
10	Capacity management review and skill mix review	Roll out development of Non-Medical Prescribers and Assistant Clinical Practitioners	Dr Mark Broadhurst Kathryn Lane Lisa Thomas	2/10/18		
11	To support local initiatives to improve the quality of Out Patient services and develop greater flow. Range of options needed to suit different individual needs and the different geographic area and associated community resources	Step down nurse clinics Recovery based group alternatives Rapid Access in Need initiatives	Dr Mark Broadhurst David Tucker	2/10/18		
12	Development of personality disorder and forensic pathways within the community setting in order to improve patient interventions and reduce blocks within clinics in line with NICE recommendations [equally applicable to ASD/ADHD]	Commissioners to consider within contracting rounds /STP developments	Lynn Wilmott Shepherd	31/3/18		
13	Improve efficacy of SMS reminders	Prof Head of Admin to arrange the addition of a Footer on appointment letters	Julie Scattergood	26/09/17		

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 1 November 2017

Quality Position Statement

Purpose of Report: This report provides the Board of Directors with an update on the Trust's continuing work to improve the quality of services it provides in line with the Trust Strategy, Quality Strategy and Framework and strategic objectives.

Executive Summary

This position statement sets out:

1. Safety – Sign up to safety and Quality improvement
2. Safety - Developing our continuous Quality improvement strategy
3. Effectiveness - Physical healthcare, Children's service developments. Adverse childhood events. Trauma informed practice into practice through working in partnership
4. Safety and Responsiveness - Learning From Very Serious Incidents and investing in mortality
5. Well led – Quality visits- review of the season
6. Well led- Supporting #iwill campaign
7. Well led Developing solutions to support – retention- Trading places
8. Well led - Our CQC Action Plan Performance, to assure the public of our commitment and the timeline for completion.

The overall theme of this paper is to highlight the complexity of the services that provide and that in providing continuous improvement in our care, we have to provide systems solutions to the challenging and wicked problems surrounding clinical care. How we operate with partners to equalise the situation through the experience or demand in our services in critical to our future sustainability.

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

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)
- Children and Families Act 2014
- The Care Act 2014
- There are legal issues under the Regulatory Reform (Fire) Safety Order 2005, the Health & Safety at Work etc. Act 1974 and the Health & Social Care Act 2010 contained within this Report
- Care Quality Commission Regulations this report provides assurance to:-
  - Outcome 4 (Regulation 9) Care and Welfare of people who use services
  - Outcome 10 (Regulation 15) Safety and suitability of premises
  - Outcome 11 (Regulation 16) Safety, availability and suitability of equipment
  - Outcome 12 Regulation 210) Requirements relating to workers
  - Outcome 14 (Regulation 23) Supporting staff
  - Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
  - Compliance with the Health & Safety at Work etc Act 1974 (HSWA)
  - Compliance with the Regulatory Reform (Fire Safety) Order 2005

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people) (Public Sector Equality Duty & Equality Impact Risk Analysis)

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).

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

Actions to Mitigate/Minimise Identified Risks

Any impact or potential impact on equality is considered as a key part of all our quality work. Some of the examples are improving the equalities position for individuals and their families are fully in line with our duties and responsibly and due regard.

Children and Adults who are looked after are equally affected by the risks associated with safety improvement work will be applied to all groups but with some groups requiring adaptation of services or information to meet their needs. This preventative work would not adversely affect specific groups.

Specifically the duty to protect children and support families with safeguarding requirements are highlighted in this report and this preventative work should be a positive outcome for this group.

Individuals with mental health and learning disabilities are often adversely affected by economic disadvantage due to the significant impact on life due to the period of illness. This model which assesses adverse childhood events would be positive in equalising the disadvantages that surround the population that we are supporting in the Trust.

Recommendations

The Board of Directors is requested to:

1) Receive this quality position statement.
2) Gain assurance, be advised on safety.
3) Review its content and seek clarity or challenge on any aspect of the report

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

Report prepared by: **Carolyn Green**
Executive Director of Nursing & Patient Experience

Quality Position Statement

1.1 Safety – Our work towards Sign up to safety and Continuous Quality improvement

We continue to make progress in our commitments to Sign up to safety; this programme of work is directly linked to the Quality priorities we are working on and our National CQUIN's.

We continue to make headway in this area.

This work will form part of our continuous quality improvement strategy we are currently developing to move form our compliance focus to a balance of Quality improvement and compliance. On completion of our comprehensive CQC action plan we will then re-focus our efforts from compliance to continual learning and effectiveness.

Safety - Investigations related to the initiation of psychotropic medications in secondary care

The recent document "The interface between primary and secondary care; Key messages for NHS Clinicians and Managers" highlights the importance of clear responsibilities around the arrangement for physical healthcare investigations in patients open to secondary care.

This is particularly poignant given the increased morbidity and mortality, largely attributable to cardiovascular illness in patients with mental illness.

The document clarifies the position that within the context of the elements of the service which it has been commissioned to provide, a secondary care provider must itself arrange and carry out all of the necessary steps in a patient's care and treatment rather than, for instance, requesting the patient's GP to undertake particular tests within the practice.

As a general rule in Derbyshire, commissioning arrangements for patients with mental illness who are open to secondary care are such that the secondary care provider (Derbyshire Healthcare NHS Foundation Trust) are responsible for investigations related to the prescription of psychotropic medication for 12 months after initiation or until prescribing is taken over by the primary care provider. Arrangements for specific drug groups may vary according to shared care agreements. The duration of prescribing by the secondary care provider is dependent on the nature of the medication and any shared care agreements. In the absence of shared care agreements (e.g. antidepressant prescribing) the primary care provider is requested to take over prescribing after a period of time which allows assessment of tolerability problems.

Patients with mental illness should be supported to access physical health investigations in order to allow initiation and monitoring of their physical health on initiating a treatment as well as for longer term monitoring of physical health parameters (particularly cardiovascular risk factors) to allow for early identification treatment if necessary. Investigations for physical health problems unrelated to psychotropic prescribing should be carried out by the primary care provider.

Patients with mental illness struggle to access physical healthcare investigations for a variety of reasons. In Derbyshire, particularly in rural areas where transport links are poor, patients find it difficult to access physical healthcare at their local hospital. It is therefore

important that they can access investigations locally at their GP surgery. The secondary care provider should, however arrange the investigations by completing the appropriate blood or ECG forms and request the patient to make an appointment to have these carried out.

In September 2017, a half day event to explore, capacity, demand and how we work with some of our Derby City GP's went ahead and was positively received. This is exploring how we work together and pilots of Consultant staff running clinics in GP surgeries with no cost to the Trust and exploring funded pilots of Primary care based mental health practitioners.

Action

1. Our Trust will support our key safety campaigns and use this work to inform our continuous improvement strategy. The timescale for a draft strategy led by the Deputy Directors of Nursing and Quality governance and Deputy Medical Director in January 2018.

2. Explore solutions with primary care provision to explore models that support physical healthcare monitoring and inclusivity and support to individuals with long term conditions to access primary care services. Follow up with Derby city GPs on models of collaboration.

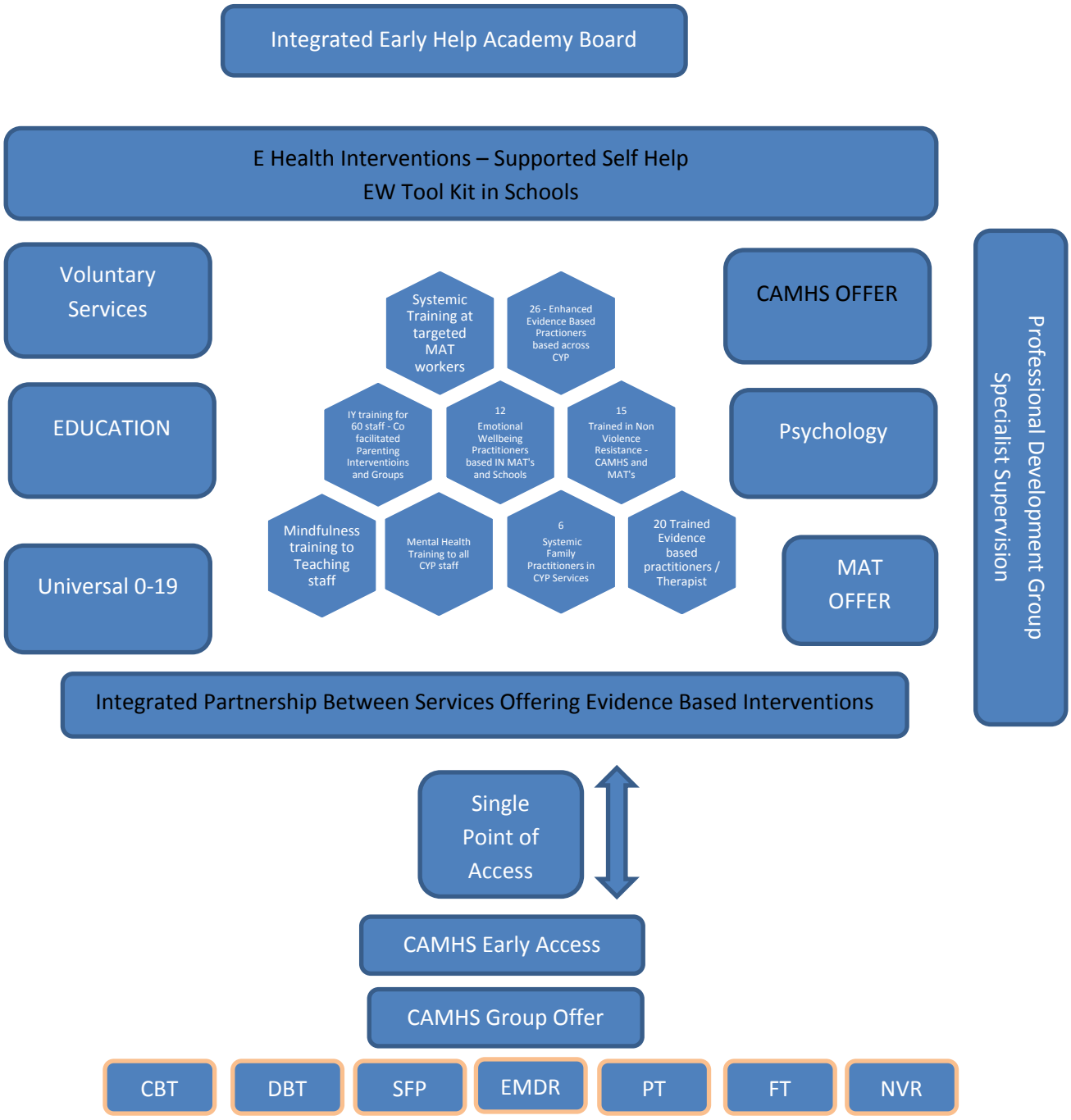
Effectiveness - working with partners

The Trust has undertaken further training with regard to Childrens Services and Mutli-agency team and development of the Emotional Well-being Practitioners connecting to social care and school nursing. To provide direct and targeted psychological therapy. This effectiveness and outcome focused work will continue to improve the Children and Young people's rapid and effective access to psychological therapy for health conditions and psychological distress. This model outlined below is a result of significant investment in Children, young people and their futures.

Emotional and Well-being Pathway to Access to Evidence Base Interventions

Future in Mind, CYP IAPT and the Five year Forward View are key drivers in the development of a whole system approach. Southern Derbyshire have developed a whole workforce development strategy that is targeted at enabling the service to provide the right intervention at the right level to the right degree at the right time by the right person.

The Integrated Early Help Academy is based on a virtual model of integrated pathways across Southern Derbyshire that provides specific evidence based targeted interventions. These are supported by an Academy Board which oversees the delivery of evidence based interventions across the Academy.



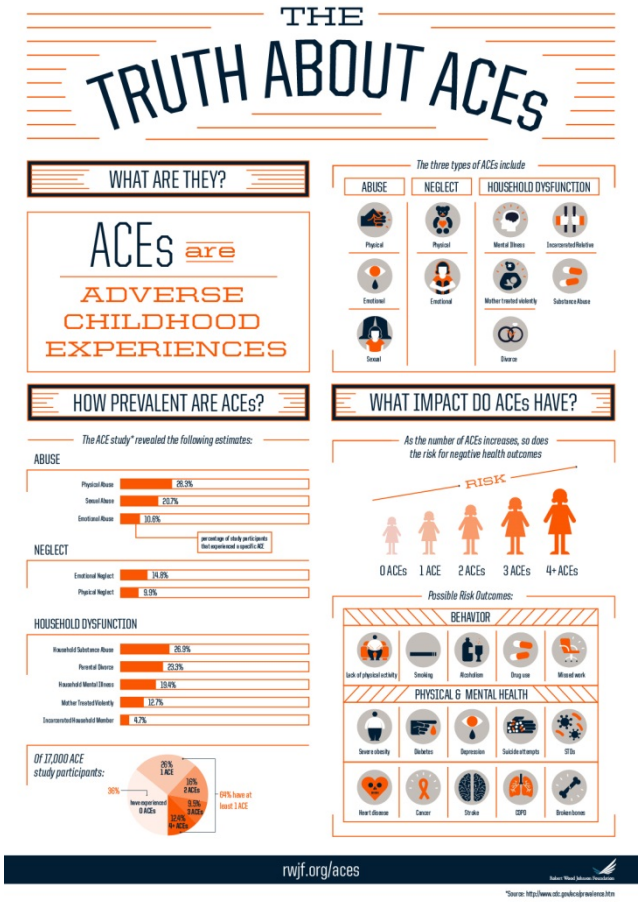
This model has been successful to date and has resulted in further investment in the service to pay for a clinical supervisor to provide targeted and in-reach support to the sider systems of care, to continually improve our community offer and manage demand at the primary and universal care levels.

Action

Clinical outcome reviews and activity reviews will be report to the Quality Committee, following these additional investments in staff in February 2018.

Effectiveness - working with partners

The Trust and Derbyshire Police held a Trauma informed conference in October 2017. This was a day to reflect on learning from significant Safeguarding incidents that have occurred both nationally and locally. This was to hear from the voice of the expert who has experienced safeguarding investigations by multi-agency reviews. To very brave individuals shared the lived experiences of abuse and the impact of adverse Child events.



This was a powerful day for Police, Social care, Third sector and Health partners to listen and learn from the experience of our safeguarding and police investigations and the experiences of our support services.

Actions

1. We have agreed as Team Derbyshire interagency partners, to host a further event 12 months on. Where are we now? In 2018 to be held at Police Headquarters in Ripley.

2. We have agreed to set up a social media Trauma informed network to share practices from all members of the attendees in addition we are linking to schools who have just undertaken some trauma informed training in Education.

3. We have developed a list of areas to work on over the year, based upon conference participants based upon a quality improvement brain storm, in interagency group work.

4. The learning and ideas will be incorporated into a pan Derbyshire development of a *Strategy and Practice Guidance for staff to enable survivors of non-recent abuse in childhood to be effectively supported.* This will be led by the Clinical Commissioning group

5. We have agreed that Safeguarding training in external partners will be reviewed to include Adverse Childhood events and practice, agreed October 2017, timescale for commencement to be agreed.

6. We will review our own Safeguarding training to include ACE thinking and Trauma informed practice, to be agreed.

7. We will be using the ACE framework in developing CPD for our staff in disclosure and formulation. We will be using this framework in the development of our Physical healthcare strategy, in development October / November 2017.

8. We will be using the ACE framework in analysis and a review of suicide in our Trust as part of mortality analysis, January to March 2018.

1.3 Safety and Responsiveness - Learning From Very Serious Incidents- Nationally

We continue to review our mortality data and make improvements. We have invested our internal resources, in a DATIX module for mortality recording and analysis.

We will continue to report on this important area of governance in our integrated reporting, led by the Quality committee.

Effectiveness in our Neighbourhood and Campus services

We will be exploring with Neighbourhoods their finding from their Neighbourhood reviews and as part of the Continuous quality improvement whether Neighbourhood teams would explore a version of community based RED to Green effective care or the adoption and accreditation of COMHS (Community Health Care Systems).

1.4 Well Led – Leadership - Quality visits are completed

Quality visits continue to be an important part of our make up in our organisation. Our more revised rating criteria has lifted the bar this year. It is shining a light both upon the outstanding range of innovations that our services are able to showcase. This model has driven to substantial improvements in our standards, namely clinical and managerial supervision performance and Family / carer inclusive practice - self-assessment of our Triangle of Care. We have submitted our clinical effectives and compliance against externally accredited standards for Level 2 compliance and at the time of writing we await the outcome of our submission.

1. Focusing on our staff, through clinical supervision and to re-define our clinical care pathways to ensure Family inclusive practice, where we have learning from very serious incidents that we need to continually improve this area.

Action

1. The Nursing and Operational Leads will ensure that they respond to quality visit feedback and support teams to overcome their service struggles, using a coaching methodology and enlisting other support teams and departments to enable them to succeed.

2. We are scheduling the end of year evaluation to receive feedback and review the quality improvement model.

1.5 Well led – Involving our people

Children's services

#iwill is a UK-wide campaign that aims to make social action part of life for as many 10 to 20 year olds as possible by the year 2020. Through collaboration and partnership, it is spreading the word about the benefits of youth social action, working to embed it in the journey of young people and create fresh opportunities for participation. The campaign is being co-ordinated by the charity 'Step Up To Serve', governed by an independent board and has cross-party support. #iwillWeek 2017 – Building Communities.

Between November 20th and 24th #iwill campaign partners will be involved in a wide range of activity that celebrates youth social action. The national campaign team will be sharing newsletters during the week featuring partner blogs, ambassador profiles, fresh #iwill pledges and news of key events. The aim is to highlight how youth social action is helping build communities in all parts of the UK and to showcase the cross-sector, cross-party support that the #iwill movement has generated since launching four years ago.

Childrens services have requested that as Trust Board we support this social action and support them in making pledges.

This will include a number of initiatives decided by the Childrens teams. The Executive Lead is Carolyn Green and I would ask other Board members to endorse and support the work of children's services in social media and through taking an interest in this work

Action

For the Board to endorse Childrens services request to be supported in their pledges to #iwill

1.6 Trading places

"Trading Places" is a nurse exchange programme across the four NHS trusts in Derbyshire. This includes the placement of RMN's into general nursing areas and general RN's into mental health areas where appropriate.

This is based upon feedback that some staff do not want to leave their role, but would like to gain wider experience to support them in their current endeavours. This project is part of a Chief Nurse fellow scheme to support ***Team Derbyshire*** initiatives across providers to aid both recruitment and retention.

Are you:

Wondering what to do next?
Looking to expand your knowledge and skills?
Seeking something a little different, but without taking a permanent leap?
If you're a Band 5, Post Preceptorship Registered Nurse (General or Mental Health), then why not consider?

"Trading Places" is a Nurse exchange programme across the four NHS Trusts in Derbyshire. This includes the placement of RMN's into general nursing areas, and general RN's into mental health areas where appropriate (exchanges will be matched so that there are still commonalities between areas).

Participants will be given a “buddy” and a package of skills and objectives to achieve during the three months. They will also be expected to share the skills and knowledge that they bring with them.

If you are interested in participating in this exciting new initiative, or have questions, please contact

Jonathan Sansome, Chief Nurse Fellow 07920 700870
jonathan.sansome@derbyshcft.nhs.uk

“Trading Places” - Exchanges for healthcare professionals in Derbyshire.

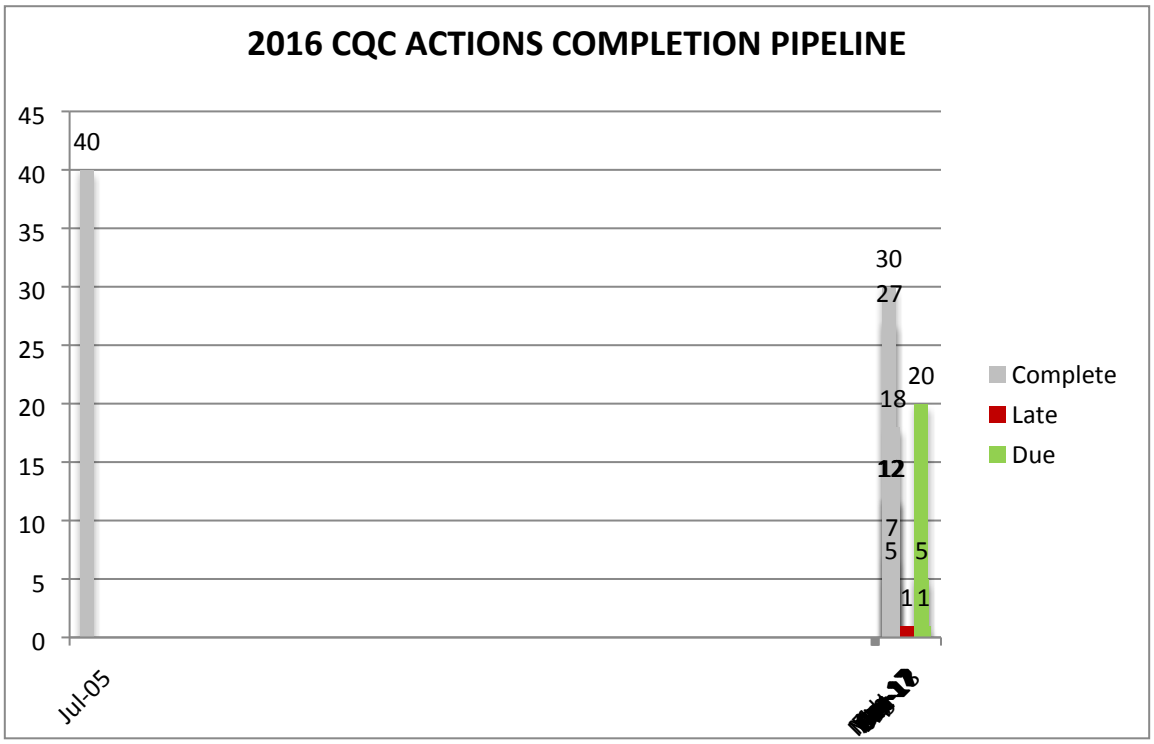
NHS Derbyshire Healthcare NHS Foundation Trust
NHS Derby Teaching Hospitals NHS Foundation Trust
NHS Derbyshire Community Health Services NHS Foundation Trust
NHS Chesterfield Royal Hospital NHS Foundation Trust

1.7 Care Quality Commission Comprehensive – completing our action plan

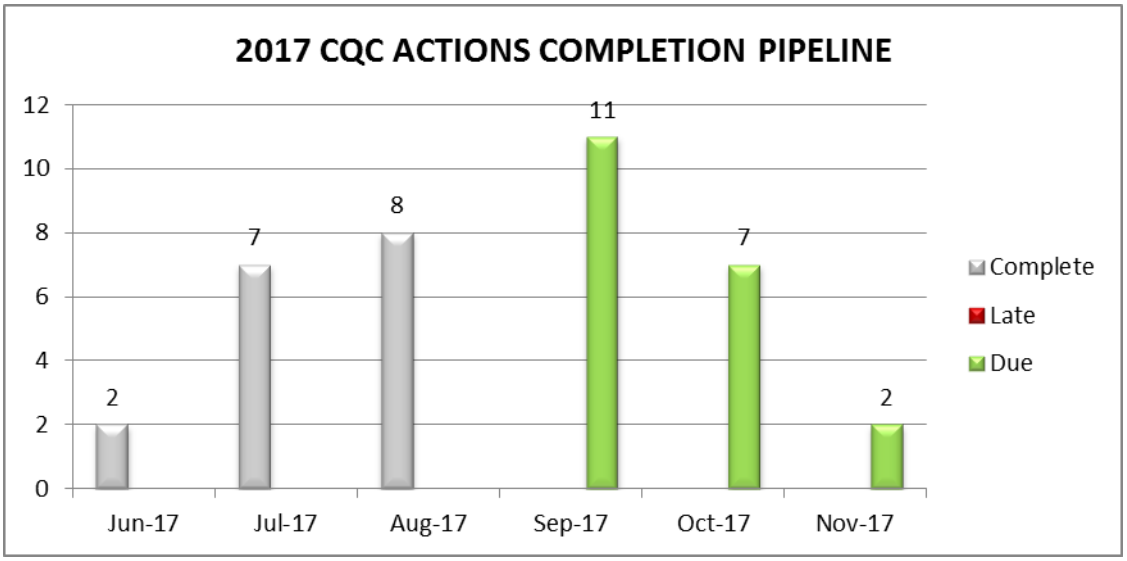
The learning from the Care Quality Commission Comprehensive visit continues and this is closely monitored by the Quality Committee.

There has been overall improvement in the status of the **2016** comprehesive inspections actions in this report:

	Current 2016 Action Status			
Portal Review	**At Risk of Not Delivering**	**Concerns**	**In Progress and on Target**	**Completed**
October 2016	0	34	136	20
December 2016	0	22	128	40
January 2017	0	24	96	70
February 2017	0	12	81	97
March 2017	0	5	76	109
April 2017	0	4	65	121
May 2017	0	4	60	126
June 2017	0	1	56	133
July 2017	0	0	45	145
August 2017	0	0	27	163
Comparison To Previous Month (% of all actions)	**The Same**	**0.5% Decrease**	**9.5% Decrease**	**9.5% Increase**



	Current 2017 Action Status			
Portal Review	**At Risk of Not Delivering**	**Concerns**	**In Progress and on Target**	**Completed**
May 2017	0	0	37	0
June 2017	0	0	35	2
July 2017	0	0	28	9
August 2017	0	0	20	17
Comparison To Previous Month (% of all actions)	**The Same**	**The Same**	**22% Decrease**	**22% Increase**



Action

We continue to make progress on our CQC action and improvement plan and we will continue to ensure that these recommendations and actions are fully delivered.

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

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

Board Committee Summary Report to Trust Board
Safeguarding Committee held on 7 September 2017

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Welcome and Apologies **Minutes from Safeguarding Committee held on 5 May 2017** **Matters Arising, Action Matrix and Policy Matrix**	Reviewed and Actions Matrix Updates were provided and noted directly on to the actions matrix agreed	Policy Matrix There are three out of date policies on the matrix: One policy is identified in risk areas Intimate Care Policy – on today's agenda. Safeguarding those vulnerable to extremism, CONTEST, PREVENT and Channel – going to Quality Committee in October.	Attendance was noted Admission of children and young people to an adult ward – In the process of update being published. Final revisions have been made	Minutes ratified	
Safeguarding Children and Adults at Risk Annual Report	Carolyn Green presented the first integrated report which summarises the year 2016/17 and includes Safeguarding Children's & Adults Board strategic plans and the Trust's position in providing assurance to the Board on performance. Chair commended the		Expressed concerns regarding levels of domestic violence and radicalisation. Issues and risk related to new communities were identified. Karen Billyeald reported that she attends an Emerging Communities Group Substantial pressure on clinical teams and the	Carolyn Green reported that a deep dive / exploration will be undertaken into domestic violence at the committee due to the volume of work Significant assurance was received. Key risk areas were scheduled on the	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	excellent report and welcomed the integration of adults and children's. The integrated report gave a stronger assurance on the grip on safeguarding issues. Gave feedback on the annual assurance report, scrutinised and endorsed the report, accepting its recommendations		safeguarding unit supporting clinical practice	forward plan to ensure the safeguarding committee is monitoring these risks and issues/ seeking assurance on mitigation actions.	
Safeguarding Committee Terms of Reference Review	Carolyn Green presented revisions to the Committee's Terms of Reference	Agreed with further additional revisions in line with governance changes		Further changes are anticipated to Board Committee Terms of Reference due to the refresh of the Corporate Governance Framework and, as such, a further revised version	
Safeguarding Children Strategy Update Against Workplan 2017/18 – to only include matters not covered in Safeguarding Children and Adults at Risk Annual Report	Carolyn Green delivered a verbal update, in the absence of Tina Ndili. The Quality Committee will be receiving a report regarding a CAHMS serious incident of a patient Anne Wright expressed her concern regarding		It was noted that there had been a substantial increase in PREVENT referrals since March, many of which are for people under the age of 18.	Further feedback to committees post investigation and learning.	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	people on waiting lists				
Training Needs Analysis for Trauma and Disclosure Work – **For information - details of Trauma Conference as evidence of professional development**	The conference invitation for the Inter-Agency Event on Trauma was noted. 90 places are available and have been allocated the police, healthcare and social care colleagues.	Progress has been made; further progress has been identified to resolve staff training needs. The Safeguarding Committee received limited assurance, in the absence of the training needs analysis.	Delays in this being confirmed and actioned. Plans and scheduled meetings in place to rectify this	Additional work on trauma training needs analysis and support to staff in receiving disclosures safely and respectively will be developed with Education	
Safeguarding Children Training Progress Report – April to August 2017	Tracy Shaw provided the Committee with an update on the safeguarding children training as at the end of June 2017. Funding has been approved for a six month FTE appointment and an internal candidate has been appointed who is expected to commence in October. The gap between trainers has impacted on the Trust's plan to achieve 80% compliance with level 3 training.	Limited assurance until training performance and medium term mitigation plans are in place	Maintaining training compliance and quality continues to be a challenge which is exacerbated following the departure of the previous trainer.	Further assurance reports and updates on long term solutions to e supplied to the October meeting	Escalation to executive leadership team

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Serious Case Reviews Update	Carolyn Green presented the Serious Case Review (SCR); an exception report to ensure the Trust and the Safeguarding Committee are up to date with the progress of both Derby City and Derbyshire SCR actions and to update the Committee on new cases that are currently under discussion.	Received and noted	The resource issues relating to the extensive process.	Future agenda item to ensure board briefing and ensure investigations are completed and learning is embedded	
Update Report on SEND Action Plan – Derbyshire inspection 2016/17	Hayley Darn updated the on the action plan developed following feedback from the stakeholders action planning session, held on 24 January 2017 and the subsequent release of the report. Despite the significant work that has gone into the development of the plan, tightening up of processes and improved information flow is required. Statutory SEND compliance. Resources with current capacity are a significant contributing factor. If the	At this point only limited assurance can be provided.	Carolyn Green confirmed that the organisation is exposed if it in not fully compliant with SEND reforms and demonstrating compliance with the statutory timescales and this may include in financial terms. NEDS expressed concern with the level of potential risk.	The following actions were agreed Carolyn Green to escalate SEND for inclusion on the Board Assurance Framework. Mark Powell to raise at Children's' Performance Review Meeting on 12 September to work through requirements. Update report requested for the November Safeguarding	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	Trust were to be inspected on its compliance at this point , improvements would be required .				
Report on Voice of the Child	The voice of the person and their experience is included in the October conference Gave suggestions on capturing the voice of the child.	Received limited assurance of the Trust's position but that the organisation is fully involved in the process and pleased with the Trust's position, noting that further work is required.		Explore CAFCASS and ideas to listen to the voice of the child in a meaningful and respectful manner	
Medical Workforce Training Report - mechanism for making level 3 training mandatory and training trajectory plan for 2017/18	Deep Sirur presented the report, on behalf of Dr John Sykes, to update the Safeguarding Committee on the progress made on the improvement plan for compliance of medical staff with the Safeguarding Children training. Revalidation can be declined by the Medical Director if training is not compliant. Compliance for GPs and their training is being followed up.	Significant improvements in compliance have been achieved against all safeguarding competencies	Data cleansing work continues to improve the reporting figures. Escalations are being managed more robustly, including an improved structure through reporting at medical management meetings	Improvement accepted and recommendations for further improvement were agreed	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Safeguarding Adults Strategy Update Against Workplan 2017/18 – to only include matters not covered in Safeguarding Children and Adults at Risk Annual Report	A summary of significant work and progress was given The first safeguarding adults dashboard was provided to demonstrate trend Confirmation of progress on very serious incident actions. Revision of CPA policy scheduled for the Quality committee Update on Triangle of care and the dated for the Trusts external review.	Significant assurance	Activity and trend Specific detail on the significant levels of domestic violence.	An update on resourcing to support PREVENT reporting requested for the November meeting. The dashboard to be taken earlier on the agenda to inform discussions throughout. A draft children's dashboard was requested by Carolyn Green for the November meeting	
Safeguarding Adults Training Progress Report – April to August 2017	Tracy Shaw presented the report to give an update on the Safeguarding Adults Training position and PREVENT training position as at 30 June 2017.	Limited assurance PREVENT Awareness is increasing, as is WRAP level 3.	A passport cleanse resulted in a significant number of people having level 2 added, which caused a significant drop in safeguarding. Level 1 is static. Safeguarding Adults Training to be added back to the BAF as part of Risk 1A	Continued progress and monitoring required.	
Intimate care policy	Carolyn Green presented the updated	Significant assurance		Policy ratified	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	Intimate Care Policy & Procedure on behalf of Sam Kelly. The document has been updated to reflect the needs of transgender patients.				
Safeguarding those Vulnerable to Extremism Contest Prevent and Channel deferred to September meeting expires 31/07/2017					
Forward Plan	The Safeguarding Committee reviewed the forward plan and agreed that the following items would be received based upon the meetings findings/ data and risk: Deep Dives • Voice of the Child – February 2018 to include a summary of the work of the operational groups. • New and emerging communities – February 2018.	Agreed	Themed Review of Homicides has been requested to review and further explore risks CCG has been asked to provide information on the report to encompass 'black risks' e.g. BAF safety the release of prisoners with indeterminate sentences who pose risks to the community and the risks associated with our county not having a commissioned community forensic	Forward plan scheduled	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	• Domestic violence – February 2018		service.		
Consideration of BAF Risks Related to Safeguarding Committee	Safeguarding adults and children training compliance SEND compliance				
Meeting Effectiveness	Both Mark Powell and Carolyn Green felt there had been sufficient challenge. Julia Tabreham commented on the quality of papers and good levels of assurance seen. Mark Powell noted that some discussions had resulted in limited assurance, leading to further requests for action. Anne Wright felt the meeting had been less operational and more focussed. Carolyn Green commented that the update on medical workforce training had been valuable on improving performance and gaining assurance				

Board Committee Summary Report to Trust Board
Audit & Risk Committee held on 3 October 2017

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Welcome/ Apologies Draft Minutes Committee meeting 11 July 2017 Action Matrix and Matters Arising:	Minutes were agreed. Action matrix updated – completed actions were confirmed and progress on outstanding items was challenged.	Assurance was received that completed actions were complete. A&R members to complete clinical audit survey before end of October.	None	Updates agreed to actions matrix.	N/A
Policy update	Noted	Noted that Intellectual Property Policy and procedures would be brought to December meeting.	None	N/A	N/A
Matters arising	Claire Wright gave a response to the query arising from the 2016/17 waiver report relating to supply of anti-ligature windows.	Full Assurance was received about the review process implemented within procurement for these items. The detail of the paper was welcomed. Agreed that oversight of the market was clear from evidence presented.	None	To take this approach going forward for major items of procurement activity where Waivers are involved	N/A
Mental Health Act Committee Six Month Update Report	John Sykes presented the update report on business of Mental Health Act Committee (MHAC) - by phone. He outlined the approach to internal control in respect of the MHAC outlining work underway.	Significant assurance was received in terms of controls set in place relating to compliance and quality improvement. In terms of consistent application, this is being developed across the organisation hence limited	Risks associated with changes in the Mental Capacity Act which will impact on volume of DOLs work for the Trust were noted.	Agreed that the work outlined will be taken forward through the MHA Committee and sub-group. Agreed that	N/A

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
		assurance received at the current time. Noted that the operational group was now in place to provide addition support to the MHAC work and develop reporting to focus on assurance, escalation, trends and variations Assurance was given relating to progress relating to transfer of records from paper to Electronic Patient Record in response to a query from M Gildea. Overall there is limited assurance received from the report but note progress and review this level once work is embedded.	This will be addressed by the operational MHA subgroup when required, for consideration by MHAC. Similarly the risks associated with the implementation of the Police and Crime Bill.	benchmarking would be undertaken through visit to high performing Trust.	
Report on Complaints and Themes	Carolyn Green presented details of themes arising from the complaints process.	Limited assurance at this time – contractual notice to improve has been received. Report shows that we are technically compliant but there is progress to be made on compliance against internal standards. Assurance received that we are legally compliant. Noted ongoing reporting to Quality Committee.	Mitigation plan outlined. The issue remains on the risk register.	Gap in control and gaps in assurance agreed to be covered in reporting to the Quality Committee only going forwards. No routine reporting to the A&R Committee required – feedback would be provided via J Tabreham as QC chair as appropriate.	N/A

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
		Factors involved in longstanding complex complaints were outlined. Offer to A&R members to review complex cases to get additional control and assurance. Members to approach C Green as appropriate.			
Deep Dive BAF Risk 2a System Change	Lynn Wilmott- Shepherd presented details of the BAF risk relating to system-wide change and progress with controls were outlined. The evidence presented was challenged and scrutinised by the Committee.	Key controls, gaps in control and gaps in assurance and actions to increase controls/assurance were outlined. Limited assurance was received on impact of actions underway to mitigate this risk, due to external factors. Claire Wright confirmed she is to articulate the finance outturn impact through planning assumptions and normalised position as part of IPR to Board. External Audit reaffirmed the importance of focussing on this risk as a priority for the Trust It was confirmed that Board was giving due focus to this issue.	That planned actions once achieved will not reduce overall risk score. Risks were noted as outlined including emerging risks, and steps to mitigate these were noted. Risks relating to sovereignty and STP commitment was articulated.	It was agreed that the BAF risk score should remain as Extreme (5x4) Executive Directors to consider the potential to expand current BAF or create new BAF risk addressing sovereignty/STP issue.	Escalation to ELT to review BAF risk description/addition risk and escalate to debate at Board re Trust's strategy relating to the STP
Quarterly BAF	Rachel Kempster gave an update on the third issue of	Assurance received on ELT confirm and challenge process	As identified in the report along with	Approved third issue to go forward to the Trust	N/A

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
update	the BAF this year. There are no changes to the ratings from last issue.	to produce BAF updates. Scheduling of deep dives to A&R Committee and other Board Committees was outlined. Updates/amends noted to the report.	mitigating actions and review programme.	Board on 1 November subject to amendments noted	
Audit & Risk Committee Objectives Action Plan	The objectives and actions plan to achieve these were noted.	It was agreed that the actions outline would serve to provide assurance on achievement of objectives when completed.	None	It was agreed to review progress with the objectives as part of the year-end review of effectiveness. Summary of Board Committee chairs discussion to come to Audit and Risk Committee in December	N/A
Embeddedness of GIAP Actions	The update on embeddedness of the GIAP actions falling to A&R were outlined.	All were proposed and agreed as green rated (embedded in business as usual). Significant assurance was received that these were embedded within business as usual.	None	Agreed that the update would be reported as part of full GIAP embeddedness report to Trust Board on1 November.	N/A
Refresh of Corporate Governance Framework	The revised Corporate Governance Framework was presented and updated areas noted to include confirmation of escalation processes and best practice additions to the Board	Significant assurance was received on the update as presented. The frequency of meetings including Quality Committee were noted. It was noted that there will be an increased focus on production	That Board/Committee reports focus on presentation of data not escalations/ assurance	That the Corporate Governance Framework should be submitted to Trust Board for approval. Sue Corden (KPMG) to attend Quality Committee for	Escalate the issue of development of Board/Committee reporting guidelines to ELT and update to Board

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 terms of reference.	of concise and focussed reports to Board and Committees.		benchmarking exercise ELT to consider implementing guidelines and volume limits for Board/Committee papers Reference to membership of TMT to be added to document Schedule with Committees to ensure timetable for year-end reports 2017/18 is on forward plans	
Implementation of Internal and External Audit Recommendations Progress Report	Rachel Kempster outlined the report highlighting those actions completed and outstanding	Significance assurance was received from the completion of actions with the exception of the job planning action where no assurance was received on proposed plans to deliver/address. The Committee expressed disappointment at the lack of progress on this action. It was confirmed that this matter had been escalated	Risk to implementation of job planning arising from protracted delay to delivery	Ifti Majid to contact Barry Mellor outside of the meeting to update on current position. A update from the Medical Director/Chief Executive would be circulated relating to the proposed trajectory	N/A

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Losses and Compensations Exception Report	Claire Wright presented the report which outlined a second incident of theft at the Medical Annex.	Significant assurance was received on actions now set in place. An update on the internal investigation is awaited.	Risks to recurrence have been mitigated and an internal investigation is underway.	The Committee supported the recommendation Evidence is to be sought that there are no safeguarding issues arising	N/A
Benchmarking Report on 2015/16 Annual Report	Sam Harrison presented details of the benchmarking report and learning from the annual report project group for 2016/17	Significant assurance was received on the production of a high quality report with a well-coordinated approach. All contributors were thanked. Lessons learned were noted and these will feed into 2017/18 project planning.	None	It was agreed that proposals would be brought back to the December meeting re project planning and proposed timetable It was agreed that the 2017/18 annual report should aim to be as concise as possible whilst meeting statutory requirements.	N/A
Internal audit (tabled report)	Rob Chidlow outlined the current position with the internal audit plan. The data quality audit specification was in development. It was noted that there is a high proportion of contingency days yet to be allocated. An audit of IG toolkit work is arranged for Quarter 4.	Significant assurance was received on progress with the internal audit plan. Technical updates were noted.	None	Contingency days and planning for the remainder of the year to be taken forward in next client meeting with KMPG (Director of Corporate Affairs and Director of Finance)	N/A

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Fraud report	Rob Chidlow presented the details of counter fraud activity for the year to date. Details of cases and progress was noted.	Significant assurance was received that fraud is being reported and promptly investigated. . The high number of days used to date was queried and KPMG explained that the planned days could be reviewed flexibly across internal audit and fraud allocations.	The number of days utilised to date is well above plan for this time in the programme	Number of days to be reviewed in next client meeting with KMPG (Director of Corporate Affairs and Director of Finance)	N/A
Update on external audit progress	Joan Barnett updated on the programme for 2017/18 accounts work and documents of interest to A&R members.	Timeframes were noted.	None	Technical updates to be circulated for information to Board members who are not members of the Audit and Risk Committee	N/A
Any other business	Sam Harrison raised the proposal that Information Governance oversight should be transferred to the remit of the Committee	This was outlined to include oversight/assurance of the Data Protection Act compliance, General Data Protection Regulations readiness, IG toolkit progress and ICO actions arising from Caldicott 3. Reporting would take place quarterly. It was noted that operational issues arising from IG would continue to be reported to the Trust Management Trust and/or the Executive	None	It was agreed that reporting would transfer from the Quality Committee to Audit and Risk Committee and that terms of reference would be amended to reflect this	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
		Leadership Team.			
Board Assurance Framework	The Committee considered whether any items under discussion impacted on any of the Trust's BAF risks.	It was agreed that no additional impact had been identified. The BAF report had been considered as a separate agenda item.	None	N/A	N/A
2017/18 Forward Plan	Noted – agreed fit for purpose.	None	None	To be updated to reflect additional requirements relating to IG oversight/reporting.	N/A
Issues for escalation	- Emerging BAF risk relating to Trust's Strategy relating to the STP Focus on Committee papers becoming more standardised and focussed	It was noted that a training session was in the process of development to focus on sovereignty issues relating to STP It was noted that training for report authors was arranged for November and this would support Executive work to lead improvements in creating of reports	Balance of Trust/STP strategy to be articulated within the BAF That Committee debate is not appropriately focussed and key risks/assurances/ issues are missed by members	- -	To Board To ELT

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Meeting effectiveness	- Guidance for presenters of Deep Dives to be updated and recirculated to emphasise drawing out of exception issues for debate	-	None	Guidance to be circulated to Executive Leads (Rachel Kempster)	N/A
	- Contribution from all attendees was discussed and encouraged, whilst acknowledging the NED-only membership of the Committee	-	None	All	N/A

Board Committee Summary Report to Trust Board
Quality Committee held on 12 October 2017

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Welcome, apologies and declarations of interest	Agreed	Not applicable			
Minutes of previous meeting held 7/9/17	Agreed	Not applicable			
Matters Arising	None noted	Not applicable			
Actions Matrix	Reviewed and updates on actions Briefing on carers and representation Review to SIRI policy due to reduce to 6 months	Not applicable	Risk to support to mental health carers		
Policy Status Matrix	All policies are in-date	Not applicable			
Attendance Log	Confirmation of attendance, to include deputies	Confirmed			
BAF risks for the Quality Committee	Reviewed	Limited assurance	Lack of movement on key risks.	Review summary sheet	
Quality Dashboard	Reviewed of complaints, has continued to improve. Clinical supervision rates and trajectories for	Limited assurance	Lack of movement on key risks.	Mark Powell to bring back performance issues and trajectory.	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	improvement.				
CQC Action Plan	Agreed and 10 overdue risks	Significant assurance Limited assurance on overdue risks.			
Recovery and Enablement Strategy	Agreed, Return to the committee in March 2017	No assurance. Draft strategy to go out to the services and COATS	Engagement and involvement	Agreed to return to QC in March QC	
Serious Incidents monthly report	Investigation capacity and overdue actions Five overdue actions not high risk issues to be reviewed	Limited assurance due to capacity and overdue actions	Pressure and overdue, SIRI reports and actions	Recommendations and changes to ELT and to CQC. Estimated for December and to be confirmed	
Risk Assurance & Escalation Report	Red rated risks are overdue, the senior assurance report	Limited assurance	Ensure mitigating actions are overdue, are updated, with full mitigating actions or risk appetite	Ensure up-date next month to confirm this has been rectified	
Deep Dive – BAF Risk 1d – Business Continuity	Currently fully compliant, achieved risks	Significant assurance	Workload to complete and maintain		
Physical Healthcare Committee update	Significant assurance on falls improvement work. National and local benchmarking Pilot for physical healthcare clinic. Bloods and ECG.	Significant assurance	Falls questions on the safety plan, to feed in to improve this areas. Exploring with falls lead at RDH evidence and issues. Physical healthcare, early mortality	Improvement plan to work on falls, quality improvement on care planning, environmental factors and family involvement.	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	No new resources- effective use of existing resources. Link to GP's Pilot for January- Monday to Friday am, clinic		Use of the LESTER tool, CQUIN and Quality priority Physical healthcare strategy in draft, to include CQC regulatory new standards, estimated Nov or December 2017 Explore starting Hartington physical healthcare clinic		
Trust Strategy on Infection Control	Significant assurance	Full assurance	No current unmitigated risks	Agreed, infection control on the annual plan	
Community Mental Health Team Capacity and Risk Mitigation	Extensive paper on Neighbourhood pressure and service demand. CQC informal visit	Limited assurance	Significant risk To receive a mitigation action plan on discharge and transformation	Agreed mitigation action plan to develop a transformation plan, with agreed timescales	
Quality Assurance Group Summary Report	Agreed Front sheet and review of why it's changed	Limited assurance	Evidence of openness and clarity on risk issues and commissioning concerns		
TMT Escalation Reports **TMT to ELT July 2017** **TMT performance review – Children's** **TMT performance**	Reviewed Confirmation that TMT is operational Clear evidence of scrutiny of clinical and operational performance and red rated risks. Confirmation of GIAP	Significant assurance	Improved performance	Agreed	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
review – Neighbourhoods **TMT to ELT 18/9**	actions in practice and escalation Evidence of trajectories for improvement				
Policy Governance Report/ O	Agreed, exception into Quality dashboard.	Significant assurance	This is now fully embedded reduce to quality dashboard	Agreed no longer a standing agenda item on the committee, to be reported by exception	
General Data protection regulation implementation	Reviewed work plan and improvement plan which requires delivery by May 2018	Significant assurance on work plan	Substantial piece of work Positive position for areas and high risk areas, with a clear plan. Challenges to delivery	Agreed to be reviewed by Risk and Audit, through Sam Harrison	To be reviewed to transfer for TMT and move to Risk and Audit committee.
Any other business	Carers and 4e's feedback. Raising issues important to the community, changes to benefits arrangements.	For information	Carers being aware of benefit changes- drafted to go into leaflet, to contact welfare rights. Benefits support as a risk to people. Benefits briefing to staff to monitor and raise issues and advise on access to welfare rights. Monitoring near misses and Serious incidents, to search for patterns.	Actions on Carers briefings and leaflets.	
Items for escalation to Board or other	Risk and audit committee to receive changes too				

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Committees	TOR from Quality.				
Consideration of any items affecting the BAF	No new considerations, detailed review on issues.				
Forward Plan and draft agenda for October meeting	Review SI reports to two monthly.				
Meeting Effectiveness	Review to SI report to bi-monthly Governor observer of the NEDS. Strategic review Information and actions. Evidence of continually improving Evidence of holding to account				

NHS
Derbyshire Healthcare
NHS Foundation Trust

Nutritional Care across Mental Health Inpatient Services

Kayleigh Daltrey- Lead Dietitian/ Service Manager
David Harrison- Catering Manager

1/11/17

Mental Health Dietitians

- Team established in 2016
- 3 Registered Dietitians and 1 Dietetic Assistant
- Provide a specialist nutrition and dietetics service to mental health inpatient wards and units across DHCFT
- Based in the AHP Hub, Ashbourne Centre, Kingsway Hospital
- Sit within Central Services
- Work with service users both 1:1 and in groups and advise multi-disciplinary teams and the Trust on evidenced based nutritional care

Mental Health Dietitians

- **What are we proud of?**
- Embracing new ways of working
- Providing new opportunities for our service users e.g. Healthy cooking education and skills group
- Nutrition and hydration training for nursing staff
- New placement provider for student dietitians at University of Nottingham

- **What are our challenges?**
- Recruitment
- Physical healthcare
- No professional lead for dietitians

Nutrition Steering Committee

- Reports to Physical Care Committee
- Chaired by Director of Public and Physical Healthcare and deputy chaired by Lead Dietitian
- Meet quarterly to review nutritional care standards for inpatient wards
- Oversee and advise hospital on all aspects of nutrition
- Representation from Nursing, Dietetics, Catering, Estates and Facilities, Speech and Language Therapy

Hospital Food Standards

- Department of Health (2014)
- Five required hospital food standards:

1. 10 characteristics of good nutrition and hydration care (NHS England)
2. Nutrition and Hydration Digest (The British Dietetic Association)
3. Malnutrition Universal Screening Tool
4. Healthier and More Sustainable Catering
5. Government Buying Standards for Food and Catering Services

Nutritional analysis of Hospital menu

Nutritional analysis

- Initial menu analysis (using Dietplan© software)
- 98 recipes completed between January to May2016

Project group

- Menu capacity assessment- compare against standards
- Additional food items/ recipes identified and analysed
- August to December 2016 (total analysed 228)

Changes

- 58 recipes were amended and implemented in March 2017

Menu review

- As part of PLACE audit
- By nutrition steering group committee

Catering

- Food allergen information to comply with EU Food Information for Consumers Regulation
- Moving to an electronic menu system: Maple
- Improving staff health and wellbeing CQUIN
- Indicator 1b: ‘Healthier food for NHS staff, visitors and patients’
- Introduction of new menus to offer more choice for service users: halal, vegan and modified texture
- Meeting with service users on the ward and working together with dietitians to meet dietary requirements

Future vision

- Dietetics and Catering to continue to work collaboratively to provide high standard nutritional care and meet our service users needs

- Catering to implement electronic menu ordering system and roll out to inpatient wards

- The role of the dietitian in improving the physical healthcare of our service users to be integrated into other areas of mental health services and other service divisions provided by DHCFT

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 November 2017

Board Assurance Framework (BAF) 2017/18
Third issue

Purpose of Report: To meet the requirement for Boards to produce an Assurance Framework. This report details the third issue of the BAF for 2017/18

Executive Summary

- There are currently eleven risks identified on the BAF for 2017/18
- Following debate and challenge by the Executive Leadership Team on 18 September 2017, it was agreed that the current risk rating for all risks remained unchanged, reflecting the current situation with respect to pressure and demands including the impact from the wider healthcare economy
- The Audit and Risk Committee on 3 October 2017 scrutinised and challenged the risk ratings and recommended that the Board approve this third issue, but proposed that Executive Directors consider the potential to expand the current BAF risk or create a new BAF risk to address sovereignty/STP issues associated with risk 2a (inability to deliver system wide change) during the next round of updates of the BAF cycle
- Of the current eleven risks, four remain identified as extreme, four as high and three as moderate risk
- Risk ratings at Q1 and Q2 are shown, together with risks which have been removed from the BAF in year. This will be updated each quarter to show the movement of risk ratings during the year.
- An updated programme for undertaking 'Deep Dives' for all risks remaining on the BAF is detailed, with the Audit and Risk Committee undertaking those for risks with a current rating of extreme and risks for which it is the 'responsible committee'. Other Deep Dives are being undertaken by the responsible committee for the risk. The programme outlined is based on the current risk rating at Q3 17/18, and is therefore subject to change.
- From October 2017, the BAF risks for the responsible committee are being presented at the start of each Board Committee agenda in order to drive the committee agenda. Reflection of changes to the BAF, following discussion of agenda items, remains as a standing item.

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

Assurances

This paper provides an update on all Board Assurance risks and provides significant assurance of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives

Consultation

- Individual Executive Directors – during August 2017
- Executive Leadership Team - 18 September 2017
- Audit and Risk Committee - 3 October 2017

Governance or Legal Issues

Governance or legal implications relating to individual risks are referred to in the BAF itself

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

Recommendations

The Board of Directors is requested to:

1. Agree and approve this third issue of the BAF for 2017/18
2. Obtain significant assurance that the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives

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

Report prepared by: **Samantha Harrison**
and Rachel Kempster
Risk and Assurance Manager

Board Assurance Framework 2017/18 - Third issue

The Board Assurance Framework (BAF) is a high level report which enables the Board of Directors to demonstrate how it has identified and met its assurance needs, focused on the delivery of its objectives and subsequent principal risks. The BAF provides a central basis to support the Board's disclosure requirements with regard to the Annual Governance Statement (AGS), which the Chief Executive signs on behalf of the Board of Directors, as part of the statutory accounts and annual report. This is the third formal presentation of the Board Assurance Framework to the Audit & Risk Committee for 2017/18

1) Overview and movement of risks: A summary of all risks currently identified in the 2017/18 BAF is shown below, together with any movement of these risks to date

BAF ID	Risk title	Director Lead	Risk rating Q1 (LxI)	Risk rating Q2 (current)	Movement Q2
1a	Failure to achieve clinical quality safety standards required by our regulators	Director of Nursing and Patient Experience	HIGH (4x4)	HIGH (4x4)	⟷
1b	Failure to achieve clinical quality standards required by our regulators in relation to providing effective care for our patients	Director of Nursing and Patient Experience	HIGH (4x4)	HIGH (4x4)	⟷
1c	Failure to fully comply with the statutory requirements of the Mental Health Act (MHA) Code of Practice and the Mental Capacity Act (MCA)	Medical Director	HIGH (4x4)	HIGH (3x4)	⟷
1d	Risk of inadequate systems to ensure business continuity is maintained in the event of a major incident	Acting Chief Operating Officer	MOD (3x3)	MOD (4x3)	⟷
2a*	Inability to deliver system wide change due to changing commissioner landscape and financial constraints within the health and social care system	Interim Director of Strategic Development	EXTREME (4x5)	EXTREME (4x5)	⟷
3a	Ability to attract and retain high quality clinical staff across all professions	Director of People and Organisational Effectiveness	EXTREME (4x5)	EXTREME (4x5)	⟷
3b	There is a risk to staff engagement and wellbeing by the Trust not having supportive and engaging leaders	Director of People and Organisational Effectiveness	HIGH (4x4)	HIGH (4x4)	⟷
3d	There is a risk that the Trust does not operate inclusively and may be unable to deliver equity of outcomes for staff and service users	Director of People and Organisational Effectiveness	MOD (4x2)	MOD (4x2)	⟷
3e	Board turnover	Director of Corporate Affairs and Trust Secretary	NEW	MOD (3x4)	
4a	Failure to deliver financial plans	Director of Finance	EXTREME (4x5)	EXTREME (4x5)	⟷
4b	Failure to deliver internal transformational change at pace	Interim Director of Strategic Development	EXTREME (4x5)	EXTREME (4x5)	⟷

Risks removed from the BAF during 2017/18, are summarised below:

BAF ID	Risk title	Date removed from BAF	Rationale
2b	Insufficient engagement with staff side and governors in relation to proposed merger with DCHS	July 2017	Due to decision of 6 June 2017 to withdraw from the merger with DCHS.
4c	That the process leading to acquisition of DHCFT by DCHS may have a detrimental impact on the Trust's ability to manage day to day performance due to increased capacity demands on senior leaders and directors	July 2017	Due to decision of 6 June 2017 to withdraw from the merger with DCHS.
3c	There is a risk that the Trust will continue to be subject to NHSI enforcement action and CQC requirement/warning notices	July 2017	Target risk rating achieved and within limits of the agreed risk appetite, so risk removed.

The risk ratings for each Quarter of the year 2017/18 are shown above. Q3 and Q4 2017/18 ratings will be added in future reports.

Following debate and challenge by the Executive Leadership Team at its meeting on 18 September 2017, it was agreed that the current risk rating for all risks remains unchanged. This reflects the current situation with respect to pressure and demands including the impact from the wider healthcare economy.

*At the Audit and Risk Committee held on 3 October it was agreed that Executive Directors are to consider the potential to expand the current BAF risk or create a new BAF risk to address sovereignty/STP issues associated with risk 2a (inability to deliver system wide change).

Changes to the BAF since Issue 2 are highlighted in blue text in the detailed word document attached.

2) Deep Dives

Deep Dives are fully embedded in the BAF process and enable review and challenge of the controls and assurances associated with each risk.

The plan for Deep Dives for 2017/18 is shown below, in line with the Q3 2017/18 position for the current risks on the BAF.

Risk ID	Subject of risk	Director Lead	Committee
1a	Clinical quality safety standards	Carolyn Green	*Audit and Risk Committee: Jul 2017. Completed
1b	Clinical quality effectiveness standards	Carolyn Green	Quality Committee: Nov 2017
1c	Compliance with MHA/MCA	Dr John Sykes	Mental Health Act Committee: Oct 2017. Completed

Risk ID	Subject of risk	Director Lead	Committee
1d	Business continuity	Mark Powell	Quality Committee: Oct 2017. Completed
2a	System change	Lynn Wilmott-Shepherd	Audit and Risk Committee: Oct 2017. Completed
3a	Attract and retain clinical staff	Amanda Rawlings	Audit and Risk Committee: Jan 2018
3b	Staff engagement and wellbeing	Amanda Rawlings	People and Culture Committee: Nov 2017
3d	Inclusivity	Amanda Rawlings	People and Culture Committee: Jan 2018
3e	Board turnover	Samantha Harrison	Remuneration and Appointments Committee Dec 2017
4a	Financial plan	Claire Wright	Audit and Risk Committee: Dec 2017
4b	Internal transformation	Lynn Wilmott-Shepherd	Audit and Risk Committee Mar 2018

*Note the Deep Dive for this risk was planned prior to the proposal that only risks currently graded as extreme be required to present their Deep Dive to the Audit and Risk Committee

Summary of Board Assurance Framework Risks 2017/18. Issue 3.0

Ref	Principal risk	Director Lead	Current rating (Likelihood x Impact)
Strategic Outcome 1. We will deliver quality in everything we do providing safe, effective and person centred care			
1a	Failure to achieve clinical quality safety standards required by our regulators	Executive Director of Nursing and Patient Experience	HIGH (4x4)
1b	Failure to achieve clinical quality standards required by our regulators in relation to providing effective care for our patients	Executive Director of Nursing and Patient Experience	HIGH (4x4)
1c	Failure to fully comply with the statutory requirements of the Mental Health Act (MHA) Code of Practice and the Mental Capacity Act (MCA)	Medical Director	HIGH (4x4)
1d	Risk of inadequate systems to ensure business continuity is maintained in the event of a major incident	Acting Chief Operating Officer	MODERATE (4x3)
Strategic Outcome 2: We will develop strong, effective, credible and sustainable partnerships with key stakeholders to deliver care in the right place at the right time			
2a	Inability to deliver system wide change due to changing commissioner landscape and financial constraints within the health and social care system	Interim Director of Strategic Development	EXTREME (4x5)
Strategic Outcome 3. We will develop our people to allow them to be innovative, empowered, engage and motivated. We will retain and attract the best staff			
3a	Ability to attract and retain high quality clinical staff across all professions	Interim Director of People and Organisational Effectiveness	EXTREME (4x5)
3b	There is a risk to staff engagement and wellbeing by the trust not having supportive and engaging leaders	Interim Director of People and Organisational Effectiveness	HIGH (4x4)
3d	There is a risk that the Trust does not operate inclusively and may be unable to deliver equity of outcomes for staff and service receivers	Interim Director of People and Organisational Effectiveness	MODERATE (4x2)
3e	Potential turnover of board members	Director of Corporate Affairs and Board Secretary	MODERATE (3x4)
Strategic Outcome 4. We will transform services to achieve long-term financial sustainability			
4a	Failure to deliver financial plans	Executive Director of Finance	EXTREME (4x5)
4b	Failure to deliver internal transformational change at pace	Interim Director of Strategic Development	EXTREME (4x5)

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

Principal risk:

Risk: **Failure to achieve clinical quality safety standards required by our regulators.**

Impact: May lead to harm to service receivers, their family members, staff, or the public

Root causes:

a) Financial settlement in contracts chronically underfunded
b) Workforce supply
c) Substantial increase in clinical demand
d) Increasing service receivers and family expectations of service
e) Changing demographics of population
f) Stability of clinical leadership at all levels
g) Interconnectivity with Risk 1c (MCA/MHA) and Risk 3a (retention of staff)
h) Compliance with CQC standards

BAF ref: **1a**	**Director Lead**: Carolyn Green, Executive Director of Nursing and Patient Experience	**Responsible Committee**: Quality Committee	Datix ID: 21103

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating EXTREME	Likelihood 4	Impact 5	Rating HIGH	Likelihood 4	Impact 4	Direction ⟷	Rating MODERATE	Likelihood 3	Impact 4	Accepted	Tolerated	Not accepted

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative – Quality governance structures, teams and processes to identify quality related issues; Implementation of Safe Wards programme; Induction and mandatory training; 'Duty of Candour' processes; clinical audits, health and safety audits and fire risk assessments. Detective – Quality dashboard reporting; Quality visit programme (including commissioner	Quality dashboard Scrutiny of Quality Account (pre-submission) by committees and governors Clinical analysis and triangulation from across governance reports leading to actions to rectify clinical practice concerns through Patient Experience Reports to be followed by QUEST	National enquiry into suicide and homicide identifies rates lower than national average, although increase in homicide incidents evident for 2017. NHLSA Scorecard demonstrating low levels of claims Safety Thermometer identifies positive position

involvement); Incident, complaints and risk investigation and learning - including monitoring actions plans; Annual Training Needs Analysis; Directive – Quality Framework (Strategy) outlining how quality is managed within the Trust Corrective – Board committee structures and processes ensuring escalation of quality issues; Annual skill mix review; CQC and GIAP action plans; Incident investigation and learning; Actions following clinical and compliance audits; Workforce issues escalation procedures; Reporting to commissioner led Quality Assurance Group on compliance with quality standards	model reporting	against national benchmark Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review identified 4 services rated as 'good' for safety 2016/17 BAF and Risk Register Review Schedule 4/6 analysis and scrutiny by commissioners Results of Section 11 Safeguarding Children Inspection, July 2017

Gaps in control:	Actions to close gaps in control:	Action/ review due:	Progress on action:	Risk to delivery:
Ability to recruit and retain adequate numbers of staff to ensure safe practice	Workforce plan to be implemented, with annual action plan [ACTION OWNER DPOE] Develop and implement training plan to increase number of staff trained to deliver psychological therapy in the community. [ACTION OWNER DPOE/DON] Test model of non-medical Responsible Clinicians (RC) role in community setting to mitigate vacancies in psychiatry. [ACTION OWNER DON]	31/12/2017 31/12/2017	Number of successful recruitment days, chesterfield area and CAMHS. Still substantial vacancies in campus and neighbourhood services. Further expansion of recruitment strategies underway for OT, social workers and RGN's in core areas. Job description of non-medical (RC's) drafted. To go out to advert Sept 2017. Coaching group set up to develop existing nurse consultants into RC role.	High
Commissioner commitment to invest in mental health and children's services	Commissioner lobbying and provision of evidence to support need to increase funding or to provide an alternative strategic plan [ACTION OWNER DON]	31/12/2017	Two reviews considered by QAG – neighbourhood and crisis. Actions identified. New primary mental health service model with STP's being developed	High

Stable clinical workforce in neighbourhood, children's services, crisis services, psychology and forensic services and model	Clinical and operational leadership to develop an improvement plan [ACTION OWNER DPOE/DON]	31/01/2018	Neighbourhood improvement plan completed. To be reviewed by Quality Committee Sept 2017	High
Seclusion room at Kedleston Unit not fit for purpose	Rebuild underway to meet standards required [ACTION OWNER DOF]	Completed	Completed June 2017	Achieved
Staff competence and knowledge in suicide prevention	Suicide reduction strategy in place and roll out of patient safety planning to be completed [ACTION OWNER DON]	31/03/2018	Update provided to Quality Committee June 2017 against safety prevention plan (Sign Up to Safety). Safety planning completion monitoring through Quality Dashboard. Survey underway to staff and patients re attitude to suicide, in support of the strategy	Low ⬇
Early warning signs of service failure and independent service modelling	Plans in place to implement QUESTT from Sept 2017 Explore and commission remodelling exercise of community mental health services and inpatient beds [ACTION OWNER DON]	31/10/2017	Final draft of QUESTT completed. Data validation underway Jul/Aug 2017. Roll out to commence Sept 2017.	Low
Non commissioned services for Derbyshire based PICU beds and a secure and effective forensic pathway, and CAMHS Tier 4 beds	Improvement plan with commissioners in place [ACTION OWNER DON]	31/12/2017	New project in development for CAMHS Tier 3.5 service. PICU provision now responsibility of commissioners. No adverse incidents currently	Medium
Embedded security and safeguarding culture	Complete security action plan and ongoing investigations [ACTION OWNER DON]	Completed	Policy amendments completed. Ward security investigation completed and reported to SIG 20/07/2017	Achieved
Compliance with medicines management code, including storage compliance	Improvement plan in place to deliver [ACTION OWNER DON]	31/10/2017	Audits demonstrate considerable improvements. Updated pharmacy plan presented to Aug 2017 Quality Committee. One high level actions remains re compliance with fridge temperatures for storage of medicines	Medium
Lack of effective forensic clinical service pathway following prison release. In addition new policy to release IPP prisoners (indeterminate imprisonment for public protection) increases risks.	Interagency solutions being sought, including proposal for commissioner solutions including benchmarking and mitigation plans [ACTION OWNER MD]	31/10/2017	To be included in new STP priorities. Progress report considered by Quality Committee (confidential) June 2017. Email received from CCG COO accepting risk. Awaiting formal written response. Exploring potential commissioning solutions	High
Fully integrated Quality Leadership Teams and escalation to Quality Committee	Executive team to continue to act down to support campus and neighbourhood QLT's in particular to develop model to level of children's and central QLT's.	30/11/2017	Children's and CAMHS QLT (COAT) working and effective. Neighbourhood QLT developing. Campus QLT requires further intervention	Medium

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Gaps in assurances:	Actions to close gaps in assurances:	Action/ review due:	Progress on action:	Risk to delivery.
CQC comprehensive review identified 6 services as 'requires improvement' for safety	Fully implement CQC actions plan, with subsequent plan to raise all services identified as requires improvement to a rating of good [ACTION OWNER DON]	31/03/2018	Significant improvement reported. Warning notice lifted. Remaining actions monitored monthly and reported to the Quality Committee. Monthly improvement, but still not fully delivered	Medium
Effective plan to ensure ability to achieve quality priorities, CQUIN and Non CQUIN targets	Implement CQC action plan. Identify ring fenced resources to ensure implementation of required targets.[ACTION OWNER DOF/ DON]	31/10/2017	Contract negotiations underway to prioritise neighbourhoods and paediatric structural deficits, led by STP workstreams	High
Participate in national 'Sign Up to Safety' campaign to meet contractual requirements	Implement CQUIN improvement plan including 'Sign up to Safety'. Each integrated quality leadership team to complete one quality improvement project of their design [ACTION OWNER DON]	31/03/2018	First draft improvement plan for 'Sign Up to Safety' submitted to commissioners July 2017	Low
Increase in number of mental health related homicides (3 incidents over 3 month period during 2017), and inpatient deaths (2 over recent 3 month period)	Learning reviews by DHCFT. Elevating commissioning risk for forensic pathway with commissioners [ACTION OWNER DON]	31/12/2017	External investigators assigned for all homicide investigations. Peer review commissioned with Medical Director for Lincolnshire trust and external consultant nurse	High
Gap in governance and system processes to meet revised essential CQC standards to meet 110 changes of PIR	Develop automated process to meet requirements of revised CQC PIR	31/10/2017	PIR in process. Portal 3 launched	Medium
Safeguarding processes are effective to prevent sexual assault of our patients	Explore breath of potential issue and learning from adult sexual assault referrals to safeguarding	31/10/2017	Report to Safeguarding Committee Oct 2017 to include benchmarking and further action to identify is there are potential patterns or clusters Trauma and support conference planned for Oct 2017 to support staff competency re victim support strategies	Medium

Related operational high/extreme risks:

Trust wide Risk Assessment (Clinical)	21068	Pharmacy	Clinical - Medication/ Pharmaceutical	Medicines Management - providing effective care for patients
Divisional Risk Assessment (Clinical)	21002		Commissioning Risk	Withdrawal of police support for inter-facility transport of patients

Divisional Risk Assessment (Clinical)	21013	Campus - Radbourne Unit	H&S - Violence and Aggression	Sec 136 suite

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

Principal risk:

Risk: **Failure to achieve clinical quality standards required by our regulators in relation to providing effective care for our patients**

Impact: May lead to our service receivers not receiving effective treatment leading to delays in recovery and longer episodes of treatment

Root causes:

a) Lack of investment in clinical workforce
b) Gaps in clinical evidence
c) Complex cases
d) Capacity to deliver effective care across all services
e) Lack of embedded outcome measures – clinically defined and patient defined
f) Staff capacity in patient centred care planning

BAF ref: **1b**	**Director Lead**: Carolyn Green, Executive Director of Nursing and Patient Experience	**Responsible Committee**: Quality Committee	Datix ID: 21107

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating EXTREME	Likelihood 4	Impact 5	Rating HIGH	Likelihood 4	Impact 4	Direction ⟷	Rating MODERATE	Likelihood 3	Impact 4	Accepted	Tolerated	Not accepted

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative – Quality governance structures and processes in to manage quality related issues; engagement with clinical audit and research programmes Detective – Quality visit programme; HoNoS clustering; CAMHS IAPT measures; use of EPR to identify gaps in effectiveness through compliance checks Directive – Quality Framework (Strategy) outlining how quality is managed within the trust,	Clinical Audit Programme and action plans where gaps identified	National Community Patient Survey results (above average results) National Inpatient survey (above average results) CQC comprehensive inspection identified 8 services as 'good' and 2 as 'outstanding' for caring and 3 services 'good' for effectiveness Mental Health Benchmarking Scorecard from NHS England identifies the Trust as 12/58 on effectiveness

Agreed clinical policies and standards, available to all staff via Connect. Corrective – Board committee structures and processes ensuring escalation of quality issues;		

Gaps in control:	Actions to close gaps in control:	Action/ review due:	Progress on action:	Risk to delivery:
Clinical buy in to review of NICE guidelines	Clinical buy in to review of NICE guidelines [ACTION OWNER DON]	31/10/2017	Task and finish group to redefine process. Policy to be revised following review	High
Embeddedness of integrated clinical/leadership teams	Integrated 'plan on a page' to be developed for each clinical pathway [ACTION OWNER DON] CPD support plan for Chairs of integrated quality meetings [ACTION OWNER DON]	Completed 31/10/2017	Performance management plan through Trust Management Team (TMT) from July 2017. Performance management in place Evaluation of QLT's in place and completed 6 monthly. Positive assurance received. CPD for Chairs to be developed from Oct 2017 onwards	Achieved ⇩ High
Embedded personalised care planning, physical health cheeks and clinical standards	Implement CQC action plan around care planning [ACTION OWNER DON]	31/12/2017	Recent CQC mental health reports demonstrate improvement in care planning.	Medium ⇩
Demands of the Derbyshire population out strips capacity in particular community teams paediatrics, psychological therapies and fast track PREVENT referrals.	Gap analysis and training needs analysis with investment plan to increase psychological therapies in neighbourhoods [ACTION OWNER DON/COO]	31/10/2017	Contract negotiations underway to prioritise neighbourhoods and paediatric structural deficits, led by STP workstreams. Development of non-medical consultant and advanced clinical practitioner posts	High Medium ⇩
Learning from Serious Case and Homicide Reviews	Review of CPA policy. Review adequacy of family support services through triangle of care implementation plan [ACTION OWNER DON]	31/12/2017	Revised CPA policy commenced agreed by Quality Committee Sept 2017. Triangle of care implementation plan underway	Medium
Effective patient reported outcome measures which actively involves service receivers	Implementation plan for roll out of ReQoL and Patient Activation Measure (PAM) [ACTION OWNER DON]	31/10/2017	In roll out phase	Medium
Potential lack of formal patient and public involvement following external tender process	New provider identified, DON meeting to provide support through transition [ACTION OWNER DON]	31/10/2017	DON meeting with new providers. Interventions to support current providers. Negotiated for ward visits to continue in	Medium

			interim	
Gaps in assurances:	Actions to close gaps in assurances:	Action/ review due:	Progress on action:	Risk to delivery.
CQC inspection comprehensive review identified 9 services as requiring improvement for effectiveness	Fully implement CQC actions plan, with subsequent plan to raise all services identified as requires improvement to a rating of good [ACTION OWNER DON]	31/03/2018	Significant improvement reported. Warning notice lifted. Remaining actions monitored monthly and reported to the Quality Committee	Medium
'Transforming Care' (learning disability services) red rated across Derbyshire County against required strategic plan	Participate in learning disability services review re effectiveness of service pathways.	31/10/2017	Workshops with staff underway, along with negotiations with Commissioners	Medium

Related operational high/extreme risks:

Trust wide Risk Assessment (Clinical)	21106	Children's Therapies & Complex Needs	Commissioning Risk	Sexual Abuse Referrals
Trust wide Risk Assessment (Clinical)	21101	Workforce, Organisational Development & Culture	Strategic risk - Other	Insufficient safeguarding children's training resources.

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

Principal risk:

Risk: **Failure to fully comply with the statutory requirements of the Mental Health Act (MHA) Code of Practice and the Mental Capacity Act (MCA)**

Impact: Resulted in a 'requires improvement' action from the CQC and an impact on person centred care

Root causes:

a) Previous mantra to use MHA (rather than MCA) in psychiatric in-patient settings but not MCA case law and MHA Code of Practice 2015 stipulates use of dynamic interface between MHA/MCA
b) Lack of compliance historically with MHA process partly due to reliance on audits with inherent time lag
c) Frequent turnover of junior doctors presenting training challenges
d) Historically seen as a medical issue, not multi-professional
e) Uncertainty over issues around 'presumption of capacity' for community patients

BAF ref: **1c**	**Director Lead**: John Sykes, Medical Director	**Responsible Committee**: Mental Health Act Committee	Datix ID: 21108

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 4	Impact 4	Rating HIGH	Likelihood 4	Impact 4	Direction ⟷	Rating MODERATE	Likelihood 2	Impact 4	Accepted	Tolerated	Not accepted

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative – Comprehensive training plan supported by MCA Training Manual developed by trust clinicians; Increased general awareness of issues (inc. podcasts) amongst clinicians with multidisciplinary team approach; Enhanced junior doctor training; Single place created in PARIS to record MCA assessments Detective – Rolling compliance checks; Programme of quality improvement audits; Regular feedback on compliance to executive	Reporting of training compliance against plan to MHA Committee Range of compliance checks and audits agreed in MHA Committee forward plan and clinical audit programme	CQC note improvement with compliance with MCA with gaps remaining to close

directors via next in line managers; Improved monitoring and reporting processes for seclusion and long term segregation following revision of policy Directive – MHA and MCA policies and procedures; Lead director accountability and chain of accountability through to consultants senior nurse; Designated MCA medical lead Corrective – MHA Committee oversight of dynamic application of MHA/MCA		

Gaps in control:	Actions to close gaps in control:	Action/ review due:	Progress on action:	Risk to delivery:
Electronic reminders to undertake assessments	Develop electronic reminders for capacity assessments and Best Interest assessments [ACTION OWNER MD]	Completed	Electronic reminders in place and running. Compliance has improved (as reported to the MHA Committee through the MHA Managers Report Aug 2017)	Achieved
Appointment of Deputy Medical Director to lead on compliance reporting from clinical directors	Appointment of a Deputy Medical Director [ACTION OWNER MD]	Completed	Appointed April 2017. Commenced in post Chairing monthly new medical management meeting to monitor and improve performance, including aspects of compliance with MHA and MCA requirements	Achieved
Consistent application of seclusion and segregation	Embed consistent application in clinical practice led by Chief Nurse [ACTION OWNER DON] Improve training for junior doctors regarding seclusion reviews [ACTION OWNER MD]	Completed Completed	Regular reports to Quality Committee and Mental Health Act Committee demonstrate improved compliance. Last report to MHAC Aug 2017, provided significant assurance. Training now part of Dr Toolkit	Achieved
Delays by local authorities in undertaking DoLS assessments	Continue to monitor and report compliance to the MHA Committee including where escalation to local authorities where illegal detention is a risk [ACTION OWNER MD]	31/12/2017	Monitoring continues to MHA Committee at each meeting; however compliance is dependent on local authority rather than Trust resources. Position is defensible by	Low

			the Trust.	
Monitoring of application of MHA against equality standards	Year-end analysis to be completed and presented to MHA Committee Aug 2017 [ACTION OWNER MD]	Completed	Provided as part of MHA Managers annual report to MHA Committee – Aug 2017. Monitoring to continue an annual basis, as numbers too low for more frequent analysis.	Achieved
Staff competence and checking for compliance with CTO's, Best Interest Assessments and Capacity Assessments	Delivery of CQC action plan in relation to MHA/MCA actions [ACTION OWNER MD]	31/10/2017	Largely completed. Small number of outstanding actions from 2016 review still to be finalised. These are dependent on PARIS developments, issues escalated to FSR Board	Medium
Gaps in assurances:	Actions to close gaps in assurances:	Action: due	Progress on action:	Risk to delivery.
Completion of all actions in relation to 2016/17 Section 132 Rights internal audit	Reporting functionality in PARIS to be developed [ACTION OWNER MD/COO]	Completed	All actions completed. Updated reported went to MHAC June 2017	Achieved
Assurance of junior doctor supervision taking place, which includes focus on MHA/MCA compliance	Improving systems to consistently record supervision [ACTION OWNER MD]	Completed	Supervision reporting supported by medial secretaries from electronic timetables. Trajectory for performance improvement monitored through new medical management meeting .	Achieved
Evidence of compliance with CTO and Section 37/41 reviews undertaken by Responsible Clinicians (RC's) to a sufficient degree to protect patients and the public	Audit of compliance of clinical practice of RC's.[ACTION OWNER MD]	31/12/2017	Re-audit of CTO quality improvement to be completed Continued reporting through MHA Managers report to MHAC Deputy MD to undertake case review as part of peer review of 2 recent mental health homicides S41 register to be developed supported by MHA Manager. Forensic consultant to review as to how S41's are managed.	Medium
Current compliance with MCA training below 50%	Increase compliance with MCA training	31/12/2017	Training current position and trajectory considered by MHAC Sub Group 25/09/2017. Work underway by training team and MHA Lead to revise e-learning and identify if current 3 modules can be combined. Escalation continues through the issuing of training passports and monitoring at performance meetings.	High

Related operational high/extreme risks: None specifically identified

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

Principal risk:

Risk: **Risk of inadequate systems to ensure business continuity is maintained in the event of a major incident**

Impact: An inability to deliver services, which may result in harm to service receivers

Root causes:

a) Increasing dependence on IT systems to support the delivery of clinical care and 'back office' functions such as procurement, finance
b) Insufficient mitigation against potential cyber attacks
c) Lack of coherent training plan to ensure that staff know what to do in the event of a major incident
d) Inadequate business continuity planning at service level

BAF ref: **1d**	**Director Lead**: Mark Powell, Acting Chief Operating Officer	**Responsible Committee**: Quality Committee	Datix ID: 21036

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 3	Impact 5	Rating MOD	Likelihood 4	Impact 3	Direction ⟷	Rating MOD	Likelihood 3*	Impact 3	Accepted	Tolerated	Not accepted

*Due to recent cyber-attack, likelihood of target rating has been increased from 2 (unlikely) to 3 (possible)

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative – On-call training, table top major incident scenario exercises, fire training and drills, incident/near miss reporting and escalation, risk management processes. Range of defences against cyber-attack including: virus updates and patching of laptops and servers, prevention of use of unencrypted USB devices, email filtering , IT firewall and filters	EPRR Annual Report to Trust Board and periodic reports to Quality Committee and Trust Management Team evidence the overall actual performance against national Core Standards for EPRR, rated against a compliance scale from non-compliant to fully compliant Includes several sections covering the efficacy of controls include:	CCG confirm and challenge process against all Core Standards – substantial compliance IT penetration test undertaken by CareCert 31/3/17 – 1/2/17. Final report produced 2/3/17. 24 actions remaining (Sept 17), 5 relate to high risk issues

Detective – IT systems testing, incident response plan testing , IM&T Rigor meeting to test strength of protection, response plans tested during recent cyber-attack and found to be robust Directive – Emergency Plan, Business Continuity Plan, Lockdown Policy, disconnection of IT devices not regularly connected to the network, Corrective – Use of extra training, further practice to aid understanding and confidence, GEM employment of security experts to review processes, plan to reduce time (from 90 to 45 days) before disconnection of IT devices not regularly connected to the network	a) Leadership b) Business Impact Assessments c) Business Continuity Planning d) Incident Response Plan e) Training needs and delivery	

Gaps in control:	Actions to close gaps in control:	Action/ review due:	Progress on action:	Risk to delivery:
Learning review following cyber-attack in May 2017 has identified some gaps in control. None have been identified as major.	Action plan developed to include: Laptops and computers infrequently logged onto the network (to enable anti-virus patches to be applied) will be permanently disabled following a risk assessment of the impact Business continuity plans to be developed by departments in the event of an IT major incident (other types of incidents could cause business continuity to be required)	31/10/2017 31/12/2017	Action plan developed following cyber attach. Agreed by Board June 2017. Actions overseen by EPRR Steering Group and progress is reported to the Quality Committee (last report Sept 2107) Business continuity plans underway in highest risk areas	Low ⇓
Not all staff who undertake management on-call duties have received approved training	Ensure there is sufficient training opportunities for both silver and gold command.[ACTION OWNER: COO]	31/10/2017	Testing full capacity plan through table top exercise Sept 2017. Flu plan table top exercise being run in Oct 2017.	Low
As identified in CareCert 'Penetration Trust Report' 02/03/17	Complete actions identified in CareCert report. Action due date to be agreed in line with actions identified. .[ACTION OWNER: COO]	Completed	Actions relating to DHCFT on track. Actions relating to external suppliers escalated and being monitored. Now covered by EPRR on going work	Achieved
Gaps in assurances:	Actions to close gaps in assurances:	Action/	Progress on action:	Risk to

		review due:		delivery
4 Core standards remain amber, resulting in the Trust being graded as substantial compliance and not fully compliant	Deliver actions set out in Core Standards action plan and embed ongoing review process, via EPRR steering group, for all standards. [ACTION OWNER: COO] Progress reported to TMT and QC via EPRR reporting process	Complete	EPRR core standards self-assessment for 2016/17 submitted to Quality Committee Sept 2017 for approval, prior to submission to NHSE mid Sept 2017. All areas self assessed as green RAG rating.	Achieved

Related operational high/extreme risks:

Trust wide Risk Assessment (Corporate)	21016	IM & T	Operational - Information Security	Introduction of a Virus \ malware via an unpatched server or PC

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

Principal risk:

Risk: **Inability to deliver system wide change due to changing commissioner landscape and financial constraints within the health and social care system**

Impact:

1. If not delivered this could lead to deterioration of the Trusts financial position which could result in regulatory action
2. Deterioration of services available to service receivers

Root causes:

a) Financial constraints nationally and locally
b) Lack of confidence by Acute providers in the delivery of local STP outcomes
c) Lack of system wide leadership and 'grip'
d) Lack of engagement with staff groups
e) Lack of engagement with staff from other organisations
f) Changing national directives
g) Regulatory bodies imposing different rules and boundaries

BAF ref: **2a**	**Director Lead**: Lynn Wilmott-Shepherd, Interim Director of Strategic Development	**Responsible Committee**: Finance and Performance Committee	Datix ID: 21109

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating EXTREME	Likelihood 4	Impact 5	Rating EXTREME	Likelihood 4	Impact 5	Direction ⟷	Rating HIGH	Likelihood 3	Impact 5	Accepted	Tolerated	Not accepted

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative - Maintenance of strong relationships with commissioners; Full involvement with appropriate system wide groups; Maintenance of strong relationships with other providers; service receiver engagement Detective - Scrutiny of national directives; Translation to local action i.e. are national	Reports to Board regarding any system wide changes or risks Regular progress feedback to F&P on system change Updates and feedback at TMT and ELT in order to update on system change or 'blockers'	NHSE/I agreement of plans Minutes of CMB

directives being adhered to? Directive- National agreement of Derbyshire's STP; Reforming of structure for delivery of STP Corrective- Ongoing discussions with key stakeholders on proposed changes, progress, establishment of partnerships etc. ; Engagement and consultation with patients, carers, public and staff as appropriate	Engagement with Governors in order to get feedback and update them on progress Engagement with staff though managers, staff side, focus groups etc.	

Gaps in control:	Actions to close gaps in control:	Action/ review due:	Progress on action:	Risk to delivery:
System wide governance to oversee the STP not fully embedded	Work with system leaders and other senior stakeholders to embed governance structure [ACTION OWNER CEO]	31/10/2017	Provider alliance group commenced meeting and STP Board meeting regularly to drive processes and governance structures, however still early days	Extreme
MH System Delivery Board unable to put robust programme structures into place, owing to system changes not yet having taken place	Work with STP central team re co-ordination of release of key project personnel. Full alignment with the CCG QUIP agenda	31/10/2017	Individuals identified and programme leads in place, but not yet released to commit full time	High
Lack of clarity around collaboration and competition	Continue working with NHSI to gain clarity [ACTION OWNER DSD]	31/10/2017	Further update expected, not yet received	Medium
Issues of communication owing to divergent messages between NHSE and NHSI. This includes Turnaround Directors within CCG's	Communication between differing groups – replay the message [ACTION OWNER DSD]	31/10/2017	STP governance now includes NHSI and NHSE membership. Restructuring should then impact following appointment of Accountable Officer and Chief Finance Officer at CCG. This requires embedding and messages fully aligned	High
Lack of long term strategic partnerships to deliver quality, sustainable services	Aim to develop partnerships through collaborative working [ACTION OWNER DSD]	31/10/2017	Initial STP business case identifying need for partnership organisations such as housing and voluntary sector to be represented at next STP systems event.	Medium
Lack of clinical capacity within DHCFT to fully contribute to system wide programmes of change	To be fully involved in clinic and professional reference groups using key clinical staff and their capacity appropriately [ACTION OWNER DSD]	31/10/2017	Discussion taken place and people initially identified to support programme	Medium
Lack of engagement with staff internally and	Development of a robust 'Engagement Plan' overseen	31/12/2017	MH STP launch event held 1/8/2017,	Medium

staff from other organisations who will be key to success	by the MH System Delivery Board.[ACTION OWNER CEO/DSD]		involving over 100 people from variety of organisations including DHCFT.	⇩
Gaps in assurances:	Actions to close gaps in assurances:	Action/ review due:	Progress on action:	Risk to delivery.
Feedback from system wide groups	Maintenance of relationships and involvement in relevant groups [ACTION OWNER CO/DSD]	31/10/2017	Trust fully involved with system wide groups and re-establishment of the STP. MH system delivery board in place. Cross system workshop arranged for Sept 2017 to review alignment of various STP programmes. CEO and DSD attending TMAC Sept 2017.	Medium
The provision of reliable system wide information	Maintenance of relationships and involvement in relevant groups [ACTION OWNER CO/DSD]	31/10/2017	System wide information is integral to success of STP and remains under review	Medium
Robust feedback methodology from engagement with internal staff and those from other organisations	Delivery of Engagement Plan and implementation of actions arising. (ACTION OWNER: CEO/DSD)	30/11/2017	Launch event undertaken 1/8/2017, further event planned for 9/11/2017. Contacts made with system wide STP communication.	High

Related operational high/extreme risks:

Divisional Risk Assessment (Clinical)	21125	Neighbourhood Services - Admin & Management Team	Clinical - Therapeutic activity	Lack of dedicated resource for personality disorder conditions
Trust wide Risk Assessment (Clinical)	3260		Commissioning Risk	Lack of ADHD service for adults

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

Principal risk:

Risk: **Ability to attract and retain high quality clinical staff across all professions**

Impact: Risk to the delivery of high quality clinical care including increased waiting times
Exceeding of budgets allocated for temporary staff
Loss of income

Root causes:

a) National shortage of key occupations
b) Future commissions of key posts insufficient for current and expected demand
c) Trust reputation as a place to work
d) Trust seen as small with limited development opportunities
e) Lack of a workforce plan and sufficient funding to accelerate the introduction of alternative workforce models
f) Organisational appetite to try and test alternative workforce models
g) Turnover of key personnel/professions

BAF ref: **3a**	**Director Lead**: Amanda Rawlings, Interim Director of People and Organisational Effectiveness	**Responsible Committee**: People and Culture Committee	Datix ID: 21110

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating EXTREME	Likelihood 4	Impact 5	Rating EXTREME	Likelihood 4	Impact 5	Direction ⟷	Rating HIGH	Likelihood 3	Impact 5	Accepted	Tolerated	Not accepted

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative – Recruitment campaigns. Detective – Reflection and action taken following staff survey, Performance Reports, Quarterly Pulse Checks Directive – Executive led weekly meeting using collaborative approach to reduce recruitment	Recruitment tracker reporting to People and Culture Committee and Board Success reporting to from specific recruitment campaigns Financial impact tracking on agency spend through Board	HEEM (Health Education East Midlands) quality assurance visit, to test infrastructure and support mechanisms are sufficient for people in training [potential assurance] Staff survey results and Pulse Checks[potential assurance]

gaps Corrective – Additional capacity to lead recruitment campaigns. Focused recruitment campaigns i.e. India, and further afield.	Quarterly staff 'pulse checks'. Improvement from staff survey to pulse check evident for Q1 17/18	CQC visits identify caring and engaging staff

Gaps in control:	Actions to close gaps in control:	Action/ review due:	Progress on action:	Risk to delivery:
Workforce plan to include alternative workforce models	Develop a precise workforce plan to include a bottom up workforce plan with owners of new roles that is costed with a timeline as to what the trust can afford to implement and by when [ACTION OWNER DPOE]	31/12/2017	Workforce plan was approved at the July Board meeting with investment as required for the next 12 months India trip has built pipeline for 13 medics to join the Trust over next 2 years. First person commenced on 12/06/17. Medical vacancies halved over last 3-6 months. The Strategic Workforce Group monthly tracks progress on implementation. PCC will receive quarterly updates	Achieved
Appeal of the trust as a place to work	Develop programme of incentives for key national occupational shortages [ACTION OWNER DPOE] Incentives scheme agreed by Executive Leadership Team	31/10/2017	Staff survey actions in place (see actions for risk 21111) The Recruitment and Retention Group continues to meet. Survey being conducted around how recruitment could be done better. Rotation Policy being developed which is aimed to be adopted to retain nurses across the county, along the lines as the OT rotation policy currently in operation within the Trust. A Retire and Return Scheme is being developed.	Medium
Gaps in assurances:	**Actions to close gaps in assurances:**	**Action/ review due:**	**Progress on action:**	**Risk to delivery.**
Funding and commitment to local STP (Sustainability and Transformation Plan) collaboration	To be undertaken in collaboration with the Local Workforce Advisory Board to support new models of care i.e. Place [ACTION OWNER DPOE]	31/10/2017	Allocation of Learning Beyond Registration (LBR) money has now been received. Is significantly lower than previous years.	High

			Trust are reviewing where best to support staff and looking for alternative funding streams from HEE STP funds	

Related operational high/extreme risks:

Team Risk Assessment	21102	Neighbourhood Services - North	Clinical - Staffing levels	clinic capacity
Team Risk Assessment	21123	Neighbourhood Services - South	Clinical - Staffing levels	low staffing levels
Team Risk Assessment	21070	Neighbourhood Services - North	Clinical - Staffing levels	Extreme Pressures in team
Team Risk Assessment	21044	Neighbourhood Services - North	Clinical - Staffing levels	reduction in medical support
Divisional Risk Assessment (Corporate)	867		Clinical - Staffing levels	Capacity of adult recovery teams
Divisional Risk Assessment (Clinical)	2772	Child and Adolescent Mental Health Services (CAMHS)	Clinical - Staffing levels	insufficient resources CAMHS workforce
Divisional Risk Assessment (Clinical)	20867	Learning Disabilities Services	Clinical - Staffing levels	Lengthy waiting times for psychological involvement
Team Risk Assessment	20928	Neighbourhood Services - North	Clinical - Staffing levels	Long waiting times for MAS Diagnosis
Team Risk Assessment	20946	Neighbourhood Services - City	Clinical - Staffing levels	Staffing Levels
Team Risk Assessment	20988	Neighbourhood Services - City	Clinical - Staffing levels	Not enough nurses to manage the initial assessments, waiting list for community intervention and to cover long term sickness
Divisional Risk Assessment (Clinical)	3262	Community Paediatrics	Clinical - Staffing levels	Long waiting lists following reduction in paediatrician staffing levels
Divisional Risk Assessment (Clinical)	3385		Clinical - Staffing levels	Waiting Times for Psychological Assessment and Intervention
Divisional Risk Assessment (Clinical)	3386	Campus - Radbourne Unit	Clinical - Staffing levels	Radbourne Unit - Staffing risk assessment

	Team Risk Assessment	3410	Campus - Radbourne Unit	Clinical - Staffing levels	Ward 34 Vacancy levels above 30%_Ward 34	
	Team Risk Assessment	21124	Neighbourhood Services - South	Clinical risk - Other	No consultant psychiatrist	

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

Principal risk:

Risk: **There is a risk to staff engagement and wellbeing by the trust not having supportive and engaging leaders**

Impact: Negative impact on staff engagement and staff retention
Impact on staff wellbeing
Impact on quality of care
Impact on compliance with internal and external performance requirements

Root causes:

a) Lack of management capacity and capability
b) Clear leadership expectations
c) Lack of leadership and team development
d) Robust recruitment processes ensuring suitability for role
e) Culture of organisation including role modelling by peers and senior managers

BAF ref: **3b**	**Director Lead**: Amanda Rawlings, Interim Director of People and Organisational Effectiveness	**Responsible Committee**: People and Culture Committee	Datix ID: 21111

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 4	Impact 4	Rating HIGH	Likelihood 4	Impact 4	Direction ⟷	Rating MODERATE	Likelihood 3	Impact 4	Accepted	Tolerated	Not accepted

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative – Spotlight on our Leaders events to engage leaders, Membership of East Midlands Leadership Academy offering leadership development menu Detective – Staff survey results year on year, quarterly pulse check quarterly, people metrics tracked monthly.	Quarterly Pulse check. Improvement from staff survey to pulse check evident for Q1 17/18	

Directive – Leadership development training supporting managers to implement policies Corrective – appraisal and supervision processes		

Gaps in control:	Actions to close gaps in control:	Action/ review due:	Progress on action:	Risk to delivery:
Lack of a Leadership Development Strategy	Develop and implement a Leadership Development Strategy	31/10/2017	Leadership Development Strategy drafted for discussion with ELT and People and Culture Committee. Strategy still being refined.	Medium
- Recruitment of leaders for their leadership talents	Develop leadership recruitment process [ACTION OWNER DPOE]	31/12/2017	Agreeing framework of how to recruit – includes leadership development guide and coaching and mentoring support	Medium
- Clearly defined leadership expectations, monitored via appraisals and the detective tools	Develop a leadership expectation guide and leadership induction process [ACTION OWNER DPOE]	31/12/2017	To be developed following agreement of Leadership Development Strategy	Medium
- Coaching/mentoring and development/improvement plans for leaders that need support	Build infrastructure and menu of offer for leaders [ACTION OWNER DPOE]	31/12/2017	As per action above - agree framework of how to recruit including leadership development guide and coaching and mentoring support	Medium
Gaps in assurances:	**Actions to close gaps in assurances:**	**Action/ review due:**	**Progress on action:**	**Risk to delivery.**
Annual staff survey results	Actions to be focused on: ensuring staff have 'tools to do the job', ensuring staff have a voice, staffing, leadership development [ACTION OWNER DPOE]	31/12/2017	Bi-monthly monitoring by Trust Management Team of local area staff survey plans and progress. Engagement group overseeing overarching action pan and reporting to People and Culture Committee	Medium
Lack of capacity in operational HR department	Delivery of revised model for operational HR [Action Owner :DPOE]	31/12/2017	Consultation has commenced on the restructure and joining together of the HR Teams within DCHC and DHCFT. This is scheduled to be implemented by December 2017. The effect will be to increase the resilience of the HR Team in DHCFT by broadening the number of staff available	Moderate

Related operational high/extreme risks:

Team Risk Assessment	3188	Learning Disabilities Services	H&S - Work Related Stress	Workplace stress in the Derby City CLD Team

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

Principal risk:

Risk: **There is a risk that the Trust does not operate inclusively**

Impact: May be unable to deliver equity of outcomes for staff and service receivers and demonstrate compliance with the Equality Act

Root causes:

a) Implementation of Equality Delivery System (EDS2)
   a. Improvement in recording of all protected characteristics of service receivers on clinical systems in order to support equality analysis
   b. Capacity of stakeholders to engage with Trust in order to validate EDS2
   c. Consistent identification of equality related impact in papers presented to Board and Board level committee papers

BAF ref: **3d**	**Director Lead**: Amanda Rawlings, Interim Director of People and Organisational Effectiveness	**Responsible Committee**: People and Culture Committee	Datix ID: 20936

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 4	Impact 4	Rating MOD	Likelihood 4	Impact 2	Direction ⟷	Rating Low	Likelihood 3	Impact 2	Accepted	Tolerated	Not accepted

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative – Reporting of approach and progress reported to Board and the People and Culture Committee Detective –Urgent non-compliance addressed and reported to the People and Culture Committee Directive – Full time expertise in post, Launch of a new Equalities Forum,	Self-assessment grading based on equality evidence	Self-assessment grading validated by external stakeholders including HealthWatch (Derby)

Gaps in control:	Actions to close gaps in control:	Action/	Progress on action:	Risk to

		review due:		delivery:
Delivered equality strategic action plan	Reporting on progress to Equalities Forum, Quality Committee, and People and Culture Committee [ACTION OWNER: DPOE]	31/12/2017	Reporting identifies progress, all objectives on target to achieve amber rating by Q3 17/18. Board paper April 2017 updated against EDS2 goals. Updates presented at key committees (Quality Committee, People and Culture Committee & Board) June, July Sept 17. EDS2 2018 implementation plan on target, annual grading taking place on 23/11/2017 focusing on Children Services and core Corporate KPIs Annual WRES 2017 submitted via UNIFY 1/8/2017 and action plan tabled BoD 27/9/2017. ED& I Strategic Framework overview submitted for approval on PCC 21/9/2017 & BoD 27/9/2017.	Low
Evidence of managers supporting staff to work in culturally ways	Delivering equality training. Undertake EDS assessment of services. [ACTION OWNER: DPOE]	31/12/2017	Equality training commenced through induction and EIRA training. Plan to deliver managing inclusion workshop. Board Development session April 2017. Workforce EDS2 Feb 2018 date to be confirmed by November 2017. Executive Director champions identified for BME: Acting Chief Executive and LGBTQ Deputy Chief Executive/Director of Finance. Other REGARDS champions being explored. Equality E-learning compliance 75% (Sept 2017). Monthly Induction now includes 'Why ED & I matters to us' session Engagement meeting with Carers arranged	Low

			for 6/11/2017.	
Improve recording of service receivers protected characteristics on clinical systems	Deputy Director of Operations, Chief Nurse, General Manager IM&T and Assistant Director of Engagement and Inclusion to improve data capture though training, improvement of IT systems and performance management [ACTION OWNER: COO|DON|DPOE]	31/12/2017	Draft Board Equality action plan identifies how will be managed and timescales using the Integrated Performance Report to mainstream existing processes. Completion rate (at Sept 2017) via REGARDS Connect indicates: Race/Ethnicity 88.85% Age : 100% Gender :99% (field to record other gender not available) Disability 18.55%. Sexual Orientation 16.86% recorded. Religion 79.12% not captured. Employment 83.25% not captured. Improved recording being developed through existing performance management mechanisms, staff training and ensuring system is able to capture the correct data in line with national guidance. REGARDS monitoring guide and Podcast to be delivered. REGARDS equality monitoring training plan, including 'Train the Trainer' to be identified to enable training to cascaded within teams.	Medium
Consistent identification of equality related impact in papers presented to Board and Board level committee papers	Evidence of EIRA compliance across selection of Board and Board level committee papers [ACTION OWNER: DPOE]	31/12/2017	Completion audit of EIRA compliance and reporting progress to People and Culture Committee. New template, and training with Board, has resulted in improved standards. Audit to be completed Feb 2018. EIRA compliance for policies ratified April to June 2017 - 21 to be audited 9/10/2017	Low
Gaps in assurances:	Actions to close gaps in assurances:	Action/ review due:	Progress on action:	Risk to delivery.
Implementation plan for undertaking EDS2 national performance framework	Plan against EDS2 national performance framework to be developed and implemented [ACTION OWNER:	Completed	EDS2 taking place on 23/11/2017 EDS2 Service grading will focus on Children	Achieved

	DPOE]		Services. EDS2 Corporate grading - Better health outcomes and experience – complaints manager to assemble equality data to support corporate self-assessment in preparing for grading by external stakeholders. Workforce Goals - 3 & 4 planning stages	
Related operational high/extreme risks: None specifically identified				

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

Principal risk:

Risk: **Potential turnover of board members**

Impact: Could adversely affect delivery of the organisational strategy and have a negative impact on wider Trust staff morale

Root causes:

a) Loss of specialist organisational knowledge on Board
b) Loss of Board capacity
c) Disruption of Board stability

BAF ref: **3e**	**Director Lead**: Samantha Harrison, Director of Corporate Affairs and Trust Secretary	**Responsible Committee**: Remuneration and Appointments Committee	Datix ID: 21138

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating EXTREME	Likelihood 4	Impact 5	Rating MOD	Likelihood 3	Impact 4	Direction ⟷	Rating LOW	Likelihood 1	Impact 1	Accepted	Tolerated	Not accepted

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative – Deputising posts in place for Chief Executive and Chair; Succession plan for Board members; Existing NED/Chair of Audit and Risk Committee able to extend appointment until replacement post in place Directive – Notice periods for Board Members Corrective – Recruitment processes commencing July 2017		Deloitte Well Led review

Gaps in control:	Actions to close gaps in control:	Action/ review due:	Progress on action:	Risk to delivery:
Full populated cascade for Board member	To develop full populated cascade for succession of	30/09/2017	To be considered by the Remuneration and	Moderate

succession planning	Board members		Appointments Committee Sept 2017	
Communication and engagement plan for trust staff	Communicate with trust staff to raise awareness of forthcoming advertisements and plans to recruit to substantive posts	Completed	Communication sent to staff via Weekly Connect 28/7/17. Chair interviews held 6/9/2017 and recommendations agreed at Council of Governors to appoint new Chair. Staff informed through All staff email 13/9/2017 CEO interviews set for 4/10/2017	Achieved
Gaps in assurances:	Actions to close gaps in assurances:	Action/ review due:	Progress on action:	Risk to delivery.
Related operational high/extreme risks: None specifically identified				

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

Principal risk:

Risk: **Failure to deliver financial plans**

Impact: Trust becomes financially unsustainable.

Root causes:

a) Non-delivery of internal CIP including back office efficiency
b) 'QIPP' disinvestment by commissioners leaves unfunded stranded costs in Trust
c) Other income loss without equivalent cost reduction (e.g. CQUIN, cost per case activity, commissioner clawback)
d) Costs to deliver services exceed the Trust financial resources available, including contingency reserves.
e) Lack of sufficient cash and working capital

BAF ref: **4a**	**Director Lead**: Claire Wright, Executive Director of Finance	**Responsible Committee**: Finance and Performance Committee	Datix ID: 21113

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating EXTREME	Likelihood 5	Impact 5	Rating EXTREME	Likelihood 4	Impact 5	Direction ⟷	Rating MODERATE	Likelihood 2	Impact 5	Accepted	Tolerated	Not accepted

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative – Budget training, segregation of duties, contract with commissioners to reach mutual agreement on QIPP disinvestment Detective –Scrutiny of financial delivery, bank reconciliations, scrutiny of CIP delivery Directive – Standing financial instructions, budget control, delegated limits, non-PO no pay rules, agency staff approval controls, approval to appoint process, business case approval process (e.g. back office), CIP targets issued Corrective – corrective management action, use of contingency reserve, disaster recovery plan	Financial performance reports to Trust Board and Finance and Performance Committee evidence the overall actual performance as well as the forecast performance. Includes several sections covering the efficacy of controls include: - CIP delivery achievement - Agency expenditure - Balance sheet cash value The Integrated Performance Report evidences delivery of services, workforce information, quality information set against the financial performance evidencing whether we deliver services within our resources Service Line Reporting define financial	Internal Audits– low risk findings on 2016/17 Key Financial Systems - data analysis External Audits – strong record of high quality statutory reporting (gap: VFM impact) Grant Thornton shows good benchmarking for key financial metrics (gap: liquidity) NHSI Use of Resources Metrics – shows good performance (gap: agency metric) National Fraud Initiative – no areas of concern Local Counterfraud work – no significant concerns

implementation	performance for each service line.			
Gaps in control:	**Actions to close gaps in control:**	**Action/ review due:**	**Progress on action:**	**Risk to delivery:**
The current agency approval controls are failing to reduce agency expenditure – we continue to pay in excess of capped rates for some roles. Also the volume of agency usage is increasing because we have not yet succeeded in improving recruitment and retention	Executives continue to have weekly meetings.[ACTION OWNER: COO] Implement a collective approach to holding the line on paying cap rates only for medical staff is being explored aim to be introduced [ACTION OWNER: MD] AIM: achieve average £250k per month agency spend (or less)	30/11/2017	This is improving. This gap may not fully close: The ability to exert maximum control on agency is undermined by the override of patient safety and delivery of services. Until recruitment to substantive roles is more successful the Trust will continue to choose to engage agency staff rather than deliver unsafe services	High
The CIP targets that have been issued do not yet have approved plans for the total CIP requirement and they have not yet been quality impact assessed	QIPP and CIP incorporated into the mental health STP workstream [ACTION OWNER DSD] Increased CIP meetings and project scrutiny, management action via TMT {ACTION OWNER – COO] AIM: full CIP programme, quality assured. New PMO approach in train for CIP	31/12/2017	Commissioners are now following the 'QIPP' approach, however a substantive amount of QIPP is yet to be agreed and may overlap with CIP CIP progress reported each F&P and Board meeting. ELT undertook financial risk 'stock take' on 4/9/2017. New PMO (Programme Management Office) lead appointed, starting Sept 2017	High
Commissioners appear to not be following the 'QIPP' approach that was agreed as part of contract sign off	QIPP and CIP incorporated into the mental health STP workstream [ACTION OWNER COO/DSD] AIM: agreed plan showing income reduction is matched by cost reduction	31/12/2017	CIP and QIPP are being looked at system wide as part of the move towards an ACS. 4 MH programmes are set-up and all looking at transformational change, some may deliver Q4. Internally Head of Programme Delivery has been appointed and will start 1st September. We continue to review transactional CIP.	Medium
Gaps in assurances:	**Actions to close gaps in assurances:**	**Action/ review due:**	**Progress on action:**	**Risk to delivery.**
Agency costs exceed NHSI ceiling by >50% and generate 'use of resources' agency score of 4.	Weekly agency meetings to reduce costs. Implementation of recruitment drive and incentives	Completed	As of month 4, performance shows use of resources agency score as 2. Forecast for 3 by year end. Evidence reported to F&P,	Achieved

	AIM: To have a UoR agency score of 2 or 3 for agency as a minimum)[ACTION OWNER: COO]		Board and People and Culture committee now evidences improvement in performance	
Liquidity is below peer levels	Continued strategic objective to increase cash through retention of disposals and limiting capex programme. AIM: Reach a 'sufficient' cash balance of £18m [ACTION OWNER DOF]	31/03/2018	Improving quarter on quarter cash balance. Month 4 cash is £16.6m	Low
Adverse VFM opinion from External Auditors for 15/16 and 16/17 accounts	Complete CQC action plan and governance improvement plan AIM 1: Trust released from NHSI licence conditions and rated as segment 1 or 2. [ACTION OWNER: DCA&TS] AIM 2: Clean VFM opinion for 17/18 accounts [ACTION OWNER: DCA&TS]	Aim 1: 30/09/2017 for licence and segment - complete Aim 2: 31/03/2018 for updated audit opinion	Aim 1: Completed: Rated as segment 2. Full compliance with licence conditions as of 24/05/2017 Audit Opinion updates cannot be delivered until 17/18 audit. Good progress being made.	Low
Related operational high/extreme risks: None specifically identified				

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

Principal risk:

Risk: **Failure to deliver internal transformational change at pace**

Impact: Could lead to reduced outcomes for service receivers and failure to deliver national 'must do's' i.e. Early intervention in Psychosis, Mental Health Liaison, Crisis and acute care, and physical healthcare interventions.

Root causes:

a) Lack of capacity within Transformational Team
b) Lack of capacity in the Business Development Team to support managers
c) Capacity and capability of managers to deliver change programmes
d) Lack of staff, vacant posts and lack of investment
e) Impact of CIP

BAF ref: **4b**	**Director Lead** Lynn Wilmott-Shepherd, Interim Director of Strategic Development	**Responsible Committee**: Finance and Performance Committee	Datix ID: 21114

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating EXTREME	Likelihood 5	Impact 5	Rating HIGH	Likelihood 4	Impact 5	Direction ⟷	Rating MODERATE	Likelihood 2	Impact 5	Accepted	Tolerated	Not accepted

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative - Robust project assurance process; Regular reporting to F&P showing progress on internal transformation linked to system change; Maintenance of strong links to system wide change including STP, Commissioners and other partners; Full involvement with appropriate system wide groups which translate to internal changes; Maintenance of strong relationships with other providers; service receiver engagement Detective -5 year Trust wide strategy; Performance management of annual business	Reports to Board regarding any system wide changes or risks which may impact on internal transformation Regular feedback to F&P showing progress on internal transformation linked to system change Updates and feedback at TMT and ELT on progress on internal transformation linked to system change together with 'barriers' to change Engagement with Governors in order to update	Reporting to NHSI Updates to CMDG/CMB

plans; Scrutiny on the performance of national 'must do's' Directive - Clear alignment of internal transformational plans to the Derbyshire's STP; Clear alignment to CIP i.e. transform to improve quality and reduce costs Corrective - Ongoing discussions on transformational change with key managers; Ongoing discussions transformational change with key stakeholders; Engagement and consultation with patients, public and staff as appropriate	them and gain feedback Engagement with staff though managers, staff side, focus groups etc.	

Gaps in control:	Actions to close gaps in control:	Action/ review due:	Progress on action:	Risk to delivery:
No clear links to external transformation	Be proactive in STP programme [ACTION OWNER DSD]	31/10/2017	CEO set up MH delivery programme. DSD regularly meeting with programme leads to ensure progress and alignment Appointed Head of Programme delivery (for 6 months) who will be key link to 4 STP MH programmes. Starting Sept 2017	Medium
Managers and clinicians not actively involved	Review new accountability framework and TMT as a way of ensuring transformational change is viewed as an imperative [ACTION OWNER DSD]	31/10/2017	Regular updates with Trust Management Team (TMT) linked to internal CIP. Managers and clinicians being identified for external STP programme	Medium
'Must do's' are not being met or have slipped when previously being met.	Performance management via TMT, CMDG and CMB [ACTION OWNER DSD]	31/10/2017	Performance management in place. Being extended to include corporate areas. CMDG and CMB continue to monitor contractual activity.	High
Lack of capacity within business development team to drive forward planning	Appointment of Business Development Manager and graduate trainee	31/10/2017	Secured graduate trainee. Starting in post 3/10/2017. In recruitment process for Business Development Manager	Medium

Gaps in assurances:	Actions to close gaps in assurances:	Action/ review due:	Progress on action:	Risk to delivery.
Evidence of real change	Implementation of PDSA cycles and rapid improvement [ACTION OWNER DSD]	31/10/2017	Implementation of quick win improvements. Launch of 'red to green' projects to help reduce length of stay.	Medium
Feedback from project groups	Clear project management structures [ACTION OWNER DSD]	31/10/2017	Regular reports to TMT in place. Escalated to ELT where necessary	Medium

Related operational high/extreme risks:

Divisional Risk Assessment (Clinical)	21127	Neighbourhood Services - Admin & Management Team	Clinical risk - Other	Lack of Forensic Specialist Community Resource
Divisional Risk Assessment (Clinical)	21031	Neighbourhood Services - City	Clinical risk - Other	Non-Adherence to Waiting List Management Policy and Procedure
Divisional Risk Assessment (Clinical)	20857	Neighbourhood Services - North	Clinical risk - Other	Transfer of patients through the change in neighbourhood boundaries
Team Risk Assessment	20819	Neighbourhood Services - City	Operational - Business Continuity	Waiting lists for assessment and interventions_Neighbourhood City

Abbreviations: Action owners

CEO Acting Chief Executive

COO Acting Chief Operating Officer

DCA&TS Director of Corporate Affairs and Trust Secretary

DON Executive Director of Nursing and Patient Experience

DOF Executive Director of Finance

DPOE Interim Director of People and Organisational Effectiveness

DSD Interim Director of Strategic Development

MD Medical Director

Risk Assessment Matrix

The Risk Score is simply a multiplication of the Consequence Rating x the Likelihood Rating.
The Risk Grade is the colour determined from the Risk Assessment Matrix below.

LIKELIHOOD	CONSEQUENCE				
	INSIGNIFICANT 1	MINOR 2	MODERATE 3	MAJOR 4	CATASTROPHIC 5
RARE 1	1	2	3	4	5
UNLIKELY 2	2	4	6	8	10
POSSIBLE 3	3	6	9	12	15
LIKELY 4	4	8	12	16	20
ALMOST CERTAIN 5	5	10	15	20	25

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Trust Board – 1 November 2017

Corporate Governance Framework

Purpose of Report

To present the updated and refreshed Corporate Governance Framework to the Trust Board for approval following review by the Audit and Risk Committee.

Executive Summary

The Trust's Corporate Governance Framework was developed and approved in July 2016 as part of the Governance Improvement Action Plan and as good governance practice. The framework has now been reviewed as per the agreement for annual refresh and a range of amendments have been made as outlined below. The framework and changes were reviewed by the Audit and Risk Committee at the meeting on 3 October and subject to the addition of detail relating to the membership of the Trust Management Team, which has now been added, was agreed for recommendation for approval to the public Trust Board.

The Corporate Governance Framework comprises:

1. **BOARD ROLES AND RESPONSIBILITIES**
2. **STRUCTURES & PROCESSES FOR ASSURANCE AND ESCALATION**
3. **SCHEME OF DELEGATION (including Committee terms of reference)**

APPENDICES TO THE CORPORATE GOVERNANCE FRAMEWORK:
Appendix 1 – Board Committee Assurance Report Template
Appendix 2 – Board Front Sheet Template
Appendix C – Standing Orders of the Board of Directors

The full Corporate Governance Framework is attached for information and reference, with the changes summarised below:

1. BOARD ROLES AND RESPONSIBILITIES
Minor reformatting. No material changes.

2. STRUCTURES & PROCESSES FOR ASSURANCE AND ESCALATION
This element of the Corporate Governance Framework has been updated to reflect the creation of the Trust Management Team and its role in providing assurance/ escalation to the Executive Leadership Team and Board Committees. A summary of the membership of the Committee has now been added at the request of the Audit and Risk Committee. The purpose of the Quality Committee has been updated and clarified and agreed by the Committee (see highlighted sections).

The Board Committee structure has been further reviewed in the context of current priorities and following annual review of effectiveness of each Committee. It has been recognised that the potential to reduce the number of Board Committees, specifically to consider whether the Safeguarding Committee and Mental Health Act Committee should remain as Board Committees should be considered regularly.

This was debated when the Corporate Governance Framework was developed in July 2016 and was further reviewed as part of the year-end review of relevant Committees by the Audit and Risk Committee. It is proposed that the two Committees remain as Board Committees for the following reasons:

- The supporting structures underneath the Quality Committee are still developing and as such it is proposed that it would not be appropriate at this time for the Safeguarding Committee to be subsumed within the remit of the Quality Committee. In addition, it is recognised that the Safeguarding Committee has a challenging strategic agenda and that its status as a Board Committee was supported by the CQC in their last safeguarding inspection.

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

It is proposed that arrangements for Board Committees be reviewed as part of the end of year review of each Board Committee (March 2018).

3. SCHEME OF DELEGATION

Part One – Scheme of Delegation and Decisions Reserved for the Board

No material changes.

Part Two – Responsibilities Delegated to Board Committees

Terms of Reference

The Terms of Reference of the Committees of the Board have been updated to reflect a number of additions and the format aligned for consistency as much as possible. All Committee Terms of Reference were reviewed by respective Committees as part of the year-end review process.

Standardised paragraphs have been incorporated to reflect Trust commitment to a range of areas and to ensure good governance practice. These are now consistent across all Terms of Reference and are as outlined below. Please note that the Mental Health Act Committee Terms of Reference are under current review in response to recommendations from the Deloitte external assurance review received in May 2017 and will be brought to the Committee in due course. A first update was reviewed in August 2017 with a further update underway. Similarly the Safeguarding Committee is in the process of further updating the Terms of Reference to clarify membership and focus. These have been reviewed by the Committee in September with a further update scheduled for November.

Ongoing review

Further to the Board Development Session held on 11 October where corporate governance was debated, all Committees may wish to further review their terms of

reference particularly in terms of membership and review of duties to reflect organisational priorities. Also the frequency of meetings is to be reviewed going forwards with work already underway on planning the governance calendar from April 2018 to reflect optimum Board and Board Committee effectiveness.

Standardised paragraphs added to all Terms of Reference:

Public Sector Equality Duties
The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Committee will ensure consideration has been given to equality impact related risks.

Governance Improvement Action Plan
The Committee has a role during the 2017/18 financial year to oversee implementation of key tasks as outlined in the Trust's Governance Improvement Action Plan. The Committee was assigned as responsible Committee for a range of tasks and is required to provide assurance to the Board that effective governance processes are embedded within the Trust.

Responsibility for Policies
As a designated policy ratification group, (see Policy on Policy Documents) the [x] Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

Meetings Held by Conference Call
Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

Obtaining External Advice
The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice and to secure the attendance of both internal and external officers with relevant experiences and expertise it if considers this necessary.

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

APPENDICES TO THE CORPORATE GOVERNANCE FRAMEWORK

APPENDIX 3 - STANDING ORDERS OF THE BOARD OF DIRECTORS & STANDARDS OF BUSINESS CONDUCT

GOVERNOR OBSERVERS

Following the introduction of the Governor Observer Protocol, it is suggested that the Standing Orders of the Board of Directors is updated to reflect this. The proposed text below is suggested to be added to Appendix 5, Section 5, Meetings of the Trust, as a new paragraph:

5.28 Observers at Board Committee meetings

The Trust Board will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board meetings and may change, alter or vary these terms and conditions as it deems fit.

USE OF THE TRUST SEAL

Guidance on the Use of the Trust Seal is contained in the Standing Orders of the Board (Section 12), Appendix 3 to the Constitution. In order to reflect best practice we would wish to strengthen the governance reference to this within the Standing Orders by adding the additional points, below which outline the delegated authority for use of the seal:

12.5 ***Where it is necessary that a document shall be sealed the seal shall be affixed in the presence of the Trust Secretary and an Executive Director (voting or non-voting) duly authorised by the Chief Executive and not also from the originating department and shall be attested by them.***

12.6 ***A report of all sealing shall be made to the Trust Board twice a year. The report will contain details of the seal number, the description of the document and date of sealing. The register will be retained by the Trust Secretary.***

This change also requires an update to the Standing Financial Instructions relating to use of the Seal. The former version of the SFIs stipulated that it was only the Trust Chair and the Trust Secretary who could execute the seal. The Director of Finance has confirmed agreement with the change as proposed which aligns the SFIs and SOs on use of the seal:

Standing Financial instructions

8*.18 All contract documents, up to the value of £100,000, shall be signed on behalf of the Trust by an Executive Director* ***(voting or non-voting)*** *or nominated officer. Every contract the value of which exceeds £100,000 shall be executed under the Common seal of the Trust and be signed by the* ***Trust Secretary and an Executive Director (voting or non voting)*** *duly authorised by the Chief Executive and not from the originating department.*

ATTENDANCE AT MEETINGS BY CONFERENCE CALL

From time to time it may be necessary for attendance at meetings via electronic means in order to maximise efficient use of time and ensure quorum. Terms of Reference of Board Committees have been amended to reflect this additional flexibility as per below.

> **Terms of Reference**
> Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

We suggest an addition to the Standing Orders of the Board of Directors, Appendix 3 of Corporate Governance Framework, Section 5, Meetings of the Trust, as additional points:

5.29 A Director in electronic communication with the Chairman and all other parties to a meeting of the Board of Directors or of a committee or sub-committee of the Board of Directors shall be regarded for all purposes as personally attending such a meeting provided that, but only for so long as, at such a meeting he has the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

5.30 For such a meeting to be valid, a quorum MUST be present and maintained throughout the meeting.

5.31 The minutes of a meeting held in this way MUST state that it was held by electronic communication and that the Directors were all able to hear each other and were present throughout the meeting.

In addition, there has also been a general updating of reference to policies/organisations as follows throughout the Corporate Governance Framework:

- NHS Protect - Now known as the NHS Counter Fraud Authority (NHSCFA)
- Bribery Policy - Now the Counter Fraud & Bribery Policy
- Declaration of Interest, Hospitality and Sponsorship Policy - now known as the Conflict of Interest Policy

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

their Terms of Reference to reflect their role, remit and good governance practice. The Corporate Governance Framework has been updated in the light of best practice guidance and reflecting current practice.

Consultation
Terms of Reference have been reviewed by each Board Committee and received by the Audit and Risk Committee at its meeting on 27 April 2017. The Audit and Risk Committee agreed the updates to the Corporate Governance Framework at its meeting on 3 October 2017.

Governance or Legal Issues
The Corporate Governance Framework is an essential document for the Trust which outlines the decision making and assurance arrangements for the Trust to effectively deliver its Strategy. Review of the Corporate Governance Framework on an annual basis is good governance practice that is outlined in the Governance Improvement Action Plan.

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

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

Recommendations
The Trust Board is requested to:

1. To approve of the Corporate Governance Framework including:
   - Board roles and responsibilities
   - Structures and processes for Escalation
   - Scheme of Delegation and decisions reserved for the Board
2. To confirm agreement with the updated Terms of Reference with regards to the addition of standardised paragraphs
3. Agree the update to the Standing Financial Instructions to align procedure relating to use of the Seal.
4. To recommend the implementation of the Corporate Governance Framework to be implemented throughout the Trust
5. To note the review of the Board Committee structure as part of year-end review arrangements to be undertaken in March/April 2018.

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

Derbyshire Healthcare
NHS Foundation Trust

CORPORATE GOVERNANCE FRAMEWORK DOCUMENT
JULY 2017

1. Board Roles and Responsibilities

2. Structures and Processes for Assurance and Escalation

3. Scheme of Delegation

- **Part One - Scheme of Delegation**
  Decisions Reserved for the Board

- **Part Two - Responsibilities Delegated to Board Committees:**

  Terms of Reference:
  Audit and Risk
  Finance and Performance
  Quality
  Mental Health Act
  Safeguarding
  Remuneration and Appointments Committee
  People and Culture

Appendices:

- **Appendix 1 – Board Committee Assurance Report Template**
- **Appendix 2 – Board Front Sheet Template**
- **Appendix 3 – Standing Orders of the Board of Directors**

1. BOARD OF DIRECTORS – ROLES AND RESPONSIBILITIES

1. This Document

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

2. Role and Purpose

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

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

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

The Board leads the Trust by undertaking three key roles:

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

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

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

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

3. General Responsibilities

The general responsibilities of the Board are:

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

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

3.1 Leadership

The Board provides active leadership to the organisation by:

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

3.2 Quality

The Board:

- Ensures that the Trust's quality of service responsibilities for clinical effectiveness, patient safety and patient experience, are achieved.
- Has an intolerance of poor standards, and fosters a culture which puts patients first.
- Ensures that it engages with all its stakeholders, including patients and staff on quality issues and that issues are escalated appropriately and dealt with.

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

3.3 Strategy

The Board:

- Sets and maintains the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives, taking into account the views of the Council of Governors.
- Determines the nature and extent of the risk it is willing to take in achieving its strategic objectives.
- Monitors and reviews management performance to ensure the Trust's objectives are met.
- Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required.
- Develops and maintains an annual plan, with due regard to the views of the Council of Governors, and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders.
- Ensures that national policies and strategies are effectively addressed and implemented within the Trust.

3.4 Culture, Ethics and Integrity

The Board:

- Is responsible for setting values, ensuring they are widely communicated and adhered to and that the behaviour of the Board is entirely consistent with those values.
- Promotes a patient-centred culture of openness, transparency and candour.
- Ensures that high standards of corporate governance and personal integrity are maintained in the conduct of Trust business.
- Establishes appeals panels as required by employment policies particularly to address appeals against dismissal and final stage grievance hearings.
- Ensures that Directors and staff adhere to any codes of conduct adopted or introduced from time to time.
- Ensures the application of appropriate ethical standards in areas such as research and development.

3.5 Governance/Compliance

The Board:

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

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

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

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

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

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

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

3.6 Risk Management

The Board:

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

3.7 Committees

The Board:

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

3.8 Communication

The Board:

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

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

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

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

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

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

- Publishes an annual report and annual accounts.

3.9 Finance

The Board:

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

- Ensures the continuing financial viability of the organisation.

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

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

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

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

4. Role of the Chair

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

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

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

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

5. Role of the Chief Executive

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

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

- The Chief Executive is responsible for implementing the decisions of the Board and its Committees and providing information and support to the Board and Council of Governors.

6. Deputy Chair

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

7. Role of the Senior Independent Director

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

8. Accountability

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

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

9. Council of Governors

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

The statutory general duties of the Council of Governors are:

- To hold the Non-Executive Directors individually and collectively to account for the performance of the Board, and

- To represent the interests of the members of the Trust as a whole and the interests of the public.

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

10. Other Matters

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

- Agreement of the agenda, for Board and Board Committee meetings, with the relevant Chair, in consultation with the Chief Executive, or the lead Executive Director for that Committee.

- Collation of reports and papers for Board and Committee meetings.

- Ensuring that suitable minutes are taken, keeping a record of matters arising, actions and issues to be carried forward.

- Ensuring that Board procedures are complied with.

- Supporting the Chair in ensuring good information flows within and between the Board, its Committees, the Council of Governors and senior management.

- Advising the Board and Board Committees on governance matters.

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

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

2. STRUCTURE AND PROCESSES FOR ASSURANCE AND ESCALATION

Board Committees

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

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

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

Roles of the Committees

The Audit and Risk Committee

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

The Finance and Performance Committee

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

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

The Quality Committee

- The prime purpose of the Committee is to enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to promote safety and excellence in patient care, Identify, prioritise and manage risk arising from clinical care, ensure the effective and efficient use of resources through evidence-based clinical practice; and protect the health and safety of Trust employees.

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

The Mental Health Act Committee

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

People and Culture Committee

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

The Safeguarding Committee

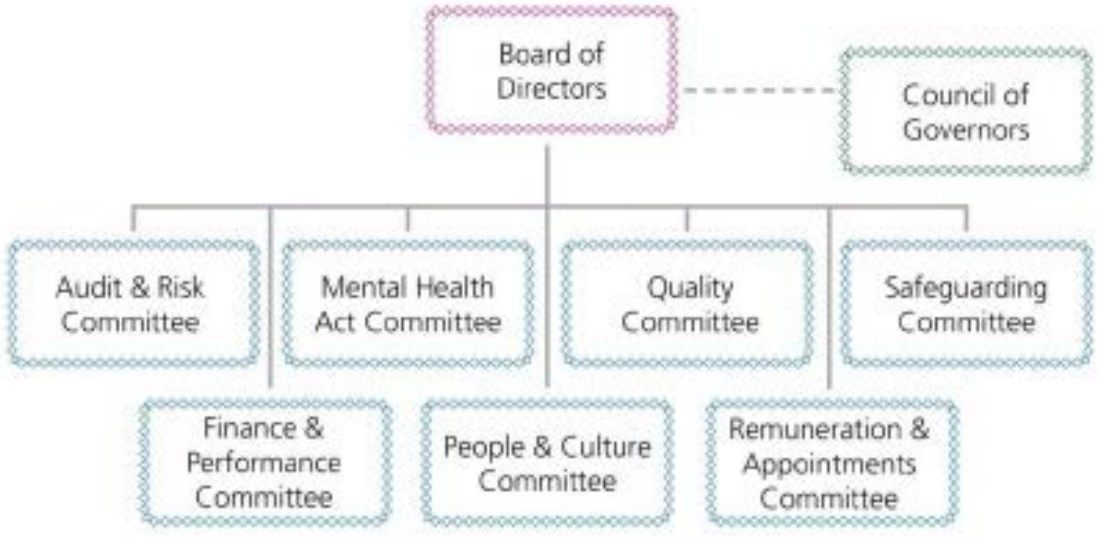
- The Committee is responsible for setting the Safeguarding Quality Strategy, to provide quality governance and gain assurance on all aspects of the safeguarding agenda. The Committee's purpose is to provide assurance to the Trust Board that the organisation is effectively discharging and fulfilling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

The Remuneration and Appointments Committee

- The Committee is responsible for identifying and appointing candidates to fill Director positions on the Board including the Chief Executive, voting and non-voting Executive Directors. The Committee is also responsible for establishing and keeping under review a remuneration policy in respect of Executive Directors and to advise upon and oversee contractual arrangements for Executive Directors.

Structure

The Board Committee structure is shown below:-



Assurance and Escalation

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

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

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

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

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

Each Committee:

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

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

- Co-operates with any request from the Audit and Risk Committee regarding a risk-related matter, and provides assurance as appropriate

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

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

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

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

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

Systems for Assurance and Escalation

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

The Executive Leadership Team (ELT)

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

The Trust Management Team (TMT)

The Trust Management Team (TMT) is accountable to the Trust Board for the management of operational implementation of the Trust strategic plan, regulatory requirements and objectives applied by the Trust Board. The TMT will be set appropriate frameworks and policies and procedures to support delivery of the organisational objectives. Using the frameworks in place, TMT will continually monitor and review the operational performance of the Trust and put in place corrective measures where necessary. The Trust Management Team will oversee the development of the Trust Annual Plan so that when it is presented to Trust Board for approval it is robust in terms of its objectives, performance measures, investment priorities and affordability. The Trust Management Team will also oversee the development of the budgets for approval by the Trust Board. The Trust Management Team plays a key role in developing the overall strategy of the Trust and has a key responsibility in risk management. It is also the formal route to support the Chief Executive in effectively discharging their responsibilities as Accountable Officer. The TMT has a membership which

includes several executive directors, deputy directors, associate clinical directors, divisional general managers, heads of services/senior nurses and the Chief Pharmacist.

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

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

Forward plan

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

Part One : Scheme of Delegation Decisions Reserved to the Board

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

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

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

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

Audit & Risk Committee Terms of Reference

Purpose

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

1. Authority

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

1.2 As a Committee of the Board, the Audit and Risk Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's Strategic objectives which fall within the Committee's remit. This includes identification, review and scrutiny of all relevant risks on the Board Assurance Framework.

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

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

1.5 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Audit and Risk Committee will ensure consideration has been given to equality impact related risks.

1.6 The Committee has a role during the 2017/18 financial year to oversee implementation of key tasks as outlined in the Trust's Governance Improvement Action Plan. The Committee was assigned as responsible Committee for a range of tasks and is required to provide assurance to the Board that effective governance processes are embedded within the Trust

1.7 As a designated policy ratification group, (see 'Policy on Policy Documents) the Audit and Risk Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

2. Membership

2.1 The Committee shall be composed of at least three independent non-executive directors, at least one of whom should have recent and relevant financial experience.

2.2 One of the members shall be appointed Chair of the Committee by the Board of Directors.

2.3 The Trust Chairman shall not be a member of the Committee (but may attend by invitation as appropriate).

2.4 Members of the Committee must attend at least 80% of all meetings each financial year but should aim to attend all scheduled meetings.

3. Attendance

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

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

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

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

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

3.6 A governor representative may be invited to attend meetings of the Committee as an observer when the Committee considers the Annual Governance Statement and the annual report and accounts.

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

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

Access

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

4. Quorum

4.1 A quorum shall be two Non-Executive Directors.

4.2 Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Trust Board meeting as an urgent item.

5. Frequency of meetings

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

6. Duties and Responsibilities

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

Integrated governance, risk management and internal control

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

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

6.4 In particular to review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances.

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

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

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

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

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

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

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

Internal audit

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

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

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

6.10 To consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

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

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

External audit

6.13 To make a recommendation to the Council of Governors in respect of the appointment, re-appointment and removal of an external auditor and related fees as applicable. To

the extent that the recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

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

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

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

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

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

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

Annual accounts review

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

- The meaning and significance of the figures, notes and significant changes
- Changes in, and compliance with the accounting policies, practices and estimation techniques
- Areas where judgment has been exercised
- Explanation of estimates or provisions having material effect
- Explanations for significant variances
- The schedule of losses and special payments
- Significant adjustments in the preparation of the financial statements and any unadjusted statements and
- Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved
- Changes in and compliance with guidance relating to the preparation of the Quality Account
- Compliance with the Annual Reporting Manual requirements for the content of the annual report as published by NHS Improvement

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

Raising Concerns (Whistleblowing)

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

Standing orders, standing financial instructions and standards of business conduct

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

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

6.25 To review the scheme of delegation.

Other

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

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

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

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

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

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

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded and made available to the Board of Directors.

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed. This will include details of any evidence of potentially *ultra vires*, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters. To the extent that such matters arise, the Chair of the Committee shall present details to a meeting of the Board of Directors in addition to the assurance summary.

7.3 The Committee will report annually to the Board of Directors and the Council of Governors in respect of its work in support of the Annual Governance Statement,

specifically commenting on:

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

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

7.5 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting. .

8. Administrative Support

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

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

9. Review of Terms of Reference

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

Approved by Audit & Risk Committee	
Approved by Trust Board	

Finance & Performance Committee Terms of Reference

Purpose
The prime purpose of the Committee is to gain assurance on all aspects of financial and operational performance, on behalf of the Board. The Committee also oversees and approves business developments as well as considering progress with commercial and contractual matters. The Committee is responsible for agreeing terms of reference and annual work programmes for its supporting sub-committees. It also receives agreed assurance and escalation reports as defined in the forward plan for the Committee.

1. Authority

1.1 The Committee oversees and approves business developments as well as considering progress with commercial and contractual matters.

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

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

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

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

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

1.5 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Finance & Performance Committee will ensure consideration has been given to equality impact related risks.

1.6 The Committee has a role during the 2017/18 financial year to oversee implementation of key tasks as outlined in the Trust's Governance Improvement Action Plan. The Committee was assigned as responsible Committee for a range of tasks and is required to provide assurance to the Board that effective governance processes are embedded within the Trust

1.7 As a designated policy ratification group, (see 'Policy on Policy Documents) the Finance & Performance Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

1.8 As a Committee of the Board, the Finance & Performance Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit

2. Membership

2.1 The membership of the Committee shall comprise:

- Chair of Committee – Non Executive Director
- Two other Non-Executive Directors
- Executive Director of Finance
- Chief Operating Officer
- Medical Director
- Director of Strategic Development
- Director of People and Organisational effectiveness

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

3. Attendance

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

4. Quorum

4.1 A quorum shall be three members, including at least one Executive Director and two Non-Executive Directors. Noting that as a minimum the executive attendance must include both the Director of Finance and the Chief Operating Officer or their deputies acting as their direct representative

4.2 Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Trust Board meeting as an urgent item.

5. Frequency

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

6. Duties and Responsibilities

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

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

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

6.3 To oversee progress on contractual negotiations.

6.4 To receive reports on business and commercial matters.

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

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

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

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

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

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded and made available to the Board of Directors.

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

7.3 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its Terms of Reference and give details of any significant issues and how they have been addressed.

7.4 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

7.5 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair.

8. Terms of Reference Review

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

Approved by Audit & Risk Committee	
Approved by Trust Board	

Quality Committee Terms of Reference

Purpose

The prime purpose of the Committee is to enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to promote safety and excellence in patient care, Identify, prioritise and manage risk arising from clinical care, ensure the effective and efficient use of resources through evidence-based clinical practice; and protect the health and safety of Trust employees. The Quality Committee is responsible for agreeing terms of reference and annual work programmes for its supporting sub-committees. It also receives agreed assurance and escalation reports as defined in the forward plan for the Committee.

1. Authority

1.1 The Board of Directors has approved the establishment of a Quality Committee as a Committee of the Board in accordance with standing orders.

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

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

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

1.5 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Quality Committee will ensure consideration has been given to equality impact related risks.

1.6 The Committee has a role during the 2017/18 financial year to oversee implementation of key tasks as outlined in the Trust's Governance Improvement Action Plan. The Committee was assigned as responsible Committee for a range of tasks and is required to provide assurance to the Board that effective governance processes are embedded within the Trust.

1.7 As a designated policy ratification group, (see 'Policy on Policy Documents) the Quality Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring

that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

2. Membership

2.1 The membership of the Committee shall comprise:-

- Non-Executive Director – Chair of the Committee
- Non-Executive Director (2)
- Executive Director of Nursing and Patient Experience
- Medical Director or a nominated Deputy
- Chief Operating Officer

3. Attendance

3.1 In attendance at the Committee:

- Deputy Director of Nursing & Quality Governance
- Lead professional for Patient Safety
- Chairs or Deputy Chair of Integrated Quality Leadership Teams on a rotational/bimonthly basis
- Divisional Clinical Director
- Chief Pharmacist
- Research and Clinical Audit Manager
- Risk and Assurance Manager
- Senior Psychologist
- Service Receiver representatives from a Mental Health representation group, currently Derbyshire Mental Health Alliance (2) with an additional named representative in reserve
- Carer representative from a named Carer organisation
- Assistant Director of Clinical Professional Practice
- Governor Observer

3.2 The following may also attend:

- Chief Executive Officer
- Trust Chair
- Assistant Director of Education
- Head of Transformation
- Director of People and Organisational Effectiveness
- Director of Corporate Affairs & Trust Secretary

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

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

3.5 Other staff may be co-opted to attend meetings as considered appropriate by the Committee on an ad hoc basis.

3.6 Service User and Carer Group representatives will be required to have an induction with the Executive Director of Nursing & Patient Experience prior to attending any Quality Committee meetings. They will also be required to sign a Confidentiality Agreement.

4. Quorum

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

4.2 Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Board of Directors meeting as an urgent item.

5. Frequency

5.1 Meetings shall be held monthly.

6. Duties and Responsibilities

In respect of general governance arrangements:

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

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

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

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

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

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

6.7 To scrutinise the work of the Trust Management Team and receive assurance from the Chair of the group on quality performance issues and mitigating actions to ensure safe and effective services.

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

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

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

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

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

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

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

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

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

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

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

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

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

6.21 To co-operate with and assist the work of other Trust-wide groups which report or scrutinise the work of the Quality Committee, e.g. governors' Governance Committee or the Council of Governors.

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

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

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

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

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded and made available to the Board of Directors.

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

7.3 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its Terms of Reference and give details of any significant issues and how they have been addressed.

7.4 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

7.5 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair.

8. Terms of Reference Review

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

Approved by Audit & Risk Committee	

Approved by Trust Board	

Mental Health Act Committee Terms of Reference

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

1. Authority

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

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

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

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

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

1.6 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Mental Health Act Committee will ensure consideration has been given to equality impact related risks.

1.7 The Committee has a role during the 2017/18 financial year to oversee implementation of key tasks as outlined in the Trust's Governance Improvement Action Plan. The Committee was assigned as responsible Committee for a range of tasks and is required to provide assurance to the Board that effective governance processes are embedded within the Trust

1.8 As a designated policy ratification group, (see 'Policy on Policy Documents) the Mental Health Act Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

1.9 An operational subgroup will meet approximately one month before the full Committee to prepare assurances and highlight exceptions.

2. Membership

2.1 The membership of the Committee shall comprise:-

- Non-Executive Director – Chair of the Committee
- Non-Executive Director (2)
- Executive Medical Director or a nominated Deputy
- Executive Director of Nursing and Patient Experience or a nominated Deputy
- Director of Corporate Affairs or a nominated Deputy

3. Attendance

3.1 The associated membership shall comprise:-

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

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

4. Quorum

4.1 Quorum is a minimum of three members including at least two Non-Executive Directors.

4.2 Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Trust Board meeting as an urgent item.

5. Frequency

5.1 Meetings will be held quarterly.

6. Duties and Responsibilities

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

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

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

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

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

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

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

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

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

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

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

6.11 To maintain a forward plan of regular agenda items.

6.12 Receive feedback from Associate Hospital Mangers and review any performance issues arising from mental health tribunals.

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded and made available to the Board of Directors.

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

7.3 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its Terms of Reference and give details of any significant issues and how they have been addressed.

7.4 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

7.5 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair.

8. Terms of Reference Review

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

Approved by Audit & Risk Committee	
Approved by Trust Board	

Safeguarding Committee Terms of Reference

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

1. Authority

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

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

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

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

1.5 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Safeguarding Committee will ensure consideration has been given to equality impact related risks.

1.6 The Committee has a role during the 2017/18 financial year to oversee implementation of key tasks as outlined in the Trust's Governance Improvement Action Plan. The Committee was assigned as responsible Committee for a range of tasks and is required to provide assurance to the Board that effective governance processes are embedded within the Trust.

1.7 As a designated policy ratification group, (see 'Policy on Policy Documents) the Safeguarding Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current

policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

2. Membership

2.1 The membership of the Committee shall comprise:-

Non-Executive Director – Chair of the Committee
Non-Executive Director (2)
Executive Director of Nursing & Patient Experience
Medical Director or nominated deputy
Chief Operating Officer or nominated deputy
Director of People & Organisational Effectiveness or nominated deputy

2.2 At least one the non-executive directors should have recent and relevant safeguarding experience.

2.3 The Trust Chairman shall not be a member of the Safeguarding Committee (but may attend by invitation as appropriate).

3. Attendance

3.1 In attendance at the Committee:

- Assistant Director of Safeguarding Children
- Named Nurse – Looked after Children
- Named Doctor – Safeguarding Children
- Opportunities for people with care and support needs and carers to contribute to and inform its work, to be represented by this group with the Voice of the Child, Voice of the Adult and the Voice of the Carer represented by this group through listening events and its extended work
- Designated Nurse – Safeguarding Children (CCG)
- Named Safeguarding Adult representative from the CCG – Named Lead Chief Nurse and/ or Head of Safeguarding representing all CCGs
- HR member of workforce sub-group of DSCB (Derby and Derbyshire Safeguarding Children Boards)
- Divisional Director or General Manager – covering Children's Services, CAMHS
- Director with Board level Director responsible for Education
- Named Divisional lead – Clinical Director/Associate Clinical Director/Head of Nursing/Nurse or other Consultant level 1 representative per Division
- Assistant Director for Safeguarding Adults
- Named Doctor for Safeguarding Adults

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

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

3.4 Other staff may be co-opted to attend meetings as considered appropriate by the Committee on an ad hoc basis.

4. Quorum

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

4.2 Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Trust Board meeting as an urgent item.

5. Frequency

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

6. Duties and Responsibilities

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

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

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

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

6.2.2 **The Care Act (2014)** Safeguarding adults at risk of abuse or neglect (Section 42 and named other relevant NHS legislation and NHS Safeguarding Adults policy and procedures.

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

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

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

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

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

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

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

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

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

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

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

6.2.14 The Committee will oversee and assure itself on the PREVENT and Channel: Supporting Individuals Vulnerable to Recruitment by Violent Extremists agenda. Establish or use existing mechanisms for understanding the risk of radicalisation. Communicate and promote the importance of the duty; as outlined in any counter terrorism legislation (2015) and ensure staff implement the duty effectively.

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

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

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

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

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

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

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

6.3 Safeguarding Adults Key Responsibilities

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

- Review suitable governance arrangements an effective infrastructure and adequate resources.
- Deliver operational and strategic requirements
- Provide links to other boards and partnerships
- Provide links to other boards and partnerships
- Provide a person-centred, outcome focused safeguarding policy and procedures
- Ensure that there is awareness training for all health and social care staff and Police who work directly with people with care and support needs
- Ensure that there is a specialist training for all practitioners who have direct responsibilities for safeguarding work
- Develop and publish a Trust strategy specifying each service areas responsibilities
- Link with the wider community to inform its work and learn of the work of the Board
- Sign off the Safeguarding Adult Annual reports, detailing what the Trust and its members have achieved, including how they have contributed to the Board's objectives and what has been learned from and acted upon from the findings of Safeguarding Adults Reviews and Case Reviews and other Domestic Homicide reviews and associated audits
- Arrangements for the quality assurance of the effectiveness of safeguarding work

6.4 Safeguarding Children Key Responsibilities

- Scrutinise the Safeguarding Children's Annual report, oversight of the Section 11 audit work and assurance that the Trust discharges its duty responsibly in line with National requirements.
- Review suitable governance arrangements an effective infrastructure, adequate resources
- Deliver operational and strategic requirements

- Provide links to other boards and partnerships
- Provide a child centred, outcome focused safeguarding policy and procedures
- Ensure that there is training for all health and social care staff and Police who work directly with people with care and support needs
- Develop and publish a Trust strategy specifying each service areas' responsibilities
- Sign off the Children's, Looked After Children Annual Reports, detailing what the Trust and its members have achieved, including how they have contributed to the board's objectives and what has been learned from and acted upon from the findings of Safeguarding Serious Case Reviews

6.5 Groups and Officers reporting schedule

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

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded and made available to the Board of Directors.

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

7.3 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its Terms of Reference and give details of any significant issues and how they have been addressed.

7.4 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

7.5 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair.

8. Terms of Reference Review

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

Approved by Audit & Risk Committee	
Approved by Trust Board	

Remuneration and Appointments Committee Terms of Reference

Purpose
The Committee is responsible for identifying and appointing candidates to fill Director positions on the Board including the Chief Executive, voting and non-voting Executive Directors. The Committee is also responsible for establishing and keeping under review a remuneration policy in respect of Executive Directors and to advise upon and oversee contractual arrangements for Executive Directors.

1. Authority

1.1 The Remuneration and Appointments Committee (the Committee) is constituted as a standing Committee of the Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings.

1.2 The Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Committee.

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

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

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

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

1.7 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Remuneration & Appointments Committee will ensure consideration has been given to equality impact related risks.

1.8 The Committee has a role during the 2017/18 financial year to oversee implementation of key tasks as outlined in the Trust's Governance Improvement Action Plan. The Committee was assigned as responsible Committee for a range of tasks and is required to provide assurance to the Board that effective governance processes are embedded within the Trust.

1.9 As a designated policy ratification group, (see 'Policy on Policy Documents) the Remuneration & Appointments Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

2. Membership

2.1 The membership of the Committee shall consist of:

- Trust Chair, and
- All Non-Executive Directors on the Board of Directors.

2.2 The Trust Chair will chair the Committee.

2.4 When appointing or removing the Chief Executive, the Committee shall be the committee described in Schedule 7, 17(3) of the National Health Service Act 2006 as amended by the Health and Social care Act 2012 (the Act) (that is all the non-executive directors). When appointing or removing the other executive directors the Committee shall be the committee described in Schedule 7, 17(4) of the Act (that is the Trust chair, the chief executive and the non-executive directors).

3. Attendance

3.1 Meetings of the Committee may be attended by:

- Chief Executive
- Director of Workforce, Organisational Development and Culture; and
- Director of Corporate Affairs; and
- Any other person who has been invited to attend the meeting by the Committee so as to assist in deliberations

4. Quorum

4.1 A quorum shall be three members.

4.2 Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Trust Board meeting as an urgent item.

5. Frequency of Meetings

Meetings shall be held quarterly or as required.

6. Duties & Responsibilities

Monitor's Code of Governance (July 2014) - These terms of reference are based in part, on best practice as set out in that code and have been drafted referring to the provision in the code. The code states as two of its principles that;

"There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration."

"There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board. Directors of NHS foundation trusts must be "fit and proper" to meet the requirements of the general conditions of the provider licence."

To be responsible for identifying and appointing candidates to fill all the executive director positions on the Board and for determining their remuneration and other conditions of service.

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

These terms of reference are intended to ensure that the Trust's procedure for the appointment of the chief executive and other directors (excluding Non-Executive Directors) to the Board of Directors reflect these principles.

6.1 Appointments role

6.1.1 To be responsible for identifying and appointing candidates to fill all the executive director positions on the board including the Chief Executive, voting and non-voting Directors. Non-executive Directors are appointed through the Nominations and Remuneration Committee of the Council of Governors.

6.1.2 Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate, and make recommendations to the board, and nomination committee of the Council of Governors, as applicable, with regard to any changes.

6.1.3 Give full consideration to and make plans for succession planning for the Chief Executive and other executive board director roles taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the board in the future.

6.1.4 To advise upon and oversee contractual arrangements for executive directors, including but not limited to termination payments.

6.1.5 Ensure that a proposed executive director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise.

6.1.6 Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

6.1.7 Consider any matter relating to the continuation in office of any board executive director including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract. The Committee will oversee ongoing compliance with the Fit and Proper Person requirements of Directors.

6.2 Remuneration Role

6.2.1 Establish and keep under review a remuneration policy in respect of executive board directors.

6.2.2 Consult the Chief Executive about proposals relating to the remuneration of the other executive directors.

6.2.3 In accordance with all relevant laws, regulations and Trust policies, decide and keep under review the terms and conditions of office of the Trust's executive directors (voting and non-voting) on locally-determined pay in accordance with all relevant Foundation Trust policies, including:

- salary, including any performance-related pay or bonus;
- provisions for other benefits, including pensions and cars; and
- allowances.

6.2.4 In adhering to all relevant laws, regulations and Trust policies:

- establish levels of remuneration which are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust;

- use national guidance and market benchmarking analysis in the annual determination of remuneration of executive directors (both voting and non-voting) on locally-determined pay, while ensuring that increases are not made where Trust or individual performance do not justify them;

6.2.5 Monitor, and assess the output of the evaluation of the performance of individual executive directors, and consider this output when reviewing changes to remuneration levels.

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded. These will be held confidentially by the Director of Corporate Affairs on behalf of the Trust Chair.

7.2 The Committee will report to the full Board of Directors (confidential session) after each meeting.

7.3 The Committee shall ensure that Board of Directors emoluments are accurately reported in the required format in the Trust’s annual report.

7.4 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its Terms of Reference and give details of any significant issues and how they have been addressed.

7.5 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

7.6 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair.

8. Terms of Reference Review

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

Approved by Audit & Risk Committee	
Approved by Trust Board	

People & Culture Committee Terms of Reference

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

1. Authority

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

1.2 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice and to secure the attendance of both internal and external officers with relevant experiences and expertise it if considers this necessary.

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

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

1.5 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The People & Culture Committee will ensure consideration has been given to equality impact related risks.

1.6 The Committee has a role during the 2017/18 financial year to oversee implementation of key tasks as outlined in the Trust's Governance Improvement Action Plan. The Committee was assigned as responsible Committee for a range of tasks and is required to provide assurance to the Board that effective governance processes are embedded within the Trust

1.7 As a designated policy ratification group, (see 'Policy on Policy Documents) the People & Culture Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current

policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

1.8 As a Committee of the Board, the People & Culture Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit

2. Membership

2.1 The membership of the Committee will comprise:

- Non-Executive Directors x 3 (one will be appointed as the Chair)
- Director of People and Organisational Effectiveness
- Medical Director
- Chief Operating Officer
- Chairs of the sub-committees

2.2 A quorum shall be three (not less than two non-executive directors and one executive director).

2.3 Members are expected to attend a minimum of eight meetings per year.

3. Attendance

3.1 Only members of the Committee have the right to attend and vote at Committee meetings. The Committee may require other officers of the Trust, and other individuals may attend all or any part of its meetings as and when is necessary. It is expected that a member of staff side, a governor, a representative from the Trust BME Network Group and a member of the communications team will attend each meeting.

3.2 The Board of Directors will appoint the Chair of the Committee

3.3 The Trust Board has delegated authority to any Non-Executive Director of the Trust to act as nominated deputy in the absence of any Non-Executive and this attendance will count towards the quorum.

3.4 The Board Secretary will be in attendance and provide administrative support.

3.5 A register of attendance will be maintained and reviewed by the Committee annually.

4. Quorum

4.1 A quorum shall be three (not less than two non-executive directors and one executive director).

4.2 Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Trust Board meeting as an urgent item.

5. Frequency

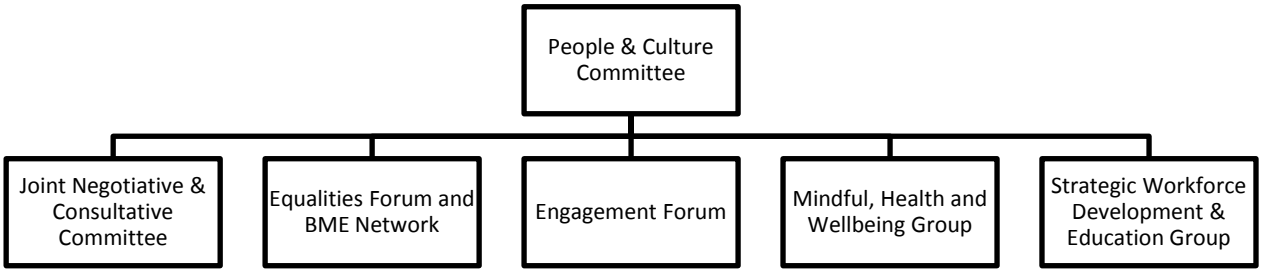
5.1 The Committee will meet on a monthly basis with additional meetings being called when necessary.

6. Duties and Responsibilities

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

6.2 The Committee will monitor the implementation of the People Strategy and report progress to the Board by exception

6.3 A number of supporting groups / forums will be accountable to the People and Culture Committee whilst not exhaustive; it is anticipated that the following groups will have a direct or indirect relationship and will be agreed within the Committee



6.4 The Committee will oversee and monitor workforce performance.

6.5 The Committee review and monitor the Workforce metrics and Board Assurance Framework and ensure the Board is kept informed of any significant workforce risks.

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

6.7 The Committee is to be assured that mechanisms are in place to review and monitor the effectiveness and capability of the workforce across the whole Trust and that appropriate actions are taken to address issues of poor performance and bring about continuous quality improvement.

6.8 The Committee is to be assured that the Trust identifies lessons for improvement and implements these in all relevant areas

6.9 The Committee is to be assured that National standards, guidance and best practice are systematically reviewed and embedded within the Trust

6.10 The Committee is to be assured that the views of staff and appropriate others are systematically and effectively engaged in organisational development activities

6.11 The Committee will oversee the leadership, training and education framework and monitor progress

6.12 The Committee will monitor the implementation of agreed action plans in relation to organisational interventions and measure the effectiveness of change.

6.13 The Committee will review its effectiveness by self-assessment on an annual basis and at the end of each meeting. The annual review will be presented to the Audit and Risk Committee.

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded and made available to the Board of Directors.

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

7.3 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its Terms of Reference and give details of any significant issues and how they have been addressed.

7.4 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

7.5 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair.

8. Terms of Reference Review

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

Approved by Audit & Risk Committee	
Approved by Trust Board	

Board Committee Summary Report to Trust Board
XXXX Committee - meeting held on XXXX

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)

Derbyshire Healthcare NHS Foundation Trust
Report to the XXXXXX – Date of Meeting

Title of Paper

Purpose of Report

Executive Summary

Strategic Considerations (All applicable strategic considerations to be marked with X in end column)	
1) We will deliver **quality** in everything we do providing safe, effective and service user centred care	
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.	
4) We will **transform** services to achieve long-term financial sustainability.	

Assurances

Consultation

Governance or Legal Issues

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

Recommendations

The XXXX Committee is requested to:

1)
2)
3)

Report presented by:

Report prepared by:

Derbyshire Healthcare
NHS Foundation Trust

Appendix 3

Standing Orders of the Board of Directors

&

Standards of Business Conduct

CONTENTS

1. INTRODUCTION TO STANDING ORDERS

Who should read these Standing Orders?

1.1 You should read these Standing Orders and be aware of their relevance to you as you discharge your responsibilities if you:

- Are a Director of the Trust
- Attend Board meetings
- Are a member of a Committee or sub-committee established by the Board, or attend its meetings
- Are a senior officer of the Trust
- Are involved in letting contracts on behalf of the Trust
- Are responsible for any aspect of the procurement of goods and services on behalf of the Trust
- Have a pecuniary interest in a contract that the Trust is entering into
- Are required to sign any legal document on behalf of the Trust.

Statutory Framework

1.2. Derbyshire Healthcare NHS Foundation Trust (the Trust) is a public benefit corporation which was established under the 2006 Act on 1 February 2011, subject to its Constitution and Provider Licence.

1.3. The headquarters of the Trust is at The Ashbourne Centre, Kingsway Site, Kingsway, Derby, DE22 3LZ.

1.4. NHS foundation trusts are governed by a regulatory framework that confers the functions of the Trust and comprises the 2006 Act, the Constitution and Terms of Authorisation. The powers of the Trust are set out in the 2006 Act subject to any restrictions in the Terms of Authorisation.

1.5. The Trust will be bound by such other statute and legal provisions or guidance which governs the conduct of its affairs.

1.6. As a public benefit corporation the Trust has specific powers to contract in its own name and to act as a corporate trustee. The Trust has a common law duty as a bailee for patients' property held by the Trust on behalf of patients. The Trust also has statutory powers to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

1.7. In accordance with paragraph 27 of the Constitution, the Standing Orders of the Board of Directors is to be set out in Annex 3 to the Constitution. The Trust adopts Standing Orders for the regulation of proceedings and business.

NHS Framework

1.8. In addition to the statutory requirements the Secretary of State (through the Department of Health), the Care Quality Commission or NHS Improvement may issue further requirements and guidance. These are normally issued under cover of a circulation or letter. The Board will be made aware of additional statutory requirements as they arise and amendments made to the Trust's Corporate Governance Framework as appropriate. Codes of Conduct and Accountability make various requirements concerning possible conflicts of interest of Directors. The

Codes (and the Constitution) also require the establishment of Audit and Remuneration Committees with terms of reference formally agreed by the Trust Board.

Delegation of Powers

1.9. The powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

1.10. Where officers are designated in these Standing Orders, they may designate their responsibility through approved Schemes of Delegation.

2. INTERPRETATIONS AND DEFINITIONS

2.1. At any meeting, the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (in which he should be advised by the Chief Executive or the Director of Corporate Affairs/Trust Secretary (hereafter referred to as the Trust Secretary), except where this would contravene any statutory provision or direction made by the Secretary of State (applicable to NHS foundation trusts) or such authorisation as may be given by the Independent Regulator.

2.2. All references in these Standing Orders to the masculine gender shall be read equally applicable to the feminine gender.

2.3. For convenience and unless the context otherwise requires the terms and expressions contained within paragraph 40 of the Constitution relating to Interpretation are incorporated and are deemed to have been repeated here verbatim for the purposes or interpreting words contained in this document:

'COMMITTEE' means a Committee or sub-committee appointed by the Trust.

'COMMITTEE MEMBERS' shall be persons formally appointed by the Trust to sit on or to Chair specific Committees.

'CONTRACTING AND PROCURING' means the systems for obtaining the supply of goods, material, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal or surplus and obsolete assets.

'NOMINATED OFFICER' means an Officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

'OFFICER' means and employee of the Trust or any other person holding a paid appointment or office with the Trust.

'SFIs' means Standing Financial Instructions.

'SOs' mean Standing Orders.

3. BRIBERY ACT 2010

3.1 Implementation of the Counter Fraud and Bribery Policy and Procedures:

3.1.1 It is a long established principle that public sector bodies, including the NHS, must be scrupulously impartial and honest in the conduct of their business and that as an employee of the Trust you should remain above suspicion.

3.1.2 The introduction of the Bribery Act 2010 places responsibility on the organisation to ensure robust procedures are in place to prevent bribery and corruption taking place within the Trust. The Trust believes it is the responsibility of all employees to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interest and their NHS duties.

3.1.3 All individuals within healthcare organisations are capable of being prosecuted for taking or offering a bribe. There is no maximum level of fines that can be imposed and an individual convicted of an offence can be imprisoned for up to ten years. The Bribery Act 2010 came into force on 1 July 2011 and creates five basic offences:

- Bribing another person with the intention of inducing that person to perform a relevant function or activity improperly or to reward that person for doing so
- Accepting a bribe with the intention that a relevant function or activity should be performed improperly as a result
- Bribing a foreign public official
- A director, manager or officer of a commercial organisation allowing or turning a blind eye to bribery within the organisation (the question of whether any particular organisation falls within the definition of a 'commercial organisation' will be considered on the facts of individual cases. It is, however, reasonable to assume that an NHS trust or NHS foundation trust could be deemed a 'commercial organisation' for the purpose of this Act)
- Failing to prevent bribery – where a person (including employees, agents and external third parties) associated with a relevant commercial organisation bribes another person intending to obtain or retain a business advantage. This is a strict liability offence which can be committed by the organisation unless it can show, in its defence, that it had adequate procedures in place to prevent bribery.

3.1.4 As an employee you have a responsibility to respond to other employees, patients and suppliers impartially, to achieve value for money from the public funds with which you are entrusted and to demonstrate high ethical standards of personal conduct. Recognising the statements of this nature cannot allude to every possible contingency, it is assumed that all employees are able to distinguish between acceptable and unacceptable behaviour in the conduct of their duties. Staff must not misuse or make official 'commercial in confidence' information to persons or organisations not reasonably needing access, particularly if its disclosure would prejudice the principle of a purchasing system for the Trust based on fair competition. If, however you are uncertain about the correctness or propriety of any proposed business transaction, or in relation to hospitality, declaration of interests or commercial sponsorship then you must seek advice from a senior manager.

3.1.5 The aim of this policy is to:

Provide you as an employee with clear guidance to ensure that you are aware of your responsibilities in relation to the conduct of business within the NHS and the consequences of failing to observe those responsibilities.

3.1.6 It is an offence for a person to offer, promise or give a financial or other advantage to another person in one or two cases:

- Case 1 applies to where that person intends the advantage to bring about the improper performance by another person of a relevant function or activity or to reward such improper performance
- Case 2 applies where the person knows or believes that the acceptance of the advantage offered, promised or given in itself constitutes the improper performance or a relevant function or activity.

3.1.7 Trust staff must not:

- Abuse their past or present official position to obtain preferential rates for private deals
- Unfairly advantage one competitor over another or show favouritism in agreeing sponsorship
- Misuse or make available official 'commercial in confidence' information
- Accept any inducements or inappropriate hospitality or gifts

3.1.8 You should refer to the Trust Raising Concerns (Whistleblowing) Policy for guidance on how to report concerns that you do not feel able to raise though normal reporting channels.

3.2 Breaches of the Counter Fraud and Bribery Policy

3.2.1 Alleged breaches of this policy will be investigated under the terms of the Trust Disciplinary Procedure.

3.2.2 In accordance with the Trust's Counter Fraud and Bribery Policy and Procedures, all suspicions of fraud and/or corruption occurring within the NHS will be referred to the Trust's Local Counter Fraud Specialist and/or NHS Counter Fraud Authority (NHSCFA) for formal investigation. Should evidence of fraud or corruption be discovered the Trust may initiate disciplinary, criminal and civil sanctions as appropriate.

3.2.3 The Bribery Act creates the offence of offering or receiving bribes and if failure to prevent a bribe being paid on an organisation's behalf. It makes it an offence for a person to offer, promise or give a financial or other advantage to another person if:

- That person intends the advantage to bring about the improper performance by another person of a relevant function or activity or to reward such improper performance or

- That person knows or believes that the acceptance of the advantage offered, promised or given in itself constitutes the improper performance of a relevant function or activity

3.2.4 The maximum sentence for bribery committed by an individual is 10 years imprisonment. The offence applies to bribery relating to any function of a public nature, connected with a business, performed in the course of a person's employment or performed on behalf of a company or another body of persons. Therefore bribery in both the public and private sectors is covered by the Act.

You should be aware that breaches of these Acts renders you liable to prosecution which may also lead to loss of employment and pension rights in the NHS.

4. THE TRUST

4.1 Composition of the Trust – in accordance with the Constitution the composition of the Board of the Trust shall comprise:

- A Non-Executive Chair
- Up to 6 other Non-Executive Directors (one of whom may be nominated as the Senior Independent Director); and
- Up to 6 Executive Directors (voting)

The Board of Directors shall at all times be constituted so that at least half the Board, excluding the Chair, shall comprise of the Non-Executive Directors.

The Board may appoint one of the Non-Executive Directors as the Senior Independent Director, in consultation with the governors.

4.2 **Appointment of the Chair and Directors** – The Chair and Non-Executive Directors are appointed (and removed) by the Council of Governors, through their Nominations and Remuneration Committee. The Chief Executive will be appointed or removed by the Non-Executive Directors and the appointment (but not the removal) will be subject to approval by the Council of Governors. The Trust shall appoint a Remuneration and Appointments Committee and/or other nominated persons whose members shall be the Chair, Non-Executive Directors and the Chief Executive whose function will be to appoint the other Executive Directors of the Trust.

4.3 **Terms of Office of the Chair and Directors** – the provisions governing the period of tenure of the office of the Chair and Directors and for the termination or suspension of office of the Chair and Directors are set out in the Constitution and these Standing Orders. Non-Executive Directors, including the Chair, shall be appointed by the Council of Governors for specified terms at intervals of usually no more than three (3) years. Any term beyond six years (eg two three year terms) shall be subject to rigorous review and shall take into account the need for progressive refreshing of the Board. Non-Executive Directors may be in exceptional circumstances serve longer than six (6) years but in such circumstances shall be subject to annual re-appointment.

4.4 **Appointment of Deputy Chair** – for the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chair, the Council of Governors may appoint a Non-Executive Director to be Deputy Chair for such a period, not exceeding the remainder of his term as Non-Executive Director of the Trust, as they may specify on appointing them.

4.5. Any Non-Executive Director so elected may at any time resign from the office of Deputy Chair by giving notice in writing to the Chair and the Directors of the Trust may thereupon appoint another Non-Executive Director as Deputy Chair in accordance with the governors' Nominations and Remuneration Committee Terms of Reference.

4.6 **Powers of Deputy Chair** – where the Chair of the Trust has ceased to hold office or where he has been unable to perform his duties as Chair owing to illness, or any other cause, the Deputy Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes his duties.

4.7. **Joint Directors**

4.7.1 Where more than one person is appointed jointly to a post of Director those persons shall count for the purposes of Standing Order 2.1 as one person.

4.7.2 Where the office of Director of the Board is shared jointly by more than one person:

- Either or both of those persons may attend or take part in meetings of the Board
- If both are present at a meeting they should cast one vote if they agree
- In the case of disagreements no vote should be cast
- The presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 5.25 Quorum.

4.8. **Role of Directors –** the Board will function as a corporate decision-making body within which all Directors (voting) will be equal. Their role as members of the Board will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory functions. In exercising these functions the Board will consider guidance from NHS Improvement's 'the NHS Foundation Trust Code of Governance' as amended from time to time.

4.8.1 **Executive Directors** - Executive Directors shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

4.8.2 **Chief Executive** - the Chief Executive shall be responsible for the overall performance of the Trust. He is the **Accounting Officer** for the Trust and shall be responsible for ensuring the discharge of obligations under financial directions and in line with the requirements of the NHS Foundation Trust Accounting Officer Memorandum for Trust Chief Executives.

4.8.3 **Executive Director of Finance** - the Executive Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. She shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant financial directions.

4.8.4 **Non-Executive Directors** - the Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of, or when chairing, a Committee of the Trust which has delegated powers.

4.8.5 **Chair** - the Chair shall be responsible for the operation of the Board and Chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of appointment and with these Standing Orders. The Chair shall liaise with the Council of Governors over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance. The Chair shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely

manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

4.9 **Corporate Role of the Board**

4.9.1 All business shall be conducted in the name of the Trust

4.9.2 All charitable funds received in the Trust shall be held in the name of Derbyshire Community Health Services NHS Foundation Trust, acting as corporate trustee on behalf of the Trust

4.9.3 The powers of the Trust shall be exercised by the Board meeting in private session except as otherwise provided in Standing Order (5.1).

4.10 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in the Scheme of Delegation: Decisions reserved to the Board.

4.11 **Lead Roles for Directors**

The Chair will ensure that the designation of lead roles or appointments of Board members as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (eg appointing a Lead Board Director with responsibilities for Infection Control or Child Protection Services etc).

5. MEETINGS OF THE TRUST

5.1 **Admission of the Public and the Press** – The meetings of the Board of Directors shall be open to members of the public and press unless the Board decides otherwise in relation to all or part of a meeting for reason of confidentiality or on other proper grounds.

In the event that the public and press are admitted to all or part of a Board meeting the Chair shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board business shall be conducted without interruption and disruption and the public will be required to withdraw upon the Board resolving that in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete its business without the presence of the public.

Nothing in these Standing Orders shall require the Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report or proceedings without permission granted by resolution of the Trust.

5.2. **Calling of Meetings** – Ordinary meetings of the Trust shall be held as such times and places as the Board determines.

5.3 One third or more members of the Directors may requisition a meeting in writing. If the Chair refuses, or fails, to call a meeting within seven days of the requisition being presented, the Directors signing the requisition may forthwith call a meeting.

5.4 **Notice of Meetings** – Before each meeting of the Trust Board, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or the Trust Secretary shall be delivered to every Director, sent by email and/or sent by post to the usual place of residence of such Director, so as to be available to him at least three clear days before the meeting.

Lack of service of the notice on any Director shall not affect the validity of the meeting.

5.5 In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

5.6 Failure to serve such a notice on more than three Directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice is delivered via email.

5.7 Before any meeting of the Board which is to be held in public, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Trust's website at least three clear days before the meeting.

5.8 **Agenda and Supporting Papers** – The Agenda will be sent to Directors three days before the meeting and supporting papers, whenever possible, shall accompany the agenda.

5.9 A Director desiring a matter to be included on an agenda shall make his request in writing to the Chair at least six clear days before the meeting subject to SO 5.3.

Requests made less than six days before a meeting may be included on the agenda at the discretion of the Chair.

5.10 At any meeting of the Trust, the Chair, if present shall preside. If the Chair is absent from the meeting the Deputy Chair, if present shall preside. If the Chair and the Deputy Chair are absent such Non-Executive Director as the Directors present shall choose shall preside.

5.11 **Annual Members' Meeting** – The Trust will publicise and hold an annual meeting of its members by the end of September each year. The meeting must be open to members of the public.

5.12 **Chair's Ruling** – The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

5.13 **Voting** – All questions put to the vote at a meeting shall be determined by a majority of the votes of the voting Directors present and voting on the question and, in the case of an equal vote, the person presiding shall have a second or casting vote.

5.14 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

5.15 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any questions may be recorded to show how each Director present voted or abstained.

5.16 If a Director so requests, his vote shall be recorded by name.

5.17 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

5.18 An officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

5.19 **Minutes** – The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next meeting where after they will be signed by the Chair. The names of the Directors present at the meeting shall be recorded in the minutes.

5.20 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

5.21 **Suspension of Standing Orders** – Except where this would contravene any provision in the Constitution, the Terms of Authorisation any statutory provision or authorisation by the Independent Regulator any one or more of the Standing Orders may be temporarily or permanently suspended at any meeting, provided that at

least two thirds of the Board are present signifying their agreement to such suspension, including one Executive Director and one Non-Executive Director.

5.22 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting. A separate record of matters discussed during this suspension shall be made and shall be available to the Directors.

5.23 The Audit and Risk Committee shall review every decision to suspend Standing Orders.

5.24 These Standing Orders shall be amended only if:

- At least half the total of the Trust's Non-Executive Directors present vote in favour of the amendment, and
- At least two-thirds of the Directors are present, and
- The variation proposed does not contravene any applicable statutory provision or direction;

5.25 **Quorum** – No business shall be transacted at a meeting of the Trust Board unless at least three of the whole numbers of the Directors are present including at least one Executive Director and one Non-Executive Director.

5.26 An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

5.27 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 9.5) he/she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

5.28 Observers at Board Committee meetings
The Trust Board will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board meetings and may change, alter or vary these terms and conditions as it deems fit.

5.29 A Director in electronic communication with the Chairman and all other parties to a meeting of the Board of Directors or of a committee or sub-committee of the Board of Directors shall be regarded for all purposes as personally attending such a meeting provided that, but only for so long as, at such a meeting he has the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

5.30 For such a meeting to be valid, a quorum MUST be present and maintained throughout the meeting.

5.31 The minutes of a meeting held in this way MUST state that it was held by electronic communication and that the Directors were all able to hear each other and were present throughout the meeting.

6. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

6.1 Subject to SO 6.1.1 below and subject to the Mental Health Act 1983, the Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO 7.1 or 7.2 below, or by an Executive Director of the Trust in each case subject to such restrictions and conditions as the Board thinks fit.

6.1.1 **Hospital Managers Powers to Discharge** – When the Trust is exercising the functions of the managers referred to in Section 45 of the Mental Health Act 2007 those functions may be exercised by any three or more persons authorised by the Board, each of whom is neither an Executive Director of the Board nor an employee of the Trust.

6.2 **Emergency Powers** – The powers which the Board has reserved to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board for ratification.

6.3 **Delegation to Committees** – Subject to SO 6.1 above, the Board shall agree from time to time to the delegation of executive powers to be exercised by committees and sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board.

6.4 **Delegation to Officers** – The Chief Executive is responsible for those functions of the Trust which have not been retained as reserved by the Board or delegated to a committee. The Chief Executive shall determine which functions he will perform personally and shall nominate officers to undertake the remaining functions for which he will still retain accountability to the Trust.

6.5 The Chief Executive shall prepare a Scheme of Delegation identifying his proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board.

6.6 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Executive Director of Finance or other Executive Director to provide information and advise the Board in accordance with statutory requirements.

6.8 The Board shall comply with the arrangements set out in the Decisions Reserved for the Board and Scheme of Delegation.

6.9 **Overriding Standing Orders** – If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

7. COMMITTEES

7.1 **Appointment of Committees** – Subject to the Constitution and any applicable statutory provision or direction the Trust may appoint committees or sub-committees of the Trust, consisting wholly or partly of Directors of the Trust or wholly or partly of persons who are not Directors of the Trust. The Standing Orders of the Trust shall apply to committees and sub-committees of the Trust.

7.2 A Committee appointed under SO 7.1 may appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include Directors of the Trust or other health service bodies in question); or wholly of persons who are not members of the Trust or other health service bodies or the committee of the Trust or other health service bodies in question.

7.3 Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as reporting back to the Board), as the Board shall decide.

7.4 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board.

7.5 The Board shall approve the appointments to each of the committees, which it has formally constituted. Where the Board determines and regulations permit, that persons, who are neither Directors nor Officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement of loss of earnings, and/or expenses in accordance where appropriate with national guidance.

7.6 Where the Board is required to appoint persons to a committee and/or to undertake statutory functions, and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with any regulations and direction.

7.7 The Chief Executive will be appointed or removed by the Non-Executive Directors subject to approval by the Council of Governors.

7.8 Appointment of Executive Directors other than the Chief Executive – it is for the Remuneration and Appointments Committee, consisting of the Chair, the Chief Executive and other Non-Executive Directors, to appoint or remove the Executive Directors.

7.9 Committees, sub-committees and joint committees established by the Board shall include:

- Audit and Risk Committee
- Remuneration and Appointments Committee
- Quality Committee
- Finance and Performance Committee
- Mental Health Act Committee
- Safeguarding Committee
- People and Culture Committee

And any other such committees as required by the Board to discharge its responsibilities.

7.10 **Confidentiality** - a member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board or shall otherwise have concluded on that matter, or if the Board shall resolve that any matter will remain confidential.

7.11 Committee meetings of the Board will not be held in public unless expressly stated.

8. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

8.1 **Policy statements: general principles**
The Board of Directors will from time to time agree and approve policy statements/ procedures which will apply to all or specific groups of staff employed by the Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Board of Directors or Board Committee minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

8.2 **Specific Policy statements**
Notwithstanding the application of SO 8.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following policy statements:

- Conflicts of Interest Policy for the Trust staff
- The Disciplinary Policy and Procedures of the Trust

both of which shall have effect as if incorporated into these Standing Orders.

8.3 **Standing Financial Instructions**

8.3.1 Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

8.4 **Specific Guidance**
Notwithstanding the application of SO 8.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

- Caldicott Guardian 1997
- Human Rights Act 1998
- Freedom of Information Act 2000.
- Public Sector Equality Duty

9. DECLARATION OF INTERESTS

9.1 **Declaration of Interests**
The NHS Code of Accountability and the Constitution and the Trust's Conflict of Interest Policy requires the Board of Directors to declare interests which are relevant and material to the NHS Board of which they are a Director. All existing Directors should declare such interest. Any Directors appointed subsequently should do so on appointment. This forms an important part of the Fit and Proper Persons Regulation Test which is carried out for all directors on appointment, reviewed regularly and with an annual declaration made by the Chair of the Board (see the Trust's Fit and Proper Person Regulation Policy and Procedure).

9.2 Interests which should be regarded as 'relevant and material' are:

9.2.1 Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those dormant companies)

9.2.2 Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS

9.2.3 Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS

9.2.4 A position of authority in a charity or voluntary organisation in the field of health and social care

9.2.5 Any connection with a voluntary or other organisation contracting for NHS services

9.2.7 Research funding/grants that may be received by an individual or their department

9.2.8 Interests in pooled funds that are under separate management.

9.3 If any Director has any doubt about the relevance of an interest, this should be discussed with the Chair or Trust Secretary.

9.4 Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

9.5 At the time Board of Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring.

9.5 Board of Directors' directorships of companies likely or possibly seeking to do business with the Trust should be published in the Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports.

9.6 During the course of a Board meeting, if a conflict of interest is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

9.7 **Register of Interests**

The Trust Secretary will ensure that a Register of Interests is established to record formally declarations of interest of Directors. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Board of Directors.

9.8 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be included.

9.9 The Register will be available to the public and the Trust Secretary will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

10. DISABILITY OF DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

10.1 Subject to the following provisions of this Standing Order, if the Chair, or a Director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

10.2 The Trust shall exclude a Director from a meeting of the Trust while any contract, proposed contract or other matter in which he/she has a pecuniary interest, is under consideration.

10.3 Any remuneration, compensation or allowances payable to a Director by virtue of 2006 Act shall not be treated as a pecuniary interest for the purpose of this Standing Order.

10.4 For the purpose of this Standing Order the Chair or a Director shall be treated, subject to SO 10.5, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

10.4.1 A nominee of his is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration;

Or

10.4.2 He is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

And in the case of married persons living together the interest of one spouse shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest to the other.

10.5 A Director shall not be treated as having a pecuniary interest in any contract or other matter by reason only:

10.5.1 Of his membership of a company or other body, if he/she has no beneficial interest in any securities of that company or other body;

10.5.2 Of an interest in any company, body or person with which he is connected as mentioned in SO 10.4 above which is so remote or insignificant that it cannot be reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

10.6 Where a Director:

10.6.1 Has an indirect pecuniary interest in a contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

10.6.2 The total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

10.6.3 If the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class, this Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his/her duty to disclose his/her interest.

10.7 Standing Order 11 applies to a Committee or sub-committee of the Trust as it applies to the Trust and applies to any member of any such committee or sub-committee (whether or not he is also a Director of the Trust) as it applies to a Director of the Trust.

10.8 Directors should comply with the Trusts Conflict of Interest Policy.

11. STANDARDS OF BUSINESS CONDUCT

11.1 **Policy** – staff must comply with the national guidance contained in HSG(93)5 Standards of Business Conduct for NHS staff as well as the Trust's Conflict of Interest Policy. The following provisions should be read in conjunction with this document.

11.2 **Hospitality** – staff shall decline all except modest hospitality offers by potential or actual suppliers to the Trust. For the purpose of this Standing Order, modest hospitality shall be defined as that which is similar to the scale of hospitality which the NHS as an employer would be likely to offer.

- Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.
- Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.
- Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable. Senior approval must be obtained.

The Trust shall maintain a hospitality register, detailing both the hospitality accepted and that which has been offered but declined. The register will be held by the Trust Secretary.

11.3 **Interests of Officers in Contracts** – if it comes to the knowledge of a Director or an officer of the Trust that a contract in which he has any pecuniary interest not being a contract to which he himself is a party, has been, or is proposed to be, entered into by the Trust he shall at once give notice in writing to the Trust Secretary of the fact that he is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

11.4 An Officer must also declare to the Chief Executive any other employment or business or other relationship of his, or of a cohabiting partner, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

11.5 All Board Directors are required, upon appointment, to subscribe to the NHS Code of Conduct and Code of Accountability.

11.6 **Canvassing of and Recommendations by, Directors in Relation to Appointments** – Canvassing of Directors of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in the application form or otherwise brought to the attention of candidates.

11.7 A Director of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

11.8 **Relatives of Directors or Officers** – candidates for any staff appointment shall when making application disclose in writing whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.

11.9 The Directors and every Officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.

11.10 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other Director or holder of any office under the Trust.

11.11 Where the relationship of an Officer or another Director to a Director of the Trust is disclosed, Standing Order Disability of Directors in proceedings on account of pecuniary interest (SO10) shall apply.

12. CUSTODY AND SEALING OF DOCUMENTS

12.1 **Custody of Seal** – The Common Seal of the Trust shall be kept by the Trust Secretary in a secure place.

12.2 **Sealing of Documents** – The Seal of the Trust shall not be fixed to any document unless the sealing has been authorised by a resolution of the Board or of a committee, thereof or where the Board has delegated its power.

12.3 Attestation of Sealing – The Common Seal of the Trust shall be affixed in the presence of those with delegated authority conferred by the Board.

12.4 **Register of Sealing** – An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal.

12.5 Where it is necessary that a document shall be sealed the seal shall be affixed in the presence of the Trust Secretary and an Executive Director, voting or non-voting, duly authorised by the Chief Executive and not from the originating department.

12.6 A report of all sealing shall be made to the Trust Board twice a year. The report will contain details of the seal number, the description of the document and date of sealing. The register will be retained by the Trust Secretary.

13. SIGNATURE OF DOCUMENTS

13.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive or Trust Secretary as designated signatory.

13.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed), the subject matter of which has been approved by the Board or Committee or sub-committee to which the Board has delegated appropriate authority.

Board Committee Summary Report to Trust Board
XXXXX Committee
DATE

Agenda Item Full agenda item title (within reason)	Summary of issue discussed To outline what was presented/outlined/ reviewed/discussed and by whom. Key points/highlights – eg one or two key issues.	Assurance and actions required Please state whether FULL, SIGNFICANT LIMITED or NO, assurance received. All references to assurance to be included in this column. Actions to be outlined including lead and timeframe.	Key risks identified Please identify what (if any) risks arise from the discussion and scale of these (eg whether these impact on operational risk or BAF risks) Please write NONE if no risks	Decisions made Please identify what decisions were made. This may include agreement or acknowledgement that items are to be considered by the Trust Board as part of scheduled reports. Please state NONE if no decisions made	Escalations to Trust Board (or referral to other Committee) Please use this column to refer items to the Board which are not routine or planned items. This column is to escalate specific items that are to the Board as agreed at the Committee. This column to be used BY EXCEPTION ONLY. Please write NONE if no escalations

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Derbyshire Healthcare NHS Foundation Trust
Report to the Trust Board 1 November 2017

GIAP Actions Embeddedness Update 1 November 2017

Purpose of Report

To update on the embeddedness of actions undertaken as part of the Trust's Governance Improvement Action Plan (GIAP).

Executive Summary

All actions within the Governance Improvement Action Plan were completed and signed off by the Trust Board in May 2017. A key focus of the GIAP was to ensure ongoing implementation of the actions and embeddedness in business as usual for the Trust. This six month update outlines evidence and updates on further work relating to actions that fall under the remit of the Board and its Committees.

Narrative is outlined against each action and a RAG rating has been assigned to reflect the following:

GREEN: Recommendation fully implemented and Executive Director/Committee confidence that these are now part of business as usual (either forming part of policy or annual cycle of business for example).

AMBER: The recommendation has been implemented either in part, or for a limited time only such that further period of evidence gathering is required to demonstrate impact or that the action is fully embedded.

RED: Work has not been completed or embedded to deadline and revised plan of action is required.

GIAP Governance: The GIAP itself had a total of 53 recommendations which were assigned across Board Committees as follows:

Core	Committee	Lead Director
Core 1 - HR and associated Functions (5)	People and Culture	Interim Director of Workforce, Culture and OD
Core 2 - People and Culture (6)	People and Culture	Interim Director of Workforce, Culture and OD
Core 3 - Clinical Governance (3)	Quality	Director of Nursing
Core 4 - Corporate Governance (13)	Audit & Risk	Director of Corporate Affairs
Core 5 - Council of Governors (3)	Council of Governors	Director of Corporate Affairs
Core 6 - Roles and Responsibilities	Remuneration and	Director of Corporate

of Board Members (5)	Appointments	Affairs
Core 7 - HR and OD (8)	People and Culture	Interim Director of Workforce, Culture and OD
Core 8 - Raising concerns at work (1)	People and Culture	Interim Director of Workforce, Culture and OD
Core 9 - Fit and Proper (1)	Remuneration and Appointments	Director of Corporate Affairs
Core 10 – CQC (2)	People and Culture	Acting Chief Operating Officer
Core 11 - NHS improvement undertakings (6)	Board of Directors	Acting Chief Operating Officer

During September all Board Committees reviewed progress against the recommendations assigned to them and Committee updates are as follows:

People and Culture Committee:
As at September there were 14 greens and 7 amber actions. The ambers are all well in progress and relate to:

- The HR restructure which is at final business case stage and moving towards approval and implementation.
- Staff engagement and involvement is progressing well as evidenced by improvements the last two pulse checks and we hope will be further enhanced as we embed the new staff forum
- The policy audit is planned into 2018
- HR cases have tight control and oversight but are some months off full closure.

Audit & Risk Committee:
The Audit & Risk Committee is responsible for overseeing 13 recommendations from the Governance Improvement Action Plan (GIAP). These have all been rated as green and detail provided on embeddedness as business as usual within ongoing governance practice within the Trust.

Council of Governors:
The Council of Governors is responsible for oversight of 3 GIAP actions which were originally signed off as complete by the Council of Governors on 24 November 2016 and supported by the Board at its meeting on 7 December 2016. There has been sustained work to maintain and develop the systems and processes set in place to ensure effective support and operation of the Council of Governors and to ensure that governors have clarity in their role and have opportunity for appropriate training and development to further enhance their work. Governors confirmed that they felt these recommendations should all be rated green at their Council of Governors meeting held on 26 September.

Quality:
Three recommendations fall under the remit of the Committee and were considered at the meeting held on 7 September. Two of these are designated amber and one is designated green. The amber rated actions relate to ongoing work relating to

embeddedness of the accountability framework and the other relates to overall developing maturity of the Committee. Both are expected to be green following implementation of current actions over forthcoming months with a January target date to achieve a green rating.

Remuneration and Appointments Committee
Following discussion at the Committee held on 27 September these were agreed as all green rated and embedded in business as usual of the Trust.

Board of Directors
Recommendations falling directly to Board oversight relate to Monitor enforcement undertakings. The Trust is now fully compliant with its foundation trust licence and as such embeddedness of these recommendations is fulfilled by the ongoing review as presented in this paper across all the GIAP recommendations.

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

Assurances

Actions were signed off by the Committees/the Board during early 2017 with detail outlined how ongoing embeddedness would be evidenced.

Consultation

Board Committees have reviewed prior to collation of all embeddedness information for submission to 1 November Trust Board.

Governance or Legal Issues

The second external review by Deloitte was a key part of providing assurance to NHSI and the CQC that we had made identified governance improvements to fulfil our foundation trust licence conditions. The review was used by NHSI to consider our licence breach and a certificate of compliance was subsequently issued on 24 May 2017.

Public Sector Equality Duty & Equality Impact Risk Analysis	
The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people) (Public Sector Equality Duty & Equality Impact Risk Analysis) The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).	
There are no adverse effects on people with protected characteristics (REGARDS).	X
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	

Recommendations

The Trust Board is requested to:

1) Receive assurance from the evidence as outlined and assurance from Board Committees on the embeddedness of actions taken to address GIAP recommendations
2) Consider and agree the RAG ratings as proposed
3) Agree that a further review will be undertaken in March 2018 to confirm sustained implementation of actions to address GIAP recommendations and full implementation of those actions currently outlined as amber.

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

Core Area	Issue Raised / Action	Key Tasks	Director	PEOPLE & CULTURE COMMITTEE Blue Form Narrative	On-going Monitoring Arrangements	Update on Embededness - Oct 2017	RAG Rating
CORE 1 - REUNIFICATION OF THE HR AND ASSOCIATED FUNCTIONS							
HR1	The HR and OD departments should be under the management of one Executive Director	1) Recruitment of Director of Workforce, OD and culture 2) Job Description approved at Rem Com 3) Inform staff affected by the change 4) Formal recruitment to the post 5) Communicate the change to affected departments 6) Communicate the change to the organisation	P&OE	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.	Will be further reviewed by CQC and also monitored on an annual basis by the Board	Current arrangements with Amanda Rawlings acting as Interm Director of People and Organisational Effectiveness (joint post with DCHS) continues to be in place and is working successfully. A full time Deputy HR role has been appointed in September 2017.	**Green**
HR2	Ensure external resources for the newly appointed Director of Workforce, OD and Culture are obtained in order to drive the transformation of HR and related functions through a combination of coaching, buddying, and mentoring support	1) Develop and agree a plan which identifies additional resources to ensure successful delivery of HR, Workforce and OD GIAP actions 2) Deliver the Resource Plan	P&OE	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 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.	To be monitored by PCC and the Board	The new HR structure provides the resources and focus to ensure the Trust delivers on its people priorities. Additional capacity remains in place to support the delivery of the People Plan whilst thew new structure is being consulted on and approved.	**Green**
HR3	Undertake an exercise to update the model for HR. Utilising the model as a guide, expertise and best practice across the LHE, and beyond. As a priority the Trust should focus on establishing clear foundations, utilising key building blocks to create sustainability in the long term	1) In consultation with the team develop and deliver the new model for HR	P&OE	During 2016 some refinements to the HR and Workforce Team structure was undertaken which included the alignment of the Principle HR Managers to service areas. P&CC received a paper in June 2016 outlining a proposed future model for the function and it was agreed that more work should be undertaken to progress this to a full business case. During the summer of 2016 a national mandate was received regarding the focus on back office consolidation and rationalisation across the NHS. The Director of Workforce, OD and Culture left the Trust in August 2016 and the Trust entered into an agreement to work with DCHS to look at all the back office functions to look at sharing where appropriate. The Director of People and Organisational Effectiveness from DCHS joined the Trust in September 2016 as a shared director for both Trusts. In October 2016 P&CC received an HR Status report as assurance on how the staff in the structure where aligned to the organisation's key priorities and the plan for the structure going forward. In March 2017 the Finance and Performance Committee and Trust Board received a business case outlining a new shared service structure for the HR/Workforce team for DCHS/DHCFT hosted by DCHS. This was a phase 1 business case starting with the senior team restructure and shape of the future service. The Phase 2 business case is in development and will be presented in May/June 2017 for approval. Deloitte have reviewed the new model at the one to one meeting with the Director of People and Organisational Effectiveness held on 22 March 2017	As part of the new shared function each team has a detailed service specification and a set of KPI's that will be reviewed and monitored as part of the ongoing back office governance arrangements	A business case been developed and is open to consultatiton and approval for implementation October/November.	**Amber**

Core Area	Issue Raised / Action	Key Tasks	Director	PEOPLE & CULTURE COMMITTEE Blue Form Narrative	On-going Monitoring Arrangements	Update on Embededness - Oct 2017	RAG Rating
HR4	Define a new structure for HR and its related functions with a priority on operational efficiency and strategic impact taking into account the refreshed People Strategy and revised model for HR and related functions	1) Develop and implement a new structure for HR and its related functions with a priority on operational efficiency and strategic impact	P&OE	A revised HR model based on the one suggested by Deloitte was presented to P&CC in June 2016. The Committee acknowledged the paper and agreed a further paper would be presented to the Committee which set out additional detail. A further paper was discussed and approved by P&CC in July 2016, with an agreement that the team would progress as quickly as possible to embed the new way of working which resulted in the Principle HR and OD Managers being aligned to Service areas. In October 2016 P&CC received a paper with a proposed way forward for the function which included the additional capacity that the Trust had invested in to support the GIAP actions and for workforce supply – including both permanent and temporary resourcing. This paper provided assurance to the Committee that the resources of the team where aligned and focused on the organisation's priorities. The 2017 People Plan was presented to P&CC in January 2017 with the work programme for the year which has seven focus areas to meet the strategic needs of the Trust and each one has designated lead. In March 2017 the Finance & Performance Committee and Trust Board received a new structure for HR and Workforce which is progressing now to implementation. The structure is designed to provide increased value and efficiency for the Trust and has increased focus on the Trust's people priorities	The Trust People Performance report is presented to P&CC each month (part of annual Committee workplan) The recruitment progress report is presented to P&CC each month (part of annual Committee workplan) People Plan progress reports and deep dives are provided to P&CC each month and quarterly progress reports are submitted (part of annual Committee workplan). The service specifications for each team in the new HR structure and KPIs was agreed at ELT on 03.04.17, to be monitored through the back office governance	Phase 1 of the implementation of a new HR shared service has been approved and post holders identified. Phase 2 business case is progressng through the approval process during September ready for staff consultation and implementation during October/November. Service will underpin and further enhance the delivery of the people plan and the Trust priorities	Amber
HR5	As part of the development of the People strategy and developing the model for HR, the function should define how it measures and evaluates the impact of HR, particularly around securing organisational development. A clear set of metrics demonstrating the impact of the function should be a focus on the newly created People and Culture committee	1) Develop a suite of metrics to measure impact of interventions at an organisation and service line level 2) Develop an internal suite of metrics to measure functional effectiveness	P&OE	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 paper would include an outline of the SLA and customer charter. 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.	PCC to oversee the approval and delivery of the People Plan	The people metrics are a key part of the Integrated Performance Report and People Performance report which are reviewed at each Board meeting and PCC meeting. The People Plan delivery is reviewed at each PCC meeting with a deep dive into one of the six domains.	Green
CORE 2 - PEOPLE AND CULTURE							
PC1	The Trust should adopt an Organisational Development and Workforce Committee	1) Terms of Reference Developed 2) Terms of Reference approved by Board 3) First Committee meeting	P&OE	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. 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. 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.	At least annually the terms of reference will be reviewed and refreshed	The terms of reference for PCC are reviewed annually and the Chair and the Director of People and Organisational Effectiveness review on a regular basis membership and focus. the year end report of the Committee was preared and reviewed by the Audit and Risk Committee in May 2017. The terms of reference were approved by the Audit and Risk Committee in October 2017	Green

Core Area	Issue Raised / Action	Key Tasks	Director	PEOPLE & CULTURE COMMITTEE Blue Form Narrative	On-going Monitoring Arrangements	Update on Embededness - Oct 2017	RAG Rating
PC2	Develop and undertake a clear programme of work around culture, utilising the expertise of other NHS Trusts in the LHE, and where necessary beyond, to inform the programme of activities	1) Develop a programme of work against the delivery of the people strategy 2) Develop a clear plan which outlines an on-going focus on pulse surveys to enable targeted activity 3) Based on Pulse Checks develop a focused coaching within teams 4) Implement events focused on staff health and well-being 5) Ensure there is an agreed approach to extensively share good practice and innovation 6) Develop and implement a leadership development programme	P&OE	The initial People Strategy framework was presented to P&CC on 20.04.16. A survey was distributed to all staff asking them if we should refresh the Trust Values; the feedback of the survey was discussed at the Board Development Session on 11.05.16 and at P&CC in May 2016. Following feedback from the survey and other feedback from engagement events, it has been agreed that the Trust values will be refreshed and not rewritten. A revised People Plan was discussed and approved by the P&CC in July 2016. The Committee noted that the committee agenda would now reflect the plan. A paper outlining the engagement approach and plan was presented to P&CC in July 2016. The paper and the next steps were approved by the Committee. P&CC received an update report on engagement at the September 2016 meeting. Analysis was undertaken between June - November 2016 using data from previous staff surveys and staff family and friends' tests, plus interviews and meetings with different staff groups which identified a range of areas of focus. A Staff Engagement Group was established and has been in place since June 2016 and providing a voice of staff on the key issues impacting staff engagement. We have listened to staff members who attend and we are now looking to expand this group into a larger staff forum. We have explored what peer organisations had done to enhance their culture and staff engagement. The trust board received a paper in December 2016 on the NHSI tool kit and how we can utilise aspects of this tool kit. We are learning from their experiences and utilising the tools that will build on the work programme we have scoped. Additionally in the past few months the Trust has: Set an ambitious goal to be in the top 20% of NHS employers by 2020, refined our appraisal process and paperwork, developed and rolled out a range of Managing People courses for line Managers, implemented a weekly blog from Acting CEO Refreshed the People Plan and approved in January 2017 with seven key focus areas for 2017: Effective workforce planning /development to meet current and future patient needs, get the basics right, develop and embed a meaningful and effective appraisal process, increase the engagement and involvement of staff, support the wellbeing of our staff, effective and visible ;leadership, equalities, diversity and inclusion Identified our priorities for action from the 2016 Staff Survey: Employee voice, tools for the job, leadership engagement, staffing/resources We have launched a quarterly Pulse check March 2017 incorporating Staff Friends and Family questions. This was presented to the P&CC in January 2017. This links to the Engagement Strategy which presented an engagement proposal to work through teams using a Pioneer role. The Trust is now planning a Talent Management plan. A joint programme of work has now commenced with DCHS to develop a shared culture, vision and values for the future organisation.	Engagement Group will support and drive the ongoing work programme. The People and Culture Committee will oversee the progress of the work programme including the implementation of the People Plan and Staff Survey actions. The People and Culture Committee will receive the Pulse Check results quarterly at team level - 2017 staff survey results	The People Plan progress is monitored at each meeting with a deep dive into at least one of the six priorities at each meeting	Green
PC3	Supplement the current mechanisms to engage with staff through the inclusion of more informal activities across both clinical and corporate areas. Develop clearer reporting of information and trends from these activities in order to triangulate with other information, for example, through the CEO report and Quality Position Statement	1) Develop a comprehensive internal Comms plan, which clearly articulates engagement approaches both formal and informal 2) Develop a clear system to record feedback received from staff	C.A.	The CEO Report to Board has been enhanced to include more detail about staff engagement. This summarises feedback from staff and provides evidence of where action has been taken in response to this feedback. In May 2016 P&CC received an internal communications plan which was then further developed in line with the Engagement Plan and supported by setting up the Engagement Group. At June P&CC a revised report was presented which outlined the Comms approach to recording feedback. The Engagement Group provided feedback to July's P&CC on how the feedback would be used. A paper detailing how feedback would be monitored was presented to July P&CC. The system identifies common themes and priority areas which will be monitored by the Engagement Group and reported to the P&CC on a quarterly basis. A summary of engagement activity was presented to the Board Development session in September 2016. This included team meetings, attendance at Band 7 Development sessions Kingsway Campus; Medical Staff meetings and individual interviews with staff and Managers. Information from these meetings in 2016 is stored on Sharepoint (a platform for storing data) and collated into themes, which have been presented to the P&CC, and highlights were presented to the Board in September 2016 at a development session. The Engagement Group is in place and meets monthly. Examples of staff engagement plans being implemented include the staff survey and the 'Spotlight on our Leaders' events. A quarterly pulse check incorporating the staff Friends and Family questions starts end of February 2017, administered by Picker. This will enable us to continuously monitor improvement in staff engagement. This plan was presented to the P&CC in January 2017. The results of the pulse check will be presented to the People and Culture Committee in April 2017. This links to the Engagement Strategy which presented an engagement proposal to work through teams using a 'Pioneer' role. Volunteers from teams will work on action plans for the staff survey.	Engagement Group monthly meeting People and Culture Committee: Bi-monthly reporting	The Engagement Group and PCC track the progress in staff engagement. There are formal and informal ranges of communication now fully operatimg across the Trust. The Trust is implementating a staff forum to further enhance the employer voice and engagement and to help focus on the key things that matter to staff	Amber

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PC4	Prioritise the development of the People Strategy and ensure the agenda and focus of the newly formed People and Culture Committee is clearly aligned the Trust's overall strategy	1) Refresh People Strategy including reporting metrics 2) Ensure the people Strategy places greater emphasis at divisional and service lines to support our leaders to deliver the strategic objectives	P&OE	A draft People Strategy framework and plan was presented to P&CC on 20.4.16. The Committee acknowledged progress and discussed the draft documents, agreeing that the content was good, but that the People Plan (implementation) was not complete. A further revision was taken in June 2016 and the Committee requested a revised plan to be developed which would provide clarity on ownership of actions, clearly defined KPIs, timescales and deliverables and was finally approved at the P&CC in July 2016. The Revised People Plan was submitted to the January 2017 P&CC meeting and approved. This captures actions and priorities for 2017 P&CC agenda.	P&CC to receive People Plan progress reports by featured segments at each meeting – Standing item as outlined on Forward Plan. Quarterly update on progress on full People Plan to P&CC.	People Plan is a 12 month plan which was approved in January 2017. The performance report and pulse check enable PCC to see from a metric perspective the Trust's performance on the people agenda	**Green**
PC5	Undertake an exercise to refresh the Trust values. As part of this exercise engage with staff to ensure that values are meaningful and expected behaviours are clear. Prelaunch revised values across the Trust	1) HR and OD to undertake a review of the Trust values 2) Set a programme of engagement with staff to consultant on the refresh of the values 3) Ensure a comprehensive Comms plan in place to ensure values are visible across the Trust 4) HR and OD to undertake a refresh of the behavioural framework	P&OE	An externally facilitated Board Development session on Trust values took place and was discussed by ELT on 18.04.16. A Board discussion took place on 27.04.16 which focused on the feedback from the Board Development session and reflections on the Trust values. The Director of Workforce, OD, and Culture delivered a podcast to staff explaining this part of the GIAP. This has been supplemented with a Trust survey (via the intranet) to seek staff's views on whether the current Trust values are still valid, valid with small changes or whether a full re-write of them is required. Intranet survey results were discussed at the Board development session on 11.05.16. Results indicated that the majority of staff wished to retain the current Trust Values, but that these should be refreshed. A further update was presented to the P&CC in June 2016, noting that proactive communication was underway, ensuring that the refreshed Trust Values are referenced in all communications. The communications to staff around the Values was aligned to the new Trust Strategy, which was launched in July 2016. A Spotlight on Leaders event was held in July 2016. The Trust values are embedded in the recruitment process. The concept of the behavioural framework is not currently required; future cultural engagement work is required. The Trust has agreed to use the NHSI Collective Leadership and culture resource and is now costing options, which will be presented to the People and Culture Committee in February 2017. Revision of the values and behaviours will be reviewed as part of the joint development work with DCHS. Values are clearly linked into the new appraisal process and sessions have been running on all policies including appraisals from November 2016-February 2017 for all managers.	People and Culture Committee quarterly progress reporting. Quarterly Pulse Checks will provide monitoring of progress on staff engagement scores. Ongoing monitoring of implementation of staff values will be assessed via staff survey (annually) and pulse check by Picker (quarterly).	Values were reviewed and communicated across the Trust in 2016. The pulse check and staff survey enable the Trust to monitor progress on how staff and leaders are living the values	**Green**
PC6	Expand the current Chair and CEO reports to provide a greater depth of information regarding key priorities for stakeholder engagement, feedback provided and any barriers to progress	1) Chairman and CEO reports to include information about stakeholder engagement and feedback from commissioners	Act CEO	The CEO report to the Board has been enhanced to include more detailed information about stakeholder engagement and it now includes a detailed section called 'listen, learn, lead'. This summarises feedback from staff and provides evidence of where action has been taken in response to this feedback. The Trust Board confirmed its assurance on the delivery of Chair and CEO reports at the 27.04.16 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.	Board and COG papers and minutes	Each Board meeting has a standing item for Chair report (verbal) and CEO report (written), which includes updates on stakeholder engagement and feedback	**Green**
CORE 7 - HR AND OD							
	DR34- Define and agree a process to regularly monitor the consistent application of HR policies and procedures for the full range of Employee Relations cases **CQC 1** - The trust must ensure HR policies and procedures are followed and monitored for all staff	1) To undertake a review of HR policies and procedures to ensure all are in date and are compliant with expected HR practice 2) Develop an internal compliance monitoring process for HR policies and procedures including case management and tracking. This will be monitored by Trust Board and integrated into its performance reporting 3) A training programme on HR policies and process is designed, available and accessible	P&OE	**DR34** The Director of Workforce, OD and Culture met with internal audit during the week commencing 09.05.16. It was suggested that Internal Audit should review the Disciplinary and Health Attendance policies. Policy audit reviews were completed by our internal auditors, PWC; actions were identified and undertaken – detail of these can be seen in the PWC audit paper. In January 2017 the People and Culture Committee agreed that the PWC audit actions paper produced by the Principal Workforce and OD Manager (Garry Southall) provided assurance that this action is now complete. The paper detailed all actions, mitigations, progress to date and forward planning. The employment relations paper, also produced by Garry Southall, was submitted to the January People and Culture Committee. The Committee agreed that this also provided sufficient evidence of completion of actions WOD1 and WOD7 – the 'points to consider' section of the paper provides assurance that this action can now be signed off. **CQC1** A series of management development programme sessions have been implemented from November 2016 to train staff on implementation and adherence to HR policies and procedures. The Managing People Policy training took place from 14 November 2016 to 30 January 2017 with enough places for all of the relevant managers including contingencies where people were unable to attend for operational reasons. The programme consisted of six sessions covering the following policies and process:	**DR34** In order to monitor and ensure adherence to the ER Policies and Procedures the ER Case Tracker is the subject of a two weekly review meeting between Principal Workforce & OD Managers and the Director of People & Organisational Effectiveness. This meeting identifies any pinch points and discusses ways of taking complex cases forward. There is also regular review meeting between Principal Workforce & OD Managers and staff side colleagues. The meeting with Staff Side is paramount in ensuring policies are followed as Staff Side are often privy to information around this, therefore this acts as a monitoring process from both sides. A Principal Workforce & OD Manager attends ELT on a monthly basis to provide an overview of current and new cases and resolved cases. At the meeting any complex, overrunning cases and non-compliance are escalated upwards to the relevant Director. HR&OD will continue to work with Staff Side to review all employee related policies, and information will inform the review of grievance, dignity at work and disciplinary policies.	All policies have been reviewed, refreshed and are on a renewal tracker	

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WOD1		4) HR function to Audit compliance against two selected HR policies		• Health and attendance • Employee Improvement (capability) • Grievance and Dignity at Work • Recruitment and selection • Discipline • Appraisal (process) It was agreed at the January People and Culture Committee meeting that a blue form should be completed and submitted to the February 2017 Committee meeting.	**CQC1** In January 2017 work commenced with IT on a project to improve the mechanism for reporting Employee Relations cases. This system will be an enhancement on the current ER Tracker and will track the process of each stage in all ER cases. There will be access not only for Workforce & OD staff but also restricted access to track each stage of their relevant investigations. They will also be able to populate their investigations also. Therefore at any one time information on what stage the case is at, any complexities and whether process is being followed will be known. A Workforce & OD Working Group is set up to ensure the system covers everything that is necessary and it is anticipated that this will be complete by end of April 2017. At the end of each month a progress report will be produced and where timescales in accordance with the policy haven't been met; the manager be reminded than an exception report will need to be included. Another internal audit will be undertaken to review the benefits and adherence to policies towards the end of 2017.		**Green**
		5) Internal Audit review of control process and assurance to demonstrate sustained improvement in compliance levels	C.A.				
WOD2	The Trust should ensure that recruitment processes for all staff are transparent, open & adhere to relevant trust policies	1) Review and ensure that Trust recruitment and acting up policies are fit for purpose	P&OE	In November 2015 PWC completed an audit of HR recruitment processes. The audit looked at the recruitment process for clinical and medical staff. The outcome confirmed that general recruitment processes were considered to be operating effectively. A peer audit of the Acting Up Policy was presented to the People and Culture Committee in July 2016. As a result of the audit the acting up policy was revised to make the requirement for 'expression of interest' to be completed as part of the formal process. Adherence to the revised policy would ensure that the acting up process was transparent and open for staff. In order to check adherence to the revised policy a second audit using the electronic staff record as the data source was undertaken in January 2017. The audit focused on staff that were in acting up positions as at 31 December 2016. 52 employees in total were identified as 'acting up' as at 31 December 2016. Of these, eight employees were identified as 'new acting up' cases during October to December 2016. These new cases of acting up would be based on the revised policy following the new process. The sample selected was checked whether the 'expression of interest' process had been followed. The audit revealed that the sample selected followed the process which included trust wide expressions of interest via weekly Connect email and also appeared on the Connect website as expressions of interest. This confirmed that the recruitment process for staff was transparent and open and that the policy had been adhered to. In order to ensure future ongoing compliance to the trust policy a number of recommendations were agreed and included in the plan of work going forwards. These included ad-hoc audits during one of the Trust's formal annual internal / external audits.	The audit will be repeated to assess compliance, and will be included in the 2017/18 internal audit plan	The acting up policy is now embedded across the Trust and arrangements have been reviewed and refreshed in the policy. A review will be completed as part of the future audit process	**Amber**
		2) Agree a plan and deliver recruitment training to all appointing officers					
		3) Deliver a peer audit of recruitment policies compliance to demonstrate improvement					
WOD3	Address the relationship issues identified within the function, and alongside this agree a development programme for HR and its related functions that starts by building relationships at a senior level before seeking to develop an effective and efficient function	1) Develop and implement an HR and related function Development programme, which includes building good working relationships	P&OE	A high-level paper outlining the development for the HR team was presented to P&CC in May 2016, which outlined the approach and broad areas of development for the HR team. A new InterimDirector of People and Organisational Effectiveness joined the Trust in September 2016 and has brought the whole of the team together. There was an away day was held in October 2016 which gave the team space to talk through the challenges of the past and to discuss the way forward. The legacy employee relations in the team when resolved in January 2017. Senior team meetings are in place plus monthly operational meetings which provide direction and cohesion to the team. January 2017 P&CC agreed this action can be reviewed in February 2017 and signed off.	On-going monitoring via programme of weekly senior/operational meetings.	The senior team members of the HR team meet weekly and there is a monthly operations meeting. Working relationships across the team are strong and positive	**Green**
		2) Implement Development Programme					

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WOD4	As part of its review programme, the Trust may wish to consider a mandatory programme for line managers in order to embed the revised policies and procedures	1) A training programme on HR policies and process is designed, available and accessible	P&OE	The post of Management Trainer was appointed to on 01.08.16. The training programme started in November 2016. Staffside had input on the comprehensive programme. The Managing People Policy Training took place from 14 November to 30 January 2017 with enough places for all of the relevant managers including contingencies where people were unable to attend for operational reasons. The programme consisted of six sessions covering the following policies and process: • Health and attendance • Employee Improvement (capability) • Grievance and dignity at Work • Recruitment and selection • Discipline • Appraisal (process). Staff-side were involved in the design process providing many of the scenario case studies and essential inputs into the challenges, traps and pitfalls section of the workshops and the job aids (provided for each policy). The requirement has been placed in the relevant managers' training passports and compliance monitored centrally by the training manager and as part of line management. All sessions had registers and these are captured on the training monitoring system. Evaluation forms have also been submitted and are recorded on the training monitoring system. The responses in the evaluation forms was very positive. Mop-up sessions are also being provided during February and March 2017 for those people who were unable to attend sessions between November 2016 and January 2017. At January 2017 P&CC the Committee agreed the preparation of a blue completion form to present evidence of assurance to the Committee so that they may assess completion of this recommendation.	P&CC updates on leadership training roll out. Leadership development strategy coming to P&CC in May 2017 will capture progress and next steps plan. Non-compliance will be dealt with additional training or through the capability process. Internal audit – potential for programme 2017/18	Leadership training has been rolled out across the Trust with ongoing mop up sessions and new leaders enrolled onto the programmes. Leadership development strategy is drafted and has been out to consultation for fine tuning	**Green**
WOD5	Consider a range of development interventions for the operational HR team to ensure employment law risks are mitigated	1) As part of the wider HR development programme (WOD3) deliver specific interventions on employment law	P&OE	As part of the wider HR development programme delivery of specific interventions on employment law are required. Employment Law Training for the Workforce and Organisational Development Team and Staffside was commissioned with Capsticks Solicitors and took place on 16 March 2017. The training session provided all attendees with an update on employment law including, TUPE, Equality Act, Flexible Working, Subject Access Requests and Disciplinary and Grievance. Members of the Workforce and Organisational Development Team and Staff Side colleagues had the opportunity to present questions to Capsticks to obtain advice and guidance on a range of employment law matters to ensure that employment legislation is adhered to and best practice is achieved. Further training sessions on managing sickness absence and on disciplinaries and grievances have been arranged as follows: • 29 March 2017 at 12.30 pm in Meeting Room 14, Kingsway House, Kingsway Hospital - Equality Act and managing sickness absence • 10 April 2017 at 1pm in Meeting Room 2, Albany House, Kingsway Hospital - Disciplinary and Grievances	Monitoring arrangements will be undertaken through the Workforce Policy Review Group, which is a structured mechanism for the review and development of workforce policies in accordance with employment legislation. This allows for Managers, Workforce Managers and staff side representatives to discuss and review any areas of learning from past cases. The Workforce and OD Team ensure Group and 1:1 Supervision sessions take place on a regular basis which allows for reflection, support and development to be provided regarding case management. A monthly case review meeting provides a further opportunity for staff side representatives and Workforce and OD Managers to collectively discuss ongoing cases in accordance with policy and employment legislation with the opportunity to monitor adherence to policies across the Trust.Further training sessions: • 29 March 2017 at 12.30 pm in Meeting Room 14, Kingsway House, Kingsway Hospital - Equality Act and managing sickness absence • 10 April 2017 at 1pm in Meeting Room 2, Albany House, Kingsway Hospital - Disciplinary and Grievances Ongoing briefings received from Capsticks and other legal advisors. Circulation of information from Healthcare People Management organisation, to which the Trust is registered.	Many of the HR team members have completed the employment law training. The team are members of the HPMA, including national conferences, and have engaged in a range of development opportunties including national conference. Team members are acitvely encouraged to engage in development activities	**Green**
	Consider mechanisms to regularly seek feedback from the HR function on the extent to which the candour, openness, honesty, transparency and challenge to poor performance are the norm, e.g. through monthly pulse checks	1) Introduce a monthly pulse check for the HR team		A paper was delivered to the People and Culture Committee in May 2016 which outlined the approach and broad areas of development for the HR team. Using existing survey software already available to the Trust at no additional cost, a 'monthly' Workforce &OD Service Satisfaction & Improvement survey was created. The survey is run during the first week of every month and covers nature of query, service received rating and a free text section for comments/compliments and suggestions for improvement. The survey link is sent to a sample of employees who have made contact with the Workforce & OD team either by telephone, email, in writing or in person during the survey week. Employees then complete and submit the survey should they wish to. The first monthly survey ran from 6 to 10 March 2017 and the results were reviewed at the following senior team meeting. The survey continues to be run during the first week of every month. To further ensure that mechanisms are in place to regularly seek feedback from the HR function on the extent to	'Monthly' and ongoing 'anytime' Workforce &OD Service Satisfaction & Improvement survey (runs first week of each month) reviewed at Workforce and OD team meetings Results from quarterly pulse checks will be analysed for the HR function and reviewed by the Executive Director Feedback route to Margaret Gildea (Senior Independent Director) as required	An initial one off survey was completed now the team are part of the Trust staff survey and pulse check cycle.	

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WOD6		2) Implement Integrated team meetings	P&OE	which the candour, openness, honesty, transparency and challenge to poor performance are the norm, an additional 'anytime' Workforce &OD Service Satisfaction & Improvement survey has been created and embedded within the W&OD web page on Connect. The 'anytime' survey covers the same questions as the monthly survey, i.e. nature of query, service received rating and a free text section for comments/compliments and suggestions for improvement. The 'anytime' survey is available for staff to complete 24 hours a day, 7 days a week, 365 days a year. The 'anytime' survey results will be reviewed quarterly at the W&OD senior team meeting and run alongside the proactive monthly survey			**Green**
WOD7	The Trust should monitor the adherence to the grievance, disciplinary, whistle-blowing policies and the current backlog of cases concluded	1) Implement a proactive system which monitors adherence to the grievance, disciplinary, whistle-blowing policies, including a robust case tracking system 2) Internal audit compliance against named policies and the defined timescales against cases identified on the tracker 3) Ensure the backlog of cases made known to the CQC at the time of the inspection are concluded	P&OE	The Interim Director of Workforce, OD and Culture met with internal audit during the week commencing 09.05.16. It was suggested that Internal Audit should review the Disciplinary and Health Attendance policies. Policy audit reviews were completed by our internal auditors, PWC; actions were identified and undertaken – details of these can be seen in the PWC audit paper. In January 2017 the People and Culture Committee agreed that the PWC audit actions paper produced by the Principal Workforce and OD Manager (Garry Southall) provided assurance that this action is now complete. The paper detailed all actions, mitigations, progress to date and forward planning. The employment relations paper, also produced by Garry Southall, was submitted to the January People and Culture Committee. The Committee agreed that this also provided sufficient evidence of completion of actions WOD1 and WOD7 – the 'points to consider' section of the paper provides assurance that this action can now be signed off. A series of management development programme sessions have been implemented from November 2016 to train staff on implementation and adherence to HR policies and procedures. A report on activity against the Trust Raising Concerns (whistleblowing) policy has been presented to the Audit and Risk committee May 2016 and December 2016 and is scheduled for reporting on a six monthly basis. It was agreed at the January People and Culture Committee meeting that a blue form should be completed and submitted to the February Committee meeting.	In order to monitor and ensure adherence to the ER Policies and Procedures the ER Case Tracker is the subject of a two weekly review meeting between Principal Workforce & OD Managers and the Director of People & Organisational Effectiveness. This meeting identifies any pinch points and discusses ways of taking complex cases forward. There is also regular review meeting between Principal Workforce & OD Managers and staff side colleagues. The meeting with Staff Side is paramount in ensuring policies are followed as Staff Side are often privy to information around this, therefore this acts as a monitoring process from both sides. A Principal Workforce & OD Manager attends ELT on a monthly basis to provide an overview of current and new cases and resolved cases. At the meeting any complex, overrunning cases and non-compliance are escalated upwards to the relevant Director. HR&OD will continue to work with Staff Side to review all employee related policies, and information will inform the review of grievance, dignity at work and disciplinary policies. In January 2017 work commenced with IT on a project to improve the mechanism for reporting Employee Relations cases. This system will be an enhancement on the current ER Tracker and will track the process of each stage in all ER cases. There will be access not only for Workforce & OD staff but also restricted access to track each stage of their relevant investigations. They will also be able to populate their investigations also. Therefore at any one time information on what stage the case is at, any complexities and whether process is being followed will be known. A Workforce & OD Working Group is set up to ensure the system covers everything that is necessary and it is anticipated that this will be complete by end of April 2017. At the end of each month a progress report will be produced and where timescales in accordance with the policy haven't been met; the manager be reminded than an exception report will need to be included. Another internal audit will be undertaken to review the benefits and adherence to policies will be undertaken towards the end of 2017	The complex HR cases are overseen by the Director of People & OE and reviewed monthly with the Executive Leadership Team. Independent support has been brought into identify ways to unblock and move things forward where appropriate. A Spotlight on Leaders event was held in September focussing on Employee Relations including case review and lessons learned. The backlog of cases referred to in the orignal GIAP action are all now concluded.	**Amber**

Core Area	Issue Raised / Action	Key Tasks	Director	PEOPLE & CULTURE COMMITTEE Blue Form Narrative	On-going Monitoring Arrangements	Update on Embededness - Oct 2017	RAG Rating
WOD8	The Trust should continue to make improvements in staff engagement and communication	1) Develop a clear staff engagement plan that takes account of listen, learn and lead, wider open staff forums and enhances existing good practice 2) Publish and implement agreed engagement plan 3) Monitor delivery of the plan at P&C Committee using feedback mechanisms such as pulse checks and staff survey	P&OE	The approach and direction, as outlined in the Engagement & Culture Plan was presented to the Board in December 2016; this was discussed and agreed at the Board and People and Culture Committee. The Engagement Group meets monthly. At January 2017 P&CC the Committee agreed the preparation of a blue completion form to present evidence and assurance to the Committee so that they could assess that this action is complete. A number of improvements have been made, and continue to be made, to staff communication. The Acting Chief Executive now sends a weekly message to all staff, which he personally writes, outlining his work during the preceding week; this has given staff a greater insight into the work of the executive team and has resulted in many staff responding and engaging with the Acting Chief Executive. A Trust Management Team meeting now takes place once every two weeks to bring together clinical and operational leadership from across the Trust. The group has made a commitment to cascade information and key messages down through service lines. A Trust staff app has been introduced, which staff can download on their personal smartphones to read latest news, access the e-rostering system and find useful contact numbers (such as for the Workforce team or the 24-hour employee assistance programme). 450 staff have downloaded the app, which particularly aims to support staff without regular access to a computer during working hours. The Trust's monthly corporate video message to staff, the 'team talk', has been revised and is now in the form of an interview, with a staff representative putting questions to a director. This provides a new outlet for staff at all levels to challenge the executive team and encourage dialogue about issues that matter to them. In a staff survey in the summer of 2016, 71% of respondents said that Trust-wide communications were either 'good' or 'very good'. We are continuing to refine the corporate communications channels and approach to ensure this figure continues to increase. The corporate Communications team also manages the ongoing staff recognition scheme, the DEED scheme, which has continued to grow in popularity since its launch in 2015. The scheme had its most successful period to date in January and February 2017 with 43 nominations submitted by staff (and a small number of members of the public) for individual employees and Trust teams who had delivered excellence in their roles. This reflects staff's growing willingness to praise colleagues who demonstrate the Trust values, while feedback from individuals who have been nominated suggests that they feel very positively about this recognition. We will continuously improve staff engagement energy and well-being increasing the positive pulse check year on year. A new quarterly pulse check starts end of February 2017. NHS Staff survey action plans are being developed through teams. These will be overseen by the Engagement Group and will feed directly into the People and Culture Committee. A new quarterly pulse check will start in February 2017, administered by Picker.	People and Culture Committee bi-monthly reporting on progress with Engagement Plan. Engagement group monthly meetings. We will continuously improve staff engagement energy and well-being increasing the positive pulse check year on year. A new quarterly pulse check starts at the end of February 2017 and the findings will be reported quarterly from April 2017 to People and Culture Committee meeting. NHS Staff survey action plans are being developed through teams. Once in place they will also be monitored through the Trust Management Team meeting	The Engagement Group and PCC track the progress in staff engagement. There are formal and informal ranges of communication now fully operating across the Trust. The Trust is implementing a staff forum to further enhance employer voice and engagement and to help focus on the key things that matter to staff (see PC3)	**Amber**

Core Area	Issue Raised / Action	Key Tasks	Director	PEOPLE & CULTURE COMMITTEE Blue Form Narrative	On-going Monitoring Arrangements	Update on Embededness - Oct 2017	RAG Rating
CORE 8 - RAISING CONCERNS AT WORK							
RC1	As part of the Trust's Well Led Self assessment we identified the need to take further action around the recommendations from the Francis report relating to whistleblowing in order that staff, patients and stakeholders feel confident to raise concerns	1) Freedom to speak up action plan will be refreshed and approved 2) Freedom to Speak up action plan will be delivered and monitored through the People and Culture Committee	C.A.	In February 2015, Robert Francis QC published his report on the 'Freedom to Speak Up' review into whistleblowing in the NHS. The report sets out 20 Principles and Actions which when implemented, aim to create the right conditions for NHS staff to speak up, share what works across the NHS, and get all organisations up to the standard of the best, and provide redress when things go wrong in the future. The Freedom to Speak up action plan was set up by the Trust in March 2015 and has been reviewed by the Quality Committee, The Board (June 2015) Executive Leadership Team in January 2016 and by the People and Culture Committee in March, May, June and September 2016. The May 2016 P&CC Committee received limited assurance on the plan and as such the Committee received an updated Freedom to speak up / Raising Concerns action plan in June, which had been updated in line with comments received the previous month by the Committee. The Committee received positive assurance and agreed that the plan would be added to the Committee's forward plan for quarterly update. The national Raising Concerns (Whistleblowing) Policy was published on 01.04.16. The Trust's existing Raising Concerns (Whistleblowing) policy was reviewed and confirmed to encompass all required elements and was therefore fit for purpose. This policy was updated and reissued with name contact in key roles including Freedom to Speak Up Guardian, Executive Lead, Non-Executive Director Lead, Chief Executive, staff governors and external routes. A podcast outlining the Trust's approach to Raising Concerns was issued in June 2016 to ensure staff awareness alongside coverage in staff Connect. A further podcast was issued on 6 March 2017. In addition, reports on Raising Concerns (Whistleblowing) are presented every six months to the Audit and Risk Committee to provide assurance and opportunity for scrutiny on the robustness of the implementation of the policy and related processes. Results of the Staff Survey as available from March 2017 will be reviewed to inform future work on this issue, which will be taken forwards as business as usual by the People and Culture Committee. The results show that there is further work to be undertaken to understand staff responses and build confidence in the raising concerns process. The Trust has undertaken a range of actions to implement the recommendations and has established a clear regular oversight role for the PCC on this issue. Much work has already been completed and embedded and there is further improvement planned. Raising concerns will be explored as part of the wider Culture and Engagement agenda being undertaken by the Trust to ensure that we build a supportive culture.	Further updates on the Freedom to Speak up/Raising Concerns action plan will be scheduled for for review as part of the 2017/18 P&CC work plan Actions to address the Raising Concerns elements of the Staff Survey Results to be monitored and implemented as part of Culture and Engagement work to address outcomes from staff survey (regular reporting to People and Culture Committee)	An update on the Freedom to Speak up/Raising Concerns action plan was presented to PCC in March 2017. It was agreed that actions from the Freedom to Speak up action plan now form part of business as usual for the Trust. The Trust continues to implement its Raising Concerns policy and six monthly monitoring is in place to the Audit and Risk Committee to ensure robustness of the process. Discussions at March PCC agreed that Freedom to Speak up/Raising Concerns actions were complete. An update report on implementaiton of the Raising Concerns policy was presented to the Audit and Risk Committee in July 2017.	**Green**

Audit & Risk Committee

Core Area	Issue Raised / Action	Key Tasks	Director	AUDIT & RISK COM Blue Form Narrative	On-Going Monitoring Arrangements	Update on Embeddedness Oct 2017	RAG Rating
CORE 4 - CORPORATE GOVERNANCE							
CorpG1	The Trust should consider how its governance arrangements could better match its strategy and plans	1) Develop and approve a Corporate Governance Framework which supports the delivery of the Trust strategy ensuring that the Board of Directors and Board Committee agendas adequately reflect the strategic objectives of the Trust	CA	The Corporate Governance Framework which supports the delivery of the Trust's Strategy was noted as complete by the Board of Directors on 27 July 2016. This followed input from the full Board at a Board Development Session in May and further consideration by the Audit and Risk Committee at its June meeting. Terms of reference of all Board Committees were reviewed as part of the Corporate Governance Framework considered by the Board in July 2016 and include reference to the role of each Committee to deliver the Trust's strategic objectives. Full use of Board/Committee cover sheets was reiterated to all Board/Committee paper authors in November/December 2016 to reference the relevant Trust strategic objective(s) and to make the strategic link clear. An audit of use of cover sheets including reference to the link to appropriate strategic objectives was undertaken in March 2017 and confirmed that almost all cover sheets submitted to the previous month's Committees included this element of the cover sheet. Those authors who did not use the cover sheets correctly were contacted directly to ensure this was remedied in future reports.	Annual review of Terms of Reference (part of each Committee's work plan) Year-end reports (annual requirement for all Committees) to reference delivery of strategic objectives as key element of the report	Annual review of Terms of Reference carried out for each Committee. Review of Corporate Governance Framework, including all Terms of Reference to be discussed at Audit & Risk Committee on 3 October 2017 and Trust Board on 1 November 2017. Mental Health Act Commitee and Safeguarding Commitee are undergoing further review and will be presented to 29 November 2017 Board. All Terms of Reference now include the requirement to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit. Year end reports were completed for all Committees for 2016/17 and submitted to the Audit & Risk Committee and the Trust Board. Year end reports to be compiled March/April 2018 will reference delivery of strategic objectives as part of measuring the effectiveness of the terms of reference. Annual production of year end reports and review of Terms of Reference are both standard items in Committee forward plans. Cover sheets continue to be completed on an ongoing basis including identification of relevant strategic objectives for agenda items.	**Green**
CorpG2	The Governance Framework should be updated to give greater clarity regarding roles of key individuals and governance forums, including: all EDs, the SID and Vice Chair, PCOG, QLTs and the Safeguarding Committee	1) Develop and approve a Corporate Governance Framework	CA	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 QLTs and PCOG 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).	Terms of Reference within the Corporate Governance Framework are subject to annual review Work plans are a standing agenda item at every Board Committee meeting	The Corporate Governance Framework has been refreshed during July/August 2017 and reported to Audit & Risk Committee on 3 October 2017, scheduled for Board review on 1 November 2017.	**Green**

Core Area	Issue Raised / Action	Key Tasks	Director	AUDIT & RISK COM Blue Form Narrative	On-Going Monitoring Arrangements	Update on Embeddedness Oct 2017	RAG Rating
CorpG3	The Board and its committees need to have a greater focus on capturing, recording and holding to account for agreed actions	1) Board Development programme to be updated to include a session on holding to account which will include holding to account for agreed actions. 2) Ensure a fit for purpose action log process is in place ensuring that the Board and Board committee action trackers are revised so that all actions captured have a clear close date, 'current position' and 'status of action'; and that RAG ratings are more clearly utilised to demonstrate progress	CA	The Board Development programme was approved by the Board in March 2016 which included a session on Holding to Account. The session was delivered on 13 July 2016 by an external facilitator, Deloitte, and covered; the role of Board members, holding to account and the effectiveness of Board and its committees. The Director of Corporate Affairs reviewed the Trust's action logs and discussed the current process with ELT and with the Board at the May 2016 Board Development Session. Target completion dates are now added to the actions agreed and there has been increased focus on summarising agreed actions and clarifying action owners at the end of each agenda item. Action logs from all Board Committees and the Board itself are a standing agenda item monthly on ELT for review, update and holding to account by the Executive Team. It has been reiterated to the Board Secretary and other regular minute takers for meetings within the Trust to focus on accurate capture of actions and related discussions and to prompt chairs when key detail (e.g. target date, lead officer) is not clear. The percentage of status of actions Board and Board Committees has been included in actions logs from November 2016 – to highlight performance in terms of actions complete, outstanding, or scheduled for a future date. This information is used by Committee chairs to inform their overall management of actions. This action was reviewed by Deloitte in their Phase 1 September 2016 report and it was noted that 'timely steps were taken by the Trust to address the process issues associated with the initial recommendation'. Discussions at the Board Committee chairs meetings held on 16 November 2016 and 8 February 2017 noted the comments in the Deloitte Phase 1 report regarding further potential improvement and discussed the issue of ensuring that actions are not deemed complete until there is evidence that these are fully addressed and where necessary revised process is embedded. To ensure that actions rated as complete and transferred to business as usual, reviews may be added to forward plans of the respective Committees to provide assurance of this at a future date. Holding to account and thorough review of actions (both in clearly setting these, allocating a lead and appropriate timeline) and in ensuring those noted as complete are scrutinised as being so have been reiterated as a key part of the effective chairing role. This was discussed at the Board Committee Chairs meeting held on 8 February 2017. An audit and peer informal observation of Board and Board Committee meetings was undertaken during December-March with feedback provided to Board Chair/Committee chairs. This included a focus on management of actions. Each Committee will consider the output from the observation and identify further actions for improvement in practice as appropriate as part of their work plans for 2017/18.	Review as part of annual effectiveness review of Committees ELT monthly review of action log – Standing agenda item The percentage of actions completed on the in actions logs is reviewed at each Committee/Board meeting	Review of annual effectiveness of committees to include analysis of percentage of actions completed for each meeting. ELT continues to review monthly the integrated actions matrix which incorporates actions from Board and all Board Committees. Guidance document to Board Chairs on effective chair of meetings includes focus on ensuring scrutiny of actions designated complete, challenge on incomplete or overdue actions and accurate capture of actions agreed. Cross-committee actions are overseen by the Quarterly Board Committee Chairs Meeting.	Green

Core Area	Issue Raised / Action	Key Tasks	Director	AUDIT & RISK COM Blue Form Narrative	On-Going Monitoring Arrangements	Update on Embeddedness Oct 2017	RAG Rating
CorpG4	Review the operation of all committees seeking to minimise duplication, revising membership, ensuring a focus on capturing and tracking actions, and increasing contribution to the debate. -a review of forward plans against ToR to ensure clarity of purpose -minimise duplication of papers -committee chairs should also meet quarterly to ensure effective co-working -ensure robust attendance of all key EDs at committee meetings -ensure a consistent focus on summarising debate and capturing actions (feedback on this should be sought in annual effectiveness reviews) -review appropriateness of membership and provide a focus on members and attendees contributing equitably and effectively -timely submission of papers and consistent use over cover sheets	1) Undertake a comprehensive review of the Board Committee structures including TOR 2) Arrange for Committee Chairs to meet on a quarterly basis 3) Review ED attendance at Committees 4) Review the minutes of the Board and Board Committees and consider the use of action notes as a more effect way of recording debate and actions 5) Embed a process for the yearly review of the effectiveness of Board Committee against TOR	CA	The review of Executive Directors' attendance at Board Committees was discussed at ELT in March 2016 and the revised attendance of EDs at Board Committees was incorporated into the 2016/17 terms of reference of each Committee. Board Committee chairs at their 5 October meeting further reviewed Executive Director attendance and NED attendance from November 2016 across Committees as part of a review of portfolios. This was further reviewed in December 2016 following appointment of new NEDs and the Acting Trust Chair. Committee chairs met on 5 October 2016 with discussions including review of the meetings/governance schedule, review of Board member attendance at Committees, review of actions between Board Committees and review of NED Committee chair roles. They also reviewed recommendations from the Deloitte Phase 1 (September 2016) report. The second meeting held on16 November 2016 reviewed annual forward plans, further review of actions between Committees and review of Committee Assurance Summaries. A further meeting was held on 8 February 2017 where the role of Committee chairs, intra-committee working, duplication of papers/topics and general intelligence was discussed. A yearly review of effectiveness is included in all terms of reference. These year-end reviews were completed for all Committees for 2015/16 and reviewed by the Audit and Risk Committee in July 2016. All Committees are currently preparing their reviews for 2016/17 during March for submission to the April 2017 Audit and Risk Committee. Forward plans for all Committees have been in place during 2016/17 and these are being developed for 2017/18. These are based on the agreed terms of reference for the Committees. Attendance logs for all members and key attendees of Committees have been routinely included in Committee papers from December 2016. A year end summary will also be published in the Trust's Annual Report and Accounts. Committee chairs have agreed to add expected attendance thresholds for both NEDs and EDs at Committees in the terms of reference being reviewed in March 2017. A report on the consistent use of cover sheets has been conducted (March 2017) and individual reports where the cover sheet has not been fully used have been contacted to ensure this is rectified for future reports. An audit and peer informal observation of the Board and Board Committee meetings was undertaken during December 2016-March 2017 with feedback provided to Board Chair/Committee chairs. This included a focus on management of actions, contribution of members and submission of papers. Each Committee will consider the output from the observation and identify further actions for improvement in practice as appropriate as part of their work plans for 2017/18.	Annual effectiveness review of Committees is part of all Committee work plans and are scrutinised by Audit and Risk Committee Ongoing attendance logs as standing item on all Committees Action plans arising from observations to be monitored by each Committee during 2017/18	Annual Effectviness review of Committees reviewed by Audit Committee on 27 April 2017 and this included review of members' attendance. Further review of Director attendance at Board Committees issued June 2017. Terms of Reference updated to reflect minimum attendance requirement of members. Review of Terms of Reference included review of membership and other attendees. Committee Chairs continue to meet quarterly (meetings held 2 May and 26 September). Forward plans have been developed in 2017 and are based on the agreed Terms of Reference for the Committees. Meeting effectiveness is reviewed as a standing item on each Board and Board Committee agenda to capture areas of positive practice, report content, scrutiny, challenge, debate and areas for further development. Duplication of work of various Board Committees is evalauted as part of the Board Effectiveness Survey. Latest results for survey undertaken in March 2017 indicate that 60% of Board members agree or strongly agree that there is minimal duplication. Committee Chairs are clear that should any duplication arise this is flagged at the time and redressed. Duplication continues to be discussed as a standing item at quarterly Board Committee Chairs meetings. The Board Effectiveness Survey, conducted in March 2017, evidenced that 100% of Board members considered that after a decision had been made by the Board it is clear who is responsible for implementing it and by when.	Green

Core Area	Issue Raised / Action	Key Tasks	Director	AUDIT & RISK COM Blue Form Narrative	On-Going Monitoring Arrangements	Update on Embeddedness Oct 2017	RAG Rating
CorpG5	Undertake a review of the Finance and Performance Committee outlined below -a review of forward plans against ToR to ensure clarity of purpose; -minimise duplication of papers; -committee chairs should also meet quarterly to ensure effective co-working; -ensure robust attendance of all key EDs at committee meetings; -ensure a consistent focus on summarising debate and capturing actions. (feedback on this should be sought in annual effectiveness reviews); -review appropriateness of membership and provide a focus on members and attendees contributing equitably and effectively; and -timely submission of papers and consistent use over cover sheets	1)Undertake a comprehensive review of the Committee aligned to the TOR of the Committee 2) Finance and Performance Forward Plan approved by F&P 3) Embed a process for the yearly review of the effectiveness of Board Committee against TOR	CA	The Finance and Performance Committee reviewed their Terms of Reference in March 2016 and these were also considered by the Director of Corporate Affairs as part of the refresh of the Governance Framework from May-June 2016. In addition the Committee has an agreed annual work plan, aligned to its terms of reference, which has been implemented successfully during 2016/17. The Committee Chair has taken an active role in Board Committee Chairs meetings since his appointment in November 2016. These meetings have focussed on scrutiny, challenge, effective chairing skills, summarising debate, seeking to avoid duplication across Committee business and setting attendance levels. It has been relayed to the Board Secretary and other regular minute takers for meetings within the Trust to focus on accurate capture of actions, debate and related discussions and to prompt chairs when key detail is not clear. This recommendation was one of the actions reviewed by Deloitte in September 2016. Following feedback on the report, the Committee considered the challenge in terms of how strongly it is assured that challenge and debate is robust and effective and how has this improved in the last six months. Committee members considered examples of where challenge has brought about change. Finally, the Committee considered and confirmed that it was satisfied that agenda items are afforded sufficient debate and scrutiny from all members and key attendees. It was agreed that further evidence of the impact and results of those challenges should be given to F&P in future. The Committee agreed that they were satisfied with the level of scrutiny and debate undertaken at the Committee. Membership of the Committee was reviewed and amended. Attendance grids are now included in all Committee papers (from November 2016). The year-end report as submitted to the Committee in January 2017 noted the GIAP recommendations and the peer review comments and the Committee confirmed that they were satisfied with the progress as outlined. In order to seek assurance that best practice was embedded an audit and peer informal observation of the Committee was undertaken during December-March with feedback provided to the Executive Lead and Committee chair. The Committee will consider the output from the observation and identify further actions for improvement in practice as appropriate as part of their work plans for 2017/18.	Annual effectiveness review of the Committee – To be reviewed by the Audit and Risk Committee in April 2016 Forward plan for 2017/18 to be presented to the April 2017 Committee meeting Output from informal peer observation to be discussed at April 2017 Committee meeting and action plans arising to be monitored by each Committee during 2017/18 as part of ongoing business	Finance and Performance Committee GIAP actions are GREEN: Deloitte's follow up report in April 2017 provided independent confirmation: 'There is good evidence to suggest the committee has implemented our previous recommendations and has closely monitored the embeddedness of these through its routine self-assessments'. The F&P agenda was reviewed and updated appropriately, the TOR were appropriately reviewed, the length of agenda and quality of papers are good. There is clear summarisation of actions and assurance at the end of each item. All items are afforded sufficient debate from all attendees.	Green

Core Area	Issue Raised / Action	Key Tasks	Director	AUDIT & RISK COM Blue Form Narrative	On-Going Monitoring Arrangements	Update on Embeddedness Oct 2017	RAG Rating
CorpG6	The Audit Committee should reaffirm its role in seeking assurance over systems, controls and processes and not matters of operational or managerial detail	1) Ensure processes are in place for Audit Committee to undertake a review of its effectiveness 2) Review reporting and monitoring process to ensure Audit Committee is receiving required assurance on systems, controls and processes 3) Review Audit committee TOR in line with best practice from across the NHS	CA	The Audit and Risk Committee reviewed its Terms of Reference in April 2016 and these were also considered by the Director of Corporate Affairs as part of the refresh of the Corporate Governance Framework in May-June 2016. In addition the Committee has reviewed and agreed a work plan, aligned to its terms of reference, and which has been implemented successfully throughout 2016/17. The Committee undertook a year-end review which was considered by the Committee in March 2016. The Audit and Risk Committee considers the annual effectiveness reviews from all the Committees of the Board. This was undertaken in July 2016 for 2015/16 Committee reviews and for 2017/18 reviews this is scheduled for April 2017. A review of meeting effectiveness as a standing item on each agenda gives the opportunity for reflection on appropriate focus of discussion or noting where there may be improvements made. Board Committee chairs at their quarterly meetings have considered areas of good practice for committee chairing including ensuring appropriate focus of all Board Committees on assurance, and reaffirming that it is not the remit of Board Committees to cover operational detail. An audit and peer informal observation of Board and Board Committee meetings was undertaken during December-March with feedback provided to Board Chair/Committee chairs and relevant Executive Director leads. Each Committee will consider the output from the observation and identify further actions for improvement in practice as appropriate as part of their work plans for 2017/18.	Refreshed terms of reference – On forward plan for April 2017 Forward plan for the Committee 2017/18 – On forward plan for April 2017 Output from informal peer observation to be discussed at April Committee meeting and actions arising to be implemented during 2017/18 as part of ongoing business Review of self-assessment outcomes from the Audit Committee survey, March 2017 Audit and Risk Committee to review overall peer observation feedback and action plans in overall oversight role (provisionally scheduled for May 2017) Review of meeting effectiveness – Standing item at each meeting Year-end review of Committee effectiveness scheduled for April 2017	Terms of Reference and year end effectiveness review of the committee were reviewed and agreed along with forward plan for the Committee in April 2017. Self assessment outcomes reviewed and used to inform Committee objectives for 2017/18. Actions arising from informal peer observation have been addressed in the amended terms of reference, review of cover sheets and guidance issued to chairs. Meeting effectiveness continues to be a standing item at each meeting.	Green

Core Area	Issue Raised / Action	Key Tasks	Director	AUDIT & RISK COM Blue Form Narrative	On-Going Monitoring Arrangements	Update on Embeddedness Oct 2017	RAG Rating
CorpG7	In light of the changing governance and accountability structures (such as neighbourhoods, campuses and QLTs), an accountability framework should be designed to fully engage staff in how these changes will affect ways of working, performance management structures and desired behaviours moving forward	1) Aligned to the Corporate Governance Framework develop and approve an organisational accountability framework 2) Develop and fully engage senior staff in an accountability framework which should define: •the values, behaviours and culture to be role modelled by senior management; •roles and responsibility of key divisional leaders, including delegated authorities and duties; •expectations of performance; and •mechanisms to be used for holding to account both by EDs and within divisions.	Act COO	This recommendation relates to the alignment of the Trust's Accountability Framework to the Trust's revised Corporate Governance Framework (as approved by the Board in July 2016). A review of the former structure was undertaken by the Executive Leadership Team and the Senior Leadership Team (SLT) which identified that a new structure was required. An Accountability Framework has subsequently been developed and approved in the confidential session of the Trust Board meeting held on 2 November 2016. The Trust Management Team (TMT) has been in operation since January 2017 and has a pivotal role in the Accountability Framework. The Team oversees a range of operational and performance areas and escalates issues and reports into the Executive Leadership Team following each meeting. At subsequent meetings on 27 February and 13 March, the detail of the governance structure sitting below the TMT was discussed. This was also discussed at the Quality Committee as part of the recommendation ClinG1, which also relates to the effective implementation of the Accountability Framework as TMT supports the Divisional leadership teams to develop fully into their roles of quality governance. In spring/summer TMT will have an annual planner which indicates when all TMT members will attend a performance management review, when a collective leadership model will present their progress against their area plan on a page and integrated priorities. This will be an integrated leadership slide pack/presentation and performance review, driving a shared quad or triumvirate collective model of accountability and exception reporting against agreed quality governance targets against the agreed plan on a page priorities. This includes a section on risk based issues that are determined at national or local level or generated by the clinical and operational front line. These proposals were presented and agreed at the Quality Committee in April as part of the update on progress against ClinG1. This included example Divisional Management Team's terms of reference to be replicated across all divisions.	Accountability Framework to be reviewed annually - this is included within the Trust Management Team's terms of reference A review of effectiveness of the Accountability Framework is listed for consideration as part of the internal audit programme for 2017/18 ELT to review effectiveness of TMT on a six monthly basis Assurance report to be presented to Quality Committee in September 2017	Accountability framework is scheduled for TMT review in November 2017. ELT review of effectiveness scheduled for October 2017. ELT have received minutes of TMT meetings and now an escalation summary (from September 2017) to identify and escalate performance and operational risks. TMT minutes/escalation summary are presented to Quality Committee. Schedule of divisional performance reviews commenced June 2017 and risks escalated to ELT via the escalation summary. Performance framework was developed in September 2017 and is undergoing discussion at relevant governance committees, scheduled to be presented to Trust Board October 2017.	Green

Core Area	Issue Raised / Action	Key Tasks	Director	AUDIT & RISK COM Blue Form Narrative	On-Going Monitoring Arrangements	Update on Embeddedness Oct 2017	RAG Rating
CorpG8	The Board needs to introduce an integrated performance report which encompasses key operational, quality, workforce and finance metrics	1) The Trust will revise the integrated performance report which will include: •key operational metrics •a workforce dashboard •the Quality Dashboard, updated to show the refreshed Quality Priorities •a finance dashboard •a summary of performance of groups to highlight any underlying themes	Act COO	This was agreed as complete by the Board of Directors in May 2016 and the integrated report has been presented to the Board and developed in response to feedback over recent months. It now provides a broad overview of Trust wide performance across four domains. Quality Indicators have continued to be developed during this time and it now recognised as a much broader quality section. In addition, the report was been reviewed during late 2016/early 2017 to ensure alignment to measures set out within the Single Oversight Framework. The Board of Directors agreed to further enhance the report for 2017/18. A Board Development Session has been scheduled for 12 April 2017 to explore how the report can be further developed to continue to support triangulation of information, clear focus on key risks and performance issues and ensure that it remains fit for purpose for the Board of Directors. Following discussion at the Trust Board meeting on 1 March it was agreed that the revised IPR for 2017/18 differentiated between level KPIs (national measures) and level 2 KPIs (those that provide a greater insight into the performance of a wider service portfolio). This will be addressed via Board Development and be in place for April 2017.	To be determined following review of the IPR IPR is standing Board agenda item	The integrated performance report continues to develop in line with ongoing feedback from Board members during Board meetings and the Board Development Session held on 12 April. The report now aligns to measures set out within the Single Oversight Framework. The executive summary is used to highlight key areas of each month's report and to triangulate information.	Green
CorpG9	Formalise the role of PCOG as a key forum in the Trust's governance structure	1) As part of the Governance Framework review the Trust will formalise the role of PCOG 2) Increasing ED attendance at PCOG 3) Improving the quality of minutes and action trackers and the timeliness of papers to this forum 4) Clarifying the role of PCOG in light of the move to neighbourhoods and campuses	Act COO	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	N/A	N/A	Grey
CorpG10	Further improve the function of the ELT by improving the timeliness of papers and quality of debate	1) Ensure ELT agenda focuses on agreed key priorities and items appropriately escalated through the Governance Structures. Agenda and papers will be circulated on a Thursday	Act CEO	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.	Annual review of effectiveness of ELT	Annual review of effectiveness of ELT undertaken in a facilitated development session held on 21 June 2017. Further development sessions are scheduled for ELT throughout 2017/18. ELT agendas are now themed by escalations/quality/finance/operational issues/workforce/strategy (from August 2017). Meeting effectiveness is reviewed as a standing item. Actions are robustly scrutinised and reviewed and Executive Directors held to account.	Green

Core Area	Issue Raised / Action	Key Tasks	Director	AUDIT & RISK COM Blue Form Narrative	On-Going Monitoring Arrangements	Update on Embeddedness Oct 2017	RAG Rating
CorpG11	The Board needs to address the quality of debate and dialogue, focussing on increasing contributions across all BMs, displaying greater leadership and vision, ensuring an appropriate balance between strategic and operational debate, and pushing for increased momentum around key issues	1) Ensure a Board development programme which is linked to the Trust Strategy	CA	A Board Development Programme was agreed in March 2016. This has been successfully implemented throughout 2016/17, including a refresh undertaken and overseen by the Remuneration and Appointments Committee in December 2016 to align the programme with current Trust priorities, challenges and strategy and to reflect new NED and ED appointments. The Board Forward Plan was approved in March 2016, including a balance of operational and strategic items. The Director of Corporate Affairs reviewed the Trust's action logs and discussed the current process with ELT and with the Board at the May Development Session. Target completion dates are now added to the actions agreed and there has been increased focus on summarising agreed actions and clarifying action owners at the end of each agenda item and holding Board members to account to delivery. This has ensured pace of delivery on priority issues. The Board Secretary and other regular minute takers for meetings within the Trust have been encouraged to ensure focus on accurate capture of actions and related discussions and to prompt chairs when key detail (e.g. target date, lead officer) is not clear. The percentage of each RAG status for Board actions has been included in actions logs from November 2016 – to highlight performance in terms of actions complete, outstanding, or scheduled for a future date. A process was agreed by the Remuneration and Appointments Committee regarding 360 appraisals for Board members. This focuses on effectiveness as a Board member and helps support identification of areas for development. For Executive Directors these are being undertaken during March 2017. The summary results are scheduled to be presented to the Remuneration and Appointments in Committee in May 2017. These 360 appraisals are undertaken for NEDs annually - aligned to their appointment with the Trust. Appraisal for the Interim Trust Chair was undertaken in November/December 2016 and this was considered by the Council of Governors Nominations and Remuneration Committee and reported to the Council of Governors on 19.01.17. An audit and peer informal observation of Board and Board Committee meetings was undertaken during December-March with feedback provided to Board Chair/Committee chairs. The Board and each Committee will consider the output from their observation and identify further actions for improvement in practice as appropriate as part of their work plans for 2017/18.	Board Effectiveness survey results, March 2017 – To be presented to 12 April Board Development Session Output from observation of Board to be discussed at April Board Development session and actions arising to be implemented	The Board Development Programme has continued to be implemented during 2017/18 encompssing both strategic, operational, interpersonal and wider needs. Topics have included focus on transaction process, equality, diversity and involvement and Trust strategy. These have included internally faciliated and externally facilitated sessions. (Cross-reference RR2 - Board Development, overseen by Remuneration & Appointments Committee.) Review and update of the Board forward plan and accurate monitoring and holding to account for actions are embedded in business as usual for the Board and all Committees. 360 degree appraisals have been carried out for Executive Directors and for Non-Executive Directors to align with the anniversary of their appointment date. (Cross-reference RR3 - 360 feedback - overseen by Remuneration & Appointments Committee.) Board Effectiveness Survey results were presented to the Board Development Session, highlighting that 80% of Board members felt that all Board members acted as corporate directors, demonstrating the ability to think strategically and contribute to areas outside their specialist field. Deloitte phase 2 review highlighted that Board and Committee debate had improved from that observed in their previous review (February 2016). Examples of good debate were observed during fieldwork undertaken in March/April 2017.	Green
		2) Ensure all Board Members have completed 360 appraisals which focus on development	POE				
		3) Ensure that there is the appropriate balance of strategic and operational items on the Board agenda	CA				

Core Area	Issue Raised / Action	Key Tasks	Director	AUDIT & RISK COM Blue Form Narrative	On-Going Monitoring Arrangements	Update on Embeddedness Oct 2017	RAG Rating
CorpG12	Reintroduce short summary reports from committee chairs to the Board to supplement minutes. These should identify key risks, successes and decisions made / escalated from the meeting	1) Reintroduce short summary reports from committee chairs to the Board which identify key risks, successes and decisions made / escalated from the meeting	CA	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.	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	Production of assurance summary reports is now fully embedded as business as usual following each Board Committee meeting. These have been further enhanced, in April 2017, to clarify and report consistently the level of assurance (full, signficant, limited or none) and to clarify where escalations to Trust Board or referral to other Board Committees is appropriate. The effectiveness of the summaries continue to be reviewed by the Board Committee Chairs at their quarterly meetings.	Green
CorpG13	The Board should re-establish the Board Assurance Framework as one for all risks including risks which it is involved in and when that risk has an element of confidentiality how it is handled. It should write and implement a plan for BoD development which includes these objectives	Develop and Agree BAF 16/17 Schedule BAF deep dive reviews for Board Committees	CA	The Board Assurance Framework (BAF) was agreed in March 2016 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 was undertaken in February 2017, attended by internal auditors, KPMG. This included discussion on how risks with element of confidentiality are managed. Review of BAF risks is a standing item on all Committee Forward Plans.	BAF is standing item on all Board and Committee Forward Plans	There is an established cycle of review and update of the BAF which is presented to the Audit & Risk Committee and then Trust Board on a quarterly basis. An internal audit review, undertaken by KPMG (internal auditor) in March 2017, focussing on BAF and risk management, highlighted significant assurance with minor improvement opportunities on the Trust's management of risks and the BAF. All recommendations arising from the audit have now been implemented.	Green

CA - Director of Corporate Affairs & Trust Secretary
Act COO - Acting Chief Operating Officer
Act CEI - Acting Chief Executive Officer
POE - Director or People and Organisational Effectiveness

Core Area	Issue Raised/Action	Key Tasks	Director	COUNCIL OF GOVERNORS Blue Form Narrative	Ongoing Monitoring Arrangements	Update on Embeddedness October 2017	RAG Rating
COG1	The relationship between the BoD and the CoG is poor. Both parties should adopt a conciliatory approach rather than continuing with the antagonism which inflicts the current relationship	1) The Board and Council of governors will co-write a policy on how the Board and council of governors will work in partnership 5) Implement a Code of Conduct for all Governors	CA	Policy for Engagement between the Trust Board and Council of Governors The Policy for Engagement between the Trust Board and Council of Governors has been developed over several months to outline how both will work in partnership and was agreed by the Council of Governors at its meeting on 6 September and Board of Directors on 5 October 2016. This policy encompasses arrangements already set in place including the twice yearly Council of Governors and Board session and the regular Non-Executive Director and Council of Governor sessions. Agreed governor representatives have also been invited to attend Board Committee meetings to observe the work of Committees and further understand their role and to hold Non-Executive Directors to account. Review of the effectiveness of this policy is scheduled as part of the annual work plan of the Trust Board and Council of Governors and evaluation of effectiveness of the ongoing relationship is included in both the Governor Effectiveness annual survey and the six-monthly Board Effectiveness survey. Evidence of the improved relationship is evidenced through the Governors' Review of Effectiveness survey results (discussed at the Governance Committee in October 2016 and presented to the Council of Governors in December 2016). The Board Effectiveness survey, discussed by the Trust Board in October also triangulated the feedback that Board members felt that there was an improved and now effective working relationship with governors. As part of work to address this action, the role description of the lead governor has been reviewed and was agreed at the Council of Governors meeting in January 2016. This reflects an expanded role to include greater responsibility and accountability and to ensure greater collaborative working with the Chairman and Senior Independent Director. John Morrissey was appointed to the role. Governor review of effectiveness A process for the assessment of the effectiveness of the Council of Governors has been developed with Governors, via the Governance Committee and using a best practice model. The Governor Effectiveness Survey was implemented in September 2016. The results were reported to the Governance Committee in October 2016 and the full Council of Governors in November 2016. Several actions have been agreed and fed into the ongoing work plan of the Governance Committee. The survey is to be repeated on an annual basis. Review of Governance Structure The Council of Governors have also reviewed and embedded a new governance structure, focussing on more joined up working between the Council of Governors and the Board of Directors. This includes the development of a single sub-committee of the Council of Governors (the Governance Committee), replacing a range of sub-committees which were poorly attended, to include focus on areas of governance, quality, membership, engagement and performance. The Committee has agreed terms of reference, which are to be reviewed annually, and all governors are encouraged to attend. There is an annual work plan in place to ensure key areas are covered by the group and the Committee presents a report on its work to each Council of Governors meeting. Code of Conduct A Code of Conduct has been drawn up with governors and was approved at the Council of Governors meeting on 6 September 2016. All governors have signed up to this Code and any issues arising from implementation of the Code fall initially within the remit of the Governance Committee. The Code will be reviewed annually and all new governors will be asked to sign up to the Code on appointment. Finding from the Governor Task and Finish Group The Task and Finish group from the Council of Governors was tasked to undertake independent review of the actions of the Trust Board in the circumstances surrounding the Employment Tribunal. The report concluded that Non-Executive Directors (NEDs) had not acted as if accountable to the Council of Governors but there had since been a marked change in this approach. It was noted that Governors and NEDs had worked hard on communications in the intervening period and relationships are much improved.	Policy for Engagement between the Trust Board and Council of Governors, review of governor effectiveness survey, review of Governance Committee terms of reference, and review of Code of Conduct is included on both the Council of Governors and Governance Committee's annual work plan.	The Policy for Engagement between the Trust Board and Council of Governors (CoG) outlines the key principles for the Board and Council of Governors and there has been a good working relationship sustained during the year. The governor effectiveness survey is to be repeated in September 2017 (this is an annual survey and embedded in the forward programme for both the Governance Committee and CoG meetings). The six monthly CoG to Board development session in June 2017 focussed on the decision to withdraw from the transaction with DCHS. The November session has been arranged as a facilitated session on the holding to account relationship between the Council of Governors and the Non Executive Directors. Future meetings between COG and the Board are part of future forward plans for the Board and CoG. Governor representatives observe several Board Committees and a protocol for governor involvement in this was approved by CoG in July 2017. The Governors' Code of Conduct has been reviewed by the Governance Committee during July and August 2017. The Lead Governor role was reappointed to in March 2017 with John Morrissey being appointed and Carole Riley appointed to the newly created Deputy Lead Governor role. The Governance Committee have undertaken a review of their effectiveness which has been reviewed by the Committee and scheduled to be presented to the CoG in Septmeber 2017. The terms of reference of the Committee have been reviewed and updated to reflect the work of the Committee and this is an embedded part of the annual programme of work for the Committee. A review of the Policy for Engagement is to be considered by the Governance Committee at its October meeting and at the CoG to Board session scheduled for November 2017.	**Green**

COG2	Deloitte 12 - Formal training should be required for all current members of the CoG and to future members as they join. This training should include the role of the Governors, the context of organisational governance and the personal conduct expected of Governors CQC 3 - The trust should ensure that all board members and the council of governors undertake a robust development plan	1) Develop a new induction programme for the Council of Governors and roll out its delivery	CA	Governor recruitment was undertaken in Spring 2016 for vacant public and staff governor roles. Nine new governors were appointed to the Council of Governors and started in their role with the Trust in May 2016. The Chairman has contacted stakeholders to ensure ongoing representation on the Council of Governors and these are now in place. The Governors' Governance Committee on 7 July reviewed future plans for elections to be held during 2016/17 and agreed to go ahead with two rounds of elections, commencing July and November. The July elections resulted in appointment of three further public governors who joined the Trust in October 2016. A range of engagement activities have been established and implemented. These include: • Monthly development sessions focussing on areas identified by governors with evaluation fed back to the Governance Committee • Externally led training has been implemented in conjunction with Derbyshire Community Health Services NHS FT (DCHS) (November 2016) • Ongoing involvement in the Quality Visits programme set in place by the Trust • Attendance of Non-Executive Directors at Council of Governors meetings, including a standing agenda item for NEDs to report back on activities undertaken in their role • Board to CoG sessions have been scheduled on a six monthly basis. The first of these took place on 27 October 2016 and focussed on the Strategic Options Case relating to closer collaboration with DCHS • The governors' Governance Committee has been established and terms of reference agreed to discuss a range of quality, governance, membership and engagement issues with an agreed annual workplan. The Committee formally reports into the Council of Governors • Governors are involved in the 360 degree appraisal process for the Chair and NEDs. This process is currently underway for the Chair in November/December 2016 • The Governor Effectiveness Survey outcomes (as reported to the October Governance Committee and November Council of Governors) noted that relationships with the Board were positive • CoG to NED sessions have been implemented to allow informal interaction between Governors and NEDs. These have been undertaken in June and November 2016 prior to the formal CoG meetings • An induction event was held on 31 May for new governors, with existing governors encouraged to attend. The Chair, Chief Executive and wider Board members attended and contributed to this event. This induction programme will be rolled out for all future new governor appointments and an induction was carried out for the three new governors on 9 November	Items including election updates, governor training development, and review of terms of reference are now scheduled as part of the annual work plan of the Governance Committee Review of Governor Effectiveness Survey, NED reporting on activities are part of the CoG annual work plan Governor involvement in NED and Chair appraisal is part of the annual workplan of the Nominations and Remuneration Committee. Governor to Board meetings now part of established governance meeting schedule for the Trust	All new governors have received induction either as group or individually on commencement of their role and this is mandatory. This covers details of the Trust, organisational governance, the governor role and an outline of governor roles and activities. the training programme for governors has been successfully implemented and alternative scheduling of delivery is to be explored to maximise attendance going forwards with block training planned from October 2017. Feedback on training delivered and discussion on future training content is a standard item on the Governance Committee agenda. The Governor effectiveness survey (carried out six monthly) will continue to elicit feedback about the training that governors receive and whether this equips governors for their role. The Board to CoG joint session for November 2017 has been arranged as a facilitated event to focus on roles and responsiblities and the governor role of holding to account. Governors continue to be involved in quality visits on an ongoing basis.	**Green**
CoG3	Prioritise the recruitment to the Council of Governors, ensuring that the role of the governor and vacancies are publicised	1) Chairman will engage stakeholders to ensure representation on the Council of Governors	CA	Governor recruitment was undertaken in Spring 2016 for vacant public and staff governor roles. Nine new governors were appointed to the Council of Governors and started in their role with the Trust in May 2016. The Chairman contacted stakeholders to ensure ongoing representation on the Council of Governors and these are now in place. The Governors' Governance Committee on 7 July reviewed future plans for elections to be held during 2016/17 and agreed to go ahead with two rounds of elections, commencing July and November. The July elections resulted in appointment of three further public governors who joined the Trust in October 2016. A range of engagement activities have been established and implemented. These include: • Monthly development sessions focussing on areas identified by governors with evaluation fed back to the Governance Committee • Externally led training has been implemented in conjunction with Derbyshire Community Health Services NHS FT (DCHS) (November 2016) • Ongoing involvement in the Quality Visits programme set in place by the Trust • Attendance of Non-Executive Directors at Council of Governors meetings, including a standing agenda item for NEDs to report back on activities undertaken in their role • Board to CoG sessions have been scheduled on a six monthly basis. The first of these took place on 27 October 2016 and focussed on the Strategic Options Case relating to closer collaboration with DCHS • The governors' Governance Committee has been established and terms of reference agreed to discuss a range of quality, governance, membership and engagement issues with an agreed annual workplan. The Committee formally reports into the Council of Governors • Governors are involved in the 360 degree appraisal process for the Chair and NEDs. This is currently underway for the Chair in November/December 2016 • The Governor Effectiveness Survey outcomes (as reported to the October Governance Committee and November Council of Governors) noted that relationships with the Board were positive • CoG to NED sessions have been implemented to allow informal interaction between Governors and NEDs. These have been undertaken in June and November 2016 prior to the formal CoG meetings • An induction event was held on 31 May for new governors, with existing governors encouraged to attend. The Chair, Chief Executive and wider Board members attended and contributed to this event. This induction programme will be rolled out for all future new governor appointments and an induction was carried out for the three new governors on 9 November	Items including election updates, governor training development, and review of terms of reference are a now a scheduled as part of the annual work plan of the Governance Committee Review of Governor Effectiveness Survey, NED reporting on activities are part of the CoG annual work plan Governor involvement in NED and Chair appraisal is part of the annual workplan of the Nominations and Remuneration Committee. Governor to Board meetings now part of established governance meeting schedule for the Trust	Recruitment has been undertaken to fill vacant roles on an ongoing basis. We are currently out of election for four constituencies to cover recent resignations. Governors are requested to support the recruitment of new governors. Election updates are presented to the Governance Committee regularly during election periods with all appointments and resignations presented to CoG. Governors who have resigned are invited to feedback back on their experience to either the Director of Corporate Affairs or Lead Governor to help the Trust in future support of governors and to improve governor retention. A recent staff governor election has been held (August 2017) with the existing staff governor reelected to the role.	**Green**

CA - Director of Corporate Affairs & Trust Secretary

Core Area	Issue Raised / Action	Key Tasks	Director	QUALITY COMMITTEE Blue Form Narrative	On-Going Monitoring Arrangements	Update on Embeddedness - Oct 2017	RAG Rating
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 QLT's 3) Review frequency of clinical reference groups so that QLTs are enabled to undertake their work as defined by TOR 4) For a 6 month period Don and MD to attend QLTs to provide coaching and oversight of meeting effectiveness.	DoN	The Director of Nursing and the Medical Director met with the Chairs of the QLTs, and plans were put in place for further collective and individual development. Additional development in quality governance and monitoring of the CQC regulations were noted as required. Quality Committee reviewed this recommendation at their September 2016 meeting. Concerns were raised regarding the effectiveness of the current QLTs. QC members agreed that this recommendation was no longer on track and that there were some issues that required resolution. QC requested that in order to address the issues that QLT chairs were required to attend QC, QLTs should provide minutes and escalations via the agreed escalation template and that the wider issue of QLT effectiveness be incorporated as part of the Trust-wide accountability framework which was set for agreement by the end of October 2016 November 2016: The DoN has continued with unannounced visits to 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 and a wider monitoring role of QLTs in not just receiving information but monitoring information, quality indicators and making decisions to mitigate issues or escalate to senior managers if additional support is required. Discussed at ELT 20.02.17 and action plan agreed, and further discussed at Quality Committee on 14.03.17. Agreed that Terms of Reference, purpose and reporting arrangements will be reported back to 13.04.17 Quality Committee to reflect revised arrangements agreed. The revised accountability arrangements. Paper being presented to Trust management team and structures. The Trust Management Team is fully operational and is supporting integrated quality leadership teams to develop fully into their roles of quality governance. In spring/summer the TMT will have an annual planner which indicates when all TMT members will attend a performance management review function, when a collective leadership model will present their progress against their area plan on a page and integrated priorities. This will be an integrated leadership slide pack/presentation and performance review, driving a shared quad or triumvirate collective model of accountability and exception reporting against agreed quality governance targets against the agreed plan on a page priorities. This includes a section on risk based issues that are determined at national, local or generated by the clinical and operational front line. Paper on the Divisional Leadership Teams presented to Quality Committee in April 2017 and agreed.	Accountability Framework to be reviewed annually - this is included within the Trust Management Team's terms of reference ELT to review effectiveness of TMT on a six monthly basis Assurance report to be presented to Quality Committee in September 2016 A review of effectiveness of the Accountability Framework is listed for consideration as part of the internal audit programme for 2017/18	The accountability review will include a review of the TOR of the TMT, this was undertaken on 30/08/17 with the proposed adjustments received at the next TMT meeting. The performance management and accountability reviews have commenced and additional scrutiny is showing early indicators of performance improvement. This has been complemented by a plan on page approach to meeting service/clinical and business integrated objectives. An ELT review of effectiveness and the impact of TMT will be scheduled for October / November 2017. This will include feedback from meeting members on the impact and reflection on areas to improve. A performance and quality summary has been scheduled for October rather than September to enable meeting attendees in QLTs to fully engage with a review of the groups, based upon 6 months worth of activity rather than 4-5 months. The internal audit programme will undertake a review of the effectiveness of the accountability framework in 2017	Amber
ClinG2	The Trust would benefit from a robust and thorough policy review programme	1) Undertake a review of Trust policies in order to: a)Revise the number of policies b) update to ensure for plain English c) ensure consistency and clarity in how policies are presented , e.g. managers guide, policy or procedure	DoN	Extra resource to support this action was approved by ELT and a member of staff was seconded to the role for six months in order to review policies. The policy tracker was presented to the Audit & Risk Committee in July 2016 to provide assurance on the process. The Risk Manager has reviewed the number of Trust policies and benchmarked against other organisations. There was room to consolidate a number of policies and due to changes to professional clinical practice there were a number of new policies required. Progress reports have been provided to the Quality Committee in June 2016 and October 2016 with respect to progress against the policy review programme as a whole. This recommendation is listed on the GIAP for oversight by the Audit & Risk Committee but with overall oversight falling to the Quality Committee. The Audit & Risk Committee has therefore been updated on progress with the actions required to address the recommendation and progress has been challenged and scrutinised as part of GIAP reporting to this Committee. Reporting on progress culminated in a report presented to the December 2016 Audit & Risk Committee by both Rachel Kempster (Lead for policy governance within the Trust) and Susan Spray (HR lead) to provide assurance that all aspects of the recommendation had been addressed. The Audit & Risk Committee therefore confirmed that they were assured that the required work had been completed and a blue form should be prepared. Deloitte reviewed progress on this recommendation as part of their phase 1 report and the December to the Audit & Risk Committee addresses the gap in reporting identified as part of this review (section 2.4). It was agreed at the December Quality Committee that this recommendation has been completed and a blue form could be prepared and submitted to in January 2017.	The Quality Committee will continue to monitor compliance as part of its policy governance role (quarterly reports)	Quarterly reports have been presented to Quality Committee with the final report in October 2017. From this point forwards monitoring will be overseen through the presentation of the quality dashboard in the integrated performance report which is presented to Quality Committee and Board on a monthly basis. This improvement in policy governance is sustained and achieved	Green
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	1) Board Development to focus on NED challenge of overdue actions and reports (see RR2) 2) As part of the review of all Committee TOR ensure there is clarity of Quality Committee TOR and work plans in relation to the Audit and Risk Committee and People and Culture 3) Introduce a Quality Governance Group that will report to Quality Committee 4) Ensure that Quality Committee agenda is structured so that it focuses on topics to deliver quality strategy and goals	CA	The terms of reference of the Committee were reviewed and agreed in May 2016 and further reviewed in December 2016. These revised terms of reference aim to outline the remit of the Committee to seek assurance on delivery of the Quality Strategy. All terms of reference were reviewed collectively by the Audit and Risk Committee to ensure alignment and coordination. The Quality Committee previously agreed that the action matrix requires richer narrative when capturing actions and accountabilities and this was reviewed in January's Committee meeting. It was agreed that this has been achieved. A Board Development Session was held in July focussing on Board Committee effectiveness and including holding to account for completion of actions. Actions are now clearly articulated, with a named lead, agreed timeframe and updates provided. These are RAG rated and analysed prior to each meeting to provide percentage of actions completed (green), set for forward agendas (yellow), ongoing (orange) or overdue (red). Progress against actions are reviewed at each meeting and scrutinised to ensure that evidence is provided on appropriate progress. A forward work plan has been developed to cover all areas of the Quality Committee terms of reference and is reviewed at each Committee meeting. The Committee agenda has been reviewed and from July 2016 has been structured according to CQC domains and covers topics to support the delivery of the quality strategy and is cross referenced against quality priorities. The link to organisational strategic objectives is outlined on the cover sheet which accompanies all papers (strategic prompt added from December 2016). A review of the Committee, including considering effectiveness, was undertaken at the end of March 2016 and presented to the Committee and also the Audit and Risk Committee, along with all other Board Committee year end reports for 2015/16. A report of the business of the Committee for 2016/17 is being developed and will be brought to the March meeting. This will review the Committee's effectiveness against all areas of the terms of reference. A peer observation exercise was carried out for the Committee in January 2017. Feedback has been given to the Executive Lead and will be shared with the Committee Chair and actions arising will be agreed by the Committee for implementation.	Annual review of terms of reference (due March 2017 and annually on work plan) Forward plan for the Committee (agenda item April 2017) Annual review of the Committee (to the Committee in March and Audit and Risk Committee in April 2017) Implementation of actions arising from peer observation (for agreement and discussion at March 2017 Committee)	We have increased the effectiveness of the Quality Committee by ensuring clear alignment of the committee with the quality strategy and the agenda is mapped to this amd associated objectives, and ensuring a clear focus on seeking assurance. This can be evidenced through the review a review of the TOR, there is a Quality dashboard in place, there is a Trust management team as the sub group to the Quality comittee to focus on operational develivery and performance. This model is becoming increasingly effective over the late summer to date. The qualtiy sub groups have moved to an intergrated model of clinical and operational, and effectiveness reviews have been scheduled for October. The Quality Committee's focus has been on setting strategy, reviewing assurance of clincial priorities and the CQC action plan ot ensure effectice standards. On completion of the CQC action plan, clear evidence of communication and esclation of risk from the TMT to QC with mitigating operational action plans and embedding of the COAT improvements and a period of stability of the Trust management team this objective will be achieved. There is significant improvement in the integrated clinical operational groups and a clear model of clinical operational performance management. the estimated time of completion this action into business as usual is January 2018.	Amber

Core Area	Issue Raised / Action	Key Tasks	Director	REMUNERATION AND APPOINTMENTS COMMITTEE Blue Form Narrative	On-Going Monitoring Arrangements	Update on Embeddedness - Oct 2017	RAG Rating
CORE 1 - REUNIFICATION OF THE HR AND ASSOCIATED FUNCTIONS							
HR1	The HR and OD departments should be under the management of one Executive Director	1) Recruitment of Director of Workforce, OD and culture	P&OE	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.	Will be further reviewed by CQC and also monitored on an annual basis by the Board	Amanda Rawlings has been in the Trust since September 2016 as Interm Director of People and Organisational Effectiveness which is a joint post with DCHS. The arrangement is working sucessfully and will be further strengthened when the HR/Workforce/OD service becomes part of a shared function with DCHS. A full time Assistant Director of People, Culture and Transformation has been appointed in September 2017.	**Green**
CORE 6 - ROLE AND RESPONSIBILITIES OF BOARD MEMBERS							
RR1	Implement proposals to improve succession planning at Board level, including ensuring that Governors are adequately engaged in this process. Alongside this, develop processes for succession planning for Senior Leader positions	1) Develop and approve Board level, key divisional and corporate leaders succession plan 2) Implement and embed succession plan	P&OE	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, agreed as off-track, and proposed to be deferred until the new year due to priorities of other work areas and the launch and embedding of the new appraisal process. The status was reported and noted at the January Board meeting and agreed following recommendation of the Remuneration and Appointments committee held in February that the status of this action be amended to 'Some Issues' reflecting the reprioritised timeline of April 2017. Work is underway throughout the Trust to identify succession plans and talent ratings for all staff band 7 and above and this will be complete by the end of April 2017 to be discussed with Executive Directors and the Remuneration and Appointments Committee in April 2017.	The outcome of the initial succession planning process will inform the Leadership Development Strategy for PCC in May 2017. The Remuneration and Appointments Committee will receive annual reports and the process will be operationalised with the Executive Leadership Team and their senior team members. Quarterly review by ELT	A succession and talent management process has been developed and introduced across the Trust which has the involvement and engagement of the Trust Management Team and Executive Leadership Team and is reported to the Trust's Remuneration and Appointments Committee. All key leadership roles have identified emergency cover and succession gaps are known with ongoing discussions about how to managed the gaps.	**Green**
RR2	**Deloitte 5** - Agree a programme of Board development work which includes a mix of internal and externally facilitated sessions, is clearly aligned to the combined governance action plan. the Board development plan should consider: •more detailed consideration of the governance action plan •a focus on Board challenge, including assurance, reassurance and the role of the corporate director; •facilitated 360 feedback •Board cohesion and dynamics •use of external speakers to add insight and prompt debate •joint sessions governors	1) Develop a Board development plan for 2016/17 2) Implement Board development programme which will include Board effectiveness sessions to address team dynamics and agreed ways of working including: •clarity of purpose and vision •effective challenge and leadership •individual coaching	CA	The Board agreed a development programme in March 2016, linked to both the Governance Improvement Action Plan (GIAP) recommendations and strategic priorities, and this has been delivered as per the summary report previously presented to the Committee in December 2016. The programme has been revisited and revised in year, with updates agreed by the Committee. The programme was reviewed in Autumn 2016 to ensure that topics reflected current priorities and challenges. This was particularly relevant considering the four new Non-Executive Directors and appointment of Acting/Interim Directors. It was also important to ensure that development sessions reflected the CQC inspection outcomes and help ensure that Board members are well informed on issues relating to the proposed collaboration arrangements with Derbyshire Community Health Services NHS Foundation Trust. The revised programme was presented to the December Committee. A KPI on attendance was agreed at this time. A target of attendance at 77% of sessions was set. At the January meeting it was also agreed that further reports summarising Board Development Sessions held during 2016/17 would include noting attendance to be able to provide evidence that this recommendation had been satisfied. As previously agreed by the Committee, attendance that falls below the target attendance is dealt with via relevant line management. Evaluation forms have been introduced from January 2017 to ensure ongoing learning and feedback to inform the future programme. The December Committee confirmed that receipt of a report outlining the completed 2016/17 programme including noting attendance would provide assurance that this recommendation had been met. The Committee agreed at the February 2017 meeting that the development of this programme for 2017/18 is to be taken forward as business as usual as this is not a requirement for completion of the GIAP recommendation.	Monthly Board Development session scheduled throughout 2017/18 as part of ongoing business as usual for the Board	The Board Development Programme has continued to be implemented during 2017/18 encompassing both strategic and operational, interpersonal and wider needs. Topics have included focus on transaction process, equality, diversity and involvement, Trust strategy. These have included internally faciliated and externally facilitated sessions. The October session is to be externally facilitated by NHS Providers and focus on achieving and sustaining improvement. The November session is a joint session with the Council of governors (also externally facilitated) and focussing on holding to account.	**Green**
RR3	**Deloitte 6** - Complete the full process of 360 feedback for all BMs and utilise the outcome to set clear objectives in relation to portfolio areas (for EDs) as well as in relation to the role of the corporate director and contribution to the Board **CQC 8** - The trust should introduce and effectively monitor 360 degree feedback for all senior managers and directors	1) Develop a 360 feedback process for BM's with forms and expectations on what and how to feedback 2) Implement 360 degree feedback for all BMs 3) Integrate 360 feedback into BM's appraisal objectives and personal development goals 4) Implement 360 degree feedback for all senior managers 5) Integrate 360 feedback into senior manager appraisal objectives and personal development goals	P&OE	360 degree appraisals were undertaken in 2016 for three Non-Executive Directors (Caroline Maley, Maura Teager and Jim Dixon), the Acting CEO and the Interim Chair. A 360 appraisal was undertaken in April 2017 for Maura Teager, prior to her departure from the Trust. The Council of Governors Nominations and Remunerations Committee agreed the paperwork and framework for this process and reviewed the outcome of the appraisals, which were in turn reported to the full Council of Governors. The Board Development programme was approved at the Trust Board in March 2016, which included a balance of operational and strategic items relating to board member development. This has been successfully implemented during 2016/17. A revised process for 360 degree appraisals was agreed at the December 2016 Remuneration and Appointments Committee meeting. 360 degree appraisals were undertaken for all Executive Directors during March and early April 2017. The Chief Executive's 360 appraisal took place on 18 April 2017. Objectives have been set for each Director as part of this process and a process of regular 1:1 sessions is undertaken on an ongoing basis. Themes arising from the Executive Director appraisals will be outlined in a summary report to the Committee. Non-Executive appraisals are to be completed on a rolling basis, aligned to terms of service start dates, and will be reviewed by the Governors Nominations and Remunerations Committee.	360 feedback appraisals are to be repeated on an annual basis. 1:1 sessions will continue on an ongoing basis throughout the year for all Board members.	The Trust has a 360 degree appraisal process in place for all Board members - Executive and Non Executive Directors. The appraisal documentation is sent out one month prior to the anniversary of the appraisal and the Chair leads on the NED appraisal process and the CE on the Executive Director appraisals. The Remuneration and Appointments Committee receives an update from the Chair and CEO on CE/Exec appraisals and the governor Nominations and Remuneration Committee receives the update on the Chair and NEDs appraisals. All NEDs have quarterly 1:1s with the Trust Chair and Executive Directors have 1:1s with the Chief Executive on a monthly basis. All other leaders across the Trust are on the Trust's wider staff appraisal process and have been trained to provide and receive a constructive appraisal	**Green**

Core Area	Issue Raised / Action	Key Tasks	Director	REMUNERATION AND APPOINTMENTS COMMITTEE Blue Form Narrative	On-Going Monitoring Arrangements	Update on Embeddedness - Oct 2017	RAG Rating
RR4	Implement a programme of Executive Team development which focuses on team dynamics, effective challenge and leadership and is supported by individual coaching where necessary	1) Develop and agree Executive Team development programme which will include: team dynamics and agreed ways of working •clarity of purpose and vision •effective challenge and leadership •individual coaching 2) Implement development programme and monitor effectiveness through 360 feedback	Act CEO	The Acting Chief Executive's Report on Executive Team development was presented to the Remuneration and Appointments Committee on 27 April 2016. This highlighted plans for personal development and support, team operating principles and development sessions. A review of the implementation of this programme is to be discussed by the Executive Team on 20 February 2017 and will be presented to the March 2017 Committee. The Committee agreed at the January meeting that subject to this being satisfactory that this recommendation would be considered as addressed. The review considers effectiveness of implementation of the team principles, reflection on team achievements and team effectiveness, and identification where improvements could be made and well as next steps for the team. Evaluation of the personal development aspects of the programme are to be reviewed as part of scheduled appraisal reviews (February and March 2017). These will be reported back to the committee in June as part of the business as usual programme of work. (*This has since been delayed to September REMCOM meeting*).	Further reflective sessions held by ELT every 6 months (scheduled for September 2017) Use of informal directors sessions (one hour weekly) to discuss developmental/team coaching approach to management issues Review of individual effectiveness and development as part of individual 1:1s held at least monthly between CE and Execs (as evidenced through supervision recording) Annual PADRs undertaken including review of all training and development	A facilitated session has been undertaken (12 June 2017) with the Executive Leadership Team, focussing on priorities and teambuilding. A follow on session is to be arranged for November 2017 to build upon team synergies. Reflective sessions are a scheduled as part of the Executive Leadership Team annual programme going forwards with the next planned for 18 October 2017 to review the team's approach to regulatory compliance resourcing and coordination.	**Green**
RR5	The trust should ensure that training passports for directors reflect development required for their corporate roles	1) Training requirement for all EDs and NEDS are agreed by CEO and Chair, with passports updated accordingly 2) Developmental training requirements are discussed and agreed with Board members in their Appraisals 3) Provide BM and NED training update reports to Rem Com to demonstrate completion in line with mandatory and CPD requirements	Act CEO/ Chair	A report on Board member training was presented to the Remuneration and Appointments Committee in December 2016. This report provided assurance on recording on mandatory and CPD training processes. It was agreed that mandatory training reports would be received by the Committee on a quarterly basis. An on-going review of Non-Executive Director mandatory training requirements is underway to ensure that training requirements are appropriate and this is being considered as part of the Trust-wide training framework, falling under the remit of the People and Culture Committee. The Committee agreed at the January 2017 meeting that along with the assurances outlined in the December 2016 report relating to CPD and ongoing training and development for Board members, receipt of a satisfactory end of year mandatory training compliance report in April 2017 would meet the evidence requirements that actions were complete and embedded in an ongoing process. Issues relating to non-compliance are taken forwards as part of line management arrangements.	To be reviewed at ELT on a quarterly basis and process established with Chair to monitor Non-Executive Director compliance. Review of training and development as standard part of 1:1 line management conversations and appraisal reviews	Scheduled for quarterly review at ELT and reviewed as part of ongoing appraisal reviews. NED training passport has been the subject of further review and bespoke passport developed. To be reviewed at Remuneration and Appointments Committee in September 2017. Reviewed at Remuneration and Appointments Committee in September 2017 and progress noted.	**Green**

Core Area	Issue Raised / Action	Key Tasks	Director	BOARD OF DIRECTORS Blue Form Narrative	On-going Monitoring Arrangements	Update on Embeddedness - Oct 2017	RAG Rating
CORE 10 - CQC							
CQC1	The Trust should ensure that the outcome of this focussed inspection impacts directly upon the organisational strategy	1) The CQC targeted report is used as a key guide in Trust strategy development days	Int. S	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.	To be monitored as part of strategy implementation (e.g. Board agenda item)	During 2016/17 all areas (operational and corporate) produced a 'Plan on a Page' which outlined the key actions to deliver the strategy up to March 2018. This in monitored through the TMT performance structure. A report will also go to the Trust Board twice yearly detailing the progress of all areas i.e. number of green, amber, red actions. The planning process has been further refined for 18/19.	**Green**
CORE 11 - MONITOR ENFORCEMENT UNDERTAKINGS							
M1	The Trust will deliver a Governance Improvement Action Plan (GIAP) to address the findings and recommendations from the Employment Tribunal Investigation, Deloitte report, and the CQC focused inspection DR13; Further iterations of the governance action plan should include a greater depth of detail, including summary of progress and clearer insight into priority actions required The action plan should include: •priority ratings for each action •key tasks required for each recommendation / action area •associated risks with non-implementation •outline of any key resources required •completion of KPIs and success measures •comments on progress comments •links to demonstrable outcomes	1) Governance Improvement Action plan approved by Board of Directors 2) GIAP and Governance and Delivery Framework sent to Monitor 3) Governance and Delivery Framework developed and approved 4) Governance Action plan delivered	Resp.	The GIAP and governance and delivery framework were agreed by the Board in March 2016. The GIAP included the findings and recommendations from the employment tribunal investigation, Deloitte report February 2016 and the CQC focused inspection February 2016. The GIAP delivery framework was implemented from April 2016, with updates made to the plan accordingly. The GIAP has been in operation throughout 2016/17 with progress against key tasks monitored and overseen, progress RAG rated and associated risks to delivery of actions reviewed. Deloitte carried out a review of the implementation of the GIAP, which took place between February 2017 and April 2017. (See M3). On 10 April 2017 verbal feedback was provided, a draft report was received on (19 April) followed by the final report on (24 April).	Ongoing monitoring arrangements have been defined and agreed for all recommendations, as outlined in blue completion forms. Work will continue to ensure embeddedness and effectiveness of these monitoring arrangements as part of our work towards an anticipated full well-led review during 2017/18.	Update on embeddedness of actions reviewed by Board Committees September 2017 and collectively to Board 1 November 2017. Further review planned for March/April 2018.	**Green**
M2	The Governance Improvement Action Plan will be updated to reflect material matters arising from the HR investigation	1) The HR Investigation report relating to the overall HR function will be reviewed for lessons learnt and incorporated into the Action Plan 2) Action Plan approved by Board of Directors	CA	The HR investigation report was reviewed during the development of the GIAP and there were no material issues not already included in the GIAP. The Trust Board approved closure of this recommendation on 27.04.16.	GIAP actions have been monitored and overseen as part of overall GIAP programme management during 2016/17, and will continue until all recommendations are completed.	Update on embeddedness of actions reviewed by Board Committees September 2017 and collectively to Board 1 November 2017. Further review planned for March/April 2018	**Green**
M3	The Trust will undertake to gain external assurance that the Governance improvement action plan has been implemented in full or that it can be implemented in full	1) The Trust will gain external assurance that the Governance improvement action plan has been implemented	Act CEO	A phase one external review was undertaken by Deloitte LLP in September 2016 to review progress and approach to implementation of the GIAP. This provided positive assurance of programme approach and informed further work on implementation and ensuring embeddedness and monitoring of actions undertaken. Deloitte were commissioned to undertake a full review (phase two) of implementation of the GIAP between February and April 2017. During this period Board and Board Committees were observed, interviews took place with staff and Board members, focus groups were held with our governors, and information was submitted as part of their desk top review process. On 10 April 2017 verbal feedback was provided, a draft report was received on (19 April) followed by the final report on (24 April). This gave positive assurance that significant improvement had been made across all three areas of the scope of the review, namely Board effectiveness, governance and HR associated functions, such that the Trust now meets the benchmark associated with organisations rated Amber/Green through similar well-led reviews. This Amber/Green rating reflects 'some areas of good practice, no major omissions and robust action plans to meet perceived gaps with proven track record of delivery'.	Ongoing monitoring arrangements have been defined and agreed for all recommendations, as outlined in blue completion forms. Work will continue to ensure embeddedness and effectiveness of these monitoring arrangements as part of our work towards an anticipated full well-led review during 2017/18.	Update on embeddedness of actions reviewed by Board Committees September 2017 and collectively to Board 1 November 2017. Further review planned for March/April 2018. Selected areas will in addition be reviewed as part of Deloitte Phase 3 external assurance during October-December 2017.	**Green**
M4	The Trust will implement Programme management and Governance arrangements to ensure the delivery of the Governance Action Plan	1) Governance and Delivery Framework developed and approved 2) A programme manager will be appointed to support Responsible Director to hold Directors to account for the delivery of the programme	Resp.	The governance and delivery framework was agreed in April 2016. This has been effectively followed throughout 2016/17 with reporting regularly to oversight Board Committees, the Trust Board, Council of Governors and regulators. Robust project management arrangements have been followed to ensure a clear audit trail of evidence. Document management and use of a pipeline tool were implemented to allow overview of progress and completion of actions to fulfil recommendations. A Programme Manager was recruited for six months starting April 2016. Further programme support was set in place from September 2016, reporting to a designated responsible Director. The Board agreed closure of this recommendation at the April 2016 meeting.	All recommendations require detail of ongoing monitoring and embeddedness of actions, which have been agreed as part of the completion and approval process. These will be monitored for each recommendation on an ongoing basis during 2017/18.	Update on embeddedness of actions reviewed by Board Committees September 2017 and collectively to Board 1 November 2017. Further review planned for March/April 2018	**Green**

Core Area	Issue Raised / Action	Key Tasks	Director	BOARD OF DIRECTORS Blue Form Narrative	On-going Monitoring Arrangements	Update on Embeddedness - Oct 2017	RAG Rating
M5	The Trust will provide regular reports to Monitor	1) The Trust will report on a monthly basis on the delivery of the action plan	Act CEO	Reports have been provided to NHSI as part of regular performance review meetings (PRM), generally held monthly, which are attended by the CQC. The GIAP has been a standing agenda item for these meetings and progress and risks have been discussed in detail.	GIAP will continue to be discussed at PRM meetings into 2017/18.	Update on embeddedness of actions reviewed by Board Committees September 2017 and collectively to Board 1 November 2017. Further review planned for March/April 2018	
M6	The Licensee will, by 18th March 2016 or such other date as agreed with Monitor, develop and submit to Monitor a timetable for making permanent appointments to all director roles which are currently vacant and/or filled on an interim basis. It will, by a date to be agreed with Monitor, revise that timetable in response to any comments made on it by Monitor	1) Develop a timetable for making permanent appointments to all director roles which are currently vacant and/or filled on an interim basis	Act CEO	The Remuneration and Appointments Committee agreed the timetable for recruitment of all Board level posts outlined and these were recruited to successfully. Trust Board agreed closure of this recommendation at its April 2016 meeting.	Regular review of composition of the Board is a stated role of the Remuneration and Appointments Committee, to be undertaken on an annual basis (included on the forward plan).	Substantive appointments made to Chair and CE role in September 2017 and October 2017 respectiveley.	**Green**

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Trust Board 1 November 2017

Implementation of Recommendations from Deloitte Phase 2 Report (April 2017)

Purpose of Report

To present an update on progress with the implementation of recommendations arising from the Deloitte (Phase 2) external review undertaken during April 2017.

Executive Summary

In March/April 2017 Deloitte LLP undertook an external assurance exercise to review governance arrangements within the Trust. The review focussed in particular on the extent of progress against the recommendations set out in their initial report dated 22 February 2016, which in turn were incorporated into the Governance Improvement Action Plan.

The review focussed on three specific areas, namely:

- Human resources and culture
- Governance and
- Board effectiveness

Seventeen recommendations were outlined within the final report, which were accepted when the report was presented to the Trust Board. It was agreed that an update against the recommendations would be presented to the Board in six months' time.

To support analysis of the progress against the recommendations, progress has been RAG rated. The key is as follows:

GREEN: recommendation fully implemented and Executive Director confidence that these are now part of business as usual (either forming part of policy or annual cycle of business for example).

AMBER: The recommendation has been implemented either in part, or for a limited time only such that there is not a full evidence base to provide confidence that the action is fully embedded.

RED: There has been no clear action agreed or implemented or agreed work has not been completed to deadline.

For areas that have been identified as amber (none have been designated red) it should be noted that these require embedding of process and review of effectiveness before these can be designated as green.

Executive Directors have reviewed progress across all recommendations and an update report was presented to the Executive Leadership Team on 4 September

2017. At this meeting, the progress was reviewed, scrutinised and challenged and the RAG ratings moderated. This collective review resulted in updates to the narrative and also agreed amendments to several RAG ratings.

In summary, 12 (out of 17) areas are rated as green. The five areas noted as amber are as follows and these include linked areas for ongoing action:

Recommendation 2.2: Accountability Framework & Recommendation 10 (Quality Committee)
We have made significant progress in establishing both the Trust Management Team (comprising deputies, senior operational managers and executives) and the Performance Management Review meetings which are now in their second round for each Division. Escalations are now routinely made to the Executive Leadership Team and we are confident that we will be able to consider this recommendation embedded following ongoing implementation over forthcoming months. Deloitte are to further explore the embeddedness of both the accountability and performance review frameworks as part of their Phase 3 review which will give us further valuable feedback.

Recommendation 3.1 Leadership of the People and Organisational Effectiveness function & 3.3 Model and Structure
Progress with implementation of the review and new structure for the HR back office function is under close review by Executive Directors and is regularly reported to the wider Board.

Recommendations relating to Committee Overview: Finance and Performance Committee
Recommendation 9 involves arranging end of year qualitative reviews by Committee members and this has been discussed with internal auditors, Executive Leads and Board Committee chairs. Qualitative feedback will be elicited through each Committee, determined by the Committee Chair and fed into the end of year reviews of effectiveness of all Committees scheduled for March/April 2018.

Next Steps
It is proposed that a further review of the progress against the recommendations is carried out in March 2018 to confirm all actions are complete. The Executive Leadership Team will review the action plan in December 2017/January 2018 and any exceptions to expected progress will be escalated to the Trust Board.

The recommendations within the report have also been considered by individual Committee chairs at their quarterly meetings and within their respective Committees.

It should be noted that the majority of the recommendations overlap with or are enhancements to existing GIAP actions which continue to be embedded within the Trust and will be subject to separate reporting to the 1 November Trust Board. The mapping exercise has now been completed and shows the overlap with GIAP actions for completeness.

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

Assurances

Executive Directors individually and collectively have reviewed the recommendations and provided further details detail on progress.

Consultation

Considered and agreed by ELT on 4 September 2017.

Governance or Legal Issues

The external review by Deloitte was a key part of providing assurance to NHSI and the CQC that we had made identified governance improvements to fulfil our foundation trust licence conditions. The review was used by NHSI to consider our licence breach and a certificate of compliance was subsequently issued on 24 May 2017.

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people) (Public Sector Equality Duty & Equality Impact Risk Analysis)

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)).

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

Recommendations

The Trust Board is requested to:

1. Receive assurance on the process used to identify and agree progress with the actions arising from the Deloitte Phase 2 review
2. Note the overlap with GIAP actions that are also being monitored for embeddedness within the organisation as 'business as usual'
3. Agree that a further review of progress will be undertaken by the Executive Team in December 2017/January 2018, to align with the review of embeddedness of GIAP actions and receipt of the Deloitte phase 3 external review report.

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

Implementation of Recommendations from Deloitte Phase 2 Report (received April 2017)

Report Section	Lead director and reference	Recommendations:	Comments	RAG rating and GIAP cross reference
SECTION ONE BOARD EFFECTIVENESS				
1.3 Board debate	R1: Ifti Majid/Sam Harrison	Recognising the improvements made, the Trust should continue to focus on the quality and impact of Board and Committee debate through the programme of Board development and individual feedback.	The Board has continued to undertake Board Development Sessions since April 2017 and has these scheduled monthly or bi monthly for the remainder of the year. Those undertaken have included focus on merger specific development (June 2017), Equality, Diversity and Involvement (May 2017) and a facilitated session focussing on the Trust as a team and reflecting on the Trust's Strategy (July 2017) in the context of the withdrawal from the DCHS transaction. Sessions include a mix of internally led and externally facilitated sessions. The October Board session was delivered by NHS Providers with the theme 'Requires Improvement to Good – sustaining a culture of continuous improvement' which was a bespoke session of their nationally delivered event focusing on supporting trusts to improve and sustain CQC requirements. A NED to Council of Governors event is planned for 8 November, again externally facilitated, as a joint development session to focus on clarity of roles and implementing the principles of holding to account. Following appointment to the substantive chair and chief executive roles a full programme is to be developed for the remainder of the year and will continue to include focus on learning as well as Board dynamics. A Board Effectiveness survey was repeated in May 2017 and has been reviewed as part of a Board Development Session (June 2017) to identify any particular learning and development needs arising. The Chief Executive and Executive Directors have all undertaken 360 degree appraisals. Non- Executive Directors have an agreed schedule for their appraisals to be carried out according to their start dates with	GREEN CorpG3 RR2 CorpG11

Report Section	Lead director and reference	Recommendations:	Comments	RAG rating and GIAP cross reference
			the Trust. This is to an established format agreed by the governors' Nominations and Remuneration Committee. In addition the Board Committee chairs/NEDs have continued to meet quarterly to review the effectiveness of their Committees, discuss cross-Committee working and share best practice. Review of meeting effectiveness is a key part of all Board and Board Committee agendas and continues to enable feedback, learning and development on effectiveness to be captured and shared.	
SECTION TWO GOVERNANCE ARRANGEMENTS				
2.2 Accountability framework	R2: Mark Powell	Agree a date for the post implementation review of the new clinical division board meetings (COATs). Their success should be measured in part by the quality of their reporting to TMT. Refer also to commentary and recommendations made in Appendix 2.B with regard to support in developing agendas and defining escalation processes.	A review is planned to take place during October/November and is linked to effective reporting via TMT, which has now developed to have alternate meetings focussing on Performance Review. These Performance Reviews are attended by leaders from the Divisional Teams and summary reports created for each Division, using the established Committee assurance reporting templates, to escalate risks and highlight agreed actions to the Executive Leadership Team. A schedule of Performance Reviews – with two Divisions scheduled per month – has been mapped out for the remainder of the year. These summary reports will also be used by the Quality Committee to provide assurance on quality issues raise, via ELT. Rating scheduled to be green by December 2017 when Performance Reviews have completed third round and there is evidence of effective escalation processes.	AMBER ClinG1

Report Section	Lead director and reference	Recommendations:	Comments	RAG rating and GIAP cross reference
SECTION TWO (continued) GOVERNANCE ARRANGEMENTS				
2.3 Oversight of divisional performance	R3: Mark Powell	As part of the TMT meeting cycle, introduce rotational 'divisional deep dives' where all aspects of performance are reviewed, including quality, finance, operational and workforce. This part of the TMT meeting should only be attended by the divisional triumvirates or quads and relevant EDs. The Executive Team will also need to review the role of the Senior Assurance Group to ensure that it is value-adding and has a clear purpose in the revised structure.	As outlined in 2.2 above, Performance Review meetings have been introduced to focus on Divisional performance using a structured approach. Discussions are supported through the use of performance packs which are to be developed on an ongoing basis in response to requirements and to ensure the information presented supports challenge, scrutiny and debate. The first two rounds of reviews have taken place. The Senior Assurance Group continues to oversee and support Divisional Performance and is led by the Deputy Director of Operations. The Performance Review Framework has been developed, agreed by Executive Leadership Team and approved by the Finance and Performance Committee in September. This outlines the organisation's structures in relation to performance review.	GREEN. ClinG1 CorpG7
2.4 Board engagement	R4: Ifti Majid/Sam Harrison	Alongside plans already in train through the People Plan, consider further mechanisms which the Board and senior management can adopt to develop staff engagement.	Several areas of Board engagement have been identified, developed and are being implemented: The Chief Executive's blog (the weekend note') is a well established weekly update to all staff and continues to be well received. A range of Trust-wide and team staff engagement events were held in June/July following the decision to withdraw from the transaction with DCHS. The Executive Leadership Team have scheduled the majority of future meetings at venues across the Trust and time is set aside prior to the formal meeting to meet with staff and give the opportunity for issues, ideas or concerns to be raised with Executive Directors. Board members continue to lead Quality Visits which give valuable opportunity to meet with staff teams and listen to staff across the Trust.	GREEN. WOD8 PC3 CoG1

Report Section	Lead director and reference	Recommendations:	Comments	RAG rating and GIAP cross reference
			The Director shadowing programme is underway with Board members participating in reverse mentoring and shadowing junior clinical staff. Deputies are encouraged to shadow their Directors at Board meetings and this has been evidence at Board meetings held in June and July. The Trust has a succession plan that identifies who needs to be developed and future successors to be developed and nurtured and where there are gaps and risks are. The Trust has a developing leadership development strategy and subscribes with East Midlands Leadership Academy and has a range of leaders attending short and long term programmes such as the Nye Bevan. Staff Survey results have been analysed and details provided at team level, with focussed support provided to teams to identify key areas for development. This has been reviewed at TMT to identify broader organisational themes. The Trust has undertaken two quarterly pulse checks and is seeing ongoing improvement in staff engagement. The Board Development Session held in June identified focus on our people as the main priority for the Trust and investment has been made to resource posts within the Communications team to take forward staff engagement. This will also include overseeing a programme of activities to promote Board visibility across the Trust. Work has also been recently undertaken to identify the key motivators/values for staff working at the Trust – through implementing a 'working together and feeling connected' survey the result have been used to inform development of a new engagement and values branding planned for rollout in November. This work will align to the staff engagement outlined in the People Plan,	

Report Section	Lead director and reference	Recommendations:	Comments	RAG rating and GIAP cross reference
			including 'The Voice' staff forum which commenced in September and includes representatives from across the Trust and will provide the opportunity to raise issues with Executive Directors directly.	
SECTION THREE PEOPLE AND ORGANISATIONAL EFFECTIVENESS FUNCTION				
3.1 Leadership of People & Organisational Effectiveness function	R5: Amanda Rawlings	Formalise the substantive arrangements for the Director of People and OE, and alongside this expedite the back office review and swiftly enact the longer term vision for the function.	The Phase 1 business case has been approved by the Trust Board regarding the new senior management posts and functions for the shared People and Organisational function for DCHS and DHCT. Phase 2 – the underpinning structure is due for approval in October 2017.	AMBER HR1,HR2, HR3, HR4
3.2 Strategy and Culture	R6: Amanda Rawlings	Provide opportunities for whole team development for the People and OE function. These should incorporate more junior members of staff, and provide a continued focus on behaviours and cross-team working.	Across the function there have been a range of development opportunities from Employment Law briefings, formal and informal training, acting up opportunities, shadowing the Director, working with DCHS, working on STP projects etc. The members of the People and OE function are actively encouraged to get involved in opportunities in and out of their own function.	GREEN HR5, WOD3, WOD5, WOD6
3.3 Model and Structure	R7: Amanda Rawlings	Move at pace to implement the new model and continue to engage the team in the design of the final structure	There has been two stage approach to developing the new shared People & OE service model for DHCT and DCHS. The senior team was appointed in the first instance so they could consider the design of the teams that they will lead. Full engagement and consultation will take place once there is business case to be shared with staff.	AMBER HR3, HR4
3.4.Policy and Metrics	R8: Amanda Rawlings	Review compliance with the People Policy programme and develop a plan to address the shortfall while providing clarity in respects to the potential consequences of non-compliance	There is in place a policy renewal plan and a well-functioning policy working group jointly held with Staff Side that oversees all people policies. There has been an intensive focus on 'how to' training for all leaders across the Trust which is now being formed into a rolling programme.	GREEN WOD1, WOD2, WOD4

Report Section	Lead director and reference	Recommendations:	Comments	RAG rating and GIAP cross reference
Appendix 2.A COMMITTEE OVERVIEW				
Finance and Performance Committee	R9: Claire Wright/Sam Harrison	Annual self-assessments for all committees should take into account a greater breath of members' views, such as through use of a survey. Many trusts now use their internal audit function to facilitate this. (No further recommendations have been raised as, where we have identified scope for further improvement above, the committee is sighted on these areas including amendments to committee reporting and the need to maintain focussed debate).	Annual review of effectiveness of the Committee has been undertaken and presented both the Audit and Risk Committee and the Trust Board. Discussions have been held with internal auditors to take forward annual self-assessments with a view to implementing these towards the end of March 2017. It is proposed that these take the form of structured qualitative review and internal auditors have undertaken to provide some best practice examples. Discussions held at the Board Committee Chairs/NED meeting on 26 September confirmed that Committee chairs would take forward qualitative reviews alongside year end effectiveness reviews which are planned for March 2018.	AMBER CorpG4, CorpG5
Quality Committee	R10: Carolyn Green	As each clinical division board/COAT is established, the DoN and COO should: • Collaboratively review their terms of reference to ensure that all requisite areas are covered; • Provide written guidance around the minimum requirements of their agendas to encourage both innovation and compliance; • Clearly define the reporting	See R2. Terms of reference of the Division Teams are in place. The terms of reference are to be revisited to ensure that all reporting requirements are in place and reflect on the value of the Performance Review meetings in escalating issues and risk areas. There has been improved focus on strategic and assurance issues by the Quality Committee and this is to be further developed.	AMBER CorpG4, ClinG1, ClinG3

Report Section	Lead director and reference	Recommendations:	Comments	RAG rating and GIAP cross reference
		requirements to TMT to enable the Quality Committee to receive appropriate levels of assurance. As R2, a post-implementation review date will need to be agreed for the new clinical division boards/COATs. Part of this review will also need to focus on the extent to which the revised structure has enabled the Quality Committee to become more strategic and assurance seeking in nature.		
Audit and Risk Committee	R11: Sam Harrison	Clarify the role of the BAF deep dives undertaken at the Audit and Risk Committee (as opposed to other Board committees) to ensure that their focus is on the structures and processes in place to provide the Board with assurance, as opposed to the detail of controls. Those presenting on individual BAF deep dives should be suitably briefed on this prior to the meeting.	The Audit and Risk Committee chair requested a review of the Deep Dives programme and remit and this was discussed and agreed at the June Committee meeting. A briefing note outlining the assurance focus of the Deep Dives is now circulated to all presenters. Internal Auditors have been consulted (August 2017) for their best practice view of Deep Dives and they have confirmed support for the clarified process now adopted. Effectiveness of the Deep Dives will be reviewed on an ongoing basis as part of the meeting review element of the Committee agenda and also as part of the annual review of effectiveness of the Committee.	GREEN CorpG13
People and Culture	R12: Amanda	The Committee has a heavy agenda and although the	Initially there was a heavy agenda for PCC, this has now moved into a more manageable position and the agenda is planned and aligned to	GREEN CorpG4

Report Section	Lead director and reference	Recommendations:	Comments	RAG rating and GIAP cross reference
Committee	Rawlings	appropriate place to review key strategy documents a more realistic assessment of the time for debate in order to allow dialogue needs to be considered.	provide assurance on the BAF risks and the People Plan which was approved in January 2017. Each meeting has a strategic theme to provide the Committee with a deep dive into one the strategic priorities agreed in the People Plan.	
Mental Health Act Committee	R13: John Sykes	Given the scale of risk associated with the MHAC's remit, a full review of the committee should be undertaken, to include: • The establishment of a working group beneath the MHAC to support the delivery of its key priorities (eg CQC actions). This group should provide clear reports to each MHAC • Greater focus on holding to account for delivery of CQC associated actions; and • The existing work plan should be reviewed to understand which items can be delegated this subgroup, to enable the committee to focus on assurance seeking.	The sub group has been established and the terms of reference, including membership discussed and agreed at the Committee meeting held on 24 August 2017. The operational group's role is to undertake review of operational reports and present the relevant assurance and escalations to the MHAC. The workplan of the MHAC has been reviewed to reflect the reporting which is now under the remit of the Operational sub group. The Audit and Risk Committee requested a review of the Committee to which was presented to their meeting in October 2017. This included an update on progress and built upon the review of effectiveness of the Committee relating to 2016/17. Further actions required/underway are being progressed with the oversight of MHAC.	GREEN CorpG4, CorpG3
Safeguarding Committee	R14: Carolyn Green	As part of the post-implementation review of the clinical division boards/ COATs, the Board should	The recommendation to the Trust Board (October) following discussion with the Committee chair and Executive Director lead is that the Committee should remain a Board Committee in its own right for the present time. This position will be reviewed as part of the year-end	GREEN CorpG4

Report Section	Lead director and reference	Recommendations:	Comments	RAG rating and GIAP cross reference
		decide if the Committee can become a subgroup of the Quality Committee, bringing this structure more in line with other mental health trusts.	review of the Committee to be carried out in March/April 2018.	
	R15: Carolyn Green	To encourage more focussed debate, the membership of the Safeguarding Committee should be rationalised.	In line with the discussions above the membership of the Safeguarding Committee will remain and will be reviewed at the year end March/April 2018.	GREEN CorpG4
APPENDIX 4 FOLLOW UP REVIEW OF GOVERNOR ENGAGEMENT				
Summary and next steps	R16: Sam Harrison	The Board should introduce routine NED presentations from committee chairs at CoG meetings, both to provide greater insight into key areas of assurance and to facilitate holding to account of NEDs.	Presentations have been scheduled for NEDs to present to the Council of Governors on their remit since Spring 2017, particularly focussing on their Board Committee chair roles. This has been successfully carried out by Margaret Gildea, Julia Tabreham, Barry Mellor and Anne Wright to date. Richard Wright is scheduled to present in December. The cycle will then be repeated on an ongoing basis.	GREEN CoG2
	R17: Sam Harrison	In its next joint development session, the Board needs to reflect on governor feedback regarding the visibility of all BMs, and views around the quality and openness of debate in CoG meetings.	The next joint development session is planned for 8 November and will be a facilitated session on roles and responsibilities. The facilitator has been briefed to ensure that governors have the opportunity to raise the issues as outlined.	GREEN CoG2

NHS
Derbyshire Healthcare
NHS Foundation Trust

Summary of Board Assurance Framework Risks 2017/18 - Issue 3.0

Ref	Principal risk	Director Lead	Current rating (Likelihood x Impact)
Strategic Outcome 1. We will deliver quality in everything we do providing safe, effective and person centred care			
1a	Failure to achieve clinical quality safety standards required by our regulators	Executive Director of Nursing and Patient Experience	HIGH (4x4)
1b	Failure to achieve clinical quality standards required by our regulators in relation to providing effective care for our patients	Executive Director of Nursing and Patient Experience	HIGH (4x4)
1c	Failure to fully comply with the statutory requirements of the Mental Health Act (MHA) Code of Practice and the Mental Capacity Act (MCA)	Medical Director	HIGH (4x4)
1d	Risk of inadequate systems to ensure business continuity is maintained in the event of a major incident	Acting Chief Operating Officer	MODERATE (4x3)
Strategic Outcome 2: We will develop strong, effective, credible and sustainable partnerships with key stakeholders to deliver care in the right place at the right time			
2a	Inability to deliver system wide change due to changing commissioner landscape and financial constraints within the health and social care system	Interim Director of Strategic Development	EXTREME (4x5)
Strategic Outcome 3. We will develop our people to allow them to be innovative, empowered, engage and motivated. We will retain and attract the best staff			
3a	Ability to attract and retain high quality clinical staff across all professions	Interim Director of People and Organisational Effectiveness	EXTREME (4x5)
3b	There is a risk to staff engagement and wellbeing by the trust not having supportive and engaging leaders	Interim Director of People and Organisational Effectiveness	HIGH (4x4)
3d	There is a risk that the Trust does not operate inclusively and may be unable to deliver equity of outcomes for staff and service receivers	Interim Director of People and Organisational Effectiveness	MODERATE (4x2)
3e	Potential turnover of board members	Director of Corporate Affairs and Board Secretary	MODERATE (3x4)
Strategic Outcome 4. We will transform services to achieve long-term financial sustainability			
4a	Failure to deliver financial plans	Executive Director of Finance	EXTREME (4x5)
4b	Failure to deliver internal transformational change at pace	Interim Director of Strategic Development	EXTREME (4x5)

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 November 2017

Report from the Council of Governors 26 September 2017

The Council of Governors has met once since reporting to the September Public Board. The Council of Governors met on Tuesday 26 September at the Winding Wheel in Chesterfield. The meeting was chaired by Caroline Maley, Trust Chair. Fifteen governors attended.

Chief Executive Report

The report updated governors on changes within the national health and social care sector as well as providing local updates within the health and social care community. The report supports the Council in its duty of holding the Board to account by way of informing members on internal and external developments.

It was noted that the Derbyshire Sustainability & Transformation Partnership (STP) has been rated as 'advanced' by NHS England, which means that the STP can apply for extra resources. This will lead to the introduction of the 'urgent care village' at the Royal Derby Hospital where mental health practitioners will be sited to assess people on presentation and divert them to the most appropriate services, which is expected to lead to improved outcomes for those people.

Ifti Majid commended the work of colleagues on World Suicide Prevention Day, 10 September 2017, and took the opportunity to remind governors about World Mental Health Day which is 10 October 2017.

Over the coming months Ifti Majid outlined that he will be reaching out to local MPs to update them on the organisation's progress and also address the fact that although the national awareness of mental health is rising, the improvements promised towards increased funding for the front line to allow for improvements in pathways and support at all levels for improvements in performance is not forthcoming.

Integrated Performance Report

Claire Wright, Deputy Chief Executive & Finance Director presented the Integrated Performance Report to provide governors with an overview of performance as at the end of August 2017 with regards to workforce, finance, operational delivery and quality performance. Board Committee Chairs reported on how the report is used to hold Executive Leads to account in each of the Board Committees.

Non-Executive Director Update on Audit & Risk Committee

Dr Anne Wright, Non-Executive Director and Chair of Mental Health Act Committee and the Safeguarding Committee gave an update on the work of each of the committees, highlighting the purpose and membership of the Committee.

Staff Engagement & Pulse Check Update

Margaret Gildea presented the latest Pulse Check results and informed governors regarding the plan for the 2017 Staff Survey.

Escalation Items to the Council of Governors
A number of items were escalated to the Council of Governors from the Governance Committee. Non-Executive Directors responded to the escalations, which will in turn be reported in full in the public minutes.

Amendment to the Governors' Code of Conduct
The Governors' Code of Conduct was amended, at the request of governors, to clarify what constitutes a 'formal complaint' and the process for triggering the investigation of a complaint. A formal process will be deemed to be initiated once it has been communicated in writing to either the Trust Chair, Lead Governor or Senior Independent Director.

Governance Improvement Action Plan (GIAP)
The Council of Governors received and approved a report illustrating where evidence of embeddedness and ongoing implementation has underpinned that completion of the three GIAP actions assigned to the Council of Governors. Governance Committee had reviewed the update at its meeting on 13 September and agreed that the implementation of actions had been effectively embedded as 'business as usual'.

Governance Committee Update
Gillian Hough, Chair of Governance Committee, presented an update on meetings of the Governance Committee held on 15 August and 13 September. Notably the Committee had completed a year-end report for 2016/17 summarising the activities undertaken by the Committee in line with its terms of reference. The Council of Governors approved the year-end report.

Nominations & Remuneration Committee Report
Margaret Gildea presented the report to update the Council of Governors on the activities undertaken by the Nominations & Remuneration Committee. The Council of Governors approved a request to a change in membership of the Committee.

Elections Update
Governors received update on preparations for the current public governor elections and the broad range of activities undertaken to promote the vacancies. One further resignation had been received, from the Public Governor for Amber Valley North. The election for this vacancy is to be arranged in addition to the current activity – it cannot be incorporated into the current election round.

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

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

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

2017-18 Board Annual Forward Plan

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	26 Apr 17	24 May 17	28 Jun 17	26 Jul 17	27 Sep 17	1 Nov 17	29 Nov 17	27 Jan 18	28 Feb 18	28 Mar 18
		Deadline for papers	**18 Apr**	**15 May**	**19 Jun**	**17 Jul**	**18 Sep**	**23 Oct**	**20 Nov**	**22 Jan**	**19 Feb**	**19 Mar**
CM	Apologies given		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
CM	Minutes/Matters arising/Action Matrix	FT Constitution	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
CM	Board Forward Plan	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X
CM	Board review of effectiveness of the meeting	Statutory Outcome 3	X	X	X	X	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE												
CM	Chair's report	Licence Condition FT4	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
MP/ CW	NHSI Annual Plan *TBC awaiting NHSI guidance*	FT Constitution/NHSI Risk Assurance Framework (RAF)										
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 - annual report April interim report November	Strategic Outcome 1 Strategic Outcome 3 Information Gov toolkit	AR					IR				
AR	Staff Survey Results and Action Plan	Strategic Outcome 3 and 4	X									
AR	Equality Delivery System2 (EDS2) & Workforce Face Equality Standard (WRES) Submission * (Jul & Sep 2017)	Strategic Outcome 3 and 4	AR		X *	X *	X Update					
AR	Pulse Check Results and Staff Survey Plan						X					
AR	Approval of Equality Delivery System2 (EDS2) 2017/18	Strategic Outcome 3 and 4					X					
SH	Review SOs, SFIs, SoD	FT Constitution Standing Orders					AR					
SH	Trust Sealings	FT Constitution Standing Orders	AR									

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	26 Apr 17	24 May 17	28 Jun 17	26 Jul 17	27 Sep 17	1 Nov 17	29 Nov 17	27 Jan 18	28 Feb 18	28 Mar 18
SH	Annual Review of Register of Interests	FT Constitution Annual Reporting Manual	AR									
SH	Board Assurance Framework Update	Licence Condition FT4	X				X	X		X		
SH	Raising Concerns (whistleblowing)	Strategic Outcome 1 Public Interest Disclosure Act			X							
SH	Committee Assurance Summaries (following every meeting) - Audit & Risk Committee - Finance & Performance - Confidential - Mental Health Act Committee - Quality Committee - Safeguarding Committee - People & Culture Committee	Strategic Outcome 3	X	X	X	X	X	X	X	X	X	X
SH	Governance Improvement Action Plan	Licence Condition FT4	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 (EPPR)								X			
SH	Board Effectiveness Survey			X			X					
SH	Report from Council of Governors Meeting		X	X		X	X	X		X	X	X
SH	Review of Policy for Engagement between the Board & COG								AR			
SH	Board Development Programme										X	
LWS	Business Plan 2017-18 Monitoring		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

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	26 Apr 17	24 May 17	28 Jun 17	26 Jul 17	27 Sep 17	1 Nov 17	29 Nov 17	27 Jan 18	28 Feb 18	28 Mar 18
QUALITY GOVERNANCE												
CG	Position Statement on Quality (Incorporates Strategy and assurance aspects of Quality management) Quarterly publication of specicified information on death in September Includes Annual Review of Recovery Outcomes in November and Annual Looked After Children Report in December	Strategic Outcome 1 CQC and Monitor	X	X	X	X	X	X	X	X	X	x
CG/JS	Safeguarding Children & Adults at Risk Annual Report	Children Act Mental Health Standard Contract					AR					
CG	Control of Infection Report	Health Act Hygiene Code		AR								
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							AR			
CG	Annual Community Patient Survey	Clinical Practice CQC							AR			
JS	Re-validation of Doctors	Strategic Outcome 3			AR							
CG	Annual Review of Recovery Outcomes *							AR				
CG	Annual Looked After Children Report *									AR		

* Incorporated in Quality Position Statement