Derbyshire Healthcare NHS
NHS Foundation Trust

Meeting of the Board of Directors

30 March 2016

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

Better together

NOTICE OF BOARD MEETING
WEDNESDAY 30 MARCH 2016
TO COMMENCE AT 1.00 PM IN THE CONFERENCE ROOMS A & B,
RESEARCH & DEVELOPMENT CENTRE, KINGSWAY, DERBY DE22 3LZ

	Time	AGENDA	Enc Ref	Discussion led by
1.	1:00	Chairman's Welcome and Opening Remarks	**-**	Richard Gregory
2.	1:05	Service Receiver Story – Early Intervention Service		Richard Gregory
3.	1:30	Apologies for Absence Declarations of Interest		Richard Gregory
4.	1:35	Minutes of Board of Directors meeting held on 24 February 2016	**A**	Richard Gregory
5.	1:40	Matters arising – Actions Matrix	**B**	Richard Gregory
6.	1:50	Chairman's Update		Richard Gregory
7.	2:00	Acting Chief Executive's Report	**C**	Ifti Majid
PATIENTS, QUALITY AND SAFETY				
8.	2:10	Position Statement on Quality	**D**	Carolyn Green
OPERATIONAL PERFORMANCE				
9.	2:20	Integrated Performance and Activity Report	**E**	Carolyn Gilby Claire Wright Jayne Storey
10.	2:30	Monitor Plan 2016/17 Operational Budget Setting	**F** **F1**	Claire Wright
B R E A K				
STRATEGY AND GOVERNANCE				
11.	3:00	Board Assurance Framework Update	**G**	Jenna Davies
12.	3:10	Governance Improvement Action Plan and Delivery Framework	**H**	Ifti Majid
13.	3:20	Strategy Update	**I**	Ifti Majid
14.	3:30	Board Development Programme ***– to follow***	**J**	Jenna Davies
15.	3:40	Board Committee Escalations: - Quality Committee ratified minutes of meeting held 11 February - People & Culture Committee – ratified minutes of meeting held 17 February - Audit Committee verbal update of meeting held 16 March - Finance & Performance Committee – verbal update of meeting held 29 March	**K**	Committee Chairs
16.	3:50	2016/17 Board Forward Plan	**L**	Jenna Davies
FOR INFORMATION ONLY				
17.		I. CQC Report, Deloitte Report, Yates Report II. Identification of any issues arising from the meeting for inclusion or updating of the Board Assurance Framework	**M**	Richard Gregory

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

The next meeting is to be held on 27 April 2016, at 1.00 pm in Conference Rooms A & B,
Centre for Research and Development, Kingsway, Derby DE22 3LZ
Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.
Participation in meetings is at the Chairman's discretion.

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Wednesday 24 February 2016

MEETING HELD IN PUBLIC

Commenced: 1pm Closed: 4.20pm

PRESENT:	Richard Gregory	Interim Chairman
	Caroline Maley	Senior Independent Director
	Maura Teager	Chair and Non-Executive Director
	Jim Dixon	Non-Executive Director
	Tony Smith	Non-Executive Director
	Ifti Majid	Acting Chief Executive
	Claire Wright	Executive Director of Finance
	Carolyn Green	Director of Nursing and Patient Experience
	Dr John Sykes	Executive Medical Director
	Carolyn Gilby	Acting Director of Operations
	Jayne Storey	Director of Workforce OD & Culture
	Mark Powell	Director of Business Development & Marketing
	Jenna Davies	Interim Director of Corporate & Legal Affairs
IN ATTENDANCE:	Anna Shaw	Deputy Director of Communications & Involvement
	Sue Turner	Board Secretary and Minute Taker
APOLOGIES:	Phil Harris	Non-Executive Director

DHCFT 2016/017	**INTERIM CHAIRMAN'S WELCOME, OPENING REMARKS AND APOLOGIES** The Interim Chairman, Richard Gregory, opened the meeting by welcoming all present and declared there was no conflict of interest in today's agenda.
DHCFT 2016/018	**SERVICE RECEIVER STORY – PROFOUND AND MULTIPLE LEARNING DISABILITIES** Richard Gregory warmly welcomed Kim, her parents, Derek and Jean, and Sharon Wright, a carer from the home where Kim lives. He also welcomed Katie, her parents, Kay and Clive, and Tonia Simpson carer for Katie. Also in attendance was Debbi Cook, Highly Specialised Clinical Community Physiotherapist, Covering Head Nurse at the Hartington Unit, Kim West, Speech and Language Therapist and Bev Green, Service Improvement/Covering Head Nurse Hartington Unit. Kim is a lady in her 50s and has profound and multiple learning disabilities (PMLD) as a product of contracting meningitis as a baby. She left home at 21 and went to live in a social services hostel and moved when that closed to Wright Home Care. She still returns home to her parents every weekend who are very involved in her care. Katie is a young lady of 22, she has PMLD as a result of Rett Syndrome. She also left

	home aged 21 and went to live at Leigh House. Katie's parents are still very involved in her care and visit often. Katie's story is similar to Kim's, just 30 years behind. Debbi Cook, Highly Specialised Clinical Community Physiotherapist, referred to the services being run in Southern Derbyshire for people with PMLD. Both ladies have had multiple interventions by the Community Learning Disability Team, particularly Physiotherapy, Occupational Therapy, Nursing and Speech and Language. Many of these interventions have been on-going for a considerable length of time as their needs are so complex and ever changing. She explained that the numbers of people with PMLD are increasing because children are surviving with far greater issues than ever before and are starting to transition through to adult services. The service the Trust provides at the moment for people with complex needs is very good and helps people live healthier for longer in South Derbyshire. The team give a good service but the service needs to prepare for the wave of children brought through to the adult services with PMLD. Debbi Cook stressed the importance of bringing this to the Board's attention as well as commissioners and to realise how many people will be coming through the service in the future. Richard Gregory asked how the Board could help on a day by day basis. Kim's parents, Jean and Derek felt they are in the prime position of being able to get help for Kim. Access to the team is very important to them and help has been made available for them. The care and comfort people with PMLD need is different for each person. Kim is happy living at Wright Care and with all the other people who live there who all support each other. Kim calls this her home and it gives Jean and Derek great pleasure that Kim wants to live there. Kay and Clive talked about their daughter Katie who was at school and college until she was 19 and has been living in an independent home for 18 months. They feel the care and service they receive from Debbi Cook and the Learning Disabilities (LD) team is outstanding. They described how having access to the specialised team and access to the hospital without having to go through their GP means a lot to them. They praised the work of the specialists who work together with the expert team who teach the staff how to look after Katie and this is a great comfort to them. Having the level of knowledge that people are concerned about Katie and know how to look after her is so important to them and they would not have moved Katie to this home if they had not had the certainty that Katie would have had the support of the Trust's service team. Debbi Cook and the service team raised with the Board that people with PMLD do not have a voice. Debbi Cook further explained how over the coming years there would be further pressure on the service and the Trust should act now to enable capacity. Richard Gregory and the Board acknowledged that the care described by Katie's and Kim's parents does not exist in various parts of the country or within the NHS. Richard Gregory specifically highlighted one of the messages he was taking away was understanding the needs of carers but also a better transition is required from paediatric into adult services. Board members were reminded that the Learning Disabilities Showcase event is taking place on 22 March and it is hoped commissioners will attend this event so they can see for themselves what the service is providing and understand what needs to be provided for the future. Ifti Majid assured the team that he was working with commissioners so they can recognise that improvements to this service can't wait. Carolyn Green was closely involved with the Learning Disabilities Showcase event and would be inviting national leaders to attend. The Board gave thanks to Debbi Cook and the team who provide a very valued service. The Board considered this to be an area of opportunity and strategic change which would be considered within the overall Trust strategy driven forward through the

	national programme. **RESOLVED: The Board of Directors expressed thanks to Katie and Kim and their families and carers for attending today's meeting and sharing their humbling and heartfelt story.**
DHCFT 2016/019	**MINUTES OF THE MEETING DATED 27 JANUARY 2016** The minutes of the meeting, dated 27 January were accepted and agreed subject to the amendment to minute item DHCFT 2016/011 Remuneration Committee Terms of Reference point V1 "Standing Financial Instructions to state that any contractual payments should be the responsibility of the committee" to be substituted with "*Standing Financial Instructions to state that any extra contractual payments should be the responsibility of the committee".*
DHCFT 2016/020	**MATTERS ARISING AND ACTIONS MATRIX** The Board agreed to close all completed actions. Updates were provided by members of the Board and were noted directly on the actions matrix.
DHCFT 2016/021	**CHAIRMAN'S VERBAL REPORT** The Interim Chairman, Richard Gregory, was pleased to announce that John Morrissey had been elected as lead governor for the Trust. Elections for vacant governor posts were on track and he was looking forward to having a fully constituted Council of Governors and working with Governors to improve the relationship between Board and Council. Richard Gregory informed the Board that he had taken the decision to resign from the Sheffield Children's Hospital Board to spend more time with the Trust until the end of his nine month term. Richard Gregory informed the Board that a meeting of the Remuneration Committee had taken place before the board meeting and the following had been discussed: i. Tony Smith would be standing down as a Non-Executive Director (NED) at the end of March. Richard Gregory commended Tony Smith's HR and OD skills which have been particularly valuable to the Remuneration Committee and will also be missed in the newly formed People and Culture Committee. ii. It was agreed that the Governors Nominations Committee would receive the recommendation for the immediate replacement of a NED on the departure of Tony Smith and to identify a suitable replacement for Maura Teager who will be ending her term in 13 months' time. The Nominations Committee would also be recommended to fill this position in six months' time with a NED with strong clinical skills to enable a smooth hand over. iii. The Remuneration Committee ratified the appointment of Samantha Harrison as the Director of Corporate and Legal Affairs and Trust Secretary. Richard Gregory thanked Jenna Davies for the outstanding job she had carried out in the interim and commended her particular skill sets and approach to the role. **RESOLVED: The Board of Directors noted the Interim Chairman's verbal update.**
Richard Gregory temporarily left the meeting to conduct a telephone call with Monitor. The meeting was chaired in his absence by the Deputy Chair, Maura Teager.	

DHCFT 2016/022	**ACTING CHIEF EXECUTIVE'S REPORT** Ifti Majid's report focused on two key national reports issued in the last week. He provided the Board of Directors with a brief summary of the documents and noted that these reports would be used to inform strategic discussions within the Board meeting. The report also provided an update on key issues internal to the Trust and focused on the implementation of the forward view of how providers will be supported to deliver the five year forward view. Ifti Majid highlighted the work of the Mental Health Taskforce commissioned to look into to the condition of current mental healthcare in the UK. The Taskforce recognised that extra investment of £1billion is required into the system over the next five years. Ifti Majid informed the Board of his intention to publish each month reports focussing on feedback from visits made by the executive directors. Maura Teager took the opportunity to request that NEDs' activities also be included in the report which would allow them to provide feedback about what they have learned. Tony Smith also welcomed this initiative in terms of promoting staff engagement. **RESOLVED: The Board of Directors noted the contents of the Acting Chief Executive's report**
Richard Gregory re-joined the meeting and resumed the Chair.	
DHCFT 2016/023	**POSITION STATEMENT ON QUALITY** Carolyn Green's report provided the Board with an update on the continuing work to improve the quality of services provided in line with the Trust's Strategy, Quality Strategy and Framework and strategic objectives. Carolyn Green pointed out key areas of the report that highlighted how the Trust's risk management system works on a Board assurance level. She was pleased to report that the Electronic Patient Record (EPR) system roll out was progressing which will allow the Dashboard to be put in place and this was a very significant area that has moved forward. Difficulties with NPS (psychoactive substances ((legal highs) are a growing problem in Derby and Carolyn Green commended the work carried out by clinicians when dealing with the aftermath from people who have used these substances. Maura Teager, Chair of the Quality Committee reinforced the impact of the growth of NPS use. She was concerned whether patients feel safe in our services and the positive work that is compromised by increased admissions and length of stay of patients who have been admitted under the influence of these substances who clearly need support and care. She informed the Board she intends to invite the Director of Public Health to the Radbourne Unit to see at first hand the effects of NPS use. The Trust has an excellent substance misuse service and some excellent staff but we need to consider our future workforce and the development of dual purpose diagnosing skills. Richard Gregory asked to be involved in the quality visit programme. He was pleased that the schedule of planning dates for quality visits is being shared with governors so they can understand how important their involvement is. Tony Smith remarked that he had taken part in a number of quality visits and found governor attendance very irregular. He felt some visits had been light on clinical input and whilst he recognised the impact on capacity of the teams, the purpose of the visit was to engage with the team and feed back to the Board. Carolyn Green agreed to revisit the mix of the teams who undertake the quality visits so they are more balanced in specific areas.

	ACTION: Quality visit teams to be reviewed and balanced in specific areas. **RESOLVED: The Board of Directors:** **1) Noted the Quality Position Statement Dashboard and trends.** **2) Scrutinised the current position**
DHCFT 2016/024	**CQC SAFEGUARDING REPORT AND ACTION PLAN** The CQC action plan was received by the Board which provided assurance to ensure that the recommendations are being met adequately to timescale or to show progress on the recommendations. The Board also recognised this issue had been escalated to the Board from the minutes of the meeting of the Safeguarding Committee held on 22 January. The Board felt the action plan contained too many inconsistencies and agreed that the Safeguarding Committee would continue to monitor progress and would receive a revised version of the action plan at its next meeting in April. Although he recognised the monitoring group of the action plan is the Safeguarding Committee, Mark Powell could not triangulate the gaps contained in the action plan with the corresponding minute item from the meeting of the Safeguarding Committee. Carolyn Green assured Mark Powell that actions were progressing and the action plan template could be adapted to provide better assurance that that activities were being progressed and she would address this with the CQC. It was agreed that the Board would receive further versions of the CQC Action Plan on an exception only basis. **RESOLVED: The Board of Directors:** **1) Monitored the progress of the CQC Action Plan to ensure compliance.** **2) Received partial assurance that the action plan is being developed within the set timescales and evidence and/or a progress report is completed** **3) Received the CQC report and was partially assured of on-going actions and improvements being made and requested the Safeguarding Committee to lead all future monitoring of this external audit and assurance of the implementation of the learning and recommendations.** **4) Requested the submission of further reports on an exception only basis.**
DHCFT 2016/025	**STAFF SURVEY RESULTS** The report on the NHS National Staff Survey Results 2015 provided the Board with a high level overview. Jayne Storey informed the Board that the results would be shared with the Council of Governors at their next meeting in March and the Joint Negotiating Committee. The Board agreed that the results showed that staff were unsatisfied but were generally happy with the service they are providing. The survey results would help inform the new organisational development plan. Proactive work will be undertaken to explore the results further and the detail will be shared with the People and Culture Committee. Staff pulse checks will take place through the organisation more frequently to track progress of interventions. **RESOLVED: The Board of Directors received the high level annual national staff survey results and agreed the monitoring and tracking of the action plan would take place through the People and Culture Committee.**

DHCFT 2016/026	**INTEGRATED PERFORMANCE AND ACTIVITY REPORT** The report defined the Trust's performance against its Key Performance Indicators plus any actions in place to ensure performance is maintained. Compliance with the Trust's performance indicators is being actively monitored and corrective actions are put in place where appropriate. Areas covered in this report include, the Main Performance Indicators, Health Visitors, IAPT and Ward Safer Staffing. The Board was pleased to note the achievement of outpatient letters responded to within 10 days and that ward safer staffing had significantly improved. **RESOLVED: The Board of Directors:** **1) Acknowledged the current performance of the Trust** **2) Noted the actions in place to ensure sustained performance**
DHCFT 2016/027	**FINANCE DIRCTORS REPORT MONTH 10** Claire Wright's paper provided the Board with an update on financial performance against the Trust's operational financial plan as at the end of January 2016. This month's report included a new summary dashboard which shows actual and forecast performance including trends to compare to previous months performances. This will be the style of reports for the future and Claire Wright asked members of the Board to provide her with feedback on the content and style so the report can evolve and be more user-friendly. The Board noted that all financial measures are better than plan with the following exceptions: • Capital expenditure is currently £1.0m behind plan year to date and is forecast to be less than plan at the end of the financial year by £0.2m. This is due to the reprioritisation of schemes during the year and revised start dates. • In month the qualified agency nursing expenditure was above the ceiling of 3% at 3.7% for the month of January but this was a significant improvement on the earlier months of the financial year. **RESOLVED: The Board of Directors considered the content of the paper and felt assured on the current and forecast financial performance for 2015/16.**
DHCFT 2016/028	**GOVERNANCE FRAMEWORK AND ACTION PLAN** The Governance Framework and Action Plan will be reformulated in line with recommendations made by Deloitte and the CQC and submitted to the Board at the March meeting. **RESOLVED: The Board of Directors noted that the Governance Framework and Action Plan will be resubmitted to the March meeting.**
DHCFT 2016/029	**BOARD COMMITTEE ESCALATIONS** Committee chairs escalated to the Board matters of interest and note from the meetings held this month. **Quality Committee:** E-learning buy-in of the safety planning CQUIN and the risks involved in the roll out of e-learning to all clinical staff before the end of the March was escalated to the Board by Maura Teager, Chair of the Quality Committee. She also highlighted the need for NICE Guidance accountability with Clinical Reference Groups to

	be phased in with the Quality Leadership Teams. She was pleased to report that suicide prevention work is being carried out and that the Trust had been positively benchmarked against the national average. Maura Teager also explained the process behind tracking outstanding actions in Serious Incidence investigations and how delivering outstanding actions was being driven down. **Audit Committee:** Caroline Maley, Chair of the Audit Committee informed the Board that a deep dive of risk 2c regulatory compliance took place at the meeting which she felt was a positive start to the Board Assurance Framework for next year. This was the last of the deep dives for this year and she intended these to be scheduled earlier in the year in future. She was pleased to report that initial work with accounting policies showed an improvement in trends, although the year end timetable is very challenging. **Safeguarding Committee:** Maura Teager, Chair of the Safeguarding Committee was pleased to report that the committee shared the Safeguarding Children and Safeguarding Adults Strategy vision. She commended the work of Tina Ndili and Tracey Holtom in formulating the strategies and looked forward to working towards an alignment of both the children and adults strategies in the future. **Finance & Performance Committee:** Jim Dixon, Chair of the committee explained that minutes of the Finance & Performance Committee are not received at the Public Board session as they are confidential. The committee covers a variety of important management policy and issues regarding the Trust's finances and budgeting cycle. The committee also monitors commercial and contractual issues. Jim Dixon explained that Monitor had introduced a ceiling on the Trust's budget that can be spent on bank and agency staff. The target is 3% and the Trust was currently operating at 3.7% above that target. He explained this was not considered a breach but was a managed override put in place to increase the reliance on agency staff in the interests of patent safety. The 3.7% override of the Trust's ceiling is also contained within the Finance Director's report. The Finance & Performance Committee will monitor the action plan to reduce the balance of agency staff and the Board will monitor the impact and risks for keeping within the 3% ceiling. **People & Culture Committee.** The committee held its first meeting on 17 February when the terms of reference and governance action plan was addressed as well as other work streams. The committee received the Community Engagement Strategy and discussed governance and people issues. **RESOLVED: The Board of Directors noted the contents of the ratified minutes of the Audit Committee, Quality Committee and the draft Mental Health Act Committee minutes.**
DHCFT 2016/030	**FUTURE RELATIONSHIP BETWEEN THE TRUST'S BOARD AND COUNCIL OF GOVERNORS** Richard Gregory was delighted to inform the Board that John Morrissey had been elected as lead governor of the Council of Governors. Richard Gregory acknowledged the importance of the relationship between the Chair and Lead Governor is crucial and he intends to meet with John Morrissey on a regular basis. Elections for vacant governor posts were on track and he was looking forward to having a fully constituted Council of Governors. John Morrissey was glad to hear that Richard Gregory intended to work with the governors on an improved relationship that will enable governors to carry out their work in holding Non-Executive Directors to account. **RESOLVED: The Board of Directors noted the appointment of the lead governor.**
DHCFT 2016/031	**BOARD FORWARD PLAN**

	The forward plan was included for information and reference purposes. **The Board of Directors received the forward plan for information.**
DHCFT 2016/032	**ANY OTHER BUSINESS** Richard Gregory updated the Board on his discussions with Monitor regarding the Section 106 enforcement notice. Monitor expressed confidence in Richard Gregory's appointment as Interim Chairman and his role in leading the development and implementation of the governance action plan. Monitor will work closely with the Trust to support the changes being made and the March Board Development session will be used to develop and sign off the governance action plan.
DHCFT 2016/033	**BOARD PERFORMANCE AND CONTENT OF MEETING** It was agreed that in future questions from the public applicable to the agenda and at the Interim Chairman's discretion can be received up to 48 hours in advance of meetings and would receive a response from the Board. This will be communicated in the notice of the meeting by the Interim Director of Corporate and Legal Affairs.

The next meeting of the Board held in Public Session will take place at 1pm on Wednesday, 30 March 2016.

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

BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - MARCH 2016						
Date	**Minute Ref**	**Action**	**Lead**	**Status of Action**	**Current Position**	**Enc B**
29.7.2015	DHCFT 2015/126	AOB - Board Development Programme	Jenna Davies	Jayne Storey to provide a clearer definition of the Board Development Programme at the next meeting of the Board in September	The Forward Plan for Board Development together with a clearer definitiion of the constraints and purpose of the Board Development framework is required from Jenna Davies and will be provided at the March meeting.	Green
30.9.2015	DHCFT 2015/134	Committee Summary Reports	Jenna Davies	Revised draft of the Raising Concerns at Work (Whistleblowing) Policy and Procedures to be submitted to the Board at the October meeting. Committee minutes to be submitted to the Board in future rather than summary reports.	Waiting for revised national guidance to be released in order to produce a revised draft of the Raising Concerns at Work (Whistleblowing) Policy and Procedures. Agenda item for March meeting.	Green
27.1.2016	DHCFT 2016/005	Acting Chief Executive's Report - Industrial Action	John Sykes	John Sykes as Medical Director will oversee communication to all staff and patients and will be available to answer external enquiries. He will liaise with neighbouring Medical Directors and CCGs in efforts to improve overall system resilience and will escalate risks as necessary to ELT for action and if necessary direct action by the Acting Chief Executive.	Further industrial action has been announced for 9 March, 11 March, 6 April 8 April, 26 April and 28 April. These will be 48 hour emergency cover only. The clinical director and associate clinical directors have been asked to consider extra outpatient clinics etc to compensate for the capacity that we losing due to repeated industrial action. There may be impact on junior doctor recruitment and retention due to an imposition of a national contract centrally. Details on implementation are being cascaded from the centre and we are looking at the possibility of overseas recruitment initiatives. There will be reports on these subjects to ELT.	Amber
27.1.2016	DHCFT 2016/011	Remuneration Committee Terms of Reference	Jenna Davies	Jenna Davies to amend the Remuneration Committee's Terms of Reference and submit to April meeting of the committee.	Amended Remuneration Committee's Terms of Reference to be agenda for April Remuneration Committee meeting.	Yellow

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

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 30 March 2016

Acting Chief Executive's Report

1. Introduction

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 our staff. The report should be used to support strategic discussion on the delivery of the Trust strategy.

2. National Context

2.1 On 1 April 2016, NHS Improvement launches, bringing together Monitor, NHS TDA, the Patient Safety team, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

A single oversight framework will be introduced during 2016/17 that is based on the principle of earned autonomy and, as described in 'Implementing the Forward View: supporting providers to deliver', that segments providers according to the extent to which they meet the single new single definition of success that incorporates: finance and use of resources; quality; operational performance; strategic change; and leadership and improvement capability. NHS Improvement will consult on their proposals for this framework during quarter 1 2016/17.

In the meantime, the current frameworks, so for us Monitor's risk assessment framework will remain in place. For the immediate term our relationship management process with Monitors Team will remain active

2.2 Monitor have released the Quarter 3 performance figures for the NHS as a whole and it is worth looking and noting some of the headlines when reviewing our performance later on the agenda

- The year to date deficit for the NHS is £2.26bn (£622m worse than plan). 179 out of 240 Trusts were reporting a Q3 deficit
- 90.66% of patients seen/treated in 4 hours (target 95%)
- For the first time the NHS as a whole has failed to meet the referral to treatment target
- Delayed transfers of care have risen

Performance is further deteriorating across the provider sector as a whole and this will be a key focus for NHS improvement and will be an area where specific actions will need to be developed as part of the Sustainability and Transformation plans to be submitted by health and social care communities.

Derbyshire Health and Social Care Community

2.4 The Derbyshire Health and Social Care Community have commenced work on the development of the Sustainability and Transformation Plan. The STP footprint has been agreed as Derbyshire (including Derby City).

The CCG Chief Officers and NHS Provider Chief Executives and Local Authority Directors of Adult Social Care have worked together to develop proposals for the governance arrangements for the STP development.

The definition of the governance arrangements includes:

- Purpose and aims: to enable and support the STP process (consistent with the guidance);
- An agreed set of principles;
- Decision making rights;
- Structure – how components of the planning will fit together and link with existing structures;
- Description of the responsibilities / expectations for each of the main components;
- Agreement and sign-off of the governance arrangements by Statutory Bodies;

We are now asked to agree and support the proposed governance arrangements for the STP development that can be seen in appendix 1. We are asked to particularly consider the principles and commentary related to decision making rights.

I will then feedback to the SRO of the STP development process (Gary Thompson) any comments by 4th April 2016.

Inside Our Trust

2.5 Listen, Learn, Lead.

During the past month Executive Directors have visited the following Teams

Team Name	Visited by	Date of visit	Themes emerging
Southern Derbyshire Crisis and Home Treatment Team	Mark Powell	26/02/16	The team would like to change their name from Crisis and Home Treatment to something akin to Assessment and Home Treatment There was a request for some guidance on what could be said to patients who asked questions about the recent Employment Tribunal and media attention Discussed the impact on the image and the perception of those who are doing a very good job for the Trust at this time and what actions the Board was taking to improve the Trusts reputation. The team were concerned about the number of patients with a PD who were presenting to the service and there was a concern about Melbourne House not accepting admissions. An issue was raised about staff from Melbourne House and then deployment to the Hub –
Information Management, Technology and Records			The team took the opportunity to bust some rumours around the ET particularly around the cost and impact on clinical services. General sense of being very busy, competing demands and how IT was often seen as key to innovation therefore demand high. Capacity seen as a problem as well as lack of clarity of who was who in Trust middle management
IAPT Team Ilkeston	Ifti Majid	15/03/2016	New contract issues, capacity, covering whole of county and differences north/south. Multiple assessments and pt experience due to bouncing from service to service.
Estates Team	Claire Wright	15/03/16	The estates team talked about what impacts on staff morale and team relationships and what we need to learn from. They also asked questions about the exits of the ex-chair and CEO and investigations. Also wanted to know more about the “Fit and Proper” Test Also discussed equality of access to training across staff groups. Discussed wanting to resolve more issues at team level rather than escalating
Neurodevelopment Team	Mark Powell	15/02/16	The team wanted to understand more about Trust finances and future financial position which we discussed in some detail The team were very keen to explore how they could develop wider Partnerships to support the development of their service They wanted to understand if the outcome of the ET would affect them in delivering their service to which I said it shouldn’t. They were happy with this and didn’t wish to talk about the ET anymore We also discussed Trust Values and the team were very clear that they should not be changed, are very good and are used by them each and every day
Learning Disability OT and	Ifti Majid	16/02/16	Verbal update due to timing of meeting

Physiotherapy			

2.6 Updates following last month's listen, learn lead visits.

You will recall when I visited Bolsover CMHT they had issues with the quality of the environment in the waiting room, my thanks to the estates team for quickly going up to Bolsover and redecorating the room, I understand the environment is much improved. Additionally the team asked for support around some specialist admin advice, thanks to Julie Scattergood admin lead who contacted the team the following week.

Last month we reported through this section following a visit to St Andrews House by Mark Powell and Carolyn Gilby lots of staff concern about parking and that this would get worse with the imminent move of St James' staff over to the site. Following this visit and feedback from staff side we have delayed the move of St James' staff whilst we review solutions around parking

2.7 CEO/Chair Engagement Sessions

Bakewell 2 March 2016

Only two staff members attended but this maybe because sessions have already been booked directly with the High Peak and Dales Team meetings.

Very brief discussion around the ET and associated media coverage, embarrassment mentioned by staff however it was commented not much had been mentioned by patients, contrary to other areas. Positive feedback was received on the approach taken to communication around the ET.

The main area of discussion was the Neighbourhoods and if innovation had gone far enough and could we have been more radical, this led to the sharing of some good practice around services for people with personality disorder and the need to build on some of the work underway in Chesterfield. Discussion around the need for staff to get feedback on submitting a datix incident, it was felt this was a simple example of staff not feeling valued.

We also received some positive feedback around increased stability in the High Peak Team though concerns were expressed around accommodation in Buxton becoming over crowded. Helpful update around neurodiversity and changes to equality rules.

Actions following the session to include:

- Invite commissioners to attend a meeting with the Chesterfield personality disorder pathway team to enable showcasing of work to support wider investment.
- Meet with Teams as part of Team meetings
- Understand rationale for combining bases in Buxton.
- Update trust equality policy in line with new rules around neuro-diversity

Ilkeston 18 March 2016

Three staff members attended the session and spoke about the dementia rapid response team and wondered if the development of the service would be delayed due to the cost of the ET. Discussed the sense in the team of uncertainty as it wasn't clear how fast or if the team would expand. The staff shared some great examples of best clinical practice and some frustrations around nursing home quality of care and training.

The staff shared some of the discussion in their team around the ET media and their concerns about how it happened, the cost and how we move on.

Great discussion around change and what the Trust needs to do to support staff but also how staff also need to 'take a leap'.

Liked the current style of communication but wanted us to consider more use of the 'world café' style we used during neighbourhood consultation.

Need to consider more opportunities for staff on lower grades to progress within the Organisation as this was something that had a negative impact on morale.

Some questions around Aston Hall and if the Trust is involved

Actions following the session:

- Ensure a Director attends the Team meeting
- Ask Jayne Storey to arrange a meeting with a selection of lower banded staff about career progression

And finally…… some feedback I received from Hayley Darn, Nurse Consultant, Safety whilst doing PLACE visits on Kingsway

'We have undertaken the PLACE assessments today on Kingsway campus, the team including service users, commended the overall site, friendliness and warm feeling on all 4 wards.

Standing out for me and the rest of the team was a palpable improvement on Cubley male – the environment was calm and welcoming, and in particular they have developed a sensory room with aromatherapy and calming environment which the gents were enjoying, with a bit of Frank Sinatra in the background. It's the whole team, we can't single out an individual nor would I want to.

As its nutrition and hydration week, there was also a tea party in the social lounge, with the team and also the Dietitian present talking to carers which was lovely'

Legal Issues

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

Equality Delivery System

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

Consultation

This paper has not been considered by other committees or groups.

Recommendation

The Board of Directors are requested:

1) To note and discuss the paper using its content to inform strategic discussion.
2) Agree the STP governance process

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

Derbyshire Sustainability and Transformation Plan (STP)

Draft **governance arrangements for <u>developing</u> the STP**

Governance Arrangements for STP Development

The purpose of this document is to describe the governance arrangements for <u>developing</u> the STP.

The definition of the governance arrangements includes:

1. Purpose and aims: to enable and support the STP process (consistent with the guidance);
2. An agreed set of principles;
3. Decision making rights;
4. Structure – how components of the planning will fit together and link with existing structures;
5. Description of the responsibilities / expectations for each of the main components;
6. Agreement and sign-off of the governance arrangements by Statutory Bodies;

Developing Sustainability and Transformation Plans to 2020/21

Enc C

Planning Guidance letter (16-Feb-16)

'STPs are not an end in themselves, but a means to:

- ***Build and strengthen local relationships;***
- ***Enabling a shared understanding of where we are now, our ambition for 2020;***
- ***Agree the concrete steps needed to get us there.***

If we get this right, then together we will:

- *Engage patients, staff and communities from the start, developing priorities through the eyes of those who use and pay for the NHS;*
- *Develop services that reflect the needs of patients and improve outcomes by 2020/21 and, in doing so, help close the three gaps across the health and care system that were highlighted in the 5YFV (health and wellbeing, care and quality, and finance and efficiency);*
- *Mobilise local energy and enthusiasm around place-based systems of health and care, and develop the partnerships, governance and capacity to deliver;*
- *Provide a platform for investment from the Sustainability and Transformation Fund;*

This will require a different type of planning process – one that releases energy and ambition and that focusses the right conversations and decisions.

It will require the NHS [and wider care system], at both the local and national level, to work in partnership across organisational boundaries and sectors.'

STP Governance Arrangements: Principles

Draft principles:

'Planning by individual institutions will increasingly be supplemented with planning by place for local populations. For many years now, the NHS has emphasised an organisational separation and autonomy that doesn't make sense to staff or the patients and communities they serve.'

1. The current health and care system is typically reactive and characterised by organisation and role boundaries; it must be replaced by a system that is centred on people and communities.
2. The STP is about sustainable services – not making the current organisations sustainable.
3. Both working as a system and the STP development process are complex and ambiguous. The process will identify / highlight / surface difficult issues and conflicting interests within the system. These will be addressed as a system and be driven by the interest of the people served by the system.
4. The STP will take account of existing patient flows in and out of neighbouring STP footprints. It will also take account of the demands of other footprints and regional networks and their impact on our providers.
5. It is recognised that the current governance arrangements of statutory organisations 'lag behind' the system governance necessary to drive transformational change, and are therefore likely to be challenged through the process. Partners involved will need to be willing to be flexible about how system governance arrangements evolve over time.
6. In addition, existing commissioning and contract arrangements are likely to need to change.
7. System leaders will support each other to address the barriers to system sustainability and transformation posed by existing governance arrangements and existing commissioning and contracting including 'managing up' to the regulators.
8. System leaders will challenge themselves and each other to reduce transactional bureaucracy and duplication. This will require trust between each other and their teams to ensure things are done as efficiently and effectively as possible.
9. The STP process will challenge the way organisations across Derbyshire are currently configured.
10. The STP is not about 'one size fits all'. Derbyshire is made up of many diverse communities. These differences will be embraced, however the outcomes of what good looks like will not vary across them.
11. Development and implementation of the STP will necessarily be through 'learning by doing'. This is because we need to (i) better understand people's needs; (ii) learn how we can better work together; (iii) build on where we have already made progress; (iv) consequently do more of what works and adapt what could be done better.

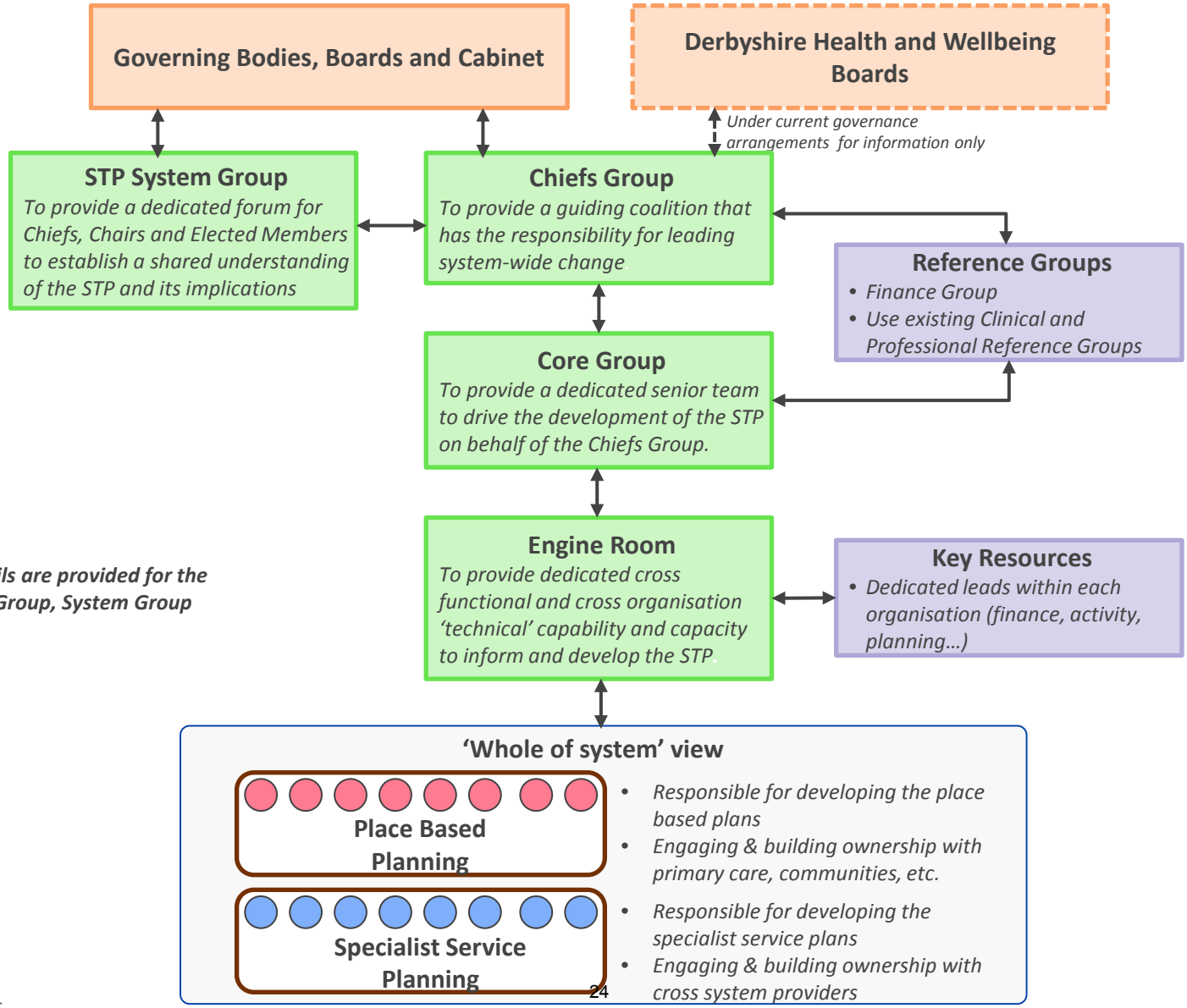
STP Governance Arrangements: Decision making rights

Decision making rights:

- Decision making rights will need to be tackled in order to successfully implement and deliver the STP. 'Whole systems' are unlikely to be effective if they are merely a forum for discussion of issues of common concern without executive responsibilities.
- And, to get on with developing the STP at the required pace, planning will be directed by the needs of the whole system and will understand the consequent implications for organisations.

- Decision making rights needs to be discussed with Boards in March:
    - Not with the expectation of resolving / agreeing changes to executive responsibilities. Specifically the STP development process will rely on existing statutory Board arrangements - it will not attempt to create a separate cross system board;
    - However, decision making rights need to be acknowledged as a complex and ambiguous area which will need to be resolved for the plans to be implemented;
    - And, Boards need to support their Chiefs with appropriate delegated authority to enable them to be full and equitable participants in the STP development process.

STP Development Governance Structure



Note – further details are provided for the Chiefs Group, Core Group, System Group and Engine Room

STP 'Chiefs Group' and 'Core Group'

Enc C

What are they?
And, what do they need to do?

Purpose of the 'Chiefs Group':

To provide a guiding coalition that has the responsibility for leading system-wide change.

Objectives:

1. To ensure the content and sign-up to the Sustainability and Transformation Plan, championing it across the system
2. To work collaboratively and agree a set of values and behaviours for taking collaboration forward; this includes holding each other to account for working in a way that is consistent with these values and behaviours.
3. To ensure Governing Bodies, Boards and Cabinets are kept up to date on the development of the STP
4. To be the conscience of the system and ensure it stays true to its principles
5. To set the pace for the development and delivery of the STP
6. To act as a conduit to resources from their own organisation involved in the development of the STP e.g. those within the engine room
7. To take system recommendations to Boards and Cabinets
8. To build on the experiences and learning from the transformation programmes in the North and South Units of Planning.

Team:

The group will be made up of the Accountable Officers and Chief Executives from the Derbyshire NHS organisations and the Directors of Adult Social Care from Derbyshire County Council and Derby City Council.

The group will meet fortnightly for 3 hours.

The Chair of the group will be the SRO for the Derbyshire STP development - Gary Thompson.

Purpose of the 'Core Group':

To provide a dedicated senior team to drive the development of the STP on behalf of the Chiefs Group.

Objectives:

1. To lead the process of developing an integrated and coherent cross system STP
2. To ensure the right conversations are being had by the Chiefs Group and decisions considered
3. To shape and guide the structure and approach for developing the STP
4. To direct and task the Engine Room, and ensure its has sufficient capacity and capability

Team:

The team is accountable to the Chiefs Group for the delivery of the STP.

The team will be made up of: Tracy Allen, Gavin Boyle, Andy Gregory, Perveez Sadiq, Gary Thompson

They will be dedicated to the STP process 2 days a week, spending at least a day of this together. This means during these two days they will focus solely on the work of the system.

Backfill and cover for this time will be covered from within their own organisations and from the wider Derbyshire system.

STP 'System Group'

Enc C

What is it?
And, what does it need to do?

Purpose of the 'System Group':

To provide a dedicated forum for Chiefs, Chairs and Elected Members to establish a shared understanding of the STP and its implications

Objectives:

1. To support Chiefs and Chairs/Elected Members to work together on 'whole system' planning
2. To ensure organisations hold each other to account for keeping to the STP development principles
3. To enable Chiefs and Chairs/Elected Members to update their Boards/Cabinets on the development of the STP

Team:

The group will be made up of Chiefs, Chairs and Elected Members

The group will meet 3 times before the end of June

The Chair of the group will be the SRO for the Derbyshire STP development - Gary Thompson.

STP 'Engine Room'

What is it?
And, what does it need to do?

Enc C

Purpose of the 'Engine Room':

To provide dedicated cross functional and cross organisation 'technical' capability and capacity to inform and develop the STP.

Objectives:

1. To support the development of an integrated and coherent cross system STP
2. To provide strong analysis and insight
3. To ensure planning assumptions and ambitions are understood and owned
4. To produce the Sustainability and Transformation Plan
5. To develop the capability of the individuals and the team as a whole
6. To ensure Derbyshire have the cross system planning capability to support STP implementation (beyond end June 2016).

Team:

The team will report to and be directed by the Core Group.

Will be up made of a combination of highly capable people from finance, information, public health, comms, workforce, 'technology' and planning backgrounds.

They will be dedicated to the STP process on a 'full time' basis.

They will typically spend significant time working from the same team base (location Babington).

Backfill will be arranged as maybe necessary.

And, the team will necessarily evolve as the process develops – under the direction of the Core Group.

Initial deliverables:

By 18th March (to inform Chiefs Group) – DRAFT understanding of the scale of the challenge:

- Health and wellbeing gap
- Care quality gap
- Finance and efficiency gap

By 1st April – confirm the scale of the challenge for inclusion in 'short return'.

Other specific deliverables and deadlines TBC.

These will include:

- *Needs and activity analysis – public health, acute, community, primary care, social care, MH, etc.*
- *Financial analysis – focused on cost to the system (rather than 'tariff')*
- *Modelling of potential and proposed changed including support for 'logic model' definition*
- *Creation of place based needs, resource, cost & activity models*
- *Scenario sensitivity analysis*

STP 'Engine Room'

How will it work?

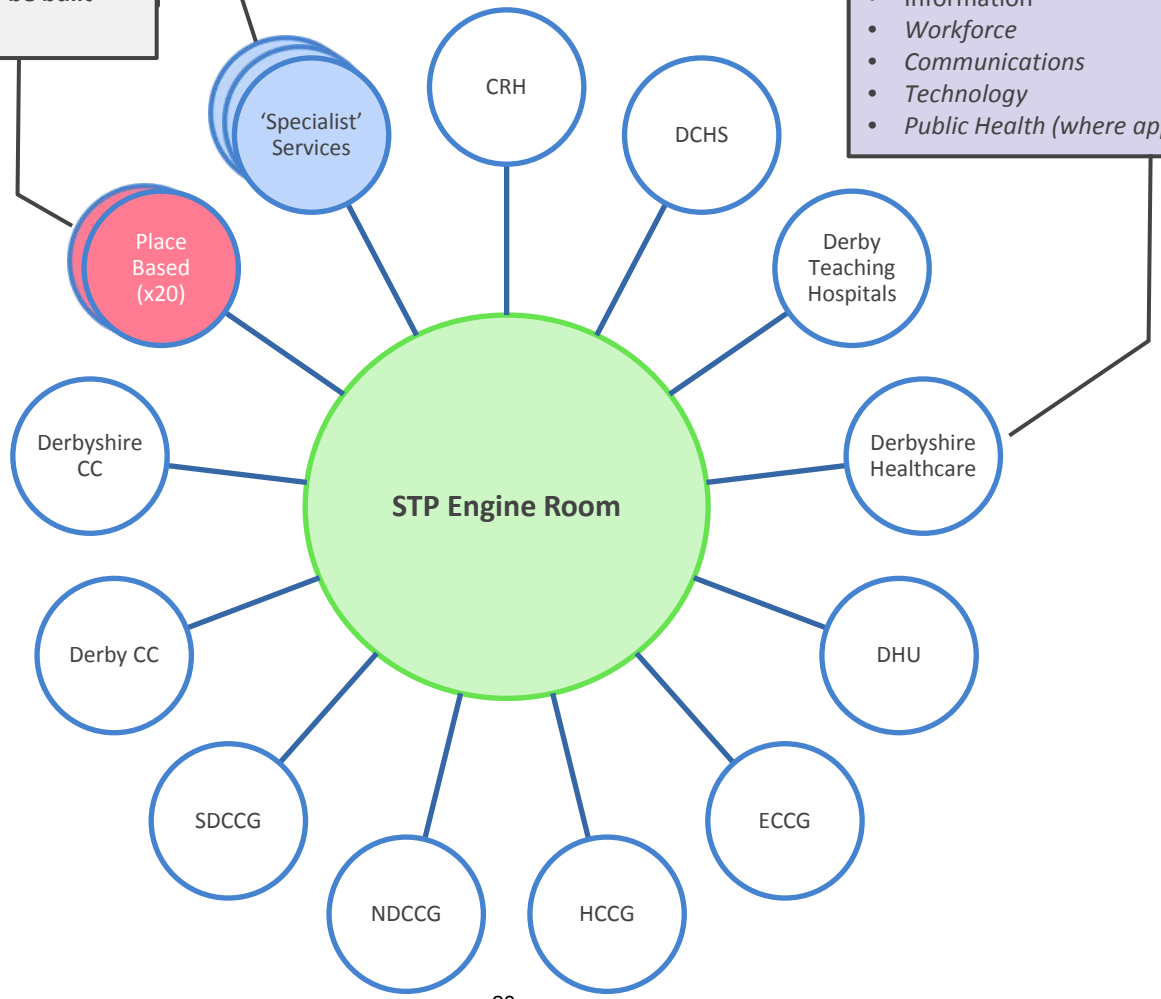
The engine room will link to key leads and groups involved in:

- **Place Based planning**
- **'Specialist' services**

Wherever possible existing groups will be built upon

Within each organisation a dedicated lead in the following areas will link with the engine room:

- Planning
- Finance
- Information
- *Workforce*
- *Communications*
- *Technology*
- *Public Health (where appropriate)*



Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 30 April 2016

Quality Position Statement

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

Executive Summary

This paper outlines our position in terms of the quality of our service since the last Board meeting.

Key areas to note;

- Revised reporting of the risk register has been included in appendix 1 of the report and includes detail on the top 6 operational risks on the Trust wide risk register
- The Trust has received a letter from the police setting out the importance of the "National Initiative" of "Child Rescue Alerts" and to request Trust Boards to consider and agree to support the process
- Details of the indicators which Governors choose to be reviewed by our auditors which are included in our quality report

Strategic considerations

Child rescue alerts

- The Trust Board are in a position of handing over employees work phone numbers without individual consent. The Trust Board need to consider information governance guidance in order to agree or decline the request.

Other considerations in the report

- To note the new requirements of the quality report and the quality indicators chosen for review by our auditors.

(Board) Assurances

- The commencement of the quality visit programme and the opportunities for Board members, commissioners and governors to hear first- hand from staff, service receivers and carers about the high quality of services we provide and to discuss those areas where further work in needed.
- Assurance that the Board level feedback around the use of advocacy following seclusion has been acted upon and a solution agreed.
- Assurance on the robustness of our medical revalidation system and processes.
- Assurance on the improvements in practice from the results of the audit work completed.

Consultation
This paper has not been previously presented.

Governance or Legal issues

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

Equality Delivery System

Any impacts or potential impacts on equality have been considered as part of all our quality work.

Recommendations:

The Board of Directors is requested to:

- Consider the proposal to submit all numbers or agreed individual numbers with regard to child rescue alerts.
- Note the Quality position statement
-

Report prepared by: **Clare Grainger**
Head of Quality and Performance

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

Derbyshire Healthcare NHS
NHS Foundation Trust

Quality Position Statement

Carolyn Green

March 2016

Better together

1. Introduction

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

2. Safe Services

2.1 Risk register

Risk register: High level strategic and operational risks (see appendix 1)

2.2 Mortality Group

The medical led Mortality Group met on Thursday 10 March 2016. Terms of reference have been redrafted in the light of the Mazars report and were considered by the Quality Committee on the same day. RMNs Nicola Cockman and Claire England presented their work on looking at physical health within the crisis team. Not only has the focus on physical health helped improve this aspect of care but also helps instil hope and motivation to address mental health issues. Work on smoking cessation was highlighted coinciding with the Trust going smoke free. 385 of service users accepted a referral to smoking cessation. Obesity is a big problem for service users. On average 25% of the adult population of Britain is obese but 54% in this sample were either overweight or obese. This led to an increase in cardio-respiratory problems as well as diabetes. 44.5% of service users accepted physical activity referrals and help with weight management.

Other issues included a high prevalence of the use of alcohol and 44% of women were overdue for cervical screening. The final report is being prepared for the East Midlands Clinical Strategic Network and there is a proposal for a focus on physical health care to be permanently within the crisis and home treatment team in keeping with patient activation initiatives. GPs are being engaged through attendance at their QUEST days and possible research projects are being considered.

A proposal has been developed for the Mortality Group to have technical support to help with further data gathering and analysis and details of this will be included in further Quality updates.

1.3 Child rescue alerts

The Trust has received a letter from the police setting out the importance of the "National Initiative" of "Child Rescue Alerts" and to request Trust Boards to consider and agree to support the process. The letter set out below:

- Outlines what the "Child Rescue Alert" is about and the reason for why it has been developed.
- Explains how the process works and what is required of each organisation.
- Requests that agencies sign up to this extremely important multi agency initiative to protect children from the risk of significant harm.
- Requests that we provide the work mobile numbers of all our employees.

Considerations

- The Trust Board are in a position of handing over employees work phone numbers without individual consent.
- Does the Trust agree to submit all numbers or agreed individual numbers?
- The Trust Board need to consider information governance guidance in order to agree or decline the request.
- The process was discussed and agreed in principle at the Safeguarding Children Board, agencies were requested to take and agree within their own organisation.

Assurances

- The Trust Board can be assured that this is a partnership initiative all other partners are signed up.
- I would encourage the Board to commit to the process in order to protect children and young people from the risk of significant harm.
- Employees work mobile phone numbers that are submitted will only be used for the purpose of the "Child Rescue Alerts".
- All employees' work mobile phone numbers are publically owned.
- The work mobile phone numbers will be secure with the National Crime Agency.
- Information Governance has agreed in principle.

Dear board members please read the letter below and consider if we, as a trust, will sign up to the process:

Letter from Derbyshire Constabulary for consideration of the DHCFT Trust Board:

Gareth Meadows Detective Chief Inspector 3325 Public Protection Unit, Derbyshire Constabulary

Dear Colleague,

I am writing to ask you consider a proposal to enhance the operational effectiveness of Child Rescue Alert [CRA.] This would involve you providing the telephone numbers of all your organisation's 'publically owned' mobile telephones to the National Crime Agency [NCA.]

You will all be aware of those thankfully rare situations where a child is forcibly kidnapped and then murdered. The loss of April Jones in mid Wales a couple of years ago is a recent example. It is easy to appreciate how critical a task mobilising the public can be from the police learning a child has been taken until it is too late.

CRA is a national system in place led by the NCA and the organisation 'Missing People.'

The basic premise of the system is as follows. Where the police learn of a child being at risk of significant harm, their whereabouts are unknown and there is some

real benefit to be derived from alerting as many members of the public as possible any police superintendent can activate its use. Pre-existing arrangements are in place with national media outlets to interrupt broadcasting as requested on a case by case basis. This can be done nationally, regionally or locally. The aim is to quickly obtain that key piece of information, an otherwise uninformed, member of the public can give that may save a child's life.

Research indicates that a child abducted by a predatory paedophile will die within three to six hours of being taken. CRA is about informing the public and asking for their help in the most serious of cases as quickly as possible. It should not be over utilised to avoid a 'cry wolf' situation developing.

As members of the Local Safeguarding Children's Board I would suggest that it is our responsibility to support CRA. It is accepted that many people do not get their news through the traditional media. Most though carry smart phones. Many members of the public work in the public sector and many carry such phones which are ultimately owned by the tax payer. The NCA are asking that public bodies consider providing them with the details of such phones. The numbers will be registered to receive 'alerts' by text message should the system be activated. Should you agree to this you will be contributing to widening the pool of those otherwise uninformed members of the public.

There will be no financial cost to you and no expectation that your staff use or carry their phones differently to how they do now.

Please consider this request and if you are agreeable I can facilitate this.

ACTION: For DHCFT to consider releasing all staff's work mobile phone numbers to the police for the purpose of the 'child rescue alerts'.

3. Caring Services

3.1 Update on our volunteering

The volunteer service currently has an active caseload of 122 volunteers who have submitted applications, are undergoing recruitment checks or are actively volunteering. 72% (88) of our volunteer population have lived experience of mental health issues or have used our services. 60 people are currently actively volunteering in the organisation and 46 have a role allocated and are undergoing recruitment checks. A further 16 are awaiting allocation of a volunteer role. Areas of development for 2016/17 are:

- Volunteer Internships. Innovations funding has been received to support a pilot to provide time-limited volunteering opportunities for early interventions service-users wishing to access paid employment but who need experience of the work place, or to build endurance, confidence, skills etc. This will be provided alongside specialist OT employment focused assessment and intervention and job searching support following the 'individual placement and support' model. The first cohort of volunteer interns has been recruited 4 are

now in post. 3 have placements within DHCFT, 1 has an external placement. 1 of the 4 has accepted a paid apprenticeship within our organisation.

- Recovery Peer Volunteers are currently being recruited for the Hope and Resilience Hub, Hartington Unit Hub and Neighbourhood Teams, Cherry Tree Close, The Beeches and Early Intervention Services

- New starters are registered on the electronic staff record.

- Currently working to ensure all active volunteers have a trust email account and learning passport

- Working to ensure REGARDS data is collected for all volunteers at application stage, and gather from those already in voluntary positions

- Volunteers to be incorporated in trust 'New Starter' system.

- On-going support for volunteers with lived experience to complete wellness plans in relation to their role. Feedback from volunteers and supervisors on the wellness plans is positive.

4. Effective Services

4.1 Audit work completed

4.1.1 Second Re-audit: Consent to Treatment – Section 58 – Nov 2015

Dr Edward Komocki and Dr Eva Bowditch have completed a 2nd cycle of re-audit on compliance to the process of consent to treatment under section 58 of the Mental Health Act (MHA) 2007

Section 58 sets out the requirements for consent to treatment under the MHA. As a result of the audits and actions taken significant improvements in practice have been demonstrated. For example, higher levels of compliance are being achieved in documentation of responsible clinician discussion with patients such as recording of patient's capacity, consent or refusal to treatment. Improvements are also being achieved in documentation of responsible clinician explanation of treatment options such as benefits, side effects, alternatives and consequences of no treatments. Improvements in completion of T2 and T3 have also been achieved with particularly good compliance in review of forms when there has been a change in treatment or responsible clinician.

Improvements in practice have been achieved through implementation of a Section 58 flow chart providing a prompt, attached to the front of the reminder letters sent to Responsible Clinician's by the MHA Office when Section 58 needs to be considered. Some doctors have taken on the role of "MHA Supporters" to remind others of their responsibilities when this process is initiated for their patients and to encourage them to complete all the appropriate documentation. Whilst these changes have proved effective and continues to be embedded along with awareness raising amongst relevant staff, in order to improve and achieve further compliance additional actions

are planned. These include potential of electronic alerts on PARIS and review of existing MHA paper forms which can act simultaneously as prompts and records of the requirements of the process. A Further re-audit is planned later in 2016,

3.1.2 Topic 9c: Antipsychotic prescribing in people with a Learning Disability (LD) 2015

The Winterbourne View report, published in 2012, raised concerns about the over-use of psychotropic medicines in people with learning disability. We participated in this Prescribing Observatory for Mental Health (POMH-UK) national audit-based quality improvement programme which aims to help mental health services improve prescribing practice in anti-psychotic medication use in people with a Learning Disability.

Gaynor Ward and Dr Gulshan Jan have lead this audit in which the team reviewed and completed audit forms for 149 patients for this 2nd cycle of re-audit and the results showed that for the:

Practice standard: The indication for treatment with antipsychotic medication should be documented in the clinical records; we continued to be fully compliant on this standard.

Practice standard: The continuing need for antipsychotic medication should be reviewed at least once a year. Our results showed that we had improved from previous audits achieving 93% compliance compared to 97% compliance in the Total National Sample (TNS).

Practice standard: Side effects of antipsychotic medication should be reviewed at least once a year - this review should include assessment for the presence of Extra-Pyramidal Side effects (EPS), and screening for the four aspects of the metabolic syndrome: obesity, hypertension, impaired glucose tolerance and dyslipidaemia. Our results indicated the need for improvements in this standard for:

- documentation of assessment of EPS in the last year which was not recorded for 49% of cases (compared to 48% non-compliance for TNS)
- documentation of measure of body weight in the last year which was not recorded for 40% of cases (compared to 34% non-compliance for TNS)
- documentation of assessment of blood pressure in the last year which was not recorded for 78% of cases (compared to 42% non-compliance for TNS)
- documentation of assessment of blood glucose in the last year which was not recorded for 18% of cases (compared to 28% non-compliance for TNS)

- documentation of assessment of lipid profile in the last year which was not recorded for 18% of cases (compared to 28% non-compliance for TNS)

As a result of participation in this audit an action plan for improvement is to be fully implemented prior to the planned local re-audit for June 2016 to ensure improvements in practice have been achieved. Improvement actions are being taken to increase service user involvement and to make changes in clinical documentation including the development of standard clinic letters which will enable the review and recording of assessment of EPS and Monitoring of side effects as per NICE guidelines for recording weight, BP, blood glucose, and lipid profile in clinical notes

and/or out-patient letter (or that they have been requested through primary care). In addition. All antipsychotic prescribing will be made, wherever possible, with the person's personal preference through the use of easy read choice sheets and medication Side Effect spider diagram - both to be laminated and included within clinic packs.

5. Responsive Services

5.1 Memorandum of Understanding for Seclusion De-briefs

Earlier in the year, Board questions were raised by Derbyshire Voice on why the trust did not provide access to independent advocacy for debriefs if seclusion occurred. This contract has been developed and will go live and fully operational on April 1st 2017.

We would like to offer thanks to Derbyshire Mind Advocacy Service & Derbyshire IMCA Service for providing this service to our patients.

5.2 Derbyshire Mind gains new Advocacy Quality Performance Mark (QPM)

Derbyshire Mind has been awarded the Advocacy Quality Performance Mark (QPM) from the National Development Team for Inclusion (NDTi). The QPM is the UK's only independent quality performance mark for organisations offering independent advocacy; an essential service for people who need support to express their needs and have increased choice and control in their lives.

Our congratulations to Derbyshire Mind in achieving this award.

6. Well Led Report

6.1 Medical revalidation

The Trust had a visit from the Medical Directorate, Midlands and East NHS England Revalidation Team on Wednesday 17February 2016. Whilst the official report is expected shortly they declared themselves satisfied with our medical appraisal procedures and particularly our approach to the quality improvement cycle as designed by Dr Ed Komocki, Trust Revalidation Lead.

6.2 Quality Report

At the Council of Governors meeting held on 8th March 2016 the Governors chose the indicators to be reviewed by our auditors which are included in the quality report. The Governors chose:

- minimising delayed transfers of care
- Admissions to inpatient services had access to crisis resolution home treatment teams.

The local indicator chosen was 7 day follow up. Monitor recognised that these same indicators have been proposed for several years but that there are a limited number of alternative mental health indicators that are standardised, well-established and included in the quality report.

Audit work commences in April and on completion auditors will provide a limited assurance report on whether two mandated indicators included in the quality report have been reasonably stated in all material respects and one local indicator.

6.3 Quality visit programme 2015

The Quality visits for 2016 is starting next month, Governor were able to sign up at the meeting held on 8th March 2016, another sign up session will be held as part of new governors induction. Governors have been asked to think about what areas they would like to visit, is it a specialist area, or is it their neighbourhood teams to represent the areas that they are the named governor for. Once again we will have a buddy system for new governors. This involves more experienced governors supporting any new governors who would like to take part in the visits.

The visits will use the same criteria with each team starting again from the base level of achievement. We will be specifically asking for teams to review the Care Quality Commission regulation outcomes of Safe, Effective, Caring, Responsive and Well led, but with particular aspects for staff presenting on Quality priorities for care planning and how they are using the assurance tool which sets out their compliance with the CQC and Monitor regulations. For non- clinical teams we are looking at how they are achieving efficiencies.

Risk register: High level strategic risks APPENDIX 1

The Board Assurance Framework (BAF) summarises the 6 strategic risks to achievement of the Trust objectives identified for 2016/17. These risks form part of the overall trust risk register, with active review and action led by the Executive Directors. Progress is monitored by the Executive Leadership Team and reported to the Audit Committee and Board. As a paper detailing fully the BAF for 2016/17 is provided as a separate paper for the Board in March 2016, only a headline summary of the risks is shown in the table below to prevent repetition.

Risk Number on BAF	Principal Risk	Risk Handler	Current risk level
1a	Failure to achieve clinical quality standards required by our regulators which may lead to harm to service users and/or staff	Executive Director of Nursing and Patient Experience	Moderate
2a	Failure to deliver the agreed transformational change, at the required pace could result in reduced outcomes for service users, failure to deliver financial requirements and negative reputational risk	Acting Director of Operations	High
2b	Risk to delivery of national and local system wide change. If not delivered this could cause the Trusts financial position to deteriorate resulting in regulatory action	Director of Business Development and Marketing	High
3a	Failure to deliver short term and long term financial plans could adversely affect the financial viability and sustainability of the organisation	Executive Director of Finance	High
3b	There is a risk that the Monitor enforcement actions and CQC requirement notice, coupled with adverse media attention may lead to significant loss of public confidence in our services and in the trust of staff as a place to work. Furthermore, failure to deliver the governance improvement action plan could lead to a risk of further breaches in licence regulations with Monitor and the CQC and further regulatory action	Acting Chief Executive	High
4a	Risk of a fundamental loss of confidence by staff in the leadership of the organisation at all levels	Director of Workforce, OD and Culture	High

Risk register: High level operational risks

The table below details the 6 operational risks on the Trust wide risk register, with a current grade as either high or extreme. Details of each risk including description, controls and mitigation are shown. Active review and action in relation to these risks is led by the Divisional General Managers, monitored through their Senior Management Team meetings. Where the risk relates to a corporate team, the actions are led by the general manager equivalent for that area i.e. Chief Pharmacist. The regular updates and review reflect a positive approach to ownership and action in relation to the risks identified.

ID	Risk type	Directorate	Risk Handler	Date of next review	Description of risk	Controls in place (summary)	Current risk level	Risk mitigation (summary)
3262	Clinical - Staffing levels	Community Paediatrics	General Manager/Area Service Manager	30/04/2016	Long waiting lists following reduction in staffing levels. Children and young people and their families are not being seen and assessed within a timely and appropriate manner. Ability to complete EHC Plans within 28 day timescale is considerable challenge and during 15/16 achieving 27% compliance. As of 29/02/16 there are a total of 1229 cyp waiting to be seen for an initial appointment with a paediatrician with 123 of those waiting over 52 weeks. Both measures have been on a reducing trajectory since August 2015. However we fear that this will begin to plateau as there will shortly be 4 vacant posts within the service. All vacant posts are in the process of being recruited to but delays have been experienced due to Royal College approval of JDs. It has not been possible to secure suitable temporary cover against vacancies and therefore it is expected that referral numbers will exceed clinical capacity shortly. There is the potential of significant deterioration of child's health while on waiting lists and also detrimental impact upon family functioning. There is also significant impact on the health, wellbeing and morale of the medical staff working within this context.	Attempts at recruitment are ongoing but have been unsuccessful so far. Follow up caseload to be transferred to ND Team and there are longer term plans for transformation in some of the areas however this will have an impact in the longer term (June 2016) rather than in the short term. Suitable locum cover has been difficult to obtain and only covers the less specialised aspects of the roles. Managers and ACD meet on a regular basis to review the situation and adjust responses accordingly. Data cleanse exercise has been completed to ensure that information is accurate and up to date. Current medical workforce (Paediatricians and CAMHs) have facilitated extra clinics on Saturday morning to provide additional clinical capacity. Referrals are triaged through SPOA to ensure most suitable pathway is identified. Referrals prioritised as required to ensure risk factors are considered within timeliness of response. Communication with GP's has taken place to describe challenges being faced and how they are able to escalate referrals should they become aware of deteriorating clinical situations.	Extreme Risk	17/3/16 Risk raised by General Manager from High to Extreme. Description and controls updated to those shown, to reflect full extent of the risk.

ID	Risk type	Directorate	Risk Handler	Date of next review	Description of risk	Controls in place (summary)	Current risk level	Risk mitigation (summary)
3301	Clinical - Medication/ Pharmaceutical	Pharmacy	Chief Pharmacist	31/03/2016	Medicines Management - Non-Compliance with Medicines Management standards A review of data and information from a variety of sources including local medicines management audits, unannounced ward visits by the chief pharmacist, a recent review of medicines-related incidents and training, pharmacy reports concerning high risk areas and pharmacy staff activity (both in and out-of-hours) has demonstrated the following: - basic concerns relating to the safe and secure handling of medicines / the management of controlled drugs / the use of medicines in line with the mental health act (MHA)/ inadequate and unsafe practice in relation to the administration and prescribing of medicines / concerns specifically relating to the Crisis teams - concerns relating to the medicines-related training in place within the Trust and the low staff completion rates demonstrated especially in relation to mandatory training i.e. 57% (June 2015 figures) - concerns relating to limited or no pharmacy input and support into high risk clinical areas such as Crisis teams, RAID teams, EIP teams, mental health community teams, and within specialist services such as Children's services, CAMHS, Learning Disability services, Substance Misuse services (City) - concerns pertaining to service use and carer support being provided by pharmacy in relation to medicines use (in May 2015 pharmacy staff recorded delivering 14	- Local medicines management audits - Unannounced ward and team compliance visits relating to medicines management with associated action plans for local improvement - A regular review of medicines-related incidents via the Trust Drugs and Therapeutics Committee - Ongoing review of the Trust Medicines Code to support practice - Enhanced specialist pharmacist support relating to high risk issues e.g. patients in seclusion and medicines use - Senior pharmacist input into Quality Committee, Serious Incident team and Quality Leadership team meetings, as well as local meeting attendance and input e.g. Radbourne unit Update 07/10/15: - Medicines management joint work plan discussed at Medicines Safety Committee 24th Sept 2015. To be uploaded onto DATIX after ratification - Pharmacy Options analysis discussed at ELT 21/09/15. Further discussions re funding taking place. To go back to ELT early Oct 2015 for immediate and longer-term action - Escalated to Commissioners via QAG meeting on the 3rd Nov 2016 by Chief Pharmacist	High Risk	Update 12/02/16: - lead pharmacist for education and training in post now (started Dec 2015) - advanced pharmacist recruited to lead on medicines management both within the campus and neighbourhood areas (to start April 2016) - in the process of recruiting enhanced pharmacist input (one pharmacist) into the DRRT and Crisis teams - electronic medicines management audits introduced within campus areas - Net Formulary up and running

ID	Risk type	Directorate	Risk Handler	Date of next review	Description of risk	Controls in place (summary)	Current risk level	Risk mitigation (summary)
3302	Clinical - Staffing levels	Pharmacy	Chief Pharmacist	31/03/2016	Due to a lack of pharmacists currently contracted to participate on the Pharmacy On-call rota (staff vacancies and previous lack of clear proactive action taken / management in 2014), the Trust is unable to provide a Pharmacy On-Call service for 16 days in September 2015 and 12 days in October, which is likely to impact on patient safety and patient care i.e. timely access to medicines and medicines-related information for both Trust patients and patients based within contracted services.	Action taken to date includes the following: - □ negotiating with other neighbouring Trusts around pharmacy on-call support (unsuccessful to date) □ employing a locum pharmacist to support the team (unsuccessful to date) □ participation on the rota by senior staff (chief pharmacist) □ provision of an information only service (departmental attendance was still required when tried. A process was initiated in May 2015 to give notice to pharmacists that are currently not contracted to provide the pharmacy on-call service. This change involved these (4) staff participating on a regular basis on the on-call rota in order to ensure the robustness of the service going forward and to support patient safety and care. However this process has been delayed (details via HR) and timescales have not been adhered to as required thus contributing to the situation from September 2015 onwards. Any new / reconfigured pharmacist posts - that are awaiting approval via ELT - ALL include the Pharmacy On-Call role.	High Risk	Update on 07/10/15 - HR process to be conducted on the 28/09/15 - which was supporting a change involving all departmental pharmacists contributing to the on-call rota - was postponed. No new date has been communicated via HR. One Trust substance misuse pharmacist now contributing to the on-call rota in the short-term - till end of Dec 2015. This arrangement will be reviewed then. Potential for another to join the on-call rota in the short-term to mitigate the risk. The financial implications of these actions have been discussed with the relevant executive director (C.G.). Also discussed at TOMM meeting 11th Sept 2015. Pharmacy on-call HR process meeting cancelled on the 9th Dec 2015. Pharmacy on-call HR process took place on the 15th Jan 2016 and feedback received 28th Jan 2016. New consultation process required. New starter (pharmacist) is now participating as part of the on-call rota (from 22nd Jan 2016). Rota frequency still below 1:7 (1:6 now).

ID	Risk type	Directorate	Risk Handler	Date of next review	Description of risk	Controls in place (summary)	Current risk level	Risk mitigation (summary)
3356	Clinical risk - Other	Neighbourhoods - City	General Manager	22/04/2016	Lack of parking for clinicians at base. Due to the volume of staff based at St Andrews House and the small number of parking spaces available, managers are already noticing a reduction in staff attending base. There have also been incidents where clinicians have been unable to leave the car park on urgent clinical visits due to being blocked in. In April 2016 there are plans to move at least a further 120 staff into the building with the majority being clinical with the need to use their car to enable them to carry out their professional duties. Teams are extremely anxious about the impact this will have on efficiency, effectiveness, quality and standards of care delivered. With already large caseloads, there is no capacity for clinicians to spend time finding a parking space and then walking into base if the space is any distance away. There are also moving and handling concerns for staff that regularly have to carry equipment, e.g. laptops, depot cases, OT equipment. If staff become too agile in their working, either working from home or other bases, there will be a significant reduction in the amount of formal and informal supervision that is provided, especially to more junior staff. It will become more difficult to provide opportunities for skill sharing and training as adult and older adult services merge as part of the neighbourhood developments. It increases the risk to service users if clinicians are unable to get out of the car park on urgent visits due to being blocked in. There is a risk of	There is a planning application in to increase the current parking space by 20 spaces, however, this will still not be enough for the number of staff due to move over in March/April 2016 - this work is now delayed. There is a plan to put a swipe access barrier to control access to the car park. The Trust is looking at a Travel Policy, but this is unlikely to resolve the issue for clinicians needing to use their car to carry out their duties. The planned moves of teams to St Andrews has been paused for 8 weeks whilst intensive search for alternate ways to support parking are considered. This raises the risks to neighbourhood operationalization and team cohesion.	HIGH	7/3/2016 update. Move of teams into St Andrews House has been paused as the risk related to the move given lack of options to support parking extension is high - risk re-assessed today. Meetings to review going ahead are being arranged with a view to sourcing parking and un-pausing moves.

ID	Risk type	Directorate	Risk Handler	Date of next review	Description of risk	Controls in place (summary)	Current risk level	Risk mitigation (summary)
3386	Clinical - Staffing levels	Campus - Radbourne Unit(general)	Area Service Manager	31/03/2016	Vacancies, reduced leadership, capacity for succession planning Across the unit there are currently x 13 B5 vacancies, with a further 4 leavers over the coming months. In addition some areas have not had their establishments uplifted to account for the requirement of 2 RN's per N shift. This means that bank usage may be higher, however nurse bank often struggle to fill RN shifts, therefore wards may be unable to meet the national safe staffing standards of 2 RN's per shift. Some areas have high levels of preceptorship and reduced capacity to take on more newly qualified staff as a result. There are also 3 areas currently with reduced leadership capacity - this impacts on the capacity to robustly manage e rosters to ensure equity of cover across the shifts. In addition there is a number of senior staff planning for retirement over the next 1-3 years; currently there is a limited capacity to develop and succession plan. update 07/01/2016 - current vacancies are higher than initially identified following review of establishment lists, potentially equating to a 3rd of RN compliment across the unit, following leavers over the next few months. Risk assessment reviewed, ISMR attached.	Safer staffing meetings - to have a robust overview of staffing across the unit. Raised awareness of the issues within the campus/ trust Generic Recruitment process for B5's Review of skill mix Urgent meeting to discuss increasing the leadership capacity across the unit in order to support recruitment of preceptorship nurses - planned 07/01/2016. Consider emergency planning measures.	HIGH	5/2/16 update. Review of establishment's lists completed. Also reviewed by SI Group as a number of incidents relating to unsafe staffing were also raised. Comprehensive action plan developed, implementation being led by General Manager.

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ID	Risk type	Directorate	Risk Handler	Date of next review	Description of risk	Controls in place (summary)	Current risk level	Risk mitigation (summary)
3410	Clinical - Staffing levels	Campus - Radbourne Unit(ward 34)	Ward Manager	10/06/2016	Vacancy levels above 30%. There are currently 6.6 WTE band 5 vacancies on ward 34 and 1 WTE band 6 vacancy 1.6 WTE will be commencing mat leave within the next 8 weeks, within this 1 WTE is on long term sick pending maternity leave. 1 WTE will be leaving in 4 weeks Within the 11.8 WTE band 5 nurses 5 WTE are preceptorship nurses. With the continued loss of staff vacancy levels will rise to 9.2 within the next 8 weeks giving a vacancy level of 50%, consequences are that ward 34 will not have adequate numbers of registered nurses to adequately and safely support 20 inpatients.	continued recruitment 2 WTE deployed from other wards in the Radbourne Unit	HIGH	As per risk 3386 above.

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 30th March 2016

Integrated Performance Report Month 11

Purpose of Report

This paper provides the Trust Board with an integrated overview of performance as at the end of February 2016 with regard to workforce, finance and operational delivery. It will evolve to also include Quality performance indicators

Recommendations

The Board of Directors is requested to:

1) Consider the content of the paper and consider their level of assurance on the current performance across the areas presented.
2) Consider the format of the report and define any changes it requires for subsequent iterations.

Executive Summary

The equivalent of the Executive Summary content is found at the first page of the main report and is not repeated here.

Strategic considerations

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

Board Assurances

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

Consultation

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

Governance or Legal issues
The integrated nature of this report is in response to the Deloitte Well Led Review and specifically recommendation R 22: *The Board needs to introduce an integrated performance report which encompasses key operational, quality, workforce and finance metrics* Information supplied in this paper is consistent with returns to the Regulator This report replaces the previous operational and financial reports reported to Trust Board.

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

Report presented by:	**Claire Wright, Director of Finance** **Carolyn Gilby, Acting Director of Operations** **Jayne Storey, Director of Workforce** **(Carolyn Green, Director of Nursing)**
Report prepared by:	**Rachel Leyland, Deputy Director of Finance** **Peter Charlton, General Manager, Information Management** **Liam Carrier, Workforce Systems & Information Manager** **(Clare Grainger, Head of Quality Performance)**

Highlights
- FSRR better than plan
- Surplus better than plan
- Cash better than plan
- Capital behind plan
- CIP achieved in full

Challenges
- Containment of expenditure in the final month of the financial year
- Mitigations of Financial risks for 16/17

Highlights
- Fully compliant with all monitor targets
- Outpatient DNAs remain under 15% since SMS implementation

Challenges
- PbR clustering
- Outpatient Cancelations continue to be high
- 15 Day Outpatient letters compliance continues to be a challenge however we are currently ahead of the commissioner agreed trajectory

Highlights
- Compulsory Training compliance continues to increase
- Annual turnover remains on target

Challenges
- Appraisal compliance remains below target
- Sickness absence rates continue to increase
- Vacancies remain high

Under Development

FINANCIAL OVERVIEW – FEBRUARY 2016

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Governance	FSRR	Financial Sustainability Risk rating	YTD	3	4	G		Overall FSRR better than plan at 4 at the end of February. No change to the overall FSRR or the individual metrics this month. Overall FSRR forecast remains at a 4.
			Forecast	3	4	G		
		Debt Service Cover	YTD	3	3	G		
			Forecast	3	3	G		
		Liquidity	YTD	4	4	G		
			Forecast	4	4	G		
		Income and Expenditure Margin	YTD	3	4	G		
			Forecast	3	4	G		
		Income and Expenditure Margin Variance	YTD	3	4	G		
			Forecast	3	4	G		
I&E and profitability	Income and Expenditure	Income and Expenditure position £'000	In-Month	171	-427	R -597	#	In month deficit is due to non-recurrent expenditure in month that was previously forecast. Forecast surplus is consistent with last month. EBITDA continues to be better than plan due to lower operating expenses.
			YTD	1,135	2,055	G 920	#	
			Forecast	1,271	1,836	G 565		
	Profitability	Profitability - EBITDA £'000	In-Month	739	191	R -548	#	
			YTD	7,476	8,705	G 1,229		
			Forecast	8,181	9,031	G 851		
		Profitability - EBITDA%	In-Month	6.7%	1.8%	R -5.0%		
			YTD	6.2%	7.3%	G 1.1%		
			Forecast	6.2%	6.9%	G 0.7%		
Liquidity	Cash	Cash £m	YTD	9.980	14.093	G 4.113		Cash remains ahead of plan due to the I&E surplus and lower capital expenditure. Capex variance to plan has increased in February compared to the previous month. Forecast underspend has increased.
			Forecast	10.097	11.517	G 1.420		
	Net Current Assets	Net Current Assets £m	YTD	1.156	4.280	G 3.124		
			Forecast	1.545	3.041	G 1.496		
	Capex	Capital expenditure £m	YTD	3.156	2.045	R -1.111		
			Forecast	3.450	3.196	R -0.254		
Efficiency	CIP	CIP achievement £m	In-Month	0.403	0.371	R -0.032		CIP is different to plan in month and year to date due to phasing of schemes.
			YTD	3.797	3.829	G 0.032		
			Forecast	4.200	4.200	G 0		
			Recurrent	4.200	3.087	R -1.113		

OPERATIONAL OVERVIEW – FEBRUARY 2016

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Monitor	CPA 7 Day Follow-up	Month	95.00%	98.57%	G	↑	Fully compliant with monitor targets
			Quarter	95.00%	97.06%	G	→	
		CPA Reviews in Last 12 months	Month	95.00%	95.54%	G	→	
			Quarter	95.00%	95.83%	G	→	
		Delayed Transfers of Care	Month	7.50%	3.54%	G	↓	
			Quarter	7.50%	2.82%	G	↓	
		Data completeness - Identifiers	Month	97.00%	99.42%	G	→	
			Quarter	97.00%	99.50%	G	→	
		Data completeness - Outcomes	Month	50.00%	94.84%	G	→	
			Quarter	50.00%	95.20%	G	→	
		Community Care Data Activity - Completeness	Month	50.00%	93.66%	G	↑	
			Quarter	50.00%	93.60%	G	↑	
		Community Care Data - RTT Completeness	Month	50.00%	92.31%	G	→	
			Quarter	50.00%	92.31%	G	→	
		Community Care Data - Referral Completeness	Month	50.00%	75.08%	G	↑	
			Quarter	50.00%	76.21%	G	↑	
		18 Week RTT incomplete	Month	92.00%	98.15%	G	→	
			Quarter	92.00%	98.15%	G	↑	
		Early Interventions New Caseload	Month	95.00%	96.83%	G	↓	
			Quarter	95.00%	102.00%	G	→	
		Clostridium Difficile Incidents	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Crisis Gatekeeping	Month	95.00%	100.00%	G	→	
			Quarter	95.00%	100.00%	G	→	
		IAPT RTT within 18 weeks	Month	95.00%	99.11%	G	→	
			Quarter	95.00%	99.25%	G	→	
		IAPT RTT within 6 weeks	Month	75.00%	92.14%	G	→	
			Quarter	75.00%	92.64%	G	→	

OPERATIONAL OVERVIEW – FEBRUARY 2016

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Locally Agreed	CPA Settled Accommodation	Month	90.00%	97.33%	G	→	The PbR Advisor is working with teams offering training, support and advice. We have an added driver to improve compliance in that an outcomes-based payment systems is to be introduced and we are implementing performance management for NTPS compliance. this will also improve HoNOS assessment as these are part of clustering.
			Quarter	90.00%	97.54%	G	→	
		CPA Employment Status	Month	90.00%	98.26%	G	→	
			Quarter	90.00%	98.52%	G	→	
		Data completeness - Identifiers	Month	99.00%	99.42%	G	→	
			Quarter	99.00%	99.50%	G	→	
		Data completeness - Outcomes	Month	90.00%	94.84%	G	→	
			Quarter	90.00%	95.20%	G	→	
		Patients Clustered not Breaching Today	Month	80.00%	80.98%	G	→	
			Quarter	80.00%	81.02%	G	↑	
		Patients Clustered regardless of review dates	Month	96.00%	94.62%	R	→	
			Quarter	96.00%	94.75%	R	→	
		CPA HONOS assessment in the last 12 months	Month	90.00%	87.86%	R	→	
			Quarter	90.00%	88.55%	R	→	
		7 Day Follow-up - all inpatients	Month	95.00%	98.75%	G	↑	
			Quarter	95.00%	97.42%	G	↑	
		Ethnicity coding	Month	90.00%	91.21%	G	↓	
			Quarter	90.00%	91.80%	G	↓	
		NHS Number	Month	99.00%	99.98%	G	→	
			Quarter	99.00%	99.98%	G	→	
	Schedule 4	Consultant Outpatient Trust Cancellations	Month	5.00%	5.94%	R	→	An audit of cancellations found that the reasons were: compassionate leave (18%), Coroner's inquest (15%), no consultant available (9.7%), appointment rescheduled – patient not aware of appointment and not inconvenienced (6.8%) and the junior doctor's strike on 10th February (6.8%). An action plan for letters is being implemented and whilst below target, we continue to perform above trajectory
			Quarter	5.00%	6.06%	R	↓	
		Consultant Outpatient DNAs	Month	15.00%	14.67%	G	→	
			Quarter	15.00%	14.27%	G	↑	
		Under 18 admissions to Adult inpatients	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Outpatient letters sent in 10 working days	Month	90.00%	94.25%	G	↑	
			Quarter	90.00%	93.54%	G	↑	
		Outpatient letters sent in 15 working days	Month	100.00%	98.06%	R	↑	
			Quarter	100.00%	96.87%	R	↑	
		Inpatient 28 day readmissions	Month	10.00%	5.65%	R	↑	
			Quarter	10.00%	6.59%	R	↑	
		MRSA - Blood stream infection	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Mixed Sex accommodation breaches	Month	0	0	G	→	
			Quarter	0	0	G	→	
		18 weeks RTT greater than 52 weeks	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Discharge Fax sent in 2 working days	Month	98.00%	100.00%	G	↑	
			Quarter	98.00%	99.52%	G	→	

OPERATIONAL OVERVIEW – FEBRUARY 2016

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Fixed Submitted Returns	18 weeks RTT greater than 52 weeks	Month	0	0	G	→	
			Quarter	0	0	G	→	
		18 Week RTT incomplete	Month	92.00%	97.81%	G	→	
			Quarter	92.00%	98.30%	G	↑	
		Mixed Sex accommodation breaches	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Completion of IAPT Data Outcomes	Month	90.00%	97.70%	G	↑	
			Quarter	90.00%	94.15%	G	↓	
		Ethnicity coding	Month	90.00%	93.57%	G	↑	
			Quarter	90.00%	92.18%	G	↓	
		NHS Number	Month	99.00%	99.99%	G	→	
			Quarter	99.00%	100.00%	G	→	
Other Dashboards	Health Visiting	% 10-14 Day Breastfeeding coverage	Month	95.00%	98.60%	G	↓	
			Quarter	95.00%	99.30%	G	→	
		% 6-8 Week Breastfeeding coverage	Month	95.00%	96.40%	G	↓	
			Quarter	95.00%	97.55%	G	↓	
		% Still Breastfeeding at 6-8 Weeks	Month	65.00%	75.50%	G	↑	
			Quarter	65.00%	72.65%	G	→	
	IAPT	Recovery Rates	Month	50.00%	55.67%	G	→	
			Quarter	50.00%	55.37%	G	↑	
		Partial and Full Recovery Rates	Month	65.00%	72.56%	G	→	
			Quarter	65.00%	72.80%	G	↑	
	Safer Staffing	Inpatient Safer Staffing Fill Rates	Month	90.00%	100.14%	G	↓	Detailed ward level information shows specific variances
			Quarter	90.00%	100.74%	G	↓	

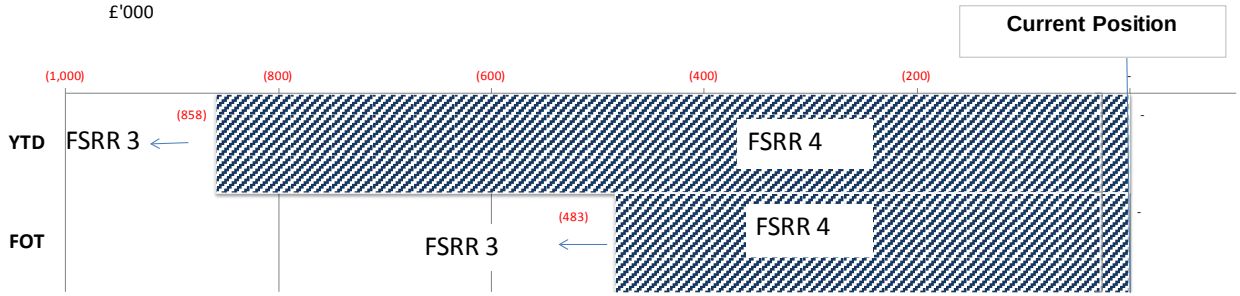
WORKFORCE OVERVIEW – FEBRUARY 2016

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Workforce Dashboard	Monitor KPI	Annual Turnover	**Feb-16**	10%	**10.54%**	G	↑	Annual turnover is meeting the Trust target and remains below the regional Mental Health & Learning Disability average of 12.87%. Sickness absence continues to increase, running at an annual rate of 5.42% as at January 2016, compared to a regional Mental Health & Learning Disability average of 5.04% (as at November 2015 latest available benchmarking data). The average budgeted vacancy rate for the year was 15.04% peaking at 16.12% in January 2016. Employees who have had an appraisal within the last 12 months has increased slightly. Contracted staff in post ratio for qualified nurses remains within target. Compulsory training compliance continues to increase and is above the 85% main contract non
			Jan-16		10.03%	G		
		Sickness Absence	**Feb-16**	3.9%	**6.26%**	R	↑	
			Jan-16		5.86%	R		
		Vacancies (Budgeted Fte)	**Feb-16**	10%	**15.91%**	A	↓	
			Jan-16		16.12%	A		
		Appraisals (All staff)	**Feb-16**	90%	**67.82%**	R	↑	
			Jan-16		67.67%	R		
		Appraisals (Medical Staff only)	**Feb-16**	90%	**42.47%**	R	↑	
			Jan-16		38.93%	R		
		Qualified Nurses (to total nurses, midwives, health visitors and HCA's)	**Feb-16**	65%	**66.04%**	G	↑	
			Jan-16		65.99%	G		
	Other KPI	Compulsory Training (In-date)	**Feb-16**	95%	**88.48%**	A	↑	
			Jan-16		86.52%	A		

Financial Section

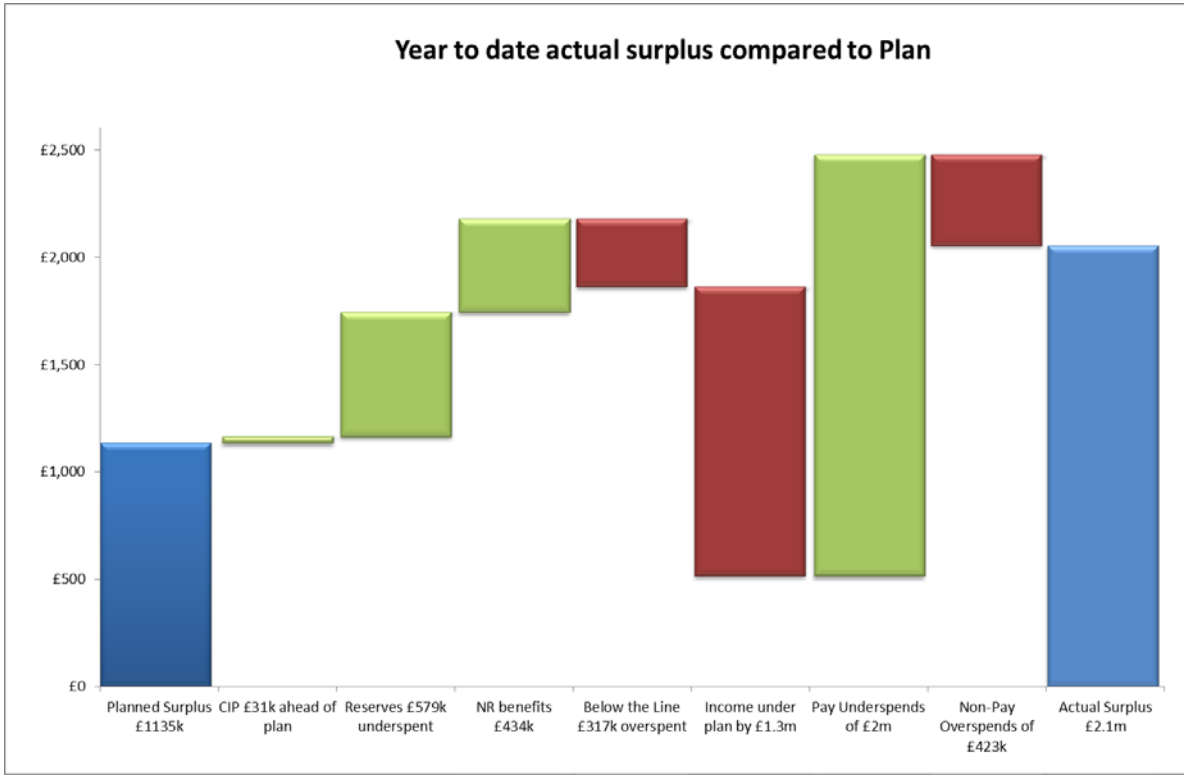
The headroom in £'000s, to a FSRR of 3 is shown in the chart below, both for year to date (YTD) and forecast outturn (FOT). This is for indicative use, based on a set of assumptions. It serves to illustrate the impact of improving or worsening revenue and cash, but there would be other variables that could also have an impact.



Income and Expenditure and Profitability

STATEMENT OF COMPREHENSIVE INCOME **FEB 2016**

	Current Month			Year to Date			Forecast		
	Plan £000	Actual £000	Variance Fav (+) / Adv (-) £000	Plan £000	Actual £000	Variance Fav (+) / Adv (-) £000	Plan £000	Actual £000	Variance Fav (+) / Adv (-) £000
Clinical Income	10,164	10,039	(125)	111,741	110,353	(1,388)	121,914	120,655	(1,259)
Non Clinical Income	832	828	(4)	9,416	9,153	(263)	10,248	10,014	(234)
Pay	(8,153)	(8,104)	50	(90,172)	(87,478)	2,693	(98,335)	(95,782)	2,554
Non Pay	(2,102)	(2,571)	(469)	(23,510)	(23,323)	187	(25,646)	(25,856)	(210)
EBITDA	**739**	**191**	**(548)**	**7,476**	**8,705**	**1,229**	**8,181**	**9,031**	**851**
Depreciation	(280)	(300)	(21)	(3,109)	(3,317)	(208)	(3,389)	(3,534)	(146)
Impairment	0	(198)	(198)	(100)	(198)	(98)	(300)	(598)	(298)
Profit (loss) on asset disposals	0	0	0	0	31	31	0	31	31
Interest/Financing	(181)	(166)	15	(2,040)	(1,957)	83	(2,221)	(2,133)	88
Dividend	(108)	(152)	(43)	(1,192)	(1,408)	(216)	(1,300)	(1,559)	(259)
Net Surplus / (Deficit)	**171**	**(625)**	**(795)**	**1,035**	**1,856**	**822**	**971**	**1,237**	**266**
Technical adj - Impairment	0	(198)	(198)	(100)	(198)	(98)	(300)	(598)	(298)
UnderlyingSurplus / (Deficit)	**171**	**(427)**	**(597)**	55 **1,135**	**2,055**	**920**	**1,271**	**1,836**	**565**



Forecast Range

Best Case	Likely Case	Worst Case
£0.8m favourable to plan	£0.6m favourable to plan	£0.1m adverse variance to plan

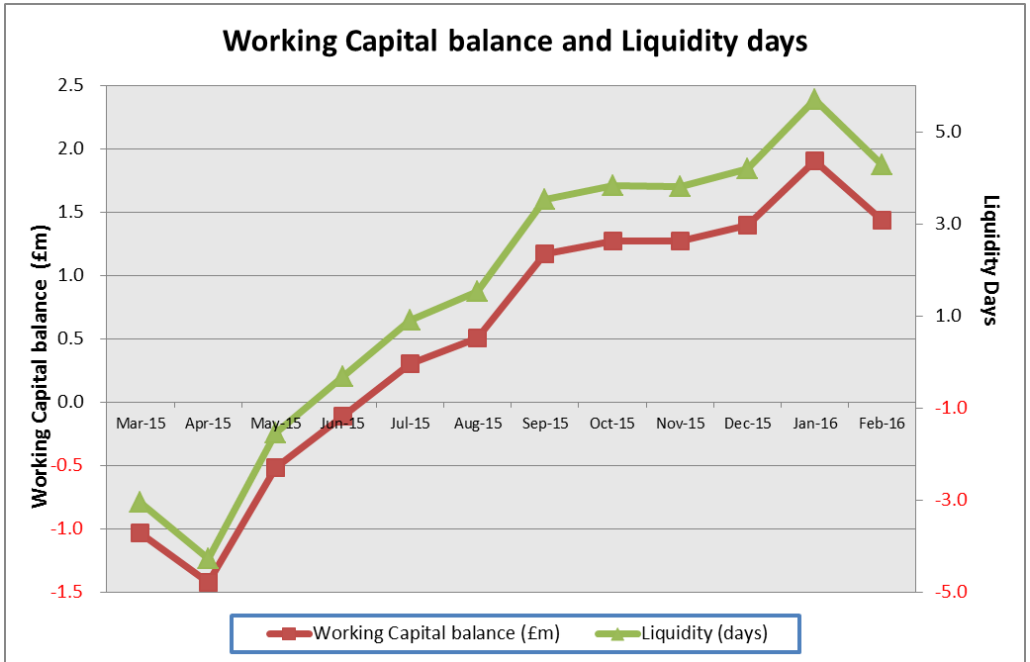
NB : Position of arrow shows current likely case forecast outturn

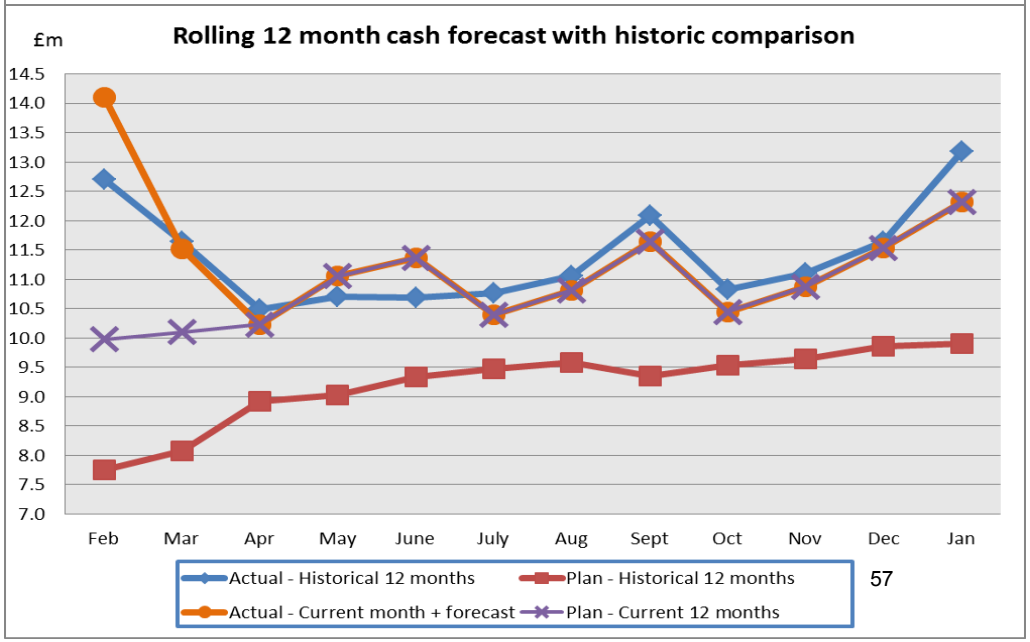
Summary of key points Enc E

- Overall adverse variance to plan in the month mainly driven by non-recurrent expenditure which was previously included in the forecast. Year to date the surplus remains ahead of plan.
- Income remains behind plan year to date and is forecast to be under plan at the end of the financial year which is driven by the phasing of service developments and lower occupancy and activity levels in cost per case services, some of which have corresponding expenditure reductions.
- Expenditure is underspent year to date and is forecast to be underspent at the end of the financial year due to service development phasing, lower occupancy levels, uncommitted reserves and some non-recurrent benefits.
- The surplus is forecast to reduce over the coming month from £2.1m at month 11 to £1.8m at the end of the financial year. This is due to non-recurrent additional expenditure forecast in the last month of the financial year.
- The forecast surplus remains £0.6m better than plan with the range shown in the graph to the left. It is important to note that the forecast range is based on an accumulation of either all the worst case or all best case scenarios happening together rather than a combination of a small group of scenarios.

Liquidity

Enc E



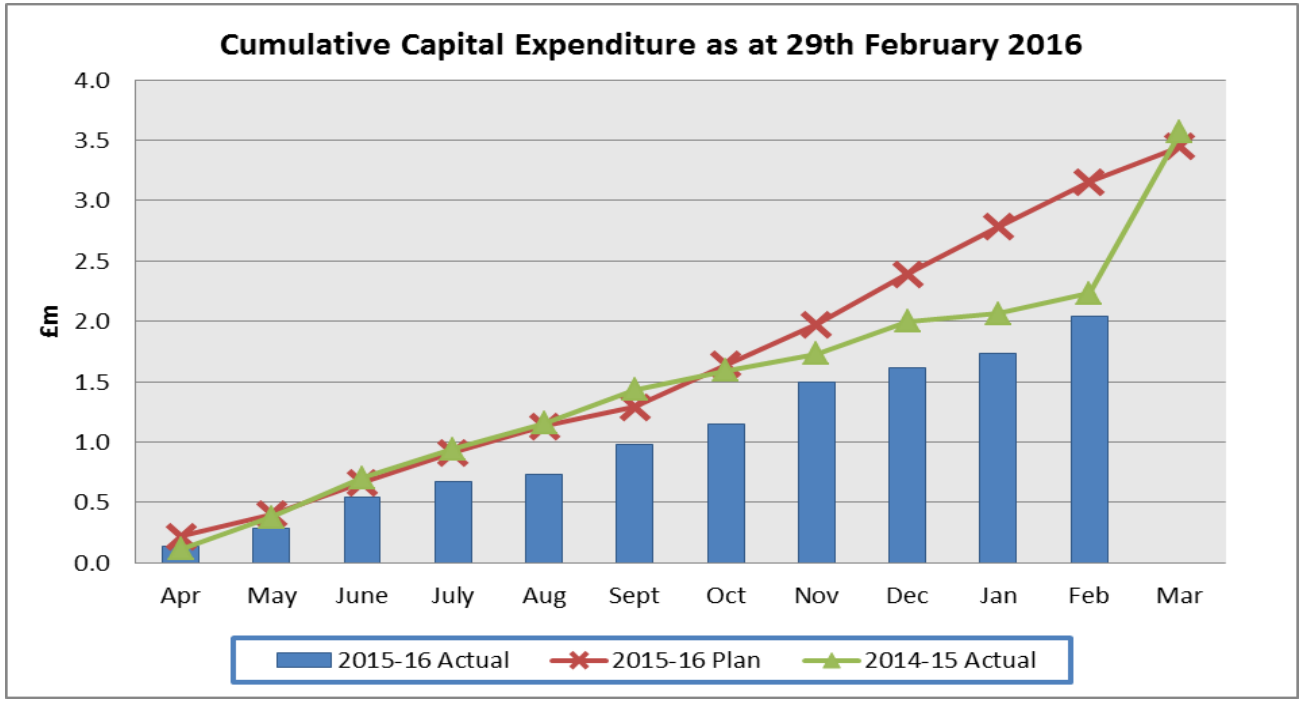


The first graph shows the working capital balance (net current assets less net current liabilities adjusted for assets held for sale and inventories) and how many days of operating expenses that balance provides.

The downward trend in March 15 related to yearend adjustments for provisions and a reduction in the levels of cash. During this financial year working capital has continued to improve due to improved cash levels.

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

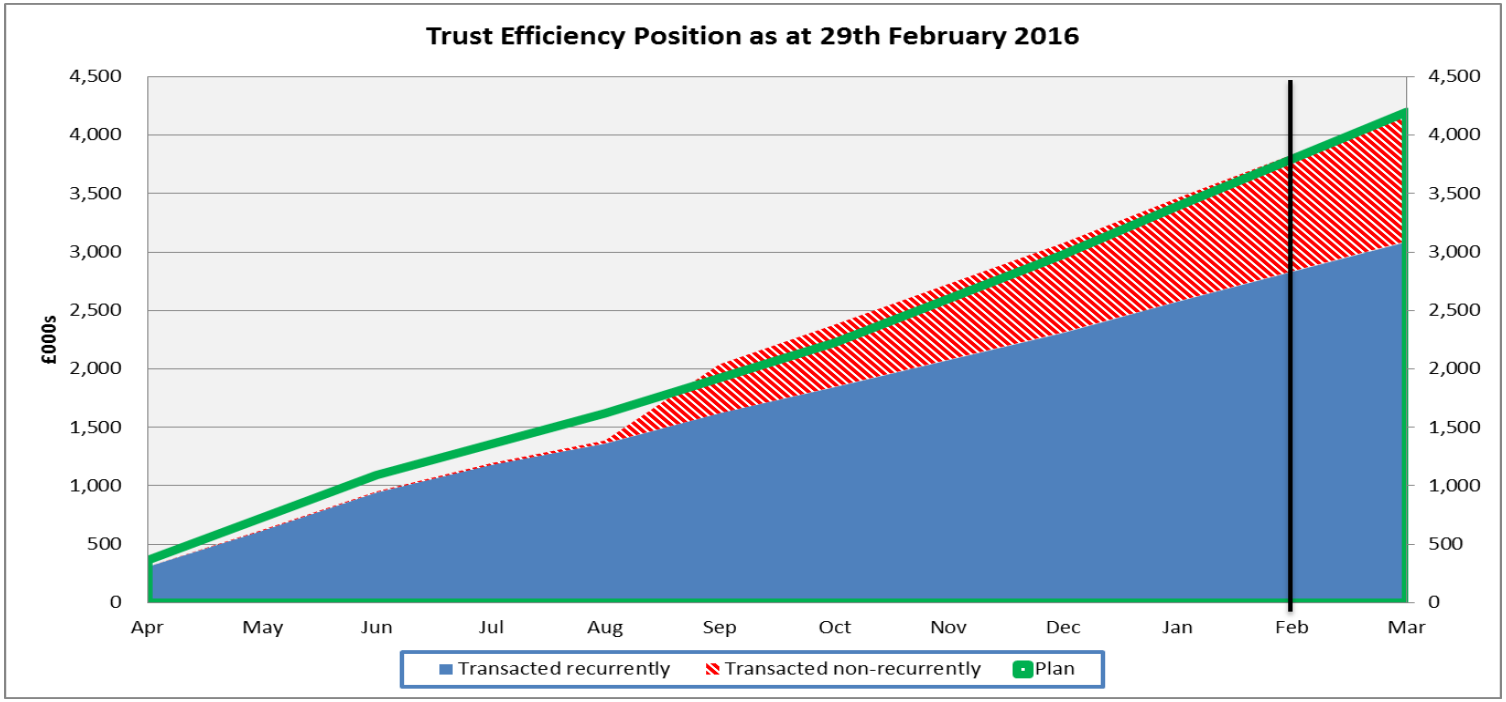
Cash is currently at £14.1m and is forecast to be at £11.5m at the end of the financial year due to the catch up in capital expenditure, the payment of PDC and some large invoices at the end of the year.



Capital Expenditure is £1.1m behind the plan at the end of February. Following the review of schemes for urgent clinical priorities, capital expenditure is forecast to be behind plan by £0.3m at the end of the financial year.

The 2015/16 schemes are regularly reviewed by Capital Action Team (CAT) and a reprioritisation to fund clinical priorities has been approved, which is the reason for the change in expected capital expenditure profile compared to original plan.

Cost Improvement Programme (CIP)



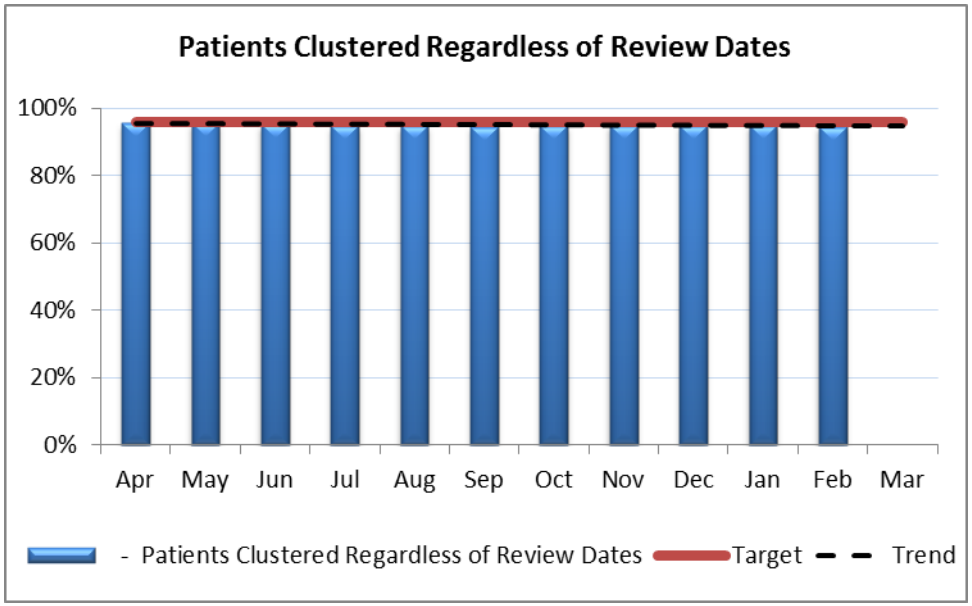
Year to date CIP achieved is £3.8m which is ahead of plan by £31k (0.8%). The reason for the CIP being ahead of plan is due to replacement schemes having a different phased delivery than that of the original schemes. The full programme has been assured which is reflected in the forecast.

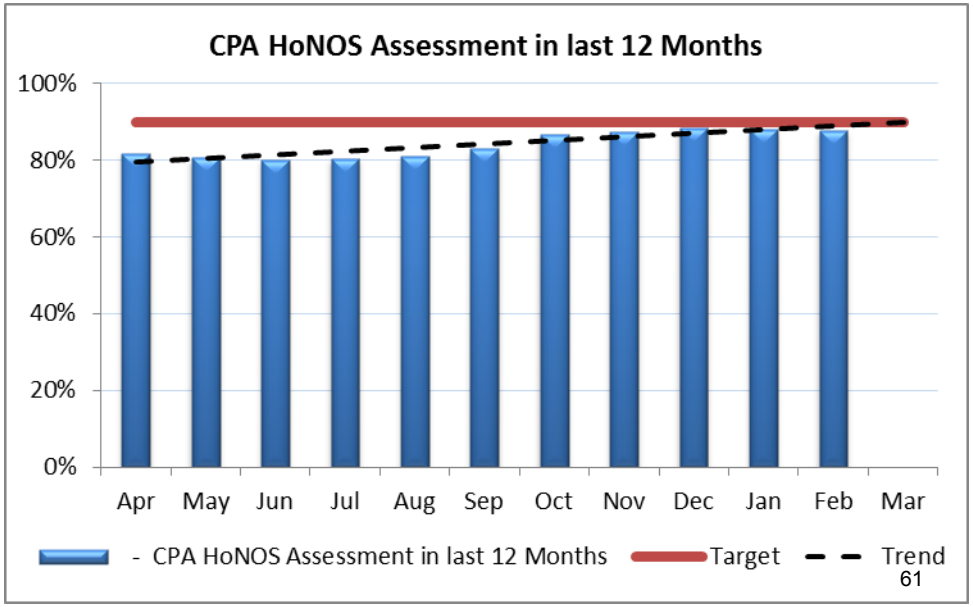
Programme Assurance Board continues to performance-monitor CIP delivery which is reported to Finance and Performance Committee who have delegated authority from Trust Board for oversight of CIP delivery.

Operational Section

Clustering and CPA HoNOS Assessments

Enc E





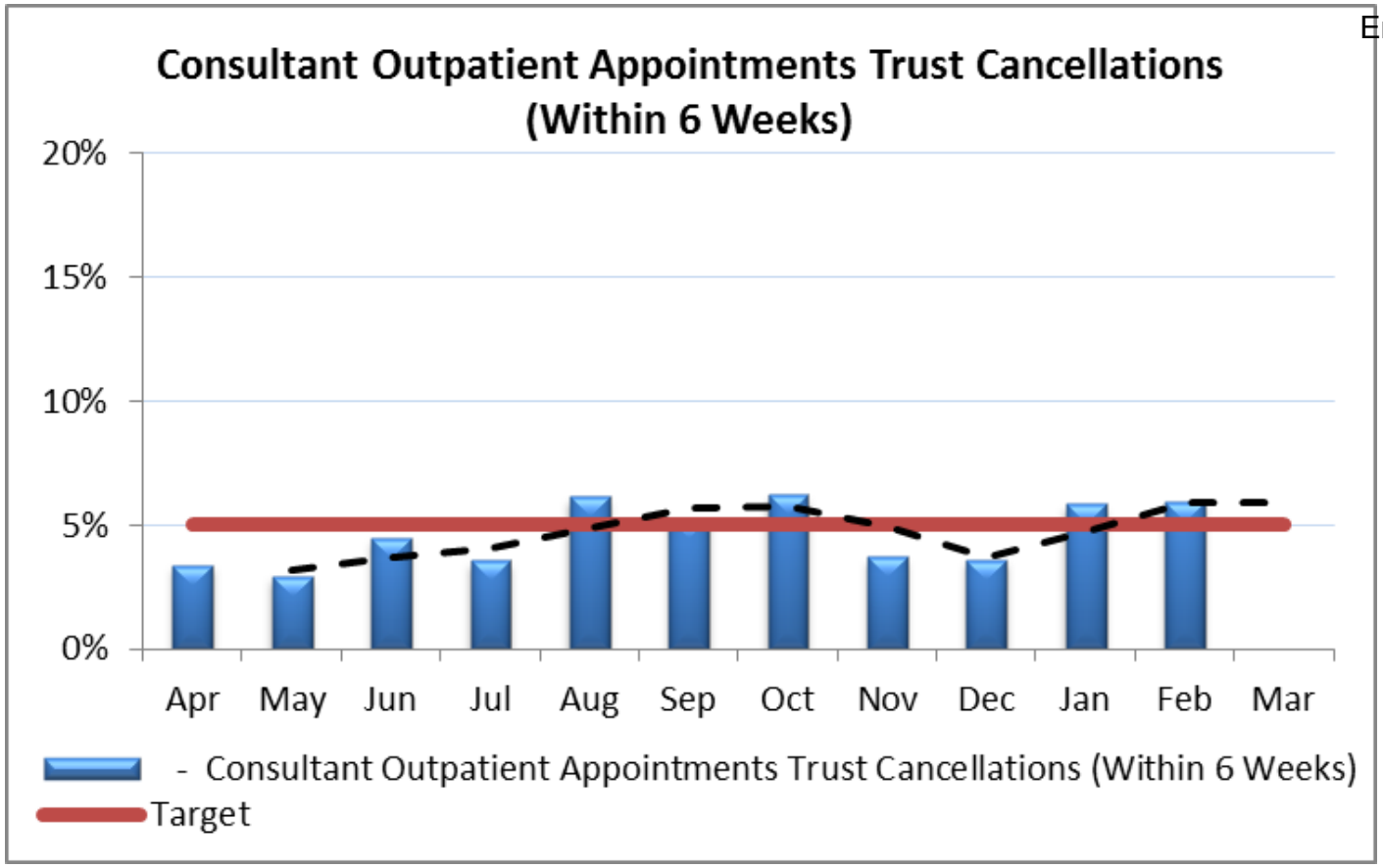
The PbR Advisor continues to work with teams and individuals offering training, support and advice. We are taking the opportunity of the WorkPro road-test to emphasise the importance of timely and accurate clustering. We highlight the importance of Clusters for understanding demand and in the commissioning of relevant training.

We now have an added driver to improve compliance in that Monitor are pressing for outcomes-based payment systems to be introduced. In light of this we are implementing performance management for NTPS compliance Medical Director's Bulletin December 2015 briefed the medical staff re these new Monitor clustering requirements and has resulted in the PbR Advisor receiving more requests for help and support with clustering

An e-learning package on mental health currencies and payment was recently developed and went live on 12th January 2016.

We are awaiting feedback from the recent Monitor visit, which may identify additional action required.

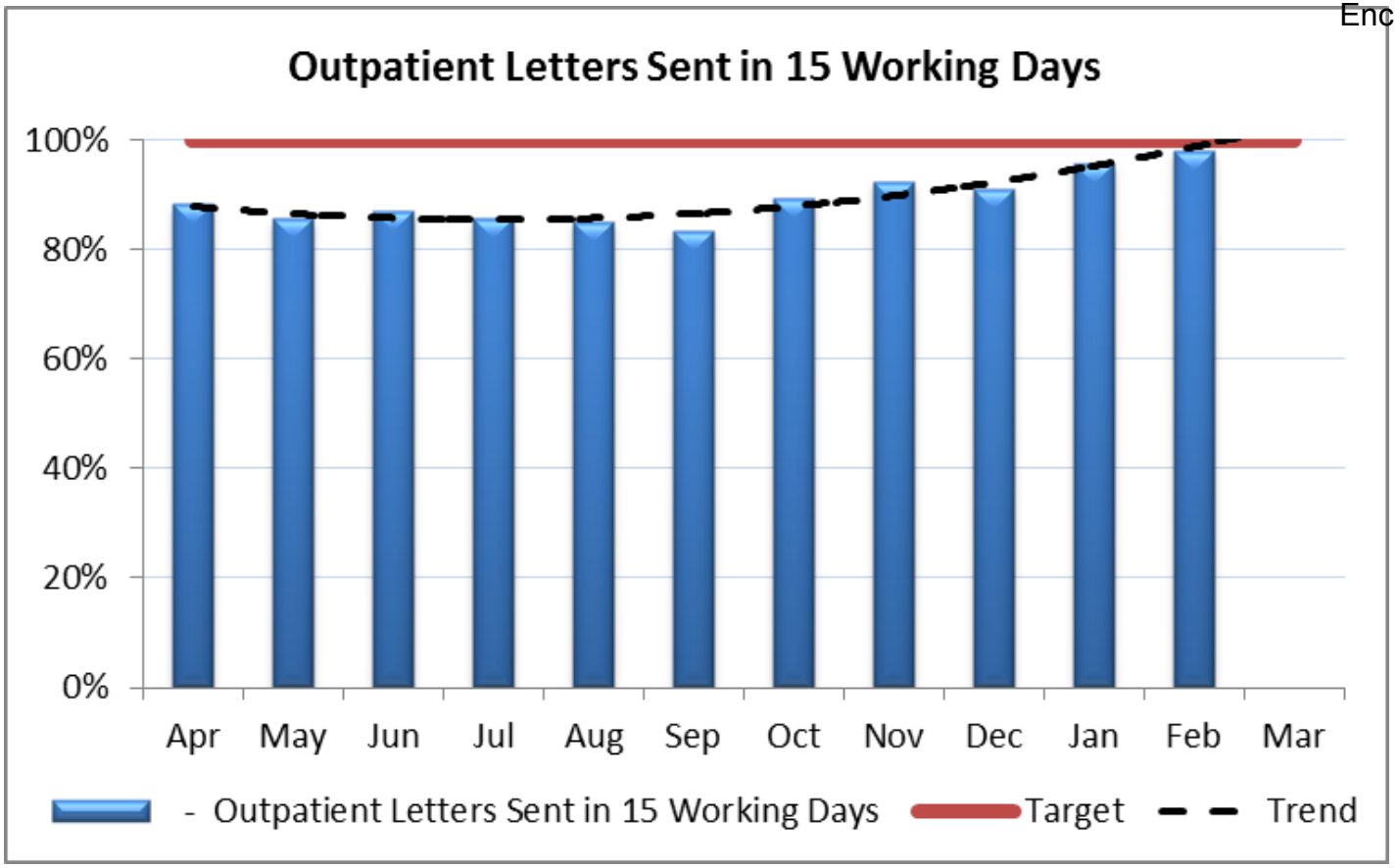
CPA HoNOS assessments are conducted as part of the PbR Process.



A manual audit of cancellations found that the main reasons for cancellation were as follows: compassionate leave (18%), Coroner's inquest (15%), no consultant available (9.7%), appointment rescheduled – patient not aware of appointment and not inconvenienced (6.8%) and the junior doctor's strike on 10th February (6.8%).

Associate Clinical Directors to review cancellation reasons and discuss with consultant concerned where the reason does not appear valid, if applicable.

List of cancellation reasons has been agreed and added to Paris to enable easy reporting and monitoring.



The action plan is being implemented. We continue to perform above trajectory.

- To continue to implement and monitor the action plan against recovery trajectory
- To request that the commissioners reduce the 100% target

WARD STAFFING

Ward name	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
Audrey House Residential Rehabilitation	99.1%	100.0%	97.3%	104.8%	No	No Comments Required
Child Bearing / Perinatal Inpatient	109.8%	156.3%	100.0%	143.8%	Yes	The current fill rate tolerances for care staff (day and night) are broken due to activity, observation levels and long term sickness absence.
CTC Residential Rehabilitation	103.2%	96.2%	100.0%	100.0%	No	No Comments Required
Enhanced Care Ward	87.5%	101.0%	93.0%	126.9%	No	We are at present experiencing high levels of sickness on the ward with 1 RN on long term sick and 3 RNs taking short term sickness during this period. We also have 1 RN presently on non clinical duties due to work related stress issues (We are seeking redeployment to release post) We also have a short fall of 2.4 RNs in budget which has been addressed from the new financial year 2016. Sickness is being monitored through normal process and we have put extra supervision in to help address stress related issues. We have covered using trust NAs. All shifts have been covered by a Trust NIC trained appropriately. Increased care staff on nights to cover increased observation high levels of clinical activity and assessed risk level.
Hartington Unit Morton Ward Adult	103.4%	101.6%	70.0%	144.7%	Yes	The rationale for this is that we continue to carry 4.3 vacancies on Morton ward at Band 5 level. We also have x 1 Band 5 seconded into the Band 6 role on Morton ward. We therefore cannot always commit to having x 2 Band 5 nurses on night shifts.
Hartington Unit Pleasley Ward Adult	108.3%	86.4%	146.7%	79.3%	Yes	The reason we have broken the current fill rates for Registered Nurses is because we currently have 6 preceptorship nurses on the ward who have to be supervised by more senior Registered Nurses which often puts us at a higher ratio of qualified to unqualified.

WARD STAFFING

Ward name	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
Hartington Unit Tansley Ward Adult	91.4%	113.1%	64.7%	139.5%	Yes	The ward continues to carry band 5 vacancies. As a result of this we are currently unable to staff night shifts with x2 band 5 RCN's which accounts for the average nurse fill rate on nights. This shortage is then filled with HCA which accounts for the high percentage fill rate for HCA's on nights.
Kedleston Unit - Curzon Ward	98.3%	97.3%	100.0%	98.3%	No	No Comments Required
Kedleston Unit - Scarsdale Ward	97.4%	93.9%	100.0%	98.2%	No	No Comments Required
KW Cubley Court Female	102.0%	95.6%	94.7%	102.7%	No	No Comments Required
KW Cubley Court Male	97.7%	92.9%	94.8%	99.2%	No	No Comments Required
LRCH Ward 1 OP	98.1%	94.2%	93.6%	123.5%	No	No Comments Required
LRCH Ward 2 OP	103.3%	95.4%	93.9%	107.0%	No	No Comments Required
RDH Ward 33 Adult Acute Inpatient	95.9%	101.2%	102.8%	101.6%	Yes	No Comments Required
RDH Ward 34 Adult Acute Inpatient	91.4%	120.0%	63.2%	193.3%	Yes	Ward 34 continues with high vacancy levels which continue to be addressed through ongoing recruitment, at this time the ward is unable to fulfil safer staffing requirements until there is successful recruitment
RDH Ward 35 Adult Acute Inpatient	97.7%	123.0%	89.1%	116.5%	Yes	We have broken the current fill rate for registered nurses due to a current high level of staff sickness
RDH Ward 36 Adult Acute Inpatient	94.9%	96.6%	82.9%	117.4%	Yes	We have broken the current fill rate for registered nurses due to a current high level of staff sickness

Workforce Section

WORKFORCE DASHBOARD

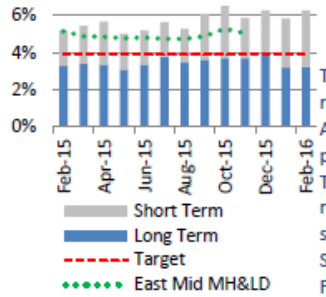
Enc E

Wellbeing

Sickness Absence

Dec-15	Jan-16	Feb-16
6.28%	5.86%	6.26%

Target 3.90%



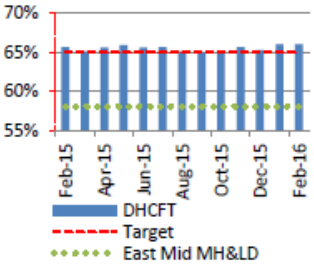
The Trust annual sickness absence rate is currently 5.42%. Anxiety/stress/depression/other psychiatric illnesses remains the Trusts highest sickness absence reason and makes up 23.28% of all sickness absence, followed by Surgery at 11.78% and Cold, Cough, Flu - Influenza at 10.25%.

Qualified Nurses

(to total nurses, midwives, health visitors and HCA's)

Dec-15	Jan-16	Feb-16
65.28%	65.99%	66.04%

Target 65%

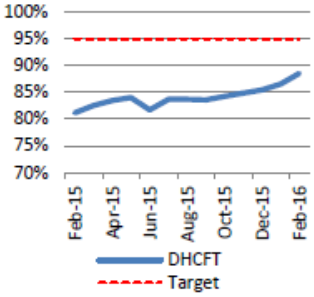


Contracted staff in post qualified nurses to total nurses, midwives, health visitors and HCA's remains within target at 66.04%. Vacancy rates can impact on this measure. The NHS average is 61.38%, National MH&LD 57.83% and East Midlands MH&LD 58.04%.

Compulsory Training

Dec-15	Jan-16	Feb-16
85.44%	86.52%	88.48%

Target 95%



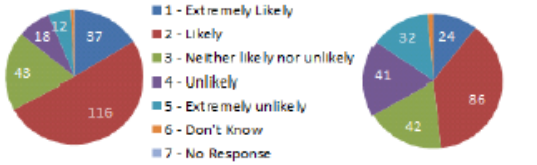
Compulsory training compliance continues to increase rising from 81.13% in February 2015 to 88.48% in February 2016 (7.35% increase). Compulsory training compliance is above the 85% main contract non CQUIN target.

Motivation

Staff FFT Q2 2015/16 & Staff Survey 2015

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

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

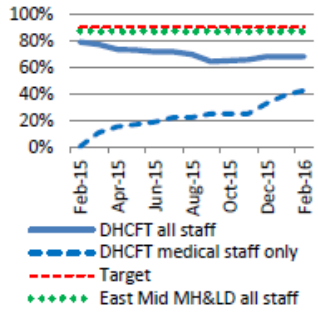


	2014	2015	National Average
Overall staff engagement	3.75	3.73	3.81

Appraisal

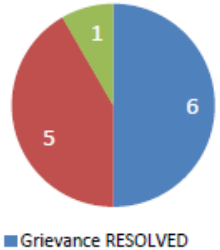
Dec-15	Jan-16	Feb-16
67.92%	67.67%	67.82%

Target 90%



The number of employees who have received an appraisal within the last 12 months has decreased overall during the year to 67.82%. According to the latest staff survey results, the national average for Mental Health & Learning Disability Trusts is 91%.

Grievances/Dignity at Work



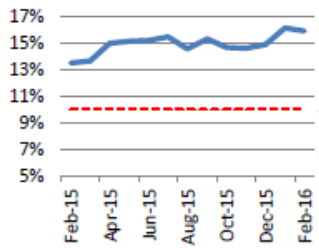
11 grievances lodged at the formal stage within the last 12 months (6 now resolved). Reasons for grievances were varied including relationships with colleagues, matters related to disciplinary process and a collective grievance connected to conditions of service. 1 case lodged formally under the dignity at work process which has been resolved, this related to peers/colleagues.

Attendance

Vacancy (Budgeted Fte)

Dec-15	Jan-16	Feb-16
14.88%	16.12%	15.91%

Target 10%

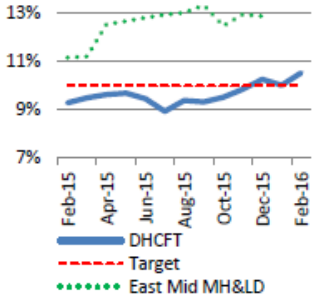


Active recruitment during February 2016 was for 46 posts. 46.21% were for qualified nursing, 20.79% scientific & technical, 15.40% admin & clerical, 6.60% medical, 6.60% additional clinical services and 4.40% allied health professionals.

Turnover

Dec-15	Jan-16	Feb-16
10.26%	10.03%	10.54%

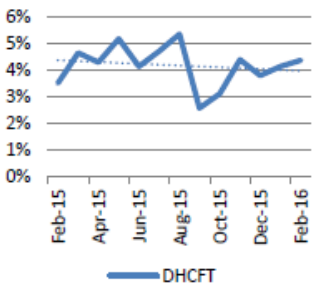
Target 10%



Annual turnover remains within the Trust target parameters at 10.54%. Average turnover for the NHS is 9.21%, 13.19% for National Mental Health & Learning Disability Trusts and 12.87% for East Midlands Mental Health & Learning Disability Trusts.

Agency Usage

Dec-15	Jan-16	Feb-16
3.81%	4.16%	4.39%



Total agency usage in February 2016 was 4.39%. Of total spend for all staff groups, Allied Health Professionals and Scientific & Technical accounted for 0.33%, Admin & Clerical and Estates 0.56%, Medical 2.03%, Qualified Nursing 1.26% and other 0.21%. Agency Qualified Nursing spend against total Qualified Nursing spend in February 2016 was 3.4%.

Quality Section

Under Development

Derbyshire Healthcare NHS Foundation Trust
Report to the Trust Board 30th March 2016

2016/17 One Year Operational Plan

Purpose of Report
This paper sets out the Trusts Final Operational Plan for submission to Monitor on the 11th April 2016. This plan forms part of the Annual Planning Review (APR) process set out by Monitor. This is an updated version from drafts seen at previous meetings and also contains the publishable version required as part of the submission.

Executive Summary
The NHS Planning Guidance for 16/17 has been revised to require a submission of a one year Operational Plan by 11th April 2016 and a five year health and social care system wide Sustainability and Transformation Plan (STP) by June 2016.

A full draft of the operational plan, including a full draft of the narrative, was signed off in the January 2016 Board and submitted by the deadline of 8th February 2016. This plan has been updated with comments from Board members and to take into account the latest financial planning assumptions as part of the 2016/17 contract negotiations.

The Board are asked to either select which statements apply (declaration 1) or confirm/deny the following declarations (declarations 2-5) as part of the self-certification process:

1 Continuity of services condition 7 - Availability of Resources

EITHER

1a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

OR

1b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box in section 3, below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

OR

1c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

2 Declaration of interim and/or planned term support requirements

The trust forecasts a requirement for Department of Health (DH) interim support or planned term support for the year ending 31 March 2017

Note: If interim support is forecast in the plan period, but was not required in the preceding year, the trust should contact its relationship team by 31 January 2016, and before including any amounts in their plan (unless the DH has already approved the interim support funding). Further information regarding the requirements for trusts forecasting a need for DH funding support can be found in the template guidance.

Proposed response: DH support not required

3 Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account, as stated in section 1b above, by the Board of Directors are as follows:

4 Declaration of review of submitted data

The board is satisfied that adequate governance measures are in place to ensure the accuracy of data entered in this planning template.

We would expect that the template's validation checks are reviewed by senior management to ensure that there are no errors arising prior to submission and that any relevant flags within the template are adequately explained.

5 Control Total and Sustainability & Transformation Fund Allocation

The Board has submitted a final operational plan for 2016/17 that meets or exceeds the required financial control total for 2016/17 and the Board agrees to the conditions associated with the Sustainability and Transformation fund

Proposed response: Confirmed - control total accepted: S&T fund allocation incorporated in the plan

Strategic considerations

This plan has been developed in line with the Trusts refreshed Strategy and previous APR strategic submissions. In addition, it takes account of the strategic changes taking place across the local and national health economy in line with the requirements for the emerging system wide STP.

In accordance with the Monitor Risk Assessment Framework, the Board is required to self-certify against the Trust's licence conditions. The self-certification is in

template form provided by Monitor.

Assurances
This plan has previously been approved by the Board in full draft version in January, and subsequently discussed at the Council of Governors.

Consultation
At their January meeting, the Board signed off the full draft operational plan, including narrative, for the February submission. This plan has been updated with feedback from the Board, and in line with the latest financial planning assumptions from the contract negotiations for 2016/17.

The plan has also been discussed at the March Council of Governors meeting. The consultation on the plan has been limited due to the condensed timescales to produce the plan, and the requirement for a full draft plan in February.

Governance or Legal issues
Submission of a forward strategic plan is a requirement for all Foundation Trusts in line with their Provider Licence conditions, including, condition G1 – provision of information and condition G5 - Monitor guidance.

This Operational Plan submission to Monitor requires full formal board sign-off.

Equality Delivery System
This report has a neutral impact on REGARDS groups.

Recommendations
The Board of Directors are requested to:

1. Review the key changes made to the 2016/17 Operational Plan
2. Seek assurances that there is alignment with the Trusts Strategy
3. Discuss and agree the Boards response to the declarations for sustainability and resilience (statements 1-5) set out in the excel template, and replicated for reference in the Executive Summary of this cover sheet
4. Approve the content of the plan and delegate sign off of the final version of the plan to the Executive Leadership Team (ELT) Meeting in order to take into account feedback on the draft plan from Monitor sent in the letter dated 24th March (attached) and any last minute alterations before the submission deadline of 11th April.

Report prepared by: **Jenny Moss, Head of Contracting and Commissioning**

Report presented by: **Claire Wright, Director of Finance.**

Derbyshire Healthcare NHS
NHS Foundation Trust

Operational Plan 2016/17

April 2016

Better together

Summary of key changes made to the final operational plan

The plan narrative has been updated to reflect:

1. The current position with contract negotiations with commissioners as part of the final year of our three year contract
2. The recommendations and outcomes from investigations and regulatory action, and the action the Trust has taken to date
3. A revision to our quality priorities
4. Minor wording and grammatical amendments
5. Financial changes as outlined below.

The following financial changes have been made between the draft and final submissions:

- The inclusion of service developments
- Some additional non-recurrent expenditure
- Phasing of contingencies
- Plan set for agency and bank staff expenditure
- The inclusion of consultancy expenditure
- CIP status and risk has been updated to reflect current progress.

Approach to activity planning

Activity levels for 2016/2017 have been agreed with commissioners across our portfolio of services. 2016/2017 activity plans that will be included in the annual plan template will be based on 2015/2016 forecast outturn and will be adjusted to take into account agreed service developments or changes funded by commissioners. However, inherent in this is the knowledge that demand for our mental health and learning disability (LD) services are growing and that, in order to meet this demand, large-scale transformation and investment is required. In addition to these pressures, the introduction of national access standards, which form part of the Risk Assessment Framework, presents further challenge for the organisation in evidencing the achievement of those standards.

Our most significant areas of growth in demand have been for Improving Access to Psychological Therapies (IAPT), adult mental health and LD services. We have seen 8% growth in the numbers of service users open to our adult mental health and LD services from 2013/2014 to 2015/16, whilst demand for IAPT services has increased by 23% over the same period. We continue to experience sustained high levels of demand for our inpatient beds which, despite every effort to minimise where possible, has had a resulting impact on the number of out of area placements for our patients.

The Trust has already undertaken significant transformation of services to meet these levels of demand. We intend to continue along this transformation journey, aligned to the development of the Derbyshire health and care system's Sustainability and Transformation Plan (STP), to deliver both a neighbourhood and campus model of care which delivers the most effective services.

Given the significance of the transformation programme, the Trust Board wanted to ensure that our plans and assumptions were rigorously and independently tested. A company called Sim:pathy were commissioned to carry out independent simulation modelling of the assumptions within the programme, to give this assurance. A number of key questions have been addressed through this process, including:

- How robust are the current plans and assumptions as to how many inpatient beds should be provided for local people with mental health problems?
- How robust are the current plans and assumptions as to how community services should be configured to deliver the right pathways for each care cluster?
- What mix of staffing and skills are required to provide optimal services within available resources?
- What level of services is required to manage the impact of demographic change?
- Will our planned and proposed model of care be deliverable in practice?

During quarter 4 of 2014/15, Sim:pathy, through use of simulation modelling, confirmed that the new neighbourhood model will be more effective than the system we have now. In addition, they have also confirmed that, when applying the resource reductions expected in future years, the neighbourhood model still works better than the current system.

However, despite the significant transformation of services to meet demand, there remains capacity issues associated with either the increase in demand or historic underinvestment across many services, the most substantial of which is within community mental health services.

Best practice guidance published by the Department of Health gives the following recommendations for community caseloads:

"The following guidance for caseload sizes and team constitution are calculated on a model of a single team for a defined population.

- *Each team to have a maximum caseload between 300–350 patients but may be considerably less. Otherwise information exchange becomes unwieldy eroding clinical capacity.*
- *Full time care co-ordinators to have a maximum caseload of 35 and part time staff to have their caseload reduced pro-rata."*

Dept. Health (2002) Mental Health Policy Implementation Guide - Community Mental Health Teams

Application of this guidance shows that the Trust's capacity in community teams needs enhancing by circa 60WTE Band 5 and/or Band 6 nursing staff in order to ensure each locality is staffed to best practise national guidance around caseloads.

We are jointly addressing the assessed shortfall in capacity and associated investment required in community resources with commissioners. We are working with commissioners to balance this need with the growing demand for other services, ensuring we mitigate the clinical risks this may pose.

Over the past year, many of our services have been going through a process of transformation to move to a neighbourhood model which has necessarily impacted upon speed of recruitment and will have impacted on short-term capacity. This is currently being addressed and we expect this to be resolved during 2016/17.

We produce activity reports on a monthly basis and share these with commissioners discussing any changes in demand and activity. Activity targets are then only changed following Contract Variations to reflect any agreed changes in service delivery. When we agree service developments, associated activity implications are agreed and reflected in the plan. We have established a joint working group with commissioners to review the activity targets in light of proposed changes to contracting and payment models for 2017/18.

Negotiations with commissioners with respect to the new national access standards have been positive and the Trust is working with commissioners to establish the funding allocation to support the changes required to deliver the step-change in access times and treatment choices. The process of adapting to these changes will be tightly governed by the Trust's operational management teams and progress will be monitored through a clear line of sight to the Trust Board.

Approach to quality planning

The quality standards for patient services are built into our organisational quality framework and our organisation has fully embraced the NHS Constitution and the fundamental standards of quality and safety published by Care Quality Commission (CQC). These quality standards continue to define the expectations of our services and during our clinical and corporate Board, governor and commissioners visits these are the standards against which services showcase their clinical and service innovations.

Our Trust has defined its quality priorities, and these are connected to the needs of the local population and also reflect national priorities. Our Quality Priorities for 2016-2017 are:

1. **Physical healthcare** – this continues into its third year in order to embed sustained change and focus on the mortality gap of those with severe and enduring mental ill health. This is in part due to the number of deaths we have due to physical health and long term conditions
2. **Preventing suicide** – through patient safety planning. Although our Trust has a lower than national average suicide rate of individuals open to our services, our community suicide rate is rising and we need to support the wider system in their endeavours. The leading cause of death in some key age profiles is suicide and therefore we continue to see suicide prevention to be a key priority
3. **Positive and Safe**, formally known as Force Free Futures – reducing the use of restrictive practice in services. Our service receiver community groups have fedback that they would like to see continued and on-going reductions in seclusion and restrictive practices. We believe this is a key component of a contemporary health service
4. **Think! Family** – working with the whole family and co-ordinating all aspects of support to address their full needs, is a learning action from a serious case review. Although we have made significant progress in key areas such as Substance Misuse, we want to fully embed this work in every aspect of our Trust.
5. To become and embed our Trust as **a person centred and recovery-focused organisation** – through our neighbourhood model of delivering community services to develop our new models of care re self-care, shared care and drawing upon clinical models such as patient activation to embed individualised personalised care.

We revise and review these priorities annually in partnership with our senior clinical leaders and through our Quality Assurance Group with commissioners to ensure our work is defined by the needs of the system and the population. This will inform the key areas of work for the Quality Committee and its sub groups. These priorities are reflected and measured within our Commissioning for Quality and Innovation (CQUINs) and internal key performance indicators (KPIs),

There are a number of additional quality goals that have come through the NHS Standard Contract:

a) In mental health, access targets for first episode psychosis, which also include requirements for ageless service and NICE-informed interventions which we will be embedding in 2016.

b) **Individualised personalised care** which has been developed in a collaborative manner will be present for all of our service receivers, community service receivers and our families in our care. There is still room for improvement in this area and this will be a key quality priority until we get it right in 2016. This will be evidenced in our in-patient survey, community survey, CQC Mental Health action visit reports and service receiver experience feedback and monitored by our quality committee.
c) We will strengthen and **re-define Clinical Leadership, Clinical ownership of Clinical performance management** through a golden thread of quality running from the Board to the service areas. We do this to enable the strength of all of our staff's clinical voices working towards quality improvements, transparency in Patient Safety in every aspect of care that we provide and in everything that we do. It will be demonstrated through an effective Quality Committee, Quality Leadership Team and Clinical Reference Groups through their work plans, ownership and demonstrable impact on key clinical priorities.

The Trust is compliant with the recommendations of the Academy of Medical Royal Colleges and Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients.

All inpatient consultants have responsibility for their patients' care throughout their admission. This includes arrangements for their discharge and care coordination in association with care mangers and CPA coordinators. Occasionally it may be necessary to transfer to another responsible consultant during an episode of inpatient care, for example if specialist treatment is required. There are cover arrangements for leave. Patients have a named nurse and should know the details of how they can be contacted.

The concept of the responsible consultant should not be confused with the status of Responsible Clinician under the Mental Health Act. Again the Trust is compliant with Mental Health Act Standards of Good practice. Clinical audits have demonstrated improvement in Consent to Treatment issues. Future audits are planned to give assurance on this and the application of the Mental Capacity Act and person centred care planning. Safety planning training and suicide prevention training are underway with a focus on person centred planning once again.

The Trust has had a CQC Safeguarding inspection and no serious concerns were noted. All recommendations and action plans for service improvements are in development, and the recommendations are in progress and are being achieved to date in 2016. We do not, at this time, envisage any blocks to delivery of these outcomes.

The Trust will be participating in the annual publication of avoidable deaths per trust. The Trust has reviewed its death reporting, analysis and learning systems in January 2016 in light of the Southern Health / MAZARS report. Any national requirements from this will be embedded across our organisation.

The Trust is focusing on quality interventions in our Quality Strategy. Some work in 2014 and 2015 has seen some early returns in our analysis of our inpatient survey. Our focus has been on clinical evidence such as restrictive practices, research led mental health, safe wards and clinical interventions. We will continue to focus on these areas to embed a

culture of continuous reflection, learning and improvement. Our early impressions of our improvements are a combination of Safewards, safer staffing levels, clinical stability both in nursing and in in-patient Psychiatry.

The Trust is revisiting its organisation-wide improvement methodology, as part of the Trust strategy redesign. At this time our approach is continued learning from serious untoward incidents, complaints and focusing on errors to reduce clinical variation. We are exploring a redefined model of analysis of both service failures and our quality visit programmes where services showcase good practice. We plan to add in a clinical good practice compendium approach to analyse clinical success, the contributing factors and model the organisational and cultural factors that created the environment for success. We believe this work, redefining and redeveloping our clinical leadership teams, are the keys to effectiveness in managing our quality and safety, wherever possible, within the financial envelope available.

The key components to our quality review of potential cost improvement schemes are as follows:

- The Project teams are responsible for considering quality and ensuring it is appropriately monitored and recorded. Following an initial assessment of potential quality impact, reviews of quality are mandatory at 3, 6 and 12 months following implementation.
- Our Cost Improvement Programme (CIP) is underpinned by a Quality Impact Assessment (QIA) process. Each project with a potential clinical impact identifies a Quality Lead with responsibility for ensuring quality is properly assessed. This provides a framework through which quality can be addressed across the projects, including provision of training and support, and linking to the Programme Assurance Board (PAB).
- The PAB has responsibility for monthly consideration of reports on issues affecting time, finance or quality for projects, and initiating necessary action. This is the focal point where quality risks are monitored and issues raised.
- The process also includes an Escalation Exception Group (EEG), a sub group of PAB, that explore in more detail projects where there are important issues including those affecting quality that are difficult to resolve.

Our Quality committee sets the strategy and oversight of our clinical assurance systems in all aspects of quality.

Our Safeguarding committee sets the strategy and oversight of our safeguarding assurance systems for our Trust and for our community. There are significant challenges related to historical sexual abuse, child sexual exploitation, domestic violence, significant levels of familial sexual abuse and community cohesion and radicalisation.

Our Mental Health Act committee sets the strategy and oversight of all of our mental health and capacity legislation and working within our legal requirements. To recognise and support the wider community and system in its safe use of the deprivation of liberty safeguards with a significant community backlog for our local authorities.

Our named executive leads are Carolyn Green, Executive Director of Nursing and Patient Experience, and Dr John Sykes, Medical Director. Our number one key clinical risk is community capacity and overall capacity outstripping demand. This is a risk that is jointly owned with commissioners and is being addressed as part of our discussions with commissioners around the investment required to address the service gap as part of parity of esteem. This is as a result of historic underinvestment in mental health services. We are in negotiations with commissioners around how the challenges of addressing the funding gap for our core services can be managed in the context of the financial challenges faced by the health economy. As this has been identified as a key clinical risk for our organisation, our view is that this needs to form a fundamental part of our contract offer for 2016/2017.

Our other key clinical risks are around meeting the staffing requirements for Section 136 suites and suicide prevention. We are negotiating investment with commissioners to help us fulfil our obligations to ensure that 136 Suites are staffed independently of the wards, and exploring how this can be developed within the wider context of our urgent care pathway review work across the health economy.

The national suicide rate has been increasing significantly since 2006 particularly in middle aged men. This is likely to be linked to economic factors often compounded by social isolation with alcohol or substance misuse representing a “final pathway”.

We have seen these trends replicated in our patient population. The Trust has no more suicides than other similar organisations but the problem is increasing in Derbyshire as elsewhere in the country. We therefore need to do everything possible to address this public health concern with our partners and the people of Derbyshire and this remains a key priority for the Trust.

We are carefully monitoring all of our death rates and specifically our physical health care rates and sudden death rates. We are awaiting our new scorecard from the national homicide and suicide enquiry, to enable the Trust to benchmark its performance. We continue to have a strong focus upon physical health care, our pharmacological interventions, deaths relation to new and novel psychoactive substances, smoking cessation until we understand our physical healthcare deaths fully in line with our public health and population data for Derby city and Derbyshire where our communities have a worse than national average mortality rate.

On 24 July 2015 Monitor launched an investigation into Derbyshire Healthcare NHS Foundation Trust after an employment tribunal involving members of the Board and wider senior staff highlighted concerns with how the Trust was run.

Following this, the Trust commissioned two independent investigations into the findings of the employment tribunal and associated correspondence. A number of recommendations were made as a result of these investigations and the Trust has a clear action plan to implement, in order to promptly resolve any issues identified. This action plan will continue into 2016/17 and focuses upon ensuring that the Trust effectively adheres to its own governance processes, improves the culture of the Trust and relationships between the Board and Council of Governors.

On 25 February 2016 the Trust's regulator, the Care Quality Commission (CQC) published two requirement notices that outline the need to ensure HR policies and procedures are followed and monitored for all staff and to ensure that, in line with national requirements, a fit and proper person review is undertaken and evidenced for all directors.

The Trust closes 2015/16 with regulatory action being enforced by Monitor, who on 25 February 2016 formally announced an enforcement notice in response to the concerns identified in the 'well led' review. The Trust takes the breach of its provider license very seriously and will be focused this year on full achievement of the governance improvement action plan, developed in the final quarter of 2015/16.

Approach to workforce planning

The shift in delivery model away from traditional individual mental health teams to one of shared ownership for a population area under the neighbourhood model will require the following high level movements in workforce profile and skill mix:

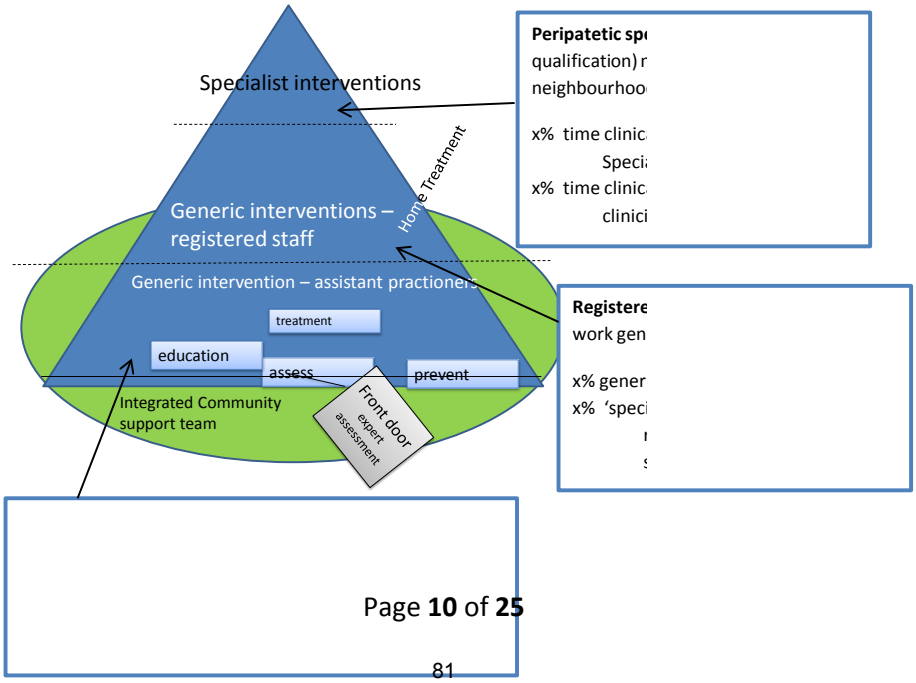
- Reduction in the amount of in-patient specialist staff and a growth in staff skilled in working in the community
- Increased number of staff with a wider skill-set to deliver more holistic interventions in both symptom and social recovery
- Increased number of other support staff and assistant practitioners with the ideal skill set to be used to meet key aspects of social recovery
- Increased number of peer support workers with a lived experience of ill health
- Increased volunteers used appropriately
- An increase in staff with the skill set to work across organisational boundaries
- Changes to move away from traditional working patterns for senior clinical leaders such as consultants – for example the start of seven-day working.

The neighbourhood service will have a workforce skilled in the delivery of interventions that have a sound evidence base in treating and supporting patients in their recovery, as well as reducing their likelihood to relapse. For patients not requiring ongoing secondary services, there is a need to work closely with GPs and voluntary sector providers to support their independence. Staff within the neighbourhood service will work alongside GPs to support this transition of care between secondary and primary care services for people with stable mental health needs.

Workforce changes

It is proposed that each neighbourhood will have three tiers of trained, skilled staff within it to deliver care as required to meet their mental health needs. We will be working towards embedding this during 2016/2017. This is indicated below:

Proposed workforce reconfiguration to support neighbourhood team development



The Trust has mapped across National Tariff Payment System (NTPS) data set information, activity and financial data, NICE guidance, Sim:pathy outputs and information pertaining to the levels of intervention within a Neighbourhood. From this we have been able to derive a workforce profile for each Neighbourhood. All teams have been asked to use the internal capacity calculating tool to determine a localised workforce picture for each Neighbourhood based on working practices

The demand and capacity modelling tool (WorkPro) is being used to provide information for workforce and training needs planning. Utilising a mental health acuity model, based on Care clustering and a locally developed complexity escalator, WorkPro is being used to model community mental health, (neighbourhood) demand - in terms of both volume and level of complexity, - capacity and skills profile. Levels of intervention within each Neighbourhood are predicated on clinical coding to support capacity analysis.

The cluster profiles of the neighbourhoods indicate that most interventions occur in levels 2 and 3, resulting in an increase in Band 3 and Band 5 clinicians and fewer band 6 and above. The outputs from WorkPro are subject to validation with individual teams. This is as much about involvement and engagement as it is about the sense check.

It is clear from discussions within teams that capacity assumptions based upon average sickness, training and time of clinical contact need to be reflective of the Neighbourhood need.

There are a number of key risks that have been identified that relate to the operational implementation of the WorkPro model. There are appropriate mitigations in place and these are being monitored through the Trust's People and Culture Committee.

Whilst further development of WorkPro will see the tool adapted for non-mental health currency services and inpatient care, the Trust identified the need for a skill mix review of inpatient services and have adopted a service in-reach approach supporting the Senior Nurses to review their own skill mix and support their own analysis of their team requirements based upon a critique and review of the year. Using a new trust designed narrative, judgements of professional's model of skill mix review and decision making completed in 1:1 sessions with each senior nurse from each unit. This analysis considers incidents, patterns, themes, the view of the senior team, stability in team and a site visit rather than a HURST model skill mix review which is primarily a number and a spreadsheet analysis without review of the wider environmental of patient presentation factors.

The methodology used for the skill mix review was as follows:

- Benchmarking team skill data against safe staffing funded resource establishment.
- Reviewing against safer staffing monitoring data.
- Reviewing against workforce metrics including sickness absence staff turnover/use of temporary staffing.
- Interviewing each inpatient Senior Nurse using a standardised approach to collect their narrative, mapping against their team data. The team data included, safe staffing data, serious untoward Incident data, patient experience data and workforce establishment data.

As part of the review consideration has been given to the organisations' wider processes concerning safer staffing. The Trust Board receives an integrated report which includes finance, operational, quality and workforce information to ensure that balanced and informed decisions are made around service related issues.

Policies and systems are in place to enable staffing establishments to be met on a shift-by-shift basis. Each inpatient area uses e –rostering and have escalation processes in place to support staffing decisions on a shift by shift basis.

The Director of Operations leads on the routine monitoring of shift by shift staffing levels. This is inclusive of temporary staffing solutions. The routine monitoring includes shift by shift reporting on planned versus actual staffing levels, datix reporting and escalation of actual levels lower than planned; regular review of temporary staff usage and actual fill rate. The Trust's Executive Leadership team reviews and signs off any shifts that do not meet agency price cap requirements but are required to maintain patient safety. Where staffing shortages are identified staff have an escalation policy and reporting structure through datix in order to provide clarity about the actions needed to mitigate problems identified.

We will continue to improve on and maintain a positive culture within operational teams to raise concerns regards staffing. Safe staffing is regularly discussed at weekly team meetings. In addition to this a monthly safe staffing meeting is held to review any identified problems, emerging difficulties or themes.

The Trust, in common with other mental health organisations, is experiencing major pressures around nurse recruitment, levels of adult acuity and demand for beds. The risks associated with these areas are being rigorously monitored as part of the internal escalation plan associated with the Trust's emergency planning processes. A detailed mitigation plan is in place supported by senior operational and clinical leaders and the situation has been under constant review. The Trust Board and Executive team are kept appraised of risks and mitigation plans.

Staffing levels, concerns around recruitment and retention and their associated impact on service capacity are included on our Trust Board Assurance Framework as a risk to the organisation. This has been subject to a deep dive review at F&P Committee to provide the Board with assurance on our approach and risk mitigations.

The Trust has recently established a project to look at resource management in terms of rostering and staffing, with the aim of delivering an implementable and safe plan which focusses towards a reduction in temporary staffing and effective rostering.

As a multispecialty provider which also includes Children's community and mental health services, we have been training staff on various therapies within the national Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme for the past few years. This is helping to develop an evidence based practice within the Child and Adolescent Mental Health Service (CAMHS). Due to the commitment involved with the

programme, we have decided that 2016/2017 will be a period of consolidation. As a result we will not be training additional staff on the CYP IAPT programme during this year.

Following a sustained period of supporting health visitor training (up to 15 students per year), we envisage a considerable reduction in health visitor trainees during 2016/17. We will continue to support trainees but the number will be significantly reduced (approx. 5 students per year).

We are entering a mobilisation period for Children's Public Health Services. This will involve engagement with staff and a process to ensure workforce skills and experience are utilised at the optimum level. This will enable staff to take on differing roles with support and training.

The People Strategy update was presented to the Trust Board in May 2015 and includes a spotlight on education which demonstrates training in continuous improvement such as inter-professional practise learning, strengthening the compassionate care culture, and Maastricht hearing voices training. The Board has recognised concerns around assurance routes for educational governance because of changes to the focus of the People Forum. Whist the Trust can demonstrate examples of quality improvement we recognise we do not have a consistent methodology.

Although we have an Education Strategy in place and educational governance arrangements for compulsory training, the need for a comprehensive training approach to support new developments and transformation change is acknowledged. Furthermore, we recognise we are in the early stages of the development of a continuous improvement methodology and this needs to be fully developed and embedded throughout the organisation.

The Trust is in the process of developing a new Trust Strategy and this will be underpinned by the quality goals. Moving forward, we are aware of the need to develop a new People's Strategy, in parallel with the new Trust Strategy.

As part of our assurance to the Board regarding our workforce related risks, we have reported that we have full spend of Health Education East Midlands (HEEM). The funding has been received and has been allocated or committed to ensure full spend by year end.

Approach to financial planning

This plan has been set on a stretching basis to meet the control total surplus issued to organisations on 15th January 2016. In order to meet the control total, the CIP requirement has had to be increased to in excess of the 2% national requirement for providers. Our CIP is 3.28% of operating expenditure (within EBITDA Less PFI interest expenses).

As part of our planning ahead for 16/17 we have created new CIP work streams that include work on procurement and agency staffing related themes. Our capital planning continues to be self-funded through depreciation and no external borrowing is assumed. Our capital planning is tightly managed so that emerging clinical priorities can be accommodated without recourse to external borrowing.

The financial performance of the Trust in 16/17 will continue to be subject to detailed financial forecasting, so that any emerging changes in trajectories or run rates can be understood, appropriately challenged and action planned.

Financial forecasts and modelling

The plans and priorities for quality, workforce and activity connect to the financial forecasts contained in our plan. As part of the process of compilation of the plan, the planning team review the contents to ensure there is consistency across sections. The plan is signed off as an entire piece before submission to ensure triangulation across sections in the narrative and the excel files.

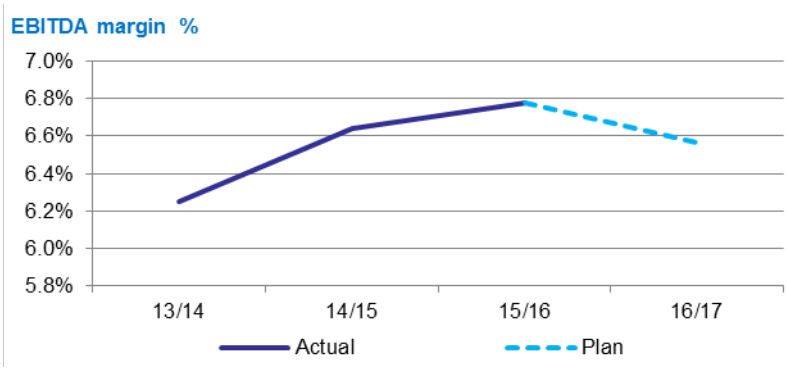
The forecast costs in the plan are based on bottom-up modelling of requirements to deliver services in 16/17. They have been discussed and agreed with budget holders and in aggregate at team and service level. As part of the process there is challenge and confirm at all stages, including a final one at executive level.

Within the final operational plan is an assumption around the level of investment from Commissioners based on CCG allocation growth, inflation and some level of service developments. However, contract discussions have not yet concluded by the time of the final submission. The national assumptions for efficiency and inflation have been assumed, along with the achievement of a surplus excluding impairments/transfers/gains and losses that meets the control total of £1.7m surplus. Income assumptions also include full achievement of CQUIN and no contract penalties. The plan assumes nil income from the sustainability and transformation fund.

The financial commentary herein provides all the summary information from the plan using charts extracted from the excel file.

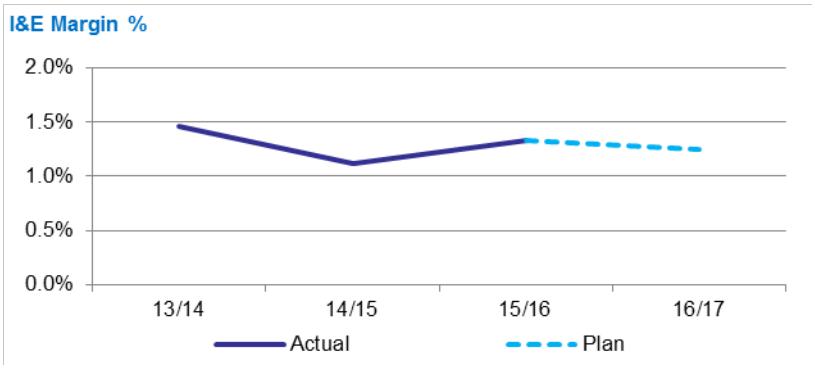
EBITDA margin %

EBITDA is planned at 6.6% which is slightly below the 15/16 forecast outturn of 6.8%.



Surplus margin %

The pre impairments and transfers surplus of £1.7m equates to c1.2% which is slightly lower than the improved forecast outturn for 15/16. This reflects the control total that has been issued to the Trust.

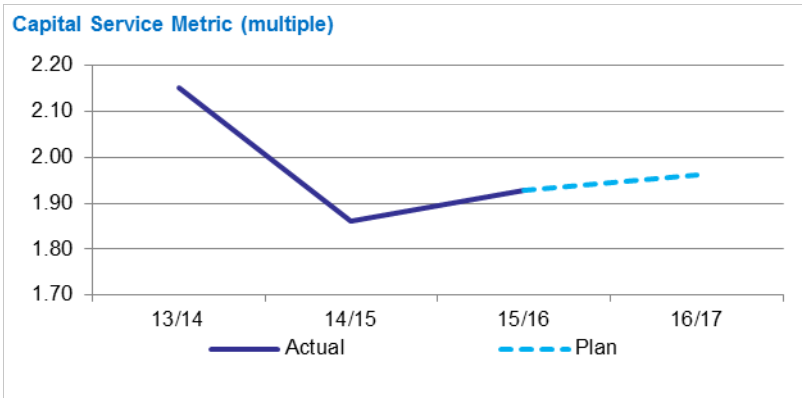


Financial Sustainability Risk Rating (FSRR)

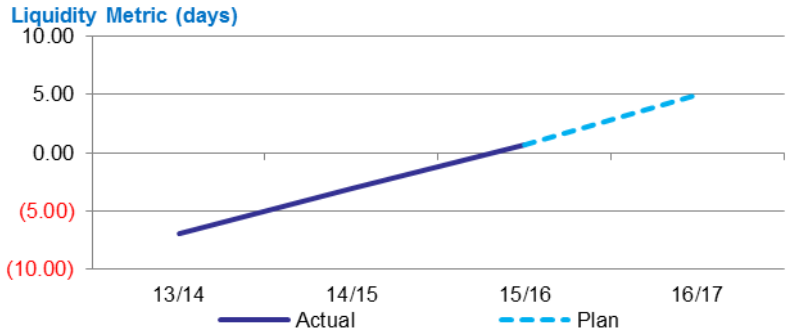
2016/17 *(15/16)*	Q1	Q2	Q3	Q4
Capital service cover	**2** *(3)*	***3*** *(3)*	**3** *(3)*	**3** *(3)*
Liquidity	**3** *(3)*	**3** *(4)*	**4** *(4)*	**4** *(4)*
I&E Margin	**2**	**3** *(4)*	**4** *(4)*	**4** *(4)*
I&E Margin variance to plan	**4**	**4** *(4)*	**4** *(4)*	**4** *(4)*
FSRR	**3** *(3)*	**3** *(4)*	**4** *(4)*	**4** *(4)*

Overall the FSRR is planned at a 3 for the first half of the financial year improving to a 4 in the second half of the year. This is change to the draft operational plan where contingency reserves where phased in the second half of the year and are now phased across the whole year. There is also some income abatement planned for in the first few months of the year along with some additional non-recurrent costs.

The Capital Service Cover is a 2 in the first quarter and improves to a 3 in quarter 2 and a further improvement is planned in quarter 3 and 4 , which as shown below is a slight improvement on 15/16.

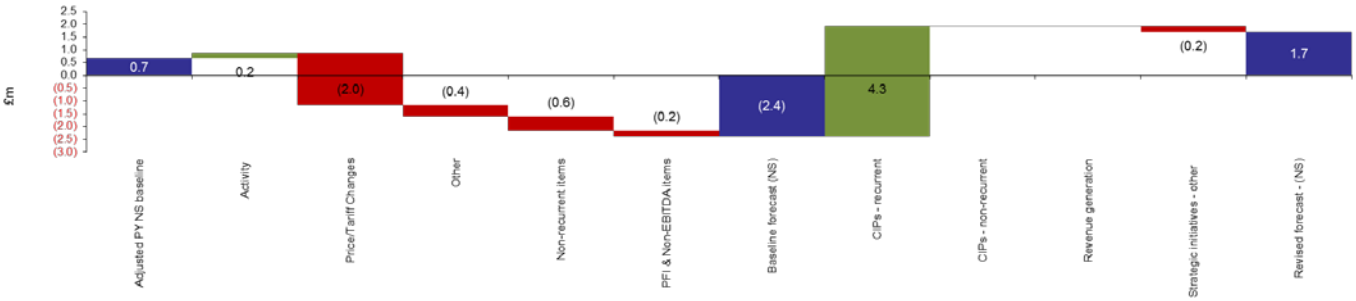


The Liquidity metric continues to improve as shown below and is planned to be at 5 days by the end of 16/17.



Key movements bridging 15/16 to 16/17

We have used the forecast outturn position as at month 9 for the 15/16 position as the most up to date information available at the time. The changes between the forecast outturn and 16/17 plan are shown below:



- The 'adjusted baseline' of £0.7m takes into account £1.1m of non-recurrent income and costs in 15/16 along with full year effects from 15/16.
- Activity adjustments of £0.2m reflect the anticipated occupancy levels for cost per case services including the reduction of some in-patient beds.
- Tariff changes includes clinical income inflation of 1.1%, assumed pay awards of 1%, National Insurance (NI) increases from pension changes, incremental pay increases and non-pay inflation.

- Other changes mainly include contingency reserves off set by miscellaneous income target.
- The above changes generate a baseline forecast of £2.4m deficit.
- After other strategic developments of £0.2m there is a requirement for CIPs of £4.3m in order to achieve the control total of £1.7m surplus.

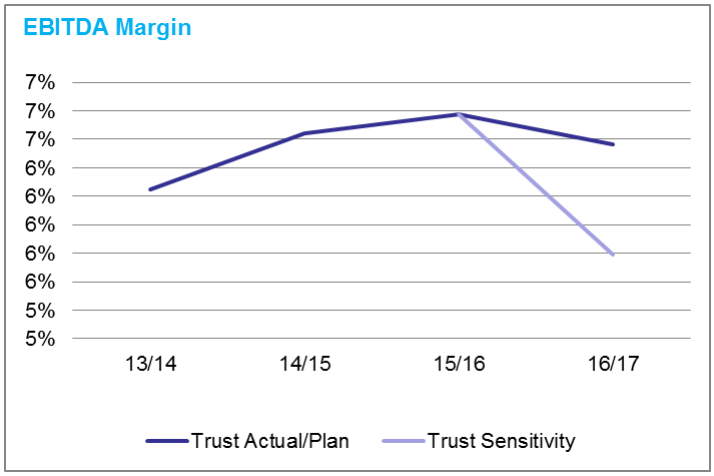
Sensitivity analysis

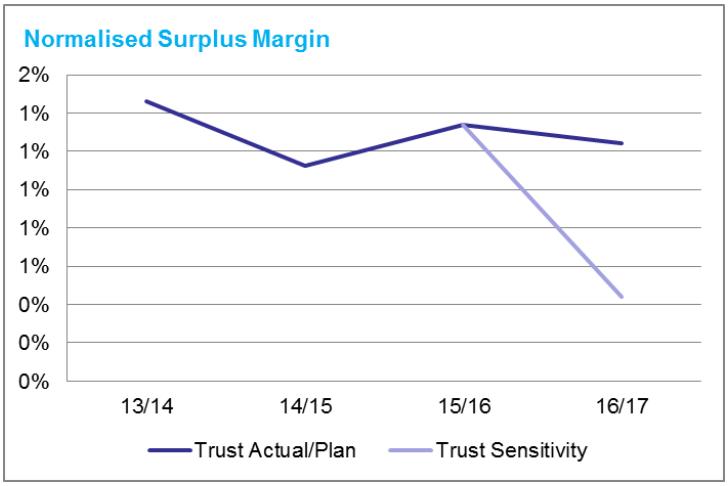
The following variations have been applied using the sensitivity analysis worksheet:

- Downside of 20% of non-delivery of CIP (£860k)
- Downside of loss of £700k of income related to not achieving non clinical income and reductions in occupancy levels.
- Upside of £463k by not committing expenditure against the contingency reserve.

The above scenarios applied together generate a FSRR of 3: Capital Service cover reduces to a 2 against a plan of 3 and the I&E Margin metric reduces to a 3 compared to a plan of 4.

The extracted worksheet charts below show the net impact of sensitivities on EBITDA % and pre-I&T surplus margin %.





Efficiency savings for 2016/17

As in previous years the focus of our efficiency programme is on cost reduction rather than income gain. The efficiency requirement has been increased in order to deliver the surplus required by the control total.

In order to deliver the CIP programme there are a number of broad workstreams which are listed below:

1. **Procurement** - to review non-pay expenditure and contracts including reference to Lord Carter's provider productivity work programme - taking account of transferable learning as it relates to estates, purchasing and medicines management such as;
    - Review of potential savings through NHS Supply Chain through the use of more cost effective products and product standardisation.
    - Collaborative procurement with other local providers
    - A refresh of category spend analysis to identify other potential savings.

    This is currently classified as a mix of low and medium risk
2. **Campus services** - there are a number of potential developments under consideration, including older adult challenging behaviour and Rehabilitation Services. Currently classified as medium risk.
3. **Rostering and temporary staffing** - to further review temporary staff usage, ensuring that the Trust is in line with national agency rules and guidance, to achieve a reduction in temporary staffing and optimise utilisation of substantive staffing. Classified as medium risk.
4. **Length of stay (campus)** - The Trust has identified there are length of stay opportunities in a number of inpatient services; a specific programme of work focussed on considering inpatient length of stay to contribute to the Campus overall efficiency. Classified as high risk.
5. **Frequency of contact (neighbourhood)** - this project will look at clinical variation in the community services including frequency and length of interventions in comparison to cluster and demographic profiles to optimise resource allocation. This has developed in part from the Sim:pathy work undertaken in 2015-16. This is medium risk.
6. **Lean working and economies of scale** - to develop awareness and ownership of lean working across all areas of the Trust's operation. This work will include process mapping and supporting the development of economies of scale initiatives elsewhere. Medium risk.
7. **Clinical variation** - To reduce variation in service delivery across Trust Medical-led services (both inpatient and community) to improve efficiency and to introduce different models for outpatient services, and non-medical prescribing. Classified as high risk.

In value terms, 39% of CIP is classified as high risk, 26% medium and 36% low risk.
16/17 CIP is an Executive Leadership Team priority, supported by the programme assurance office led by the Director of Operations, who will work with colleagues to drive the programme of work in line with governance structures. ELT will ensure oversight of delivery of CIP plans and the mitigation of associated risks. The quality impact assessment process as

described in the quality section of this plan, underpins the development process and delivery of CIP across the organisation.

Agency

The combined effect of the new agency rules is included in our approach to budget setting as described below. Oversight of compliance with the agency rules lies with a board level committee in terms of assurance. Operational delivery and day to day compliance has been outlined within our approach to workforce planning.

Budgeting approach for temporary staffing:

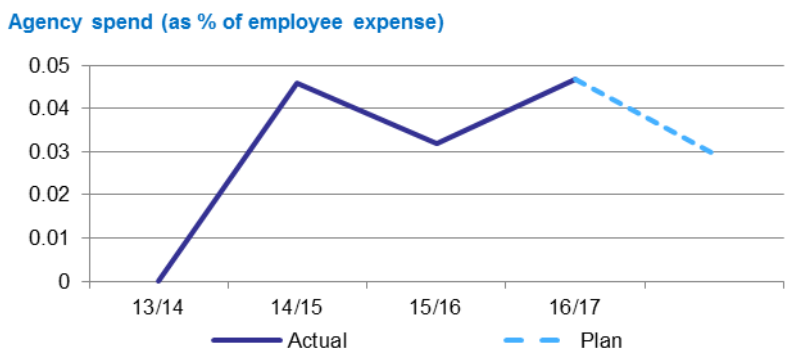
We tend not to create specific budgets for agency staffing, instead we agree the required level of staffing through bottom-up budget setting. Budgets are then set onto substantive staff cost budgets (there are minor exceptions).

In the final plan we have set a plan for temporary staffing both bank and agency for all groups of staff. This is based on historic trends including an improvement to take into account the reduced agency rates that come into effect from April 2016. The agency expenditure plan is within the ceiling of £3.03m issued to the Trust.

3 Year Total (13/14 to 15/16)	Plan	Actual	Variance	
Substantive, bank and overtime staff	-285.195	-273.329	11.866	
Locum and agency staff	-2.442	-11.807	-9.365	
Employee Expenses, total	-287.637	-285.136	2.501	Fav
	0.85%	4.14%		

2016-17	Plan
Substantive, bank and overtime staff	-98.499
Locum and agency staff	-2.993
Employee Expenses, total	-101.492
	2.95%

2016/17 agency expenditure plan is 3% of total pay expenditure compared to 15/16 forecast outturn which is at 5% as shown in the graph below.



Capital planning

Our capital plan is approved by the Trust board to ensure it is in line with clinical strategies and quality priorities in order to continue to deliver safe, productive services. We are not planning any large scale new builds or other major capital projects for 16/17 (or the near future). The Board-approved capital plan provides for the physical estate and technological priorities that are affordable within internal resources. As in previous years, should new requirements emerge for example a regulation change or a CQC requirement, we will reprioritise the capital programme accordingly.

The capital programme is managed tightly by a multi-professional team and progress is reported to the Trust board on a monthly basis.

We have for many years been progressing with estate rationalisation and are nearing the end of this process. We are now largely at the point of optimisation of the reduced estate. Key to that is our agile-working approach. We do not utilise the sort of equipment that would require a managed equipment service. We do not currently plan to purposely extend any asset lives, however this will be explored should it be required.

Link to the emerging 'Sustainability and Transformation Plan' (STP)

Historically in Derbyshire two strategic leadership groups and associated transformation programmes have been in place to address the system-level operational and financial pressures facing the health and care economy as a whole. As a Trust we span both these groups. In the north of the County, the 21C Board is composed of North Derbyshire and Hardwick CCGs (plus local authorities and NHS providers) and, in the South of the County, the Joined Up Care Board has representation from Southern Derbyshire and Erewash CCGs (plus local authorities and NHS providers).

In response to the 'Five Year Forward View', we have been working closely with Erewash Clinical Commissioning Group (CCG), Derbyshire Community Health Services (DCHS), Erewash GP Provider Company and Derbyshire Health United after NHS England chose the Erewash area to be an Multi-specialty Community Provider(MCP) vanguard site for more integrated health services. Erewash wellbeing was one of the 29 sites across the country selected by NHS England to receive additional support as part of its national New Care Models programme. The aim is to develop an Erewash prevention team across two hubs made up of health and care professionals including GPs, advanced nurse practitioners, mental health nurses, extended care support and therapy support. It delivers services to people who do not require hospital services and can be treated for their conditions in a community setting. The Acting Chief Executive Officer (CEO) is leading one of the core work streams within the Vanguard building on the expertise and experience of the Trust in enhancing Community Resilience.

With regard to the requirement for an STP to be developed, it has been agreed that the footprint for this will be across the whole of Derbyshire. Whilst this poses risks in terms of scope of alignment of planning, this is a very positive step forwards for the Trust as a Provider who delivers services across the County. It is evidently clear that there is work to do to align current plans across 21C, Joined Up Care and Erewash Vanguard, however we are of the belief that significant progress can be made and that risks in alignment of plans can managed. A defined governance structure, 11 key principles and a programme plan for the delivery of the STP has been developed and agreed by all organisations. The essence of the approach of the emerging STP is that the health and wellbeing gap, care quality gap and the finance and efficiency gap will be closed through focus on:

- Prevention
- Right care
- Efficiency

Whilst this transition takes place, DHcFT continues to lead a number of specific developments on behalf of the wider health economy. These are focused on development of the community hubs, the significant changes around older people's mental health services, development of dementia rapid response teams and community and personal resilience.

We know that there is general agreement across the two Health and Wellbeing Boards (Derby City and Derbyshire County Council), in line with what has become known locally as the 'Derbyshire Health and Care Wedge', that:

- Children and families should get the best start in life
- People should enjoy good health and wellbeing
- People have aspirations and achieve their ambitions through education, training and lifelong-learning
- People in Derbyshire live in safe and sustainable communities and are protected from harm
- Sustainable economic growth for all our communities and businesses
- People can live independently and exercise control over their lives
- The resource and activity supporting acute care needs to focus equally on prevention, early detection and keeping people in their communities avoiding hospital admission wherever possible.

Specifically with regard to mental health services, the four Derbyshire CCGs are committed to:

- A reduction in the number of people in residential care, spend on registered care, and also on supporting more people to live in their own homes
- A greater emphasis on community based care to avoid the use of institutional care
- A drive towards more personalised recovery focused services, where people have greater choice and control over the support they receive
- Engagement of service users in the co-design of services
- Improved support for carers, alongside a new statutory duty to provide more support to carers, as a result of the Care Act
- To address financial hardship and unemployment as contributors to ill health and early death in people with mental health issues
- Address health choices made by people with mental health problems, especially smoking
- Support strong parenting as key to a child's future mental wellbeing throughout its life
- Better support and management for people with dementia, their families and carers.

These remain the key focus of the developing STP coupled with the outcomes of the newly released 'Five Year Forward View for Mental Health'.

Derbyshire County Council, Public Health and the four Derbyshire CCGs – Hardwick CCG, Southern Derbyshire CCG, North Derbyshire CCG, Erewash CCG – have produced a joint strategic 'direction of travel' for mental health, called the Joint Vision and Strategy for Mental Health in Derbyshire County 2014 – 2019.

The proposed strategic themes have been developed in response to key policy drivers, local consultation and engagement feedback, and the commissioning intentions of Derbyshire CCGs (NHS) and Derbyshire County Council working to a joint strategy. All commissioning intentions will meet at least one of the six themes, with a strong focus on outcomes and agreed actions for each theme. Each action will have clearly identified work streams and governance arrangements, and progress and delivery of outcomes will be monitored by the Joint Mental Health Commissioning Board.

Theme 1 - Personalisation
Theme 2 - Promotion, prevention and early intervention
Theme 3 - Enablement and recovery
Theme 4 - Social Inclusion, fair access and equity
Theme 5 - Keeping people safe from avoidable harm
Theme 6 – Integration.

Finally, the Trust is developing a new Strategy for April 2016. This will be reflective of the 'Five Year Forward View' as well as being aligned to, and supportive of, the whole system STP.

Membership and elections (NHS foundation trusts only)

We hold elections on an ongoing basis throughout the year, either when a number of vacancies arise, or annually when tenures come to an end. For 2014/2015 elections were held in Derby City West (one of two seats) and Surrounding Areas. Candidates for Chesterfield South, Erewash North, North East Derbyshire and Nursing and Allied Professions (staff) were elected unopposed. For 2015/2016 elections were held in Derby City East (one of two seats), Erewash South and Administration and Allied Support (staff). Each of these constituencies received interest from more than one candidate and members were invited to elect a chosen governor. Members of staff were invited to stand for the Nursing and Allied Professions (staff, one of two seats) seat and as one candidate stood, they were elected unopposed.

A number of methods and activities were used in order to recruit to these seats. This included targeted events within each constituency focusing on different services and therapies of interest to the local community. Each event was delivered in a community setting, by a clinician with the support of existing governors and the Chairman. The events were advertised to members in the local area, to offer service and governor information, with the opportunity to ask questions directly to the chair and fellow governors.

Elections for governor positions to cover Amber Valley North, Bolsover, Chesterfield North, Chesterfield South, Derby City East (2 seats), Erewash North, High Peak, Surrounding Areas and Nursing and Allied Professions (staff) commenced in February 2016 , with High Peak and were Nursing and Allied Professions (staff), open to election as this plan was written. Candidates for Bolsover, Chesterfield North, Derby City East (2 seats), Erewash North and Surrounding Areas were elected unopposed leaving vacancies in Amber Valley North and Chesterfield South.

Governors are actively encouraged to engage with their local community to increase governor/member contact. In 2015 a large piece of governor/public engagement activity commenced, which involved approaching all PPGs throughout Derbyshire offering a meeting between them, the Trust and their local governor. Visibility of local governors was also improved by providing a poster, with contact details, to display in surgery waiting areas. This dedicated activity led to a number of governors taking part in PPG meetings and an increase in membership across this sector. We also held our first ‘Membership Week’, coinciding with World Mental Health Day, to create a platform for governors to better engage with their members and members of the public.

All newly elected governors receive an induction, which includes presentations from the Chairman, Executive Directors and wider members of staff. As part of this induction in 2015, the whole council and Non-Executive Directors were invited to attend an afternoon workshop to meet the new governors and brainstorm ideas surrounding working groups and membership engagement. We recently held a joint training session with two neighbouring Trusts, ‘Effective questioning of NEDs’, which was well received by the governors and also gave them the opportunity to network with other councils. Governors are also encouraged to take part in Governwell training.

The membership strategy (2014 – 2017) outlines an intention to know more about the membership of the Trust and target communication and engagement appropriately. This is supported through the use of a new membership database, which was introduced in 2015.

Monitor
Making the health sector work for patients

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London
SE1 8UG

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24 March 2016

Claire Wright
Director of Finance
Derbyshire Healthcare NHS Foundation Trust
Bramble House
Kingsway Hospital
Kingsway
Derby
DE22 3LZ

Dear Claire

Derbyshire Healthcare NHS Foundation Trust

Feedback on your trust's draft 2016/17 operational plan

Thank you for submitting your draft operational plan on 8 February 2016. We recognise the significant work that has gone into delivering this during such a challenging period.

The national planning guidance recently set out steps for local organisations to work together to deliver a sustainable, transformed health service over the next few years, through improvements in quality of care, wellbeing and NHS finances. It also outlined our expectations of individual providers in 2016/17 to deliver high quality, sustainable services for the patients and communities they serve.

To support providers in their move to a sustainable financial footing and thereby enable a year of system stability and recovery, the planning guidance introduced the £1.8 billion Sustainability and Transformation Fund for 2016/17. This additional funding is conditional on the NHS provider sector breaking even in 2016/17.

To secure access to its share of the Fund, each NHS trust and NHS foundation trust will have to meet, or exceed, an agreed financial control total for 2016/17 - as well as delivering an agreed trajectory for improvement in access standards, and (together with local partners) a robust Sustainability and Transformation Plan.

Purpose of this letter

The purpose of this letter is to feed back to you any specific observations from our review of your trust's 2016/17 draft plan submission. We expect our feedback to be considered carefully by your trust between now and 11 April, so that a final operational plan is delivered which:

- Demonstrates the consistent delivery of safe, high quality services; and either achieves, or achieves recovery milestones for, access standards
- Secures all this within the resources available
- Helps to create a sustainable organisation through sound business and financial plans for the longer term.

Control total

Your trust's control total for 2016/17 is £1.7m surplus. We will monitor your trust's progress against achievement of this on a quarterly basis through 2016/17.

We understand that you have accepted your control total. We will continue to work with you to ensure that the assumptions you have made are realistic and stretching.

Headline feedback on your draft operational plan

Having reviewed your draft submission, and based on our other recent engagements with the trust, I can report that we have no undue material concerns at this stage.

However please review our feedback on your draft plan, below, which we ask you to consider, and where appropriate address, ahead of your final plan submission on 11 April 2016.

Feedback on specific areas of your draft operational plan

Based on our review of your draft submission and our conversations with the trust since 8 February, we report the following in relation to your finance, activity, workforce and quality plans. Please provide clarification or substantiation of the matters identified, or make the required amendments, in your final submission.

Finance

We highlight the following issues in relation to your draft financial plan:

- The trust should focus on progressing its cost improvement plans, working towards a fully worked-up programme, including risks and mitigations. We expect an update on this within the final Operational Plan in April.
- The trust should consider whether the planned surplus is sufficiently stretching, including in particular whether the current planned level of contingency could be reduced, and any further opportunities that may be available as it concludes contract negotiations with commissioners.

Activity

We have no undue concerns regarding your draft activity plan.

Workforce

We highlight the following issues in relation to your draft workforce plan:

- The trust should revise how it plans and forecasts agency and locum spend within the submission. Rather than subsume this spend with planned substantive workforce budgets, the trust should set out clear forecasts for agency and locum spend across the different staff groups, and phased across the year, to allow effective mapping and challenge of performance. Please ensure that this is included within the final operational plan submission and financial template you submit in April.
- The trust has set challenging targets for improving sickness and vacancy rates. The trust should develop detailed plans for achieving these targets, and appropriate risks and mitigations, and submit these with its final operational plan.

Please also ensure that your consultancy expenditure is accurately reflected in your final operational plan submission, especially with regards to the phasing of that cost.

Quality

We highlight the following issues in relation to your draft quality plan narrative:

- The trust should develop a more structured quality plan, which explicitly addresses the four key areas set out in the planning guidance, and which more clearly articulates the key systems and processes the trust operates to assure quality of services and to deliver quality improvement.

We will work with the trust during the year to monitor progress against your quality plan, including any actions arising from your scheduled CQC inspection, and progress in the implementation of the agreed Governance Improvement Action Plan.

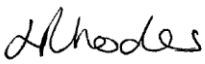
Next steps

We expect the matters raised in this letter to be addressed in your final plan submission on 11 April 2016. Our regulatory approach in 2016/17 is likely to be guided in part by the degree of assurance you provide in April that these concerns have been adequately addressed, either through clarification of the issues identified or appropriate amendments to the plan. We also expect to be able to understand and corroborate any other movements from your draft to final plans.

Between now and 11 April we will continue to work closely with you to support your development of a robust, fully-integrated operational plan for the year, underpinned by the signature of strong, fair and deliverable commissioner contracts.

If you have any queries relating to the above, please contact your Monitor relationship team at the earliest opportunity.

Yours sincerely



Jayne Rhodes
Senior Regional Manager

Forecast

Derbyshire Healthcare NHS

NHS Foundation Trust

Forward Plan Financial Return (IFRS) FINAL

Derbyshire Healthcare NHS Foundation Trust

Plan for YE 31 March 2017

APR template version 17.4.1.2

Validation errors: 1

Validation message: **Template contains errors which require correcting prior to submission**

This planning tool completed by (and Monitor queries to be directed to):

Name: Rachel Leyland

Job Title: Deputy Director of Finance

Telephone number: 01332 623700 ext 31224

Email address: Rachel.Leyland

Date:

Your relationship management team at Monitor:

Contact: **Jayne Rhodes**
Email: Jayne.Rhodes@monitor.gov.uk
Tel: 02037470167

Or: **Brendan Carey**
Email: Brendan.Carey@Monitor.gov.uk
Tel: 02037470912

For: **technical queries about this template or submission**
Email: apr@monitor.gov.uk
Link to Portal: Click on the link to go to the portal
Guidance: click for guidance (requires internet access)

Self Certification

1 Continuity of services condition 7 - Availability of Resources

EITHER:

After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

i

OR

After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box in section 3, below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

i

OR

In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

i

2 Declaration of interim and/or planned term support requirements

The trust forecasts a requirement for Department of Health (DH) interim support or planned term support for the year ending 31 March 2017

Note: If interim support is forecast in the plan period, but was not required in the preceding year, the trust should contact its relationship team by 31 January 2016, and before including any amounts in their plan (unless the DH has already approved the interim support funding). Further information regarding the requirements for trusts forecasting a need for DH funding support can be found in the template guidance.

i

DH Support Not Required

3 Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account, as stated in section 1b above, by the Board of Directors are as follows:

i

4 Declaration of review of submitted data

The board is satisfied that adequate governance measures are in place to ensure the accurat of data entered in this planning template.

We would expect that the template's validation checks are reviewed by senior management to ensure that there are no errors arising prior to submission and that any relevant flags within the template are adequately explained.

i

5 Control Total and Sustainability & Transformation Fund Allocation

The Board has submitted a final operational plan for 2016/17 that meets or exceeds the required financial control total for 2016/17 and the Board agrees to the conditions associated with the Sustainability and Transformation fund

Confirmed - control total accepted: S&T fund allocation incorporated in the plan

In signing to the right, the board is confirming that:

To the best of its knowledge, using its own processes and having assessed against Monitor's Risk Assessment Framework, the financial projections and other supporting material included in the completed Annual Plan Review Financial Template represent a true and fair view, are internally consistent with the operational and, where relevant, strategic commentaries, and are based on assumptions which the board believes to be credible.

Approved by:

i

Signature

Name

Capacity

Date

i

Signature

Name

Capacity

Date

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to the Trust Board 30th March 2016

OPERATIONAL PLAN 2016/17

Purpose of Report

This paper presents the operational start budgets for the 2016/17 financial year for Trust Board approval based on the final operation plan to be submitted to Monitor.

Recommendations

The Trust Board is requested to:
1) To approve the 2016/17 operational start budgets

Executive Summary

The overall operational budget of the Trust contained in this paper is in line with the final annual plan submission to Monitor, which is presented in a separate paper to the March Trust Board meeting.

The key financial headlines are:

- Planned Income & Expenditure for 2016/17 generates an underlying surplus of £1.7m, as per the control total issued by Monitor, which is equivalent to 1.2% of income
- Net surplus of £1.4m including £0.3m impairment (technical adjustment)
- Earnings Before Interest Tax Depreciation and Amortisation (EBITDA) of £9.0m which is 6.6%
- This includes a Cost Improvement Programme (CIP) target of £4.3m which has been only partly identified at the time of writing
- There are no revenue generation schemes within the CIP
- Includes service developments being discussed by Commissioners although negotiations continue
- Includes reserves for pay award and National Insurance changes along with two contingencies (general and Transformation)
- Overall Financial Sustainability Risk Rating (FSRR) of 4 by year end
- The Board should note however that the early part of the year has a risk rating of 3. Within that the headroom to a rating of 1 (override rule triggered from a 2) is very small in month 1 (£100k) and the first quarter (£250k). Key risks to achievement are CIP non-delivery, cost-containment and contract negotiation income attainment
- We have also for the first time set a Trust-wide agency plan (held centrally), in response to requirements from Monitor relationship team
- In addition, on 17th March we were notified of our Monitor (NHSI) ceiling for agency and locum expenditure for 16/17 which is £3.03m. (This is approximately £1m less than 15/16 equivalent expenditure). This has been incorporated in the plan.

Strategic considerations

- This paper should be considered in relation to the Trust strategy and specifically the financial performance pillar.

Board Assurances

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

3a Failure to deliver short term and long term financial plans could adversely affect the financial viability and sustainability of the organisation

and

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

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

and

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

and

2b Risk to delivery of national and local system wide change. If not delivered this could cause the Trusts financial position to deteriorate resulting in regulatory action

Consultation

- Budget setting principles, activity levels, income and staffing assumptions have been discussed and agreed with budget holders and managers, Performance and Contract Overview Group and Executive Leadership Team.
- Capital plan has been approved by Trust Board in November 2015.
- The Executive Leadership Team has reviewed the operational budgets during January and considered the funding of certain cost pressures.
- PAB has signed of the allocation of targets to departments and workstreams.
- Finance and Performance Committee has considered the draft financial plan in January and the final financial plan in March's Committee meeting.

Governance or Legal issues

The final operational budgets reflect the control total of £1.7m surplus issued by NHS Improvement in January 2016.

The final operational plan is due to be submitted to Monitor on 11th April 2016. The full financial plan and supporting narrative is contained in a separate paper to the public board meeting.

The plan takes account of the agency cost ceiling of £3,030,000

Equality Delivery System

This report has a neutral impact on REGARDS groups.

Report presented by:	**Claire Wright, Executive Director of Finance**
Report prepared by:	**Claire Wright Executive Director of Finance and Rachel Leyland, Deputy Director of Finance**

Operational Budgets for 2016/17

Introduction

The operational budgets for 2016/17 forms the basis of the operational plan submitted to Monitor.
The operational start budgets have been built up through the agreed budget setting process and signed off by budget holders. As part of this process consideration has been given to fund certain unavoidable cost pressures across the Trust.
A planned level of contract income has been based on rolled forward contracts including tariff inflation and includes a level of service developments that have been discussed with Commissioners.
Taking all the above into account and the level of required surplus for 2016/17, issued by Monitor this has resulted in a required level of cost efficiencies.

The key financial performance metrics included in the final plan are shown in the summary table below:

Category	Sub-set	Metric	Plan 15/16	FOT 15/16 (Mth 11)	Plan 16/17
Governance	FSRR	**Financial Sustainability Risk rating**	**3**	**4**	**4**
		Debt Service Cover	3	3	3
		Liquidity	4	4	4
		Income and Expenditure Margin	3	4	4
		Income and Expenditure Margin Variance	3	4	4
I&E and profitability	Income and Profitability	Income and Expenditure £'000	1,271	1,836	1,700
		Profitability - EBITDA £'000	8,181	9,031	8,975
		Profitability - EBITDA%	6.2%	6.9%	6.6%
Liquidity	Cash	Cash £m	10.097	11.517	12.323
	Net Current	Net Current Assets £m	1.545	3.041	6.740
	Capex	Capital expenditure £m	3.450	3.196	3.450
Efficiency	CIP	CIP Target £m	4.2	4.2	4.3

Income and Expenditure Account

All providers have been issued with a control total for 2016/17 which determines the level of planned surplus or in some cases deficit a Trust is required to make. The control total for this Trust is a surplus of £1.7m. The planned level of income and expenditure to generate the required surplus is shown in the Income and Expenditure Account below:

Summary Income and Expenditure Account	2015/16 Plan	2015/16 FOT mth11	2016/17 Plan
Operating income (inc. in EBITDA)	£m	£m	£m
NHS Clinical income	113.125	109.255	112.344
Non-NHS Clinical income	8.789	11.401	14.232
Non-Clinical income	10.249	10.014	10.190
Total operating income, inc. in EBITDA	**132.163**	**130.669**	**136.766**
Operating expenses (inc in EBITDA)			
Employee expense	(98.336)	(95.782)	(101.492)
Non-Pay expense	(25.646)	(25.856)	(26.298)
Total operating expense, inc. in EBITDA	**(123.982)**	**(121.638)**	**(127.790)**
EBITDA	**8.180**	**9.031**	**8.975**
EBITDA margin %	*6.2%*	*6.9%*	*6.6%*
Operating expenses (exc. from EBITDA)			
Depreciation & Amortisation	(3.389)	(3.534)	(3.534)
Impairment (Losses) / Reversals	(0.300)	(0.598)	(0.300)
Total operating expense, exc. from EBITDA	**(3.689)**	**(4.132)**	**(3.834)**
Non-operating income			
Finance income	0.024	0.066	0.024
Total non-operating income	**0.024**	**0.066**	**0.024**
Non-operating expenses			
Interest expense	(1.670)	(1.648)	(1.595)
PDC expense	(1.300)	(1.559)	(1.600)
Other finance costs	(0.049)	(0.038)	(0.039)
Non-operating PFI costs (e.g. contingent rent)	(0.526)	(0.482)	(0.531)
Total non-operating expenses	**(3.545)**	**(3.727)**	**(3.765)**
Surplus / (Deficit) after tax	**0.970**	**1.239**	**1.400**
Surplus / (Deficit) before impairments and transfers	**1.270**	**1.837**	**1.700**
Normalised surplus/(deficit) margin %	***1.3%***	***1.3%***	***1.2%***

Principles and Assumptions

The operation budgets include a set of assumptions some of which are known and some of which are informed assumptions.

Income

- Clinical Income is based on recurrent baseline contract values including any signed contract variations to date and includes other funding that has been agreed to go into the baseline through contract discussions with Commissioners.
- A level of new investment has been assumed based on the expected Commissioner contract envelope reflecting growth, inflationary uplifts and other non-tariff funded developments.
- Assumes full receipt of CQUIN income payable at 2.5% and that no contract penalties will be incurred.

- Tariff Inflation of 1.1% applied to NHS contracts. However it is important to note that a proportion of contract income is Commissioned by Non NHS organisations and is not subject to inflation.
- Non-Clinical income is mainly comprises of Education and Training income, Pharmacy recharges, Estates recharges and other miscellaneous staff recharges.

Expenditure

- Pay budgets have been set based on actual salaries of people in post and includes an assumption of a 1% pay award included in reserves along with an increase for National Insurance payments due to pension changes.
- Non-pay budgets are mainly rolled forward taking into account any specific inflationary uplifts.
- A general contingency and a transformation contingency have been built into the budgets, these will be monitored by ELT as in previous years.

Cost Improvement Programme

The level of efficiency required in order to achieve the required surplus is at 3.28% of operating expenses which equates to £4.3m.

The CIP targets have been allocated to departments based on a percentage of their operational budgets. The plans for delivery against these targets are still being finalised. It is important to note that certain budgets were excluded from an efficiency requirement due to the nature of the service provision.

It is also important to note there are no revenue generating (income) schemes within the CIP plan and assumes all efficiencies are found recurrently.

Financial Sustainability Risk Rating

Overall the rating is a 3 for the first half of the financial year which is driven by lower Income and Expenditure. There are two months in the first quarter with in month deficits which is due to additional costs and some income abatement.

This rating improves in the second half of the year as the cumulative surplus increases.

Financial Sustainability Risk Rating

	Plan M1 YTD	Plan M2 YTD	Plan M3 YTD	Plan M4 YTD	Plan M5 YTD	Plan M6 YTD	Plan M7 YTD	Plan M8 YTD	Plan M9 YTD	Plan M10 YTD	Plan M11 YTD	Plan M12 YTD	Plan Year Ending 31-Mar-17
Capital Service Capacity rating	2	2	2	2	2	3	3	3	3	3	3	3	3
Liquidity rating	3	3	3	3	3	3	4	4	4	4	4	4	4
I&E Margin rating	2	3	2	3	3	3	3	4	4	4	4	4	4
I&E Margin Variance rating	4	4	4	4	4	4	4	4	4	4	4	4	4
Overall Financial Sustainability Risk Rating	3	3	3	3	3	3	4	4	4	4	4	4	4

Head room down to a FSRR of 2 is £1.7m. The first quarter is extremely tight with only £0.3m of headroom to a 2, however this would also trigger a rating of 1on the Income and Expenditure Margin metric.

Divisional Detail

This section shows the budgets into the service areas. The Divisional budgets have been agreed with managers as part of the robust budget setting process. They also include any cost pressure funding that has been agreed at ELT, but only where there is an existing pressure, any budgets for new cost pressures is held in reserves until post are recruited to and expenditure transpires.

	2016/17 Budgets			
	Pay	Non-Pay	Income	Total
	£'000	£'000	£'000	£'000
Neighbourhood	(17,775)	(964)	401	(18,338)
Campus	(28,017)	(2,258)	23	(30,253)
Central Services	(16,638)	(5,410)	930	(21,119)
Children's Services	(14,569)	(1,575)	1,390	(14,754)
Clinical Serv Management	(1,210)	(337)	51	(1,496)
Estates and Facilities	(4,643)	(6,742)	593	(10,792)
BusinessDevtAndMarketing	(548)	(56)	(0)	(604)
Corporate	(1,479)	(732)	0	(2,211)
Finance	(859)	(1,686)	1	(2,543)
MedicalPostGrad + CRD	(4,684)	(246)	3,311	(1,620)
Nursing + Quality	(1,853)	(145)	50	(1,948)
Operations Support	(3,587)	(5,559)	2,032	(7,114)
Transformation	(691)	(152)	43	(799)
Sub Total	**(96,553)**	**(25,863)**	**8,825**	**(113,590)**
Non-Operating Expenditure		(7,599)	24	(7,575)
Central Income			124,057	124,057
Reserves - General	(6,538)	(847)	3,939	(3,446)
Reserves - Service Developments	(1,801)	(274)	(56)	(2,132)
Reserves - Provisions		(214)		(214)
Reserves - CIP	3,400	900		4,300
Surplus / (Deficit) for year	**(101,492)**	**(33,897)**	**136,790**	**1,401**
Tech Adj		300		300
Underlying Surplus / (Deficit)	**(101,492)**	**(33,598)**	**136,790**	**1,700**

The non-operating expenditure includes PFI non-operating costs and interest, depreciation and PDC dividend.

Central Income includes all the contract income and income from Services Developments. The Expenditure for new developments is included in the development reserve and is only released to the divisions once the service begins and posts recruited to.

Provisions reserve includes the unwinding of discount on pensions.

Reserves

Budgets held in reserves relate to pay award and national insurance changes which will be allocated out to departmental budgets, contingency reserves for general expenditure and transformation related expenditure. There are also some cost pressures and additional non-recurrent expenditure that has been funded which will be allocated out during the financial year as required.

Service Developments

Budgets for Service Developments are held in reserves until the service starts, the associated income is included within Central Income.

Statement of Financial Balance

The Income and Expenditure surplus has driven the level of cash along with assumptions on capital expenditure and levels of debtors and creditors. The Statement of Financial Position is summarised below.

Summary Statement of Financial Position

	2015/16 FOT mth 11	2016/17 Plan
	£m	£m
Total non-current assets	88.343	81.935
Total current assets	17.234	19.968
Total current liabilities	(14.193)	(13.228)
Net Current Assets	**3.041**	**6.740**
Total non-current liabilities	(30.524)	(29.495)
Total Assets Employed	**60.860**	**59.180**
Reserves	**60.860**	**59.180**
Working capital balance	(1.159)	1.765
Liquidity days	0.62	5.00

During 2015/16 the level of Net Current Assets has improved and the plan for 2016/17 is a net current asset position of £6.7m. Within current assets is a planned level of cash at £12.3m.

Capital

The Capital expenditure plan is set at £3.4m for 2016/17 which is slightly under the planned level of depreciation. The capital plan was approved at the Public Board meeting in November. Capital Action Team will continue to monitor the plan during 2016/17 and reprioritise the funding in the case of any urgent bids.

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 30 March 2016

Board Assurance Framework (BAF) for 2016/17 (first issue) and 2015/16 (final issue)

Purpose of Report: To meet the requirement for Boards to produce an Assurance Framework. This report includes the first issue of the BAF for 2016/17 and the final issue of the BAF for 2015/16.

Executive Summary

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 first formal presentation of the Board Assurance Framework to the Board for 2016/17 and the final presentation of the Board Assurance Framework for 2015/16

Key themes

During 2015/16 the BAF was presented and considered by the Audit Committee and Board three times during the year.

For 2016/17 the Board has agreed for the Audit Committee and Board to receive the BAF four times during the year, in line with Monitors governance guidance.

2015/16 Board Assurance Framework

The final issue of the BAF for 2015/16 identified 9 risks. Two remained graded as 'high' with respect to a) failure to deliver transformational change at the required pace and b) risk that the trust will be unable maintain its regulatory compliance and these have been carried forward in to the 2016/17 BAF. The third high risk previously reported was for 'risk to delivery of the financial plan'. This has now been reduced from a consequence of 5 to 4 as it is close to year end and a financial surplus better than plan, is expected.

The plan for deep dives on BAF risks to be undertaken by the named responsible committee has so far been completed for eight of the nine risks during 2015/16. The final risk regarding delivery of the commercial strategy is to be considered by the Finance and Performance Committee in May 2016, as part of an update on the Commercial Strategy rather than as a full deep dive. This approach was agreed by the Audit Committee in March 2016. For risks graded as 'high' the requirement for deep dives to be escalated to the Audit Committee was completed to plan during the year.

Following discussion at the March 16 Audit Committee, actions in the 2015/16 BAF that remain incomplete have either been closed with a rationale, or taken forward as actions into the 2016/17 BAF. This is clearly shown in 2015/16 BAF attached.

2016/17 Board Assurance Framework

Identification of the principle risks for 2016/17 against the trusts strategic objectives was undertaken during a Board Development Session on 10th Feb 2016. Board members identified a total of six key strategic risks going forward, together with the Director responsible for leading each risk. During meetings with individual directors these risks have been populated with risk controls, assurances, gaps and mitigation, and a current risk rating. This draft BAF for 2016/17 was then reviewed and agreed by the Executive Leadership Team on 7th March 2016 and considered by the Audit Committee in March 2016.

The 2016/17 BAF identifies five risks currently graded as high and one currently graded as moderate.

A summary of these risks is shown in the table below:

BAF ID	Risk title	Director Lead	Risk rating
1a	Failure to achieve clinical quality standards required by our regulators which may lead to harm to service users and/or staff	Executive Director of Nursing and Patient Experience	MOD
2a	Failure to deliver the agreed transformational change, at the required pace could result in reduced outcomes for service users, failure to deliver financial requirements and negative reputational risk	Acting Director of Operations	HIGH
2b	Risk to delivery of national and local system wide change. If not delivered this could cause the Trusts financial position to deteriorate resulting in regulatory action	Director of Business Development and Marketing	HIGH
3a	Failure to deliver short term and long term financial plans could adversely affect the financial viability and sustainability of the organisation	Executive Director of Finance	HIGH
3b	There is a risk that the Monitor enforcement actions and CQC requirement notice, coupled with adverse media attention may lead to significant loss of public confidence in our services and in the trust of staff as a place to work Furthermore, failure to deliver the governance improvement action plan could lead to a risk of further breaches in licence regulations with Monitor and the CQC and further regulatory action	Acting Chief Executive	HIGH
4a	Risk of a fundamental loss of confidence by staff in the leadership of the organisation at all levels	Director of Workforce, OD and Culture	HIGH

Plan for 'deep dives' into Board Assurance risks

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

The programme for deep dives for 2016/17 is planned as follows:

This is however subject to change dependent upon the current risk rating of each risk.

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

Note: The arrows show where the Audit Committee will receive the risk 'deep dives' rather than the lead responsible committee, if the risk remains high or extreme.

* Dates have been aligned to deep dives undertaken during 2015/16, to allow where possible a 12 month gap between them.

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

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

Consultation
Board Development Session – 10 February 2016
Executive Leadership Team – 7 March 2016
Audit Committee - 16 March 2016

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

Equality Delivery System
None

Recommendations

- For the Board to agree this first issue of the BAF for 2016/17 and the final issue of the BAF for 2015/16.

- Agree for the Audit Committee and Board to start to receive updates on the 2016/17 BAF four times a year:

    - March 2016, July 2016, October 2016, Jan 2016 and again in March 2017

Report presented by: **Jenna Davies, Interim Director of Corporate and Legal Affairs**

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

BOARD ASSURANCE FRAMEWORK 2015/16 v3.3

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

Key:
Internal Audit Reports from 14/15
Internal Audits Planned 15/16
Clinical Audit Programme 15/16
Changes since last reviewed by Board Oct 2015

Strategic Outcomes 1. People receive the best quality care

	Principal Risk	Director Lead and named responsible Committee	Risk Rating	Impact (1-5)	Likelihood (1-5)	Key Controls	Gaps in control	Assurances on Controls (Internal)	Positive Assurances	Gaps in Assurance	Action plan: To increase effective controls. To gain assurance.	Action: due/review date	Progress on action	Risk Register ID
1a	Failure to achieve clinical quality standards required by our regulators which may lead to harm to service users.	Executive Director of Nursing and Patient Experience Quality Committee	12 MODERATE	3	4	1) Quality Strategy and quality governance reporting structure and workplans, including escalation of quality issues to the Board 2) Quality Visit programme 3) Incident investigation and learning, including robust mechanisms for monitoring actions plans following serious incidents and serious case reviews. 4) Investigation and learning from complaints and patient experience feedback including robust monitoring of action plans and feedback from HealthWatch 5) Agreed clinical policies and standards, available to all staff via Connect 6) Engagement with clinical audit and research programmes 7) Mandatory training and performance monitoring of uptake. Availability and uptake of development training. 8) 'Duty of Candour' monitoring and reporting processes 9) Challenge and assurance checks by Commissioners on concerns around quality issues 10) Clinical podcasts to inform staff of new and emerging good practice 11) Achievement of CQUIN and quality schedule targets including suicide prevention CQUIN. Roll out of 'safety plan' with training.	Buy in and clinical variation in implementation of NICE guidelines Timely review of all policies Embedding of actions resulting from incidents and complaints into the medium to long term Understanding of reasons for higher than national average death rates, although this information is still being validated Embeddedness of Quality Leadership Teams 'Think Family' and carer feedback stating family inclusive practice is embedded Embedded personalised care planning. Routine assessment of capacity and consent Consistency of physical health care checks. Lack of current engagement strategy Compliance with medicines management policy, including gaps in capacity of pharmacy team Clinical ownership of issues logs and risks Implementation of positive and safe strategy	Service improvement mapping and contributions i.e. positive and safe, reduction in the use of seclusion Clinical Audit Programme and action plans where gaps identified Compliance with NICE Guidelines audits National Audits i.e. National Audit of Schizophrenia and POMH UK Audits Clinical interest' led audits focused on local resolution of issues	204/15 SUI Review 2015/16 Governance and Risk Management Arrangements National Community Patient Survey results (above average results) National Inpatient survey (above average results) NHS Protect inspection 2014 ('green' rating throughout) HealthWatch survey 2014 (significant assurance) CQC visits / inspection, including recent Safeguarding Children's inspection (Nov 15)	2014/15 Clinical Audit High staff vacancy rates Achievement of Quality Strategy in relation to care planning and capacity and consent , reconfirmed by audit: 2015/16 Mental Capacity Act Clinical audits identifying gaps due to inconsistent application of process i.e. capacity and consent, nutritional screening, DNAR, DEWS scoring, recording of allergies. Actions plans being implemented where gaps identified.	Continue to monitor progress against implementation of the quality strategy in relation to compliance with care planning and capacity and consent requirements, including actions resulting from recent 2015/16 Mental Capacity Act audit	Action transferred to 16/17 BAF	Implement actions arising from the 2015/16 Mental Capacity Act audit. Nursing conference focus on care planning Dec 2015. New DOLS technician - capacity and consent recruited to and start date imminent. Guidance to care planning booklet with publisher.	3333
											Further engage QLT's and the Physical Care Committee in review and implementation of NICE guidelines. Members of quality governance team to provide in-reach to monitor performance of NICE guideline monitoring. In addition, revisit with QLT's their role in managing clinical risks and issues logs and their role in escalation to the Quality Committee and Board.	Action transferred to 16/17 BAF	QLT to report on progress to Quality Committee April 2016.	
											Specific focus on ensuring the update of the now small number of policies overdue for review is completed and that tight processes remain in place going forward	Action transferred to 16/17 BAF	Escalation of policies overdue for review through Executive Leadership Team. Overarching governance of policies overseen by Quality Committee, and Mental Health Act Committee for those requiring to comply with the MHA Code of Practice and MCA.	
											Embedding of actions resulting from incidents and complaints into the medium to long term through Quality Leadership Teams	Action transferred to 16/17 BAF	Continued in reach to CRG meetings, coaching style of feedback to senior nurses/ lead professionals, time with soon to be appointed ACD's as part of developments to strive for continual embedding of learning. Continued quality priority throughout all of 2016	
											Undertake modelling work and hypothesis as to why higher than national average suicide rates.	Completed	This analysis has been completed. Working with the National Inquiry into suicides and homicides, have concluded that although national suicide rates have gone up this, Trust is not an outlier and rates are not higher than the national average. Nonetheless, the Trust is seeking to reduce suicide rates by: 1. Agreeing a suicide prevention strategy in March 2016. 2. Instigating safety planning training for clinicians 3. Instigating suicide prevention training via CWP for all clinicians.	
											Roll out of e-Rostering and emergency procedures due to gaps in staffing capacity to meet domain	Completed	Safer staffing planning meetings have been re-introduced 3x a week, to manage specific staffing issues as they emerge	
											Complete second year of Think Family CQUIN and review out of date carers policy. Co-produce model of mutual expectations for family inclusive practice	Completed	The Service Receiver and Transformation Group are developing mutual expectations for the Neighbourhood, campus and family inclusive workstreams. The family inclusive work has been slower to develop due to meeting attendance and sub group work. The revised carers strategy is completed and awaiting approval. A renewed focus on triangle of care and family inclusive approaches to serious incidents is developing including a Think Family Group to link the Derby City Children's and Derby Adults Strategic Board agendas through a shared sub group. The CQUIN work is progressing and additional training has been commissioned to meet demand.	
											Learning from any CQC inspection through analysis of other Trusts inspections as well as our own MHA visits. Incorporate learning into CQC preparedness workplan.	Completed	This is a continual improvement. Feedback from other Trust incorporated into CQC planning and preparations. Learning and planning from our own Safeguarding inspection, across providers has also been taken into account.	
											Learning from quality visits, listening to views through developing a good practice compendium to be published on Connect to showcase good practice	30/06/2016	Not completed. To complete design of the website and guidance information.	
											Implement improvement plan for medicines management	Completed	Board deep dive into medicines management (Sept 2015) identified a need for an improvement plan. Pharmacist appointed to undertake improvement work. Reporting now part of QC workplan.	
											Implement positive and safe strategy	Completed	Workplan reviewed at Quality Committee Feb 2016, and continual review and progress reporting in place.	

											Complete rewrite of the engagement strategy to include newly designed Feedback Intelligence Group (FIG) and relationship to 4E's group and patient participation and engagement	Completed	Engagement strategy revised and agreed at People and Culture Committee Feb 2016.	
1b	Risk that potential changes instigated by commissioners or providers, may result in DHCFT being required to meet any resulting unmet need without additional resource e.g. changes in social services provision.	Medical Director Finance and Performance Committee	12 MODERATE	3	4	1) Representation at integrated planning meetings with north and south commissioners, ensuring the Trust is well informed around the commissioning direction of travel 2) Transformation programme enabling the Trust to respond more flexibly to changing demand 3) Positive contracting agreements with commissioners 4) Monitoring of activity data through PCOG 5) Active waiting list management 6) Contracting groups enabling discussion and challenge around concerns re resources vs expectations 7) Working with commissioners to highlight need to maintain core services and parity of resources	Activity against block contracts, which are insensitive to activity changes until floors and ceilings have been breached Also do not differentiate between changes in different types of activity. CIP programme could reduce capacity in core services potentially reducing flexibility Weak influence on social services strategic direction Inability to agree discharge arrangements to primary care with commissioners and GP leads 'Hotspots' identified in CAMHS, children's services regarding capacity and demand. .	PbR clustering CIP plan/transformational change plan with quality impact assessment PCOG monitoring and waiting list management Commissioner challenge and protection of core services Assurance on development of new interface modes between primary care and DHCFT	Sim:pathy data (and action plans), giving accurate data regarding our capacity and ability to respond to changing demand	Skill mix and capacity planning against population needs	Director of Business Development to become involved in contracting rounds to increase pressure for investment in core services	Completed		3334
											Strategic business plan to be revised.	Ongoing		
											Finance and operational teams to weigh up risks and benefits of mixed block and activity based contracts	Completed	Operational teams working have been developing their business plans. Negotiations have started with commissioners on new contracts. Awaiting Monitor guidance, which will supersede this action	
											Recommendations and feedback for health and social care from Schedule 28 ruling to be implemented and feedback to Coroner	Completed	SBARD (Situation, Background, Assessment, Recommendation, Decision) communication tool for family and carers being implemented	
											Pro-work capacity calculator to be used to develop a workforce plan for neighbourhoods and campus. Needs to be developed to be fit for medical staffing. M Ridge arranging 2 days to work with teams to develop their skill mix and NICE requirements to plan composition of neighbourhood teams	Completed Completed	 Plan to trial now underway	
											Quality Assurance Group (QAG) review and ownership of risk register	Completed	QAG risk register reviewed regularly and new risks added. Board to board meetings with Hardwick CCG identified issues on risk register that will be scrutinised by upcoming CQC inspection.	
											Poor performance with PbR clustering in some areas	Completed	Medical Director to confirm improvement plan to F&P January 2016. Action completed.	

Strategic Outcome 2: People receive care that is joined up and easy to access

	Principal Risk	Director Lead and named responsible Committee	Risk Rating	Impact (1-5)	Likelihood (1-5)	Key Controls	Gaps in control	Assurances on Controls (Internal)	Positive Assurances	Gaps in Assurance	Action plan: To increase effective controls. To gain assurance.	Action: due/review date	Progress on action	Risk Register ID
2a	Failure to deliver the agreed transformational change, at the required pace could result in reduced outcomes for service users, failure to deliver financial requirements and negative reputational risk	Acting Director of Operations Finance and Performance Committee (Audit Committee)	15 HIGH	5	3	1) Continued engagement though project teams and Patient and Carer reference group. 2) Integrated Service Delivery Programme (standing agenda item at TOMM) providing internal mechanism for controlling compliance and risk etc. 3) Neighbourhood & Central Service and Campus Boards providing assurance against quality strands. 4) Live data reporting around regulatory contract compliance and Quality Dashboard to Board. 5) Real time mechanisms for patient experience feedback 6) Operational structures monitoring progress via TOMM and PCOG 7) 'Deep Dive' reporting to Board focused on areas of concern. 8) Project Vision programme management assurance system giving independent 'live' reports 9) Learning Disability and Psychological Therapies to remain 'pan neighbourhood' for year 1 of implementation of transformational change	Embedded transformational workstreams Insufficient visibility of health and social care community transformational plans Sufficient engagement with staff side	Regulatory compliance reporting Contract compliance reporting Contract governance reporting 'Live' dashboards required of PCOG	2015/16 Transformation 2014/15 Transformation National Inpatient survey (above average results)	Process for earned autonomy and decision making as close to patient services as possible ~~Alignment between transformation and wider health community~~.	Create map of all transformation activities in health and social care community to ensure appropriate attendance and influence at forums	Completed	Trust is a full member of both the 21st Century and Joined Up Care Boards, also the Children's Transformational Delivery Board.	3335
											Embedding transformational briefings with staff side at JNCC and with staff side members	Completed	Acting CEO chairs JNCC and Acting Director of Operations attend and share transformational briefings. Regional l and local staff side representation.	
											Plan and deliver project sponsor and project managers training around roles and responsibilities	Completed	Undertaken as part of Programme Assurance refresher session 3/7/15.	
											Plan and deliver CORA training sessions to project sponsors and managers	Completed	Undertaken as part of Programme Assurance refresher session 3/7/15.	
											Review project delivery structure though ISDP Board	Completed		
											Increase flow of communication with revision of management and leadership structure	Completed	Completed through to team manager level. Final stage to be completed end July 2015. Interim management structure in place due to current senior level acting up arrangements. All senior management posts filled substantively to SLM level.	
											Develop revised performance improvement model to support earned autonomy	Action transferred to 16/17 BAF	C Gilby to develop performance framework. Time out with general managers arranged for Feb 2016 to develop.	
											Complete roll out of neighbourhood model	31/03/2016	On plan	
											Commence consultation on campus redesign	Commence 01/04/2016		
2b	The high level of change within the organisation could lead to instability and a failure to meet contractual and regulatory key performance indicators	Acting Director of Operations) Finance and Performance Committee	10 MODERATE	5	2	1) Data warehouse providing live information to support managers to respond in a timely way to changes in performance 2) High confidence in data quality 3) Monthly performance meetings whereby senior leadership team review and take action to control performance 4) Good relationship with Monitor Compliance Team. Their confidence in action taken by the Trust reduces reputational risk 5) Good relationship with commissioners resulting in a transparent approach to performance which encourages early warning when variance 6) Reporting to PCOG and TOMM includes detailed analysis of current performance	Team ownership of KPI's Ability of local managers to respond to performance variance in timely manner	Integrated performance report to Board providing detailed performance information and supports independent challenge	2015/16 Information Governance (IG) toolkit and readiness for inspection 2015/16 Data quality - waiting times 2015/16 Business Continuity Planning 2014/15 EPR Project Review II, III	~~Lack of clinical (predominantly medical) confidence in the PARIS EPR system~~ CQC visit to Derby City Looked After Children services and Safeguarding Children Team identified concerns with respect to the number of records in use.	Define and understand clinical (predominantly medical) concerns with the PARIS system.	Completed	Full implementation of PARIS to neighbourhoods on plan for 31/03/2016	3336
											Deliver action plan in collaboration with consultant body to support efficient and effective use of the PARIS system	Completed		
											Review of KPI's by Board	Completed	Paper outlining revised metrics considered by F&P July 15 and adopted.	
											Support to team managers re use and interrogation of reporting systems to improve efficiency	Completed	Implementation of performance 'pitstops' and provision of team based performance measures in place.	
											Move to neighbourhood management to align management resources to areas of highest need	Action re transformational plans transferred to 16/17 BAF	Decision taken by ELT to delay 'go live' until 31/03/16. On track to achieve.	
											Develop a performance framework	Action transferred to 16/17 BAF	Carolyn Gilby developing with general managers. Will further enable team ownership of KPI's.	
											Run project to adopt PARIS as the single patient record for all services (except children's and substance misuse services)	Action re transformational plans transferred to 16/17 BAF	On track	
2c	There is a risk that the Trust will be unable to maintain its regulatory compliance due to identified gaps in its governance systems and processes	Acting CEO Audit Committee	16 HIGH	4	4	1) Governance committees and structures 2) Policies and procedures including workforce and organisational development and corporate 3) Risk management systems (risk, incidents and complaints), and processes for escalation 4) Trust Values 5) Recruitment of Interim Chair 6) Ongoing engagement with Regulators	Effective flow and escalation of issues through governance related committees Consistent implementation of Trust policies and procedures Lack of overall governance framework Clear expectations of Governor and Board roles Failure to effectively communicate in an open and transparent way which may impact on staff morale. Culture of governance informality	Well led' self assessment Committee self assessment Annual Governance Statement	Audit plan and processes 2015/16 HR Processes - Recruitment	PWC audit Nov 14 'Governance arrangement, structures and processes' identified gaps in some areas of governance structures and processes. Workforce and organisational development procedures (including recruitment)	Complete a 'well led' governance review to identify gaps in governance structures and processes	Completed	Well led self assessment completed and well led review underway.	3337
											Independent investigation to be undertaken to assess if behaviours within the Trust are in line with internal and external expectations and codes of conduct	Completed	Completed and findings reported to the Board of Directors 23/12/15.	
											Implementation of Governance Improvement Action Plan - Core Actions 1,2 and 5. Complete appointment of posts and instigation of committees to support review of workforce and OD functions. This will include specific actions relating to development of a people strategy and leadership and training functions.	Action transferred to 16/17 BAF		
											Implementation of Governance Improvement Action Plan - Core Actions 3,4 and 10. Recruit substantively to post of Director of Corporate l Affairs and Trust Secretary, develop governance framework and review board assurance risks.	Action transferred to 16/17 BAF		
											Implementation of Governance Improvement Action Plan - Core Actions 6 and 7. Actions are focused on relationships with governors and roles and responsibilities of board members	Action transferred to 16/17 BAF	A revised Governance Improvement Plan has been developed, building on these original actions. These will be summarised in the 2016/17 Board Assurance Framework going forward.	

						Information				Implementation of Governance Improvement Action Plan - Core Actions 8. Deliver Freedom to Speak up Action Plan and Whistleblowing Policy, training and local arrangements.	Action transferred to 16/17 BAF				
										Implementation of Governance Improvement Action Plan - Core Actions 9. Review of HR policies and compliance monitoring. Develop capability to manage people, HR supportive training and succession planning.	Action transferred to 16/17 BAF				

Strategic Outcome 3. The public has confidence in our healthcare and developments													
	Principal Risk	**Director Lead and named responsible Committee**	**Risk Rating**	**Impact (1-5)**	**Likelihood (1-5)**	**Key Controls**	**Gaps in control**	**Assurances on Controls (Internal)**	**Positive Assurances**	**Gaps in Assurance**	**Action plan: To increase effective controls. To gain assurance.**	**Action: due/review date**	**Progress on action**	**Risk Register ID**
3a	Risks to delivery of 15/16 financial plan If not delivered, this could result in regulatory action due to breach of Provider Licence with Monitor Risk rating reduced from consequence 5 to 4 as close to year end and forecast is for financial surplus to be better than plan although year end risks remain	Executive Director of Finance Finance and Performance Committee (Audit Committee)	12 MODERATE	4	3	1) Monthly Financial Performance Reporting to Public Trust Board meetings provides assurance on financial performance, 2) Reporting to Finance and Performance Committee to gain assurance on all aspects of financial (and other resources) management on behalf of the Board, including oversight of CIP delivery and contractual performance 3) With regard to Cost Improvement Programme (CIP) delivery: Project Assurance processes and systems for in-year monitoring of CIP delivery and escalation procedures 4) System of delegated budgetary responsibility - in line with standing financial instructions and scheme of delegation 5) F&P and PCOG meetings: monitoring of contractual performance that impacts on contractual payments including activity levels, CQUIN and contract levers/penalties. 6) Service Line Reporting and other financial reporting systems and action planning at Finance & Performance, Performance and Contracts Overview Group (PCOG), Integrated Services Delivery Group (ISDG), Divisional meetings, IAPT Board and other groups	Risks to delivery of CIP plan outside of our control (e.g. other providers and wider health system factors)	Monthly financial reporting systems on current and forecast performance include "challenge and review" each month before reporting Pre-submission scrutiny of annual operational financial plan prepared and submitted to Monitor April (draft) and May (final) 2015. Delivers FSRR (previously COSRR) of at least 3 each quarter Budget-setting operational requirements were signed-off by those responsible for their delivery (and the Trust Board) In-year financial forecasts are co-owned by finance and the individuals responsible for their delivery 15/16 CIP is 100% allocated and has undergone scrutiny at quality panel. Existence of contingency reserve and the contingency reserve access request process Deep dives into forecasting and cash planning at F&P during 14/15 provided full assurance to F&P on systems and processes behind the figures (these systems are the same for 15/16) Large proportion of income guaranteed through block contract . Finance and Performance confirmed they are assured by the additional financial management reporting put in place in 15/16	External Audit: the Audit Findings for DHCFT (year ended 31 March 2015) . Issued with Unqualified Opinion Confirmed External Audit:: Bespoke Key Financial Indicators 2014 report and bespoke Financial Resilience report show that aside from the gaps in assurance listed - the other indicators are amber or green (benchmarked against MH FT peers) . Strongest indicator is EBITDA Internal Audit: 2014/15 Finance Systems Audits (low rating) and PwC's annual report to Audit committee cites financial systems in their areas of good practice; stating "Our Financial Systems review has been rated low risk for the last three years and remains an area where the Trust demonstrates strong controls and processes." Monitor: FSRR (previously COSRR) submissions risk rating by Monitor as 3 or 4 Monitor: "Green" rating for Trust extant 5 year strategic financial plan (only 30% of Trusts rated as green) 2015/16 Cash forecasting and controls 2015/16 Contract Assurance Shared Business Services (SBS)	Gaps in assurance on CIP schemes in Project Vision Re: External Audit benchmarking for Financial KPIs and resilience: Areas to improve are: liquidity, return on assets , capital service cover, PSPP and Workforce (sickness and turnover) ~~During transition to new service delivery model potential to increase gaps in assurance on reliably measuring financial performance by service line as moves take place- this impacts particularly on the reliability of service line reporting~~	Escalation processes from PAB to ensure gaps in assurance on system are closed or mitigated	Completed	This action is ongoing and systems and processes are in place to escalate. CIP is fully allocated. Propose close this action	3338
											Extant financial strategic objective continue to increase liquidity and associated measures - this will be achieved by containing capital expenditure to depreciation levels, by delivering year on year surplus and by retaining proceeds of asset disposals. The key metrics highlighted in the benchmarking reports will be reported on throughout the year to F&P to provide oversight on progress with improvement	Completed Completed	Liquidity improvement continues to be a long term objective for the organisation and the KPIs are being reported, capex future plan limited to depreciation. No other specific actions required. Close this action The key metrics highlighted in the benchmarking reports will be reported on throughout the year to F&P to provide oversight on progress with improvement. The Trust is planning a surplus, has capex programme limited to depreciation levels. Asset disposal receipts not received	
											Additional financial reporting to F&P, and other meetings as appropriate, to triangulate and validate overarching Trust financial performance.	Completed	Additional reporting is in place and F&P have confirmed they are satisfied. At this BAF deep dive at Dec 15 Audit Committee the DOF proposed to remove this assurance gap as this is in place. Action therefore closed. Papers provided to F&P during 15/16 will provide evidence of additional reporting. 15/16 F&P feedback reports to Trust Board will provide evidence of assurance levels gained	
											Internally monitor and manage reduction in use of relevant temporary staffing.	Completed	Additional operational processes and procedures have been put in place, and are being further enhanced, to comply with reporting requirements to Monitor and to internally monitor and manage reduction in use of relevant temporary staffing . Progress is being reported as part of regular operational performance reporting to both Trust Board and Finance and Performance Committee	
3b	Risk to delivery of the Commercial Strategy, if not delivered it could cause the Trusts financial position to deteriorate resulting in regulatory action	Director of Business Development and Marketing Finance and Performance Committee	10 MODERATE	5	2	1) Regular briefing to ELT resulting in clear decision making about new / current service opportunities. 2) F&P reporting resulting in assurance on the key objectives of the Commercial Strategy. 3) Stakeholder and relationship management resulting in keeping the Trust competitive, with a strong reputation. 4) Inclusive approach in response to tender opportunities, resulting in a coherent joined up approach internally.	Unclear business development strategy Lack of clarity around collaboration and competition (i.e. Children's Services) Limited infrastructure to fully deliver the totality of the Commercial Strategy Unclear process for VFM review of current service lines	Successful retention of existing business in competitive market (i.e. Substance Misuse. Children's Services).			Review Commercial and Business Development infrastructure to ensure it aligns to the Strategy.	Completed	Commercial and Business development infrastructure has been reviewed in light of the objectives outlined in the commercial strategy. A proposal for changes to the business development team has been put on hold due to the Trusts financial position. As the Trusts Commercial Strategy isn't focused on significant growth the current infrastructure is able to meet current commitments. However, this does limit the Trusts ability to be flexible to pursue new opportunities.	3339
											Formulate a clear business development plan for 15/16 (PYE) and 16/17.	Action transferred to 16/17 BAF for 16/17 action	Strategic priorities identified in 15/16 (including children's services and offender healthcare services) on track. Priorities for 16/17 currently being developed by ELT. Priorities continue to be developed in line with the rewrite of the Trust Strategy	
											Develop a robust and fully resourced project plan to retain Children's Services.	Completed	Plan in place. Intent to award contract letter received	
											Refresh Commercial Strategy	Completed	To be refreshed in line with the rewrite of the Trust Strategy. On track for discussion at F&P committee April 2016.	
											Agree use of 1 Commercial Assessment Framework Tool to use across all service lines (new / current).	Revised action (as per progress update) completed	Decision making framework being developed as part of core service portfolio. This tool will be used to inform new business opportunities as well as to review current services for commercial viability.	

	Strategic Outcome 4. Care is delivered by empowered and compassionate teams													
	Principal Risk	**Director Lead and named responsible Committee**	**Risk Rating**	**Impact (1-5)**	**Likelihood (1-5)**	**Key Controls**	**Gaps in control**	**Assurances on Controls (Internal)**	**Positive Assurances**	**Gaps in Assurance**	**Action plan: To increase effective controls. To gain assurance.**	**Action: due/review date**	**Progress on action**	**Risk Register ID**
4a	Failure to recruit, retain and engage capable and compassionate staff, leading to a risk that could impact on service receiver care	Director of Transformation Finance and Performance Committee	12 MODERATE	4	3	1) Communication strategy to engage and inform staff: to take staff on the journey through national, county and Trust changes 2) 2010-2015 People Strategy in place, and reports on progress if the strategy it Board on a monthly basis 3) Detailing of the annual workforce plan and tracking of progress, including reporting of risks to F&P and Board. 4) Proactive recruitment based on workforce profile 5) Monitoring impact of People Strategy and plan through People Forum 6) Transformation programme which defines and assures progress of the programme of change 7) Training and Development framework which defines training needs for staff and monitoring delivery through Board 8) Lack of partnership agreement with staff side to deliver transformational change 9) Visible, engaging and listening collective leadership	Identified activities to support the delivery of the People Strategy - values based recruitment, proactive actions following staff survey Lack of current People Strategy	Structured approach to responding to the Annual Staff Survey Key metrics reported to Board	Benchmarking data provided at a National and Regional level External recognition re values based recruitment Annual staff survey CQC visits / inspection 2015/16 Appraisals 2015/16 HR processes - recruitment	Action plan to support staff survey findings Evaluation of interventions - leadership development Safer staffing data 2015/16 HR Processes: Recruitment. Included audit of board reporting on safer staffing Compliance with recording of appraisals is decreasing.	Establish a robust action plan to support staff survey outcomes	Completed	Staff survey 'high level roadmap' supported by People Forum' completed May 15. Further update to June 15 Board 'Healthcheck' completed and shared. 'Spotlight on Leaders' events to engage leaders. Podcasts by senior managers Staff were invited to attend staff 'HealthCheck' meeting Dec 2015 to consider future actions. Staff survey for 2015 completed, results expected Feb 2016.	3340
											Revision of existing People, Education and Leadership strategies to combine into overall People Strategy	Action transferred to 16/17 BAF in line with governance improvement actions.	To be undertaken in parallel with the rewrite of the Trust Strategy	
											Further develop a robust programme of evaluation to ensure the effectiveness of the leadership programme and monitor through the People Forum	Action transferred to 16/17 BAF in line with governance improvement actions.	Review of the existing People Strategy 2010 - 15 will include an evaluation of the impact of leadership development and inform future strategy and activity.	
											Facilitated session with ACAS arranged to support staff side partnership agreement.	Action transferred to 16/17 BAF		
											Address compliance with appraisal process	Action transferred to 16/17 BAF in line with governance improvement actions.		
											Monitoring of compliance with mandatory training against Training Framework	Action transferred to 16/17 BAF in line with governance improvement actions.	Monitoring together with gaps and controls to be flagged to the Quality Committee. To include addressing of compliance with the appraisal process to which a meeting with staff side was undertaken Dec 2015. focus on ILS training compliance also to be included.	
4b	Failure to have sufficient capability and capacity to deliver required standard of care resulting in a risk to our service receivers	Director of Transformation Finance and Performance Committee	12 MODERATE	4	3	1) Robust workforce planning process 2) QIA system in place 3) Safe staffing reports to Board, actual v target level of staff per inpatient area 4) Bi-annual workforce planning and costs report to F&P to ensure workforce plan met 5) Timeliness of recruitment activity - vacancy control process 6) Quarterly workforce planning reports to ESEC (People Forum) demonstrating actual v plan	Failure to have a robust talent management process which aligns appraisals to succession plan and identifies personal and professional development needs	Tracking and delivery of Training Needs Analysis Triangulation of appraisal output, TNA and workforce skills against workforce plan Safer staffing data	Full spend of HEEM funding Annual Staff survey: Progress against specific actions	Gap in assurance on talent management process Closer alignment of transformation workforce requirements to workforce planning process/L&D activities	Establish a robust talent management process and monitoring system	Action transferred to 16/17 BAF in line with governance improvement actions.	Participating in Derbyshire wide talent management programme for grades 8c and above	3341
											Define future workforce needs through Work-Pro	Action transferred to 16/17 BAF in line with governance improvement actions.	Through the transformation programme Work -Pro is defining needs of future workforce and papers were considered by the F&P Committee in Sept and Nov 2015. The 2016 People Strategy will ensure the future workforce planning process is clearly defined.	

Abbreviations

ACD	Associate Clinical Director
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CEO	Chief Executive Officer
CIP	Cost Improvement Programme
CORA	a project management software tool
COSRR	Continuity of Services Risk Rating
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation payment
CRG	Clinical Reference Group (accountable to QLT's)
DEWS	Derbyshire Early Warning System - tool to identify sharp physical health decline
DNAR	Do Not Attempt Resuscitation order
DHCFT	Derbyshire Healthcare NHS Foundation Trust
EBITDA	Earnings before interest, taxes, depreciation and amortization
ELT	Executive Leadership Team
EPR	Electronic Patient Record
ESEC	People committee
F&P	Finance and Performance Committee
FRR	Financial Risk Rating
FSRR	Financial Sustainability Risk Rating
HEEM	Health Education East Midlands
JNCC	Joint Negotiation Consultative Committee
KIP	Key Performance Indicator
NICE	National Institute for Health and Care Excellence
PAB	Programme Assurance Board
PARIS	Electronic Patient Record solution provided by Civica
PCOG	Performance and Contracts Overview Group
POMH-UK	Prescribing Observatory for Mental Health
PSPP	Public Sector Payment Policy
PYE	Part Year Effect
QLT	Quality Leadership Teams (accountable to Quality Committee)
QC	Quality Committee
SIRI	Serious Incidents Requiring Investigation
SLA	Service Level Agreement
TOMM	Trust Operational Management Meeting

VFM Value for Money

BOARD ASSURANCE FRAMEWORK 2016/2017 v1.3

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

Key:
Internal Audits Reports15/16
Internal Audits planned 16/17
Clinical Audit Programme

Strategic Outcomes 1. People receive the best quality care

	Principal Risk	Director Lead and named responsible Committee	Risk Rating	Impact (1-5)	Likelihood (1-5)	Key Controls	Gaps in control	Assurances on Controls (Internal)	Positive Assurances	Gaps in Assurance	Action plan: To increase effective controls. To gain assurance.	Action: due/review date	Progress on action	Risk Register ID
1a	Failure to achieve clinical quality standards required by our regulators which may lead to harm to service users and/or staff	Executive Director of Nursing and Patient Experience Quality Committee	12 MODERATE	4	3	1) Quality Framework (Strategy) outlining how quality is managed within the trust 2) Board committee structures and processes ensuring escalation of quality issues 3) Quality governance structures and processes in to manage quality related issues 4) Quality visit programme, providing partial evidence of compliance with CQC requirements 5) Incident, complaints and risk investigation and learning, including robust mechanisms for monitoring resulting actions plans 6) Agreed clinical policies and standards, available to all staff via Connect 7) Engagement with clinical audit and research programmes 8) 'Duty of Candour' monitoring and reporting processes	Clinical buy in to review of NICE guidelines Timely review of all policies Embeddedness of Quality Leadership Teams, including taking forward incident and complaint actions into the medium to long term and clinical ownership of issues logs and risks Embedded personalised care planning. Routine assessment of capacity and consent Compliance with medicines management policy, including gaps in capacity of pharmacy team Demands of the Derbyshire population out strips capacity, in particular community teams Clinical dashboards to monitor early warning signs of service failure	Service improvement mapping and contributions i.e. positive and safe, reduction in the use of seclusion Clinical Audit Programme and action plans where gaps identified Audits of compliance with NICE Guidelines National Audits i.e. National Audit of Schizophrenia and POMH UK Audits 'Clinical interest' led audits focused on local resolution of issues	National Community Patient Survey results (above average results) National Inpatient survey (above average results) HealthWatch survey 2014 (significant assurance) CQC visits / inspection	Achievement of Quality Framework in relation to care planning and capacity and consent , reconfirmed by audit: 2015/16 Mental Capacity Act Clinical audits identifying gaps due to inconsistent application of process i.e. capacity and consent, nutritional screening, DNAR, DEWS scoring, recording of allergies.	Further engage clinical leadership (though QLT's in particular) in the review and implementation of NICE guidelines.	30/06/2016		
											Ensure the now small number of policies overdue for review is completed and that tight processes remain in place going forward. ELT to support Quality Governance Committee to ensure all policies are reviewed and updated.	31/05/2016		
											Embedding of actions resulting from incidents and complaints into the medium to long term through Quality Leadership Teams	30/06/2016		
											Continue to monitor progress against implementation of the quality strategy in relation to compliance with care planning and capacity and consent requirements, including the implementation of actions resulting from the recent 2015/16 Mental Capacity Act audit	30/06/2016		
											Implement improvement plan for medicines management, as highlighted in Board deep dive into medicines management (Sept 2015) and hence to commissioners.	30/06/2016		
											Raise risks with commissioners regarding community team capacity and forensic community offer	30/06/2016	Undertaken through QAG risk register	
											Implementation of clinical dashboards to monitor early warning signs of service failure	30/06/2016	Due for release in April 2016 and to be used in practice from May and June in full use.	
											Implementation of action plans resulting from gaps identified through clinical audit projects	30/06/2016		

Strategic Outcome 2: People receive care that is joined up and easy to access														
	Principal Risk	**Director Lead and named responsible Committee**	**Risk Rating**	**Impact (1-5)**	**Likelihood (1-5)**	**Key Controls**	**Gaps in control**	**Assurances on Controls (Internal)**	**Positive Assurances**	**Gaps in Assurance**	**Action plan: To increase effective controls. To gain assurance.**	**Action: due/review date**	**Progress on action**	**Risk Register ID**
2a	Failure to deliver the agreed transformational change, at the required pace could result in reduced outcomes for service users, failure to deliver financial requirements and negative reputational risk	Acting Director of Operations Finance and Performance Committee (Audit Committee)	15 HIGH	5	3	1) Integrated Service Delivery Programme (standing agenda item at TOMM) providing internal mechanism for controlling compliance and risk etc. 2) Neighbourhood & Central Service and Campus Boards providing assurance against quality strands. 3) Live data reporting around regulatory contract compliance and Quality Dashboard to Board. 4) Real time mechanisms for patient experience feedback 5) Transformational workstreams to deliver CIP, monitored by the Project Assurance Board. 6) 'Deep Dive' reporting to Board focused on areas of concern. 7) Project Vision programme management assurance system giving independent 'live' reports	Plans have not as yet identified full CIP for year and pipeline going forward. Embedded coaching culture to deliver empowered leadership and accountability Capacity of operational managers to deliver transformational plan, alongside other project demands. Sufficient engagement with staff side	Regulatory compliance reporting Contract compliance reporting Contract governance reporting	2015/16 Transformation National Inpatient survey (above average results)	Gaps in assurance on CIP schemes in Project Vision and the future pipeline. CIP QIAs not yet complete	Fully develop transformational project plans submitted for current and future years with assurance on cost out in line with Trust strategy and national policy	31/03/2016		
											Transformational plans progressed according to project implementation and plans and delivered according to timescales.	30/06/2016		
											Develop a performance framework to support empowered leadership and accountability to ensure decision making is undertaken at the right level.	30/06/2016		
2b	Risk to delivery of national and local system wide change. If not delivered this could cause the Trusts financial position to deteriorate resulting in regulatory action	Director of Business Development and Marketing Finance and Performance Committee (Audit Committee)	16 HIGH	4	4	1) Engagement with external system wide meetings i.e. Joined Up Care and 21C, with regular progress reporting to the Board. 2) Stakeholder and relationship management resulting in keeping the Trust competitive 3) Inclusive approach in response to tender opportunities, resulting in a coherent joined up approach internally.	Unclear system wide governance to oversee delivery of national priorities Lack of clarity around collaboration and competition				Delivery of Monitor operational plan	30/04/2016		
											Agree system wide Sustainability and Transformation Plan (STP)	30/06/2016		
											Implementation of Sustainability and Transformation Plan (STP)	From 01/10/2016		

	Strategic Outcome 3. The public has confidence in our healthcare and developments												
	Principal Risk	**Director Lead and named responsible Committee**	**Risk Rating**	**Impact (1-5)**	**Likelihood (1-5)**	**Key Controls**	**Gaps in control**	**Assurances on Controls (Internal)**	**Positive Assurances**	**Gaps in Assurance**	**Action plan: To increase effective controls. To gain assurance.**	**Action: due/review date**	**Progress on action**	**Risk Register ID**
3a	Failure to deliver short term and long term financial plans could adversely affect the financial viability and sustainability of the organisation	Executive Director of Finance Finance and Performance Committee (Audit Committee)	HIGH	5	3	1) Monthly Financial Performance Reporting to Public Trust Board meetings providing assurance on financial performance, including integrated performance reporting to enhance triangulation when assessing finance, quality, workforce and operational performance 2) Reporting to Finance and Performance Committee to gain assurance on all aspects of financial (and other resources) management on behalf of the Board, including oversight of CIP delivery and contractual performance 3) Project Assurance processes and systems for in-year monitoring of CIP delivery and escalation procedures 4) System of delegated budgetary responsibility - in line with standing financial instructions and scheme of delegation 5) F&P and PCOG meeting monitoring of contractual performance that impacts on contractual payments including activity levels, CQUIN and contract levers/penalties. 6) Service Line Reporting and other financial reporting systems and action planning at Finance & Performance, Performance and Contracts Overview Group (PCOG), Integrated Services Delivery Group (ISDG), Divisional meetings, IAPT Board and other groups	Future payment systems beyond 1617 not yet defined by Regulators or agreed with commissioners Control Totals for required surplus imposed by Regulator will require stretch levels of CIP delivery Additional regulatory reporting and controls having negative impact on capacity and flexibility in financial planning	Monthly financial reporting systems on current and forecast performance include "challenge and review" each month before reporting Pre-submission scrutiny of annual operational financial plan prepared and submitted to Monitor Delivers FSRR of at least 3 each quarter Pre-submission scrutiny of health system Sustainability and Transformation Plan (STP) (5 year plan) Budget-setting operational requirements are signed-off by those responsible for their delivery (and the Trust Board) In-year financial forecasts are co-owned by finance and the individuals responsible for their delivery Existence of contingency reserve and the contingency reserve access request process Large proportion of income guaranteed through block contract for 1617 .	External Audit: the Audit Findings for DHCFT (year ended 31 March 2016) . TBC issued with Unqualified Opinion Confirmed TBC NB - VFM assessment and governance (see gap in assurance) External Audit: Bespoke Key Financial Indicators 2015 report show that aside from the gap in assurance for liquidity (as the only red indicator) - the other indicators are amber or green (benchmarked against MH FT peers) . Strongest indicator is EBITDA. Generally improving position on metrics or benchmarked position Monitor: In year compliance reporting: FSRR rating has always been 3 or 4 Monitor: "Green" rating for Trust's current 5 year strategic financial plan (only 30% of Trusts rated as green). (NB Awaiting assessment of new health system STP - TBC) Internal Audit: 2015/16 Cash forecasting and controls (low risk) Internal Audit 2015/16 Contract Assurance Shared Business Services (SBS) (medium risk) Internal Audit 2015/16 Off payroll arrangements (medium risk)	Re: External Audit benchmarking for Financial KPIs and resilience: Main area to improve is liquidity ET/Governance reviews/investigations and subsequent regulatory impact created negative external assurance (e.g. need to develop integrated reporting and update F&P TOR and had negative impact on External Audit VFM Assessment for 1516 annual accounts and report) TBC Residual gaps in assurance related to exceeding agency controls on: % cost ceilings, pay rate caps, use of approved frameworks and high cost off payroll compliance (and gaps identified in internal Audit Report on off payroll medium risk)	To minimise control gap around future payment systems: Attendance at events, keeping up to date with current thinking from Regulator, discussions with commissioners (joint exec ownership between DoF and Director of Business Development)	Oct-16	Actions are ongoing and contractual progress is reported to F&P	
											To minimise gap in control re control total required by Monitor - continue financial planning and financial control and ensure CIP delivery	April 16 submission	April 16 submit final 1617 plan -updated for contract outcomes. also Q1 will evidence performance against 1617 plan and trajectory to deliver control total delivery	
											To minimise control gap for regulatory capacity and inflexibility in planning - ensure long term financial plans are deliverable and effectively monitored, continue to improve liquidity.	October 17 submission	Long term STP submission being developed	
											To improve assurance gap on EA benchmarking indicators: continue to improve liquidity and build cash reserves (e.g. through retention of disposal proceeds), maintain tight financial control	31/03/2017	Progress continues - see latest board financial reporting for current metrics	
											To improve assurance gap related to financial components of governance gaps: achieve delivery of the relevant governance improvement actions and compliance with findings recommendations from Deloitte et al	March board meeting for new reporting (other timeframes as per the full governance improvement action plan)	Papers provided to F&P and Board during the year are being amended as required. E.g. Enhanced financial dashboard reporting actioned from Feb 16 board onwards. Also from March board 16 onwards Trust Board receive a new integrated performance report. PCOG and F&P reports from Feb/March 16 included additional content on forward financial risks and trends.	
											To improve assurance related to agency usage: Internally monitor and manage reduction in use of agency staffing and monitor the delivery of improvement trajectories and also report progress on trends to relevant committees and Trust Board. (Action owner = Ops director) Also achieve further evidence of assurance on rostering and longer term workforce planning to reduce reliance on agency (reported through People committee) (Action owner= Workforce Director)	end Q1	Additional operational processes and procedures have been put in place, and are being further enhanced, to comply with reporting requirements to Monitor and to internally monitor and manage reduction in use of relevant temporary staffing . Progress will be reported as part of regular performance reporting to both Trust Board, F&P Committee and People committee	
3b	There is a risk that the Monitor enforcement actions and CQC requirement notice, coupled with adverse media attention may lead to significant loss of public confidence in our services and in the trust of staff as a place to work. Furthermore, failure to deliver the governance improvement action plan could lead to a risk of further breaches in licence regulations with Monitor and the CQC and further regulatory action	Acting Chief Executive Audit Committee	HIGH	5	3	1) Governance committees and structures 2) Newly established People and Culture committee 3) Governance processes to deliver the governance improvement action plan including reporting to ELT and monthly reporting to Board 4) Listen, Lead and Learn - executive visibility plan 5) Formal reporting to regulators on a monthly basis. 6) Ongoing engagement with regulators	Identified in the governance improvement action plan.	Well led self assessment	Monitor agreement of governance improvement action plan	Outcomes from Deloitte and CQC reviews	Implement actions from Governance Improvement Action Plan. These have been grouped together to allow summary reporting, so as to not to replicate other comprehensive reporting on progress against the action plan. Core issue 1) Reunification of the HR and associated functions. Core issue 2) People and culture. Core Issues 7) Workforce and OD. Core Issues 8) Whistleblowing	27/06/2016		
											Implement actions from Governance Improvement Action Plan. Core issue 3) Clinical governance . 4) Corporate governance. Core Issue 9) Fit and Proper Persons test	31/08/2016		
											Implement actions from Governance Improvement Action Plan. Core issue 5) Council of Governors	27/06/2016		
											Implement actions from Governance Improvement Action Plan. Core issue 6) Roles and responsibilities of Board members.	27/06/2016		
											Implement actions from Governance Improvement Action Plan. Core issue 10) CQC. Core Issues 11) Monitor	27/01/2017		
											Internal audits to be undertaken on key areas identified in the governance improvement action plan, i.e. compliance with policies and procedures	31/05/2016		

Strategic Outcome 4. Care is delivered by empowered and compassionate teams													
	Principal Risk	**Director Lead and named responsible Committee**	**Risk Rating**	**Impact (1-5)**	**Likelihood (1-5)**	**Key Controls**	**Gaps in control**	**Assurances on Controls (Internal)**	**Positive Assurances**	**Gaps in Assurance**	**Action plan: To increase effective controls. To gain assurance.**	**Action: due/review date**	**Progress on action**	**Risk Register ID**
4a	Risk of a fundamental loss of confidence by staff in the leadership of the organisation at all levels	Director of Workforce, OD and Culture People and Culture Committee (Audit Committee)	15	5	3	1) Appointment of new Director for Workforce, OD and Culture to focus and deliver the immediate requirements of the governance improvement action plan and the HR function and organisational culture going forward 2) Leadership development programme 3) Communication Strategy to engage and inform staff 4) Trust values outlining expected behaviours of all staff 4) Monitoring and delivery of the Training and Development Framework and Training Plan	Defined People Strategy and People and Workforce Plans Lack of unification of HR and associated functions Limited informal engagement by Board with staff Lack of partnership agreement with staff side, to deliver the People Strategy Implementation of HR policies		HEEM annual quality visit	Gaps in CQC/Monitor governance standards Safer staffing data identified in 2015/16 HR Processes: Recruitment. Staff survey	Implement actions from Governance Improvement Action Plan in relation to Core issue 1) Reunification of the HR and associated functions. These have been grouped together to allow summary reporting, so as to not to replicate other comprehensive reporting on progress against the action plan.	30/06/2016		
											Implement actions from Governance Improvement Action Plan in relation to Core issue 2) People and culture	27/06/2016		
											Implement actions from Governance Improvement Action Plan in relation to Core issue 7) Workforce and OD.	27/06/2016		
											Implement actions from Governance Improvement Action Plan in relation to Core issue 8) Whistleblowing	31/03/2016		
											Facilitated session with ACAS arranged to support staff side partnership agreement.	30/04/2016		
											Seek resource and support from Derbyshire human resources system to support delivery of People Plan	30/04/2016		
											Implement actions from internal audit report (2015/16 HR Processes: Recruitment) in relation to safer staffing reports.	30/04/2016		
											Establish a robust action plan to support staff survey outcomes	30/06/2016		
											Complete Workforce Plan and supporting Training Plan	30/04/2016		

Abbreviations

ACAS	Advisory, Conciliation and Arbitration Services
CEO	Chief Executive Officer
CIP	Cost Improvement Programme
COSRR	Continuity of Services Risk Rating
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation payment
CRG	Clinical Reference Group (accountable to QLT's)
DEWS	Derbyshire Early Warning System - tool to identify sharp physical health decline
DNAR	Do Not Attempt Resuscitation order
DoF	Director of Finance
EBITDA	Earnings before interest, taxes, depreciation and amortization
ELT	Executive Leadership Team
F&P	Finance and Performance Committee
FRR	Financial Risk Rating
FSRR	Financial Sustainability Risk Rating
HR	Human Resources
IAPT	Improving Access to Psychological Therapies
NICE	National Institute for Health and Care Excellence
PARIS	Electronic Patient Record solution provided by Civica
PCOG	Performance and Contracts Overview Group
POMH-UK	Prescribing Observatory for Mental Health
PYE	Part Year Effect
QAG	Quality Assurance Group (led by Commissioners)
QC	Quality Committee
QIA	Quality Impact Assessment
QLT	Quality Leadership Teams (accountable to Quality Committee)
SLA	Service Level Agreement
STP	Sustainability and Transformation Plan
TOMM	Trust Operational Management Meeting
VFM	Value for Money

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 30 March 2016

Governance Improvement Action Plan

Governance and Delivery framework

Purpose of Report

The purpose of this paper is to set out the arrangements by which the Trust's Board will be assured that the Governance Improvement Action Plan (GIAP) is systematically implemented, delivering the agreed key outcomes so that it is able to demonstrate to all key stakeholders that the required governance improvements have been made.

Executive Summary

This paper describes how the Governance and Delivery Framework will operate, identifying key roles and responsibilities and the requirement being placed on the governance structure that currently exists within the Trust.

Briefly set out within the main body of the paper are;

1. Background
2. Purpose of the paper
3. Managing the programme of work
4. Delivery and assurance of the programme of work
5. Reporting against the programme of work
6. Communications plan

Strategic considerations

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

Assurances

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

Consultation

- This report has been discussed and informally agreed at Trust Board Development session on Wednesday 9th March.

Governance or Legal issues

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

Recommendations

The Board of Directors is asked to approve this paper

Report prepared by: **Mark Powell (Director Business Development and Marketing)**

Report presented by: **Ifti Majid (Acting Chief Executive Officer)**

1. Background

Over the course of the last year, the Board has operated in a difficult and sensitive context following the events surrounding the Employment Tribunal.

In July 2015, Monitor opened an investigation into the Trust, both due to governance concerns arising from the ET, and also following issues raised to them directly through their whistleblowing policy.

As a result of this the Trust commissioned a number of independent investigations and reports to review the governance concerns that had been raised. Deloitte, CQC and Mr Alan Yates were commissioned to undertake these investigations.

Specific Terms of Reference for all of these are available; however, Board members will be aware of the recommendations set out in these reports.

Each of the reports has recommended a series of actions that the Trust needs to deliver in order to improve the Trust's governance processes and systems.

As a result of these recommendations, the Trust's regulator Monitor has taken action to place the Trust under specific enforcement action, with undertakings being placed on the Trust's license.

In order to address these failings a programme of work known as the 'Governance Improvement Action Plan' (GIAP) has been developed in response to the recommendations and it is this plan that the Trust will need to deliver to satisfy Monitor that the required improvements have been made.

2. Purpose of the paper

The purpose of this paper is to set out the arrangements by which the Trust's Board will be assured that the GIAP is systematically implemented, delivering the agreed key outcomes so that it is able to demonstrate to all key stakeholders that the required improvements have been made.

It is important to note that given the 'governance' nature of many of the recommendations it is of paramount importance that a robust delivery framework is developed and utilised to enable all of the objectives to be delivered and to provide evidence of assurance of the delivery.

Good governance provides the foundation for organisational high performance and securing good governance needs to be a core focus for the Trust. Underpinning this are the principles of accountability, transparency, probity and long term sustainability

Set against this context, the remainder of this paper describes how the programme will operate, identifying key roles and responsibilities and the requirement being placed on the governance structure that currently exists within the Trust.

3. Managing the programme of work

Whilst the Board is the owner of, and accountable for the delivery of the GIAP, it is important to have in place a single point of responsibility for taking oversight of the totality of the plan and the supporting resource to not only enable successful delivery but to provide objectivity, challenge and clear, concise and consistent reporting to all stakeholders.

3.1 Responsible Director

It has been recognised that a significant number of the 'key tasks' rest with 3 members of the Executive team, one of which is the newly appointed Director of Corporate Affairs and Company Secretary. Given that this is a new appointment and that it would not be good governance to develop a framework that asks someone to hold themselves to account it is proposed that another member of the Executive Team takes the lead for the totality of the programme of work as the 'Responsible Director'.

The Responsible Director will work on behalf of the Board to provide oversight, leadership, transparency, reporting and programme delivery arrangements, as well as holding to account those who are required to deliver the key tasks set out within the GIAP.

This role effectively sits outside the delivery of the GIAP and a key objective of this role will be to provide a strategic view of the overall programme, enabling coherent and concise reporting to support the Board in seeking assurance and to aid in its interactions with all of its key stakeholders.

3.2 Governance Improvement Programme Manager

Given the scope and scale of the GIAP there is a recognition that dedicated resource is required to support the day to day programme management of the GIAP. A full time Governance Improvement Programme Manager will be required to undertake this role. This role will adopt a very clear programme management approach

Working with autonomy, but supporting the Responsible Director, this role will be expected to support and enable actions to be completed on time and to the expected standard, reporting any exceptions in a timely way to the Responsible Director in order that corrective action or additional support can be targeted to ensure the programme stays on track.

They will also be required to, but not limited to;

- support the Responsible Director in holding other Directors to account for the delivery of their actions and acting as a key contact and support Directors for the duration of the Program

- develop and implement a comprehensive system to support the reporting of the progress against the GIAP, ensuring outcomes/actions arising from meetings are tracked and actioned and effectively recorded /updated

- have the authority to act with autonomy

- ensure the monitoring of performance against project plans, taking action as necessary to ensure the GIAP proceeds to schedule and appropriately reporting any situation, which present potential risk to progress to achieve the required delivery outcomes.

- to structure, maintain and oversee effective project documentation and management

This Responsible Director and Governance Improvement Programme Manager will also be supported by dedicated administrative time to enable the smooth running of this complex work programme.

Programme resource will need to be reviewed regularly.

4. Delivery and assurance of the programme of work

It's absolutely vital that the overall GIAP governance arrangements are delivery focused. Delivery ownership places the responsibility to deliver on those who are required to implement the changes – in this instance Key Task Owners.

4.1 Key Task Owners

All key task owners will be Executive Leadership Team Directors.

Key task owners are responsible for the following;

- delivery of key tasks within the agreed timeframes set out in the GIAP

- for ensuring that all reporting requirements are met and for providing satisfactory evidence in support of the agreed outcomes.

- attending meetings with the Responsible Director and Programme Manager on a weekly basis (in the first instance) to provide a clear and concise update on their actions in the form that has been agreed, using a look back / look forward approach.

4.2 Board Committees

Board Committees will receive detailed GIAP reports and be expected to assimilate the information provided. This will require committee members to be fully aware of the key tasks aligned to their committee.

Alongside this each Committee will be required to review recommendations made by Key Task Owners about delivery/closure of each action, seeking their own assurance and subsequently making recommendations to Board about completion of actions or escalation concerns where necessary.

4.3 Trust Board

Trust Board will receive a consolidated GIAP report each month. At the outset this is likely to be extensive until such time that actions have been delivered / embedded.

In addition, (and over time) Board will receive recommendations from committees with respect to completion of plans or items for escalation. In both instances Board will provide further challenge to these recommendations.

Trust Board will be the final sign off for all completed actions and external reports to key stakeholders.

This will be a standing item at Public Board meetings.

5. Reporting against the programme of work

Effective and timely reporting is an essential component of this programme management approach. It will enable transparency and accountability.

5.1 Executive Leadership Team

A weekly report will be provided to ELT, summarising previous week's activity, proposed activity, progress, items for escalation, requests for a change in delivery timeframe, suggested evidence for closure of actions etc. The programme manager will develop this report based on information provided by leads. Responsible Director will lead ELT discussion.

This will be a prioritised standing agenda item.

5.2 Trust Board committees and Council of Governors

A monthly (bi-monthly for F&P) report will be provided to the relevant Board Committee and Council of Governors, giving updates on action (past/future) and evidence to give committee members or Governors assurance on all parts of the plan.

This will be a prioritised standing agenda item.

5.3 Public Trust Board

Trust Board will receive a consolidated report each month. At the outset this is likely to be extensive until such time that actions have been delivered / embedded.

Board will receive recommendations from committees with respect to completion of plans. Trust Board will provide further challenge to these recommendations. Trust Board will be the final sign off for all actions and this will be a standing item at Public Board meetings.

5.4 External Reporting

The Responsible Director supported by the Programme manager will ensure that robust and timely reporting takes place to Monitor and CQC in the required format in the required timeframe. All external reports will be signed off by Trust Board.

The Programme manager will provide high quality briefing packs to all Directors attending regulator performance meetings in a timely manner.

6. Communications plan

Given the media coverage and attention regarding the employment tribunal and subsequent regulatory action, the Trust has publicly outlined its processes regarding the governance improvement action plan.

Internal and external stakeholders will continue to be updated and involved in the plan as it develops, and will proactively be invited to shape many of the actions included in the plan – for example the development of new organisational values and culture.

With an initial focus on internal stakeholders (staff and governors) there will be regular communication that outlines the progress of the plan and its associated impact and how people can become involved.

Communications mechanisms will include:

- Regular (monthly) communications brief to be provided organisationally through Monthly Connect about progress. This is likely to follow the Board update each month. Corresponding information will be included in Governor Connect and to the Trust's key stakeholders as appropriate.

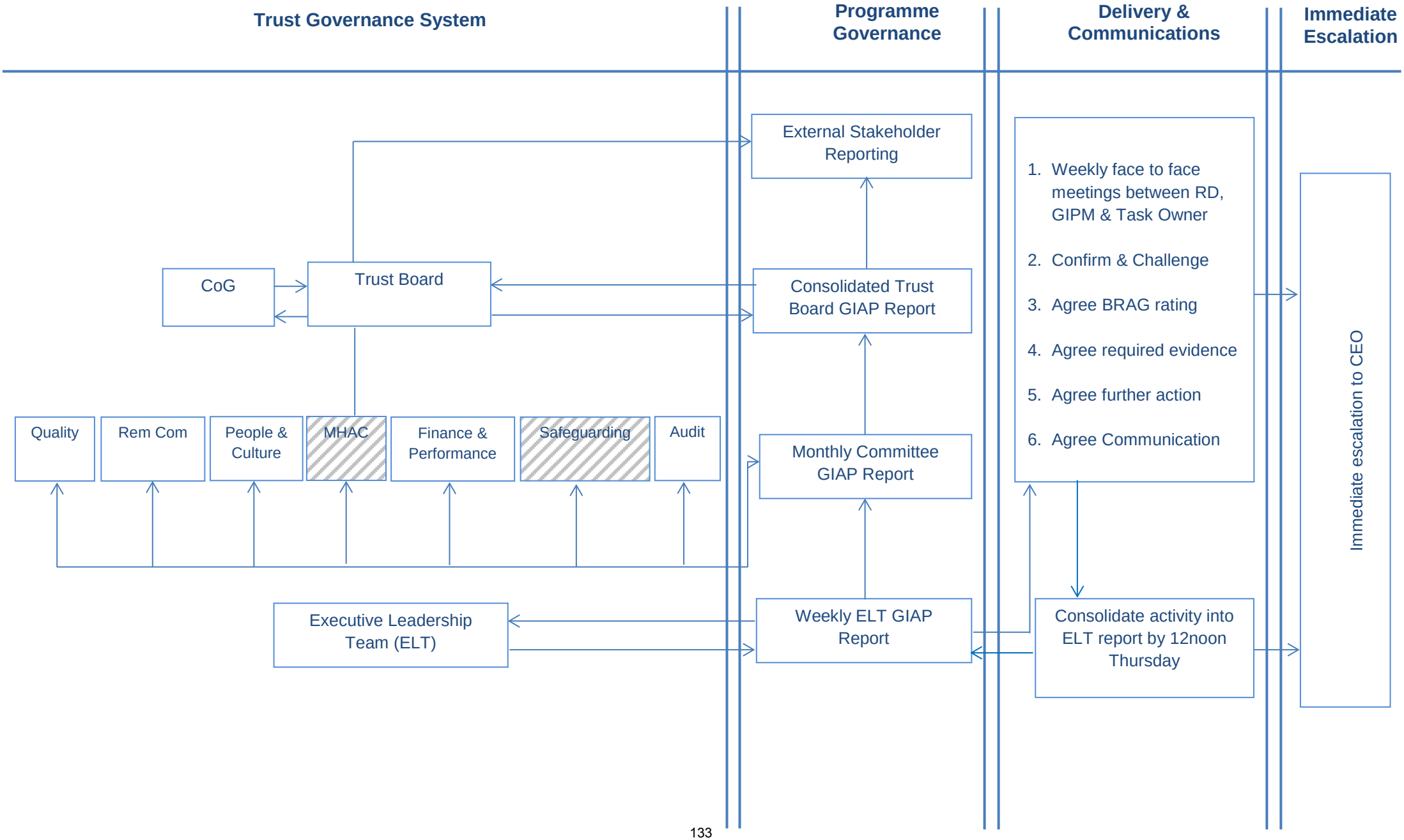
- Development of regular ways in which the executive team and wider Board members can interact with members of staff. This could include face to face sessions, attendance at team meetings and visits to services, including the development of a 'back to the floor' programme.

- Listen, learn and lead sessions

- Regular all staff communication from Ifti Majid (by email) and also in wider introductions to events, for example leadership development sessions.

- Progress on the governance improvement action plan will also be referenced alongside wider developments within the Trust, to set it in a wider context of the Trust's ongoing changes.

It is anticipated that the Governance Improvement Programme Manager will work closely with the communications and involvement team to ensure regular developments and updates are shared, ready for wider dissemination with stakeholders as appropriate.


Trust Governance System
Programme Governance
Delivery & Communications
Immediate Escalation
External Stakeholder Reporting
CoG
Trust Board
Consolidated Trust Board GIAP Report
1. Weekly face to face meetings between RD, GIPM & Task Owner
2. Confirm & Challenge
3. Agree BRAG rating
4. Agree required evidence
5. Agree further action
6. Agree Communication
Quality
Rem Com
People & Culture
MHAC
Finance & Performance
Safeguarding
Audit
Monthly Committee GIAP Report
Immediate escalation to CEO
Executive Leadership Team (ELT)
Weekly ELT GIAP Report
Consolidate activity into ELT report by 12noon Thursday

Governance Improvement Action Plan

Action Rag Rating
Completed
On track
Some Issues
Off Track

	Issue Raised/ Action	well led self assessment	Reference to AY Governance	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
	CORE 1- REUNIFICATION OF THE HR AND ASSOCIATED FUNCTIONS																		
HR1	The HR and OD departments should be under the management of one Executive Director	**HR Q11 WL Q3.2 WL Q6**	**Gov7, C3, C4**				1) Recruitment of Director of Workforce, OD and culture	14th December 2015	**Completed**	1) The agreed change will be challenged by some individuals	1) If the HR, OD and leadership function are not managed by one director there is a risk that the delivery of the OD will be significantly reduced and the outputs will not be cohesive	None Required	Acting Chief Executive	Rem Com	18th January 2016	1) Role agreed at Remuneration Committee 2) Organisational change process completed 3) Communication with individuals and organisation	1) Director of Workforce, OD and Culture is in post		
							2) Job Description approved at Rem Com	21st December 2015	**Completed**				Acting Chief Executive	Rem Com					
							3) Inform staff effected by the change	11th January 2016	**Completed**				Acting Chief Executive	Rem Com					
							4) Formal recruitment to the post	4th January 2016	**Completed**				Acting Chief Executive	Rem Com					
							5) Communicate the change to affected departments	18th January 2016	**Completed**				Director of Workforce, OD and Culture	Rem Com					
							6) Communicate the change to the organisation	18th January 2016	**Completed**				Acting Chief Executive	Rem Com					
HR2	Ensure external resources for the newly appointed Director of Workforce, OD and Culture are obtained in order to drive the transformation of HR and related functions through a combination of coaching, buddying, and mentoring support.				**R25**		1) Develop and agree a plan which identifies additional resources to ensure successful delivery of HR, Workforce and OD GIAP actions	18th March 2016		1) Availability of competent staff in areas required within timeframe and budget 2) Acceptance and integration of additional staff into existing teams	1) Lack of extra external resource to support delivery of actions will significantly impact on successful delivery of the GIAP	A resource plan will identify costs	Director of Workforce, OD and Culture	People and Culture Committee	30th April 2016		1) External resource in place fulfilling GIAP tasks	1) Demonstrable delivery of the GIAP tasks	
							2) Deliver the Resource Plan	31st March 2016					Director of Workforce, OD and Culture	People and Culture Committee					
HR3	Undertake an exercise to update the model for HR. Utilising the model as a guide, expertise and best practice across the LHE, and beyond. As a priority the Trust should focus on establishing clear foundations, utilising key building blocks to create sustainability in the long term.				**R27**		1) In consultation with team develop and deliver the new model for HR	30th June 2016		1) Inability to deliver HR service model due to staff sickness and lack of engagement from existing staff	1) Function not 'fit for purpose' to support the organisation in delivery of the Trust strategy 2) Failure to integrate into wider Derbyshire system plans	External support may be required on both the developmental and delivery stages	Director of Workforce, OD and Culture	People and Culture Committee	30th October 2016		1) Revised HR model in place 2) Positive HR Effectiveness KPI's	1) Improvement of HR KPIs	
HR4	Define a new structure for HR and its related functions with a priority on operational efficiency and strategic impact taking into account the refreshed People Strategy and revised model for HR and related functions.				**R28**		1) Develop and implement a new structure for HR and its related functions with a priority on operational efficiency and strategic impact	29th June 2016		1) Inability to deliver HR service model due to staff sickness, lack of engagement and capacity	1) Function not 'fit for purpose' and inefficient to support the organisation in delivery of the Trust strategy	External support may be required on both the developmental and delivery stages	Director of Workforce, OD and Culture	People and Culture Committee	31st October 2016		1) New HR structure in place and working effectively	1) Improvement of HR KPIs 2) Demonstrable delivery of the GIAP tasks	
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.				**R35**		1) Develop a suite of metrics to measure impact of interventions at an organisation and service line level	29th June 2016		1) Failure to recognise and accept the need to change by exciting teams	1) Lack of focus in key areas, inefficient use of resources 2) Function not 'fit for purpose' and inefficient to support the organisation in delivery of the Trust strategy	None Required	Director of Workforce, OD and Culture	People and Culture Committee	31st July 2016		1) Agreed set of metrics 2) Evidence of metrics used with Governance structures	1) Integrated performance report includes a set of HR metrics	
							2) Develop an internal suite of metrics to measure functional effectiveness	31st March 2016					Director of Workforce, OD and Culture	People and Culture Committee					
	CORE 2- PEOPLE AND CULTURE																		
PC1	The Trust should adopt an Organisational Development and Workforce Committee	**HR 11.2 HR 11.4 HR 11.7 WL Q4**	**Gov2**				1) Terms of Reference Developed	27th January 2016	Completed	1) The People and Culture Committee must ensure it remains strategic and be well supported by functioning sub-groups	1) Failure to ensure appropriate governance and accountability to deliver the People Strategy	None Required	Director of Workforce, OD and Culture	People and Culture Committee	27th January 2016	TOR for P&CC agreed in Feb Draft TOR for some of the sub-groups to be presented in March P&CC	1) People and Culture committee in place and working effectively 2) People and Culture committee agenda reflective of the priorities set out within the People Strategy	1) Well led External review provides positive assurance on the effectiveness of the Committee	
							2) Terms of Reference approved by Board	27th January 2016	Completed										
							3)First Committee meeting	17th February 2016	Completed										
PC2	Develop and undertake a clear programme of work around culture, utilising the expertise of other NHS Trusts in the LHE, and where necessary beyond, to inform the programme of activities.				**R9**		1) Develop a programme of work against the delivery of the people strategy	30th June 2016		1)Consultation fatigue and lack of belief that the organisation is willing and able to change.	1) Failure to articulate expected values and behaviours 2) Failure to engage staff impacting on productivity and patient care	Resources required to be identified within People plan.	Director of Workforce, OD and Culture	People and Culture Committee	31st March 2017		1)Monthly pulse checks 2) Annual staff survey 3) Evidence of attendance on Leadership Development courses 4) Evidence of health and well being events	1) Evidence of improvement against an agreed trajectory using the staff survey, Cultural Barometer and informal and formal feedback	
							2) Develop a clear plan which outlines an on-going focus on pulse surveys to enable targeted activity	31st July 2016					Director of Workforce, OD and Culture						
							3) Based on Pulse Checks develop a focused coaching within teams	31st August 2016					Director of Workforce, OD and Culture						

	Issue Raised/ Action	well led self assessment	Reference to AY Governance	HR Investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
							4) Implement events focused on staff health and well-being	30th June 2016					Director of Workforce, OD and Culture						
							5) Ensure there is an agreed approach to extensively share good practice and innovation	30th June 2016					Director of Workforce, OD and Culture						
							6) Develop and implement a leadership development programme	31st July 2016					Director of Workforce, OD and Culture						
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.				R10		1) Develop a comprehensive internal Comms plan, which clearly articulates engagement approaches both formal and informal	31st May 2016		1. Capacity of the communications team to support the delivery of the plan	1. Failure to support the delivery of the Trust strategy 2. Failure to engage staff impacting on productivity and patient care	Comms resource may be required	Director of Corporate Affairs	People and Culture Committee	27th June 2016		1) Evidence the delivery of the internal comms plan	1) Improvement of staff survey 2) Improvement of pulse check metrics	
							2) Develop a clear system to record feedback received from staff	31st May 2016					Director of Corporate Affairs	People and Culture Committee					
PC4	Prioritise the development of the People Strategy and ensure the agenda and focus of the newly formed People and Culture Committee is clearly aligned the Trust's overall strategy.				R26		1) Refresh People Strategy including reporting metrics	29th April 2016		1) Capacity to deliver an agreed People Strategy	1) Failure to support the delivery of the Trust strategy 2) Failure to engage staff impacting on productivity and patient care 3) Failure to establish distributed leadership and detrimental impact on ED's	Identified within the resource plan	Director of Workforce, OD and Culture	People and Culture Committee	31st July 2016		1) People Strategy and supporting plan in place	1) Well led External review provides positive assurance on the effectiveness of the Committee	
							2) ensure the people Strategy places greater emphasis at divisional and service lines to support our leaders to deliver the strategic objectives	29th April 2016					Director of Workforce, OD and Culture	People and Culture Committee					
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.				R8		1) HR and OD to undertake a review of the Trust values	31st May 2016		1) Failure to articulate expected values and behaviours	1) Failure to engage staff impacting on productivity and patient care	Investment in external consultants to support culture change programme	Director of Workforce, OD and Culture	People and Culture Committee	31st August 2016		1) Trust Values identified within Trust Strategy 2) Visibility and understanding of Trust Values	1) Staff Survey	
							2) Set a programme of engagement with staff to consultant on the refresh of the values	31st May 2016					Director of Workforce, OD and Culture	People and Culture Committee					
							3) Ensure a comprehensive Comms plan in place to ensure values are visible across the Trust; and	30th June 2016					Director of Workforce, OD and Culture	People and Culture Committee					
							4) HR and OD to undertake a refresh of the behavioural framework	31st July 2016					Director of Workforce, OD and Culture	People and Culture Committee					
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.				R11		1)Chairman and CEO reports to include information about stakeholder engagement and feedback from commissioners	31st March 2016		1) None identified at this time	1) None identified at this time	None Required	Acting Chief Executive	Board of Directors	30th April 2016		1) Regular reports received by BoD and CoG	1) Evidence of reports discussed at BoD and CoG	
							2) Chairman to provide updates to Board from Council of Governors	31st March 2016					Acting Chief Executive	Board of Directors	30th April 2016				
	CORE 3 CLINICAL GOVERNANCE																		
CG1	Refresh the role of Quality Leadership Teams to increase their effectiveness as core quality governance forums.				R24		1) Agree and implement a QLT forward plan process to ensure all required papers are received at each meeting	30th April 2016		1) Clinicians will not deliver quality priorities 2) QLTs do not meet sufficiently in order to meet there TOR	1) The Trust will not deliver the Quality Framework	Resource required to support time out days for QLT and CRG leadership teams	Director of Nursing	Quality Committee	13th October 2016		1) Evidence of implementation of QLT forward plan 2) Evidence of QLT's owning and overseeing delivery of Trust quality priorities 3) Evidence of BM attendance at QLT's	1) Achievement of the quality framework	
							2) Develop and implement a standard escalation template to be used by QLT's	30th April 2016					Director of Nursing	Quality Committee					
							3) Review frequency of clinical reference groups so that QLTs are enabled to undertake their work as defined by TOR	30th April 2016					Director of Nursing	Quality Committee					
							4) For a 6 month period DoN and MD to attend QLTs to provide coaching and oversight of meeting effectiveness.	30th September 2016					Director of Nursing	Quality Committee					
CG2	The Trust would benefit from a robust and thorough policy review programme.				R30		Undertake a review of Trust policies in order to; a)Revise the number of policies; b) update to ensure for plain English; c) ensure consistency and clarity in how policies are presented , e.g. managers guide, policy or procedure.	31st December 2016		1) Inability to review and update policies with necessary pace due to capacity	1) Employees will not adhere to policies if there are too many or if there are not clear	Resource will be required to increase capacity within the risk management function	Director of Nursing	Audit Committee	31st January 2017		1) Evidence that the Trust has reduced the number of policies 2) Evidence of policies being reviewed within date	1) Audit of policy compliance	
CG3	Increase the effectiveness of the Quality Committee by ensuring clear alignment of the committee with the quality strategy and associated objectives, and ensuring a clear focus on seeking assurance.				R18		1) Board Development to focus on NED challenge of overdue actions and reports (see RR2)	tbc		1) There is a risk that the Quality Committee agenda is to broad, and doesn't sufficiently focus on the delivery of the Quality Strategy	1) Trust will not deliver Quality strategy and goals 2) The Board will not gain assurance from quality Committee 3) Non delivery of actions will result in the failure to achieve clinical quality standards required by our regulators which may lead to harm to service users and/or staff (BAF	Resource identified in Board	Director of Nursing	Quality Committee	30th November		1) TOR agreed 2) Evidence of agenda reflecting Quality Strategy and Quality Goals 3) Quality Governance Group implemented 4) Evidence of actions agreed	1)Achievement of the quality framework 2)Annual report	
							2) As part of the review of all Committee TOR ensure there is clarity of Quality Committee TOR and work plans in relation to the Audit Committee and People and Culture Committee	31st May 2016					Director of Corporate Affairs	Audit Committee					

	Issue Raised/ Action	well led self assessment	Reference to AY Governance	HR Investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
							3) Introduce a Quality Governance Group that will report to Quality Committee	31st July 2016			risk	Development RR2	Director of Nursing	Quality Committee	2016				
							4) Ensure that Quality Committee agenda is structured so that it focuses on topics to deliver quality strategy and goals.	30th June 2016					Director of Nursing	Quality Committee					
	CORE 4; CORPORATE GOVERNANCE																		
CG1	The Trust should consider how its governance arrangements could better match its strategy and plans.	**WL Q6**	**Gov1**				1) Develop and approve a Corporate Governance Framework which supports the delivery of the Trust strategy ensuring that the Board of Directors and Board Committee agendas adequately reflect the strategic objectives of the Trust	31st May 2016		1) There is a risk that the Board of Directors and Board Committees are not focused on the correct issues	1) Failure to deliver the Trust Strategy 2)Failure to receive assurance around strategy delivery 3) Increased bureaucracy within Organisation 4) Clinical disconnect from the Strategy 5) Failure to embed the Strategy 6) Capacity Issues within the current Board may impact on delivery of the Strategy	None Required	Director of Corporate Affairs	Board of Directors	30th June 2016		1) Corporate Governance framework agreed by Board 2) Board and Committee agendas reflective of strategic objectives 3) Board and Committee papers link to the Trust's strategic objectives	1) Well led External review provides positive assurance on the effectiveness of the Corporate Governance Framework	
CG2	The Governance Framework should be updated to give greater clarity regarding roles of key individuals and governance forums, including: all EDs, the SID and Vice Chair, PCOG, QLTs and the Safeguarding Committee.				**R14**		1) Develop and approve a Corporate Governance Framework	31st May 2016		1) Failure to allocate sufficient resource to deliver this	1) Lack of clarity around roles may lead to failure to deliver key functions resulting in breach of regulatory conditions. 2) Clinical risk may increase due to lack of clinical ownership within governance structure. 3) Operational performance and operational performance assurance could deteriorate leading to a breach of regulatory or contractual requirements. 4) Inability to articulate corporate	None Required	Director of Corporate Affairs	Board of Directors	30th June 2016		1) Accountability Framework approved by Board of Directors 2) A full suite of ToRs in place with clear responsibilities for compliance monitoring and systems governance	1) Internal Audit on effectiveness of accountability framework	
CG3	The Board and its committees need to have a greater focus on capturing, recording and holding to account for agreed actions.				**R15**		1) Board Development programme to be updated to include a session on holding to account which will include holding to account for agreed actions.	15th June 2016		1) Board development session does not take place in a timely manner	1) Increased risk of non delivery of Trust Strategy or contractual/regulatory requirements 2) Loss of confidence in the Trust Board by regulators and Stakeholders 3) Staff confidence in the Board will not improve	External Support needed in order to facilitate Board Development session	Director of Corporate Affairs	Audit Committee	27th June 2016		1) Board Development Session undertaken 2) Revised action log process embedded 3) 6 month review of Action Matrix implementation undertaken 4) Reduced number of outstanding actions across Board of Directors and Board Committees	1) Well led External review provides positive assurance on the effectiveness of Board Development	
							2) Ensure a fit for purpose action log process is in place ensuring that the Board and Board committee action trackers are revised so that all actions captured have a clear close date, 'current position' and 'status of action'; and that RAG ratings are more clearly utilised to demonstrate progress	31st May 2016					Director of Corporate Affairs	Audit Committee					
CG4	Review the operation of all committees seeking to minimise duplication, revising membership, ensuring a focus on capturing and tracking actions, and increasing contribution to the debate. -a review of forward plans against ToR to ensure clarity of purpose; -minimise duplication of papers; -committee chairs should also meet quarterly to ensure effective co-working; -ensure robust attendance of all key EDs at committee meetings; -ensure a consistent focus on summarising debate and capturing actions. (feedback on this should be sought in annual effectiveness reviews); -review appropriateness of membership and provide a focus on members and attendees contributing equitably and effectively; and -timely submission of papers and consistent use over cover sheets				**R16**		1) Undertake a comprehensive review of the Board Committee structures including TOR	31st May 2016		1) Capacity of NED's	1) Board does not have sufficient capacity to service all committees 2) Appropriate assurance on performance, quality and finance is not able to be provided to the Board. 3) Lack of clarity may result in increased bureaucracy and reduced pace of action implementation.	None Required	Director of Corporate Affairs	Audit Committee	27th June 2016	ED attendance at Committees reviewed at ELT and will be reflected in revised TOR	1) Robust governance committee structure fully established 2) Annual cycle of meetings available 3) Full suite of ToRs in standardised template 4) Further Well Led Self Assessment to be completed 5) Chair of Committees meeting on a regular basis 6) Attendance at meeting reported as part of the minutes	1) Well led External review provides positive assurance on the effectiveness of Committees	
							2) Arrange for Committee Chairs to meet on a quarterly basis	31st March 2016					Director of Corporate Affairs	Audit Committee					
							3) Review ED attendance at Committees	27th January 2016	**Completed**				Director of Corporate Affairs	Audit Committee					
							4) Review the minutes of the Board and Board Committees and consider the use of action notes as a more effect way of recording debate and actions	30th April 2016					Director of Corporate Affairs	Audit Committee					
							5) Embed a process for the yearly review of the effectiveness of Board Committee against TOR	30th June 2016					Director of Corporate Affairs	Audit Committee					
CG5	Undertake a review of the Finance and Performance Committee outlined below -a review of forward plans against ToR to ensure clarity of purpose; -minimise duplication of papers; -committee chairs should also meet quarterly to ensure effective co-working; -ensure robust attendance of all key EDs at committee meetings; -ensure a consistent focus on summarising debate and capturing actions. (feedback on this should be sought in annual effectiveness reviews); -review appropriateness of membership and provide a focus on members and attendees contributing equitably and effectively; and -timely submission of papers and consistent use over cover sheets				**R19**		1)Undertake a comprehensive review of the Committee aligned to the TOR of the Committee	31st May 2016		1) Capacity of F&P Committee	1) Committee not able to meet requirements of ToR 2) Failure to provide assurance to Board 3) Key statutory reporting is not completed in a timely way	None Required	Director of Corporate Affairs	Audit Committee	27th June 2016		1) Forward plan approved 2) Review of TOR undertaken and updated TOR approved by Board 3) F&P Annual report reported to Audit Committee	1) Well led External review provides positive assurance on the effectiveness of Committees	
							2) Finance and Performance Forward Plan approved by F&P	31st May 2016					Director of Corporate Affairs	Audit Committee					

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	sheets						3) embed a process for the yearly review of the effectiveness of Board Committee against TOR	31st May 2016					Director of Corporate Affairs	Audit Committee					
CG6	The Audit Committee should reaffirm its role in seeking assurance over systems, controls and processes and not matters of operational or managerial detail.				R20		1) Ensure processes are in place for Audit Committee to undertake a review of its effectiveness	30th April 2016		1) Audit Committee agenda does not reflect TOR	1) Inability to provide assurance to the Board 2) Failure to meet ToR	None Required	Director of Corporate Affairs	Audit Committee	30th April 2016		1) Updated TOR updated and Approved by Committee and Board 2) Audit Committee Annual Report reported to Board	1) Well led External review provides positive assurance on the effectiveness of Committees	
							2) Review reporting and monitoring process to ensure Audit Committee is receiving required assurance on systems, controls and processes	30th April 2016					Director of Corporate Affairs	Audit Committee					
							3) Review Audit committee TOR in line with best practice from across the NHS	30th April 2016					Director of Corporate Affairs	Audit Committee					
CG7	In light of the changing governance and accountability structures (such as neighbourhoods, campuses and QLTs), an accountability framework should be designed to fully engage staff in how these changes will affect ways of working, performance management structures and desired behaviours moving forward.				R21		1) Aligned to the Corporate Governance Framework develop and approve an organisational accountability framework	30th June 2016		1) Capacity within teams and their ability to cope with competing priorities	1) Failure to deliver the Trusts Transformational change programme at the required pace. 2) Staff morale and engagement will reduce leading to a reduction in clinical quality. 3) Operational performance could reduce leading to failure to meet required contractual and regulatory outcomes.	None Required	Director of Corporate Affairs	Audit Committee	July 27th 2016		1) Accountability Framework approved by Board 2) Accountability Framework communicated to staff 3) Session on the Accountability framework delivered at spotlight on leaders	1) Well led External review provides positive assurance on the effectiveness of Committees	
							2) Develop and fully engage senior staff in an accountability framework which should define: •the values, behaviours and culture to be role modelled by senior management; •roles and responsibility of key divisional leaders, including delegated authorities and duties; •expectations of performance; and •mechanisms to be used for holding to account both by EDs and within divisions.	30th June 2016					Director of Corporate Affairs	Audit Committee					
CG8	The Board needs to introduce an integrated performance report which encompasses key operational, quality, workforce and finance metrics				R22		1) The Trust will revise the integrated performance report which will include: •key operational metrics; •a workforce dashboard; •the Quality Dashboard, updated to show the refreshed Quality Priorities; •a finance dashboard; and •a summary of performance of groups to highlight any underlying themes.	31st May 2016		1) Lack of clear KPIs identified by Director leads	1) Poor information leading to sub optimal decision making by the Board. 2) The Board not being sighted on key risks or poorly performing areas leading to delays in resolution. 3) Lack of clear KPIs for each section of the integrated performance report will result in trends not poor performance not being identified and improvements not monitored	None Required	Director of Operations	Board of Directors	31st May 2016		1) Integrated performance report format approved at Board	1) Evidence of links between the Integrated Performance report and Board Assurance Framework	
CG9	Formalise the role of PCOG as a key forum in the Trust's governance structure				R23		1) As part of the Governance Framework review the Trust will formalise the role of PCOG	31st May 2016		1) Lack of ED engagement in PCOG 2) Failure to clarify individual and collective roles within PCOG	1) Performance and contract information is not able to be triangulated through the governance structure leading to increased risk of reduced quality, financial inefficiency or reduced operational performance.	None Required	Director of Operations	Audit Committee	29th June 2016		1) PCOG TOR reviewed and approved 2) ED attendance reviewed and formally recorded	1) Well led External review provides positive assurance on the effectiveness of Committees	
							2) Increasing ED attendance at PCOG	31st May 2016					Director of Operations	Audit Committee					
							3) Improving the quality of minutes and action trackers and the timeliness of papers to this forum.	31st May 2016					Director of Operations	Audit Committee					
							4) Clarifying the role of PCOG in light of the move to neighbourhoods and campuses	31st July 2016					Director of Operations	Audit Committee					
CG10	Further improve the function of the ELT by improving the timeliness of papers and quality of debate.				R2		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	31st March 2016		1) Failure of ELT to take on board change	1)Pace of change and delivery of required outcomes reduced. 2) An effectiveness of executive team leads to increased organisational risk	None Required	Acting Chief Executive	Board of Directors	30th April 2016		1) Weekly ELT agenda and minutes reflects key priorities and appropriately escalated items	1) Well led External review provides positive assurance on the effectiveness of ELT	
CG11	The Board needs to address the quality of debate and dialogue, focussing on increasing contributions across all BMs, displaying greater leadership and vision, ensuring an appropriate balance between strategic and operational debate, and pushing for increased momentum around key issues.				R3		1) Ensure a Board development programme which is linked the Trust Strategy	31st March 2016		1) Failure of Board Members to engage with this change	1)The Board is not able to deliver the Organisational strategy 2)The Board breaches its regulatory requirements 3)The Board does not recognise and respond to increasing governance or clinical risks that are emerging	None Required	Director of Corporate Affairs	Board of Directors	31st March 2017		1) Board Development programme approved by Board 2) 360 Appraisals of all Board Members Completed 3) Skill Mix review of the Board completed and reported to Board	1) Well led External review provides positive assurance on the effectiveness of the Board	
							2) Ensure all Board Members have completed 360 appraisals which a focus on development	31st March 2017					Director of Workforce, OD and Culture	Rem Com					
							3) Ensure that there is the appropriate balance of strategic and operational items on the Board Agenda	30th September 2016					Director of Corporate Affairs	Board of Directors					
CG12	Reintroduce short summary reports from committee chairs to the Board to supplement minutes. These should identify key risks, successes and decisions made / escalated from the meeting.				R17		1) Reintroduce short summary reports from committee chairs to the Board which identify key risks, successes and decisions made / escalated from the meeting.	30th April 2016		1) None identified at this time	1)There is a danger that key escalations from committees to board are missed resulting in increased clinical or organisational risk	None Required	Director of Corporate Affairs	Audit Committee	31st May 2016		1) Summary reports are issued to Board 2) Clear articulation in the Board minutes of items escalated to Board from Committees 3) Minutes of Board Committees	1) Well led External review provides positive assurance on the effectiveness of the Committees	

	Issue Raised/ Action	well led s elf ass essment	Reference to A Y Governance	HR investigati on	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
CG13	The Board should re-establish the Board Assurance Framework as one for all risks including risks which it is involved in and when that risk has an element of confidentiality how it is handled. It should write and implement a plan for BoD development which includes these objectives.	WL Q7	C1, C2 Gov7				Develop and Agree BAF 16/17	31st March 2016		1) None identified at this time	1) Board is not sufficiently aware of confidential risks	None Required	Director of Corporate Affairs	Audit Committee	31st March 2016		1) 16/17 BAF approved by Board 2) Each Board committee undertaking deep dives of BAF risks 3) Board Development Session on the BAF completed	1) Well led External review provides positive assurance on the effectiveness of the Board Assurance Framework	
							Schedule BAF Deep dive reviews for Board Committees	31st March 2016					Director of Corporate Affairs						
CORE 5- COUNCIL OF GOVERNORS																			
CG1	The relationship between the BoD and the CoG is poor. Both parties should adopt a conciliatory approach rather than continuing with the antagonism which inflicts the current relationship.	WL Q3 WL Q4	Gov 4, Gov 5, Gov 6,			CQC 4- Should	1) The Board and Council of governors will co-write a policy on how the Board and council of governors will work in partnership	30th June 2016		1) The ongoing negative press and detail of the investigations may result in further distrust between the Board and Council of Governors	1) Failure to rebuild trust and confidence between the Board of Directors and CoG will impact on delivery of the Trust Strategy 2) Failure to progress the development of a positive and constructive relationship	None Required	Director of Corporate Affairs	Board of Directors & Council of Governors	Board and CoG meeting date	A number of actions have been completed ahead of schedule. The Council of Governors have approved the new meeting structures which include a more robust and effective Nomination and Remuneration Committee. In addition the Council of Governors have approved the lead Governor job description. Work continues on elections and the Chairman has written to stakeholder organisations asking them to nominate a representative	1) Partnership Policy approved by both CoG and Board of Directors 2) Code of Conduct approved by CoG 3) All Governors sign up to Code of Conduct 4) Council of Governors approval of Lead Governors Job Description 7) Council of Governors to agree, Council of Governors Governance Framework 8) Council of Governors to agree revised Constitution	1) Well led External review provides evidence of effective working relationships	
							2) The Trust will expand the role of lead governor to ensure greater collaborative working with the Chairman and SID	29th January 2016	Completed				Director of Corporate Affairs	Board of Directors & Council of Governors					
							3) Development and implement a process for the assessment of the effectiveness of Council of Governors	30th September 2016					Director of Corporate Affairs	Board of Directors & Council of Governors					
							4) Council of Governors to review and embed a new governance structure which will focus on more joined up working between CoG and the BoD	29th January 2016	Completed				Director of Corporate Affairs	Board of Directors & Council of Governors					
							5) Implement a Code of Conduct for all Governors	30th June 2016					Director of Corporate Affairs	Board of Directors & Council of Governors					
CG2	**Deloitte 12** - Formal training should be required for all current members of the CoG and to future members as they join. This training should include the role of the Governors, the context of organisational governance and the personal conduct expected of Governors. **CQC 3** - The trust should ensure that all board members and the council of governors undertake a robust development plan		Gov 4, Gov 5, Gov 6,		R12	CQC 3- Should	1) Develop a new induction programme for the Council of Governors and roll out its delivery	31st May 2016		1) Governors will not hold NED's to account in an effective way 2) Governors may not be able allocate sufficient time to undertake induction and external training	1) Failure to rebuild trust and confidence between the Board of Directors and CoG will impact on delivery of the Trust Strategy 2) Failure to progress the development of a positive and constructive relationship 3) Failure to provide Governors with the necessary skills and knowledge for them to effectively discharge there duties	Requirement for external governance training	Director of Corporate Affairs	Council of Governors	31st March 2017		1) CoG development plan in place 2) Governors attending development sessions with positive feedback 3) Governor Induction process in place with positive feedback	1) 100% of new Governors inducted 2) Evidence of Governors accessing rolling programme of training	
							2) Develop a CoG development plan for 2016/17 to include Governwell and other external training	30th April 2016					Director of Corporate Affairs	Council of Governors					
							3) Ensure that a schedule of the plans are made available to all Board members and members of the Council of governors and the plan is delivered	31st March 2017					Director of Corporate Affairs	Council of Governors					
CG3	Prioritise the recruitment to the Council of Governors, ensuring that the role of the governor and vacancies are publicised.				R12		1) Chairman will engage stakeholders to ensure representation on the Council of Governors	30th May 2016		1) Incomplete CoG impacting on its effectiveness	1) Carrying vacancies will add additional pressure to existing Governors, who may resign due to capacity	Electoral reform services will manage the Governor Elections	Director of Corporate Affairs	Council of Governors	27th June 2016		1) Contested Governor Elections	1) Minimal vacant Council of Governors seats 2) Vacant stakeholder governor seats filled	
							2) Hold Governor elections	30th May 2016					Director of Corporate Affairs	Council of Governors	27th June 2016				
	CORE 6- ROLE AND RESPONSIBILITIES OF BOARD MEMBERS																		
RR1	Implement proposals to improve succession planning at Board level, including ensuring that Governors are adequately engaged in this process. Alongside this, develop processes for succession planning for Senior Leader positions				R4		1) Develop and approve Board level, key divisional and corporate leaders succession plan	30th September 2016		1)Inability to identify key components of the succession plan 2) Due to sickness and vacancies may not adequately succession plan	1) Trust performance could deteriorate due to capacity and single points of failure 2) Risk to Business continuity	None Required	Director of Workforce, OD and Culture	Rem Com	31st March 2017		1) Evidence of a succession plan that includes nominating successors at contingency, immediate and planned levels, from ED level to head of service	1) Evidence of succession plan being enacted when the need arises	
							2) Implement and embed succession plan	31st March 2017					Director of Workforce, OD and Culture	Rem Com					
RR2	**Deloitte 5** - Agree a programme of Board development work which includes a mix of internal and externally facilitated sessions, is clearly aligned to the combined governance action plan. the Board development plan should consider: •more detailed consideration of the governance action plan; •a focus on Board challenge, including assurance, reassurance and the role of the corporate director; •facilitated 360 feedback; •Board cohesion and dynamics; •use of external speakers to add insight and prompt debate; •joint sessions governors ; and •engagement from senior Trust leaders. **CQC 3** - The trust should ensure that all board members and the council of governors undertake a robust development plan (Link to CG2)	WL Q2 WL Q3 HR Q11	G1, G2a		R5	CQC 3- Should	1) Develop a Board Development plan for 2016/17	31st March 2016		1) Conflicting Priorities 2) Availability of external presenters 3) Perception of Value of the delivery of the Board Development Plan	1) Failure to develop as a Unitary Board which will impact on delivery of strategy 2) Failure to effectively challenge will impact on Board accountability and decision making 3) Non Achievement of development objectives	External resource will be required to facilitate Board Effectiveness sessions	Director of Corporate Affairs	Board of Directors	31st March 2017		1) Evidence of delivery of Board Development plan 3) Full attendance of all Board Members 4) No cancelled Board Development Session	1) Well led External review provides evidence of effective board challenge	
							2) Implement Board Development programme which will include Board effectiveness sessions to address team dynamics and agreed ways of working including •clarity of purpose and vision; •effective challenge and leadership; and •individual coaching.	31st March 2017					Director of Corporate Affairs	Board of Directors					
	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.						1) Develop a 360 feedback process for BM's with forms and expectations on what and how to feedback	30th June 2016		1) Failure to provide clarity over Director portfolios 2) Failure to identify development needs of Directors which may	1) Capacity staff do not have the capacity to complete multiple 360 feedback forms 2) Capacity of Managers to		Director of Workforce, OD and Culture	Rem Com			1) Evidence of 360 feedback taking place 2) Evidence of 360 feedback influencing BM objectives and	1) Improvement in Board Effectiveness 2) Development plan for each BM be more tailored	

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RR3	**CQC 8** - The trust should introduce and effectively monitor 360 degree feedback all senior managers and directors.				**R6**	**CQC 8- Should**	2) Implement 360 degree feedback for all BM's	30th September 2016		impact on individual and collective performance	effectively analyse the feedback required	Support required from external organisations	Director of Workforce, OD and Culture	Rem Com	31st March 2017		development		
							3) Integrate 360 feedback into BM's appraisal objectives and personal development goals	31st March 2017					Director of Workforce, OD and Culture	Rem Com					
							4) Implement 360 degree feedback for all senior managers	31st March 2017					Director of Workforce, OD and Culture	Rem Com					
							5) Integrate 360 feedback into senior manager appraisal objectives and personal development goals	30th September 2017					Director of Workforce, OD and Culture	Rem Com					
RR4	Implement a programme of Executive Team development which focuses on team dynamics, effective challenge and leadership and is supported by individual coaching where necessary.				**R1**		1) Develop and agree Executive Team development programme which will include; team dynamics and agreed ways of working; •clarity of purpose and vision; •effective challenge and leadership; and •individual coaching.	31st May 2016		1) Conflicting Priorities and capacity within the Executive team may impact on the availability of Directors to attend Exec Development Sessions 2) Availability of external presenters 3) Perception of Value of the delivery of the ELT Development Plan	1) Failure to work cohesively as a team which will impact on performance	Support required from external organisations	Acting Chief Executive	Rem Com	31st March 2017		1) Evidence of Executive Coaching 2) Evidence of positive feedback through 360	1) Positive assurance received from external consultancy on the improvement of Exec Effectiveness 2) Tailored development plan for each Director	
							2) Implement development programme and monitor effectiveness through 360 feedback	31st March 2017					Acting Chief Executive	Rem Com					
RR5	The trust should ensure that training passports for directors reflect development required for their corporate roles.				**R5**	CQC 7- Should	1) Training requirement for all ED's and NEDS are agreed by CEO and Chair, with passports updated accordingly	30th June 2016		1) Failure to ensure Directors have the required knowledge and skills to undertake their roles	1) Failure to continually develop will impact on Board performance 2) BMs ability to challenge may be impacted without the appropriate training and knowledge	Resource may be required for individual development	Acting Chief Executive	Rem Com	26th October 2016		1) All Directors 100% Compliance with their training requirements	2) As assured by positive well led external review that the Board are competent and effective	
							2) Developmental training requirements are discussed and agreed with Board members in their Appraisals	31st May 2016					Acting Chief Executive	Rem Com					
							3) Provide BM and NED training update reports to Rem Com to demonstrate completion in line with mandatory and CPD requirements	30th September 2016					Acting Chief Executive	Rem Com					
CORE 7- HR AND OD																			
WOD1	**DR34**- Define and agree a process to regularly monitor the consistent application of HR policies and procedures for the full range of Employee Relations cases. **CQC 1** - The trust must ensure HR policies and procedures are followed and monitored for all staff	HR Q11			R34	CQC 1- Must	1) To undertake a review of HR policies and procedures to ensure all are in date and are compliant with expected HR practice	30th September 2016		1) Failure to identify capacity to review HR policies 2) Failure of JNCC to approve policies in a timely manner 3) Failure to have robust HR leadership to support this work	1) If HR policies are not followed this will continue negative impact on Governance systems of assurance 2) There will be further Employment Relationship issues if managers fail to follow policies 3) Ongoing issues with the HR department may impact on staff morale 4) negative impact of the ET and enforcement action may impact on recruitment and retention	Additional senior HR capacity is required to lead on this work. HR Resource plan to identify this is needed	Director of Workforce, OD and Culture	People and Culture Committee	January 17 committee		1) HR Policies signed off through JNCC 2) Suite of training agreed and tracking of compliance and impact evident 3) Positive Internal audit assurance	1) Improvement in the following areas of the staff survey 1.1) KF 14 Staff satisfaction with resourcing and support 1.2) KF 23 Percentage of staff experiencing physical violence from staff in last 12 months 1.3) KF 26 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months 1.4) KF 27 Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse	
							2) Develop an internal compliance monitoring process for HR policies and procedures including case management and tracking. This will be monitored by Trust Board and integrated into its performance reporting	31st July 2016					Director of Workforce, OD and Culture	People and Culture Committee					
							3) A training programme on HR policies and process is designed, available and accessible	31st December 2016					Director of Workforce, OD and Culture	People and Culture Committee					
							4) HR function to Audit compliance against two selected HR policies	30th June 2016					Director of Workforce, OD and Culture	People and Culture Committee					
							5) Internal Audit review of control process and assurance to demonstrate sustained improvement in compliance levels	quarter 4 16/17					Director of Corporate Affairs	Audit Committee					
WOD2	The trust should ensure that recruitment processes for all staff are transparent, open & adhere to relevant trust policies					CQC 9- Should	1) Review and ensure that Trust recruitment and acting up policies are fit for purpose	30th June 2016		1) Failure to identify capacity to review HR policies 2) Failure of JNCC to approve policies in a timely manner 3) Failure to have robust HR leadership to support this work	1) Inconsistency of recruitment process leading to challenge and litigation. 2) Failure to recruit competent and capable staff	Additional senior HR capacity is required to lead on this work. HR Resource plan to identify this is needed	Director of Workforce, OD and Culture	People and Culture Committee	31st July 2016		1) Approved Recruitment Policy 2) No Policy breaches	1) Positive audit Assurance on recruitment processes 2) Improvement in the following areas of the staff survey 2.1) KF 15 Percentage of staff satisfied with the opportunities for flexible working patterns 2.2) KF 21 Percentage of staff believing the organisation provides equal opportunities for career progression or promotion 3) positive outcome from external assurance visits	
							2) Agree a plan and deliver recruitment training to all appointing officers	31st March 2017					Director of Workforce, OD and Culture	People and Culture Committee					
							3) Deliver a peer audit of recruitment policies compliance to demonstrate improvement	31st December 2016					Director of Workforce, OD and Culture	People and Culture Committee					

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WOD3	Address the relationship issues identified within the function, and alongside this agree a development programme for HR and its related functions that starts by building relationships at a senior level before seeking to develop an effective and efficient function.				R29		1) Develop and implement a HR and related function Development programme, which includes building good working relationships	31st May 2016		1) Staff groups choose not to engage in the development process 2) Inconsistency of policy application leading to Employment Relation issues	1) Inability to deliver an effective HR service into the organisation presenting significant organisational risk	External resource and support required	Director of Workforce, OD and Culture	People and Culture Committee	31st March 2017		1) Evidence of backlog of cases being addressed 2) Evidence of positive assurance from Internal Audit 3) Evidence of use of case tracking system	1) Effective operational HR team 2) Compliance Management training	
							2) Implement Development Programme	31st May 2016					Director of Workforce, OD and Culture	People and Culture Committee					
WOD4	As part of its review programme, the Trust may wish to consider a mandatory programme for line managers in order to embed the revised policies and procedures.				R31		1) A training programme on HR policies and process is designed, available and accessible	31st December 2016		1) Capacity of managers to be released in order to attend training	1) Inconsistency of recruitment process leading to challenge and litigation. 2) Failure to recruit competent and capable staff	Additional capacity to develop core management training is required	Director of Workforce, OD and Culture	People and Culture Committee	31st January 2017		1) 90% of Managers trained before 31st December	1) There is a rolling pro active mandatory training programme which is regular reviewed by the people Committee	
WOD5	Consider a range of development interventions for the operational HR team to ensure employment law risks are mitigated.				R32		1) As part of the wider HR development programme (WOD 3) deliver specific interventions on employment law	31st September 2016		1) Inability to deliver team development programme	1) Failure to have the required knowledge and skills in the HR team	Specialist HR Employment law specialist request	Director of Workforce, OD and Culture	People and Culture Committee	19th October 2016		1) Evidence of CPD within HR team 2) Reduction in investigation timeframes	1) Evidence of use of enhanced training with HR team	
WOD6	Consider mechanisms to regularly seek feedback from the HR function on the extent to which the candour, openness, honesty, transparency and challenge to poor performance are the norm, e.g. through monthly pulse checks				R33		1) Introduce a monthly pulse check for the HR team	31st May 2016		1) Failure to improve culture and behaviours 2) Members of the function will not accept joint team meetings	1) Failure to deliver an effective HR function 2) Failure to provide HR support to managers across the organisation may result in further employee relations issues	None required	Director of Workforce, OD and Culture	People and Culture Committee	17th July 2017		1) Evidence of positive feedback and improvement	1) Effective operational HR team	
							2) Integrated Team meeting implement	31st June 2016					Director of Workforce, OD and Culture	People and Culture Committee					
WOD7	The trust should monitor the adherence to the grievance, disciplinary, whistle-blowing policies and the current backlog of cases concluded.					CQC 6- Should	1) Implement a proactive system which monitors adherence to the grievance, disciplinary, whistle-blowing policies, including a robust case tracking system.	30th May 2016		1) Failure to review the policies will result in further backlog of cases 2) Failure to deliver Speak up action plan at the required pace will lead to staff unable to raise issues 3) Lack of visibility of senior HR leaders	1) Failure to deliver effective HR process could lead to reduced staff morale	Resource Plan	Director of Workforce, OD and Culture	People and Culture Committee	19th October 2016		1) Evidence of backlog of cases being addressed 2) Evidence of positive assurance from Internal Audit 3) Evidence of use of case tracking system	1) Effective operational HR team 2) Compliance Management training	
							2) Internal audit compliance against named policies and the defined timescales against cases identified on the tracker.	30th September 2016					Director of Workforce, OD and Culture	Audit Committee					
							3) Ensure the backlog of cases made known to the CQC at the time of the inspection are concluded.	30th June 2016					Director of Workforce, OD and Culture	People and Culture Committee					
WOD8	The trust should continue to make improvements in staff engagement and communication					CQC 11- Should	1) Develop a clear staff engagement plan that takes account of listen, learn and lead, wider open staff forums and enhances existing good practice	30th June 2016		1) lack of clarity around the ownership of engagement actions	1. Failure to articulate expected values and behaviours 2. Failure to engage staff which will have a negative impact productivity and patient care 3. Failure of the Board and Senior Managers to be visible 4. Failure of JCNCC to approve policies 5. Failure to articulate outcome measures for the delivery of the engagement plan	1) Resource may be required for Pulse Check	Director of Workforce, OD and Culture	Board of Directors	31st March 2017		1) Evidence of published engagement plan 2) Evidence of improved engagement via pulse check	1) Improvement in the following areas of the staff survey 1.1) KF 4 Staff motivation at work 1.2) KF 5 Recognition and value of staff by managers and the organisation 1.3) KF 8 Staff satisfaction with level of responsibility and involvement 1.4) KF 6 Percentage of staff reporting good communication between senior management and staff	
							2) Publish and implement agreed engagement plan	31st December 2016					Director of Workforce, OD and Culture	People and Culture Committee					
							3) Monitor delivery of the plan at P&C Committee using feedback mechanisms such as pulse checks and staff survey.	31st March 2017					Director of Workforce, OD and Culture	People and Culture Committee					
	CORE 8- WHISTLEBLOWING																		
W1	As part of the Trusts Well Led Self assessment we identified the need to take further action around the recommendations from the Francis report relating to whistleblowing in order that staff, patients and stakeholders feel confident to raise concerns	WL 3 WL 2					1) Freedom to speak up action plan will be refreshed and approved	31st March 2016		1) Capacity within teams and their ability to cope with competing priorities	1) Action plan will not deliver culture change required		Director of Workforce, OD, and Culture	People and Culture Committee	31st March 2017		1) Refreshed Whistleblowing policy and process approved by Board 2) Freedom to Speak up action plan delivered 3) Comms plan associated with Whistleblowing approved by the People and Culture	Positive feedback from Staff Survey and pulse check	
							2)Freedom to Speak up action plan will be delivered and monitored through the People and Culture Committee	31st March 2017					Director of Workforce, OD, and Culture	People and Culture Committee					
	CORE 9- FIT AND PROPER PERSON TEST																		
	The trust must ensure that a fit and proper person review is undertaken for all directors in light of the findings of the employment tribunal.						1) Develop fit and proper persons policy and have it ratified by Board of Directors	24th February 2016	Completed	1) Delays in receiving clear DBS checks	1) Failure to fulfil a statutory requirement 2) Failure of the Fit and Proper person process may result in Directors not undergoing to necessary checks		Director of Corporate Affairs	Board of Directors		Fit and Proper Persons Policy approved by Board	1) Evidence of full compliance with fit and proper persons requirement as identified by Monitor licence conditions, CQC registration requirements and Trust constitution	1) Board Assurance via the Chair	
							2) Ensure that HR maintain the Fit and Proper Persons tracker	30th April 2016					Director of Workforce, OD and Culture	Board of Directors					

	Issue Raised/ Action	well led s eff as sessment	Reference to AY Governance	HR Investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
FF1						CQC 2 must	3) Develop and implement a proactive process for monitoring the filing system for all Directors to ensure consistency and ease of access to evidence detailed in policy	30th April 2016				None required	Director of Corporate Affairs	People and Culture Committee	29th June 2016				
							4) Ensure that all current Directors comply with all aspects of the policy and that evidence is available in revised file structures	30th May 2016					Director of Corporate Affairs	Board of Directors					
							5) The Trust will ensure that a process in place to review the fit and proper requirement on an annual basis	31st March 2016					Director of Corporate Affairs	Board of Directors					
							6) Formal confirmation to Board by Chair of full compliance with fit and proper persons requirements	30th April 2016					Chairman	Board of Directors					
CORE 10- CQC																			
CQC1	The trust should ensure that the outcome of this focussed inspection impacts directly upon the organisational strategy					CQC 5- Should	1) The CQC targeted report is used as a key guide in Trust strategy development days	30th June 2016		No significant risks identified	1) Failure to develop a new Strategy which supports cultural change	None Required	Director of Business Development	Board of Directors	30th June 2016		1) There is a clear reference made to the outcome of the focused within the Trust strategy	1) The Trust Strategy addresses the findings of the CQC report	
CQC2	The trust should continue to proactively recruit staff to fill operational vacancies.					CQC 10- Should	1) Develop and agree a proactive operational recruitment plan, including in reach to the local University and wider health community	30th April 2016		1) Lack of capacity and capability in the HR team in order to support operational Staff 2) there is a risk that recruiting managers do not follow policies 3) Inadequate supply of experienced staff 4) Poor retention levels of staff 5) Regulatory action has a negative impact on recruitment and retention	1) Failure to recruit could impact on patient safety 2) Staff confidence in the Board will not improve 3) Sustainability of workforce	None Required	Director of Operations	People and Culture	January 2017 (People Committee)		1) Reduction in the number of operational vacancies as per the operational recruitment plan	1) Reducing the number of operational vacancies	
							2) Implement the recruitment plan and monitor effectiveness against an agreed vacancy rate trajectory	31st December 2016					Director of Operations	People and Culture					
							3) Develop and implement an internal communications plan which supports pro-active recruitment	31st May 2016					Director of Operations	People and Culture					
	CORE 11- MONITOR ENFORCEMENT UNDERTAKINGS																		
M1	The Trust will deliver a Governance Improvement Action Plan (GIAP) to address the findings and recommendations from the Employment Tribunal Investigation, Deloitte report, and the CQC focused inspection DR13; Further iterations of the governance action plan should include a greater depth of detail, including summary of progress and clearer insight into priority actions required. the action plan should include: •priority ratings for each action; •key tasks required for each recommendation / action area; •associated risks with non-implementation; •outline of any key resources required; •completion of KPIs and success measures; •comments on progress comments; and •links to demonstrable outcomes		X		**R13**	X	1) Governance Improvement Action plan approved by Board of Directors	30th March 2016		1) Failure to create sufficient capacity within the key group of officers responsible for delivering the Plan 2) do not adhere to the roles and responsibilities set out in the governance arrangements of the improvement plan 3)The roles and responsibilities relating to programme governance are not understood 4) Executive Team focus on what is urgent rather than what is important, inability to prioritise	1) Risk of further enforcement action 2) Risk to the viability of the organisation 3) Risk of reputational damage	Programme Manager to be appointed PMO admin support appointed responsible Director identified	Responsible Director	Board of Directors	31st March 2017		1) Governance Improvement Action Plan in line with recommendations agreed by Board 2) Governance Improvement Action Plan assured by an external auditor 3) Monitor approval of the action plan	1) Enforcement notice removed	
							2) GIAP and Governance and Delivery Framework sent to Monitor	18th March 2016					Responsible Director	Board of Directors					
							3) Governance and Delivery Framework developed and approved	30th March 2016					Responsible Director	Board of Directors					
							4) Governance Action plan delivered	31st March 2017					Responsible Director	Board of Directors					
M2	The Governance Improvement Action Plan will be updated to reflect material matters arising from the HR investigation			X			1) The HR Investigation report relating to the overall HR function will be reviewed for lessons learnt and incorporated into the Action Plan	18th March 2016		1) None identified at this time	1) The Trust will not learn lessons from past experience	None Required	Director of Corporate Affairs	Board of Directors	31st March 2016		1) Governance Improvement Action Plan agreed by Board 2) Governance Improvement Action Plan assured by an external auditor 3) Monitor approval of the action plan 4) Governance Action plan delivered	1) Enforcement notice removed	
							2) Action Plan approved by Board of Directors	30th March 2016					Director of Corporate Affairs	Board of Directors					

	Issue Raised/ Action	well led self assessment	Reference to A Y Governance	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
M3	The Trust will undertake to gain external assurance that the Governance improvement action plan has been implemented in full or that it can be implemented in full						1) The Trust will gain external assurance that the Governance improvement action plan has been implemented	31st March 2017		1) Failure to gain external assurance in a timely manner	1) Failure to deliver enforcement undertakings 2) Failure to provide assurance to regulators may result Further Regulatory action	External Assurance from professional service consultancy e.g. Deloitte resource will be required	Acting Chief Executive	Board of Directors	31st March 2017		1) External assurance process undertaken in a timely manner	1) External positive assurance report	
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	30th March 2016		1) Failure to allocate sufficient resources (financial IT etc.) to support the delivery of the Plan 2) Staff are not effectively engaged in the Improvement Plan and progress is not communicated clearly	1) Failure to deliver enforcement undertakings 2) Failure to provide assurance to regulators may result Further Regulatory action	A programme Management resource is required	Responsible Director	Board of Directors	31st March 2016	A programme manager job description has been developed and will be approved by ELT	1) Programme manager appointed 2) Governance and Delivery Framework approved	1) Evidence of the Governance delivery framework delivered and adhered to	
							2) A programme manager will be appointed to support Responsible Director to hold Directors to account for the delivery of the programme	30th March 2016					Responsible Director	Board of Directors					
M5	The Trust will provide regular reports to Monitor						1) The Trust will report on a monthly basis on the delivery of the action plan	31st March 2017		1) Failure to allocate sufficient resources	1) Failure to deliver enforcement undertakings	None Required	Acting Chief Executive	Board of Directors	31st March 2017		1) Positive Formal correspondence with monitor on the delivery of the plan 2) Positive and credible relationship with Monitor	1) Enforcement notice removed	
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	18th March 2016		1) None identified at this time	1) Risk to Board performance and effectiveness	None Required	Acting Chief Executive	Board of Directors	18th March 2016		1) Agreed recruitment timetable	1) All interim/acting roles appointed to	

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 30 March 2016

Strategy Development Update

Purpose of Report

The purpose of this report is to update Trust Board on progress in developing the new Trust Strategy for the next three years.

Executive Summary

The Board of Directors has committed to developing a new Trust Strategy.

This report provides the Board of Directors with a brief update on progress to date, through the prioritise element of the Monitor toolkit.

It also provides an update on stakeholder engagement and next steps.

Board members should be assured that the agreed timeline for strategy development continues to be met, however, the timeframe for delivery remains challenging.

Strategic considerations

Numerous considerations are set out within the main body of the report for further discussion by Board members.

Assurances

The Board Assurance Framework for 2016/17 will be formulated from the Trust's strategy when it has been developed and approved.

Consultation

This report has not been considered at any other meeting.

Governance or Legal issues

There are no governance or legal issues.

Equality Delivery System

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

Recommendations

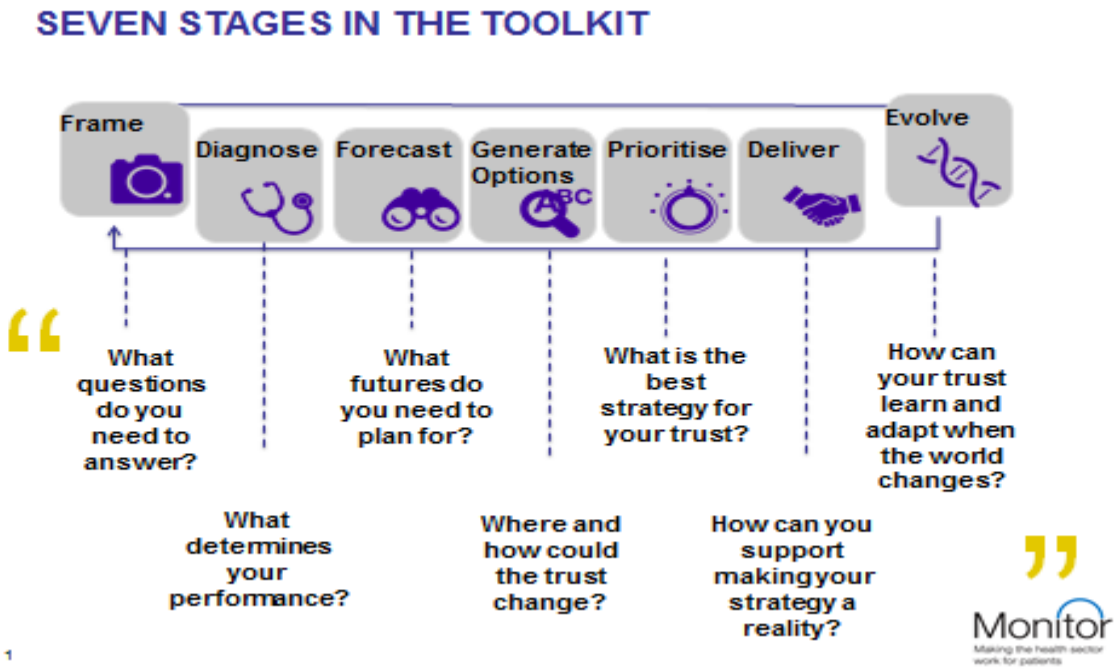
The Board of Directors is requested to discuss and note the content of this update report.

Report prepared by: **Anna Shaw, Deputy Director of Communications and Involvement**
Jenny Moss, Head of Contracting and Commissioning

Report presented by: **Ifti Majid, Acting CEO**

1. Background

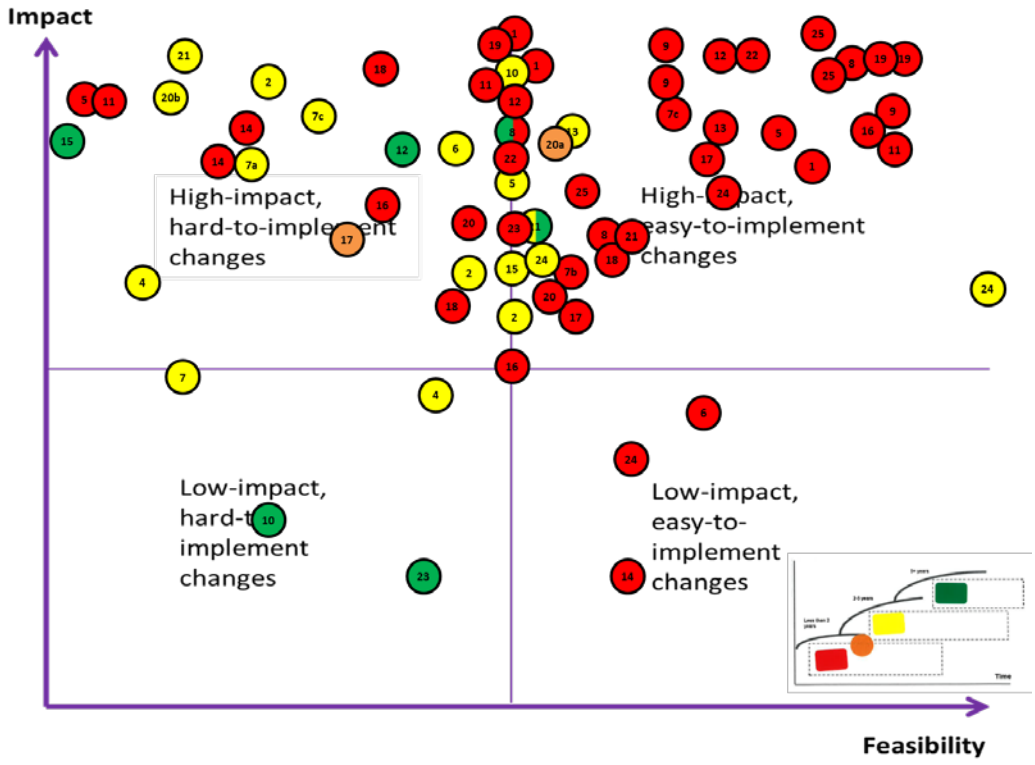
The Board of Directors has committed to developing a new Trust Strategy. This report provides the Board with an update on the progress made since the last report in January 2016, along with further clarity on the proposed next steps. The strategy is continuing to be developed in line with Monitor's strategy toolkit, as outlined below. This paper focuses on the latter three stages in the toolkit; detail on the initial stages of the toolkit is outlined in the January 2016 Board paper.



2. Prioritise: Spotlight on our leaders

The long-list of options generated by the last leadership event in January were grouped into 25 strategic themes by the strategy group, in order to create a short list of strategic priorities. Each strategic priority was worked up into a strategic initiative template from the Monitor toolkit to provide more information on impact, feasibility, evidence base, cost and timeframe for delivery.

A leadership event, focused on strategy development took place on 8th March 2016 and was attended by 20 leaders. The session, which focused on the prioritisation stage of the toolkit, asked people to place the strategic themes from the short list of options on an impact versus feasibility chart, and to indicate which of the three horizons leaders felt that the option should be placed for delivery. The feedback from all three groups on the day was then aggregated into a single document, and cross referenced with the strategic initiatives template. The general feedback is that most schemes fall in the 'harder to achieve' category, with varying degrees of impact. The workshops also placed the majority of schemes in the first horizon for delivery (within two years).



The leadership event also had an open discussion for the groups to review the Trust values and gain greater insight into how relevant staff feel the values still are. Common themes from the discussions are that:

- The values should be all encompassing, and not distinguish between staff and patients
- They should be simple
- They should build on existing value sets within the NHS or professional groups

There had been a strong feeling at the leadership event in January that the values should come from staff, and that staff felt they already had and identified with the values that had been introduced. The event in March was split between those staff who felt that the values, vision and associated material needed wholly rewriting, and those staff who felt that a more powerful message was to retain the values we currently have in place (and hold individuals/the organisation to account to live them).

The leaders in attendance at the event agreed to have an ongoing involvement in the development of the strategy.

3. Policy developments

Since the Board met in January, a number of key documents have been published nationally, which bear impact on the development of the Trust's strategy; namely the Five Year Forward View for Mental Health, which includes 58 recommendations for providers to implement.

The paper outlines that mental health needs should be treated with equal importance as physical health needs and that leaders must take steps to break down barriers to reshape how care is provided, in order to increase access, reduce variations in quality and improve outcomes. Its priorities include creating a seven day NHS with crisis response, integrating physical and mental health approaches, promoting good mental health and preventing poor mental health. These priorities are issues that have been raised during the engagement process of developing the strategy to date, and will need to be embedded in our plans going forward.

4. Stakeholder engagement

We have continued to engage with stakeholders on the development of the new strategy, in order to ensure wide input and ownership of the plan.

Notably in this period, discussions have taken place at the 4Es stakeholder alliance in February and in March the Trust held its first joint Board of Directors/Council of Governors meeting, where the emerging Trust strategy was a key agenda item.

4Es

The group discussed the national policy changes and its impact on the Foundation Trust model, through a move from competition to collaboration, such as the approach being undertaken through the 21c and Joined Up Care models in North and South Derbyshire. Attendees also provided useful feedback on the set of strategic questions that have been developed to date, the importance of language, and how the strategy can act to review the organisational culture and values.

Joint Board of Directors/Council of Governors

Mark Powell shared progress and wider feedback and provided an update on the Five Year Forward View for Mental Health and Implementing the Forward View. Mark informed governors that a composite draft strategy will be submitted to the April Board meeting and will be jointly approved by the Board and Council of Governors.

5. Next steps

The update reflects progress to date and the further steps we have taken through the prioritise stage of the toolkit.

Board members should be assured that the agreed timeline for strategy development continues to be met, with a draft Strategy document being scheduled for the April Board meeting.

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE QUALITY COMMITTEE

Held in Meeting Room 1, Albany House, Kingsway, Derby DE22 3LZ

Thursday, 11 February 2016

PRESENT:	Maura Teager	Chair and Non-Executive Director
	Tony Smith	Non-Executive Director
	Phil Harris	Non-Executive Director
	Carolyn Green	Director of Nursing and Patient Experience
	Dr John Sykes	Executive Medical Director
	Carolyn Gilby	Acting Director of Operations
	Clare Grainger	Head of Quality & Performance
	Emma Flanders	Lead Professional for Patient Safety
	Sarah Butt	Assistant Director of Clinical Practice and Nursing
	Deepak Sirur	Consultant Psychiatrist in Substance Misuse
	Rachel Kempster	Risk & Assurance Manager
	Sangeeta Bassi	Chief Pharmacist
	Richard Morrow	Head of Nursing
	Rubina Reza	Research & Clinical Audit Manager
IN ATTENDANCE:	Sue Turner	Board Secretary and Minute Taker
APOLOGIES:	Claire Wright	Executive Director of Finance
	Jenna Davies	Interim Director of Corporate & Legal Affairs
	Jayne Storey	Director of Transformation
	Petrina Brown	Consultant Clinical Psychologist
	Wendy Brown	Clinical Director
	Pam Dawson	Carer Forum
	Bev Green	Releasing Time to Care Lead (Service Improvement)
	Catherine Ingram	Chief Executive, Derbyshire Voice

QC/2016/020	**WELCOME AND APOLOGIES** The chair, Maura Teager, opened the meeting and welcomed everyone.
QC/2016/021	**MINUTES OF THE MEETING DATED 14 JANUARY 2016** The minutes of the meeting, dated 14 January 2016 were accepted and agreed.
QC/2016/022	**ACTIONS MATRIX** The committee agreed to close all completed actions. Updates were provided by members of the committee and were noted directly on the actions matrix.
QC/2016/023	**SERIOUS INCIDENT REPORT** Emma Flanders, Lead professional for Patient Safety, provided the Quality Committee with information relating to all Serious Incidents (SIs) occurring during January 2016. The committee noted there has been a decrease (by 4) in the number of incidents reported externally during January 2016 compared to December 2015. There has been a decrease the number of both catastrophic and major incidents occurring in January 2016. There are no specific patterns or issues arising within the analysis of

	the major/ catastrophic incidents reported in January 2016. There are currently 18 overdue actions from SIRI investigations A revised actions table was circulated at the meeting which showed the increase in overdue actions was down to 10 with information in excess of 3 months. The committee noted these actions only became overdue this week. Duty of Candour reporting to commissioners Section 7 showed here have been no breaches in discharging our statutory Duty of Candour at the end of December 2015. Emma Flanders was pleased to point out that the duty of candour lead had produced a podcast which was screened at a recent conference which was received positively. Carolyn Green asked John Sykes and Emma Flanders to carry out a review of how many inpatient deaths had occurred through suicide or other causes over the last three years and to analyse the cause of deaths and establish whether there are any campus patterns or clusters that give cause for concern as this would be an important part of the Trust's governance. Phil Harris recognised that progress was being made with overdue actions and asked what worked well to achieve this. Emma Flanders explained that having the time to chase people makes a difference, it is also important to devise an action that is realistic and sensible. Progress of actions was also discussed in operational meetings. The committee was disappointed that Emma Flanders found it was necessary to spend considerable time chasing overdue actions and this will be discussed and resolved at the SI Group meeting. Carolyn Green asked Emma Flanders to include an update on independent homicides in next month's report and for risk completion dates to also be included in future reports. Attention was drawn to the second recommendation contained in the outcome of catastrophic incident 2016/1174 and the need to acquire organisational learning from this incident that will guide clinicians on how to deal with the CTO (Community Treatment Order) recall when a bed cannot be identified. Carolyn Gilby pointed out that the Trust has a robust bed occupancy system in place. However, the committee requested that this incident be reviewed at the next meeting of the Mental Health Act Committee on 26 February. Themes from SI investigations were highlighted in the report and the committee requested that completion dates be included or a narrative be included to show a date for "conclusion to be agreed". John Sykes referred to the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) Scorecard. The Trust's Safety Scorecard was received in January but was then recalled due to an error in CPA figures. It was pointed out that the Trust's current rate is 5.8 which is under the national average and a full report will be given in next month's report to provide the evidence that our reporting is benchmarked above the national average. Further scrutiny will be undertaken on the Trust's sudden death rate to understand the Trust's current benchmark as well as data checks on our submissions. John Sykes and Emma Flanders are scrutinising this information and will ask for additional information from the National Inquiry Group. The committee agreed the report contained comprehensive information and provided an improved level of assurance on progress. **ACTION: John Sykes and Emma Flanders to carry out a review of inpatient deaths over the last 3 years to test patterns in campus or clusters in**

	north/south, including our sudden death rate. **ACTION: Update on independent homicides to be included in next month's report.** **ACTION: Serious incident 2016/1174 Hartington case CTO (Community Treatment Order) recall patient process to be reviewed at the February meeting of the Mental Health Act Committee.** **RESOLVED: The Quality Committee evaluated the report and accepted the level of assurance in the processes involved of emergent and current issues under a monitoring brief by the SIRI Group.**
QC/2016/024	**ESTATES STRATEGY AND PHYSICAL ENVIRONMENT UPDATE** This paper provided a high level update on the Trust's Estates Strategy and also covered physical patient environment issues. The committee noted the link between the transformational change programme and estate planning are both interlinked. The report contained detail regarding the CQC's recommendation for privacy and dignity and the need for gender sensitive wards and the committee recollected that this was the subject of a paper received by the committee in October 2015. Seclusion Rooms in the Kedleston Unit were discussed. It was pointed out that this was the subject of a capital allocation in 2016/17. Meetings have recently taken place to discuss the requirements for seclusion rooms in the Kedleston Unit and Carolyn Green and Kevin Fletcher will discuss the timescale, trajectory and planned building works outside of the meeting. Pressure on car parking was discussed. The committee recognised this was a difficult challenge to overcome and was flagged by the services on their risk register as a significant issue for staff. The Quality Committee noted that plans to extend the car park at the Radbourne Unit and near the Tissington Unit were in place. Car parking at St Andrew's House will also be improved by installing 25 new spaces but the pressures will not be fully resolved. The committee drew attention to the fact that car parking was listed as a risk to staff on the clinical risk register. It was agreed that Kevin Fletcher would inform the committee of actions that would be taken to prioritise car parking for clinical staff and how this risk would be mitigated. The committee welcomed the report and recognised that progress was being made and understood the impact the environment has on patient safety. **ACTION: Trajectory of when seclusion unit for Kedleston Unit will be fit for purpose to be progressed by Carolyn Green and Kevin Fletcher.** **ACTION: Kevin Fletcher to inform the committee with actions that would be taken to prioritise car parking for clinical staff.** **RESOLVED: The Quality Committee considered the Estates Strategy and Physical Environment Update Report and scrutinised the contents.**
QC/2016/025	**DEMENTIA STRATEGY** John Sykes' report explained that dementia is probably the biggest public health challenge facing the country. In order that individuals and families can receive the

	help that they need the Trust's strategy sets out the approach to achieve a timely diagnosis to enable specific therapeutic interventions to be put in place. The committee recognised that the more challenging aspects of delivering the strategy would be the concept of a rapid response team and bed availability and the dependence on other organisations to release patient care plans for the Trust to progress. A proposal is being put together for an assessment service for dementia patients but these are complex areas that are difficult to engage with commissioners. The committee also recognised that support to residential and nursing homes would be a way of reducing admissions into hospital services. A gap in service was identified for those people suffering from acquired brain injury and Maura Teager asked if there was anything to learn from centres of excellence e.g. Salford/Nottingham and this was thought to be a helpful suggestion by John Sykes. The committee agreed to endorse the Dementia Strategy and Maura Teager would commend the strategy to the Trust Board. She felt the committee had received an increased level of assurance from emerging evidence of patients being cared for closer to home. **ACTION: Annual report on the Dementia Strategy and the Dementia Board's Terms of Reference will be referred to this committee and this timeline will be agreed and will be reflected in the committee's forward plan.** **RESOLVED: The Quality Committee agreed to endorse the Dementia Strategy.**
QC/2016/026	**<u>POSITIVE AND SAFE STRATEGY UPDATE</u>** Sarah Butt's report provided the Quality Committee with a position statement of progress on the reducing restrictive interventions action plan, together with the action plan which was in response to the national drivers and The Mental Health Act (1983) Revised Code of Conduct (2015). At the point of writing the report was on track for actions due by the end of April. However, some issues had changed and Sarah Butt brought these to the attention of the committee • A blanket locked door policy which affects all service receivers in hospital or on a ward could, depending on its implementation amount to a restriction or a Deprivation of Liberty [Mental Health Act 1983 revised code section 8.10]. Sarah Butt pointed out that the Mental Health Act Committee will receive a report on the Kedleston Unit following a CQC standard visit which found this blanket rule. This is being addressed and is for review against the code of practice. • The conveyancing policy should have been ratified but this has been delayed due to implications on people cared for out of area and the need for an out of hours ambulance service. The committee considered these high level issues and was assured that the Mental Health Act Committee would also be reviewing the Mental Health Act specific aspects in relation to the code of practice on 26 February as well as the report on the Kedleston Unit. Additional assurance was required on care planning and clarification of training in line with the code of practice on Deprivation of Liberty, Safeguarding and the Mental Capacity Act by Tony Smith. Sarah Butt informed him that prioritised areas on restrictive practices within care planning will be contained in the Care Planning report that would be received by the committee in April. However, Tony Smith did not think the time scale of April could be achieved and asked that her report to the committee provides evidence that the care planning approach is having an

	impact and being achieved. The Guidelines for the use of medication in the management of violence and aggression was ratified at the Drugs and Therapeutics Group (the guidelines were recently amended around the use of olanzapine injection – highlighting its licence status in the UK, ensuring it is placed further down the list of alternative options (to NICE first line options)). Maura Teager asked what the impact was on the wards of patients being admitted having taken NPS substances (legal highs). Richard Morrow explained this had a significant impact on staff and patients and discussions were taking place with the police around how this problem can be resolved. The consequences of people taking these drugs created substantial challenges on the ward, not just on the patients being admitted having taken NPS substances but on staff and patients already admitted. The committee noted that this was an issue being brought to the attention of the Health and Wellbeing Board. It was agreed that Richard Morrow and Sarah Butt would invite the Director of Public Health to visit the service to discuss these issues and options for proactive interventions in this area . In addition to this, the committee asked Emma Flanders to provide data on the effects of NPS use on Serious Incidents (Sis) to inform this visit. The committee was pleased with the progress shown the report and recognised the significant challenges that staff and patients are facing and asked that an update report be brought back to the committee in June. **ACTION: Director of Public Health to be invited to visit the ward to discuss the impact on staff and other patients of patients being admitted having taken NPS substances.** **ACTION: Emma Flanders to provide data on effects of NPS use on Sis and share with Richard Morrow.** **ACTION: Update report on all actions as outlined to be received by the committee in June. This is to be reflected in the forward plan.** **RESOLVED: The Quality Committee considered the report and scrutinised the contents.**
QC/2016/027	**<u>RESEARCH AND DEVELOPMENT CENTRE STRATEGY UPDATE</u>** This report provided the Quality Committee with an update on the activity of the Trust's Research & Development (R&D) Centre. This report was due to be submitted to the Board but under the new governance action, this report is now under the remit of the Quality Committee and will feature in the committee's forward plan. The report highlighted the main areas of activity in research relating to National Research participation and local areas of focus in compassion, dementia and self-harm and suicide prevention. The report also included updates on the other aspects of the R&D centre, the Library and Knowledge Service and Clinical Audit. The report also demonstrated how the Trust's strategic outcomes are being delivered and links with other organisational services. John Sykes informed the committee he would like to develop the Trust's R&D in a way that can be related to service users and this will be addressed by him through the People & Culture Committee. Phil Harris acknowledged the good work that had taken place and asked if there were any commercial opportunities that could be exploited within R&D. In response, John Sykes informed him that this could be an area for development but would need to be

	to be carried out in line with the Trust's business development approach and a decision would have to be taken on which areas to focus on in line with the Trust's strategy. Carolyn Green was concerned about how the Trust could maintain this research focus which is important to the organisation's strategic direction and manage the difficult situation of disinvestment of front line services. Carolyn Green asked about opportunities in the research development plan and wondered whether sharing our R&D capability with other organisations that do not have a strong research profile had been explored. Rubina Reza informed her that she was holding discussions with a local organisation on ways of supporting them. Carolyn Green asked Rubina Reza on behalf of the Board to explore this possibility further in order to retain the long term assets of the R&D Centre. The committee agreed this was a potential opportunity and recommended that discussions be developed further with Mark Powell. Maura Teager felt the report showed strong clinical leadership which connected with the Trust's objectives and quality priorities and gave clarity to Research and Development. The committee was pleased to acknowledge the opportunities for commercial exploitation of the Trust's Research and Development Centre. **ACTION: John Sykes to develop the Trust's R&D in a way that can be related to service users and will address this through the People & Culture Committee** **ACTION: John Sykes and Rubina Reza to discuss with Mark Powell the potential of providing R&D support to a provider** **RESOLVED: The Quality Committee:** **1) Noted the content of the report.** **2) Received assurance from the activity reported that research and development is making a positive impact on delivery of the Trust's strategic outcomes and the areas of further development proposed in a shared research service.**
QC/2016/028	**<u>POLICY GOVERNANCE</u>** Rachel Kempster's report updated the Quality Committee on progress made and enabled the committee to review policies that had been updated and those that were overdue. The committee discussed the policies most significantly overdue and it was noted that the JNCC Committee had been unable to agree changes to the Induction Policy and this issue would be escalated to the Board. The One Health Worker One Family Policy would be reviewed by Children's and CAMHS to confirm if the policy added any value, and whether it was out dated and superseded by the Safeguarding procedures. The report recommended that a policy status spread sheet should be included alongside the action matrix of Board committees as well as QLTs. This will allow chairs and the executive leads to be prompted to escalate policies that are overdue and due for review. Guidance has been provided to the Board Secretary by Rachel Kempster to support this process and will be progressed. The committee was pleased with the progress shown in the report and looked forward to progress being made with the mechanisms suggested for escalating overdue policies. **RESOLVED: The Quality Committee:** **1) Received the update on the status of policies overdue for review**

	2) Agreed to the implementation of automated notification of policies due for review and automated escalation of those overdue to director sponsors **3) Agreed for board committees to include policy review and escalation alongside their action matrix in addition to QLT's** **4) Agreed to receive a further update report in 3 months (May)**
QC/2016/029	**GENDER SENSITIVE SERVICES POSTER AND POLICY** The committee ratified the Privacy and Dignity Policy which also included delivering same sex accommodation guidance. Additional declaration of their assisted bathroom being multi-gender rather than single sex on Wards 1 and 2 was noted. Although a bedroom area is not accessible it is housed in a central section, so has been declared in the policy. The gender assisted services poster promoting dignity and choice was noted by the committee and it was acknowledged that posters would also be in placed on Wards 1 and 2. **RESOLVED: The Quality Committee ratified the Privacy and Dignity Policy and closed down the recommendations contained in the guidance for delivery same sex accommodation.**
QC/2016/030	**QLT QUARTERLY REPORT FOR SPECIALIST SERVICES** The QLT Quarterly Report provided the Quality Committee with information relating the activities of the Specialist Services Quality Leadership Team. The committee acknowledged that the QLT is more focussed in its role and is in the process of collating the key areas of enquiry, monitoring CRGs adaptation its role and working on embeddedness. There have been areas identified that require changes in both the function and format of the CRGs although these have not yet been rectified due to imminent change in quality reporting structures in line with campus/neighbourhood/central/children's realignments. The committee noted that although attendance and engagement has generally been positive, the group is making progress to embed changes into already existing CRGs and there appears to be marked variance in the role and function of the different CRGs work still required in standardising differential approaches. There is also a growing concern that if the CRGs are to support the assurance process to allow devolution of assurance to the QLT, there needs to be a stronger mechanism aligned within the operational structure to support performance of the CRGs whose output and prompt management of workload is inconsistent from group to group. Since the report was written Deep Sirur had received additional feedback that he would like to circulate to the committee. Despite this, Maura Teager could see the report was an honest assessment of progress made so far and showed some areas had a clear understanding of their role but some required support from the organisation to take the QLT to the next developmental level. She suggested that she and Phil Harris as Non-Executive Directors carry out ad hoc visits to the QLT meeting and these would be arranged through the QLT's administrative team. Carolyn Green has scheduled time with Children's CAMHS CRG to look at their terms of reference, how they operate, issues logs and standard planning. She would also revisit this with other groups to apply standardisation. She asked that the new appointments in ACDs work with their peers and develop ways of working together. The QLT business partnership model will also be looked at in terms of policy

	standards and the CQUIN and this will form the process of how the CRGs will fit together with the new QLT teams and how the processes are constructed. The committee looked forward to receiving a progress report in April that will show clear processes firmly in place that provide improved assurance of completion of actions, escalation and embeddededness. It was noted that the quarterly report from Urgent and Planned Care QLT will be deferred to the next meeting in March. **ACTION: Arrangements will be made by the QLT admin team for Maura Teager and Phil Harris to attend the QLT monthly meetings on an ad hoc basis. Dates of meetings to be provided to Maura Teager and Phil Harris.** **ACTION: Carolyn Green will review the terms of reference of QLT and CRG groups to apply standardisation. This will be maintained for 12 months then QLTs and CRGs can request freedom within the framework** **RESOLVED: The Quality Committee:** **1) Accepted the content of report.** **2) Considered aspects of structure of QLT, aligned with the CRGs in view of changes to operational structure.** **3) Supported the request which will be made to SMT to ensure delegates of CRGs and QLT are prioritising this time allocation and send representatives in their absence-anticipated to improve as new operational clinical structure is embedded** **4) Noted that at this stage difficulties remain for the QLT to assure the Quality Committee without specific requests on key areas.** **5) Supported the assurance and scrutiny, maintain standing invitation for Non-Executive Directors to attend either planned or unannounced to QLT meetings.**
QC/2016/031	**<u>CQC STRATEGY 2016-2021</u>** The Care Quality Commission Strategy 2016-2021 was presented to the Quality Committee for comment and response. In 2013 the CQC introduced a new inspection process. Feedback so far about the new approach has confirmed that it has been successful in driving improvements for patients and their families, identifying poor practice and highlighting examples of good quality care. The CQC wants to make the process more effective and efficient over the next five years whilst responding to changes in the health and social care landscape. The document sets out six key themes, and asked a question at the end of each one to gain the views on what people and organisations think about their plans, the themes are: Theme 1: Improving our use of data and information Theme 2: Implementing a single shared view of quality Theme 3: Targeting and tailoring our inspection activity Theme 4: Developing a more flexible approach to registration Theme 5: Assessing how well hospitals use resources Theme 6: Developing methods to assess quality for populations and across local areas. The committee asked that feedback on the above themes contained in the strategy be provided to Carolyn Green by 7 March for inclusion in comments to the CQC by

	the closing date of 14 March. This matter would also be escalated to the Board in order to receive the necessary response. **RESOLVED: The Quality Committee was asked to consider the report and submit comments about each question to the Director of Nursing and Patient Experience, Carolyn Green by 7 March so that all the responses can be sent to the Care Quality Commission by the closing date of 14 March 2016.**
QC/2016/032	**CQC INTELLIGENT MONITORING PLAN** This paper was originally included for information. However, the CQC Intelligent Monitoring Plan indicated the Trust now has an elevated risk due to deaths to inpatients detained under the Mental Health Act. Intelligence monitoring is an analysis to trigger and an alert to all concerned, to consider risk changes and make the CQC aware of potential service failings. Carolyn Green pointed out that there has been deterioration in the Trust's intelligence monitoring scoring, mortality rates and analysis and understanding of these changes and highlighted the need to establish if there is any learning to be had or areas to be improved. Additional scrutiny will be applied by the CQC to SI reporting. Carolyn Green informed the committee that she had asked the Performance and Contract Operational Group (PCOG) to scrutinise the CQC Monitoring Plan and make improvements to data quality, as recommended in the MMHDS information which could be applied to data collection, or performance. . She also asked Peter Charlton to gain further intelligence from the CQC on their data analysis and thresholds as it was not clear from the report how the analysis is actually compiled to aid checking. It was agreed that Carolyn Gilby will provide an update report on intelligence monitoring to the April meeting of the committee on findings. Maura Teager informed the committee she would draw the Board's attention to the Trust's deterioration in intelligence monitoring on specific data sets. The need for improvement in intelligence monitoring would also be highlighted in the Quality Position Statement received by the Board. The deteriorating picture in intelligence monitoring will also be shared and addressed at the next Quality Assurance Group meeting with commisioners. **ACTION: A report to show improvements to data quality in intelligence monitoring to be provided by Carolyn Gilby in April.** **ACTION: Quality Position Statement to be received by the Board to highlight the need for improvement in intelligence monitoring.** **ACTION: Deteriorating picture in intelligence monitoring will also be shared and addressed at the next Quality Assurance Group meeting.** **RESOLVED: The Quality Committee received and noted the CQC Intelligent Monitoring Plan and discussed the need for improvement.**
QC/2016/034	**ITEMS INCLUDED FOR INFORMATION** The following items were received and noted by the committee: • Specialist Services Quality Leadership Team draft minutes (February meeting was not quorate and could not take place, hence the inclusion of draft minutes). • Urgent and Planned Care Quality Leadership Team ratified minutes
QC/2016/035	**FORWARD PLAN**

	The forward plan would be updated in line with today's discussions and presented for reference at the next meeting of the committee. The 2016/17 Forward Plan is to be formulated and received by the committee in March. **ACTION: 2016/17 Forward Plan is to be formulated by Clare Grainger**
QC/2016/036	**ITEMS ESCALATED TO THE BOARD OR OTHER COMMITTEES** • Impact of patients being admitted to wards having taken NPS substances (legal highs) to the Board regarding the impact on bed management, patient and staff safety and the Positive and Safe Strategy. • JNCC Committee had been unable to agree changes to the Induction Policy and this issue would be escalated to the Board and People and Culture Committee • The committee would commend the Dementia Strategy to the Trust Board.
QC/2016/037	**ANY OTHER BUSINESS** Maura Teager was very sad to announce that after six years' service Tony Smith was stepping down as a Non-Executive Director of the Trust's Board. She thanked him for his service and for his immense contribution to the effectiveness of the Quality Committee.
QC/2016/038	**EFFECTIVENESS OF THE MEETING** The meeting finished on time. The quality of papers has improved and prompted a good level of discussion.

Date and Time of next meeting: The next meeting of the Quality Committee will take place on:
Thursday, 10 March 2016 at 2.15 pm
Venue: Meeting Room 1 – Albany House, Kingsway, Derby

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DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE PEOPLE & CULTURE COMMITTEE

Held in Meeting Room 2, Albany House, Kingsway, Derby DE22 3LZ

Wednesday, 17 February 2016

PRESENT:	Richard Gregory	Interim Trust Chairman and Delegated Chair
	Phil Harris	Non-Executive Director
	Jayne Storey	Director of Transformation
	Dr John Sykes	Executive Medical Director
	Carolyn Gilby	Acting Director of Operations
IN ATTENDANCE: **For item P&C/2016/006**	Sue Turner	Board Secretary and Minute Taker
	Jayne Davies	Involvement Manager
APOLOGIES:	Tony Smith	Committee Chair and Non-Executive Director
	Jenna Davies	Interim Director of Corporate & Legal Affairs

P&C/2016/001	**WELCOME AND APOLOGIES** In Tony Smith's absence the delegated chair, Richard Gregory, opened the meeting and welcomed everyone to the inaugural meeting of the People & Culture Committee. The committee discussed and agreed that a member of the Communications and Involvement team would attend each meeting. Lee Fretwell, staff side lead would also be invited to regularly attend. It was also agreed that the Council of Governors would be represented at each meeting and recommended that Robert Quick be invited to attend.
P&C/2016/002	**ACTIONS TRANSFERRED FROM THER BOARD AND OTHER COMMITTEES** The actions matrix devised from actions transferred from the Board and other Board committees was reviewed. Jayne Storey assured the chair that she was aware of the actions required by the committee and an updated version would be received at the next meeting in March. **ACTION: Jayne Storey to update the Actions Matrix with the current status of the actions transferred from the Board and other committees.**
P&C/2016/003	**MATTERS ARISING** **Update on Audit Committee Action** Jayne Storey's report provided an update on an action arising from the meeting of the Audit Committee held in December 2015 and subsequently transferred to the People and Culture Committee for her to complete. The action involved Jayne Storey leading a review to establish the cost of sourcing and implementing an electronic recruitment system and to produce a paper which will set out the costs of a new system against the benefits that would be expected. This paper will be received by the Finance & Performance Committee to establish whether a new system should be procured.

	Jayne Storey informed the committee that a high level review has now been completed and the People and Culture Committee can be assured of the planned actions to refine and get best value from the Trust's existing electronic recruitment system i.e. the national NHS Jobs system which is free and used by the majority of Trusts in England and Wales which is fully interfaced with ESR (no cost). The Committee was assured that a Q4 review would be carried out to ensure the system was continuing to offer value and full functionality had been achieved. It was agreed this action would progress within the People & Culture Committee and no further action is required by the Audit Committee. **RESOLVED: The People & Culture Committee:** **1) Was assured that the best option is in place for the immediate future.** **2) Agreed an evaluation and benchmark of our recruitment processes can be made through the East Midlands Recruitment Streamlining Group and a further internal audit and internal customer satisfaction survey be carried out in Q4 2016/2017** **3) Agreed that no further action other than those outlined in system functionality be required.**
P&C/2016/004	**<u>CORE ITEMS FROM THE GOVERNANCE ACTION PLAN</u>** Jayne Storey's report updated the People and Culture Committee on the progress of the Governance well-led action plan and identified risks. In particular, focussing on Core 1, 2, 5, 8 and 9. The Governance well-led action plan has been a dynamic document over the past few weeks and at the time of writing the report the actions reflected the version received on 5 February 2016: • Core 1: Appointment of Director of Workforce, OD and Culture - Completed • Core 2: Set up a People and Culture Committee – Completed • Core 5: Organisational Development • Core 8: Freedom to Speak-Up • Core 9: HR Policies and Procedures A narrative overview was contained in the report of each people related core and Jayne Storey provided the committee with a high level update on the actions relating to 'people'. The committee focussed on the recommendations contained in the report and was assured by the actions so far completed for Core 1, the appointment of the Director of Workforce, OD and Culture and Core 2, the formation of the People and Culture Committee. The committee also acknowledged the risks and progress identified. **Terms of Reference:** The draft terms of reference was reviewed by the Board at the January meeting. A number of the Board's comments were noted and a revised draft was reviewed by the committee showing the tracked changes. The committee approved the terms of reference subject to minor amendments and additions. One addition was the inclusion of a sentence to describe the committee's purpose as enabling the delivery of the Trust's vision and values. A bullet point would also be added to define the organisation's values to reflect the care of both patients and staff **Core 5: Organisational Development:** Specific actions from the Well-led Governance Action Plan were reviewed. It was agreed that external capacity may need to be sourced to address a number of

	specific actions within the OD actions. John Sykes proposed that good use be made of resource within the R&D Centre as he would like to see a compassionate approach integrated within our values work. In response, Jayne Storey informed the committee that INVIGOR8 would be attending the Board Development session on 13 April to facilitate discussions on the Trust's values and suggested that Paul Gilbert could be invited. Jayne Storey informed the committee that discussions had commenced with the Associate Director of Leadership, OD and Workforce in regards to capacity and capability required, once finalised it would be discussed at ELT. A number of actions related to the completion of the People Strategy and supporting People plan and it was recognised that limited progress had been made. These specific actions included reward and recognition, review of the corporate induction, the development of a contemporary leadership framework and a review of mandatory training. It was noted that each of these actions had a completion date of 30 May. In line with the decision to revise the time line of the People Strategy and plan, Richard Gregory recommended bringing these dates forward to 30 April so they will be complete before the CQC visit commencing 6 June. The committee noted that the supporting groups mentioned in the committee's terms of reference would be tasked with supporting the delivery of a number of the more detailed actions, for example mandatory training. **Core 8: Freedom to Speak Action Plan:** This action plan was signed off by the Executive Leadership Team on 11 January. The committee agreed that the Freedom to speak Up Action Plan will be actioned and monitored through ELT and would be reviewed by the committee on a quarterly basis and will be reflected in the committee's forward plan. **ACTION: Freedom to Speak Action Plan to be flagged in the forward plan each quarter.** **Core 9: HR Policies and Procedures:** It was noted that a review of the forty HR policies and procedures would be completed by the end of April. Jayne Storey pointed out that addition resource would be sourced to support the review but there was a risk in regards to JNCC ratifying the changes. A partnership approach would be taken to work with local staff side to ensure momentum and Jayne Storey would keep the committee informed of progress. **RESOLVED: The People & Culture Committee:** **1) Was assured on actions stated as complete and acknowledged the progress and risks identified.** **2) Approved the Terms of Reference for the People and Culture Committee with minor amendments.** **3) Agreed the Freedom to Speak Up Action plan would be received by the committee on a quarterly basis.**
P&C/2016/005	**<u>2015 STAFF SURVEY</u>** Jayne Storey provided the committee with a verbal indication of the results of the staff survey. The committee noted that the results were currently subjected to an embargo and noted the outcomes were generally in line with those of last year. Jayne Storey informed the committee that a paper containing the full results of the staff survey would be submitted to the Trust Board on 24 February and a further more detailed analysis with an action plan will be provided for the March People and Culture Committee. The Engagement group would be tasked with drafting the actions and reporting back to the People Committee.

	RESOLVED: The People & Culture Committee noted the verbal update on the 2015 Staff Survey.
P&C/2016/006	**COMMUNITY ENGAGEMENT STRATEGY** The Community Engagement Strategy was submitted to the People and Culture Committee for sign off. This strategy set out the Trust's commitment to engagement and outlined the approaches the organisation would undertake to ensure we are effectively engaging with all of our stakeholder groups. It builds on the Trust's previous strategy – the 'Engagement 4 Improvement Framework 2012 – 2015' which has now expired. It was noted that the strategy had been shared in its draft form with the governors' membership working group, members of the 4Es stakeholder alliance and the Executive Leadership Team. The feedback received from these groups had been built into the final draft. The committee supported the Community Engagement Strategy and acknowledged its focus on governor engagement. Richard Gregory asked that it be explicit in its description of the role of governors in service development and their relationship with the Trust to show the different values they bring. The committee felt the reference to Arnstein's ladder of citizen participation in section 6 was disengaging and aged (1969) and asked for it to be removed as the strategy already referenced use of best practice. It was agreed that the Community Engagement Strategy was approved, subject to some minor amends from the Committee. **ACTION: Jayne Davies to reflect the discussion and make minor amends the Community Engagement Strategy and resubmit it to the next meeting in March.** **RESOLVED: The People & Culture Committee supported the Community Engagement Strategy and approved subject to some minor amends.**
P&C/2016/007	**HR METRICS** The Workforce KPI Dashboard was circulated to members of the committee during the meeting. Jayne Storey pointed out that the format and content of the Integrated Performance Report was currently being discussed and might determine future workforce KPI reporting. The success measures of the governance action plan and people plan would also be considered when presenting metrics at future meetings as well as the frequency. Jayne Storey explained that the dashboard would be refined over the next two meetings of the committee and through the progress of the Integrated Performance Report. Training would be a regular issue to report on and this information will be shown at Trust level and service level. Historically this information has been provided to the Trust's Board but from now on this this information will be referred to this committee. Richard Gregory agreed that the People Strategy will dictate the areas HR metrics would focus on. He was happy with the suggestion that the Workforce KPI Dashboard is received by this committee on a monthly basis and would look to Jayne Storey's recommendation as to the type of information that is reported to the Board and the information received by this committee. **RESOLVED: The People & Culture Committee received and noted the information contained in the Workforce KPI Dashboard.**

P&C/2016/008	**FORWARD PLAN** The forward plan would be updated in line with today's discussions and presented for reference at the next meeting of the committee.
P&C/2016/009	**ANY OTHER BUSINESS** **Board Assurance Framework:** Jayne Storey pointed out to the committee a possible failure of the risk relating to the delivery of the People Strategy. This risk would be tracked through the People and Culture Committee and will be refined in a report that will be submitted to the next meeting of the committee. **ACTION: Report on the risk relating to the delivery of the People Strategy will be an agenda item for the March meeting of the committee and will be provided by Jayne Storey.** **RESOLVED: The People & Culture Committee noted that the risk contained in the BAF relating to the delivery of the People Strategy would be tracked through this committee.**
P&C/2016/010	**EFFECTIVENESS OF THE MEETING** Richard Gregory closed the inaugural meeting of the People and Culture Committee and declared this would be a crucial committee that would drive the changes required within the Trust.
Date and Time of next meeting: The next meeting of the People & Culture Committee will take place on: **Thursday, 17 March 2016 at 2.15 pm** ***Venue: Meeting Room 2 – Albany House, Kingsway, Derby***	

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Public Board
Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 30 March 2016

Board Forward Plan 2016/17

Purpose of Report: To provide the Board with the forward plan of Board business for the next twelve months.

Executive Summary

The Board forward plan has been reviewed to ensure that any business coming forward to the Board is in line with the scheme of delegation but also considers regulatory and legislative items.

The Board forward plan has been developed in consultation with the Executive Leadership Team (ELT) who have identified business which requires Board consideration.

The Board forward plan does not preclude the Board from considering any other strategic issues it wishes or to vary the forward plan to fulfil its functions and maintain a focus on strategy, Performance and Culture.

Strategic considerations

- The forward plan has considered the Trust's strategy and areas for consideration by the Board.

(Board) Assurances

- The forward plan provides the Board with assurance that the regulatory and legislative business is considered by Board at the appropriate times.

Consultation

- The Board forward plan has been considered by ELT.

Governance or Legal Issues

- The Scheme of Delegation (The Scheme) provides a clear understanding of matters reserved for decision making at Board level and what matters are delegated to the Committees of the Board.

Equality Delivery System

- None

Recommendations

The Board of Directors is requested to:
Approve the revised Board Forward Plan 2016/17

Report presented by: Jenna Davies

Derbyshire Healthcare NHS Foundation Trust

Quality Report

Ashbourne House Trust HQ
Kingsway,
Derby
DE22 3LZ
Tel: Tel:01332 623700
Website: www.derbyshirehealthcareft.nhs.uk

Date of inspection visit: 6 – 8 & 12 January 2016
Date of publication: 25/02/2016

Core services inspected	CQC registered location	CQC location ID
Not Applicable	Trust headquarters	RXM

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Mental Health Act responsibilities and Mental Capacity Act/Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however, we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

In July 2015, Monitor opened an investigation into the Trust, due to governance concerns identified from the judgement of an Employment Tribunal. Monitor also has concerns following related complaints raised by other parties including individuals who have approached Monitor in line with its whistleblowing policy. The Trust is currently undertaking two pieces of work to respond to the issues raised by the judgement and by the Monitor investigation:

- An independent investigation into the findings of the judgement, both as they relate to the performance and conduct of individuals and to wider issues of standards of corporate governance.
- An independent investigation into individual complaints raised by current or ex-members of staff about the behaviour of current or ex-members of staff.

The Trust appointed an external agency to carry out a focused review of specific elements of its governance arrangements. Monitor, the Care Quality Commission (CQC) and Deloitte looked into the leadership and governance arrangements and into the performance of the HR and related functions at the Trust. Each body will report separately. This report describes the findings of the CQC focused inspection.

This focused inspection looked specifically at the following:-

- Vision, values & strategy
- Are recruitment and performance management processes objective and transparent?
- Are there clear roles and accountabilities in relation to board governance (including quality governance)?
- Does the board actively and effectively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?

We would like to thank the trust and its staff for their help and co-operation throughout the review.

Summary of findings

The five questions we ask about the services and what we found

We always ask the following five questions of the services.

Are services well-led?

Summary of findings

Our inspection team

Our inspection team was led by: James Mullins, Head of Hospital Inspections

The team included four CQC inspectors, an assistant inspector and two specialist advisors (a chief executive of a mental health trust and a non-executive director of a mental health trust).

CQC worked collaboratively with Deloitte & Monitor during the inspection.

Why we carried out this inspection

This focussed inspection was carried out due to concerns that were raised by whistle blowers, the context of which is described in the main body of the report.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about Derbyshire Healthcare NHS Foundation Trust. We requested information such as board and quality committee minutes, HR policies, staff survey results and relevant HR data such as exit questionnaires.

We carried out an announced visit to the provider from 6-8 January 2016 and a further follow up unannounced visit on the 12 January 2016. During the course of the visits we interviewed a total of 160 people including;

- Acting CEO
- Director of Nursing
- Director of Transformation
- Interim director of corporate & legal affairs
- Director of operations
- Medical Director
- Deputy Director of Workforce
- Complaints manager & her team
- Consultant safety nurse
- Associate directors of leadership and development, nursing & quality
- Risk manager
- Advocacy representatives
- Staff side union representatives
- Other trust staff

We also held focus groups with the following groups of staff:

- Governors
- Non-executive directors
- Heads of departments and associate directors
- Consultants and associate or junior doctors
- Senior nurses
- Allied health professionals
- Psychologists
- Healthcare support works
- Clinical commissioning groups
- Occupational Health

We invited staff and patients to attend 'drop in sessions' or to call and speak with a member of the inspection team via a telephone interview. These sessions provided an opportunity for staff to speak one-to-one with a member of the inspection team to express their opinions and experiences of the trust.

The inspection team reviewed a selection of files kept by the trust in relation to personnel, grievances, disciplinary procedures and whistleblowing.

We also visited a number of wards where care is provided at locations such as Kingsway hospital, Hartington Unit and the Radbourne Unit where we spoke to both staff and patients about their experiences.

Summary of findings

Information about the provider

Derbyshire Healthcare NHS Foundation Trust is a combined community and mental health, learning disability and substance misuse provider. The trust provides services to:

- Children, young people and families
- people with learning disabilities
- people experiencing mental health problems
- people with substance misuse problems

Trust Board

The trust is led by a unitary board (this means all participants have equal legal responsibility for the management and strategic performance of the trust). It operates within a budget of £132 million and provides 311 inpatient beds and employs 2383 staff.

The trust gained foundation status in February 2011. Since then, the trust leadership has been in transition with 3 chairmen and the same number of chief executives having held office. The current chief executive is undertaking the role on an acting up basis (at the time of our review, the substantive chief executive was suspended pending investigation).

Trust Registration

The trust registered with the CQC in 2010 to provide the following regulated activities:

- the treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the Mental Health Act.
- diagnostic and screening procedures

The trust provide services from four registered locations; Kingsway hospital, Radbourne Unit, London Road Hospital in Derby and the Hartington Unit in Chesterfield.

The trust has received three inspections following their registration and was found to be compliant with the standards reviewed.

Ten Mental Health Act monitoring visits were carried out in 2015. The trust provided action plans following each visit in order to address issues that were identified.

The June 2015, the CQC Intelligent monitoring report found no significant risks identified for the trust.

As part of our routine comprehensive inspection programme of the NHS, the trust will have an announced inspection of the core services provided carried out on the week commencing 6th June 2016.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure HR policies and procedures are followed and monitored for all staff
- The trust must ensure that a fit and proper person review is undertaken for all directors in light of the findings of the employment tribunal

Action the provider SHOULD take to improve

- The trust should ensure that all board members and the council of governors undertake a robust development plan
- The chairman should ensure that a unitary board culture is achieved by focusing on positive working relationships between board members and the council of governors
- The trust should ensure that the outcome of this focussed inspection impacts directly upon the organisational strategy
- The trust should monitor the adherence to the grievance, disciplinary, whistle-blowing policies and the current backlog of cases concluded.
- The trust should ensure that training passports for directors reflect development required for their corporate roles.
- The trust should introduce and effectively monitor 360 degree feedback all senior managers and directors.
- The trust should ensure that recruitment processes for all staff are transparent, open & adhere to relevant trust policies

Summary of findings

- The trust should continue to proactively recruit staff to fill operational vacancies.
- The trust should continue to make improvements in staff engagement and communication,

Derbyshire Healthcare NHS Foundation Trust

Detailed findings

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

During the focussed inspection, we found that:

- Following the outcome of the employment tribunal, the trust had not carried out a fit and proper person investigation with regards to directors who had been criticised in the judgements
- We saw evidence that HR policies and procedures were not being consistently followed for senior staff undergoing disciplinary or grievance procedures
- Processes for recruiting to internal or seconded posts were not being appropriately followed
- We saw evidence of a 'disjoint' between the council of governors and the trust board
- We were told by several members of staff that they were not comfortable using trust grievance processes for 'fear of repercussion'

However:

- We saw evidence of attempts by the trust to engage effectively with staff, patients and external stakeholders
- We saw evidence of quality visits to trust services by governors and board members

Our findings

Vision, values and strategy

- The vision of Derbyshire Healthcare NHS Foundation Trust has been to improve the health of the communities that they serve. Similarly, the trust values were to deliver excellence, involve people in making decisions, focus on people and put patients at the centre of everything that they do. The values were launched in May 2012, following consultation with staff, patients and partner organisations.
- The trust quality framework 2015-2018 describes the following priorities:

Outcome 1: People receive the best quality care

Outcome 2: People receive care that is joined up and easy to access

Outcome 3: The public have confidence in our healthcare and developments

Outcome 4: Care is delivered by empowered and compassionate teams

- Strategic objectives are monitored and reported in the public session of the Trust Board every quarter. An organisational change policy dated June 2015 was in place to support any changes.
- From April 1st 2015, a major transformational project to implement neighbourhood working was a key feature of the trust strategy. The Trust's community care and support services are currently divided into eight neighbourhood areas within Derbyshire. Each neighbourhood works closely and with other local health professionals, drawing on local community resources.
- Staff that we spoke to expressed concerns about the management of change in the introduction of the new model of working. Staff felt that there was lack of consultation on the introduction of generic roles and job descriptions and expressed concerns that the workforce plan was not robust. For example, staff told us that training and skill development had not taken place prior to introducing the neighbourhood model.
- Staff engagement events and road shows took place to present staff with the opportunity to influence the principles of future service delivery. Staff had fed back their concerns and the leadership team had listened and made some changes in response to the feedback. However, staff expressed frustration that decision making was not effectively cascaded and that many of the meetings repeated the same issues.
- Staff that we spoke with expressed disappointment, embarrassment and felt let down by the values and behaviours of trust board members criticised in the employment tribunal case. Staff considered that the findings of the tribunal had damaged the reputation of the trust. Consequently, many staff who we spoke to were not wholly confident in the trust board.

Are services well-led?

Recruitment & performance

- The fit and proper person (FPP) regulation was introduced in November 2014 to ensure the accountability of directors. It placed a duty upon the chair to ensure that all directors met the requirements to hold office and that they held the appropriate skills, competencies and experience commensurate to their role.
- The trust board discussed the fit and proper person test and duty of candour in September 2014. The trust carried out an audit against the FPP regulation in October 2014. This showed that majority of the checks were complete. However, there were some checks that had not been completed such as one disclosure and barring check for a director, two directors did not have references, health checks or copies of professional qualifications.
- A one page fit and proper person action plan was in place and due for completion in January 2015. A director informed us that the action plan had not been completed. Files reviewed demonstrated that the action plan had not been implemented. We found that the personnel files were not ordered in a manner that would assist a chair to establish the fitness of directors because information was not filed effectively.
- We reviewed the directors' register of interests for April 2014; these did not appear to have been renewed for 2015. A separate register of interests and hospitality was kept for the whole trust. Staff made declarations when there a conflict of interest or hospitality was received.
- We reviewed the personnel files of seven directors. The files had a good HR checklist to denote elements of the recruitment process had been completed. Recent appointments showed that the roles had been advertised and recruited to appropriately, competency based interviews were carried out and two references obtained. Enhanced disclosure and barring checks had been completed on employment although there was no evidence that these had been repeated at periodic intervals for directors in post for more than three years. For those with a professional qualification, initial checks had been carried out on appointment with professional bodies and we were informed that these were monitored on a separate data base. Qualifications and a full employment history were also checked. Files did not contain up to date information when appraisals and managerial supervision were carried out and if fit and proper person test was discussed although these were stored separately and had been completed. Not all files had remuneration/nominations committee approvals in them therefore did not show what consideration had been taken to appoint to acting roles.
- During the period 2013 to 2015, there had been ten staff above grade 8c who had left the trust. However, only three exit interviews had been conducted. Four directors and two non-executive directors left without an exit interview being carried out. This means valuable reflections that could assist the organisation in improving practice, procedures and culture was uncaptured.
- The employment tribunal judgment was critical of the actions of a number of directors and senior managers. Therefore, the chief executive officer was suspended pending investigation. However, the outcome of the employment tribunal did not immediately trigger a fit and proper person review by the chair in relation to other staff named. There was no documentation of the rationale as to why these staff continued their roles or acting up into senior roles. The trust did appoint an external panel to carry out an investigation further to the outcome of the ET; this process had not been completed at the time of our visit.
- The trust had a training passport in place for all staff and directors. We reviewed the directors training passport. This showed three executive directors who fully met the requirements of mandatory training. The remainder of the executive directors partially met them.
- Directors all received monthly managerial supervision for a minimum of one and half hours.
- 360-degree feedback was available for directors. However, we could only find evidence within one director's personnel file to show that it had occurred. The trust did not have figures available to identify how many managers took part in 360-degree feedback.
- There were 13 acting managers posts; only one of which had been internally advertised. Staff told us that processes were not transparent when appointing to secondment posts.
- Staff we spoke with stated that they did receive supervision. However, overall clinical and management supervision levels were low. Trust figures showed that 21% of staff were fully compliant with clinical

Are services well-led?

supervision and 26% with managerial supervision. Supervision was one of the mechanisms used to look at lessons learned and application of policies and procedures.

- The 2015 staff survey reported that appraisals occurred, however, there was variation in the effectiveness of them being carried out. Some staff we spoke with said they had not received an appraisal. In November 2015 the number of staff, completing appraisals was 1571 (65%), this meant that individual objectives and performance were not set and monitored for all staff.
- Recruitment of staff was a key challenge for the trust and staffing was on the trust register with mitigation plans in place.
- The budgeted vacancy rate across the trust was for 2015 was 14%.
- There was a reliance on bank and agency nurses as not all shifts could be filled. The number of shifts covered by bank and agency staff in April 2015 to November 2015 was 64,194. The trust monitored the fill rates for each ward. There were seven wards in which fill rates were between 71-85% between April 2015 and November 2015. This meant that not all shifts had their full complement of staff. This resulted in movement of staff to cover shifts. Electronic reporting of staffing issued occurred and an escalation process to managers was in place.
- The trust had proactively provided a safe staffing paper to clinical commissioning groups requesting an increase of 61 wte nurses. Staffing predictions were made following the identification of caseloads sizes, numbers of incidents & complaints and waiting lists for care co-ordinators within community teams.
- The trust annual sickness rate for 2015 was 5.3% this is above the national NHS average of 4.4%. The annual staff turnover for 2015 was 9.8%.
- The trust had commenced work to support nurses to revalidate with their professional body. The trust electronic database monitors that professional registration of clinical staff is up to date. The trust was in the process of updating their appraisal policies to include professional revalidation.

Processes, structure & accountabilities in relation to board governance

- Trust board development documentation for 2014 -2015 showed that out of 12 planned activities, five of these were cancelled and four of the planned actives were not recorded as having taken place or otherwise. Three activities that did take place showed that the board looked at preparing for a CQC inspection, the board assurance framework, relationship and flows between communities and the review of the escalation framework. There was loss of impetus in board development due to responding to the employment tribunal. .
- The role of non–executive directors (NED) is to hold the board to account for the delivery of strategy and the mitigation of risks. Board papers identified that NEDs did provide challenge. However, in relation to the events leading to the employment tribunal and following the judgement, effective challenges did not occur that would lead to senior staff who were criticised by the ET being held to account.
- The NEDS were keen for the organisation to move on, however did not appear to challenge what actions needed to be taken by the leadership to maintain the confidence and support of the rest of the organisation.
- Governors received an induction to their role upon appointment. However, there was a lack of development provided by the trust in order to enhance the skill set of the governing body. The relationship between governors and the board was reported to the inspection team by members of the executive team as being 'disjointed'.
- Non-Executive Directors are accountable to the Council of Governors for the performance of the Board of Directors. However, there is no clear evidence from the minutes of board meetings that this was happening effectively; partly due to the reported lack of mutual respect between both parties and poor communication. There also appeared to be a lack of role clarity amongst governors. This meant that serious confidential issues, such as the employment tribunal, were not shared with the entire governing body in a timely manner.
- The chair appointed in 2014 identified the disjoint between the governors and non-executive directors and made some changes to try to improve the relationships between the board and the council of governors.
- The trust had good working arrangements with the clinical commissioning groups (CCGs). The trust executives had held periodic board to board sessions with the CCG's in order to discuss quality and

Are services well-led?

performance. The CCG's informed the inspection team that the trust has performed well in terms of quality and was financially sound despite the current economic challenges facing the health economy.
- There was active involvement by the trust in the vanguard initiative in Erewash. The acting chief executive was chair of the community reliance group as part of the vanguard model.
- We observed evidence of effective systems leadership; this included sharing practice such as value based recruitment, mindfulness and compassion sessions for staff in North Derbyshire. The CCGs observed that this approach had influenced other organisations.

Engaging with patients, staff, governors and other key stakeholders

- Patient engagement to plan and deliver services occurred through a mental health action group in south Derbyshire. It had a membership of 200 people consisting of patients, service users, and representation from voluntary and local authority organisations. The group participated in projects such as the transformational change. Currently, the group were working on a mutual agreement project which would set out the expectations of patients.
- Staff engagement activities included meetings about the staff survey, a weekly electronic newsletter, chief executive listening events and electronic blog, appointment of communication champions. Various directors also provided Podcasts on specific topics such as safeguarding.
- Staff said the acting chief executive had been visible on wards. Members of the board had also undertaken quality visits to clinical areas.
- The board focused on the needs of the patients using services by inviting patients to tell their stories to board meetings in order to understand how improvements could be made. Clinical teams had also attended the board to tell their experiences of the impact of the transformational change on their service and on them.
- The trust was rated as 7/10 in the 2015 patient survey. This is comparable with the national average for mental health trusts.
- The 2015 NHS staff survey had a response rate of 43% for the trust. Results showed no significant changes in comparison with the 2014 staff survey. The positive findings related to staff agreeing that their role made a difference to patients, receiving job relevant training and development, appraisals, effectiveness of incident reporting procedures, job satisfaction and motivation. The main negative findings related to work pressures felt by staff, lack of structured appraisals, support when raising concerns regarding unsafe practice & harassment or abuse from patient's relatives or other staff. A people's strategy was put in place by the trust in response to the staff survey. The priorities of the strategy were to address the main staff concerns.
- The Joint staff side consultative committee minutes reviewed between March 2014 – June 2015 raised concerns that disciplinary/grievance investigations were not being completed within targeted times. Improvements were agreed in that any employee subject to an investigation would receive timely updates on the process. The Commissioning Officer of the investigation would also ensure the lead Investigating officer adhered to the timescales identified in the trusts policies.
- The trust had current grievance and dignity at work policies and procedures in place. The disciplinary policy was dated 2012 -2014 . Staff were aware of the policies, however not all staff that we spoke with felt were confident to engage in the grievance or dignity at work processes fear of repercussions. This commonly held view was confirmed in our interviews with staff side representatives.
- Between 2012 and 2015, there were 11 grievances reported by clinical staff. We were made aware by both whistle blowers and HR staff at the trust that there were six grievances, counter complaints and disciplinary investigations conducted because of events associated with the employment tribunal case that involved senior staff within the trust. However, we saw no evidence that HR policies or procedural guidance was being followed in cases involving senior staff. This was corroborated by HR staff.
- Other staff within the trust also advised the inspection team that policies or procedures in relation to disciplinary or grievances were not being adhered to. Common themes emerged with regards to investigation processes taking too long, staff not being informed of allegations made against them and a lack of clarity regarding the role of the staff liaison officer.
- We reviewed six disciplinary files; we found that files did not have a clear audit trail and some had no chronological history. Reasons for delays in investigations were not consistently recorded. The

Are services well-led?

investigations did take a long time for example some disciplinary cases had been ongoing for two or three years. There was separation and independence in terms of who investigated, who sat on the panel hearings and who heard appeals. Letters sent to employees did provide information about access to the staff liaison officer and that a representative could attend meetings. Files did not have information about when and who reviewed suspensions. There were clear terms of reference for the investigators. Human Resource (HR) representative did support the investigators. It was not clear who kept an overview of all the disciplinary cases and if processes were being followed and to challenge.

- We reviewed three grievance files and again, found that there were no clear audit trails. The trust reported that between 2012-2015 it had received seven reported cases of whistleblowing. Of these, only two were classified as whistleblowing events and the remainder were dealt with as HR or operational issues.
- We saw evidence that since 2013, 136 job evaluations had gone to a panel for appraisal without the involvement of staff side representation. The trust had rectified this and agreed that these job evaluations could be resubmitted to a panel which included staff side representation. At the time of our inspection, there were a further 44 job descriptions also waiting to go to panel. The trust was in the process of training staff to become panel members and was setting up extra panels in order to deal with the backlog.
- Eighty six percent of staff had received Equality and diversity training. The trust had a cultural diversity engagement post. The trust provides services to a high black and ethnic minority (BME) population in Derby city. The trust considered its workforce to be reflective of the local population.
- Staff and managers were aware of the duty of candour. This occurs when a healthcare professional must be open and honest with patients when something that goes wrong with their treatment or has the potential to cause, harm, or distress. Staff stated that they would exercise this when clinical incidents arose.
- Complaints were reported through the electronic incident reporting system. Learning from complaints occurred and was reported through a newsletter called 'practice matters'. A family liaison team were involved in the implementation of the duty of candour. Complaints leads meetings occurred quarterly in order to continue to improve complaints management.
- The trust used a number of methods to cascade learning from incidents, complaints and service user feedback. The trust intranet had a news section called 'Connect' that provided information. A monthly practice newsletter reflected lessons learned and cascaded information about national patient safety issues and new or revised guidance affecting clinical practice.
- The trust provided a range of support for employees such as a staff liaison manager and employee assistance counselling service to support adverse life events. Wellbeing plans to support staff to stay well at work were available although the trust did not provide information on how many wellbeing plans were currently in place. The trust was also an affiliated Mindful Employer. This includes a charter for employers who are positive about staff mental health and wellbeing.
- Staff had access to leadership development. Between April 2014 and January 2016, 854 staff across the trust had attended leadership courses. The majority of staff were positive about the leadership courses.

Quality improvement, innovation and sustainability

- Quality visits involves NEDS, directors, governors & commissioners visiting clinical teams has been operational since 2010. We saw evidence of an annual cycle of visits to each clinical team was in place. It provided an opportunity for teams to display good practice and engage with board members.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA (RA) Regulations 2014.** **Good governance.** **The trust must ensure that HR policies and procedures are followed for all staff** **This was a breach of Regulation 17 (2)(d)(I)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors **Regulation 5 HSCA (RA) Regulations 2014.** **Fit and proper persons: Directors** **The trust must ensure that a fit and proper person review is undertaken for all directors in light of the findings of the employment tribunal** **This was a breach of Regulation 5 (2)(a)(b)(3)(a)(b)(d)**

This section is primarily information for the provider

Enforcement actions

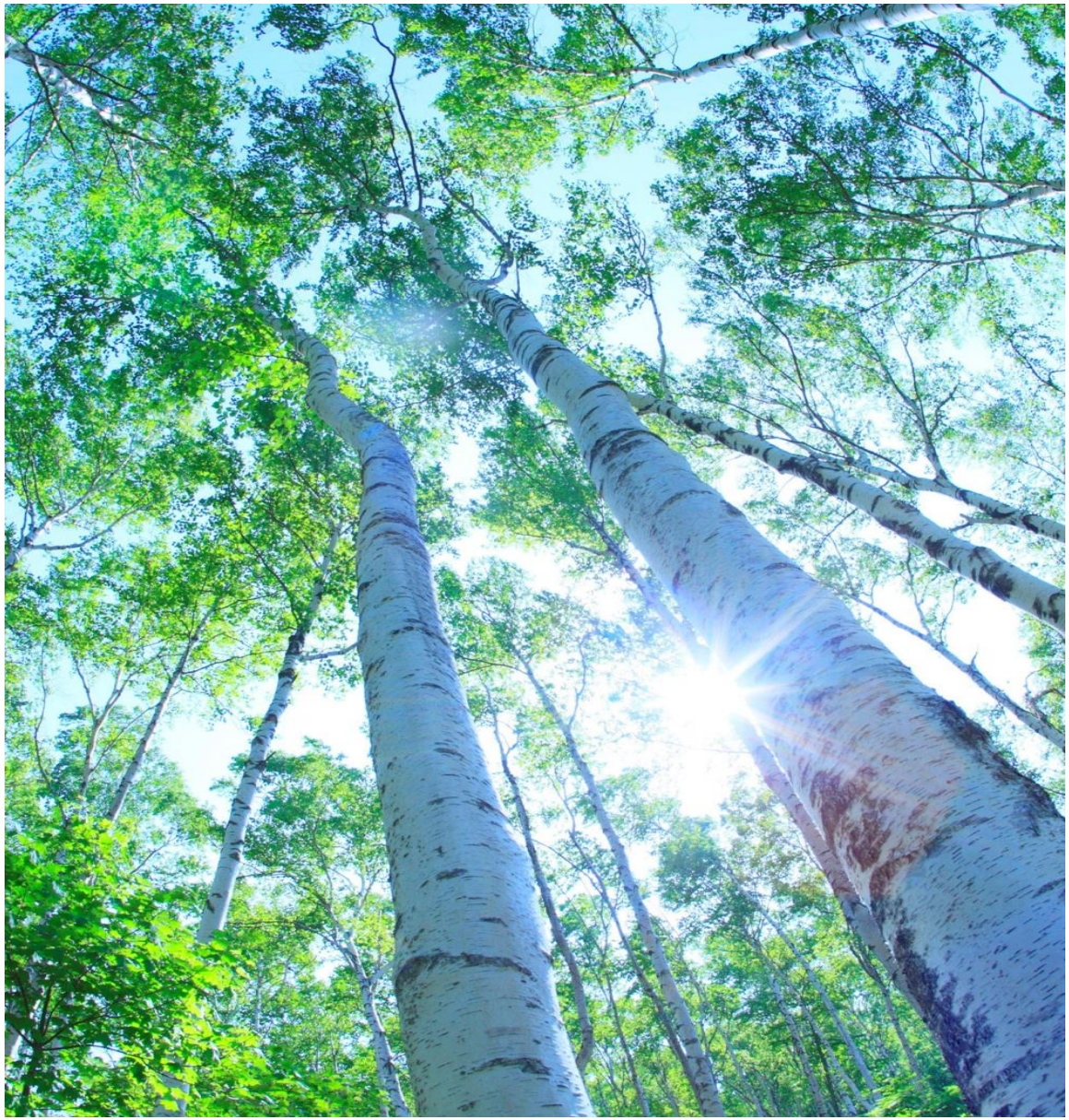
Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Deloitte.

Derbyshire Healthcare NHS Foundation Trust

Independent review of governance arrangements and HR related functions



FINAL Report

22nd February 2016

Derbyshire Healthcare NHS
NHS Foundation Trust

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22 February 2016

Dear Board of Directors

Independent review of governance arrangements and HR related functions

In accordance with our engagement letter dated 10 December 2015 (the 'Contract'), for the independent review of governance arrangements at Derbyshire Healthcare NHS Foundation Trust (the 'Trust'), we enclose our Final Report dated 22 February 2016 (the 'Final Report').

The Final Report is confidential to the Trust and is subject to the restrictions on use specified in the Contract. No party, except the addressee, is entitled to rely on the Final Report for any purpose whatsoever and we accept no responsibility or liability to any party in respect of the contents of this. This report is prepared for the Board of Directors as a body alone, and our responsibility is to the full Board and not individual Directors.

The Final Report must not, save as expressly provided for in the Contract (including, inter alia, in schedule 1, paragraph 8.7, NHS Terms and Conditions for the Provision of Services) be recited or referred to in any document, or copied or made available (in whole or in part) to any other person.

The Board is responsible for determining whether the scope of our work is sufficient for its purposes and we make no representation regarding the sufficiency of these procedures for the Trust's purposes. If we were to perform additional procedures, other matters might come to our attention that would be reported to the Trust.

We have assumed that the information provided to us and management's representations are complete, accurate and reliable; we have not independently audited, verified or confirmed their accuracy, completeness or reliability. In particular, no detailed testing regarding the accuracy of the financial information has been performed.

The matters raised in this report are only those that came to our attention during the course of our work and are not necessarily a comprehensive statement of all the strengths or weaknesses that may exist or all improvements that might be made. Any recommendations for improvements should be assessed by the Trust for their full impact before they are implemented.

Yours faithfully

Deloitte LLP

Executive Summary

Executive Summary

Authorised in February 2011, Derbyshire Healthcare NHS Foundation Trust (the "Trust") provides mental health, learning disability, and a range of specialist services in Derby city and the wider Derbyshire county. The Trust employs around 2,500 staff and serves a catchment area of around 1,000,000 people.

The Trust performs well against a range of operational, financial, and quality metrics, with the Trust continuing to be compliant with all Monitor regulatory indicators and reporting a financial sustainability risk rating of 4 as at January 2016.

Over the last 12 months, the Board has operated in a difficult and sensitive context as it continues to respond to the events surrounding the Employment Tribunal (ET) and associated reviews. In July 2015, Monitor opened an investigation into the Trust, both due to governance concerns arising from the ET, and also following issues raised to them directly through their whistleblowing policy.

We recognise that the events of the last 12 months have negatively impacted on the capacity of the Board and senior leaders in the Trust, notably:

- **the scale to which the ET has shaped Board debate and action;**
- **the resulting newness of the executive team, alongside 3 NEDs who were appointed after January 2014 and a new Chairman from December 2015;**
- **the resource required to support subsequent reviews which have led to a sense of "investigation fatigue"; and**
- **the extent to which ongoing investigations, including the ET, have impacted upon the Board's ability to make changes in certain areas.**

We have undertaken an independent review of governance arrangements at the Trust against two domains of Monitor's Well-led Governance Framework, namely:

- **capability and culture; and**
- **processes and structures.**

Alongside this we have also undertaken a review of HR and related functions.

During our review we have noted a number of areas of good practice, particularly:

- a clear acknowledgment of the need for change by the Board and others at the Trust, together with an appreciation of the areas for improvement as demonstrated through the self assessment provided for this review;
- an ongoing focus on improving performance through the use of deep dives and staff presentations to the Board and committees; and
- the Interim CEO has retained a focus on the external environment, participating in local health economy initiatives, whilst seeking to respond to the internal challenges.

However, we are of the opinion that there remain a number of key areas which need to be urgently addressed in order to strengthen the effectiveness and impact of Board leadership and governance at the Trust. These include:

- a need to improve the effectiveness of the Board, in particular to demonstrate greater leadership and momentum in implementing the changes required;
- an urgent requirement to address the strategy, model and structures within the HR team;
- a requirement to refresh the values and associated behaviours of the Trust alongside a clear and comprehensive programme of work on culture;
- improve relationships and extent of engagement with the Council of Governors; and
- a need for greater clarity in performance management processes as the organisation undergoes a transition to the new structure.

Given the extent of changes currently taking place within the Trust, and the need to further develop the areas outlined above, we suggest that the Board undertakes a further independent review of governance and Board capability in nine months' time to assess the progress made.

Executive Summary

1. Capability and culture

1A The Board self-assessment shows a clear appreciation of the need to develop the Board, Executive Team, and associated governance processes. In order to achieve this, there are a number of areas which the Board needs to address as a priority in order to become fully effective.

- These include:
  - substantive recruitment to ED posts to rebuild capacity, capability and stability;
  - development of the executive team, increasing cohesion, and continuing to clarify portfolios alongside establishing clear objectives; and
  - implementation of a robust Board development programme, including a focus on Board Member (BM) roles and responsibilities.
- Whilst we have noted some good examples of challenge, there is a need to improve the effectiveness of Board debate. In particular to demonstrate greater leadership and direction, and to ensure greater impetus in follow-up and implementation of actions

1B Our fieldwork found some well-established mechanisms in place to engage with staff and promote a quality-focussed culture. Nonetheless, the Board has received some difficult messages with regard to culture and behaviours, and there is an acknowledged need to demonstrate more concerted action and progress in this area and to *"regain the trust of staff"*.

- In particular there is a need to develop and implement a programme of cultural change to ensure that staff views are acknowledged and acted upon. This programme, alongside a relaunch of the values, should be central to the refresh of the People Strategy and the newly established People and Culture Committee.
- In terms of broader engagement, the majority of external stakeholders welcomed the extent to which the Trust had maintained an external and strategic focus despite its internal challenges. In particular, they were supportive of the leadership shown by the Interim CEO in recent months. There were however some mixed views in relation to the Trust's approach to partnership working, including the swiftness with which the Trust had responded to concerns around service delivery.
- The Board has acknowledged the need to substantially rebuild its relationship with governors and this has been outlined as a priority area of focus by the new Chairman.

2. Structures and processes

2A There is scope for further improvement in the operation of committees. In particular, there is a need to minimise duplication, review membership and attendance, and increase contribution to debate. Processes for tracking and follow-up of actions also need to be strengthened.

Recognising the level of change and pressures on capacity within the executive team, there are a number of examples whereby we would have expected to see greater accountability and pace.

- The committee structure benchmarks largely in line with trusts of a similar revenue and complexity. In recognition of the need to strengthen arrangements further, a People and Culture Committee will also be in place from February 2016.
- The Board have waited to understand the outcomes from recent independent reviews before making any substantial changes to governance arrangements. As a result the overarching governance action plan is in the early states of development. Acknowledging that further work is currently underway to add granularity, this plan needs to provide real depth and clarity of direction if it is to provide an effective framework for the Board to drive forward action.
- A Governance Framework is in draft, however there has been significant slippage in the development of this document which was initially scheduled for March 2015.

2B The Trust has a good track record of performance, and has sustained this position over time. Whilst there is an acknowledgement that a clearer performance management framework is required, we have noted good use of deep dives and staff presentations at the Board in order to respond to emerging issues. The Trust also recognises the need for greater triangulation of performance information, including the need to develop an Integrated Performance Report.

Executive Summary

- There are two key management forums for holding to account below committee level: the Performance Contracting and Oversight Group (PCOG) for finance and operations, and divisional Quality Leadership Teams (QLTs) which focus on the CQC domains.
- Several staff we spoke with reflected that holding to account at these forums could be stronger, and whilst still relatively new, there is an acknowledged need to increase the effectiveness of QLTs.
- The Trust is aware of the need to more clearly define roles, responsibilities and accountability arrangements in light of the move to neighbourhoods and campuses. Alongside this there is also an opportunity to more clearly define and communicate the role of PCOG in terms of devolved accountability moving forward.

3. HR and related functions

3A The intense and sustained scrutiny that HR and its related functions have been under is acknowledged. The impact on the team has been substantial, and whilst the team have sought to maintain services, the capacity of the function to deliver has been affected. There are a number of contributing factors which are currently constraining delivery of an appropriate and effective HR service. The absence, until recently, of strategic leadership of the function at Executive level was a significant concern.

- There is an extensive programme of work for the newly appointed Director to undertake in order to resolve a range of operational / transactional issues and to refocus the function strategically. Relationships within the function are significantly strained and in our opinion not recoverable. There is an urgent need to reset expected behaviours and to drive cultural change across the function, alongside delivering a broader Trust wider programme of change.
- The strategy, model and structures within HR currently date back to 2010 and require review and updating. The programme of work to develop a fit for purpose HR function should not be underestimated and the incoming Director will undoubtedly play a central role in shaping the agenda. That said, there is a significant role for the Board and Executive Team to play in order to achieve the required progress in this area.

Key Recommendations

Based on these findings we have made a number of recommendations with suggested timescales (see Appendix 1). However we would draw your attention to the following key areas:

1. 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;
2. agree a programme of Board and executive team development work which includes a mix of internal and externally facilitated sessions, and is clearly aligned to the combined governance action plan;
3. define a new structure and model for HR and its related functions with a priority on operational efficiency and strategic impact. Alongside this implement the planned changes to the People Strategy and introduction of the People and Culture Committee;
4. 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;
5. prioritise the recruitment to the Council of Governors, and substantially improve the relationship and engagement between the Board and the Council; and
6. develop the governance action plan to provide a greater level of depth and clarity of direction in order for it to be an effective framework for the Board to drive forward action.

Next steps

We suggest that the Chairman and Interim Chief Executive, in consultation with the Board, consider the findings outlined within this report and write a management response in relation to the matters raised. This response should clearly outline how the Board proposes to implement our various recommendations, and describe how the Board will monitor progress going forward.

Executive Summary

Summary of ratings

Outlined below is a summary of the ratings across each of the five theme areas. A summary of the scoring criteria can be found on page 11.

Monitor Domain		Detailed Criteria	Trust Rating	Deloitte Rating
Capability and culture	1A	Does the Board have the skills and capability to lead the organisation?		
	1B	Does the Board shape an open, transparent, and quality focussed culture?		
Process and structures	2A	Are there clear roles and accountability in relation to Board and quality governance?		
	2B	Are there clearly defined processes for escalating and resolving issues and managing performance?		
HR and related functions	3A	Is the structure, leadership, management and operation of the HR and related functions, fit for purpose and effective?		

Introduction

Introduction

Project scope

- This report sets out the findings of our independent review of governance arrangements at Derbyshire Healthcare NHS FT (hereafter, 'the Trust'). We would like to thank Trust Board members, staff, governors and other internal and external stakeholders for their engagement in this project.
- Our review has centred around two of the four theme areas as set out in the Monitor 'Well-Led Framework for Governance Reviews' in the publication updated in April 2015. These are:
  - **Capability and culture**, including a review of Board experience, capability and capacity along with development and succession processes; and a review of whether the Board shapes an open, transparent and quality-focussed culture; and
  - **Process and structures**, focussing on the suitability and clarity of processes in relation to Board governance, along with whether there are clearly defined, well-understood and effective processes for escalating issues and managing performance.
- In addition, our review has also considered the effectiveness of **Human Resources related functions and processes**, with a specific focus on:
  - the experience, capacity and capability to develop and implement an effective HR strategy and culture;
  - effectiveness of HR and related functions policies and processes, along with the adequacy of processes for monitoring compliance with these; and
  - consideration of the appropriateness of training, guidance provided, and whether candour, openness, transparency, and challenges to poor practice are the norm.
- Our scope did not cover the outcome of the Employment Tribunal, which has been the subject of a separate review, nor have we sought to address any individual grievances or investigations.

Our approach

- Our approach to delivering the project scope has consisted of:
  - undertaking a review of the Board self-assessment against Monitor's Well-Led Governance Framework;
  - conducting a desktop review of key Trust documentation;
  - conducting 1-1.5 hour non-attributable interviews with all Board members as well as follow up interviews with a selection of Board members;
  - conducting 1 hour non-attributable interviews with members of staff across a range of clinical and operational roles, supported by a focus group with staff;
  - conducting a focus group with Governors (6 attended) supplemented by telephone interviews with a further 3 governors;
  - observation of a range of Board and committee group meetings;
  - undertaking a Board member survey (13 responses from a total of 14 distributed surveys);
  - conducting 30 minute interviews with a sample of external stakeholders, comprising representatives from local providers and local authorities. Four stakeholders participated; and
  - providing verbal feedback to the project sponsors and a feedback session with the Board of Directors in early February 2016.
- All activities were undertaken between December 2015 and February 2016.

Observations and recommendations

- Our findings in this report are based upon the views expressed by Board members, staff across the Trust, governors, external stakeholders and our own observations.
- We have assumed that the information provided to us and management's representations are complete, accurate and reliable; we have not independently audited, verified or confirmed their accuracy, completeness or reliability. In particular, no detailed testing regarding the accuracy of any financial information has been performed.
- Our work, which is summarised in this Final Report, has been limited to matters which we have identified that would appear to us to be significant within the context of the scope.

Introduction

- In particular, this review will not identify all of the gaps that exist in relation to the Trust's approach to governance; rather the review has sought to consider performance against two of the sections in the Monitor Well-Led Governance Framework to identify the most material gaps, key exceptions or areas where insufficient evidence may give rise to the identification of material gaps in the future.

Structure of the report

- The report is divided into an overview of our findings against the two theme areas within the Monitor 'Well-Led Framework for Governance Reviews' guidance which were relevant to the scope of this review, namely:
  - capability and culture; and
  - processes and structures.
- In addition, in accordance with the scope, we have also set out our findings in relation to Human Resources and related functions.
- Each section comprises a description of our findings and observations along with suggested recommendations for improvement where appropriate. The rationale for our independent ratings is included in the 'summary of findings' box at the beginning of each question.
- The report contains 9 appendices, namely: a summary of recommendations, benchmarking from the Deloitte client basis, good practice from other NHS organisations and a glossary of terms.

Throughout this report we have included the results of surveys. The key to these graphs is as follows:

SA	=	Strongly agree
A	=	Agree
SI A	=	Slightly agree
SI D	=	Slightly disagree
D	=	Disagree
SD	=	Strongly disagree
CS	=	Cannot say

Directors

Non-executive directors

Monitor scoring criteria and survey key

- Ratings used throughout this report are based on the criteria outlined in Monitor's 'Well-Led Framework for Governance Reviews' guidance as set out in the publication updated in April 2015. These are outlined below:

Risk Rating	Definition	Evidence
	Meets or exceeds expectations	Many elements of good practice and there are no major omissions
	Partially meets expectations, but confident in management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, no major omissions and robust action plans to address perceived gaps with proven track record of delivery
	Partially meets expectations, but with some concerns on capacity to deliver within a reasonable timeframe	Some elements of good practice, has no major omissions. Action plans to address perceived gaps are in early stage of development with limited evidence of track record of delivery
	Does not meet expectations	Major omission in governance identified. Significant volume of action plans required and concerns about management's capacity to deliver

Observations

1. Capability and culture

1A: Does the Board have the skills and capability to lead the organisation?

Summary of our findings: **Deloitte Rating:** 

- **The Board self-assessment shows a clear appreciation of the need to develop the Board, Executive Team, and associated governance processes. In order to achieve this, there are a number of areas which the Board needs to address as a priority in order to become fully effective.**
- These include:
  - substantive recruitment to ED posts to rebuild capacity, capability and stability;
  - development of the executive team, increasing cohesion, and continuing to clarify portfolios and to establish clear objectives; and
  - implementation of a robust Board development programme, including a focus on BM roles and responsibilities.
- Whilst we have noted some good examples of challenge, there is a need to improve the effectiveness of Board debate, in particular to demonstrate greater leadership and direction, and to ensure greater impetus in follow-up and implementation of actions.

1A.1 Does the Board have the skills and the capability to lead the organisation?

Summary of self assessment

- The Board rated this area as amber/red, primarily as it has identified the challenges associated with:
  - the impact on governance systems and processes as a result of the ET;
  - the number of acting and interim positions currently in place both at Director and deputy level; and
  - an acknowledged need to undertake robust succession planning.
- The self assessment also outlines a need to move forward positively from recent events, and acknowledges the need to develop the Board, Executive Team and associated governance processes in order to achieve this.

Figure 1 - Board composition

Executive Directors			Non-Executive Directors	
	Role	**Start date**		**Start date**
Ifti Majid **	Interim CEO	Jul 2015	Richard Gregory	Dec 2015
John Sykes	MD	Feb 2011	Maura Teager *	Feb 2011
Carolyn Green	DoN & PE	Feb 2014	Caroline Maley	Jan 2014
Claire Wright	DoF	Oct 2012	Tony Smith *	Feb 2011
Carolyn Gilby **	Interim DoO	Aug 2015	Jim Dixon	Sep 2014
Mark Powell	Director of BD	Mar 2015	Phil Harris	Nov 2014
Jayne Storey	DoWF & OD	Nov 2014		
Jenna Davies	Interim D. of Corporate and Legal Affairs	Mar 2015		

**Note that terms of office have been shown from the date of FT authorisation for those directors previously employed by Derbyshire Healthcare NHS Trust.*
*** Date shown is that at which the individual was appointed into their current Interim role. Both bring extensive experience of working within the Trust.*

1A.1.1 - Executive team

- As outlined in Figure 1, the composition of the executive team is very new, which is in part due to the impact of the ET. In addition, a number of EDs are also in their first director position.
- Within this context, some EDs reflected that they are not yet fully functioning as a team, particularly given their range of styles and experience, and the unusual pressures within which the team has been working.
- Our observations support this view; for example we noted scope to develop team dynamics and to increase the level of challenge and debate.
- Both through this observation and interviews, we also noted a lack of clarity in some portfolios. Examples include division of responsibilities between operations, the Director of Nursing and Quality, and the Medical Director, and between workforce, transformation and business development.
- We note, however, that the Interim CEO is aware of this and has recently made a number of amendments to portfolios, including providing greater clarity around objectives and accountabilities.

1. Capability and culture

1A: Does the Board have the skills and capability to lead the organisation?

- The circumstances of the past 2 years have impacted significantly on the capacity of EDs and their teams, and there is a recognised need to rebuild a stable and substantive executive team. Recent developments include:
  - recruitment for a substantive Director of Corporate Affairs which is currently underway, and
  - the appointment to a substantive Director of Workforce and OD, alongside which there are early plans to add external resourcing support into the department.
- In support of these actions, it will also be essential to ensure that there is both appropriate resource and effective functioning of supporting teams, particularly within HR and OD (Refer to 3A).
- Following the planned substantive appointments to Executive positions, the Interim CEO should work to develop the dynamics of the team, including implementing a programme of Executive Team development, which includes a focus on:
  - team dynamics and agreed ways of working;
  - clarity of purpose and vision;
  - effective challenge and leadership; and
  - individual coaching.

R1: Implement a programme of Executive Team development which focuses on team dynamics, effective challenge and leadership and is supported by individual coaching where necessary.

- Executives meet on a weekly basis at the Executive Leadership Team (ELT). Senior staff also attend for specific papers as required.
- The Interim CEO has sought to add greater structure to this forum, including introducing greater formality around minutes and actions. Recognising improvements to this meeting are recent and on-going, there remains a need to:
  - minimise the focus on points of operational detail, prioritising debate on key topics;
  - ensure that key papers are distributed in a timely manner to enable members time to review prior to discussion; and
  - expand debate amongst the team.

R2: Further improve the function of the ELT by improving the timeliness of papers and quality of debate.

1A.1.2 Non-executive directors

- NEDs bring skills from a range of backgrounds, including HR, not-for-profit, sales, healthcare and clinical experience. Three NEDs have direct NHS or relevant healthcare experience, including the recently appointed Chairman.
- The Trust can demonstrate that skills requirements of the Board were considered for the most recent NED appointments, leading to a focus on community and commercial / business experience. (See also 1A.2.1.)
- In line with good practice, the Audit Committee Chair is a Chartered Accountant by background.
- The Board have recently separated the roles of SID and Vice Chairman. There remains, however, a view that NED roles would benefit from further clarity, including the role of the SID. This should be considered as part of the refreshed Board development programme (refer to R5).

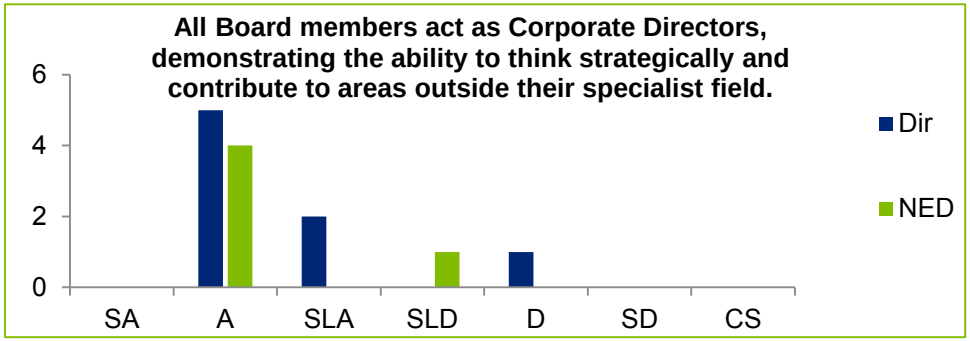
1A.1.3 Board debate

- During our observations, we have noted some examples of EDs showing contribution and challenge across the agenda. This was more noticeable at committee level, where we observed:
  - challenge in relation to the lack of assurance regarding Recovery and Wellbeing at the January Quality Committee, and
  - scrutiny in relation to the BAF risk on recruitment and retention at the January F&PC.
- Conversely, during our observations some other EDs have provided limited contribution throughout meetings.
- Similarly, whilst we have also noted examples of NED challenge and scrutiny, contribution across the NED cohort is variable.
- From our review of papers and minutes there are also a number of areas where we would have expected a greater degree of challenge. Examples include:

1. Capability and culture

1A: Does the Board have the skills and capability to lead the organisation?

- progress in relation to action plans, and assurances around the impact of changes made (see also 2A);
- oversight of HR during the interregnum particularly given the scale and significance of issues in this (see HR section); and
- pace of change around culture and staff engagement (see 1B.1).



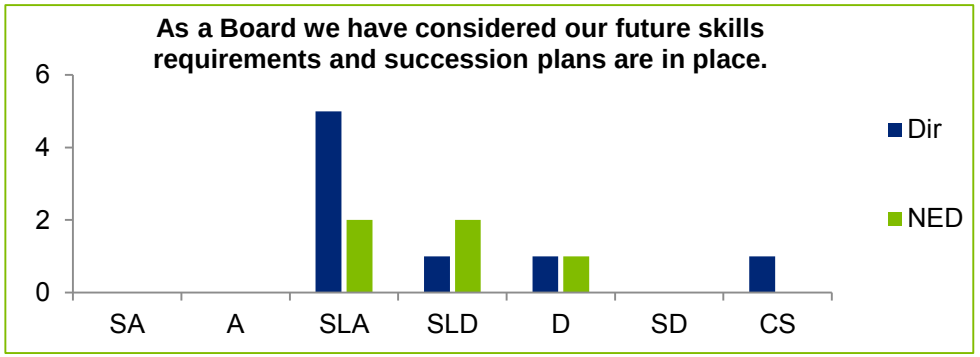
- There is also scope to increase contribution to Board dialogue. Alongside this there is a need to ensure that initial questions are followed up to probe further on progress and issues, to balance challenge and support and making statements at Board with asking questions, and to ensure that appropriate assurances are sought in response to priority areas of focus.
- During interviews several BMs reflected on the style of Board debate previously. For example:
  - some BMs commented that differing views had previously been discouraged, or that actions were seldom taken in response to issues raised; and
  - in hindsight, some felt that there should have been greater levels of challenge around some of the information with which they had been provided. For example, *"there was an entrenched inhibition to challenge the CEO… there needs to a discussion on why we didn't question things"*.
- The majority of BMs acknowledged that there could have been greater focus on pushing for progress in a number of areas, acknowledging that following the ET they had *"lost momentum"*, and *"gone through a period of inertia"*. It is also acknowledged that the legal implications of ongoing reviews and investigations (which are not yet complete) have impacted on the Trust's ability to make changes in some areas.

R3 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.

1A.2 - Does the board recruit and maintain the appropriate experience and skills through effective selection, development and succession processes?

1A.2.1 - Succession planning

- In the last 18 months, there have been three chairmen and three interims in key director posts. Succession planning arrangements have enabled people to act up into Interim roles. These have also had a subsequent effect on direct reports, a number of whom have moved up into deputy roles.
- The Trust's self-assessment recognises that the Trust's ability to update future succession plans has been challenged in light of these levels of change. This was also reflected in interviews and survey responses.



- "Stability" was often cited as a key factor to enable the Trust to move forward, both to enable greater clarity of direction for the organisation, and also to enable progress with the governance action plan and the refreshed strategy.
- In recognition of the need to develop succession planning for BM roles, and to plan for known changes in NED composition in 2017, work is about to commence to: review future skills requirements of NEDs; standardise NED contracts; and to utilise an external agency to head hunt potential applicants.

1. Capability and culture

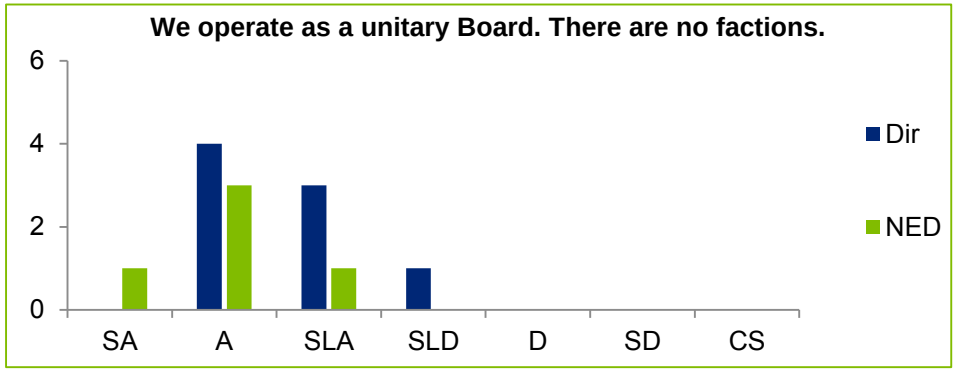
1A: Does the Board have the skills and capability to lead the organisation?

- Other Trusts also:
  - ensure a strong focus on succession planning at Board away days; and
  - plan for a period of handover particularly where this involves the change in a committee chair.
- Governors expressed mixed views with regard to their engagement in NED recruitment processes. We also note that membership of the Governor Nominations and Remuneration Committee had been unclear, although we understand this is currently being revised.
- There has been a Governor presence in interview panels and assessment centres. However, some felt they had not been able to fully participate or influence this process and that their engagement had been tokenistic. (Refer also to Governor engagement in 1B.3.3).
- In addition to the need to improve Board level succession planning, there is also a need to strengthen arrangements for senior leadership roles throughout the Trust, both within corporate functions and clinical services.
- We understand that early discussions are underway to invest in a system-wide approach to talent management at band 8c and above. We have also seen evidence of some leaders having done external leadership development courses and secondments.
- Examples of good practice we have seen in other Trusts include:
  - engaging senior leaders in discussions on succession planning discussions at Board away days;
  - nominating successors at contingency, intermediate and planned levels from ED level to heads of service; and
  - embedding plans for EDs, NEDs and key divisional and corporate leaders.
- See Appendix 2.

R4: 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.

1A.2.2 - Board development

- A number of Board seminars were held throughout 2015, including a focus on strategy development, CQC preparedness and risk training.
- Activities to develop the effectiveness of the Board were also undertaken in March and April 2015, although it is recognised that these have not continued, in part as time has been diverted to focus on emerging issues as a result of the ET.
- During interviews, BMs expressed a diverse range of views on the extent to which reflections and learnings from recent events had been captured. Some pointed to discussions on 23 December following receipt of the draft Investigation Report, whereas others felt that further work was still required for the Board to fully reflect on findings.
- Whilst BMs did not raise any specific tensions, they did express a clear appetite for renewed focus on the development of the Board, particularly in light of recent arrival of the new Chair.



- Information reviews of effectiveness are undertaken at the end of each committee meeting. Desktop analysis however shows that the depth of feedback varies across committees and more could be done to demonstrate improvements made as a result.
- At present Board development activities are scheduled for the first quarter of 2016, focussing on the BAF and strategy development We would expect to also see a focus on developing a unitary Board including for example:

1. Capability and culture

1A: Does the Board have the skills and capability to lead the organisation?

- more detailed consideration of the governance action plan, for example in relation to the operation of the Board and its Committees;
- a focus on Board challenge, including assurance, reassurance and the role of the corporate director;
- review of the role and contribution of BMs;
- Board cohesion and dynamics;
- use of external speakers to add insight and prompt debate, for example in relation to a programme of culture; and
- joint session with the governors on effective ways of working.

- The Board should also consider also how senior leaders in the Trust can be engaged in this process at an appropriate point in time.

R5: 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, and covers the points outlined in 1A.2.2.

1A.2.3 - Board Member appraisals

- An appraisal process is in place for ED and NED performance. For NEDs this incorporates feedback from peers, governors and also EDs.
- EDs also have a 360 feedback system in place, including involvement from other ELT members, direct reports and external stakeholders.
- The Trust recognises that the effectiveness of both of these processes needs to improve; For example, objectives and appraisals were not undertaken for all EDs during the last 12 months due to changes in the CEO position, and in some cases, the process was also weakened by low response rates for feedback across both EDs and NEDs.
- As referenced in 1.A.1.1, the interim CEO has acknowledged the need to clarify ED portfolios. Alongside this, clear objectives are also being developed.
- A process is in place for governors to feed into NED appraisals, and this was discussed further with the CoG in June 2015. Recent minutes of the Remuneration Committee show an acknowledgement of the need for greater governor interaction with NEDs throughout the year to add value to this process, along with more timely interaction to capture any feedback.

R6: 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.

R7: Undertake an independent review of progress made against the recommendations raised in this report in 9 months' time. As part of this review, a 360 feedback process for all BMs should be incorporated.

1. Capability and culture

1B: Does the Board shape an open, transparent and quality-focussed culture?

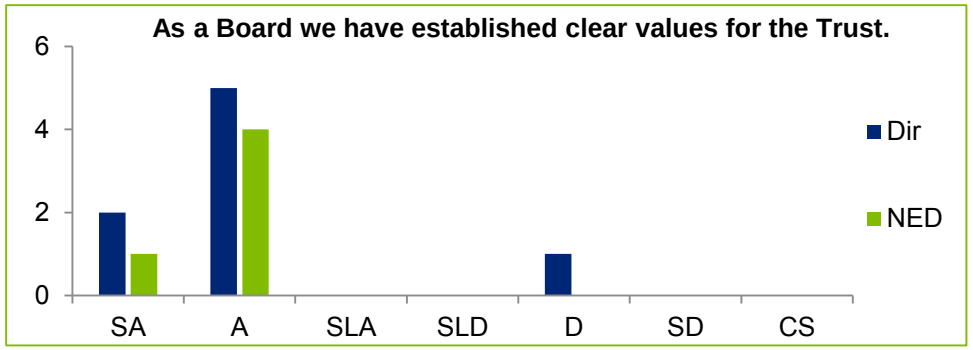
Summary of findings: **Deloitte Rating:**

- **Our fieldwork found some well-established mechanisms in place to engage with staff and promote a quality-focussed culture. Nonetheless, the Board has received some difficult messages with regard to culture and behaviours, and there is an acknowledged need to demonstrate more concerted action and progress in this area and to "regain the trust of staff".**
- In particular there is a need to develop and implement a programme of cultural change to ensure that staff views are acknowledged and acted upon. This programme, alongside a relaunch of the values, should be central to the refresh of the People Strategy and the newly established People and Culture Committee.
- In terms of broader engagement, the majority of external stakeholders welcomed the extent to which the Trust had maintained an external and strategic focus despite its internal challenges. In particular, they were supportive of the leadership shown by the Interim CEO in recent months. There were however some mixed views in relation to the Trust's approach to partnership working, including the swiftness with which the Trust had responded to concerns around service delivery.
- The Board has acknowledged the need to substantially rebuild its relationship with governors and this has been outlined as a priority area of focus for the new Chairman.

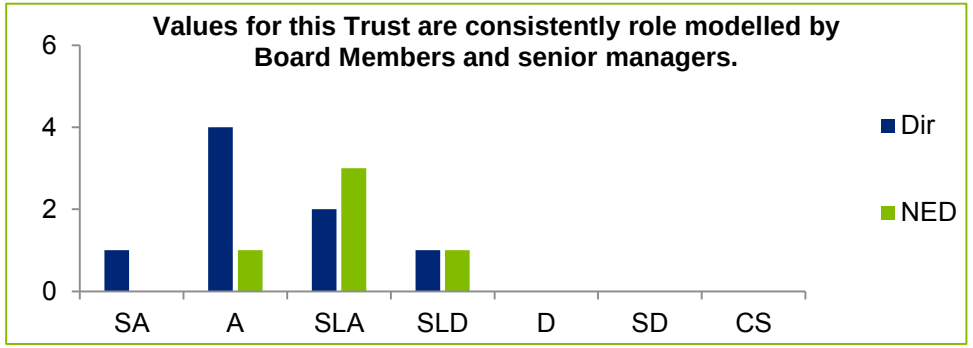
1B.1 - Do leaders at every level prioritise safe, high quality, compassionate care?

- The Trust have rated this area as amber/red in their self assessment, primarily in recognition that work is on-going to:
  - build a culture of openness and engagement;
  - enhance the focus on raising concerns and dealing with bullying and harassment; and
  - improve relationships with staff and governors.
- The Trust is currently in the process of refreshing the People Strategy which expired at the end of 2015. It is planned to launch this later in 2016 to enable alignment with the new strategy for the Trust.

- The Trust defined and implemented its values in 2013. People reported considerable effort historically to engage staff and co-create organisational values and behaviours, and the Trust should be commended for its work in this area.
- Staff we spoke with were clear about these values and felt that they were visible within the Trust. Values are used in recruitment, and there is a also a clear focus on these in the Trust's appraisal documentation.



- The impact of the ET has resulted in people questioning the extent to which these values have been 'lived' by those in the most senior position in the Trust. During interviews, we heard numerous accounts of people representing the Trust at external meetings and feeling 'embarrassed' or being 'tarred with the same brush'.



1. Capability and culture

1B: Does the Board shape an open, transparent and quality-focussed culture? (continued)

- There is an acknowledged need to refresh and relaunch the Trust values and behaviours and to reinstate credibility in this area in light of recent events. This is referred to in the governance action plan, although several senior members of staff we spoke with were unaware of this, and we have not yet seen any detailed plans.
- Trusts that we have seen undertake this well, include a focus on:
  - extensive engagement of staff in the development / refresh of values, in particular to ensure that the wording resonates and is meaningful;
  - ensuring values are visible across the Trust, for example on ward dashboards and Trust communications; and
  - reference to values in reporting, feedback and Trust publications.
- The Trust already has a behavioural framework in place, although this should also be refreshed alongside the activities outlined above.
- Typically this work is led through the HR team, although as outlined further in section 3, this needs to be addressed alongside the dynamics within this function.

R8: 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. Relaunch revised values across the Trust.

- At the May 2015 private Board meeting it was recognised that "*it would be right to demonstrate how the Board has learned lessons from both these ETs especially relating to relationship issues with staff and patients*". In response, the Personal Relationships Policy was updated and reviewed at the August Safeguarding Committee.
- Other work which has been undertaken over the last year has included:
  - initial work on defining expected behaviours, led by the CEO with clinicians;
  - the Staff Health Check, which was reported to the Board in June 2015. This outlined staff views in relation to bullying, timeliness of investigations, and a perceived blame culture; and
  - Spotlight on our Leaders' event in October 2015, which included a focus on quality, safety and leadership.
- Recognising that there have been some limitations on the extent of activities which could be undertaken due to the ongoing investigations in this area, BMs acknowledge that pace and focus has been lacking with regard to the development of a broader programme of cultural change, noting *"we've maintained the quality and financial performance but workforce has slipped"*.
- We also acknowledge the impact the number of outstanding grievance and whistleblowing cases has had upon the capacity of the HR and OD team.
- However, from our desktop review we have also noted a number of important areas in which we would have expected to see greater oversight, scrutiny and progress, including:
  - delays in implementing actions following the Freedom to Speak Up review, which was initially reported to the Board in March 2015 but AC members reported limited progress since the suspension of the CEO and a loss of traction in December 2015;
  - delays in the development of key policies, including the Whistleblowing policy (see 2B.2);
  - the Staff Health Check has not been reported back to Board since June 2015 and supporting action plans to the People Forum have been deferred; and
  - we have found limited discussion of actions being tracked against the 2014 NHS Staff Survey results.
- The Board does recognise the need to increase the focus in this area, noting that *"we need to own the problem and engage more with staff"*.
- Up to December 2015, workforce issues were primarily covered through the People Forum (which is not a formal sub-committee of the Board), with aspects also covered at F&P and QC.
- The formation of a sub-committee of the Board to focus on workforce issues has been raised previously, although no agreement on this was made. However following challenge at the November Board meeting around the effectiveness of the People Forum, and also in response to a recommendation in the Yates Report, there are now plans to introduce the People and & Culture Committee (P&CC) from February 2016.

1. Capability and culture

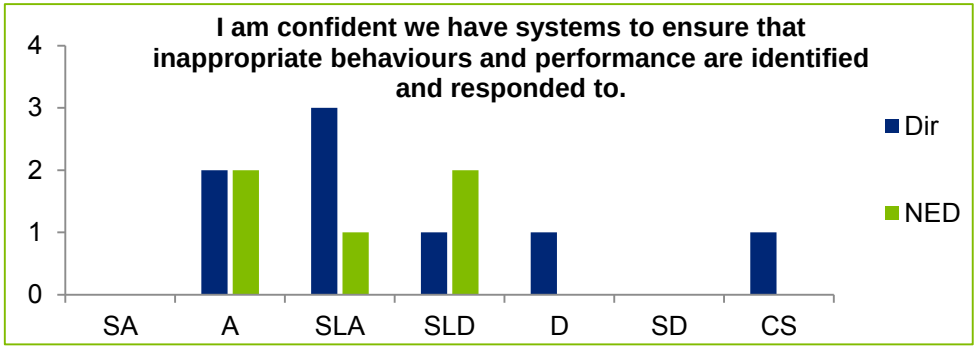
1B: Does the Board shape an open, transparent and quality-focussed culture? (continued)

- The Board must ensure that this forum has sufficient oversight of the successful development and implementation of the People Strategy as a priority, including seeking increased pace of delivery in this area (refer to 2A).
- The governance action plan tabled at the January 2016 Board meeting, includes actions in relation to organisational development, including:
  - 'develop a management of change model';
  - 'develop a pulse check process'; and
  - 'review the Trusts approach to reward and recognition'.
- As outlined further in 3A.1, the Trust are currently working on the detail behind these plans. Given the significance of findings in this area, we would have expected to see greater progress in both defining and implementing the supporting plans.
- Examples of actions taken by other trusts in this area include:
  - combining activities under a clear overarching programme with common branding to enable staff to see how component parts are interlinked;
  - a focus on seeking an extensive range of staff views, for example through large scale listening workshops supported by extensive communication of 'You said. We did';
  - a clear and on-going focus on pulse surveys with information disaggregated to teams to enable targeted activity and coaching within teams to be undertaken;
  - events focussed on staff health and well-being;
  - extensive communication of good practice and innovation throughout the Trust (which could include the use of quality champions);
  - a clear programme of leadership development.
- Refer also to Appendix 3.
- Given the capacity constraints in this area and the need to ensure that pace is demonstrated, the Trust should seek to draw on expertise within the local health economy to support the development of plans and actions in this area.

R9: 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.

1B.2 - Are candour, openness, honesty and transparency and challenges to poor practice the norm?

- During interviews, BM outlined a culture of "command and control" which had developed during the drive to achieve Foundation Trust status.
- In recognition that this needed to change, the Trust had focussed on establishing a culture of more devolved autonomy, although several of those we interviewed felt that momentum had been lost in this area.
- Some BMs also felt that as a result of this change in direction, the balance between accountability and autonomy needed to be better balanced. Refer also to 2B.1.



- Throughout our fieldwork, the length of time to review policies and complete internal investigations has been highlighted. There has also been slippage in a number of key cultural and engagement mechanisms including actions following the Freedom to Speak Up review, the Staff Survey and the Health Check. This is also reflected in the "culture of informality" and failure to adhere to policy identified in the Yates Report.
- Raising Concerns and Whistleblowing were also identified as an area where improvement was required in the 2014/15 annual report. While a Whistleblowing Policy was ratified in May 2015, members of the AC reflected that further work was required in this area, however this was not brought back to the January ELT meeting observed.

1. Capability and culture

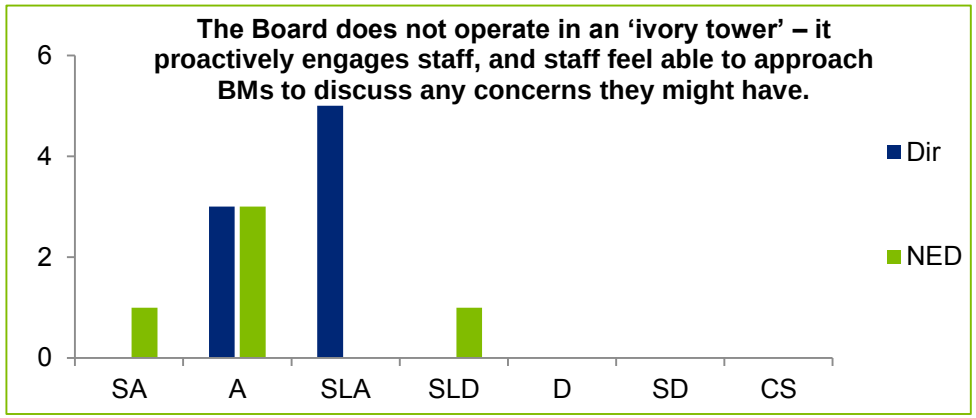
1B: Does the Board shape an open, transparent and quality-focussed culture? (continued)

- Whilst recognising the need to make improvements in this area, we have noted a number of areas of good practice:
  - Patient Surveys have been reviewed by the Quality Committee (QC) and also at the January Board meeting. It is noted that the inpatient survey results are the highest in 10 years due to a concerted focus in this area;
  - we have seen some good examples of seeking to improve practice at committee level, including increased focus on scrutiny of serious incident requiring investigation (SIRI) action plans and complaints at the QC;
  - the Nursing and Quality team has been remodelled and a redesigned post of 'Lead Professional for Patient Safety' has been recruited to better triangulate SIRIs and other complaints, litigation, incidents and PALS (CLIPs) indicators. Learning is shared via the Practice Matters Trust-wide newsletter and use of podcasts (and it is recognised that more could be done to share the learning);
  - there is good presence and interaction with staff in public Board meetings.

1B.3 - Does the trust leadership actively shape the culture through effective engagement with staff, people who use the services, their representatives and stakeholders?

1B.3.1 Staff engagement

- A number of mechanisms are in place in for BM to engage with staff including:
  - 'Spotlight on Leaders' events (see 2B.1);
  - podcasts from members of the executive team;
  - quality visits which include BMs and result in a ward accreditation rating. Platinum Wards are then linked with other areas to enable sharing of learning;
  - 'Delivering Excellence' staff awards; and
  - attendance of teams at the Board to update on specific reports or deep dives.
- While we support the range of mechanisms in place, when compared to best practice in other trusts, more could be done to supplement the current programme of activity.



- For example, effective mechanisms undertaken at other Trusts include:
  - a greater range of more informal mechanisms to enable staff to speak with BM;
  - CEO summary of the week emails;
  - back to the Floor activities led by EDs;
  - the use of staff stories at the Board;
  - ensuring activities include a focus on clinical and non-clinical areas;
- There is also scope to formalise learning and insights from these activities, for example by providing summary reports of findings to the QC, and greater insight to the newly formed P&CC. (See also examples in Appendix 3.)

R10: 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.

- While a Communications Strategy is in place (dated 2014-17), it does not set out the required activities post 2015. The document should also clearly identify its stakeholders and also ED leads for engaging these groups.

1. Capability and culture

1B: Does the Board shape an open, transparent and quality-focussed culture? (continued)

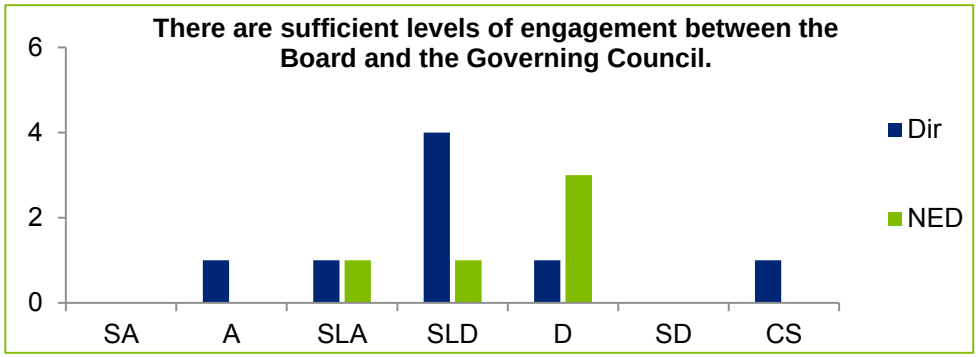
1B.3.2 - External stakeholder engagement

- External stakeholders acknowledged the extent of the changes to the Board's composition and the impact that this has had on levels of engagement.
- While some expressed positive views with regard to leadership and communications during this difficult period, others felt that more open discussion regarding the ET would have been more appropriate.
- Most stakeholders characterised the Trust as being "open", "transparent" and "responsive". In particular, there was positive feedback regarding the Interim CEO's visibility and external focus in the local health economy, especially in the context of the internal challenges faced.
- Some comments in relation to responsiveness to issues raised were outlined. While it was noted that these issues were now being addressed, pace of recognising and resolving issues by senior management had been concerning.
- Analysis of the Acting CEO's report to the Board shows some consideration of the external environment and updates from local forums although there is scope to increase this, particularly in the private Board session.
- For example, some Trusts include a summary of:
  - how key stakeholders are being engaged, along with a summary of feedback and any areas of focus;
  - key changes within the LHE and how the Trust can / is undertaking a role in these discussions;
  - how the Trust can demonstrate that it is listening to the views of stakeholders and responding to these as appropriate.

R11: 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.

1B.3.3 - Governor engagement

- The Trust Constitution states that the CoG should consist of 27 members, whereas there are at present only 15. In particular, the Trust needs to increase its partner governor membership.
- Through interview, self assessment and survey results, it is acknowledged that significant work is required to improve dynamics and levels of engagement between the Board and CoG.
- Governors articulated their dissatisfaction, and the extent of issues in this area has led some to a loss of confidence in some BMs.



- The governance action plan outlines intentions to introduce a task and finish group to identify new ways of working, alongside a skills audit, and training programme for governors. We are also aware that an extraordinary CoG was held recently to shape plans further.
- Trusts with high levels of governor engagement typically undertake a broad range of activities to develop and communicate with their CoG, including:
  - increasing attendance of both NEDs and EDs at CoG meetings;
  - introducing topical presentations by NEDs to governors in order to brief them on key Trust issues;
  - establishing a governor development programme, with a focus on behaviours and the statutory role of the governor; and
  - amending the format of the CoG to enable more informal interaction.

See also Appendix 4 for examples of governor best practice from other trusts.

R12: Prioritise the recruitment to the CoG, ensuring that the role of the governor and vacancies are publicised. Alongside this, as planned implement a programme of activities to increase engagement with governors.

1. Capability and culture

1B: Does the Board shape an open, transparent and quality-focussed culture? (continued)

1B.4 - Do leaders model and encourage co-operative, supportive relationships among staff and is there a culture of collective responsibility between teams and services ?

- A number of mechanisms are in place for leaders to support staff including:
  - the 'Delivering Excellence' staff awards to celebrate performance in effectiveness, patient experience, patient safety, and team of the year;
  - deep dives are undertaken in areas of potential concern, such as CAHMS, and include staff attending the Board to present key actions undertaken;
  - the Trust has recently started work on 'teams in distress', whereby quality and performance information is utilised to identify potential hotspots within the Trust, with support being provided; and
  - wards identified as being 'platinum wards' during Quality Visits work alongside other lower scoring wards to provide support and insight.
- In support of these activities, many other Trusts also undertake more routine pulse checks of morale across the Trust. This is then disaggregated to team level in order to identify areas of lower or declining results which may require intervention and support.
- Other mechanisms we have seen to work well in include:
  - coaching at both a team and individual level;
  - listening and celebrating success workshops; and
  - development of team charters / pledges.
- Refer also to Appendix 4 and R9.

2. Process and structures

2A: Are there clear roles and accountabilities in relation to Board governance (including quality governance)?

Summary of our findings: **Deloitte Rating:** 

- **There is scope for further improvement in the operation of committees. In particular, there is a need to minimise duplication, review membership and attendance, and increase contribution to debate. Processes for tracking and follow-up of actions also need to be strengthened. Recognising the level of change and pressures on capacity within the executive team, there are a number of examples whereby we would have expected to see greater accountability and pace.**
- The committee structure benchmarks largely in line with trusts of a similar revenue and complexity. In recognition of the need to strengthen arrangements further, a People and Culture Committee will also be in place from February 2016.
- BMs acknowledge that they have waited to understand the outcomes from recent independent reviews before taking any substantial changes to governance arrangements. As a result the overarching governance action plan is in the early states of development. Acknowledging that further work is currently underway to add granularity, this plan needs to provide real depth and clarity of direction if it is to provide an effective framework for the Board to drive forward action.
- A Governance Framework is in draft however there has been significant slippage in the development of this document which was initially scheduled for March 2015.

2A.1 Do the Board, council of governors and senior management within the organisation function effectively to deliver their respective governance responsibilities and interact with each other appropriately?

- The Trust's self assessment acknowledges the need to finalise a Board governance framework. This was initially due to be completed in March 2015, although completion was delayed. The Trust subsequently took the decision to wait until the completion of the Well-Led review.
- Other factors including the need to embed Quality Leadership Teams (QLTs), redefine accountability and ensure more stable committee attendance have resulted in the Trust rating this area amber/red.

2A.1.1 Governance Framework and action plan

- In recognition that the Board's core governance processes could be improved, the Trust commissioned an internal audit (IA) review of governance in October 2014.
- Changes made as a result include:
  - revising the Trust's approach to reviewing the BAF, including implementing BAF deep dives at committee level; and
  - increasing NED attendance at committees.
- Whilst progress has been monitored by the AC at points during the year, other BMs were unaware of progress in this area or the current status of actions in the plan.
- We have also noted that whilst a number of items are stated as being 'complete' or 'implemented', issues in these areas still remain.
- Several BM outlined frustrations in relation to the completion of the Governance Framework, which was an action outlined through the IA review.
- Our review of the current draft of this framework has noted several omissions for example:
  - providing clarity on key roles and fora including Vice Chair and the SID, the Performance Contracting and Oversight Group (PCOG) and the Safeguarding Committee;
  - descriptions do not always reflect what is actually undertaken in practice. ELT is described as being the forum through which QLTs are held to account, although our observation and desktop reviews do not show that this occurs.

R13: 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.

- As a result of further issues which arose during 2015, the Trust ended up with a number of disparate action plans including in relation to the ET, IA review, and Monitor.

2. Process and structures

2A: Are there clear roles and accountabilities in relation to Board governance (including quality governance)? (continued)

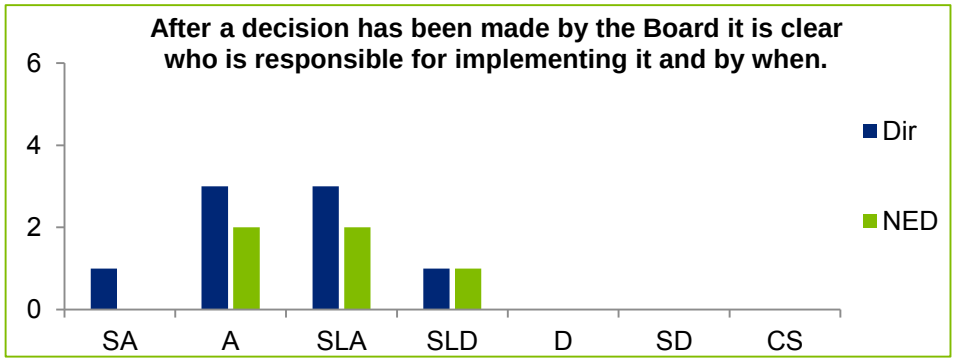
- During interviews, several BM were unaware of what had happened to these plans or how progress had been tracked. We understand that these were combined into the governance action plan which was reported to the AC, although this was not communicated across all BM.
- Following the receipt of the Yates report in December 2015, a further combined action plan has now been produced. Whilst we support the development of this plan as a central repository of all actions required, we would have expected to see greater progress in this area, particularly as many elements could have been built upon the preceding action plans. It is now imperative that pace and momentum in this area is demonstrated.
- The Trust are continuing to develop the format and content of the governance action plan, and have sought to build in good practice from other trusts, and to respond to feedback provided during our review.
- It is recognised that the plan is still in draft, and further iterations are regularly being produced. In addition we note that there is an intention to develop a number of supporting plans behind the key headline actions, although we have not been provided with copies of these.
- There remains a need to provide a much greater level of detail in order to provide an effective framework for the Board to drive forward action.
- In particular, the current iteration of the action plan would benefit from inclusion of:
  - priority ratings for each action;
  - greater detail around the action description, along with supporting detail for key tasks required;
  - reconsideration of the current use of RAG ratings, which does not easily afford the reader with a clear indication of progress or the scale of work still required;
  - associated risks with non-implementation;
  - more clearly defined outcomes and inclusion of KPIs where possible; and
  - include commentary to summarise progress. a summary of progress.

R14: 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.

- In recognition that the robustness of tracking of progress against the combined action plan needed to be improved, as well as clear ED leads, the Trust is intending to allocate specific sections of the framework to committees for monitoring and assurance purposes. The overall framework will then be reported to the Board on a monthly basis. This is more in line with what we see at other Trusts and we would support this greater level of oversight and review.

2A.1.2 Action tracking

- Throughout interviews and observations, we have noted a lack of pace and follow up of actions within agreed timescales across a number of areas. Examples include:
  - updates to the BAF, such as medicines management which were agreed in July but not added to the BAF received in October at either the Board or AC;
  - action plans surrounding the Staff Survey, Health Check and Staff FFT;
  - update of the sexual harassment policy; and
  - development of the Commercial Strategy.
- The format and use of action trackers also hinders effective monitoring of actions, for example items are often shown as 'green' before the action has been undertaken. Suggested timescales and priorities are also not assigned.
- BM also concurred through interviews and survey results that there needs to be greater rigour in this area. This has been a recent area of focus for the new Chairman, as observed at the January F&PC meeting.



2. Process and structures

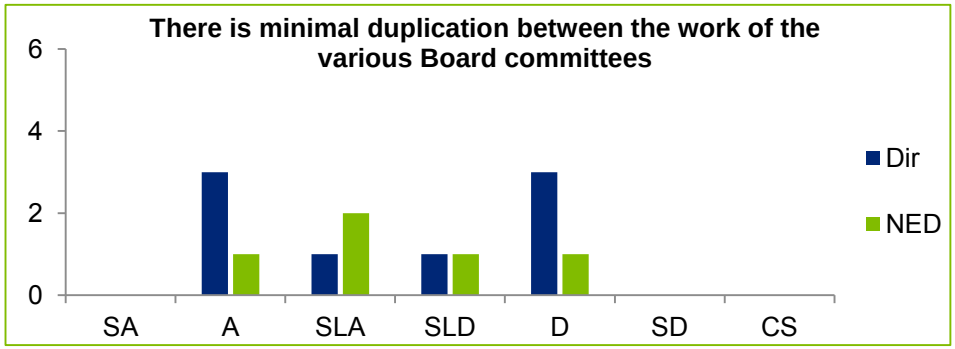
2A: Are there clear roles and accountabilities in relation to Board governance (including quality governance)? (continued)

- During interviews, we also noted that whilst some EDs routinely brief their staff following the Board meeting, this is not the case for all teams. In some areas we found staff that were not sighted on discussions and actions which impacted on their portfolio area.
- There is a need for more robust tracking of actions at committees and Board level. In particular, BMs should focus on:
  - clear summarisation of agreed actions, action owners and close dates by meeting chairs;
  - Board and committee action trackers should be 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; and
  - a greater level of robust holding to account when slippage occurs.

R15: The Board and its committees need to have a greater focus on capturing, recording and holding to account for agreed actions.

2A.1.3 Board Committees

- The Board committee structure benchmarks largely in line with trusts of a similar size and complexity. A People and Culture Committee will also be in place from February 2016 and we agree that there is a clear need for this forum (refer to 2A.1.8).
- Committees undertake BAF deep dives and regular reviews of their effectiveness. During observations and interviews BM and staff have noted a need to increase committee effectiveness, particularly in relation to quality of papers, length of agendas and the need to minimise duplication.



- Committee effectiveness could be increased further by:
  - reviewing forward plans against ToR to ensure clarity of purpose, and ensuring that agendas reflect the intended plans;
  - minimise duplication of papers received (such as the Complaints Report);
  - committee chairs meeting quarterly to ensure effective co-working;
  - review appropriateness of membership and robustly monitoring attendance;
  - ensure a consistent focus on summarising debate and capturing actions. (feedback on this should be sought in annual effectiveness reviews);
  - focus on members and attendees contributing equitably and effectively; and
  - timely submission of papers and consistent use of cover sheets and executive summaries.

R16: 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.

2A.1.4 Committee reporting to the Board

- Committee chairs previously complied a summary report of key issues and risks to escalate to the Board but a conscious decision was made to amend this to the receipt of minutes alone in September 2015. In our view escalation is most effective when both minutes and a short summary is provided to direct debate appropriately.

R17: 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.

2A.1.5 Quality Committee

- Our observation of the QC noted examples of challenge from NEDs and EDs. However, there was scope for a greater proportion of attendees to engage more fully in debate (see also 1A.1.3). There were also some areas where we would have expected greater levels of scrutiny, for example with regard to overdue SIRI investigation actions.

2. Process and structures

2A: Are there clear roles and accountabilities in relation to Board governance (including quality governance)? (continued)

- Focus on the Quality Strategy and Quality Goals could be enhanced by more explicit consideration of the Quality Dashboard. We also note that this currently reflects the old Quality Framework and should be updated.
- The Quality Committee currently has a significant number of subgroups reporting to it. In addition divisional Quality Leadership Teams which are still embedding and not yet considered to be fully effective, also now report into this forum.
- Some trusts find that the Quality Committee's strategic and assurance-seeking role is improved by introducing an executive-chaired quality governance group, which sub-groups and divisions typically report into . This enables the Quality Committee to more effectively undertake it's role rather than focussing on more detailed operational and performance focussed reports.
- In summary, the committee should:
  - ensure NED challenge of overdue actions and reports;
  - review the clarity of its TOR and work plans in relation to the AC and P&CC;
  - ensure subgroups routinely escalate key issues and risks to the QC;
  - introduce a Quality Governance Group to more review information from subgroups and quality leadership teams in order to enable the QC to focus on seeking assurance; and
  - increase its focus and alignment of topics to the quality strategy and goals.

R18: 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.

2A.1.6 Finance and Performance Committee

- Analysis of F&P agendas shows a focus on financial and business strategy, CIP delivery and operational performance. Other areas we would expect to see covered in this forum include: approval of significant business cases and monitoring of the delivery of the capital programme and scrutiny of financial forecasting.
- Given the establishment of the new P&CC, the F&PC will also need to review its ToR, to ensure that relevant workforce and OD related duties are transferred to this forum.
- Our observation found a good level of challenge, particularly from the Trust Chairman who was at this meeting for the first time. Notable examples of challenge at the meeting include the request for a dashboard on grievances performance, a lack of assurance around the workforce strategic risk, and forward-planning of CIPs.
- Review of minutes indicates that the committee has at times highlighted concerns over the quality of papers provided, and the length of the agenda. Nonetheless, at the meeting observed, the meeting finished early. This suggests a need to rebalance the committee's work plan and agendas.
- The committee would also benefit from much clearer summarisation of debate to 'close' each item clearly and ensure a shared understanding of required action. This was reflected in the feedback received by committee members at the end of the January meeting observed.
- In particular the committee should:
  - ensure a robust focus on summary of debate and actions for all agenda items;
  - review its ToR to reflect the transfer of all workforce related duties to the People and Culture Committee; and
  - ensure that all agenda items are afforded sufficient debate and scrutiny from all members and key attendees.

R19: Undertake a review of the Finance and Performance Committee in line with the actions outlined n 2A.1.6.

2A.1.7 Audit Committee

- We noted good examples of challenge at the meeting observed, in particular from the committee chair around amber-rated actions.
- Some of those we spoke with reflected that there is a tendency for members to discuss operational detail and our observation also found examples of this, such as a request for detail regarding family liaison officers.
- We also note that exceptions from all Board committees are currently reported to the AC via a combination of both summary reports and verbal updates. This arrangement is unusual and in our view duplicates the role of committee reporting to the Board, (it is recognised that the AC has previously sought other mechanisms for ensuring the effective operation of committees.)

2. Process and structures

2A: Are there clear roles and accountabilities in relation to Board governance (including quality governance)? (continued)

- At the meeting observed, updates from ED leads of other committees also lacked structure and appeared unclear on what to highlight or escalate.
- Members agree that the AC is well-chaired and has a good focus on the implementation of internal and external audit recommendations. A notable exception to this was pace in relation to the 2014 governance review. (see 2A.1.1)

R20: The Audit Committee should reaffirm its role in seeking assurance over systems, controls and processes and not matters of operational or managerial detail by:

- **reviewing its work plan to ensure a minimum of duplication of reports received at the QC; and**
- **revising the mechanisms by which it receives assurance over the effective operation of other Board Committees to minimise duplication with the role of the Board.**

2.A.1.8 People and Culture Committee

- As outlined on page 19, the Board has recently confirmed the establishment of a People and Culture Committee. In part this has arisen due to concerns around the effectiveness of the People Forum which had poor attendance of key members, concerns around the quality of papers, and limited traction on key issues.
- Given the lack of pace previously outlined with regard to improvements in workforce KPIs and the refresh of the People Strategy, the Board recognises the need to increase the momentum and focus in this area.
- It is key that learning from previous workforce groups is taken forward to ensure the success of the new P&CC, and in particular:
  - ensuring the right membership and dynamics;
  - a focus on rigour and holding to account for actions;
  - timeliness and quality of papers;
  - focus on KPIs and performance; and
  - ensuring the successful development and implementation of the People Strategy.
- ToR for this committee were ratified at the January Board meeting and comply with many elements of good practice (see also Appendix 5).

2.A.1.9 Safeguarding Committee

- The Safeguarding Committee was established in April 2015 in order to set the safeguarding quality strategy and to provide quality governance around the safeguarding agenda.
- The committee reports to the Board and has met quarterly to date. Membership includes 2 NEDs, clinical EDs, the CEO and senior clinical managers.
- While minutes show an acknowledgement that the committee and its reporting arrangements are new, there is a quarterly progress report against the Safeguarding Strategy, in line with good practice.

2A.2 Are structures, processes and systems of accountability clearly set out and understood and do they operate effectively?

- As outlined in 2A1.1, a corporate governance framework is in draft and should be ratified in March 2016.
- There is also a recognition that a performance management framework is lacking, particularly in light of a number of changes which have been made to accountability structures. This is outlined further in 2B.
- The self-assessment provided recognises that there have been a number of changes to structures and processes recently which will take time to embed.
- OD and cultural development programmes will be an important part of the new structure, both to ensure that senior managers fully understand their role as leaders and to set the right balance between accountability and autonomy.
- When moving to a culture of devolved accountability, some trusts find it helpful to 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 and expectations of performance; and
  - mechanisms to be used for holding to account both by EDs and within divisions.

R21: In light of the changing governance and accountability structures, an accountability framework should be designed to fully engage staff in how these changes will affect ways of working and desired behaviours moving forward.

2. Process and structures

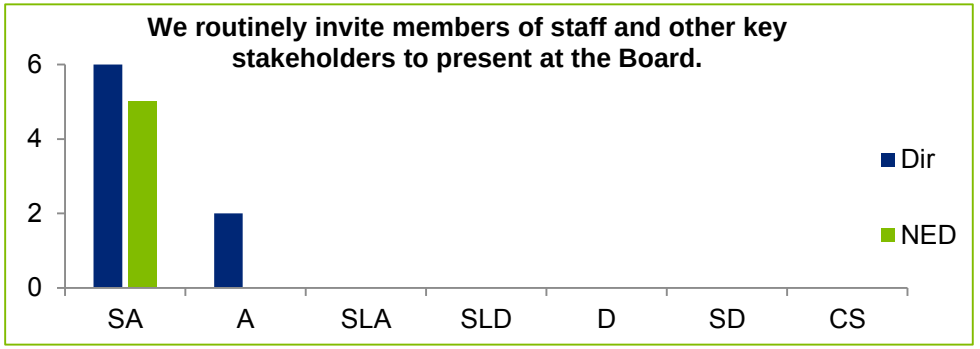
2B: Are there clearly defined, well-understood processes for escalating and resolving issues and managing performance?

Summary of our findings: **Deloitte Rating:**

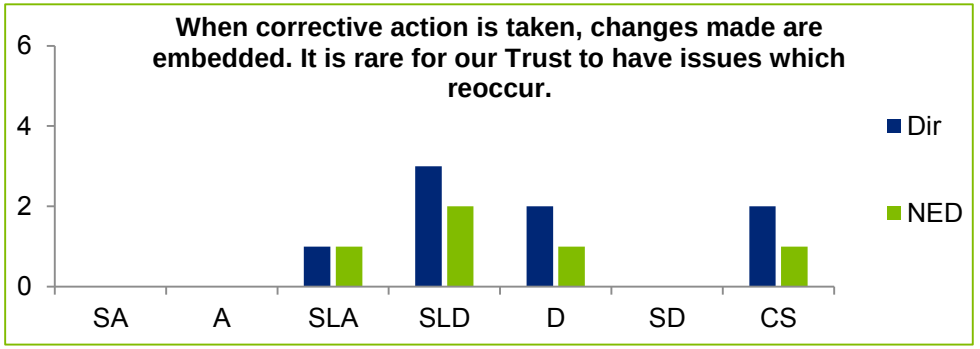
- **The Trust has a good track record of performance, and has sustained this position over time. Whilst there is an acknowledgement that a clearer performance management framework is required, we have noted good use of deep dives and staff presentations at the Board in order to respond to emerging issues. The Trust also recognises the need for greater triangulation of performance information, including the need to develop an Integrated Performance Report.**
- There are two key management forums for holding to account below committee level: the Performance Contracting and Oversight Group (PCOG) for finance and operations, and divisional Quality Leadership Teams (QLTs) which focus on the CQC domains.
- Several staff we spoke with reflected that holding to account at these forums could be stronger, and whilst still relatively new, there is an acknowledged need to increase the effectiveness of QLTs.
- The Trust is aware of the need to more clearly define roles, responsibilities and accountability arrangements in light of the move to neighbourhoods and campuses. Alongside this there is also an opportunity to more clearly define and communicate the role of PCOG in terms of devolved accountability moving forward.

2B.1 Does the organisation have the processes and information to manage current and future performance?

- The Trust rated this area of the framework amber/green. Whilst recognising the need to develop a single integrated reporting system, it was noted that they were confident in systems and processes for performance management.
- The Trust has a good track record of operational, quality and financial performance and has sustained this position over time. We have seen examples of issues being highlighted through performance information and then being tracked by the Board and its committees. An example includes capacity in the Crisis service in South Derbyshire where deep dives were undertaken, with progress being tracked by the Board and Quality Committee.
- Staff also routinely present to the Board on performance issues to add further context and also perspective into staff experience. Examples include County CAMHS capacity in April 2015 and suicide prevention in October 2015.



- There is scope, however, for greater 'closing-off' of actions. For example, while a sickness absence deep dive was undertaken at the September 2015 Board meeting, an action plan was not brought to F&PC until November. Due to a lack of assurance received at this committee, the plan was then resubmitted to the next meeting in January 2016. Refer to R15.



2B.1.1 Performance information

- Throughout our desktop reviews, observations and interviews, we have found a number of areas in which Board reporting and management information can be improved. Some NEDs for example felt that key issues are not clearly drawn out of reports and that *"we have to rely on what the executives tell us"*.

2. Process and structures

2B: Are there clearly defined, well-understood processes for escalating and resolving issues and managing performance? (continued)

- As outlined in the Trust's self assessment, there is also a lack of integrated reporting at Board level, with quality, operational and finance reports siting separately. This does not enable clear interpretation of causal factors and links between metrics. This was also recognised by a number of NEDs during interviews.
- Further, the Board receives very limited information on workforce (both operational and strategic) performance. The workforce dashboard is received inconsistently in the performance report and Quality Position Statement. Given the risks and challenges underway in this area and also the imminent introduction of the P&CC, this needs to be addressed as a priority.
- In line with good practice, service line reporting is in place.
- As part of the planned development of a comprehensive IPR the Trust should focus on:
  - rationalising the range of operational metrics included within the Performance Report which currently runs to 20 pages. This should have sufficient focus on exception reporting and actions underway;
  - developing a workforce dashboard, encompassing both 'hard' metrics (such as appraisal compliance, sickness absence, vacancies, turnover and grievances) and cultural metrics from pulse checks, Health Checks and the Staff Survey (see Appendix 6);
  - refreshing the quality dashboard, updated to show the revised Quality Priorities;
  - refining a finance dashboard, with key metrics including: I&E, FSRR, cash flow, liquidity, CIP performance and any key financial risks; and
  - including a summary of performance of groups to highlight any underlying themes.

R22: The Board needs to introduce an integrated performance report which encompasses key operational, quality, workforce and finance metrics.

2B.2 Are performance issues escalated to the relevant committees and the board through clear structures and processes?

- A structure is in place to enable escalation of performance issues, which includes reporting of financial and performance issues to PCOG through the ELT and quality matters to the QC via the QLTs.
- As outlined in 2A, this structure would benefit from a quality governance group beneath the QC. During our observation of ELT, we also noted limited debate on any issues arising from PCOG.
- In light of the move to a campus and neighbourhood-based approach, there is also an opportunity to clarify accountability and performance management arrangements and expectations.
- During interviews, staff outlined the performance management process as "convoluted", "woolly" and a "work in progress". Some also noted that the change to neighbourhoods had been undertaken without clear consultation or discussion, although we understand some further clarity has been provided more recently.
- Within services, there are also a range of governance meetings. General managers we spoke with were aware of the need to further develop their structure and consistency
- The Trust is aware of the need to clarify and implement a clear performance management framework. Following the recent appointment to all General Manager roles it is intended that discussions on this will commence in mid February. This should be undertaken alongside consideration of the behaviours and values, as well as accountability arrangements (see R21 in 2A.2).
- The Trust may wish to consider the development of an extended leadership team meeting with attendance of senior leaders and executives in order to consider key issues arising from both PCOG and QLTs in the round.

2B.2 Performance Contracting and Oversight Group

- PCOG is typically attended by the DoF, the Interim Director of Operations and the Director of Nursing and Quality along with divisional and corporate leaders.
- Some senior members of staff who attend PCOG reflected that there is scope for greater holding to account at this group. This should be considered alongside the broader review of performance management outlined above.
- The effectiveness of PCOG could be further improved by:
  - increasing ED attendance for a period to increase accountability in this forum';

2. Process and structures

2B: Are there clearly defined, well-understood processes for escalating and resolving issues and managing performance? (continued)

- clarifying the role of PCOG in light of the move to neighbourhoods and campuses;
- increasing the quality of minutes and action trackers and the timeliness of papers to this forum; and
- ensuring more consistent reporting and debate on exceptions and key issues at ELT.

R23: Formalise the role of PCOG as a key forum in the Trust's governance structure to address the issues highlighted in 2B.2.

2B.3 Quality Leadership Teams

- QLTs meet monthly, reporting to the QC. In line with good practice, agendas are standardised and structured around the CQC domains. At the January QC observed, however, some members reflected that the teams are not yet fully effective and that holding to account within the QLTs should be improved.
- Desktop analysis shows that the meetings are 'paper light'; Of the 14 agenda items on the December Specialist Services agenda for example, there were only 2 papers provided, and no risk register as scheduled. This is similar across all agendas reviewed.
- During this meeting, members also discussed the structure of this forum; it was reflected that "structures need to be in place... Lack of clarity is a concern". To address this, QLT chairs should:
  - conduct a review of forward plans to ensure all required papers are received at each meeting;
  - design a standard escalation template with key successes, risks and decisions to escalate to the Quality Committee;
  - ensure that clinical reference groups meet with sufficient frequency to enable the QLTs to undertake their work; and
  - consider a trial period of increased BM attendance at QLTs to provide coaching and oversight of meeting effectiveness.

R24: Refresh the role of Quality Leadership Teams to increase their effectiveness as core quality governance forums.

2B.3 Do clinical and internal audit processes function well and have a positive impact in relation to quality governance, with clear evidence of effective action to resolve concerns?

- We have seen evidence of the AC influencing the IA plan in line with significant risks, for example with regard to whistleblowing and complaints.
- At the December AC meeting, we observed a high degree of challenge regarding overdue clinical audits, which stood at 12% of the total plan. This was attributed to a higher volume of planned audits than other trusts and also a lack of capacity to support this within the team. A maturity assessment of the team is planned, which will be reported back to the committee in February.
- It has also been noted that clinical reference groups are not meeting with sufficient frequency to enable effective dissemination of learning from clinical audits.
- As outlined in 2A.1.7 we noted good challenge in the AC in relation to progressing IA actions.
- The 2014/15 internal audit report found a number of areas for improvement in the Trust's governance structures and processes, including:
  - a review of interaction between committees;
  - management of the BAF, including by committees;
  - improved induction processes for governors and NEDs; and
  - increasing challenge at committees.
- While progress has been made in a number of these areas, as referenced in 2A.1.1 a number of issues still remain.

3. Human Resources and related functions

3A Is the structure, leadership, management and operation of the HR and related functions, fit for purpose and effective?

Summary of our findings: **Deloitte Rating:**

- **The intense and sustained scrutiny that HR and its related functions have been under is acknowledged. The impact on the team has been substantial, and this has affected the ability of the function to deliver. There are a number of contributing factors which are currently constraining delivery of an appropriate and effective HR service. The absence, until recently, of strategic leadership of the function at Executive level was a significant concern.**
- There is an extensive programme of work for the newly appointed Director to undertake in order to resolve a range of operational / transactional issues and to refocus the function strategically. Relationships within the function are significantly strained and in our opinion not recoverable. There is an urgent need to reset expected behaviours and to drive cultural change across the function, alongside delivering a broader Trust wider programme of change.
- The strategy, model and structures within HR currently date back to 2010 and require review and updating. The programme of work to develop a fit for purpose HR function should not be underestimated and the incoming Director will undoubtedly play a central role in shaping the agenda. That said, there is a significant role for the Board and Executive Team to play in order to achieve the required progress in this area.

3A.1 Do the leadership and management teams have the experience, capacity and capability to drive the development and implementation of an appropriate and effective human resources strategy and culture within the organisation?

- HR and its related functions have been operating under considerable internal and external scrutiny over the past 2 years, as the Trust continues to respond to a range of complex and sensitive investigations as part of the impact of the ET decision.
- The self-assessment developed initially by the HR and related functions and revised by the Executive team on behalf of the Board, demonstrates a clear appreciation of the context and its impact on capacity and capability. These factors have led to the Trust rating itself red in this area.
- The extent to which an assessment can be made of the HR leadership and management team's capacity and capability needs to be set in the context of the following keys issues, which are constraining delivery:
  - until the 25th January, there was no overall Executive Director responsible for drawing together the various strands of HR and its related functions;
  - the People Strategy needs refreshing with the Strategy monitored through the newly established People and Culture Committee;
  - the model for HR appears to have been set in 2010 and would benefit from a review and update to reflect HR and the Trust in 2016;
  - the current structure of HR and its related services provides opportunities for closer working and improved efficiency;
  - key senior relationships within the function have been significantly impacted by events over the past 2 years so that they are irrevocably broken and beyond repair. These issues, also outlined in the Yates report, need to be resolved and alongside this the whole service needs to be engaged in a range of development interventions; and
  - clearer articulation of the expected behaviours would support the evolution of the current culture in HR and its related functions.
- We acknowledge that the Acting CEO confirmed the appointment of a substantive Director of Workforce, OD and Culture to the Trust on 25th January 2016. This Executive appointment will be central to driving the change required across the function and the Board recognises that this will take time to deliver.
- The absence of a joint Executive lead for HR and OD to date, has adversely impacted HR's ability to drive the development and implementation of an appropriate HR strategy. This in turn has obstructed the Trust's ability to lead cultural change.
- The team in HR expressed an increasing focus on transactional delivery over transformational and strategic HR. They attributed this to a lack of overall ED leadership and the ability to set a compelling strategic vision for HR and its related functions.
- Plans are currently being formulated to obtain external resource to support for the Director of Workforce, OD and Culture with the required changes. This will be vital as the agenda to transform HR is significant.

3. Human Resources and related functions

3A Is the structure, leadership, management and operation of the HR and related functions, fit for purpose and effective?

R25: Ensure external resources both to the newly appointed Director of Workforce, OD and Culture and the broader team are obtained in order to drive the transformation of HR and related functions and supporting programme of OD.

- BMs have acknowledged that the pace of change and the focus on HR as an enabler of a broader programme of change has been lacking. The existing Strategy, running from 2011 - 2015, sets an intention of being delivered through an organisational development model and has a number of important aspirations and objectives.
- While updates on progress against the People Strategy have been reviewed by the Board, these reports have not reported progress against all of the strategy's key objectives.
- Members of the HR team commented during interviews that the Strategy has "stood still" over the past 2 years, with a number describing HR as being disconnected from the Executive Team and the Board. Work is now underway to refresh the People Strategy and we support the need for this work to be undertaken.
- Oversight of the People Strategy and general workforce issues have, until December 2015, been covered through the People Forum. We note this was not a formal sub-committee and key workforce performance indicators, such as sickness absence, were typically discussed at F&P and QC.
- As referenced in 2A, it is therefore imperative that this committee has sufficient oversight and grip of the implementation of the refreshed People Strategy including monitoring of associated KPIs.
- The existing Strategy could be described as 'model driven' and academic in its approach. Being mindful of this and considering best practice from elsewhere, we would suggest:
  - the need to appreciate what has been achieved as well as what remains to be delivered;
  - the creation of a working strategy document that can be used and updated regularly. This should provide the Director of Workforce, OD and Culture with an opportunity to engage the workforce and the HR function in a more conversational style of change and development; and
  - develop a very clear implementation plan with actions, deliverables and targets over the next 3-5 year period, broken down into annual plans, and in particular with KPIs for 2016/17.

R26: 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.

- Our desktop review suggests the model of HR as expressed through the People Strategy, the existing structure and job descriptions, details the intentions of the HR function from 2010, when they were written. Whilst elements will undoubtedly be the same, both the NHS, the Trust and HR have moved during this intervening period.
- As referenced, while Organisational Development (OD) appears to have played a substantial part in the thinking behind the creation of the People Strategy in 2010, there is a perception that this has had a reduced importance in the past 2 years.
- This presents the Trust with an opportunity to update and revise the model for HR to take account of its current context. Trusts that have an effective model and are seen to perform well focus on a number of key factors that can be separated over 3 levels with a number of enabling elements, as described in Appendix 7 and detailed below:
  - a focus on getting all the basics right and supporting people management across the organisations – the foundations;
  - delivering the results with a compelling values proposition for people – the building blocks;
  - truly integrating HR with the business of the Trust and proactively leading the people agenda – Sustainable HR; and
  - the impact of great HR practice is underpinned by several enabling factors: sustainable innovation; continuous improvement; customer focus; value for money; value adding; and, finally, creating value.
- These are elements of HR best practice common across the sector and beyond and we would encourage the Trust to draw on this expertise in order to define its own model.

3. Human Resources and related functions

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- Best practice we have seen operating elsewhere is delivered by creating different levels of input for HR and related services in order to manage and deploy resources effectively. An example might look like:
  - First line advice through an internet portal or managed solution to resolve policy queries and set the foundations for getting the basis right, e.g. pay / salaries, holiday entitlement, sickness queries and organisational change;
  - A call centre advisory service for guidance on interpretation and guidance on policies and employee relations cases in order to deliver business results, e.g. resourcing, Medical Staffing, Health and Wellbeing, mandatory training, management and leadership development, apprentices and graduates;
  - Introduce a business partner model to pick up the strategic elements of HR and the more complex employee relations case work in order to integrate HR with divisions, supporting talent management and succession planning in order to proactively leading the people agenda across the Trust.

R27: 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.

- The structure of the leadership and management team across HR and its related functions is currently highly disparate and inefficient. We recognise that plans are being formulated to revise the structure and we would encourage the Director of Workforce, OD and Culture to prioritise this as part of programme of work development work with the HR function.
- There is a recognition that the structural split of HR and its related services, although well intended at the time, has in practice compounded the situation and further entrenched people's positions.
- Until recently, Executive level accountability for HR was split, with operational HR reporting to the Interim Director of Operations, who provides direction on operational issues and a link to the Board. The Leadership and Education function report to the Director of Transformation.
- This has impacted on the effective functioning of HR and its ability to drive the development of an appropriate and effective HR strategy and to support cultural change within the organisation. Implementing a new structure that is informed by the strategy and model for HR should be a high priority.

R28: Define a new structure for HR and its related functions with a priority on operational efficiency and strategic impact taking into account (R2) the refreshed People Strategy and (R3) revised model for HR and related functions.

- We are aware from our fieldwork that the ET has negatively impacted on relationships across the department. It was evident that a number of internal processes are ongoing and directly relate to the impact of the ET. The Trust has advised these processes are nearing a resolution. Whilst we recognise this has been a difficult period for those involved, we note frustration on both sides in respect to the pace and adherence to policy and procedure.
- Relationships at a senior level appear to have completely broken down. To the extent that the most senior leaders, the Deputy Director of HR and the Assistant Director of Leadership avoid contact, do not meet or discuss the delivery of their respective service lines with each other (see also 3A.1).
- This has further impacted on relationships across HR and its related services. People described a distinct lack of trust amongst colleagues and being fearful of having 'false' accusations made against them.
- Given the strength of feeling evidenced during our interviews, rebuilding the HR team with a leadership that can drive the HR function and act as enabler for more broader cultural change is a necessary action for the Trust.
- In light of this, we would suggest that the Director of Workforce, OD and Culture continues the work that has already been started to further develop a bespoke programme to rebuild relationships at a senior level with a clear team development programme for the function.

R29: 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.

3. Human Resources and related functions

3A Is the structure, leadership, management and operation of the HR and related functions, fit for purpose and effective?

- Whilst acknowledging and reflecting on these constraints, there would appear to be the capacity and capability within HR and its related functions to drive an appropriate and effective strategy. Our fieldwork and assessment suggests that it is principally patterns of behaviour (i.e. culture) within the HR function is currently inhibiting delivery.

3A.2 Are the policies and processes for the human resources and related functions comprehensive and compliant with legal requirements and do they reflect current best practice?

- Our desktop review demonstrates that HR policies and procedures are, in the main, comprehensive and compliant with the relevant legislation.
- Our analysis found, and interview feedback confirms, that the list of workforce-related policies is too long and unwieldy at present; At the time of our review there were 40 in in operation across the Trust. Good practice in this area would indicate a need to amalgamate or transfer a number of the policies to guidance documents.
- There is an established process for HR policy development through the Trust's Workforce Policy Review Group. The Terms of Reference state that the group will review policies every two years.
- However a review of a sample of policies and procedures found that the majority had passed their review date, or were due for review within the current calendar year. The HR team acknowledged a need for a focus on policies, but some of those we spoke with were not clear on the intended timescales for completion of this work.
- As outlined in 1B.2 a number of key policies also remain in development.
- One of the reasons for this, was attributed to the tense relationship with staff side which made the review of policies and procedures difficult. The Trust should continue the work to rebuild relationship with unions at local and regional level and this should be a priority. Alongside this, improvements to the Policy Review Group need to continue to be developed.
- It should be noted that during this period, the ELT has provided additional oversight and monitoring of policy review progress.
- Staff side colleagues stated that the general state of the relationship is hampering a range of activity and this would appear to be most acutely felt with the policy work. Whereas, members of the HR team offer a different view of the current state of the relationship and characterised these as improving.
- In particular, policy review should focus on:
  - working to revise the number of policies;
  - ensuring they are reviewed for plain English;
  - Consistency and clarity in how policies are presented , e.g. managers guide, policy or procedure.

R30: The Trust would benefit from a robust and thorough policy review programme.

3A.3 Are policies and processes clearly articulated, understood and embedded throughout the organisation?

- The length of some policies and procedures are too long and not all are written in plain English.
- Reducing the number of policies and procedures would further support the embedding process and aid understanding with line managers. It is likely that policies are only referred to when there is an issue for a member of staff. Managers reported difficulties in understanding what policy to access and have a working knowledge of all the policies in order to manage situations without recourse to formal processes.
- Throughout our fieldwork, the length of time to review policies and complete internal investigations has been highlighted. This is also reflected in the "culture of informality" and failure to adhere to policy identified in the Yates Report.
- All new and updated HR Policies and Procedures are flagged through an email communication to all managers and staff as agreed via the Trust's Policy Bulletin – although there is no formal process of sign off to ensure people have read and understood new policies and procedures.
- Our desktop review considered a number of documents, with a number selected for closer examination.

3. Human Resources and related functions

3A Is the structure, leadership, management and operation of the HR and related functions, fit for purpose and effective?

- The Disciplinary Handbook for Managers is very thorough, and appears to be accurate. The length of the document in its current format does raise the question if line managers have the time to read and digest the content, or whether they would seek to contact the HR team for advice, as the guide suggests.
- The Grievance Policy and Procedure is again very thorough, and appears to be accurate. From a technical perspective, it does not mention the handling of Collective Grievances, which whilst similar, are worth highlighting or sign posting elsewhere. Neither the Disciplinary nor the Grievance Policy mentions overlapping cases and what should be done in these instances. Good practice would require that these be referenced.
- The HR team acknowledged there is more to be done to ensure policies are adhered to and applied consistently and fairly across the Trust.
- In developing W&OD policies and procedures, the HR team referenced the production of management guidance for many of the policies to assist in the application of the policy principles. It was recognised that this is an area for review.
- All staff receive a copy of the Trust's Staff Handbook (gives a summary of the key employee related policies and procedures), but what was not apparent was a process to update existing managers with new policies and procedures.

R31: 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.

3A.4 Are appropriate and effective training and guidance on the content and application of policies and processes provided across the organisation?

- Line managers and staff commented that the application of policies and procedures could be improved. Staff side wholly supported this view and our own review of a number of HR case files against the relevant policies and procedures matched the findings from a similar exercise conducted by CQC.
- We conducted a deep dive of 6 randomly selected HR casefiles from the HR tracker. The findings of that work highlight a number of issues:
  - Audit trail – this was found to be incomplete with no copy of the concerns raised appearing on files or a letter inviting the individual to a grievance or disciplinary meeting.
  - Terms of Reference – are produced for each case and are detailed. However, often there are timescales omitted and/or not adhered to. It would appear that investigation reports were often not produced on time.
  - Timescales – this would appear to be the biggest issue. Cases were often allowed to drift with people kept in limbo, whilst further investigation work continued or people went off sick.
  - HR Support – our experience is this a fine balancing act. The line management are rightly involved in all cases and conduct investigations supported by the HR team. However, it would appear that HR do not intervene swiftly enough and take action to ensure timescales are met.
  - Process – An initial grievance and concern was raised with the Director of Nursing who asked HR to look into the concerns. This does not appear to have been handled correctly or appropriately. It would appear that the concerns were passed on and 'given' to the line to manage. Nothing documented appears to have happened and HR picked up the case a few months later and the grievance has still not been heard some 6 months later.
- A culture of informality was described by a variety of people, with inconsistent application of policy and procedure, which our deep dive would appear to corroborate.
- Implementation of policies and procedures appears to be onerous on the HR function at the present time. A number of people commented and felt this might be a potential impact of ET and that line managers were quick to get into a formal process, where previously these issues would have been handled informally.
- A more robust training programme needs to be prioritised to support line managers with understanding and interpreting policies and procedures and to ensure consistency of application.

3. Human Resources and related functions

3A Is the structure, leadership, management and operation of the HR and related functions, fit for purpose and effective?

- The HR self-assessment stated that all available internal training is advertised in the training directory that can be accessed by staff via the Trust intranet whilst limited development is provided for policy interpretation and implementation. This does raise the question on whether there is sufficient training allocation and whether this is currently prioritised.
- An e-learning package on recruitment and selection is being developed as an update for managers, but is not currently live.
- The issues outlined from the deep dive indicate some basis issues. As the Trust develops a fit for purpose HR function, consideration needs to be given to a refresh or training programme for the operational HR team, to ensure risk to the Trust is limited and mitigated from a legislative and employment tribunal perspective.
- **R32: Consider a range of development interventions for the operational HR team to ensure employment law risks are mitigated. Examples of this might be masterclasses by the Trust's solicitors or workshop sessions with ACAS.**

3A.5 Are candour, openness, honesty and transparency, and challenges to poor practice, the norm?

- In respects to the HR and related function, we identified key behaviours of candour, openness, honesty, transparency and challenge to poor performance, evident on a intra-team basis. However this did not extend to inter-team working across HR and its related functions, in fact the reverse was reported in some instances.
- A non-existent relationship was reported between operational HR and the Leadership and Education teams. The two teams reported that at present they simply do not talk or interact with each other. Both teams cited ongoing internal processes following the fallout from the ET as the rationale for the lack of candour, openness, honesty, transparency and challenge to poor performance.
- The size of the task to unite the HR function is substantial as the extent of the current issues will require a sustained programme of development, expectation setting and holding to account.
- It is widely acknowledged the culture in HR needs to evolve. Our experience of working with teams and organisations going through similar change programmes is the requirement to develop a robust plan and for regular, even monthly monitoring, e.g. a 'temperature check / cultural barometer'. This could be achieved through asking 10 to 15 questions on a regular basis, publishing the results and linking that to the delivery of the overall cultural change programme, with the ultimate aim to determining whether it feels different on the ground and the team is moving in the right direction.

R33: 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.

3A.6 Are effective monitoring processes in place to provide assurance that policies and procedures are applied appropriately and consistently and to address failure to comply?

- Effective monitoring Trust-wide does not appear to be in place at the present time in order to provide assurance on the application and consistency of the Trust's policies and procedures. There are pockets of good practice and the HR team did report reviews of cases and identification of trends, but this was more ad-hoc than scheduled and part of their forward plan.
- The HR team described a regular case review meeting that is held with the senior W&OD management team for more complex cases, with progress monitored against the relevant policies, with reports to SMT, TOMM and JNCC where necessary. These report appear to be at the request of other committees and groups, as opposed to HR proactively monitoring and providing assurance for the full range of case and policies.
- A member of the HR team did reference action taken in respects to failure to comply with Trust policies and procedures, this resulted in an offer of employment being withdrawn.
- The HR function would benefit from agreeing a universal standard for monitoring compliance across the whole Trust.

3. Human Resources and related functions

3A Is the structure, leadership, management and operation of the HR and related functions, fit for purpose and effective?

R34: Define and agree a process to regularly monitor the consistent application of HR policies and procedures for the full range of Employee Relations cases.

Refer also to, as the People and Culture Committee should monitor the application of policies and procedure as a standing item with regular reports and trend analysis scheduled on the Committee's forward plan.

3A.7 Do the HR and related functions effectively support and secure the delivery of organisational development and of staff performance management processes across the organisation?

- The Trust should expect HR and its related services to be more effective in securing the delivery of organisational development. At the current time the function reported an over-focus on transactional delivery, due to the perceived lack of a clear vison, with numerous people stating *there isn't a clear vision for HR.*
- The HR team stated in the self-assessment that they provide HR support with organisational change. The recent restructuring work to create a neighbourhood approach provided HR and its related function with an opportunity to secure development of the organisation.
- Reports from the workforce suggested confusion with the consultation and lack of clarity in communication. Although this is a management issue, HR does have a role to play as the custodians of the organisation.
- From a staff management of performance perspective, the last National Staff Survey indicated that 65% of staff had received an appraisal and the Survey outlined concerns with the quality of staff performance management processes.
- Overall, there are pockets of positive practice. What wasn't evident at the current time is a robust mechanism for evaluating the impact and whether the range of HR/OD interventions is adding real value in support of the Trust's strategic direction. The HR function would benefit from defining, capturing and reporting how HR is making a positive impact and delivering what the business needs.

R35: As part of R26 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.

3A.8 Are inappropriate behaviours and performance identified, and dealt with swiftly and effectively?

- A number of behavioural issues with people in HR and related functions were identified during the course of the fieldwork. There was a general perception among those interviewed that the timeliness with which formally raised issues are being investigated does not suggest a swift or effective response.
- We also identified a number of issues with regard to behaviours, performance management and leadership which are pertinent to the broader Trust and as such have been discussed elsewhere in this report, including:
  - examples of poor behaviours going unchecked or unchallenged (refer to 1B.1);
  - a tendency for managers to engage prematurely in a formal grievance process (refer to 3A.3 and 3A.4);
  - a need for more structured processes to enable holding to account, which are closely aligned to strategy (refer to 2B.2); and
  - the need to refresh and relaunch the Trust values in order to rebuild credibility in this area. Alongside this, we found that the responsibility of Trust leaders in role modelling the values needed to be re-emphasised. (refer to 1B.1).

Appendices

Appendix 1
Summary of recommendations

#	Section	Recommendation	Supporting detail / enabling actions
1	1A	Implement a programme of Executive Team development which focuses on team dynamics, effective challenge and leadership and is supported by individual coaching where necessary.	As per 1A1.1, the programme should have a focus on: • team dynamics and agreed ways of working; • clarity of purpose and vision; • effective challenge and leadership; and • individual coaching.
2	1A	Further improve the function of the ELT by improving the timeliness of papers and quality of debate.	Not applicable.
3	1A	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.	Not applicable.
4	1A	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.	As per 1A2.1, succession plans should have include: • nominating successors at contingency, intermediate and planned levels from ED level to heads of service; and; • embedding these plans for EDs, NEDs and key divisional and corporate leaders.
5	1A	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, and covers the points outlined in 1A.2.2	As per 1A2.2, the Board development plan should consider: • more detailed consideration of the governance action plan; • a focus on Board challenge, including assurance, reassurance and the role of the corporate director; • facilitated 360 feedback; • Board cohesion and dynamics; • use of external speakers to add insight and prompt debate; • joint sessions governors ; and • engagement from senior Trust leaders.
6	1A	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.	Not applicable
7	1A	Undertake an independent review of progress made against the recommendations raised in this report in 9 months' time. As part of this review, a 360 feedback process for all BMs should be incorporated.	

Appendix 1
Summary of recommendations (continued)

#	Section	Recommendation	Supporting detail / enabling actions
8	1B	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. Relaunch revised values across the Trust.	As part of this work, consider the points outlined in 1B.1, namely: • engaging HR and its related functions to lead this key piece of work; • extensive engagement of staff • ensuring values are visible across the Trust ; and • a refresh of the behavioural framework
9	1B	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.	As per 1B.1, this work should include: • combining activities under a clear overarching programme with common branding to enable staff to see how component parts are interlinked; • a focus on seeking an extensive range of staff views; • a clear and on-going focus on pulse surveys to enable targeted activity and coaching within teams; • events focussed on staff health and well-being; • extensive communication of good practice and innovation; • a clear programme of leadership development.
10	1B	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.	Refer to appendix 4 for good practice examples of staff engagement.
11	1B	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.	Consider for example: • how key stakeholders are being engaged, along with a summary of feedback and any areas of focus; • key changes within the LHE and how the Trust can / is undertaking a role in these discussions; • how the Trust can demonstrate that it is listening to the views of stakeholders and responding to these as appropriate.
12	1B	Prioritise the recruitment to the Council of Governors, ensuring that the role of the governor and vacancies are publicised. Alongside this, as planned implement a programme of engagement with governors, encompassing additional activities from 1B.3.3 and Appendix 5.	Refer to Appendix 5 for examples of good practice governor engagement.

Appendix 1
Summary of recommendations (continued)

#	Section	Recommendation	Supporting detail / enabling actions
13	2A	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.	As per Appendix 3 and 2A.1, the action plan should include: • priority ratings for each action; • key tasks required for each recommendation / action area; • associated risks with non-implementation; • outline of any key resources required; • completion of KPIs and success measures; • comments on progress comments; and • links to demonstrable outcomes
14	2A	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.	Not applicable.
15	2A	The Board and its committees need to have a greater focus on capturing, recording and holding to account for agreed actions.	As per 2A.1.2, this action should focus on: • clear summarisation of agreed actions, action owners and close dates by meeting chairs; • Board and committee action trackers should be 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; and • a greater level of robust holding to account when slippage occurs.
16	2A	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.	As per 2A.1.3, the review needs to cover: • 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
17	2A	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.	Not applicable.

Appendix 1

Summary of recommendations (continued)

#	Section	Recommendation	Supporting detail / enabling actions
18	2A	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.	As per 2A.1.5, this action should focus on: • NED challenge of overdue actions and reports; • the clarity of its TOR and workplans in relation to the AC and P&CC; • introduce a Quality Governance Group; • increase its focus and alignment of topics to the quality strategy and goals.
19	2A	Undertake a review of the Finance and Performance Committee in line with the actions outlined n 2A.1.6.	In particular, there is a need for this committee to: • ensure a robust focus on summary of debate and actions for all agenda items; • review its ToR to reflect the transfer of all workforce related duties to the People and Culture Committee; and • ensure that all agenda items are afforded sufficient debate and scrutiny from all members and key attendees.
20	2A	The Audit Committee should reaffirm its role in seeking assurance over systems, controls and processes and not matters of operational or managerial detail.	In particular, there is a need for this committee to: • review its workplan to ensure a minimum of duplication of reports received at the QC; and • cease to receive summary reports from other committee chairs and executive leads.
21	2A	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.	As per 2A.2, When moving to a culture of devolved accountability, some trusts find it helpful to 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.
22	2B	The Board needs to introduce an integrated performance report which encompasses key operational, quality, workforce and finance metrics.	As per 2B.1.1, the IPR should include: • key operational metrics; • a workforce dashboard; • the Quality Dashboard, updated to show the refreshed Quality Priorities; • a finance dashboard; and • a summary of performance of groups to highlight any underlying themes.

Appendix 1
Summary of recommendations (continued)

#	Section	Recommendation	Supporting detail / enabling actions
23	2B	Formalise the role of PCOG as a key forum in the Trust's governance structure to address the issues highlighted in 2B.2.	Consider: • increasing ED attendance for a period to increase accountability in this forum; • clarifying the role of PCOG in light of the move to neighbourhoods and campuses; and • increasing the quality of minutes and action trackers and the timeliness of papers to this forum.
24	2B	Refresh the role of Quality Leadership Teams to increase their effectiveness as core quality governance forums.	As per 2.B.3, QLT chairs should: • Conduct a review of forward plans to ensure all required papers are received at each meeting; • Design a standard escalation template; • Ensure that clinical reference groups meet with sufficient frequency to enable the QLTs to undertake their work; and • Consider a trial period of increased BM attendance at QLTs to provide coaching and oversight of meeting effectiveness.
25	3A	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.	Not applicable.
26	3A	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.	Not applicable.
27	3A	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.	
28	3A	Define a new structure for HR and its related functions with a priority on operational efficiency and strategic impact taking into account (R26), the refreshed People Strategy and (R25) revised model for HR and related functions.	
29	3A	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.	

Appendix 1
Summary of recommendations (continued)

#	Section	Recommendation	Supporting detail / enabling actions
30	3A	The Trust would benefit for a robust and thorough policy review programme.	The review should focus on: • working to revise the number of policies; • ensuring they are reviewed for plain English; • Consistency and clarity in how policies are presented , e.g. managers guide, policy or procedure.
31	3A	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.	Not applicable.
32	3A	Consider a range of development interventions for the operational HR team to ensure employment law risks are mitigated. Examples of this might be masterclasses by the Trust's solicitors or workshop sessions with ACAS.	
33	3A	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.	
34	3A	Define and agree a process to regularly monitor the consistent application of HR policies and procedures for the full range of Employee Relations cases.	
35	3A	As part of R26 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.	

Appendix 2
Model succession plan

Directorate/ Department	Role	Current Post Holder	Contingency Successor (Short term)	Immediate Successor (Successor ready imminently)	Planned Successor (1 – 3 years)	Planned Successor (3 + years)
Executive Directors						
	CEO			A number of individuals from the senior leadership team are in a position for entry to these categories for the CEO		
	Deputy CEO		A number of individuals from the senior leadership team are in a position for entry to these categories for the Deputy CEO roles.			
	Chief Nurse		Aliso			
	Medical Director		Dr D Dr Cl			

Directorate/ Department	Role	Current Post Holder	Contingency Successor (Short term)	Immediate Successor (Successor ready imminently)	Planned Successor (1 – 3 years)	Planned Successor (3 + years)
Integrated Care	Clinical Director					
	Operational Director			External recruitment required	External recruitment required	
	General Manager		External recruitment required	External recruitment required		

- Succession planning completed and ratified at Board, divisional and corporate department level for all Trust leaders (i.e. clinical or deputy directors to matrons / service managers).
- Successors identified at short-term, immediate and planned levels.

Appendix 3
Cultural and engagement mechanisms

Mechanisms to engage with staff and elements of good practice

NHS FT 1	NHS FT 2	NHS FT 3	Other suggestions to consider
• 'Back to the Floor' events e.g. EDs undertaking shifts within A&E	• Staff support networks	• Annual planning and business cycle: engaged staff in development of Trust strategy	• CEO forums
• CEO/MD send updates regarding Trust ongoing via Twitter	• CEO Monday message	• Workshops to encourage open reporting and raising concerns	• Roadshows
• 'Listening into Action' programme	• Director shadowing programme	• Well known processes to cascade messages from the Board & ET	• Staff development days
• Cascading of key messages and actions via from the Board via intranet site	• Regular communication re rota review	• Staff co-design pathway development	• Career path initiatives
• Team Brief	• Occupational health roadshow	• Team brief	
• BM walkabouts	• Healthy Lifestyle Programme	• Weekly staff bulletin	
• Staff invitations to committee	• Rewards and recognition schemes	• Trust newsletter	
• Social media	• HR policy implementation training	• Staff social media initiative	
• Open invitation to public Board meetings	• Internal opportunities webpage	• Staff Involvement and Wellbeing workshops	
	• Coaching programmes	• 'Don't be a Spectator' campaign	
		• Stress awareness initiatives	
		• Invitations to public Board meetings	

Appendix 4

Governor engagement good practice

Mechanisms to engage with governors and elements of good practice	NHS FT 1	NHS FT 2	NHS FT 3	Other suggestions to consider
	• Governors participate in service visits and PLACE inspections	• Board to Boards: Trust Board and the Council of Governors on a biannual basis	• Governors attended annual away day with Board members	• Information provided to governors is suitably redacted for their purposes, included clear glossaries provided
	• Governor development sessions	• The Chair holds regular informal meetings	• Governor development programme	• Strategic workshops with BMs and Governors
	• Committee Chairs attend Governors Council meetings to enable to ask finance, quality or audit specific questions.	• Director visit programme: Governor participation in service visits with Board members	• Governor quality group	• Full opportunities for governors to provide feedback as part of NED 360 appraisal
	• Lead Governor attends private Board sessions	• Governor development programme	• Governor co-ordination group	• Trust Chair meets regularly with Governors

Governor membership comparison with other providers	Mental Health trust 1	Mental Health trust 2	Mental Health trust 3	Mental Health trust 4	Mental Health trust 5	Mental Health trust 6	Mental Health trust 7	Mental Health trust 8
	• 9 Public • 13 Service User/Carer • 6 Staff • 12 Appointed	• 6 Public • 13 Service User/Carer • 5 Staff • 8 Appointed	• 8 Public • 11 Service User/Carer • 6 Staff • 13 Appointed	• 21 Public • 6 Staff • 10 Appointed	• 11 Public • 6 Service User • 4 Staff • 8 Appointed	• 8 Public • 11 Service User/Carer • 6 Staff • 6 Appointed	• 31 Public • 9 Staff • 7 Appointed	• 17 Public • 7 Staff • 9 Appointed
	40	32	38	37	29	31	47	33

Appendix 5
Typical workforce committee ToR

Authority
- The committee holds the authority to approve policies and procedures relating to the workforce and welfare strategy
- Authorised to seek legal advice and to commission external advice and support including reports
- Investigate any activities or matters within its terms of reference
- Request specific reports from service areas/individual functions within the organisation and to seek the information it requires from any member of staff to perform its duties

Purpose
- The committee will report regularly to the Board to provide assurance on all workforce matters
- Make recommendations, as appropriate, on strategic and operational workforce matters to the Board of Directors

Duties
- Advise on direction and priorities for the development of workforce strategies, including approval of the Trust's workforce and welfare strategy monitoring effectiveness on an ongoing basis
- Approval of policies, procedures and strategy appertaining to workforce development and welfare.
- To review and approve workforce development and welfare key performance indicators
- To review performance against agreed key performance indicators
- Identify risks associated with identified areas of performance, ensure that they are managed appropriately, and reported back to the Committee
- Advise and monitor workforce welfare, reviewing terms and conditions of employment and health and safety issues relating to staff
- Review and advise on workforce development and welfare associated governance systems and processes

Duties (continued)
- Monitor workforce efficiency and effectiveness and review reports on the achievement of workforce development objectives
- Monitor the development of talent management plans
- Provide oversight of succession planning
- Oversee the development of the Trust plans relating to workforce equality and diversity
- Monitor national best practice and make recommendations to the Board to further workforce wellbeing and engagement
- Review the annual staff survey results, monitor actions taken and advise the Board on developments arising as a consequence

Membership
- Non-executive Chair
- Non-executive Directors (3 including Chair)
- Chief Executive Officer
- Director of Workforce and Organisational Development
- Director of Nursing and Midwifery
- Medical Director

Frequency of meetings
- At least 6 meetings will be held per annum. Additional meetings may be held on an exceptional basis at the request of the Chair

Minutes and reporting
- The minutes of all meetings of the committee shall be formally recorded and shall be submitted to the Board of Directors

Review
- The Committee shall review its Terms of Reference and make any recommendations to the Board for approval annually

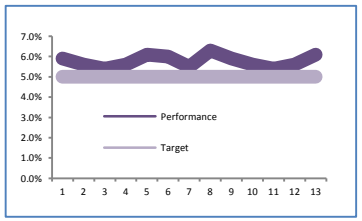
Appendix 6

Model workforce dashboard

Wellbeing

[Overarching workforce KPIs]

1. Sickness absence



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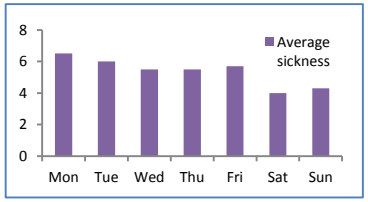
x	x	x

2. Sickness by day



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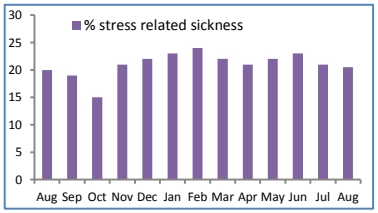
x	x	x

3. Stress-related sickness



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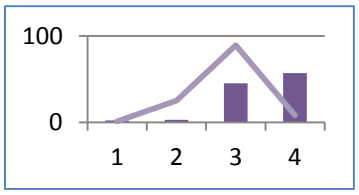
x	x	x

3. Extra contractual hours



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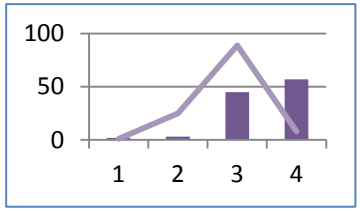
Motivation

[Overarching workforce KPIs]

1. Staff Survey



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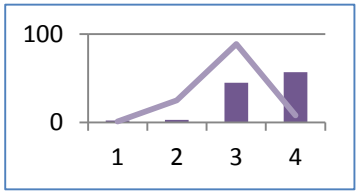
2. PDR compliance



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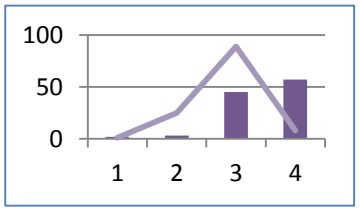
3. Grievances and bullying



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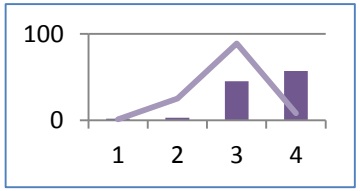
4. Staff FFT



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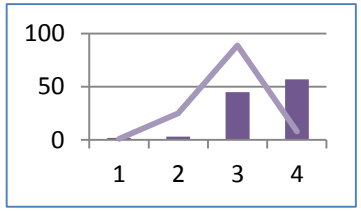
Attendance

[Overarching workforce KPIs]

1. Vacancies



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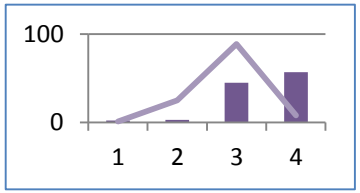
2. Stability / churn



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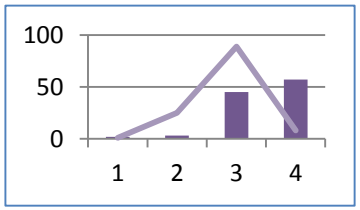
3. New starter feedback – survey scores



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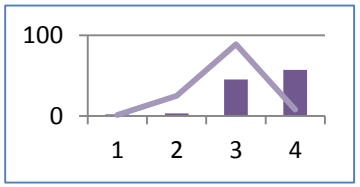
4. Use of agency staff



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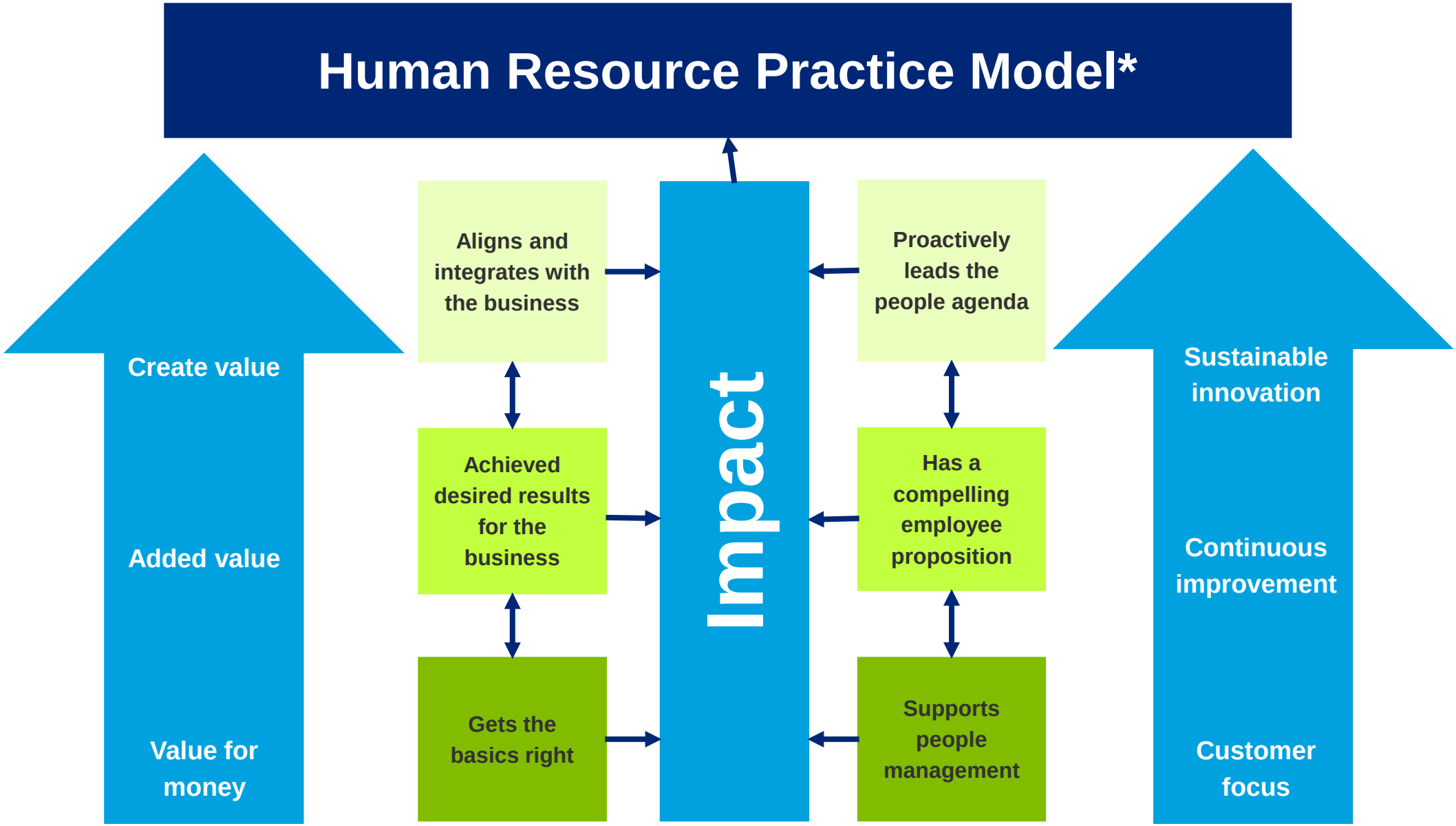
Appendix 7

Human Resources and related functions model



*Based on the World Class HR Model

Appendix 8

Glossary of terms

AC	=	Audit Committee
BAF	=	Board Assurance Framework
BM	=	Board member
Board	=	The Board of Directors
CCG	=	Clinical Commissioning Group
CEO	=	Chief Executive
CLIPs	=	Complaints, litigation, incidents and PALS
CoG	=	Council of Governors
CQC	=	Care Quality Commission
CQUIN	=	Commissioning for Quality and Innovation
Directors	=	Any member of the Board (either Director or NED)
ED	=	Executive Director
ET	=	Employment Tribunal
FT	=	Foundation Trust
F&PC	=	Finance and Performance Committee
HR	=	Human Resources
IAPR	=	Integrated Activity and Performance Report
IA	=	Internal Audit
KPI	=	Key performance indicator
Monitor	=	Independent Regulator of NHS Foundation Trusts
NED	=	Non Executive Director
NHS	=	National Health Service
P&CC	=	People and Culture Committee
PCOG	=	Performance Contracting and Oversight Group
QC	=	Quality Committee
QLT	=	Quality Leadership Teams
RAG	=	Red, amber, green
SIRI	=	Serious incident requiring investigation
ToR	=	Terms of Reference
Trust	=	Derbyshire Healthcare NHS Foundation Trust

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

REPORT

GOVERNANCE REVIEW PANEL

Martin Chitty

Sarah Woodman

Alan Yates

DISCLAIMER

This report comprises confidential analysis, conclusions and advice prepared by a panel of external advisors comprising the panel being Alan Yates, Sarah Woodman and Martin Chitty and is provided for the sole use of the Council of Governors ("CoG") and the Board of Directors ("BoD") and is made to the "body corporate" Derbyshire Healthcare NHS Foundation Trust. The report is provided to the Trust through the office of the Senior Independent Director, Caroline Maley. In providing this report through her to the BoD and CoG the panel will regard its task as complete. It is for the appropriate governing organ of the Trust to decide if further circulation should be made and how that should occur. No part of the report or any of its contents are to be communicated whether in whole or in part to any person who is not a member of the CoG or the BoD other than with the prior consent of all members of the CoG and the BoD. Wider circulation by the Trust or any individual Director or Governor and any consequences which follow will be the responsibility of the Trust and the individual and not the panel.

CONTENTS

Chapter 1	**Executive Summary**
Chapter 2	**Terms of Reference**
Chapter 3	**Methodology and Approach**
Chapter 4	**Factual Background**
Chapter 5	**Organisational Governance**
Chapter 6	**Organisational Culture**
Chapter 7	**Organisational Response to Staff Concerns**
Chapter 8	**Recommendations**

CHAPTER 1

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

1 In July 2013 Helen Marks was suspended by her manager Steve Trenchard, the Chief Executive, from her post as Director of Workforce and Organisational Development.

2 Over the following month she expressed concern about lack of due process, reported diminished confidence in Steve Trenchard and in September 2013 made a complaint about the Trust Chairman, Alan Baines, and soon after took out a grievance against Alan Baines and Steve Trenchard. This resulted in the Chairman's resignation as he felt his relationship with Helen Marks had been inappropriate.

3 In the absence of the Chair, the Senior Independent Director, Mick Martin became the Acting Chairman and set about trying to resolve the situation. This resulted in an attempt to reach a settlement with Helen Marks which was unsuccessful. The grievance process was not completed. In addition Helen Marks was offered a public apology which was never fulfilled, was promised cessation of her suspension and was put on "special leave" instead and shortly after took sick leave. Ultimately in February 2014 she resigned and sought redress in an Employment Tribunal.

4 The tribunal found in her favour on all four counts of her claim those being Sexual Discrimination, Sexual Harassment, Victimisation and Constructive Dismissal.

5 The independent review panel was established by the Senior Independent Director of the Trust to investigate the circumstances leading up to the Tribunal and to see what had led to such an outcome.

6 The panel consisted of Alan Yates, an experienced NHS Mental Health Chief Executive, Martin Chitty, Partner, Wragge Lawrence Graham & Co LLP an employment solicitor and Sarah Woodman, Managing Consultant, ENSO HR Consultancy, an experienced human resources professional.

7 The terms of reference are described in the main body of the text but overall were twofold:

- to provide an independent report into the actions of the Trust and specifically identify areas in which the Trust has failed to apply appropriate standards of corporate governance and;

- to provide independent reports on the specific actions of past and current officers of the Trust.

8 The panel has provided one report on the first objective to which this summary is attached. The second objective has been fulfilled by individual reports to the Senior Independent Director who the panel anticipates will forward to the appropriate decision makers only.

Findings

1 The panel has seen no evidence that the services of the Trust have suffered as a result of the circumstances surrounding the Employment Tribunal, rather we have seen senior leaders making great efforts to ensure that that does not occur.

2 The panel has found largely that the governance machinery as illustrated by this issue was generally sound.

3 The panel found that it was in the lack of observation of the Trust's rules, policies and procedures that the issues arose and became as difficult as they did.

4 The panel also found that not only was there a lack of discipline in the observance of good governance but that there was a general culture of informality which contributed to the consistency of error which aligned to create such an emphatic outcome in the Employment Tribunal.

5 This informality also enabled staff to believe that issues raised outside the formal processes of the Trust should and would be acted upon. Meanwhile the relevant managers did not regard them as requiring action. This allowed the perception that the complaints and concerns were not followed up or treated seriously.

6 One aspect of the organisation's arrangements which were particularly challenged was the relationship between the BoD and the CoG. The difficulty of this relationship pre-existed the Employment Tribunal but this issue became a "lightening rod" for the sense of marginalisation felt by some Governors.

7 The panel found that some Governors described themselves as being unsure of their role or locus.

8 The panel found working arrangements and practices sometimes orientated around personal relationships and not the plans and purposes of the Trust. These relationships both good and bad had influence on the work, its content and the efficiency with which it was carried out.

Recommendations

These are not repeated here but can be found in Chapter 8 of this report.

Conclusions

1 The panel was asked to look into the arrangements which could enable an event such as the Employment Tribunal of Helen Marks to occur.

2 The Tribunal itself is not the concern of the panel.

3 This report and the individual reports try to throw light on the truth of the issues and the panel feels it has been able to do that. There is some difficulty in all of those interested seeing that that is the case. We have felt it important to avoid in our report the criticisms which have been levelled at the Trust, particularly poor observation of good practice. Consequently we have chosen to defend individual's confidentiality where appropriate. The Trust has sustained considerable damage to its reputation and there is a loss of trust between some senior figures in the organisation. What is needed now is a clear plan to resolve the issues highlighted in the report but also everyone involved contributing to the reconciliation needed if this plan is to be successful.

4 The Trust has a new interim Chairman and his leadership will be important to enable the Trust's governance arrangements to be used effectively again. The panel urges all those who can to help Derbyshire Healthcare NHS Foundation Trust to be the organisation the public deserves. This will necessitate giving the Interim Chairman their support in enabling him to take the Trust out of these difficult times into the effective leadership of services which are vital to the population of Derbyshire.

CHAPTER 2

TERMS OF REFERENCE

1 INTRODUCTION

1.1 Terms of Reference were issued to the panel by the Trust. It is these Terms of Reference that have provided the basis for the nature of the investigation. These are repeated below.

2 TERMS OF REFERENCE

2.1 The outcome of the Employment Tribunal - Introduction

2.1.1 The Trust has recently received the judgement in an Employment Tribunal in which Helen Marks presented a claim of:

(A) Constructive unfair dismissal

(B) Elements of harassment / victimisation

(C) Discriminatory dismissal.

2.1.2 The outcome of the employment tribunal was received by the Trust on the 23rd June 2015. The outcome criticised a number of officers of the Trust including the Chief Executive. In addition to the outcome of the Employment Tribunal the Trust has received a number of subsequent complaints about the actions of the Chief Executive (and current chairman) as well as a number of other senior managers. The Chief Executive has been suspended pending formal investigation.

2.1.3 As stated above the Trust has received a number of complaints and counter complaints, some of the issues raised in these complaints relate directly to the ET claim and other raise concerns about wider issues relating to individuals and their grievances. A separate investigation has been commissioned into the issues relating to the individuals. Where interdependencies exist investigators will need to work together and share information.

2.2 Aim of the Investigation

2.3 The aim of the investigation in relation to the recent employment tribunal and subsequent complaints is twofold:

2.3.1 to provide an independent report into the actions of the Trust and specifically identify areas in which the Trust has failed to apply appropriate standards of corporate governance and;

2.3.2 to provide independent reports on the specific actions of past and current officers of the Trust.

2.4 **Investigation**

The specific aims of stage 1 of this investigation are to:

2.4.1 Investigate the Chief Executive's on-going fitness under the 'fit and proper person' test under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 5;

2.4.2 Investigate the conduct of senior members of staff in relation to behaviours and professional conduct, where appropriate this will also include behaviours and conduct expected by professional bodies;

2.4.3 Ascertain whether the Trust failed to apply appropriate standards of Corporate Governance. This will be assessed against the Trust policies, procedures, constitution as well as regulatory frameworks;

2.4.4 Consider whether the current chairman has executed his role effectively in this case since starting at the Trust in January 2014;

2.4.5 Consider whether the communication flow between the Trust and the CoG was sufficient to enable the Governors to discharge their statutory duty of 'holding non-executive directors' to account;

2.4.6 Ascertain whether the Trust has failed to support staff who have previously raised concerns about individual members of staff;

2.4.7 Consider the process of appointment for senior managers in the Trust as deemed appropriate.

2.5 **Method of investigation**

2.5.1 The panel with consist of three external independent investigators; one with experience as a senior NHS executive, one a senior solicitor with experience of Board level issues, one a senior Human Resources professional with experience of Board level issues.

2.5.2 The panel will examine all appropriate documentation which in its view relates to the outcome of this investigation in order to properly carry out its investigation.

2.5.3 The panel will agree appropriate communication arrangements with parties involved in the investigation including previous employees.

2.5.4 The panel will ensure appropriate communication with other investigation panels and will ensure that were appropriate issues are escalated between the panels.

2.5.5 The panel will ensure its work is conducted confidentially.

2.5.6 The Senior Independent Director will be the organisational sponsor for the investigation.

2.5.7 The panel will coordinate its work through the Interim Director of Corporate and Legal Affairs i.e. arranging meetings; accessing documentation.

2.6 **Output and reporting arrangements**

2.6.1 The panel will provide regular updates to the Senior Independent Director.

2.6.2 Requests for the amendment to the scope of this investigation must be approved through the Senior Independent Director.

2.6.3 The panel will provide a written report including recommendations to the Senior Independent Director.

2.6.4 Where the panel recommends further action against individual members of staff, they will provide separate reports on each individual to the senior independent director.

There were five appendices attached to the Terms of Reference, the first contained details of the background of the panel members, the remaining four provided the panel with specific lines of enquiry relating to individual employees of the Trust. For reasons of confidentiality they are not repeated here.

CHAPTER 3

METHODOLOGY AND APPROACH

1 INTRODUCTION

1.1 This chapter sets out the methodology and approach used by the panel in conducting its investigation.

2 TERMS OF REFERENCE

2.1 The terms of reference utilised by the panel are outlined in the previous chapter.

3 DOCUMENTATION

3.1 The panel had access to significantly more information than the papers than were available in the Employment Tribunal bundle. This is significant to some of the panel's conclusions.

3.2 The documentation relied upon by the panel consisted of the following:

3.2.1 Employment Tribunal Judgment – Helen Marks v Derbyshire Healthcare NHS Foundation Trust; (amended)

3.2.2 Employment Tribunal Bundle;

3.2.3 Employment Tribunal Preparation Files – DAC Beachcroft Solicitors ("DACB");

3.2.4 Derbyshire Healthcare NHS Foundation Trust BoD meeting, both public and private minutes from June 2013 to June 2015 inclusive;

3.2.5 Derbyshire Healthcare Foundation Trust CoG meeting minutes for 2013 to 2015;

3.2.6 Written representations from Steve Trenchard and Alan Baines.

3.2.7 Additional documentary evidence provided by Lee O'Bryan, Harinder Dhaliwal, Tony Smith, Lorraine Statham and Maura Teager.

3.2.8 Performance review documentation of Steve Trenchard carried out by Alan Baines and Mark Todd conducted in 2013 and 2014.

3.2.9 Recruitment and appointment process – CEO appointment including Odgers Berndtson's evaluation of candidates.

3.3 The panel took steps to obtain additional information and documentation as and when it became apparent that it was required from the perspective of providing further evidence.

4 APPROACH AND STRUCTURE

4.1 Following a period of familiarisation with the Trust, the Employment Tribunal Judgment and any associated documentation, the panel took an 'outside-in' approach to structuring the investigation. As far as practicable those who were perceived to have had least involvement or influence in the case were interviewed earliest in the process and those who were perceived to have been most involved or influential, later in the investigatory process.

4.2 A list of names was produced of all of those who were perceived to be relevant to the investigation, in accordance with the terms of reference.

4.3 Some of these individuals are no longer employees of the Trust and therefore their contribution was entirely voluntary.

4.4 The panel made a decision to approach witnesses direct where possible to ensure complete independence was maintained though for some it was more convenient to make arrangements via the Trust.

4.5 The intention from speaking with each of these individuals was to help the panel to form as complete a picture as possible of the Trust and the internal culture alongside gathering specific information in relation to the Employment Tribunal and staff complaints.

4.6 Some witnesses feature later in the interview process than was intended, largely due to conflicting diaries, outstanding questions, holidays or illness.

4.7 The members of the CoG were invited to complete a pro-forma about the issues which was drafted by the Lead Governor.

4.7.1 The relevant solicitors who had been involved in this matter on behalf of DACB were also interviewed.

4.7.2 The interviews were initially recorded by handwriting with a note taker present. However, to ensure as much accuracy as possible, these were changed to audio recordings early on in the process. Transcripts were produced of each recording.

4.7.3 Interviewees were given the opportunity to review the transcript of their interview and to provide clarification and additions where appropriate.

5 INTERVIEW FORMAT

5.1 The panel took a holistic approach to each interview, seeking to understand the following key issues relevant to the interviewee, but often exploring a range of issues outside these areas:

5.1.1 Career history (both inside and prior to the Trust) to present day.

5.1.2 Experience of internal culture and leadership styles.

5.1.3 Awareness of Helen Marks' suspension and related issues.

5.1.4 Awareness of any internal complaints / issues and what was done about these before, during and after the Tribunal.

5.1.5 Employment Tribunal – knowledge and involvement before, during and after Tribunal.

5.1.6 Governance and adherence to internal policy and procedure.

5.1.7 Key reflections.

5.1.8 Present day insights.

6 INTERNAL COMMUNICATIONS

6.1 The panel met with the CoG on 8th September 2015 to provide an introduction to the individual members of the panel, to share information in relation to the process being adopted around the investigation and to respond to any questions.

7 INDIVIDUAL GRIEVANCES

7.1 The panel was not tasked with investigating individual grievances within the Terms of Reference. A separate investigation has been commissioned in relation to these.

7.2 It was agreed that where interdependencies exist, investigators from both panels would work together to share information where appropriate.

7.3 Where serious issues were brought to the attention of the panel that were outside the remit of the investigation, these were built in to the investigatory process where possible.

8 REPORTING

8.1 In addition to this report, separate reports will be provided to the Senior Independent Director in relation to individual contribution and conduct where appropriate, as dictated by the Terms of Reference.

8.2 These reports will be forwarded to the decision maker only.

8.3 The Trust will be responsible for all decisions taken in relation to individual conduct reported on in the context of this investigation. However the panel would recommend that individual reports on Executive Directors are reviewed by the Chairman of the Trust, and reports on current Non-Executive Directors are reviewed by some, though not all Governors.

CHAPTER 4

FACTUAL BACKGROUND

1 INTRODUCTION

1.1 This chapter sets out the key events to which this report relates. It does not seek to include every aspect of every issue which has taken place, only those relevant to the panel's terms of reference, findings and recommendations. The panel has sought to divide the timeline in to relevant periods for ease of reference.

2 THE PERIOD PRIOR TO FOUNDATION TRUST STATUS

2.1 Prior to 2011 two unsuccessful applications were made for Foundation Trust status. Given the importance of that status being granted the second failure lead to a number of changes to the senior management team including but not limited to:

2.1.1 Alan Baines appointment as Chairman in 2009;

2.1.2 The appointment of Mick Martin and Graham Foster as NEDs;

2.1.3 The appointment of Tim Woods as Finance Director. Other senior executives during this period were Mike Shewan, Ifti Majid, Graham Gillham, Kathryn Blackshaw, Paul Lumsdon and Helen Marks (from 1st Aug 2010) together with pre-existing NEDs Lesley Thompson, Tony Smith and Maura Teager.

2.2 The second failed FT application forced the newly formed BoD team to concentrate on getting the organisation through the process. The panel has been informed that there was material criticism after the second failure about financial and strategic planning. As the intention was to make and succeed in a further application completion of the process became a focus for all of those involved.

2.3 The cultural shift and revised focus resulted in a "top down" approach leading to a "commanding" style of leadership. This point has been described to the panel by many of those seen who recall this as their experience of the Trust during this period. The panel does not for these purposes draw any conclusion as to whether this was appropriate – it was the style adopted and the Trust did succeed in its third application.

2.4 The panel has received comments from many people that, internally at least, the drive for FT status resulted in:

2.4.1 Intolerance of challenge to the view from the senior team;

2.4.2 Insecurity as those who were perceived as having challenged the prevailing view were seen as suffering for having done so;

2.4.3 Little room for debate;

2.4.4 A perception that the outcome rather than the improvement from the process leading to it was the key.

2.5 The panel is of the opinion that what developed was a position where there was only one acceptable way of things being done – that being the way identified by the senior management team.

3 NEW GOVERNANCE STRUCTURES AND SENIOR MANAGEMENT CHANGES IN THE PERIOD AFTER FT STATUS UP TO THE APPOINTMENT OF STEVE TRENCHARD

3.1 Achievement of FT status was seen as the goal. Having achieved that there is a perception amongst a number of NEDs seen by this panel, none of whom remain with the Trust, that a degree of complacency and stagnation set in. In part this is attributed to attainment of a hard-fought end result, that it was not just a means to an end but the end itself. Further there was a lack of clarity about how the Trust could and should take things forward. This has been described to the panel as a "lost period".

3.2 With FT status came new governance structures. The Unitary Board had worked together through the FT process and was viewed by those involved as cohesive. It now had a different and local oversight body, the CoG ("CoG"), an entity with at the time a relatively narrow remit in terms of appointing and removing the NEDs including the Chair; fixing their remuneration; approving the appointment or not of the Chief Executive; appointing the Trust auditors and receiving the Trust's annual report and other documents.

3.3 This remit was widened in the 2012 Health and Social Care Act to include holding the NEDs individually and collectively to account, representing the interests of members, approving "significant" transactions and other specified roles. The CoG includes staff governors and has a Monitor-requested role of Lead Governor. The post holder is to be the communicant with Monitor when there are leadership concerns, but it is not expected to be the leader of the Governors. Lew Hall, an elected member for Erewash North was appointed to that role in 2010.

3.4 The evidence we have heard from individuals from the Board and the CoG is that there was a lack of clarity about how the two were to work together, what was required and what was discretionary in terms of reporting, about lack of training for CoG members and their limited understanding of the role itself. We have heard of a dismissiveness of the CoG expressed at Board level.

3.5 Helen Marks joined the Trust as Director of Workforce and Organisational Development in 2010. Her appointment was the result of a transfer in to the Trust under TUPE. She had considerable experience within the NHS and the local health community. Her appointment reflected what we have been told was a change in policy within the Trust to move towards a

more values and people based system of management within which there would be a need for an experienced senior manager with organisation development experience. For that reason Helen Marks' appointment has been described to the panel as well matched with the cultural change that had been begun.

3.6 In April 2012 Mike Shewan left the Trust to go on secondment elsewhere within the NHS.

3.7 The exit of Mike Shewan resulted in the appointment of Kathryn Blackshaw as Acting Chief Executive, a post she held from March 2012 until Steve Trenchard's appointment with effect from 1st February 2013.

3.8 In about September 2012 Tim Woods, who had been Finance Director, left the Trust. He was replaced in January 2013 by Claire Wright.

3.9 The position at 3.7 necessitated the recruitment of a new permanent Chief Executive. This process was undertaken in several stages using external head-hunters Odgers Berndtson, who have an established record in such matters, and involved the identification of likely candidates, their assessment against the agreed criteria set out by the Trust (which included a more values based approach to the Trust's operation), various presentations and interviews.

3.10 This resulted in a shortlist of 5 candidates for final interview, 3 internal and two external, one of whom was Steve Trenchard. Based upon our interviews Steve Trenchard was agreed to be the best candidate and was appointed. This was supported by Odgers Berndtson's evaluation of the candidates before the final selection process. This process ended on or about 19 October 2012. He came in to post formally on 1st February 2013.

3.11 Steve Trenchard's appointment resulted in the departure of Kathryn Blackshaw soon after he came in to post.

4 SENIOR MANAGEMENT AND NED CHANGES BETWEEN FEBRUARY 2013 AND MAY 2015.

4.1 Paul Lumsdon left his position of Chief Nurse with the Trust in September 2013.

4.2 Carolyn Green was appointed to the role of Head Nurse in February 2014.

4.3 Ifti Majid became Chief Operating Officer and Deputy Chief Executive with effect from April 2013.

4.4 Graham Gillham remained as Director of Corporate Affairs and Governance until September 2015 with interim cover being provided since January 2015 by Jenna Davies.

4.5 Jayne Storey was appointed as Head of Transformation, including responsibility for human resource management, in November 2014. In the period between October 2013 and October 2014 the senior HR role was filled by Lee O'Bryan.

4.6 Alan Baines resigned as Chairman on 19 September 2013 and was replaced by Mick Martin as acting Chairman from then until Mark Todd was appointed with effect from 20th January 2014.

4.7 At an indeterminate date between 20th October and 26th November, Lesley Thompson was appointed acting Senior Independent Director and Deputy Chair. This was notified to the CoG at their meeting on 10th December 2013 but not subsequently formally transacted at a BoD meeting until April 2014.

4.8 Caroline Maley was appointed as an NED and as Chair of the Audit Committee on 20 January 2014.

4.9 Lew Hall resigned as Lead Governor (and as a Governor) in June 2014.

5 ISSUES AND CONCERNS RAISED BY OR ON BEHALF OF STAFF IN THE PERIOD 2013 TO 2014

5.1 In this context "staff" includes current and former staff of the Trust and one NED.

5.2 There were a number of matters discussed by Harinder Dhaliwal, Sarah Carter, Karen Herriman and Maura Teager with Alan Baines in about June 2013 which Steve Trenchard then discussed with those concerned in the period between about 19 and 25 July 2013. These conversations and subsequent notes became the basis for the decision to suspend Helen Marks and are referred to in detail in the Employment Tribunal Judgement. The panel has interviewed all of the above with the exception of Sarah Carter together with Jayne Davies and Shirley Houston who had relevant information to report.

5.3 In addition, and over a longer period, there were concerns expressed by a senior staff member about a range of issues which she raised with Lesley Thompson (then a NED) on about 18 March 2013, Ifti Majid on 19 March 2013, Steve Trenchard on 16 August 2013 and Carolyn Green on 15 July 2014. In each case it is her position that they failed to address her concerns or action her complaints. These issues did not form part of the basis for the Employment Tribunal claim.

6 BACKGROUND ISSUES RELEVANT TO THE EMPLOYMENT TRIBUNAL PROCEEDINGS

6.1 The matters referred to in this and section 7 are relevant to the case as presented before the Employment Tribunal. As such certain issues are in the public domain and are the subject of judicial findings as to what has occurred. As appropriate the panel has adopted the findings of the Employment Tribunal but have, in some instances, commented upon such matters.

6.2 It has been suggested that the process leading to the appointment of Steve Trenchard was subverted to ensure that he, and not any other candidate was appointed. We have found no evidence to support any suggestion that Steve Trenchard was anything other than the best candidate.

6.3 From about August 2012 there was a considerable volume of text messages sent between Helen Marks and Alan Baines. The individuals accepted in the Employment Tribunal that they had formed a friendship in working together although they gave evidence that they had differing views as to the way in which their relationship should develop.

6.4 The messages varied between exchanges on work/Trust related issues, observations on colleagues, social arrangements and discussions of a more personal nature. On some dates there were numerous exchanges. Reference is made in the Employment Tribunal to the specific content of some of those exchanges.

6.5 Helen Marks was awarded the Healthcare People Management Association's "HR Director of the Year" award on 27th June 2013 for her work at the Trust.

6.6 Steve Trenchard had requested that Alan Baines cease to have what had been described as coaching meetings with Helen Marks at some point between about March and May 2013. The closeness of their relationship was not known to or suspected by other members of the management team until one of their text exchanges was raised on Helen Marks' behalf by her solicitors in a letter to the Trust dated 11 September 2013 and then by Helen Marks in a grievance filed by letter dated 17 September 2013.

7 FROM JUNE 2013 TO THE EMPLOYMENT TRIBUNAL HEARING

7.1 At the relevant times DACB were the Trust solicitors.

7.2 The background papers in this matter make clear that Steve Trenchard was aware, from Alan Baines, of allegations in relation to Helen Marks' conduct from about 21 June 2013 (although Alan Baines had not disclosed her identity at that point). The precise nature of the matters which had been made known to Alan Baines were not entirely clear to Steve

Trenchard. Further information was provided by Alan Baines to Steve Trenchard on 16 and 19 July 2013.

7.3 As appears in the Employment Tribunal Judgment Steve Trenchard decided to defer the implementation of any acts in relation to these matters until after the conclusion of a meeting with the Trust's trade unions at which he wanted Helen Marks to be present.

7.4 Mr Trenchard sought advice from a partner at DAC Beachcroft on 28 July 2013 and 30 July 2013 about the seriousness of the allegations being made against Helen Marks thought it very likely that, despite her position and her recent receipt of the HR Director of the Year award, it would be necessary to suspend her from duty pending investigation.

7.5 Advice was given to Steve Trenchard by DACB to the effect that attendance at the meeting on his own, and any failing on the part of the Trust to ensure that Helen Marks was accompanied, could be regarded as being a breach of the relevant Trust's procedures.

7.6 There is evidence from the file of discussions between DACB and Steve Trenchard in relation to the conduct of the suspension meeting itself in relation to both parties being accompanied or represented and the provision of information about the nature of the allegations.

7.7 It is the panel's understanding from Steve Trenchard, confirmed by DACB that he had a specific and underlying concern about the reputational damage which could have been caused to Helen Marks given her seniority and the issue of suspension. For that reason he wanted to have knowledge of the matter kept within as small a circle of Trust employees as possible.

7.8 The conduct of the meeting was discussed at some length with Steve Trenchard by DACB. It is clear that Steve Trenchard's preference was to go to the meeting alone for the reasons stated above. DACB explored with him a closer adherence to the Trust's policies and indeed drafted the supporting suspension letter in terms which reflected both that he had been accompanied and that he had ensured that Helen Marks had been reminded of her right to be accompanied or represented.

7.9 At this point Steve Trenchard had been made aware by Alan Baines both of the underlying nature of the allegations and the names of those concerned. Steve Trenchard had already spoken to the four complainants and had obtained information from them. It is Steve Trenchard's position that he felt it inappropriate to disclose this information as it had been provided outside the scope of the formalised disciplinary investigation procedure.

7.10 On 31 July Steve Trenchard met Helen Marks and suspended her. On 1 August 2013, Helen Marks wrote to the Trust highlighting her view that the Trust has failed to act in

accordance with its own procedures. As seen above, and as noted very directly by the Employment Judge, the Trust had failed to act in accordance with its own procedures. This failure, albeit for reasons considered logical at the time, gave Helen Marks and her advisers an obvious opportunity to seek to challenge the Trust's position from the very outset.

7.11 The ensuing exchanges of correspondence between the Trust and Helen Marks in the period up to about 13 August were drafted initially by DACB but were subject to extensive discussion and amendment in conjunction with Steve Trenchard. There was a recognition as early as 2 August 2013 that the failure to adhere to the Trust's policies in strict terms was likely to present a problem.

7.12 In this initial period Helen Marks continued to seek to identify and place reliance on failures or alleged failures in the Trust's own approach to this matter.

7.13 On 6 August 2013 Helen Marks sent an email to Steve Trenchard raising further questions regarding both the timeline within which he became aware of the allegations and the extent of his knowledge. The fact that Steve Trenchard had been aware of the allegations for some weeks before taking any action reflected poorly on the Trust's position and indeed upon any argument which was put forward as to the seriousness of the allegations and need to suspend Helen Marks in light of them.

7.14 On 7 August there was a meeting between Steve Trenchard, Alan Baines and Louise Ludgrove, who had been appointed as an appropriate independent person to deal with the disciplinary investigation. At this initial stage there was discussion about the nature of the allegations and the disclosure of the statements already provided to/by Alan Baines and later by the individuals to Steve Trenchard, including discussion with DACB.

7.15 By letter to Alan Baines dated 11 August 2013 Helen Marks raised specific concerns about the process and alleged prejudice caused to her. Alan Baines sent this to Steve Trenchard on 12 August by email commenting that he was now aware that Helen Marks had taken legal advice. On 13 August 2013 there was a conference call between Steve Trenchard and DACB, about the position and the visit by Alan Baines to Helen Marks (a meeting which had been approved as a means of seeking to resolve matters) and the possibility of a managed exit. The issue, which was neither known nor recognised, was that Steve Trenchard and the Trust had lost control of the process.

7.16 The outcome from the meeting on 13 August was a draft email prepared by DACB to be sent to Helen Marks by Alan Baines. As far as any of the others involved in this matter were aware, Alan Baines had to this point been acting entirely in accordance with his role and responsibilities as Chairman and in the overall interests of the Trust. Such draft was

prepared and was sent by DACB on or about 13 August 2013. An email from Alan Baines on 14 August confirmed that it had been passed to Helen Marks.

7.17 On or about 14 or 15 August Ifti Majid, who acknowledges that he had a personal friendship with Helen Marks, visited Helen Marks at her home following his return from holiday.

7.18 On 15 August Helen Marks made it clear that she no longer wished to deal with Steve Trenchard and identified Ifti Majid as someone with whom she was prepared to deal going forward. She identified a loss of trust and confidence in Steve Trenchard.

7.19 It is not clear from the papers which the panel has seen what it was that caused this alleged loss of confidence. On 15 August 2013, DACB sought to recover from the Trust/Alan Baines a copy of the email which was actually sent to Helen Marks but it is not known whether this was provided at any point and it has not been made available to the panel. The ET Judgment comments adversely in relation to Alan Baines and his conduct during this period.

7.20 There is evidence to suggest that he was throughout this period seeking to present Steve Trenchard to Helen Marks in an adverse light whilst seeking to maintain his own relationship with her.

7.21 On 15 August 2013 Helen Marks' emailed Alan Baines confirming that he had told her that the investigation was being terminated. This is not what had been suggested at any point by DACB, indeed they had stressed in an email to Steve Trenchard on the same date that if discussion about a settlement did not bring matters to a conclusion then it would be necessary to progress the investigation. DACB were advising Steve Trenchard, but by this stage Steve Trenchard no longer had control over the communication with Helen Marks.

7.22 DACB expressed concern on 16 August over the way in which the matter was now being handled and that the messages being given to Helen Marks were very materially different to the approach which they had agreed with Steve Trenchard on 13 August 2013.

7.23 On 21 August 2013 DACB contacted Freeths who had been appointed by Helen Marks. On 28 August Stephen Trenchard emailed a partner at DAC Beachcroft raising a number of concerns about delay, lack of clarity around the process being undertaken and the risk that over time this may prejudice the Trust.

7.24 The initial letter received from Freeths dated 28 August 2013 focused primarily upon complaints by Helen Marks regarding alleged sex discrimination. This remained the position until, in February 2014; she eventually resigned from the Trust asserting that she had been constructively dismissed.

7.25 On 29 August DACB emailed Steve Trenchard making it clear that they wished to speak to Alan Baines direct in relation to this matter. The panel regard this as an indication that Alan Baines' involvement was perceived as contributing to the problem rather than having the more obvious and preferable outcome of reducing the degree of risk. This took place at a meeting in Derby on 2 September.

7.26 On 30 August a draft letter was prepared to be sent to Freeths by DACB and, at the same time a draft letter to be sent by the Trust to Helen Marks. We have been informed that the agreed approach at this point was to seek to maintain two lines of dialogue, one with Freeths in terms of their more formal complaints and/or the possibility of pursuing an agreed exit the second continuing dialogue with Helen Marks direct. This approach is reflected in correspondence.

7.27 In the period between 1 September and 12 September there is an increasing level of concern on the part of DACB and Steve Trenchard regarding Alan Baines comments. The underlying issue was that there seemed to be a conflict between Alan Baines' statements on the one hand to Steve Trenchard and DACB and on the other hand his interaction with Helen Marks nominally on behalf of the Trust.

7.28 On 9 September 2013 DACB attended a meeting at the Trust in Derby with Steve Trenchard, Alan Baines and Ifti Majid. This was intended to be an opportunity for DACB to identify what Alan Baines had said in the meetings he had held with Helen Marks about cessation of the investigation.

7.29 On 9 September Alan Baines sent an email to Steve Trenchard and DACB. This was followed on 10 September by a further email from Alan Baines in which he made it clear that from his perspective it was important that DACB were seen to "drive the agenda", which the panel takes to mean that it is for the Trust's side to seek to control the exchanges, narrative and progression of any settlements.

7.30 On 11 September Alan Baines emailed DACB and Steve Trenchard to say that Helen Marks had made it clear that she wanted him to stop contacting her. He said that he would cease all contact. There is no indication from the information which the panel has seen that there was a material level of concern on the part either of DACB or Steve Trenchard at this point about Helen Marks' sudden change of stance. This was the first negative indication from Helen Marks regarding Alan Baines as a conduit of communication.

7.31 On 11 September DACB wrote to Freeths against the backdrop of Helen Marks' change of mind in relation to communication with Alan Baines.

7.32 On 11 September Freeths wrote to DACB outlining concerns about the content of text messages from Alan Baines to Helen Marks and making allegations of harassment.

7.33 After 11 September matters evolved relatively quickly. By 13 September Alan Baines, in email correspondence, expressed concern about what it was that Freeths may have to say. He has been described in this period as agitated, but for no reason that was obvious at the time.

7.34 Although the DACB file identifies the change in Alan Baines behaviour as noteworthy no further action was taken at this point.

7.35 As a consequence of the letter from Freeths of 11 September advice was taken by Mick Martin in relation to the position of Alan Baines and meetings took place on 17 and 19 September 2013 and at the second of those meetings Alan Baines resigned.

7.36 A formal grievance letter dated 17 September 2013 requesting an independent investigation in to the conduct of Alan Baines and Steve Trenchard was sent by Helen Marks to Lew Hall, then Lead Governor, copied to Mick Martin, the then Senior Independent Director and Deputy Chair and Ifti Majid in which she identified specific allegations of sexual harassment against Alan Baines. In this she referred to the text message of 6 September mentioned in the Freeths' letter of 11 September. This letter was marked confidential but this was not respected by Lew Hall who contacted Alan Baines and read to him the content of the letter.

7.37 Alan Baines' resignation from the Trust was effective on and from 19 September 2013.

7.38 Two announcements were made regarding his exit from the organisation. One, in the name of Mick Martin appeared in the Trust's newsletter. This referred to Alan Baines' exit as being with "the love, thanks and best wishes" of the Trust. There was significant adverse comment upon this in the context of the Tribunal judgment. In particular, it was identified as being in marked contrast in tone to the comments made around Helen Marks' departure. A further announcement was made by Steve Trenchard which, although not unsympathetic to Alan Baines, did not use such informal language and thanked him for his contribution.

7.39 Alan Baines' resignation from the organisation, and the underlying grievance raised and his acceptance of his conduct in relation to the points raised, caused concern on the part of the Trust and DACB. The issue was that, in light of the complaints raised there may be cause to reconsider the validity and provenance of the complaints upon which reliance had been placed in choosing to suspend Helen Marks.

7.40 Steve Trenchard had booked and took leave during the week commencing 16 September 2013, returning to the Trust on 23 September. In this period he had limited contact with the Trust by email and did not return to work, or offer to do so although he informed Ifti Majid, Graham Gillham and Mick Martin on 17 September that they should contact him if he was needed. They did not do so despite the issues which arose. Despite the significance of the

issues there is no record of a formal handover between Steve Trenchard and Ifti Majid his deputy before he went on holiday.

7.41 The relevant file on this matter is not entirely clear as to the degree of input sought from DACB during this period. There are exchanges initiated by Ifti Majid on 17 and 18 September regarding a process for reviewing the suspension and progressing Helen Marks' new grievance and some draft correspondence was prepared. Ifti Majid, by email to DACB, confirmed that he sent a letter confirming the continuation of the suspension and investigation whilst the grievance was investigated to Helen Marks on 18 September 2013.

7.42 On 19 September Ifti Majid, acting on behalf of the Trust and with the authority of Mick Martin met with Helen Marks at her home to discuss both the investigation and her continued suspension. It is noted that this meeting took place without either party being accompanied.

7.43 Ifti Majid's personal notes of the meeting indicate that he informed Helen Marks that the investigation and suspension had been abandoned entirely. The panel has been informed that this was not the intention of the advice given by DACB. It left the Trust with no immediate plan as to a return to work or an approach to the complaints originally made.

7.44 In this period between mid-September and end of September 2013 a resolution was sought by way of a negotiated exit for Helen Marks. Such attempts were unsuccessful.

7.45 It is clear that advice was sought from DACB upon these points at the relevant times and advice was given both as to the sustainability of the proposal being put forward by Helen Marks and the restrictions on the Trust's ability to negotiate as against these aspirations given the relevant Treasury rules.

7.46 Advice was sought from DACB regarding pursuit of the grievance and correspondence was drafted for the Trust to send regarding progression of the process. That advice identified the steps which needed to be taken.

7.47 The proposed return to work was without doubt a difficult issue. To allow for a plan to be developed it was proposed, with advice, that there be a period of "special leave". Within this period there were also attempts to negotiate an exit and arrange a site visit by Helen Marks. The basis of the special leave was imprecise – it was never intended to be more than a temporary arrangement whilst plans emerged. There was no clarity over the timetable and/or how it would be brought to an end if a clear way forward did not emerge or its status.

7.48 Attempts to resolve matters foundered for several reasons. There was confusion over issues which Helen Marks believed to have been agreed – an example being an apology at a public meeting of the BoD to be given by Mick Martin and an independent investigation

which from evidence the panel has seen was promised by Mick Martin on or about 2 October 2013.

7.49 The Trust's approach to the management of Helen Marks' absence on the grounds of ill health has also been heavily criticised. Advice was sought from DACB upon this point. This aspect of the matter was dealt with directly by Steve Trenchard as her line manager. The decision appears to have been taken on the basis that it was reflective of the management structure. The end result was that it came across as Steve Trenchard, against whom the grievance had already been taken, continuing to deal with Helen Marks even though she had asked that this not be done. Although advice was taken it is the view of the panel that it should have been made clearer by DACB that Steve Trenchard should not be involved and should not be the point of contact even though to have removed him from that role would have been contrary to the pre-existing line management arrangements.

7.50 In early October Lee O'Bryan was appointed to produce a report for Mick Martin on the events between the first discussions between Alan Baines in June and the process since that point. The two had worked together more than three years prior to this at the Post Office. Lee O'Bryan had material HR experience and was available at a time when resource was needed. His appointment did not follow any of the Trust's recruitment procedures.

7.51 The initial report from Lee O'Bryan was completed within his anticipated timescale. Lee O'Bryan, by 28 October 2013, had identified the risks faced by the Trust and raised these with Mick Martin and Graham Gillham. The issues were further raised with Lesley Thompson in her role as acting Senior Independent Director on 26 November 2013. There is no evidence which has been seen by the panel to indicate that its contents were discussed with other NEDs or that any action was taken to consider and limit the risk identified by Lee O'Bryan.

7.52 In the period from late October 2013 the Trust needed to have an active and present head of its HR function. These were challenging times and the Trust had no senior HR resource upon which it could rely. This resulted in the appointment of Lee O'Bryan on an interim basis to fulfil the role part-time until Helen Marks was able to return. This was notified to Helen Marks on 15 November 2013.

7.53 The attempts by the Trust to progress the various issues previously described lacked focus, in terms of preferred and alternative outcomes, and the experience within the NHS on the managed exit of senior employees should that become an appropriate path.

7.54 The correspondence in this period is detailed in paragraphs 195 to 222 of the Tribunal's judgement. The facts referred to were relied upon by Helen Marks in resigning with effect from 19 February 2014.

7.55 In the period between Helen Marks' resignation and about June 2014 the principal issues under consideration were:

7.55.1 a response to the questionnaire served under the Equality Act; and

7.55.2 preparation of the formal defence to the second set of Employment Tribunal proceedings; and

7.55.3 identification of the Trust's position in relation to the possibility of, and subsequent request made by Helen Marks in relation to, joining Alan Baines as a second and separate Respondent to the Employment Tribunal proceedings.

7.56 The panel is aware that a partner at DAC Beachcroft of DACB attended at the BoD on 26 March 2014. At the time this meeting took place:

7.56.1 the initial Tribunal claim raised in August 2013 was already in process;

7.56.2 Helen Marks had resigned on 19 February 2014 but no claim had yet been made in relation to the claim for constructive dismissal; and

7.56.3 Helen Marks had not disclosed any text traffic other than the points complained of in Freeths' letter of 11 September.

7.57 At the board meeting a presentation was given by a partner at DAC Beachcroft and a summary note of the issues was available to those in attendance but then collected in at the end of the meeting. The panel understands that advice was given to the Board at that time in relation to the risk of any award being made.

7.58 On about 27 May 2014 DACB received the amended grounds of a claim in relation to the first claim. This made clear that the focus at that point was very much on sexual harassment regarding Alan Baines and sex discrimination.

7.59 On 30 May 2014 a memo was sent by a partner at DAC Beachcroft to the Trust identifying the risk issues and steps to be considered regarding attempts to have Alan Baines joined to the claim as a separate Respondent and that he be regarded as personally liable for his conduct. A partner at DAC Beachcroft also updated his advice on prospective liability under the claims as filed and expected (being constructive dismissal).

7.60 On 3 June 2014 DACB and Lee O'Bryan discussed whether and to what extent Alan Baines needed to be informed that the Trust would not be prepared to represent him in the context of the Tribunal proceedings.

7.61 On 13 June 2014, DACB wrote to Alan Baines to notify him that he would need to take separate and independent legal advice.

7.62 Between this date and 24 June 2014, being in receipt of the second Employment Tribunal claim from Helen Marks, there were exchanges between DACB and Lee O'Bryan for the Trust regarding the approach that they intended to make.

7.63 On 21 July 2014 there was discussion between DACB and Lee O'Bryan regarding the approach to be taken in relation to Alan Baines being identified as a second Respondent to the proceedings. The issue at that point therefore was whether the Trust could seek to distance itself from Alan Baines.

7.64 DACB progressed the preparations for the Tribunal through August, September and into October 2014 in accordance with the directions timetable and identified risk issues as faced by the Trust.

7.65 A Partner at DAC Beachcroft met with Alan Baines on 29 October 2014 to go through his likely witness evidence.

7.66 Between October and the end of December 2014 there were continuing disputes over the adequacy of the disclosure as made by both parties. Each side asserted the other had failed to disclose relevant documents. DACB applied considerable pressure to Freeths during this period in relation to their failure to disclose any/all of the text exchanges.

7.67 On 19 December, Freeths sent to DACB 24 pages of text extracts which formed the basis of Helen Marks' case when the matter came before the Employment Tribunal albeit that they were supplemented by later disclosure on the part of Freeths.

7.68 On 5 January 2015 DACB discussed the matter with Lee O'Bryan and identified that fundamental to the entire case would be the question of whether a Tribunal was prepared to find that there was collusion between Alan Baines and Steve Trenchard (as alleged by Helen Marks) or not.

7.69 As the preparation moved into February 2015, there was further discussion with Alan Baines' lawyer regarding the text exchanges.

7.70 On 6 February there were discussions between DACB, Lee O'Bryan and Steve Trenchard about the Treasury rules. Steve Trenchard made clear that the Trust must operate within the spirit of the Treasury rules. This was a position reiterated by Mark Todd throughout this period.

7.71 In this period progress was being made on a number of fronts in relation to the preparation of witness evidence which needed to be exchanged in advance of the Tribunal hearing. This included the identification of likely witnesses and preparation of witness statements.

7.72 DACB provided updated advice on risk and quantum in March and April 2015. The continuing advice was that the prospects of success were "50:50" which the panel is informed by DACB was intended to indicate that the Trust was as likely to win (and there would be no award) or lose (with an award at the upper end of the range claimed) and that the prospects of success were dependent on the performance of the witnesses on both sides. This assessment, in effect all or nothing, represented a view across all of the claims when taken together rather than as assessment of the prospects of success for each element. The underlying advice, that the Trust might avoid liability entirely or be liable for everything claimed failed to result in any change of approach.

7.73 In this matter DACB had identified that there were gaps in the data regarding text traffic from Helen Marks' Trust provided phone. After considerable pressure had been applied the content of further text traffic was disclosed within days of the hearing. Certain of the texts disclosed at this late stage were regarded as potentially detrimental to Helen Marks' case and undermining of her credibility although the underlying content was "more of the same" in terms of the texts previously disclosed rather new and material facts not previously known to DACB/the Trust.

CHAPTER 5

ORGANISATIONAL GOVERNANCE

1 ISSUES

1.1 In the terms of reference the panel was asked to provide an independent report into the actions of the Trust and specifically identify areas in which the Trust has failed to apply appropriate standards of corporate governance. As required, the panel has assessed this against the Trust policies, procedures, constitution as well as regulatory frameworks and has considered whether the communication flow between the Trust and the CoG was sufficient to enable Governors to discharge their statutory duty of 'holding non-executive directors' to account.

1.2 The review of the independent panel has been conducted in the light of the Employment Tribunal of Helen Marks and its findings. It has reviewed Governance issue through the lens of this matter and not more generally. The Trust has commissioned a thoroughgoing review of governance as part of a "Well-led" review with attention being drawn in particular to Capability and Culture, Processes and Structure, Human Resources and related functions.

1.3 The Trust should take care to note the relatively narrow scope of the review of the independent panel and rely on the "Well-led" review for wider conclusions and advice on governance matters.

2 APPROACH

2.1 The panel received a wide range of Trust documents from HR policies (in particular the Disciplinary Policy) to the Trust Constitution, the Trust's Corporate Governance Framework Document, its Standing Orders and Standing Financial Instructions and Minutes of Board meetings including all private Board meetings for the period January 2013 until June 2015.

2.2 All of the past and present Board members but one who were asked agreed to be interviewed and Governance issues were discussed with them. The panel met the CoG on 8th September 2015 and many Governors completed a pro-forma response and several of the Governors were interviewed either in person or by telephone.

2.3 The panel also reviewed external references, in particular the Monitor Framework for "well-led" organisations and a chronology of contacts between Monitor and the Trust concerning Governance issues. The panel also reviewed the so called "fit and proper person" test as described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 5.

2.4 The observations and conclusions result from all of the evidence referred to above.

2.5 In assessing the robustness of the Trust's arrangements and practices the Panel used the Monitor "Well-led framework" as its fundamental reference document. This framework has four main areas of concern:

2.5.1 Strategy and Planning;

2.5.2 Capability and Culture;

2.5.3 Processes and Structure;

2.5.4 Measurement.

2.6 There are 10 high level questions about those four areas of concern:

Strategy and Planning	Capability and culture	Process and structures	Measurement
Does the board have a credible strategy to provide quality, sustainable services to patients and is there a robust plan to deliver? Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?	Does the board have the skills and capability to lead the organisation? Does the board shape an open, transparent and quality-focused culture? Does the board support continuous learning and development across the organisation?	Are there clear roles and accountabilities in relation to board governance (including quality governance?) Are there clearly defined, well- understood processes for escalating and resolving issues and managing performance? Does the board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?	Is appropriate information on organisational and operational performance being analysed and challenged? Is the board assured of the robustness of information?

2.7 Of these "Well-led" questions the Panel's interest was especially drawn to:

2.7.1 Culture;

2.7.2 Skills and capability;

2.7.3 Roles and accountability;

2.7.4 Defined, well understood processes for escalation and resolution;

2.7.5 Engagement of stakeholders (particularly Governors in this instance); and

2.7.6 Robustness of information.

2.8 The issue of organisational culture is very relevant to the Panel's conclusions and has such significance that its findings are written in a separate chapter.

2.9 As well as addressing these questions the Panel took the view that the BoD has three main functions: setting strategy; leading the organisation and overseeing operations; and being accountable to stakeholders in an open and effective manner.

2.9.1 In dealing with those issues this chapter is ordered as follows:

2.9.1.1 The issues the Board and its officers were dealing with.

2.9.1.2 The machinery of Governance in the Trust.

2.9.1.3 How well was that machinery used?

2.9.1.4 Capability and capacity.

2.9.1.5 Issues.

2.9.1.6 Recommendations.

3 THE ISSUES THE BOARD AND ITS OFFICERS WERE DEALING WITH.

3.1 The events under consideration are described in Chapter 4. This section does not repeat them but attempts to describe their significance.

3.2 The relationship between the Chairman and the HR Director had an effect on the Board and the Trust as a whole.

3.3 The suspension of an executive director is significant and unusual. The suspension of the HR Director provides even greater rarity and also effectively disabled the normal source of advice on senior employment matters.

3.4 That these matters result in the unavailability of that normal source of HR advice and was soon followed by the resignation of the Chairman removes the two post holders on whom a Chief Executive would most rely in difficult senior personnel issues.

3.5 The Trust's governance systems and policies were designed for the Board to be able to govern the organisation. They were mal-adapted to such challenges within the Board itself.

3.6 When these circumstances were emerging the Chief Executive had been in post less than six months. He was inexperienced in operational and business management having held staff and education posts rather than line management posts for several years before his appointment.

3.7 The issues were difficult to anticipate, were unlikely to have policies which did not need adaptation to deal with them and a very experienced Chief Executive would have been tested by them.

4 THE MACHINERY OF GOVERNANCE IN THE TRUST

4.1 Derbyshire Healthcare was an NHS Trust which had become a Foundation Trust on 1st December 2011. It had been unsuccessful in two previous attempts to obtain Foundation Trust status. It is fair to assume that the Trust's Governance arrangements had undergone a very high level of scrutiny to be successful in 2011. There had been no significant changes to those arrangements between obtaining Foundation Trust status and the start of the issues of concern. It is reasonable to expect that Monitor's scrutiny still applied when the issues arose which led to the Helen Marks employment tribunal.

4.2 One significant difference though was cultural. Some Board members sensed that the Trust Board had been concentrating on the "exam question" of becoming a Foundation Trust too much and had become an organisation of "command and control" and about business rather than care. After achieving Foundation Trust status the Board consciously considered how to change the organisational culture to a more inclusive, caring and supportive one. This is discussed in more detail in the culture chapter but has significance to the nascent values-based culture into which the new Chief Executive was appointed.

4.3 The panel expects that the regulator would have found in its assessment of the Trust for Foundation Trust Status that the Trust had the normal suite of Constitution, regulatory policies such as a Corporate Governance Framework Document, Standing Orders and Standing Financial Instructions as well as policies for employment and other matters. Insofar as it has been necessary for the pursuit of this enquiry the panel has reviewed these policies and confirmed that they are consistent with normal standards and with the exception of one or two comments later they did not cause or add to the difficulties the Trust experienced in the employment case of Helen Marks.

4.4 The Trust had normal rules for bringing significant risks to the attention of the Board; it had a Board Assurance Framework in place, had delegation rules established and the rules of conduct of Board meetings was consistent with them. The Panel saw evidence of concerns which were escalated appropriately.

4.5 Board meetings had clear agendas, focussed management and regular reviews of effectiveness. There remains the question about whether the agendas were orientated around the purpose and strategy of the organisation.

4.6 The panel would remark on three parts of the governance machinery only.

4.7 The first came to light through the issues themselves. Where the Senior Independent Director is also the Deputy Chair this can cause role conflict. This has been recognised by the Board and the two roles are now separated.

4.8 The second is that it is notable that the Trust Board did not have an Organisational Development and Workforce (OD & W) committee. Many Trusts describe the workforce as the organisation's greatest asset and give great priority to OD&W. It is particularly curious that at a time when we were told the Board wished to change the culture of the organisation it decided to subsume its Workforce Strategy Committee into its Finance and Performance Committee.

4.9 The panel also reviewed the executive management arrangements and again they are similar to those in similar organisations with one exception. The panel received evidence from several witnesses that the organisational development, learning and development and human resources management had reporting lines changed as a pragmatic solution designed to avoid rather than address some vituperative relationships within and between those departments rather than arranging them around the strategy and plans of the organisation. In particular the distribution of those functions across more than one executive director as well as the continuing poor relationships has led to inefficiency, ineffectiveness and loss of focus in the panel's view.

5 HOW WELL WAS THAT MACHINERY USED?

5.1 The panel in its interviews received multiple reports of tensions before the issues in question arose.

5.2 During the period in the lead-up to the final Foundation Trust application the panel received reports of favouritism within the Board. It was reported to the panel that those who preferred a business approach and a strategy of commercial growth were favoured in discussion. Some Board members felt marginalised as a result. There was single-minded pursuit of

Foundation Trust status with other priorities de-emphasised. This resulted in a reported loss of purpose and focus once Foundation status was achieved.

5.3 Many Governors reported that they had little sense that the BoD wished to engage or include the CoG in its work before 2014 though several did note that, with the arrival of a new Chair in February 2014, this improved.

5.4 The panel received several reports of personal relationships which had a distorting effect on the business of the Trust and not just the relationship between Helen Marks and Alan Baines. That relationship though was highly significant. In the words of the Tribunal Judge "Helen Marks was using her relationship to try and influence Mr Baines, who was on the appointments panel of the new Chief Executive". The friendship between the Chair of the Board and the lead Governor in 2013 and 2014 allowed a breach of Helen Marks' confidentiality to be criticised in the Employment Tribunal. The previous working relationship between the Mick Martin and Lee O'Bryan and the manner of Lee O'Bryan's appointment process caused doubts about the probity of the "table top review" process. There was also concern about a friendship between three of the executive directors which was described as material in the Employment Tribunal. We also received testimony from one Governor who identified his/herself as a long standing friend of Helen Marks and appeared to ask a panel member questions on her behalf.

5.5 Whilst these friendships distorted the application of good governance discipline, poor relationships also had an effect and in particular the schism within the OD and workforce disciplines in the Trust, the difficult relationship between the BoD and some of the CoG as well as distrust between executive directors at various times had a negative influence on good governance.

5.6 In the Culture section the panel comments on the culture of informality. Whether it is the design of management arrangements around personal relationship, the process of employment of Lee O'Bryan or the failure to follow policy there is evidence of poor governance discipline in several aspects of the Trust's life.

5.7 The Board had conventional arrangements, but not only was there a suggestion of unequal membership but in his testimony to the Employment Tribunal the Chair described the role of "the non-executive Board in holding the executive Board to account". The notion of two Boards within a Board does not speak of the "Unitary Board" envisaged in the governance arrangements described in the Trust's constitution or those expected of a Foundation Trust.

5.8 When the allegations made against Helen Marks arose the disciplinary procedure issued on 1st January 2012 and due for review on 1st January 2014 was available to guide the

responsible manager's actions. This policy was a fairly standard policy with no obvious significant flaws.

5.9 Early on it states: "When a disciplinary issue arises the Manager concerned should contact the Workforce and Organisational Department to discuss the full facts and establish the potential seriousness of the allegations/actions/complaint." As the issues involved Helen Marks that could mean that that discussion needed to be with one of her subordinates. That was inappropriate and so the Chief Executive sought the support of the Trust's solicitors as well as the advice of more experienced Chief Executives elsewhere.

5.10 It also states "Throughout all stages of the Suspension, Investigation, and Disciplinary processes employees have the right to be accompanied by a companion." The legal advice was to comply with this requirement, when the Chief Executive gave reasons for not doing so, the legal advisers provided the Chief executive with a "script" for the meeting.

5.11 The Redeployment & Suspension Management Guidelines make it clear that upon suspension the member of staff is entitled to meaningful information about the nature of the allegations. Helen Marks did not receive them in a way consistent with the policy in the panel's view.

5.12 Finally the Trust had "Guidelines for Conducting Investigations" which specified inter alia that "The Lead Commissioning Officer for the Investigation will produce a set of Terms of Reference for the investigation process and will appoint a minimum of two independent Investigating Officers to conduct the investigation following the Guidelines for Conducting Investigations." The panel did not see evidence that this had been complied with.

5.13 Whilst the panel has been told why the provisions of the policies were not followed and appreciate the sensitivities in the case, the failure to follow the policy became a fundamental plank of Helen Mark's case in the Employment Tribunal and amount to a serious error on the part of the Trust in the panel's view.

5.14 The interaction between complaints, grievances, disciplinary processes, multiple players, the seniority of the person under scrutiny and private relationships complicated the established processes for dealing with such issues and the Trust did not find a single consistent plan to deal with this.

5.15 Though the depth of their personal relationship was not disclosed at the point of allegations being raised and the suspension taking place, the use of the Chairman to act as an intermediary between the Trust and Helen Marks during August was inconsistent with role of a non-executive Chairman.

5.16 When Alan Baines resigned it does not appear to the panel that those then responsible for the governance of the Trust at the time sought to enquire about the facts with sufficient rigour. Alan Baines told the panel that he left because of his inappropriate relationship with Helen Marks. Following Alan Baines resignation Mick Martin reported that Alan Baines had described his actions as "foolish".

5.17 In the ensuing weeks Mick Martin issued a statement that Alan Baines left with the Trust's "love, thanks and very best wishes", offered to Helen Marks via her solicitors a public apology which was never delivered, appointed Lee O'Bryan to conduct an initial assessment of the position based on the papers available and sought to negotiate a financial settlement with Helen Marks' solicitors. He later concluded that the right course was to stop investigating and continue to seek a settlement. He was in short acting as an executive Chairman which was inconsistent with the governance machinery of the Trust.

5.18 The panel understands that the Acting Chair at the time stepped in because he thought the performance of the Chief Executive was questionable. He did not act on that view other than to side-line the Chief Executive from the discussion.

5.19 The review conducted by Lee O'Bryan resulted in specific advice from him to Mick Martin and Graham Gillham in or around 28 October 2013 which was also provided on about 26 November 2013 to Lesley Thompson as the acting Senior Independent Director . This advice is clear about the risks to reputation, individuals and finance. The recollection of those involved is unclear but the panel has been provided with no evidence that this was escalated further.

5.20 The record of Board meetings at this time shows a record of Helen Marks' absence and Alan Baines' departure but with no explanation. No BoD member present at BoD meetings between July 2013 and February 2014 in which period most actions which drew negative comment at the Employment Tribunal identified any substantial content in those discussions or actions derived from them. The significance of losing the HR Director to suspension and the Chairman appears to have resulted in little or no assessment of the circumstances in the Board.

5.21 After Helen Marks resignation it became clear that Lee O'Bryan's advice in October was justified and perceptive. A new permanent Chair, Mark Todd, was appointed in early 2014. It appears to the panel that Mark Todd realised the significance of the issues and spoke to the Chief Executive about his conflict of interest as one of the people criticised in the claim of Helen Marks and the lead officer for the case.

5.22 Before a confidential meeting of the Board on 26th March 2014 the panel believes Mark Todd asked the Chief Executive not to attend but following discussion relented and insisted

instead that the Steve Trenchard, Ifti Majid and Graham Gillham declare an interest instead, which they are recorded as doing. At this meeting the Trust's solicitors attended to provide a review of the case.

5.23 The panel does not wish to divulge the contents of a confidential Board meeting with its legal advisers. However, it is clear from a note which DACB circulated at the meeting and then withdrew that the nature and scale of the issue was properly identified to the Board**.** No Board member who was in attendance at this meeting and to whom the panel has spoken could recall clearly its nature or seriousness.

5.24 Other than the briefing of the lead Governor by Mick Martin the panel can find no substantial communication of the issues to the CoG. It is arguable that whilst this remained a staffing matter it was not within the purview of the Governors' role of supervising the Non-executives. However the panel take the view that once it was clear that a settlement would not be possible, once Helen Marks had resigned and started proceedings against the Trust, once the BoD had been told of the substantial risk to finance and reputation and given that it has caused the resignation of Alan Baines the issue was sufficiently serious to justify escalating at least in outline terms to the Governors. The panel has seen evidence of the Clerk to the Board asking for that to happen and this was refused. There is a record of the COG being told in June 2015 of the issues after the Employment Tribunal hearing.

5.25 Notwithstanding that constitutional position, some members of the BoD identified concerns about some Governors' commitment to adhering to their constitutional role and to a fair and balanced approach to their role. The panel has seen some evidence to support those concerns. The panel believes that the provision by the Trust to the Governors of their own legal adviser has helped substantially and will be needed during the consideration of this report if the Governors are to be seen to be able to consider the issues objectively.

6 CAPABILITY AND CAPACITY

6.1 As the panel describes at the start of this report it has written reports on individual's conduct, capability and capacity which it will provide only to the Senior Independent Director with the expectation that she will forward them to the appropriate supervisory body or individual. It is important that in reviewing the governance of the Trust that the panel does not commit any breach of good governance standards itself.

6.2 This section of the report concerns itself with general and not individual commentary.

6.3 It is apparent that the top of the organisation was seriously affected by Alain Baines and Helen Marks relationship and the Chief Executive not knowing the extent of the issues. The Chief Executive's normal sources of support in a senior employment issue were both involved.

6.4 The Chief Executive was still in his probationary period (as described in the Remuneration Committee paper on his appointment). There was very little recognition of the Chief Executive's lack of recent operational experience and no-one identified to the panel a concerted plan to develop this area despite placing him in this probationary state.

6.5 The Chief Executive tried to compensate for this lack of experience by turning to the Trust's solicitors, experienced Chief Executive colleagues and later to the adviser brought in by the acting Chair. This adviser appeared to the panel to have an accurate view of the issues and provided advice along those lines. His influence in the organisation was weakened by the manner of his appointment.

6.6 Throughout the case there were opportunities for Board members to be more inquisitive and demanding. The panel is concerned that the lack of recall by many members of the Board could suggest a lack of engagement with or appreciation of the seriousness of the issues to the Trust.

6.7 Whilst the Trust's capability and capacity was severely stretched by the issues it did not make use of some knowledgeable and skilled support that it had available to it in Tony Smith and latterly in Rob Quick.

7 FINDINGS

7.1 From the foregoing it is clear to the panel that the governance difficulties largely arose not from the governance machinery but how it was used or sometimes not used. In the use of the disciplinary procedure, the bespoke approaches to Helen Marks' absence, the lack of escalation, the absence of a significant identified risk appearing on the risk register, the manner of some appointments and lack of engagement of the CoG the panel believes the Trust did not use the Governance machinery as it would have done in other circumstances.

7.2 As a by-product of its enquiries the panel saw evidence of appropriate use of the Trust's governance arrangements. It appears to the panel that the Trust found it difficult to apply normal procedures because the issues involved Board members.

7.3 The Trust seemed to be overwhelmed by the nature of the challenge and decided perhaps sometimes unconsciously or culturally that its machinery would not work in the circumstances. This view created the basis for widespread extemporisation which led in turn to the governance failures.

7.4 Part of the motive for a bespoke approach seems to have been concern that if a disciplinary hearing and possibly an appeal needed to be held then Board members could be compromised. There are commonly understood ways of overcoming that concern without undermining good governance.

7.5 The Trust's failure to adhere to its employment policies was the subject of great criticism in the Employment Tribunal.

7.6 The Trust's failure to use its standard reporting machinery, approach to risk management and normal approaches to escalation resulted in an approach which was not supported by the whole Board and denied those involved the protection as well as the support good governance offers. It also led to the suspicion that an issue which affected Board members was treated differently to other issues of governance.

7.7 The investigations into concerns raised about Helen Marks conduct were never concluded. That was unhelpful to the Trust and all the individuals concerned.

7.8 The limited engagement felt by the CoG was evident before the Employment Tribunal of Helen Marks. This issue became the "lightening rod" for the concerns of the Governors. The confidentiality of an employee was given as a significant reason for not informing the CoG about the issues. After Helen Marks resigned this concern was greatly diminished. The opportunity this presented for the Board to be more open with the CoG was not taken.

7.9 The Governors meet only every three months so it is hard to provide information on a progressively developing issue.

7.10 Many Governors were unclear about their role and though the Trust had offered training it was only taken up to a limited extent. The Trust constitution states that:

"The general duties of the CoG are: to hold the Non-Executive Directors individually and collectively to account for the performance of the BoD; and to represent the interests of the Members as a whole and the interests of the public.".

7.11 This constitution appears not to have been amended as a result of the additions made to the Governors role as a result of the 2014 regulations;

Governors must comply with the principles outlines in HSG(93)5 "Standards of Business Conduct of NHS Staff. Further according to the Standing Orders "The CoG and the BoD shall be committed to developing and maintaining a constructive and positive relationship".

7.12 It is the panel's view that the relationship is currently a significant way short of that expectation.

7.13 Several people were conflicted at various parts of the process. This was sometimes recognised and sometimes not, but seldom fully addressed.

8 RECOMMENDATIONS

8.1 The Trust should use its Well-led review to question further its use of the governance machinery of the Trust. It is the panel's view that it was the lack of awareness, good behaviour and good practice which were the origins of the problems and not the arrangements themselves. The Trust will want to satisfy itself that these problems are not more widely observed in governance arrangements into which the panel has not investigated.

8.2 Given its strategic emphasis on cultural change and values-based work and given the need to recover from the events surrounding the Employment Tribunal of Helen Marks the Trust should consider how it could better fulfil its obligations in this endeavour. Several Trusts have an Organisational Development and Workforce Committee to give this emphasis. The Trust should consider how its governance arrangements could better match its strategy and plans.

8.3 The Board should improve its approach to being a unitary Board. It should consider how it can develop a greater consciousness about the significance of the business it is transacting. It 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.

8.4 It is important to note that when the panel describes concerns about the use of governance machinery this applies to the CoG as well as the BoD of Directors. In particular the CoG's "task and finish" group has a difficult task in appropriately satisfying itself that some Governors can be "impartial and honest" as described in the Standards of Business Conduct.

8.5 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. The constitutional position is that all components and members of the Trust's governance arrangements are expected to act in the public interest.

8.6 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. Over the following few months the Trust should retain the services of the solicitor appointed to support the Governors.

8.7 The HR, OD and training departments should to be under the management of one executive director and the panel believes that this could be the Director of Transformation with a suitable operational HR deputy. The resolution of the poor relationships within those

departments will require great wisdom and insight. It seems to the panel that there are colleagues in those departments who will find it very difficult if not impossible to work together again and it may be necessary to address the issues fundamentally rather than developmentally.

CHAPTER 6

ORGANISATIONAL CULTURE

ORGANISATIONAL CULTURE AND LEADERSHIP

1 INTRODUCTION

The relevance of leadership styles and culture

1.1 Understanding the culture of the organisation was a crucial task for the panel in order to provide insight and observations in to what led to some of the key failings in this case.

1.2 The Hay Group defines culture as:

'*the combination of organisational inspiration and purpose, motives and beliefs of individuals, and the norms and patterns of interactions of groups, which provides the meaning to drive leaders' and employees' behaviours and results*'.

1.3 The cultural characteristics of an organisation are a key driver of the behaviours of the employees within it, at all levels.

1.4 Culture shapes judgments, ethics and behaviours at key moments. These key moments matter to the performance and reputation of the organisation.

1.5 Leaders are proven to play a significant role in shaping and maintaining an organisation's culture. If one wishes to understand the culture of an organisation, one should first examine the leadership practices within it.

1.6 In reviewing leadership behaviours within the Trust and in order to bring them to life within the context of our findings, the panel reviewed behaviours against the leadership styles defined by the Hay Group (below). It should be stated here that leaders are often inclined to adopt more than one leadership style, maybe a combination of two or three, but it is likely that they will revert to their predominant type when under duress.

	COMMANDING	VISIONARY	AFFILIATIVE	DEMOCRATIC	PACESETTING	COACHING
The leaders modus operandi	Demands immediate compliance	Mobilises people towards a vision	Creates harmony and builds emotional bonds	Forges consensus through participation	Sets high standards for performance	Develops people for the future
The style in a phrase	"Do what I tell you"	"Come with me"	"People come first"	"What do you think"	"Do as I do now"	"Try this"
Underlying emotional intelligence competency	Drive to achieve, initiative, self-control	Self-confidence, empathy, change catalyst	Empathy, building relationships, communication	Collaboration, team leadership, communication	Conscientiousness, drive to achieve, initiative	Developing others, empathy, self-awareness
When the style works best	In a crisis, to kick start a turnaround, or with problem employees	When changes require a new vision, or when a clear direction is needed	To heal rifts in a team or to motivate people during stressful circumstances	To build buy-in or consensus, or to get input from valuable employees	To get quick results from a highly motivated and competent team	To help an employee improve performance or develop long-term strengths
Overall impact on climate	Negative	Most strongly positive	Positive	Positive	Negative	Positive

2 RISKS OF CHANGING ORGANISATIONAL CULTURE

2.1 Culture is hard to define, even harder to change and takes dedicated, persistent focus over many years in order to embed different approaches and behaviours.

2.2 Creating and maintaining changes to culture is challenging. Leadership is key. Cultural change will be unsustainable unless leaders themselves commit to consistently modelling the behaviours and values that define the new culture. Leaders need to walk the talk.

2.3 Where change management is handled poorly, organisations risk experiencing detrimental effects to varying degrees. These might include loss of direction and confusion around expectations, mistrust, demotivation, breakdowns in communication / internal conflict, apathy and ultimately decreased productivity or performance.

2.4 The behaviours of the Board set the tone for the behaviour of the organisation. If the Board aren't fully committed and acting as role models for change, the process quickly falls down.

3 TRUST CULTURE ANALYSIS

Pre Foundation Trust

3.1 The Trust went through two unsuccessful attempts at becoming a Foundation Trust.

3.2 The evidence that the Panel have heard suggests that prior to Foundation Trust status being achieved, the leadership style was strongly 'commanding' in nature.

3.3 It was generally reported that business was a higher priority than 'people' on Board agendas.

3.4 With the appointment of a new Chairman, the leadership style took a different slant. He demonstrated a strong 'pacesetting' style, although there is also evidence of a continuation of 'commanding'.

3.5 He had been appointed to guide the Trust towards achieving Foundation Trust status as quickly as possible. A highly motivated and competent leadership team was put in place, many of them newly appointed and high standards of performance and delivery were set, in accordance with the required commercial deliverables.

3.6 The panel found evidence of conflicts between Board members during this time and also between Board members and Governors.

3.7 Foundation Trust status was achieved.

Post Foundation Trust

3.8 Once the Foundation Trust status had been achieved, witnesses reported that the pacesetting style waivered in an environment of 'what next?' and the Chair became frustrated with what he saw as apathy.

3.9 The pacesetting style requires a vision and a challenge and the most pressing challenge had been achieved.

3.10 The CEO departed and an interim CEO appointment was made.

3.11 This was a critical period for the Trust and there was a developing view in the Board that an inclusive, values-based approach was more appropriate to a mental health trust and that what was needed at this time was the appointment of a 'visionary' CEO who would have the ability to mobilise the Trust through a period of change with a negotiated but ultimately clear direction.

3.12 The panel heard that during the period of 'commanding' leadership, individuals rarely complained openly and so issues were dealt with informally or not addressed. If issues did come to light, the panel have heard that they would be quickly closed down, often resulting in departures from the organisation.

3.13 With new leadership in place, the ideal opportunity presented itself to ensure that vision combined with more determined and governed organisational effectiveness was indicated.

3.14 Instead, the evidence suggests that the predominant focus at this time was around establishing an emphasis on people, values and engagement at Board level.

3.15 There were three members of the Board who had seized the opportunity to push for a clear people agenda. These individuals were the interim CEO, a NED with a professional background in organisational development / culture change and the newly appointed Director of Workforce and Organisational Development who had joined shortly before FT status had been awarded.

3.16 In terms of leadership styles, the interim CEO and NED based on the information gathered by the panel, represented a combination of 'affiliative, democratic and coaching' styles although there is some evidence that the interim CEO demonstrated a commanding style of leadership from time to time.

3.17 There is evidence of some strong push back at Board level around elements of the people agenda. This did not impede the work of the individuals responsible for these initiatives. They pushed ahead with the intention of taking those with negative opinions with them on the journey.

3.18 The Board ultimately signed off this approach and change initiatives were being delivered 'bottom up' through the introduction of values and engagement through collaboration and increased communication with employees at all levels.

3.19 The panel received no evidence that a strategic transformation programme was written nor that there was any formal assessment of the risks associated with the proposed change of culture of the organisation.

CEO Appointment

3.20 An assessment process was carried out and Steve Trenchard was appointed on the basis of evidence of a strong focus on people and engagement. It is apparent that he was viewed as someone who would introduce fresh, modern ideas and support and drive the people agenda.

3.21 In terms of leadership style, it is evident that his style was a strong combination of 'democratic and coaching' in nature.

3.22 No consideration appears to have been given to bringing into the Trust an inexperienced CEO, with a style entirely at odds with the previous 'commanding' culture.

3.23 The view of the panel is that the Trust did not recognise in a practical way that they were appointing a CEO with limited experience of the application of strong governance.

3.24 There was little ownership or structure provided by any of the leadership team around the Steve Trenchard's induction process. It was assumed that the Chair was dealing with it and he did not think he was.

3.25 In the Steve Trenchard's well-intentioned efforts to get out into the Trust, collaborate, build buy-in and encourage participation, the panel is aware that concerns were expressed by others that he was booked up for weeks in advance, he was too familiar for the office and his informal style encouraged a less rigorous approach in others.

3.26 This resulted in little space or time to focus on developing the top level vision / strategy moving forwards for the Trust. The BoD struggled to identify and establish an overall strategy that converted into an integrated business plan.

3.27 The panel heard that those who had been accustomed to a more controlling style of leadership were delighted by now having an approachable CEO and described him as 'a breath of fresh air'.

3.28 He was popular as an individual, but not necessarily in his capacity as CEO.

Change of Chair

3.29 When the Chair's contribution to Helen Marks complaint became apparent, the Chair resigned and was replaced.

3.30 The new Chair, based on the evidence the panel has seen, demonstrated a 'commanding' style of leadership.

4 LEADERSHIP AND BEHAVIOURAL ANALYSIS

4.1 The panel has heard evidence relating to a number of leadership behaviours in relation to informality and lack of adherence to procedure that were exhibited within the Trust both pre and post Foundation Trust status being awarded.

4.2 These behaviours provide a clear indication of an entrenched culture within the Trust going back many years. It is apparent that many of these behaviours would have been considered to be the norm at the time and there was little awareness of the impact.

4.3 It is apparent that these behaviours had not been recognised or addressed by the CEO in his relatively short time within the Trust. Indeed, it is evident that the CEO has engaged in some of these behaviours, either consciously or unconsciously, perhaps as a result of joining an organisation where the behaviours were so entrenched that they seemed normal.

4.4 The panel heard from witnesses that out-of-professional relationships, friendships were formed in the workplace that occasionally extended outside of work. This created a perception of a lack of transparency and a risk of friendships being used to gain leverage.

4.5 It is evident that this resulted in an over reliance on informal approaches to resolving issues, rather than an adherence to internal policy and procedure. It is perhaps for this reason that the risk involved in these circumstances was not recognised sufficiently.

4.6 The panel also heard evidence from some employees that where they attempted to speak up about issues in the workplace their confidentiality was breached, or there was a perception that it could be. As a result employees were reluctant to approach the leadership team with issues.

4.7 After the new CEO was appointed the culture continued to manifest itself in a number of ways.

4.8 There was a lack of team cohesion in supporting the new CEO in relation to a thorough induction. It is also apparent that the values based leadership that was being heavily emphasised throughout the Trust was not always reflected in senior management behaviour.

4.9 The appointment of Steve Trenchard with his associated democratic leadership style, along with the work that was being carried out around culture change, brought about progressive and significant change from control to liberalism.

5 EMPLOYMENT TRIBUNAL AND RELATED ISSUES

5.1 In specific relation to the issues highlighted in the Employment Tribunal, it is very apparent where the previous culture manifested itself to create some significant failings.

5.2 There were failings to follow up on complaints in a formal fashion and to revert immediately to and rely upon internal Policies and Procedures.

5.3 The key contributors in the case were compromised by the informality of their relationships and lack of professional boundaries. This is reflected in the over reliance on informal discussions and the hope of achieving a settlement, whilst at the same time losing a grasp on the internal processes that ought to have taken priority.

5.4 In the midst of the crisis, the leadership team failed to assess the scale of the risk and act appropriately.

6 SUMMARY

6.1 The Trust had a command structure at the time of its final and successful application for Trust status. The panel does not comment on the appropriateness or otherwise of this.

6.2 That style suppressed the concerns and complaints of several people who identified themselves to the panel.

6.3 That the style was accompanied by some informality of approach was obscured by the command style.

6.4 The Trust decided that it wanted to change its approach to one of inclusion and values. In its endeavour to change its approach and the absence of a risk analysis, the Trust introduced a more informal style without the countervailing influence of a command style and thus became less disciplined than before.

6.5 It was in this sort of environment that the conditions were right for such a serious untoward event as the Helen Marks Employment Tribunal.

7 RECOMMENDATIONS

7.1 The Trust should use the “well-led” review to establish what management style it thinks is appropriate to a mental health Trust in an area of mixed city and rural populations over a significant geography.

7.2 The Trust should develop a plan to implement that culture as part of its transformation work. This should include recognised best practice for culture change, a risk analysis, an analysis of organisational effectiveness and milestones for this whole organisational shift.

7.3 The Trust should invest in its capacity and capability to lead cultural change.

7.4 The organisational development capability is severely limited by the poor relationships in the HR and OD departments and will need concerted action to ensure what is needed is available.

CHAPTER 7

ORGANISATIONAL RESPONSES TO STAFF CONCERNS

1 INTRODUCTION

1.1 This chapter sets out the types of complaints that were received within the Trust and an overview of the organisations response.

1.2 The chapter does not set out to provide a response to the complaints themselves, or make any comment around the validity of those complaints as this does not fall within the Terms of Reference in relation to this investigation. A separate investigation panel has been put in place to address individual complaints.

2 BACKGROUND

2.1 It is apparent that complaints were raised, either orally or in writing and informally or formally by a number of employees in the period between 2013 to present.

2.2 Of those complaints that have been brought to the attention of the Panel, the nature of the allegations fall into the following categories:

2.2.1 Concerns about the bullying and harassment of others.

2.2.2 Individual concerns around bullying and harassment.

2.2.3 Concerns around the conduct of others, including at the Employment Tribunal.

2.2.4 Insecurities around job role / expectations / level of support in role.

2.2.5 Failures by the Trust to adhere to policy and procedure or corporate governance

2.2.6 Sexual harassment.

3 METHOD OF RAISING COMPLAINTS

3.1 It is evident that prior to the Employment Tribunal the majority of the complaints that the panel has heard evidence of were raised verbally and informally. This is with the exception of Helen Marks formal grievance which was submitted to the Trust in writing. The actions taken in relation to Helen Marks' grievance are outlined in the Tribunal Judgment and so this chapter will refer only to other complaints that have been brought to the attention of the Panel and how the Trust dealt with them at that time. Some complaints fall within the context of the investigation that is currently underway within the Trust, as referred to earlier in 1.2 in this Chapter.

3.2 These complaints were reported on an ad-hoc basis and the specific areas of complaint were usually included in part of a wider discussion.

3.3 Complaints were raised by individuals with one or more people, including immediate line managers, non-executives, the deputy Chief Executive, the Chief Executive and the Chair.

3.4 Discussions often took place on a one-to-one basis.

3.5 Individuals did not indicate that their complaints constituted formal grievances either orally or in writing. The complaints rarely followed the formal process for complaints as set out in the Trust Grievance Procedure.

4 HANDLING OF COMPLAINTS

4.1 In the absence of any clear indication around the formality of complaints, they were received informally by the recipient in the context of a wider conversation.

4.2 It is apparent to the panel that there was often a disparity between the individual's perception of their complaint, and that of the recipient.

4.3 Often complaints were discussed by the recipient with the person perceived to be responsible for the employee i.e. their line manager.

4.4 Issues were sometimes followed up by way of 'checking in on' the individual who had expressed discontent, from a welfare perspective.

4.5 Sometimes complaints were not followed up at all. There is evidence that once the details of the complaint had been passed on to the person perceived to be responsible, often any action stopped there. Sometimes this was due to the Trust experiencing and handling the Helen Marks case. This resulted in some frustration on the part of employees who had raised concerns.

5 FINDINGS

5.1 The panel found evidence of an informality of approach throughout the investigation. The handling of concerns is a good example of where informality fails to adequately address problems.

5.2 From the information the panel has been provided with it is very apparent that individuals failed to highlight concerns through any formal process. The recipient of the complaint then failed to clearly establish with the individual the intended formality of their complaint, often assuming it to be informal or in many cases, not a complaint at all.

5.3 If Trust Policies and Procedures were consistently utilised in the event of a complaint there would naturally be a level of formality introduced that would:

- Establish the nature of the complaint.
- Establish the formality / informality of the complaint.
- Establish the employees' expectations around how their complaint might be handled, if indeed they wish for it to be handled.
- Establish clear expectations around next steps and potential outcomes.
- Establish an end result, or an outcome which would be formalised in writing.

5.4 This has two benefits;

5.5 Firstly the individual would more clearly understand what to expect and may then decide how best to pursue their complaint, or not.

5.6 Secondly the Trust would be able to demonstrate that it has taken an individuals' complaint seriously and acted in accordance with the individuals' expectations which are established at the outset. This would in turn enable issues to be dealt with promptly, minimising the possibility of issues escalating.

5.7 It is recommended that wherever possible all complaints by or in relation to are satisfactorily resolved to enable the individuals concerned to achieve some closure.

CHAPTER 8

RECOMMENDATIONS

1 INTRODUCTION

In this chapter the panel has summarised its recommendations from individual chapters. It is intended to provide a single point of reference for steps which the panel believes should be considered by the Trust.

Certain of these recommendations do not appear elsewhere in the report as they represent conclusions reached based upon all of the evidence which the panel has considered rather than being specific to any one aspect of the terms of reference.

2 RECOMMENDATIONS

2.1 Governance

The Trust should use its Well-led review to question further its use of the governance machinery of the Trust. It is the panel's view that it was the lack of awareness, good behaviour and good practice which were the origins of the problems and not the arrangements themselves. The Trust will want to satisfy itself that these problems are not more widely observed in governance arrangements into which the panel has not investigated.

Given its strategic emphasis on cultural change and values-based work and given the need to recover from the events surrounding the Employment Tribunal of Helen Marks the Trust should consider how it could better fulfil its obligations in this endeavour. Several Trusts have an Organisational Development and Workforce Committee to give this emphasis. The Trust should consider how its governance arrangements could better match its strategy and plans.

The Board should improve its approach to being a unitary Board. It should consider how it can develop a greater consciousness about the significance of the business it is transacting It 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 is the view of the panel that the Board should establish an OD&W committee. It should write and implement a plan for Board development which includes these objectives.

It is important to note that when the panel describes concerns about the use of governance machinery this applies to the CoG as well as the Board of Directors. In particular the CoG "task and finish" group has a difficult task in appropriately satisfying itself that some of the Governors can be "impartial and honest" as described in the Standards of Business Conduct.

The relationship between the BoD and the CoG is poor. Both parties should adopt a conciliatory approach rather than continuing with the antagonism which impacts the current relationship. The constitutional position is that all components and members of the Trust's governance arrangements are expected to act in the public interest.

Mandatory training should be required for 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. Over the following few months the Trust should retain the services of the solicitor appointed to support the Governors.

The HR and OD departments should to be under the management of one executive director and the panel would recommend that that is the Director of Transformation with a suitable operational HR deputy. The resolution of the poor relationships within those departments will require great wisdom and insight. It seems to the panel that there are colleagues in those departments who will find it very difficult if not impossible to work together again and it may be necessary to address the issues fundamentally rather than developmentally.

2.2 **Culture**

The Trust should use the "well-led" review to establish what management style it thinks is appropriate to a mental health Trust in an area of mixed city and rural populations over a significant geography.

The Trust should develop a plan to implement that culture as part of its transformation work. This should include recognised best practice for culture change, a risk analysis, an analysis of organisational effectiveness and milestones for this whole organisational shift.

The Trust should invest in its capacity and capability to lead cultural change.

The organisational development capability is severely limited by the poor relationships in the HR and OD departments and will need concerted action to ensure what is needed is available.

2.3 **General**

The Trust should recognise that every member of the senior management team is an employee and is entitled to expect support in doing the job. That should range from good induction, the identification of training needs, the support of a formal mentor, the scrutiny of the board as a protection of the post-holder and the provision of trustworthy Board colleagues.

In more general terms it is our recommendation that every NED or senior employee needs to ensure that:

- they identify the best interests of the Trust and the wider ramifications of their decisions;

- use is made of the experience within the Trust, whether amongst the executive or non-executive team. As an example, in a complex case involving HR issues the panel questions why no use appears to have been made of Tony Smith's expertise at any point other than to be held in reserve for a grievance; and

- NEDs and executive alike must understand that their obligation to the organisation does not end when they leave. If asked to do so there is an expectation that they will re-engage with and for the benefit of the Trust and the public interest. That must be an accepted part of the psychological contract.

EMPLOYMENT TRIBUNALS

To: David Potter
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Zoe Thomas
DAC Beachcroft LLP
DX 14099 Leeds

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Office : 0115 947 5701

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Your Ref:

Date 22 June 2015

Case Number: 2603606/2013

Claimant		**Respondent**
Mrs H Marks	**v**	**Derbyshire Healthcare Nhs Foundation Trust**

EMPLOYMENT TRIBUNAL JUDGMENT

A copy of the Employment Tribunal's judgment is enclosed. There is important information in the booklet 'The Judgment' which you should read. The booklet can be found on our website at www.justice.gov.uk/tribunals/employment/claims/booklets

If you do not have access to the internet, paper copies can be obtained by telephoning the tribunal office dealing with the claim.

The Judgment booklet explains that you may request the employment tribunal to reconsider a judgment or a decision. It also explains the appeal process to the Employment Appeal Tribunal. These processes are quite different, and you will need to decide whether to follow either or both. **Both are subject to strict time limits.** An application for a reconsideration must be made within 14 days of the date the decision was sent to you. An application to *appeal* must generally be made within 42 days of the date the decision was sent to you; but there are exceptions: see the booklet.

The booklet also explains about asking for written reasons for the judgment (if they are not included with the judgment). These will almost always be necessary if you wish to appeal. You must apply for reasons (if not included with the judgment) within 14 days of the date on which the judgment was sent. If you do so, the 42 day time limit for appeal runs from when these reasons were sent to you. Otherwise time runs from the date the judgment was sent to you or your representative.

For further information, it is important that you read the Judgment booklet. You may find further information about the EAT at –

www.justice.gov.uk/tribunals/employment-appeals

An appeal form can be obtained from the Employment Appeal Tribunal at: Employment Appeal Tribunal, Second Floor, Fleetbank House, 2-6 Salisbury Square, London EC4Y 8JX or in Scotland at 52 Melville Street, Edinburgh EH3 7HS.

Yours faithfully,

SHABANA AKHTAR
For the Tribunal Office

I have a Judgment from the Employment Tribunal but the Respondent has not paid. What do I do?

The Employment tribunal has no statutory authority to enforce its own awards. However, there are a number of options available to you.

If your award has not been paid you can register your award as a debt at your local County Court (Civil Section) and explore various options for enforcement with them. This can be done at any time following the issue of the Judgment by the Tribunal.

Details of your local County Court can be found online: http://hmctscourtfinder.justice.gov.uk/

Additionally, you are advised to read the following booklets which may be helpful. These are available on our website: http://hmctsformfinder.justice.gov.uk/

- **T426 –** The Judgment (Employment Tribunal)
- **EX328 –** I have a Tribunal decision but the Respondent has not paid – How do I enforce it?
- **EX727** – I have an Employment or an Employment Appeal Tribunal award but the Respondent has not paid – How do I enforce it?

Further information about enforcing your Judgment can be obtained by contacting your local County Court.

Please note that the Employment Tribunal is unable to provide any advice on enforcement procedures.

Case Nos: 2603606/13 & 2600717/14

EMPLOYMENT TRIBUNALS

Claimant:	Mrs H Marks
Respondent:	Derbyshire Heathcare NHS Foundation Trust
Heard at:	Nottingham
On: 28 April 2015	**Reading day**: 13 April reading day **Hearing days:** 14 - 17, 20 - 24, 27 – **Judgment days**: 9 - 30 April, 1 May 2015
Before:	Employment Judge Hutchinson **Members:** Mrs S J Drummond Mr W J Dawson

Appearances:
The Claimant: Miss A Reindorf - Counsel
The Respondent: Mr S Sweeney - Counsel

JUDGMENT

The Employment tribunal gave unanimous judgment as follows:-

1. The Claimant was unfairly dismissed.

2. The claims of direct sex discrimination, harassment and victimisation succeed.

3. The issue of remedy will be dealt with at a separate hearing on **2 and 3 September 2015** at the Nottingham employment tribunal.

4. A case management discussion will be conducted on **3 July 2015 at 0930** to give further directions after the parties have been able to consider the reasons.

RESERVED REASONS

Background and issues

1. The Claimant had presented 2 claims to the employment tribunal, namely
   1.1 On 9 December 2013, whilst the Claimant was still in the employ of the Respondents, she presented a claim of sex discrimination only;

1.2 On 27 May 2014 the Claimant presented amended grounds of complaint incorporating further particulars. She applied to add Mr Alan Baines as a second Respondent to the proceedings.
1.3 On 23 June 2014, she presented a second claim following her resignation from the Respondent on 19 February 2014. At this time, she claimed

- constructive unfair dismissal
- direct sex discrimination
- harassment
- victimisation.

2. On 23 July 2014, the Claimant was granted permission to rely on her amended grounds of complaint. This was by my colleague, Employment Judge Camp. At that hearing, the Claimant's application to join Mr Alan Baines as a Respondent and to amend her claim so as to bring complaints against him was refused.

3. The Claimant's complaints can be summarised. That there was a close personal relationship between herself and Mr Baines, who was also the Chair of the Trust; that she refused to have a sexual relationship with him and that he turned against her and caused complaints to be made against her which led to her suspension.

4. After he left the Trust, she was not allowed to return to her position and only at a very late stage did the Respondents agree to carry out any form of investigation. Because of the behaviour of the Trust by the Chief Executive and Governors and Mr Baines, she resigned and now claims constructive unfair dismissal and discrimination because of a protected characteristic, namely her sex.

5. There was an agreed list of issues in respect of the liability hearing, which this became, and these are as follows:

Unfair dismissal claim

5.1 Was the Claimant constructively dismissed, i.e. was there a fundamental breach of her contract of employment and did she resign because of the breach. If so did she affirm the contract before resigning by delaying too long? The term of the contract alleged to have been breached is the implied term of mutual trust and confidence.

5.2 If so, what was the principal reason for dismissal and was it a potentially fair one under Section 98(1) of the Employment Rights Act 1996 ("ERA")?

5.3 If so, was the dismissal fair or unfair under ERA Section 98(4)?

Discriminatory dismissal/dismissal by way of victimisation

5.4 If the Claimant was dismissed
5.4.1 Was she dismissed because of her sex; and/or
5.4.2 Was her dismissal an act of harassment related to her sex; and/or
5.4.3 If the Claimant did a protected act as set out at the

paragraphs below, was her dismissal an act of victimisation?

Direct sex discrimination

5.5 Did the Respondent subject the Claimant to less favourable treatment as follows:

5.5.1 by subjecting the Claimant to sexual harassment and bullying by its Chair, Mr Baines, by placing her under pressure to have a sexual relationship with him, acting in such as way as to make the Claimant fearful of displeasing him and accusing the Claimant of having an affair with Professor Trenchard and on 13 March 2013 of being a "whore", and did it fail to take any action to prevent such conduct or to protect the Claimant from it;

5.5.2 by subjecting the Claimant to spurious and unfounded allegations of bullying and harassment which had been engineered by Mr Baines in an attempt to secure her dismissal;

5.5.3 by subjecting the Claimant to unjustified suspension;

5.5.4 by Professor Trenchard and Mr Baines colluding in attempting to dismiss the Claimant, alternatively persuade her to resign;

5.5.5 by imposing, conducting and pursuing the Claimant's suspension in a manner which was unfair and in breach of the Respondent's internal policies and procedures;

5.5.6 by Mr Baines seeking to manipulate the suspension and investigation process in such a way as to cause the Claimant significant detriment and distress, including in his email to Professor Trenchard of 29 July 2013; his visit and email to the Claimant of 7 August 2013; his email to Professor Trenchard of 12 August 2013; his communication to the Claimant of 13 August 2013; his letter to the Claimant of 2 September 2013; his letter to the Claimant of 4 September 2013 and his text message to the Claimant of 6 September 2013;

5.5.7 by Mr Baines subjecting the Claimant to abusive and discriminatory language by text and email up to and including in his text of 6 September 2013 in which he called her "you stupid woman";

5.5.8 by treating the Claimant inequitably in that it suspended immediately on receipt of allegations of bullying and harassment against her but took no action against Professor Trenchard and Mr Baines in response to her complaints of sexual harassment; sex discrimination; bullying and harassment against them. Professor Trenchard and Mr Baines are relied upon as actual comparators for the purpose of this part of the complaint;

5.5.9 by protecting and defending Mr Baines and seeking to obscure his wrongdoing, including in its manner of announcing his departure from the Trust;

5.5.10 by refusing or failing to give a proper or adequate reason to the Claimant as to why her suspension was lifted and the investigation discontinued;

5.5.11 by refusing to exonerate the Claimant following the lifting of

her suspension and discontinuance of the investigation into the complaints against her;

5.5.12 by refusing to issue an apology to the Claimant for her suspension or any of the other treatment to which she was subjected;

5.5.13 by putting in place a reorganisation with a view to managing the Claimant out of her post following a disclosure of information to Monitor on 13 September 2013 and her grievance on 17 September 2013;

5.5.14 by seeking to impose conditions on the Claimant's return to work from sick leave which were unfair and which gave the impression that she was guilty of wrongdoing;

5.5.15 by persistently ignoring the Claimant's complaints of sexual harassment and sex discrimination against both Mr Baines and Professor Trenchard;

5.5.16 by failing properly or at all to investigate the Claimant's grievance, including by producing a "desktop review" of the Claimant's grievance which was entirely inadequate and was conducted by Mr O'Bryan who had a conflict of interest;

5.5.17 by causing wholly unreasonable delays in the investigation into the Claimant's grievance?

If so, was this because of her sex?

Harassment

5.6 Did the Respondent harass the Claimant contrary to Section 26(2) of the Equality Act 2010 ("EQA") in relation to her sex as follows;

5.6.1 by Mr Baines placing the Claimant under pressure to have a sexual relationship with him and acting in such a way as to make her fearful of displeasing him; and

5.6.2 by such conduct having the purpose and/or effect of violating the Claimant's dignity and/or creating an intimidating, hostile, degrading, humiliating or offensive environment for her?

5.6.3 did the Respondent subject the Claimant to sexual harassment contrary to Section 26(3) EQA in that it treated the Claimant less favourably in the respects set out above on the ground of her rejection of the unwanted conduct mentioned in subparagraph 5.6.1 above than it would have treated her had she not rejected the conduct?

Victimisation

5.7 Do the following constitute protected acts for the purposes of Section 27 EQA?

5.7.1 the Claimant's letters to the Respondent dated 28 August 2013 and 6 and 11 September 2013;

5.7.2 the Claimant's written grievance of 17 and 20 September 2013; and

5.7.3 the Claimant's grievance meeting on 2 October 2013?

5.8 Did the Respondent subject the Claimant to detriments as follows;

5.8.1 by Professor Trenchard and Mr Baines colluding in attempting to dismiss the Claimant, alternatively persuading

her to resign;

5.8.2 by imposing, conducting and pursuing the Claimant's suspension in a manner which was unfair and in breach of the Respondent's internal policies and procedures;

5.8.3 by Mr Baines seeking to manipulate the suspension investigation process in such a way as to cause the Claimant significant detriment and distress, including in his email to Professor Trenchard of 29 July 2013, his visit and email to the Claimant of 7 August 2013, his email to Professor Trenchard of 12 August 2013, his communication to the Claimant of 13 August 2013, his letter to the Claimant of 2 September 2013, his letter to the Claimant of 4 September 2014 and his text message to the Claimant of 6 September 2013;

5.8.4 by Mr Baines subjecting the Claimant to abusive and discriminatory language by text and email up to and including in his text of 6 September 2013 in which he called her "you stupid woman";

5.8.5 by treating the Claimant inequitably in that it suspended her immediately on receipt of allegations of bullying and harassment against her but took no action against Professor Trenchard and Mr Baines in response to her complaints of sexual harassment, sex discrimination, bullying and harassment against them. Professor Trenchard and Mr Baines are relied upon as actual comparators for the purposes of this part of the complaint;

5.8.6 by protecting and defending Mr Baines and seeking to obscure his wrongdoing, including in its manner of announcing his departure from the Trust;

5.8.7 by refusing or failing to give a proper or adequate reason to the Claimant as to why her suspension was lifted and the investigation discontinued;

5.8.8 by refusing to exonerate the Claimant following the lifting of her suspension and discontinuance of the investigation into the complaints against her;

5.8.9 by refusing to issue an apology to the Claimant for her suspension or any of the other treatment to which she was subjected;

5.8.10 by putting in place a reorganisation with a view to managing the Claimant out of her post following her disclosure of information to monitor on 13 September 2013 and her grievance on 17 September 2013;

5.8.11 by seeking to impose conditions on the Claimant's return to work from sick leave which were unfair and which gave the impression that she was guilty of wrongdoing;

5.8.12 by persistently ignoring the Claimant's complaints of sexual harassment and sex discrimination against both Mr Baines and Professor Trenchard;

5.8.13 by failing properly or at all to investigate the Claimant's grievance, including by producing a "desktop review" of the Claimant's grievance which was entirely inadequate and was conducted by Mr O'Bryan, who had a conflict of interest;

5.8.14 by causing wholly unreasonable delays in the investigation of the Claimant's grievance;

5.8.15 in its manner of announcing the Claimant's resignation,

particularly by comparison with its treatment of Mr Baines in respect of his departure from the Trust;

If so was this because she did a protected act?

Jurisdiction

6. Were the proceedings or any of the Claimant's complaints brought outside the time limits set out in Section 123 EQA?

Evidence

7. The tribunal heard evidence for the Claimant as follows:
   - 7.1 The Claimant;
   - 7.2 Lorraine Statham, Assistant Director of Leadership and Organisational Development for the Respondent;
   - 7.3 Paul Lumsdon, former chief nurse of the Respondent;
   - 7.4 Sue Flynn, Staff Governor of the Respondent and member of the Leadership Development Team;

8. The tribunal heard evidence for the Respondent from:
   - 8.1 Alan Baines, former Chairman of the Trust;
   - 8.2 Harinder Dhalliwal, Assistant Director for Engagement and Inclusion for the Respondent;
   - 8.3 Karen Herriman, Deputy Director of Workforce and Organisational Development'
   - 8.4 Professor Steve Trenchard, Chief Executive of the Trust since 1 February 2013;
   - 8.5 Lee O'Bryan, Interim HR Director of the Trust between November 2013 and October 2014;
   - 8.6 Ifti Majid, Deputy Chief Executive since 2013.

9. There was an agreed bundle of documents and where I refer to page numbers, it is from that bundle. There was also a report from Afentis Forensics following a forensic analysis of the Claimant's Blackberry.

Facts

10. The Respondent has approximately 2,300 employees and provides a range of services over 90 sites throughout Derbyshire.

11. The Claimant had worked in Human Resources since 1984. Mrs Marks joined the National Health Service in 1999 and became Director of Human Resources for Leicester City West Primary Care Trust. She left the NHS between 2003 and 2004 and then returned in December 2004, working initially for Derbyshire Dales Primary Care Trust. On 1 August 2010 she became Director of Workforce and Organisational Development for the Respondent.

12. Her job was to manage the HR function in the Trust as well as the organisational development, education and learning.

13. The senior management team around the time of the alleged incidents was as follows:
   - Alan Baines who was Chairman of the Trust from 2008 until September 2013;

- Mike Shewan, who was Chief Executive from 1999 until April 2012;
- Professor Steve Trenchard, Chief Executive of the Trust from February 2013 until the present;
- Paul Lumsdon, who was Chief Nurse and member of the Board of Directors until September 2013;
- Ifti Majid who was the Chief Operating Officer and Deputy Chief Executive from April 2013 to date;
- Kathryn Blackshaw who was Director of Business Strategy from January 2009 and Acting Chief Executive between April and December 2012;
- Graham Gillham, Director of Corporate and Legal Affairs;
- Tim Woods, Director of Finance until September 2012;
- Claire Wright, Director of Finance since January 2013.

14. The Claimant had been responsible for the implementation of all the various policies that we were referred to in the course of the proceedings. She has an intimate knowledge of them and is a highly experienced HR professional.

15. The grievance policy is at pages 225-34. Under "*Purpose*" it provides:-

> "...
> *Grievances are best dealt with at an early stage, and wherever possible, informally with the immediate line manager. It is in the interest of both employees and the Trust to resolve problems before they can develop into major difficulties."*

16. Under the section "*Raising a Grievance*" it provides:-

> *"3.4.1 An employee must attempt to resolve the issue informally before proceeding to the formal stage of this procedure. An employee must be able to demonstrate or evidence that every effort has been made to resolve the issue."*

17. It goes on to provide for a discussion to take place between the parties. It says in paragraph 3.4.2:-

> *"... This is best achieved by means of an open and constructive discussion in which both parties are willing to understand the other's point of view. The manager will then attempt to resolve the grievance in an informal manner by facilitating discussion between the necessary parties."*

18. It is clear from the procedure that it is necessary to seek to resolve matters informally before the matter can go forward as a formal grievance.

19. The disciplinary policy is at page 235 - 53. We were particularly referred to:-

> ***"2.1 An employee's right to be accompanied***
>
> *Throughout all stages of the Suspension, Investigation, and Disciplinary processes employees have the right to be accompanied by a companion."*

20. We were also referred to:-

> ***"3.1 Reporting the matter***

When a disciplinary issue arises the Manager concerned should contact the Workforce and Organisational Department to discuss the full facts and establish the potential seriousness of the allegations/actions/complaint. The Manager and Workforce and Organisational Development Representative should complete the Disciplinary Report Form included within the Disciplinary Handbook in order to ensure that all the appropriate information is recorded and to ensure that the issue will be managed appropriately in accordance with the Disciplinary Procedure."

21. We were also referred to:-

"3.2 Review Working Arrangements

If it is decided to invoke the formal disciplinary procedure the Manager/Director should consult with the Workforce and Organisational Development Representative in order to determine whether it is appropriate for the individual to continue working in their normal role.

...

It should be made clear to the individual that suspension is not a form of disciplinary action, and it should be brief and kept under review."

22. With regard to the process of investigation, the procedure provides:-

"3.3 Investigation Process

... The Lead Commissioning Officer for the investigation will produce a set of Terms of Reference for the investigation process and will appoint a minimum of two independent investigating officer's to conduct the investigation following the Guidelines for Conducting Investigations. ...

The investigation should be concluded as promptly and efficiently as possible before memories fade...

The employee subject to the investigation must be given advance notice of the allegations made against them."

23. We were also referred to the Suspension from Duty Guidelines which are at pages 254-7. In particular under the guideline for managers it makes clear that suspension is a measure which should only be used in appropriate circumstances. It gives guidance regarding the decision to suspend, namely;

> *"The manager should carry out some preliminary investigations to establish precisely what the allegations are to ensure the accuracy of information and the reliability of the source.*
> *In deciding to suspend, the manager should give due consideration to any alternative available, for example the reallocation of duties or for the member of staff to move to an alternative location."*

24. The procedure also provides that the member of staff should be informed that if they so wished, they can have a representative or friend present at the suspension meeting and says that wherever possible a manager should not suspend an employee on his/her own.

25. The process also provides for employees to be supported properly

throughout the process and that counselling and support from the Occupational Health Department should be offered to the employee. Further, a designated support manager should be identified for all members of staff who are suspended.

26. The Respondent's Dignity at Work procedure is at pages 314-27. It says in that document that the Trust considers bullying and harassment to be totally unacceptable and will not condone behaviour that is abusive, offensive and which affects the dignity of any of its employees. There are two parts of the process, namely an informal approach and a formal procedure. In particular, it states:-

> ***5. INFORMAL APPROACH***
>
> *5.1 An employee who believes that he/she has been the subject of harassment or bullying should in the first instance make it clear that the behaviour is unwelcome and unacceptable. Often a person is unaware of the effect of their behaviour on others, and once made aware of the distress caused by their actions, the offensive behaviour ceases. Effort should be made to try and resolve the issues as soon as possible after they arise.*
>
> *5.2 Where this is not appropriate or the alleged harasser's reaction gives cause for concern the employee may ask their line manager or a more senior manager to raise the issue with the alleged harasser on their behalf. It is advisable for all parties to keep a short confidential note, recording details of any discussions."*

27. The formal procedure is therefore where it has not been possible to resolve the matter though the informal procedure or where the concern or complaint relates to discrimination as a result of a protected characteristic, racial or sexual harassment. It says:-

> *"**FORMAL PROCEDURE***
>
> *6.2.2 The complaint should be raised with the employee's immediate manager and followed up in writing. However, there may be times when this is not appropriate and the following arrangements will apply:*
>
> *a) If the complaint is about the employee's manager it should be raised with the next level manager and followed up in writing.*
>
> ..."

28. The Special Leave Policy is at pages 328-32. The provisions in this part of the Respondent's procedures recognises the difficulties faced by employees in attempting to balance work and family life and all the stress this induces. It is the aim of the Policy to provide:-

> *"... a compassionate response to employees at times of particular need to assist them in balancing these demands ..."*

29. The leave granted under the arrangements is intended to cover certain broad categories, including bereavement leave and domestic leave but it is

agreed that none of the circumstances set out in that Policy applied in this case.

30. Mr Baines and Mrs Marks started having lunch together in July 2010. The purpose of these lunches was to discuss mainly work issues. They developed a friendship and became close confidantes. They talked not only about work matters but also their personal lives.

31. We were referred extensively by both parties to a report that Mrs Marks obtained from Afentis Forensics following a forensic analysis of her Blackberry. In these Reasons, I will be referring extensively to that report and I will be referring to that report by way of text number in the document. The report only provides details of text messages that the Claimant sent and so has to be viewed in that light. No doubt the Respondent could have obtained a similar report for text messages sent particularly by Mr Baines and Professor Trenchard but they have chosen not to do so. The first text message from Mrs Marks to Mr Baines is number 733 on 27 July 2012. From the contents of the message, it appears that this is the first text message that the Claimant sent to Mr Baines as it says:-

> " ... *Hope u don't mind me txting you ...*"

32. Helen Marks married her husband, Peter, in March 2012. Before she took her leave to get married in Sri Lanka, Mr Baines invited her to the pub for a drink to congratulate her. We are satisfied this was the first time they had been together outside work hours and at the point of leaving, Mr Baines gave her a hug and told her that he loved her. We accept that whilst Mrs Marks was surprised at the choice of words, she took his actions to be well wishes for her wedding.

33. In April 2012, Mike Shewan left the post of Chief Executive to go on secondment and Kathryn Blackshaw assumed the role of Acting Chief Executive. Mr Baines increased his role in the organisation, involving himself in the executive function.

34. Mrs Marks was concerned about the appointment of Ms Blackshaw from the beginning and says that she did not trust her.

35. In May 2012, the Director of Finance (Tim Woods) and Mrs Marks were called to a meeting with Ms Blackshaw and Mr Baines where they were accused of breaching standing financial instructions. This related to a payment made to an employee who left the organisation. It was about the obtaining of approval of financial payments to staff. This incident was a catalyst for Tim Woods leaving the Trust that summer. The first text that we have referred to above, i.e. number 733, refers to Mrs Marks's difficulties with Ms Blackshaw.

36. The second text that we were referred to was sent to Mr Baines on 21 August 2012 (number 717). It is clear that they were arranging to meet outside work hours in a country pub on the way home.

37. After that meeting, they began to text more regularly and the texts from Mrs Marks become more familiar. Text number 688 dated 20 September says:-

> "*My darling I was quite upset, hurt and confused after our discussion on Tuesday and got the impression you would not want me to come and see you although I did pass your office but noticed you weren't in. I would love*

to go out for a drink when I get back from holiday. I do you think you are wonderful but I know you don't believe me! Anyway be good whilst I am away and I will see you soon, x"

38. It is clear from the texts that they had regular "drink dates" and there is in many of the text a mixture of personal affection and work issues raised. An example of this was on 18 October 2012 (text 650):-

> "*Ok darling. Its like a work of fiction, she said she has done a 3-5 year strategy. She didn't she did the integrated business plan and just followed monitors template!!! We need to make it clear to the external that this is not correct and in fact each director took responsibility for their own chapter. That it is so disingenuous!! She also said she has set up a patient volunteer programme. WE HAVENT GOT ONE!!! Is mick supporting Kathryn? U r wonderful and u should feel good xxxx.*"

39. That text was referring to a document Kathryn Blackshaw had prepared in connection with her application to be Chief Executive and clearly Mrs Marks was using her relationship to try and influence Mr Baines, who was on the appointments panel of the new Chief Executive. It is clear from the text, that he was fully participative in the discussions, which was not appropriate bearing in mind his position as Chair of the Trust.

40. On 19 October, Ms Blackshaw failed in her effort to become Chief Executive. From the messages it can be seen that Mrs Marks was delighted. Despite this, she sent a text to Ms Blackshaw on 19 October (text 643) saying:-

> "*Sweetie I am so sorry such the wrong decision!!!xxx.*"

41. In fact, Mrs Marks had offered her good wishes to all three of the internal applicants, comprising Ifti Majid, Paul Lumsdon and Kathryn Blackshaw. She was in contact with Mr Baines by text whilst the interviews were taking place. She was also contacting Mike Shewan during the interview who was also on the interview panel and her texts to him on that date are at numbers 640, 642, 644 and 645.

42. On the non-appointment of Kathryn Blackshaw, Mrs Marks saw Mr Baines after the decisions had been taken. He came into her office, put his arms around her and kissed her, saying: "*That is how I want you to kiss me*". He suggested they go for a drink in a pub nearby which they did. Whilst Mrs Marks says that she did not know what to do, it is clear that Mr Baines thought he had obtained for her the result that she desired and wished to seek some reward for what he had done. He was disappointed.

43. On 23 October (text 615), the Claimant said:-

> "*I am fine. I am worried about u! I don't want u to be hurting! If it wud be easier for me to leave the trust rather than me keep hurting u then I will go so u don't have to see me. The last thing I want is u to feel how I appear to be making u feel u mean too much to me for that. xx*"

44. This is the first indication of the discomfort felt by Mrs Marks about their relationship. Although we have not seen the text from Mr Baines, it is clear that he sent a large number of texts to the Claimant over this period. In her text of 24 October (text 606) she says:-

"*Stop this. I am boring u... to claustophibic ... I have never said any of this and never given u any indication that I think or feel that way.*"

45. In a later text, on 25 October (text 598) she says:-

"*You are everything to me and I don't want to make you grumpy!! ...*"

46. The person appointed as Chief Executive was Professor Trenchard and Mrs Marks used her relationship with Mr Baines on 9 November to ask for a favour (text 514). She said:-

"*Sweetie would u do me a big favour and give steve a call to see how he got on with his visit and his first impressions. He met Ifti, Claire, Graham and me and spoke to Paul on the phone. I think I may have not been as impressive as shud have been so worried that he will think I am stupid. But don't want u to say that or to ask about me specifically! I am such a worrier! Wish u were here to give me a hug as feel insecure xxxxxxx*"

47. Mrs Marks continued to meet Mr Baines for lunch and referred to him affectionately in her texts. On 12 November, she said in text 505:-

"*Hi gorgeous! Just wanted to say thank u for lunch, thank u for being wonderful and thank u for loving me! U make my life complete xx xxx*".

48. Similar affection is shown by her in other texts around that time, for example texts numbered 485, 473 and 471.

49. They had a luncheon meeting in a Chinese restaurant in November 2012. When they came out of the restaurant Mr Baines kissed her in the street. Mrs Marks was worried about being seen and told him that she did not want him to do this. He accused her of not being affectionate enough towards him.

50. On 22 November, her text referred to them needing to be careful, that they might be seen (texts 455-6) and then on 26 November (text 446) she says:-

"*Baby you make everything feel ok. I love the fact with one word or smile you brighten my life!!! I hope ST has the courage to have that discussion with her! Won't be happy til she is gone she has such bad karma on the director team!! I can't wait to see u tomorrow gorgeous its great to know we have a special time that no one can spoil!! xxxxx.*"

51. Mrs Marks was using Mr Baines's affection for her to obtain what she wanted, namely that Ms Blackshaw should leave the organisation. Mr Baines knew this and was quite happy to participate in the behaviour.

52. On 29 November, Mrs Marks expresses a concern again about being seen kissing (text 427) and her concerns about them being found out. In the text at 428 sent just before this she mixes compliments and affection towards Mr Baines with comments about him sending texts to her:-

"*... whilst sitting next to the two biggest bitches (KB&MT) ...*"

53. On 30 November, Mrs Marks again shows her own duplicity. This relates to an issue Mr Shewan had regarding his pension. Mrs Marks clearly took great pleasure in his own difficulties, texting Mr Lumsdon (text 411) saying:-

"This will make you laugh. NHS pensions are querying Mike MHO status and whether he should have it. If they are not satisfied will affect his pension, you do have to be careful what you put out in the world!!!."

54. Mrs Marks texts continued to Mr Baines during December in an affectionate manner referring to him as *"sweetie"*, *"stud"*, *"darling"* and they continued to meet for lunch and drinks after work.

55. Whilst we have not seen the email, there is a reference at text 340 on 20 December to an email that the Claimant received from Mr Baines. It is clear that this upset Mrs Marks and in her text of 24 December (text 339) she says:-

"I am sorry you feel that way. From that email I see you have moved to hating me. This will be my last txt and I promise I will make any contact with you again or meet or see you. You will always be special to me and thank you for the times we share. Helen."

56. Her subsequent texts of that date number 333-8 are clearly in response to some texts that Mr Baines sent to her which upset her and they arranged to meet on their return to work on 4 January.

57. The meeting appeared to be successful, briefly, but not for long. On 13 January, there is a text numbered 287 which says:-

"I do worry, I worry about you as I always seem to do or say (not say) that let's you down and hurt your feelings. Your feelings mean a lot to me as you do! I thought we had a understanding about our relationship? I kno you want from me something I can't give you. I am sure how you would define our relationship. I want you in my life but if this isn't the way you want things to be then let's be clear that we are friends. I worry a lot that I hurt you and that's not me. It will kill our relationship if you want something I cannot give and worry that I am hurting you xxxxxxxx."

58. Text 286 then says:-

"I hope you find the physical and emotional love you desire xxxxxx."

59 On 14 January, at text 285 she says:-

"I have been honest with you we talk about the parameters in our relationship. You say you accept them and then you seem not accepting of the relationship. I want you in my life but it seems that you want me something I can't give you. You are not honest with me. You say that if this the relationship then you are happy with it as long as I am in your life. I think I am the fool because I believe you! Don't worry I will make every effort to find another position so you don't have to see this cold hearted, unfeeling woman who has treated you as rubbish!!!."

60. Later that same day the texts continue. In fact there were 17 texts sent on that day which are numbered 266-285. They are clearly in response to many texts that she was receiving from Mr Baines throughout that day. It can be seen from the contents of those texts that she is trying to calm the situation and that he is very angry with her that the relationship has not become a sexual one. Her text at 282 could not make it clearer that she did not wish the relationship to

become a sexual one. She says:-

> "*Thank you that you feel that you cab afford me some civility! I have done NOTHING wrong!! We talk you LEAD me to believe that you accepted the relationship on the grounds we established! You said youselff that not having the physical aspect makes it simpler your words!! Then you change your mind! It has to be the way you want it! What you have done is made me feel very stupid!! You never did just want my affection this was about you getting me into bed which seems all rather sorid!*"

61. We find that Mrs Marks was trying to set some parameters to their relationship. She wanted to have a close and affectionate friendship with him but was not prepared to jeopardise her marriage by having sex with him. She was trying to keep Mr Baines happy. She knew that he could make her working life difficult but she wanted to cool the relationship, which had gone further than she intended.

62. There was then a short gap until 26 January when she sent a text to him about their meeting the following Monday. We are satisfied that the amount of contact between them clearly reduced substantially and it can be seen that between 14 January and 5 March there were only 12 texts sent by the Claimant to Mr Baines. Things seemed to be back under her control. The texts are numbered 251-264 and they are not just responsive. It can be seen that at times she was the person who initiated the contact.

63. On 12 and 13 March, the Board attended Callow Hall. A dinner was held in the evening and at the dinner; Mrs Marks sat between Mr Baines and Professor Trenchard. Professor Trenchard bought some Prosecco for the Claimant and she drank it. Mr Baines became jealous and left immediately after the meal. We are satisfied that he became jealous; that Mrs Marks was paying Professor Trenchard too much attention.

64. They spent the following day at Callow Hall continuing with the conference and Mr Baines was rude towards Mrs Marks.

65. On returning home, Mrs Marks turned off her telephone and when she switched the 'phone back on which was on 14 March, she awoke to what she described as:-

> "*A barrage of nasty texts from Alan berating me for my behaviour.*"

66. It is accepted by Mr Baines that he, in one of these texts, called her "*a whore*" and commented that "*I know why Maura hates you because I hate you as well*".

67. The texts included an allegation that Mrs Marks had "*Slept with Steve*". He said that he would be confronting Professor Trenchard about this and that she should tell her husband what had happened before he found out. This was a clear threat to cause trouble for her with her husband.

68. The texts made her feel unwell and she did not go into work because she was so upset.

69. Mr Baines visited her at home on the following day, 15 March, at his suggestion. She had said in one of her texts (242) that she had not got the

same confidence or self-belief as Mr Baines and when he came round he told her that she needed a life plan and that he would help her with one to one coaching sessions. After receiving the texts she had become afraid of what would happen if she cooled the relationship. The situation was becoming increasingly difficult, not helped by the fact that she had not told anyone (including her husband) about her relationship with Mr Baines. She was clearly afraid that Mr Baines might tell her husband.

70. Matters between them again cooled for a short while, although she still sent him affectionate texts. She refers to him as her "*guardian angel*" in her text of 29 March (text 226).

71. We are satisfied with the Claimant's evidence that around 24 April, he accused her again of having a sexual affair with Professor Trenchard because she had attended a one to one work meeting with him. He was rude to her at a Remuneration Committee meeting and also at a Board meeting and intended to humiliate her. She again said in her text that she did not want to have a sexual relationship with him. She was clear on that point. An example is at 209:-

> "*I think more of us than sex I don't think of us in a sexual way because our relationship isn't built on sex. I thoight it was more loving! I don't view relationships in that way I never have. That's something about me again! If I failed then I am sorry you said we had something special.*"

72. At the beginning of May, Mrs Marks was to attend the HPMA awards ceremony where she was to receive an award for HR Director of the Year. Mr Baines wanted to come along and said that he would take her to La Gavroche, which is an expensive Michelin starred restaurant. In view of what had happened, Mrs Marks was concerned that he saw this overnight stay as a further opportunity to put pressure on her to have a sexual relationship with him. She tried to dissuade him from attending. She managed eventually to extract herself from the situation by inviting her husband, Peter, to attend the awards ceremony with her.

73. At the end of May, Mr Baines again became jealous about Professor Trenchard and her text number 115 dated 28 May relates to the difficulties that she was having;

> "*Here we go again you promised that you wouldn't do this to me last month but here we are. I cannot cope with this. You knew so why are you kicking off now. This is the last time you make me feel like I have done something wrong I said I would get to you as soon as I could!*

74. There is a further text later that day which is clearly in response to the specific allegation concerning her relationship with Professor Trenchard. She says in text 109:-

> "*I had a 1:1 like every other director round here! What you have shown by thinking I am carrying on with steve is what you really think of me. This is the last txt you will get from me. I will expect your being rude to me tomorrow just like month and the month before seems to be a pattern.*"

75. His response to this situation was to purchase an expensive watch for her and the Claimant refers to this in her text of 31 May (text 93). She says:-

> *"Sweetie what a gorgeous, very beautiful present but its so extravagant and expensive. Without warning to sound ungrateful or dismissive you shouldn't have bought it. It has been a tough week and we do need to talk on Monday when we meet x."*

76. She was still trying to placate Mr Baines and tells her again in her text at 91 that she wanted to be friends and "*... that's all I can offer*".

77. It can be seen from the texts that Mr Baines was not prepared to accept this position and we are satisfied that he continued to send affectionate text messages to her. We also accept Mrs Marks's evidence that he left long love letters on her desk at work.

78. On the evening of 24 June, Mr Baines sent her a series of messages, again pushing her to have an intimate relationship with him. In her response on 25 June (text 26) she said:-

> *"... Yesterday gave me a wake up call that I can't live in two worlds and that my marriage could so easily be damaged and I am not prepared for that to happen. So I think its for the best to bring things to an end. I will always be your best friend and confidant and I will always be here for you. I am so sorry and you need to know that you are a wonderful man and my very best friend."*

79. Even prior to this, he had been accusing her of being silent and that he was requiring her to be in touch far more than she was. We are satisfied that even before 25 June when she clearly brought the relationship to an end, he realised that the relationship was not going in the direction that he wished it to, and that Mrs Marks would not have a sexual relationship with him.

80. Mr Baines had regular contact with Harinder Dhaliwal. She worked in Mrs Marks's team as the Assistant Director of Engagement and Inclusion. She was transferred to Mrs Marks's line management in April 2013 following a restructure and had previously been managed by Mrs Marks.

81. On 13 June, Mrs Marks had a meeting with her. A note is at page 425. A corporate decision had been made to review services within the Trust, including the service lines that Mrs Dhaliwal managed. Mrs Marks gave her notice that the review was going to happen.

82. Immediately after the meeting, Mrs Dhaliwal spoke to Shirley Houston, the Engagement Officer. A note of the discussion is at page 664. Mrs Dhaliwal announced to the office that their jobs were under review and that she thought the Chaplaincy Service would be discontinued. She told Miss Houston that she was sure that Mrs Marks wanted to get rid of her and that she would "*play the race card and sue the Trust*" She also said that Mrs Marks was having an affair with Mr Baines. That she would make it impossible for Mrs Marks to get rid of her.

83. Ms Houston discussed this with Mrs Marks's PA, Chris Gration, who advised her to raise her concerns with Karen Herriman, Mrs Marks's deputy, which she did.

84. On 20 June, Mrs Dhaliwal spoke to Mr Baines and complained to him about Mrs Marks. Mr Baines was clearly delighted to receive those complaints

and on the following day he met with Sarah Carter for lunch. Sarah Carter had taken voluntary redundancy in March 2013. We did not hear evidence from Sarah Carter but it is a strange coincidence that he met with her the day after speaking to Harinder Dhaliwal. It is clear from her own statement at pages 483a-c that she had been approached by Mr Baines who had asked her to provide:-

> ".. *my comments regarding my brief experience of working with Helen Marks.*"

85. Later that same day, Mr Baines also spoke to Maura Teager over the telephone, who he knew did not like Mrs Marks. This conversation again was designed to see if he could obtain allegations against Mrs Marks.

86. Mr Baines clearly thought he had been successful in doing so and wrote to Professor Trenchard on 21 June at page 429. It is headed "*This is dynamite and totally confidential*". In the memo he asked how well Professor Trenchard knew his executives. Whilst he did not name Mrs Marks, he said that this had "*...shocked me beyond measure*" about a "*member of your team*". It made little sense and Professor Trenchard was confused by it as in his reply the following day he suggested that they should talk about what had been disclosed.

87. On 23 June, Mr Baines wrote again. The note is at page 430. Again, it made little sense. He said that he had spoken to three people. Those three people we now know were Harinder Dhaliwal, Sarah Carter and Maura Teager. He did not name Mrs Marks but referred to people describing "... *our director as having evil tendencies and I am told is not liked within his/her team here* ". Apart from expressing his shock and being "... *genuinely disturbed*" he did not set out any specific allegations at all.

88. Professor Trenchard tried to make sense of what he was being told and wrote again at page 431. He said that Harinder Dhaliwal may be in touch because Professor Trenchard had asked for Corporate Services to have their lines reviewed following an external exercise and Professor Trenchard was aware of the statements that Harinder Dhaliwal had made after her meeting with Mrs Marks. Mr Baines's reponse was that Harinder Dhaliwal was not his issue but that her manager had spoken to him.

89. Mr Baines was in emotional turmoil about his relationship with Mrs Marks and his irrational behaviour was in response to the cooling off of the relationship by Mrs Marks.

90. Whilst he was gathering this information, he was continuing to text message Mrs Marks and on 28 June at 16.28 he finally received what he thought was a hopeful text. It is number 15 and says:-

> "*Sweetie we will talk about it when you get back off holiday! You are right external factors have impacted so we need to be sensible and I don't want to attract attention and nor do you. We will find a way now go and have a relaxing holiday x*"

91. Five minutes after receiving that text at 16.33, he wrote to Professor Trenchard saying :-

> "*Subject HM*

Steve I am now "parking" this issue and hopefully it will die away. I would like to regain my trust but if you hear anything relevant I know you will keep me posted.
I hope you don't.

Alan".

With that, Mr Baines went on holiday. He was on holiday between 1 and 15 July and whilst he was away he continued to text Helen Marks. He only had one response which was on 9 July and is text 9.

92. Whilst he was away and was not receiving a response to his texts, he reconsidered his decision about "*parking*" the issue regarding Helen Marks. He got in touch with Harinder Dhaliwal on 11 July about her not attending an awards evening and also on that date he texted Karen Herriman, as she described "*out of the blue*". The message is at page 449. At first, she did not realise that the text was from Mr Baines. She had not given any indication to anyone prior to this that she wanted to meet with him but having received a text from her Chair asking her to meet him on the Monday, she agreed to do so. They met on Monday 15 July at the Mickleover Hotel in Derby. The basis of the meeting was set out in his text on 11 July at 3.39 pm, i.e. "*Chatham House*" rules (also page 449). This meant that Miss Herriman would be able to give information confidentially. Whilst Mr Baines would be able to use the information her identity would remain confidential. She would be "*fully protected*".

93. At their meeting on 15 July, no notes were taken, other than those that are referred to in the message from Mr Baines to Professor Trenchard on 16 July at pages 450-1. Immediately after the meeting, he sent a text to Miss Herriman saying:-

"Thanks Karen, promise to solve it for you. Alan".

94. Mr Baines wrote with his notes of the meeting to Professor Trenchard on 16 July (page 450-1). As with his previous messages, they are very general with no specific allegations made. They include sweeping statements such as "has surrounded herself with private "toys" as trophies". They are incoherent. Whilst it does not mention Mrs Marks by name, it is clear that it is about her. The subject is "HR Colleague".

95. On 19 July, Mr Bains and Professor Trenchard met. By this time, Mr Baines had talked to Harinder Dhaliwal, Sarah Carter, Karen Herriman and Maura Teager. None of these people had ever raised any informal or formal concerns about Helen Marks. We are satisfied that all four came forward at the instigation of Mr Baines. They did not come forward of their own volition. Karen Herriman does not say that she has been bullied herself and neither did Maura Teager.

96. Professor Trenchard accepted what Mr Baines told him without question. We are satisfied that he should have been concerned about the behaviour of his Chair. He says that he challenged Mr Baines on how and why they had spoken to him. He does not say how Mr Baines satisfied him that they had come forward to make these complaints when there had been no previous concerns expressed to him by anyone about the behaviour of Mrs Marks and he had no concerns of his own. Without taking any advice he embarked on his own investigation of the allegations. These matters were disciplinary issues and he failed to follow the

Respondents own procedure set out at page 239. In particular

- He did not produce terms of reference
- There should have been two independent investigating officers appointed.

97. Instead he decided to speak to each of them himself. He first spoke to Karen Herriman on 23 July. His notes are at pages 468-70. Karen Herriman was unaccompanied and there was no official note taker at the meeting. Mr Baines was in attendance. She told Professor Trenchard that she had been aware that Harinder Dhaliwal had spoken to Mr Baines and she said that she felt that she ought to as well. What was not said was that Alan Baines had directly approached Karen Herriman after speaking to Harinder Dhaliwal. It was at his behest that she had come forward. Professor Trenchard did not challenge what she was saying and why she had not raised any of these issues before despite being a very experienced HR professional. The comments that she made that are noted are very general and there are no specific allegations of bullying made, simply general comments about the team and Helen Marks's style of working. At the end of the meeting, she was asked to put her thoughts in writing.

98. On 30 July, she did so (pages 500-3). In that note, she acknowledges that she had worked with Helen Marks since 2004 and says:-

> *"I have taken the decision to raise concerns now, in response to other concerns raised by colleagues and as I feel that I can no longer tolerate or ignore behaviour which is not in line with the Trust values and which challenges my professional and ethical principles."*

99. She accused Helen Marks of having a negative influence on the appointment process of the new CEO. That she had wanted "rid of" Ms Carter and behaved inappropriately in the exit of Dr Gillespie. This last matter had occurred almost two years previously and she had not previously expressed any concerns at all. Most of what she said is general comments about the behaviour of Helen Marks describing it as inappropriate and oppressive. She acknowledged that she had never raised her concerns with Helen Marks directly or indeed anyone else. No mention is made that she had been approached by Mr Baines and requested by him to raise these concerns.

100. Professor Trenchard spoke to Sarah Carter on the telephone in what he described as a brief conversation. This was on 24 July. In fact, from his telephone records we can see that it lasted 24 minutes. He asked Sarah Carter if she would be prepared to put her concerns in writing to him, which she did on 30 July (pages 499a and pages 483a-483c). It can be seen from the note at page 483a that she had been asked to provide comments regarding her brief experience of working with Helen Marks. It is clearly not something that she raised of her own volition. Generally allegations were made about Helen Marks's behaviour towards her and others. No dates were given or specific allegations made. She talked about the behaviour amounting to "*bullying*" but is not asked to explain why she had never raised any concern, either with Helen Marks or with anyone else during the time that she was employed by the organisation.

101. On 25 July, Professor Trenchard spoke to Maura Teager. She confirmed that she had also spoken to Mr Baines. She was not asked whether Mr Baines had asked her to come forward. She described the issue of Helen Marks as: "*Not much of a big deal from her perspective.*" She was asked to put her thoughts in writing, which she did on 29 July (pages 495-6).

102. The note refers to two parts of what she had to say. The first concerned issues raised by Harinder Dhaliwal with her in confidence on 13 and 14 June. This related to Harinder Dhaliwal's one to one meeting with Helen Marks. The second part related to comments made by Mr Baines to her in mid June when he said he had been advised by Helen Marks to "get rid of her" which was another untrue allegation made by Mr Baines. She had only heard this from Mr Baines. She also mentioned Helen Marks's attendance at an event called *"Mad Pride"* on 10 July. They do not constitute any allegations of bullying and harassment that she had seen herself.

103. Professor Trenchard then spoke to Harinder Dhaliwal on 25 July and her notes are at page 484-8. Her statement complains of:-

> *"... discriminative and bullying experiences I have been subjected to by my line manager Helen Marks."*

104 She complained about various incidents dating back to April 2013. Despite her position as Assistant Director of Engagement and therefore a senior figure in the Respondent's Human Resources Department, she does not explain in her statement why she had not at any stage used the informal or formal procedures before in accordance with the policies of the organisation.

105. Professor Trenchard also spoke to Jayne Davies on 25 July. She was a communications officer who had returned from maternity leave in April 2013. Her statement is at pages 560-5. This was as a result of information he had received from Karen Herriman about Helen Marks's alleged behaviour towards her. Much of what she said amounted to a complaint about Helen Marks at a meeting with her on her return from maternity leave on 8 April 2013. Again, she had not made any complaint about this meeting before or after it until she was asked to do so by Professor Trenchard.

106. Having had his discussions with the five individuals and before he had received anything in writing from any of them, he decided that they were all credible and believable. He had not spoken to Helen Marks at all when he made this decision. He accepted that Maura Teager had not made any complaint herself and Karen Herriman and Jayne Davies were only really concerned about others. This left Sarah Carter, who had left the organisation three months before, and Harinder Dhaliwal, who Professor Trenchard already knew had allegedly said that she would raise the "*race card*" to protect her position.

107. On 28 July, he made a note of his own thought process, which is at pages 488-91. It is clear that he made his decision at that time. He had taken legal advice and spoken to other chief executive officers, namely Peter Cubbon and Steve Shrub and notes of his discussions with them are at pages 481 and 483. He also took advice from another HR Director at a different NHS Trust. At no stage did he consider the Respondents own procedures or the manner in which this had all come to light. He knew that Helen Marks would be returning from holiday on Monday 29 July and he decided to delay the suspension until Wednesday morning, 31 July. This would enable him to have Helen Marks with him at a difficult meeting with the unions that morning over a grievance that they had raised. It can be seen from the note that the reason for the suspension was apparently because:-

> *"Can't have values being undermined by Director - especially HR who is*

driving them supposedly."

108. In his evidence he said to us that he had drawn no conclusions about the allegations but it is clear to us that without speaking to Helen Marks, he had decided that she was guilty.

109. There was then an email exchange between himself and Mr Baines. We were told by Professor Trenchard that Mr Baines was not involved in the decision to suspend. We do not believe him. The email exchange shows this. This was on 29 July and is at page 497. Mr Baines wrote to Professor Trenchard saying:-

> *"That's why I love being a Chairman - best job I've ever had.*
> *You and I need to see the 4 (now) opportunities to really restructure the Board which I have wanted to do since authorisation. It is a complacent team that needs revitalising.*
> *Do not panic as we could take the Board now to a new level of expertise.*
> *Interesting that HM was told of PL's application before we were. The sooner we break up this comfy clique the happier I will be.*
> *The next 6 months will define the Board for the next 3 years so don't lose your nerve. However, many leave or we dispense with this week we shall deal with it. Together.*
> *Rather work through new challenge than have a wrong one like HM. She feels totally wrong to me now.*
> *Alan."*

110. Professor Trenchard's response was as follows:-

> *"Agreed and looking forward to it."*

111. Professor Trenchard was of course not aware at that time about the relationship between Mr Baines and Mrs Marks. He was not aware that Mr Baines had sought to have a sexual relationship with Mrs Marks and that as a result of her cooling the relationship and not wanting to have a sexual relationship with him, he had brought forward these allegations. It is clear though that he was a willing participant in the decision that Mr Baines had made that they should dispense with her services and that the suspension was simply the first stage in dealing with her. To make it clear, we find that they had by then already agreed that her services should be dispensed with, i.e. she should be sacked.

112. On 31 July, at around 12 noon after the meeting with the trade unions, Professor Trenchard met with Helen Marks. She had been on holiday during the period 22 - 26 July. Mrs Marks was simply asked by Professor Trenchard if he could "*have 5 minutes*". She had no idea what they were going to discuss. Professor Trenchard had a piece of paper which he read from, saying: "*I am going to have to suspend you for bullying*". He was speaking to her on his own and she had no representative with her and had no idea that he was going to suspend her. All these matters are in breach of the Respondent's suspension policy. We are satisfied that she was not at any stage told that she had a right to be accompanied. No notes were taken of the meeting and as between the conflicting version of what was said, we prefer the version of Mrs Marks.

113. In particular, we are satisfied that:

- he provided no details about the allegations, even though by then he had statements from those accusing her;

- Mrs Marks said that she believed that he had already found her guilty and he did not deny this;
- she asked if he was looking for her resignation and he replied: "*Not at this stage*";
- she asked whether Mr Baines knew about the suspension and he replied: "*The Chair was very disappointed with you*";
- when she commented that this made a mockery of her HR Director of the Year award, he replied: "*It's not good timing for anyone*". He told her that he would be sending an email to all staff informing them of the suspension and the reason for it and she replied that: "*I couldn't come back from that*". He then said: "*Honesty is the best policy*";
- she asked whether this was anything to do with Harinder and the matters that Shirley Houston had reported but he did not reply;
- she asked whether Karen knew and he said: "*No*". He refused her permission to tell Karen about the position.

114. After the meeting, she was escorted to her office to obtain her laptop, iPad and mobile 'phone and he escorted her out of the building. She was not allowed to speak to anyone, including her PA. She never returned. Mrs Marks had clearly been, as she describes, "*ambushed*" by the way the meeting had been conducted and there had been a failure to follow any of the procedures of the Respondent. This is entirely consistent with our view that the decision had already been made to dispense with her services at the behest of Mr Baines with Professor Trenchard supporting him to this end.

115. At 4 pm on the same day, Professor Trenchard met with the HR team and told them that Mrs Marks was not going to be around and that concerns had been raised about her which were going to be investigated. He asked everyone not to contact Mrs Marks during the period. He said that he took this approach to protect Mrs Marks.Helen. We do not accept this. He did it to isolate her as he had decided already that she would not return to the Trust.

116. On 1 August, Mrs Marks wrote to Professor Trenchard (page 517). In it, she asked for information including details of the allegations. He did have full details of the allegations now and could have provided these to her. She asked also for a copy of the Trust policy that was being relied upon to enact the suspension and commissioned the investigation. She also asked for copies of her contract of employment and any communication issued regarding her suspension.

117. Professor Trenchard forwarded this communication on to Mr Baines, whose response was: "*Over to the lawyers?*" Professor Trenchard's response was to say: "*Indeed - just sharing with you her response*".

118. In the meantime, Mr Baines, on 31 July, contacted Harinder Dhaliwal (pages 518-9) saying:-

> "*If you are in come and spend some time with me. I am free all day. Would really look forward to that. Buy you lunch if you have time?*
> *Best wishes*
> *A*"

119. Harinder Dhaliwal responded later saying:-

"*... that would be lovely and I would appreciate your company too. ...*"

120. After the arrangements were made, Harinder Dhaliwal wrote to Mr Baines saying: "*A, looking forward to it! Regards H*" and Mr Baines replied: "*Good --- you should be!!!*"

121. It is likely that they were rewarding themselves with some lunch to celebrate the downfall of Mrs Marks. Her imminent departure from the Trust seemed assured.

122. Amazingly, despite what Mr Baines was saying to Professor Trenchard about the need to dispense with the services of Helen Marks, he was keeping close contact with her also.

123. Professor Trenchard wrote to Mrs Marks two letters on 1 August. The first at page 524-6 was a response to the email that we have referred to earlier. The second was a confirmation of their meeting (page 527-8).

124. He confirmed that he had suspended Mrs Marks from work pending an investigation into allegations made under the Trust's Dignity at Work Policy of bullying and harassment. There is no explanation as to why he had not followed the Respondent's procedures regarding suspension. Similarly, no information was provided regarding the allegations, even though he had it. He told her that an independent investigation would be undertaken. He sent her a copy of the Respondents disciplinary policy and the "suspension from work" leaflet but gave no explanation as to why he had not followed either.

125. On 2 August, Mrs Marks acknowledged his letters and pointed out that the Trust's Dignity at Work Policy had not been enclosed, which was the policy that he was allegedly relying on. She also pointed out that he had chosen to wait until 31 July to enact the suspension when under the policy any suspension should be implemented as soon as possible. She said that he had not offered her a representative (page 529-30).

126. On 1 August, Mr Baines had contacted Mrs Marks asking her how she was (page 521a). Her response was understandable:

"*Sweetie how do you think I am! I can't think straight I feel sick*".

127. He replied to that:

"*And don't go "Callow Hall" and sit in your bedroom looking out of the window. I will not let you have a breakdown.*
Axx."

128. On 5 August, Mr Baines attended a meeting between Professor Trenchard and Louise Ludgrove, an HR consultant who was to carry out the investigation. We are told by both Professor Trenchard and Mr Baines that whilst Mr Baines was there he took no part in the meeting. We do not believe this and this is supported by Louise Ludgrove's email of the same day to Professor Trenchard at page 532. It says:-

"...
It was good to meet with you and Alan today and agree next steps ..."

129. Clearly, Mr Baines was very much involved in setting up this investigation.

130. On the very same day, Mr Baines sent a message to Mrs Marks (page 532a). The message, in view of Mr Baines's behaviour, really beggars belief. He says:-

> *"Helen my duty to you is to do the very best job I can to help you to dispel these aspersions and get you back to the trust. I will work tirelessly to do that. For the last 2 months I have been in an emotional wilderness after you ended the dearest relationship in my life. I felt as you do now. Yes as bad as that. Total sadness and bewilderment. I had my most personal relationship shattered. Now I have been ecstatic at what you have told me about you refinding your feelings for me. Helen please treat me well. I am your devoted lover and friend so please never let me go again. If you do that you will destroy me emotionally. I have never had a relationship like this so please keep me close to you Helen. Love you. Xxxx."*

131. On 6 August, Professor Trenchard responded to Helen Marks's letter of 2 August at pages 537-8. He said that a suspension meeting had been held at the earliest possible opportunity. It had not. He went on to say that he needed to confirm the allegations with the complainants before it was possible and fair to bring the allegations to her attention. That was not true. He had not suspended her at the earliest opportunity and he had decided to suspend her before he received their written statements. He did not bring to Helen Marks's attention the allegations that she faced. He only delayed the suspension because it was convenient for him to have Helen Marks's involvement in the grievance meeting with the trade union.

132. On 7 August, Mr Baines arranged to visit Helen Marks at her home. This was without the knowledge of Professor Trenchard. Not surprisingly, she was feeling vulnerable at the time. He said that he intended to stay for the rest of the day. He told her that he had missed her and that he would stay close to her because they could not be without each other. He suggested that they should go upstairs and lay down.

133. He discussed with her the allegations saying that he had been contacted by Karen whilst he was away on holiday. This was of course untrue. He also led her to believe that Steve Trenchard had taken the decision to suspend Helen Marks and that it was he who had orchestrated the action against her. That was not true. His intention was to manoeuvre Mrs Marks into leaving the Trust under an agreement with no one discovering his relationship with Helen Marks or his behaviour. He emailed her later that day saying:-

> *"What I want you to do ASAP follows:-*
>
> *1capture as many of the points you raised today against each allegation. There were very many points all good and I want them noted for the letter.*
>
> *...*
>
> *4. Call your HR friend ... and tell him that if you wait to see this through it could take 3 - 4 months and there is no way back in. As you want to get your job back you intend writing to refute each allegation next week in advance of being interviewed by the investigating official but does he think that by doing so you are*

prejudicing any of your HR rights. I need you to act fast before news spreads of your suspension and before any of your team are leant on. JUst check that the strategy is sound cos I think the sooner you get a "without prejudice" letter in front of ST the better.

And I know just how demoralising this is for you but I have faith in you and will not see you isolated. So keep those spirits up, get annoyed at being fitted up and come out fighting. There are plenty of people who want to see you back and your Chairman is at the front of a very long queue.

Best wishes Helen.
Alan"

134. On the same day, Mrs Marks received a letter dated 31 July detailing a change to staff contracts (page 510-512). It was signed by Gary Southall pp Helen Marks. She had not authorised this letter. Indeed, she knew that as they were in discussions with the trade unions about other matters, they had agreed to put this on hold. The letter was retracted on 15 August (page 602). The complaints against her included a breach of Trust values, which would have been a breach of contract if this amendment was made. This is referred to also in the complaint by Harinder Dhaliwal, which must have been sent before these letters were sent out.

135. On 9 August, Professor Trenchard wrote to Helen Marks again saying:-

- he had met with Mr Baines on 19 July to discuss the allegations that had been raised with him;
- that on 23 July, he and Mr Baines had met with a senior member of staff to discuss the allegations;
- during the same week, he had met with several other members of staff to discuss similar allegations.

136. He had made no reference at all to the fact that the initial allegations had been made by Mr Baines on 21 June. With his email (page 580-1), he sent the terms of reference for the investigation. There was still no details of the allegations made, simply that she had bullied and harassment Trust employees. He was not providing her with as much information as possible. In fact he was providing her with as little information as possible.

137. On 11 August, Mr Baines telephoned Mrs Marks at her request. By then she had taken legal advice and she told him that she intended to write a letter raising her concerns about the way the process had been handled. He advised her to put the name of her barrister at the foot of the letter to give it more weight and she agreed to send him the letter on 11 August (page 584-92). That letter raised concerns about breaches of the Trust's policies and procedures and confirmed her belief that the allegations made against her were malicious and vexatious.

138. On receipt of her email, Mr Baines came to see her at his insistence. He took Mrs Marks out for lunch. She explained to him that she did not feel that an independent investigation could be undertaken with Professor Trenchard involved. She asked Mr Baines not to show the letter to Professor Trenchard but he said that he had to and once he did so it would be impossible for her to return

to work. He said that her options were to retract the letter or surrender any hope of returning to the organisation. She said: "*So be it then*" and he suggested that they explore a settlement for her to exit the organisation and advised her to get a solicitor.

139. During their discussion, Mr Baines said that he had had a conversation with Mick Martin about Professor Trenchard and that he did not think he was up to the job. He also described Karen Herriman and Professor Trenchard as "*bastards for doing this to you and I will never forgive them*". He gave no indication of his own involvement in the plan to dispense with her services. All was going to plan at this stage.

140. On 12 August, Mr Baines emailed Professor Trenchard (page 593). He copied the email to Helen Marks. It said:-

> "*Steve,*
>
> ...
>
> *those allegations had a vindictive and vexatious motive.*
>
> ...
>
> *Steve my antennae are sending me strong signals about this case. I feel now that it needs burying and bringing to a close swiftly or I can see messy escalation ensuing.*
>
> ..."

141. He was absolutely correct. What he did not say was that it was himself who had the vindictive and vexatious motive. Having lunched with Mrs Marks and moved her towards exiting the Respondent's employment by agreement, Mr Baines then wrote to her on 13 August. It acknowledged her letter and said they would need time to consider the comments. At the same time, Mr Baines wrote to Professor Trenchard about "*closure*" (page 596). That related to his hope that they would seen be able to agree Mrs Marks's departure without anyone discovering his own behaviour.

142. Later that day, he called Mrs Marks to inform her that the investigation had ceased and her suspension was to be lifted and that she could contact who she wanted but asked her to be discreet. He also told Mrs Marks's PA and Paul Lumsdon, who in turn told Ifti Majid about the lifting of the suspension. He acknowledges this and says that he went round to see her on that day. He arrived with a bouquet of flowers. He was supportive and pleased that the suspension had been lifted and the investigation terminated.

143. Mr Baines had also contacted Professor Trenchard after his meeting with Helen Marks. He did not tell him that he had met with Helen and said to him:-

> "...
> *My conclusion is that this can get very nasty unless we move now to plan B and get closure quickly.*
> *Alan*"

144. On 15 August, Helen Marks sent an email to Mr Baines (page 606-7). It

said that she was thanking him for advising her that the investigation had been terminated; that the structure of her exit as advised would be handled by their legal representatives; that she wanted to deal with Ifti Majid.

145. Mr Baines did not dispute that the investigation had been terminated in his response. His reply at page 606 says:-

> *"Thanks for this Helen and I understand.*
> *I shall be seeing Ifti tomorrow and we can take things from there.*
> *Hopefully the lawyers can become engaged next week.*
> *Best wishes*
> *Alan"*

146. Professor Trenchard was aware that Helen Marks did not want any further involvement with him and agreed that he would not have further contact with her. In an email to Mr Baines on 15 August he said (page 608) that:-

> *" ... Whilst I am her line manager, I am happy, on her request and to cause her no further distress, for Ifti to liaise re: the practical aspects of her no longer being an employee. Obviously this will be after any negotiations and final approval of settlement.*
>
> *Clearly, I would like to remain fully involved with the decision making process around final communications etc. so that I am happy that this is palatable for the organisation.*
>
> *..."*

147. At this stage, all was going well for Mr Baines in that Mrs Marks was leaving the employment of the Respondent quietly and no one would be aware of his involvement in dispensing with her services. Professor Trenchard, although he knew nothing of Mr Baines motive was assisting him. Mrs Marks instructed solicitors as per her agreement with Mr Baines and on 28 August they wrote (pages 665-70). Mrs Marks had not told them about her relationship with Mr Baines. The letter complains about Professor Trenchard. It did not refer to Mr Baines. At this stage they were not aware of Mr Baines behaviour towards Mrs Marks or, of course, his involvement in the discussions taking place between himself and Professor Trenchard and Mrs Marks. The letter made "without prejudice" proposals for resolution of the matter.

148. Despite the involvement of the solicitors by now, Mr Baines continued to contact Mrs Marks and on 2 September he sent an email to her (page 676) sending her a copy of the draft letter which would be sent to her mid week. He pointed out that the letter was couched in formal tones and sought to reserve the Trust's position in case the attempt to reach a financial settlement failed. The letter itself is at pages 674-5. Mr Baines in his letter said that the investigation had not been terminated simply put on hold at her request. This statement was simply untrue. He warned her that if an early resolution could not be reached between the parties, the investigation would need to continue. He reiterated to her that she would be on a period of suspension, which was not what he had said earlier about the lifting of the suspension.

149. At the same time, he was demanding to see Mrs Marks, ranting at her about not responding to his texts. This had taken place whilst he was in a car park waiting to see the solicitors.

150. The Trust's solicitors also wrote to Mrs Marks's solicitors saying that the suspension and investigation had not been ended (page 677-8). The letter stated that the investigation had been put on hold at her request which was untrue. It suggested that the Trust had "not taken a view on these allegations" when Professor Trenchard and Mr Baines had.

151. On 4 September, Mr Baines wrote to Christine Gration (Mrs Marks's PA) saying (page 682):-

> "...
> *Sadly I have had to write to Helen today advising her that her suspension had been activated again."* ..."

To be activated again, it clearly had to be lifted.

152. On 4 September, Mr Baines continued to text Helen Marks. He berated her for her failure to respond and he accused her of lying to the solicitors. She responded accusing him of not telling the truth to the solicitors and said that he was "*as bad as Steve*". She told him not to text her again. He replied denying he had lied and wanting to come to her house again. She told him she did not want him in her house again.

153. Mr Baines wrote to her at 12.35 by email attaching a letter that day to say that early resolution had not been possible (page 684-5). That the Trust was going to continue with its investigation and that she would "remain on suspension". He did so without sending a copy to Professor Trenchard and without consultation with anyone. He had not posted the letter at the time. It is in response to the exchange with Mrs Marks by text message referred to above. It was meant to bully Mrs Marks into being more compliant and agree the terms being offered her.

154. On 6 September, Mrs Marks's solicitors wrote to the Respondent's solicitors at pages 688-9 requesting a reply to the issues raised in their letter of 28 August. They pointed out that by his behaviour Mr Baines was bullying and harassing their client. It goes on to assert;
"that the malicious and vexatious allegations on which our client was suspended were engineered to instigate disciplinary action against our client and remove our client from the Trust."
How true. At 3 pm, Mr Baines texted Helen Marks asking if she had calmed down and saying he had no option but to send the letter.

155. That evening as Mrs Marks describes at paragraph 159 of her witness statement she received a further text from Mr Baines. It said:-

> "...*'You are clearly incensed with me but you never thought to come and ask me why certain things had to happen. You just jumped to a conclusion, the wrong one. What a lot of damage you have done and why? Because you don't think and that isn't intelligent. Please call me Monday morning and listen to me you stupid woman. If you don't call then we won't talk ever and that's not truly what you want. I am not and never have been your problem and you know damn well that to be true. Go on admit it'. A few minutes later a second text came 'Come on'."*

156. Mrs Marks did not reply to either of these texts or a text sent the following day asking her to meet at Chatsworth Farm Shop on the Monday afternoon so

that he could explain everything and that there had been a gross misunderstanding.

157. On 11 September, Mrs Marks's solicitors wrote to the Trust solicitors to ask them to advise Mr Baines to stop making contact with her and confirm when they had done so. They set out the contents of the text message Mrs Marks had received referred to above. They replied that he was on holiday. Mr Baines does not deny the contents of the text. He said in his statement;
"that she appeared to be blaming me for the position that she was in, when it was nothing of my doing".
The text message was the last contact that he had with her.

158. Only on 13 September did DAC Beachcroft finally give a substantive reply to the letter sent to them on 12 August (pages 698-704). It is lengthy. In it they deny any breach of process. There had been many breaches of process.

159. On 13 September, Mrs Marks wrote to Adam Cayley, Regional Director of Monitor, who is the regulator for the NHS Foundation Trust. The letter is at pages 707-9 and raised concerns about governance and probity within the Trust. It alleged that Mr Baines and Professor Trenchard had colluded in the *"vexatious and malicious"* allegations made against her. That she had suffered victimisation, sexual harassment and sex discrimination.

160. On 17 September, Mrs Marks wrote a grievance letter to Lew Hall, who was Lead Governor, which was copied to Mick Martin, Senior Independent Director, and Ifti Majid, Deputy Chief Executive. The letter is at pages 711-2 and complained about her treatment by the Trust and in particular Professor Trenchard and Mr Baines. It stated that she had been sexually harassed by Mr Baines. It was headed: "*STRICTLY PRIVATE AND CONFIDENTIAL - ADDRESSES ONLY*". This was not respected. Mr Baines emailed Mr Martin, Professor Trenchard and Mr Gillham later that same day to say that Lew Hall had contacted him and read out the full statement that Mrs Marks had made. He said that he intended to defend himself (page 713).

161. On 18 September, Mrs Marks received a letter from Ifti Majid saying that he had reviewed the suspension, which would continue as would the investigation (pages 714-5). By this stage, Mrs Marks had been suspended for 7 weeks and had still not received any details of the allegations made against her.

162. On 19 September, Mr Baines had a meeting with Mick Martin. Mr Baines's description of him standing down as Chairman of the Trust in his witness statement gives very few details. He simply says:-

> "*Once it became known that I had a relationship with her that I had not been open about, and given the allegations she was now making against me and the Trust, I felt that my position was compromised and I had no option but to step down as Chairman on 19 September.*"

163. His version is supported by Professor Trenchard. The tribunal has not heard from Mr Martin. We have not seen any minutes of any discussions. We do have a little further information from Ifti Majid who was called into a meeting with Mr Martin after the resignation of Mr Baines. He describes how they were concerned that Alan Baines had been the person who had originally brought the allegations regarding Mrs Marks to Professor Trenchard's attention and that the charges could be trumped up, fabricated or exaggerated by Mr Baines. They

were worried that there may have been a personal motivation for Mr Baines in taking the allegations to Professor Trenchard who had also not known of the relationship. He describes "a very difficult situation". We are satisfied that, again Mr Baines has not told us the truth. He did not stand down for the reasons he gave us. His position had been compromised by his unacceptable behaviour.

164. In this new situation the Trust decided that they should lift the suspension and Ifti Majid wanted them to allow Helen to return back to work. Surprisingly though, they felt that there was no reason to question the allegations per se. They decided as a group to lift Mrs Marks's suspension but this seems to be on the basis that they were now aware of the personal relationship between Mr Baines and Mrs Marks. They discussed the grievance and decided to acknowledge it and they would make a decision on how to proceed with it at a later stage. The acknowledgment is in an email dated 19 September and is at page 716.

165. Ifti Majid then contacted Helen Marks. He told her that the disciplinary investigation into the allegations against her would terminate; that there was no case to answer due to procedural flaws. He did not describe what the procedural flaws were. A note of his conversation is at pages 717a - b. He told her that the investigation was "stopped permanently".

166. Later that evening, he went to see Mrs Marks and said that the reason why the suspension was lifted was that the process was flawed and it had been "*potentially driven by Alan*". He confirmed to her that there was no case to answer due to a flawed process. He told her that Mr Baines had resigned and Mrs Marks was unhappy about this, feeling that he had "*got off scot-free*". He would not have to face the consequences of his behaviour. There was no explanation by him as to why they felt the process was flawed. This was confirmed in a letter dated 20 September, page 718.

167. On that day, Mrs Marks wrote to Mr Martin with a further grievance (pages 719-21). She complained that the process of gathering allegations against her, her suspension and subsequent correspondence had been characterised by many breaches of process and procedure, inaccuracies and dishonesty. She outlined her major issues relating to;

167.1 the allegations made against her;
167.2 the process of her suspension;
167.3 the contract variation letter;
167.4 the involvement of Mr Baines.

168. She also pointed out that there was no apology for the distress that had been caused to her and she was concerned about communications to her team who had been informed of her suspension. She pointed out that although the investigation had ended it was because of a *"flawed process"* not because there was no foundation to the allegations made against her. Ifti Majid had told her that she should not go into Bramble House or to attend a staff awards evening next week. Although officially her suspension had been lifted, it was still in place. She wanted an independent external review of her grievance.

169. On 24 September, Ifti Majid confirmed the position (page 722-3). The letter said:-

> "... *For the time being, and to allow us time to agree a way forward, the Trust considers it appropriate that you remain absent from the Trust on special leave.*

..."

170. He said that they wished to do all that they could to facilitate her return to work and explore opportunities to reconcile working relationships. He said that they would be contacting her shortly to discuss a proposed way forward.

171. On 26 September, Professor Trenchard wrote to the staff (page 724) saying that Mr Baines "*had stepped down as Chairman of the Trust for personal reasons*". He described Mr Baines as a great ambassador to the Trust and gave thanks for the work that he had undertaken. He said that Mr Baines was approaching imminent retirement with a vastly reduced workload and level of responsibility. An announcement of Mr Baines's departure was made in the Respondent's newsletter. Mr Martin, the Acting Chairman, described how:-

> "*Alan had decided that retirement beckons. He departs with our love, thanks and very best wishes*".

172. On 27 September, Mr Martin wrote to Mrs Marks (pages 725-6) inviting her to a meeting to discuss her grievance. He acknowledged that they had not complied with their procedure in holding a meeting within 5 working days of her letter. The meeting took place on 2 October. In the meantime, her team was finally told on 1 October about the lifting of the suspension.

173. At the meeting on 2 October, Mrs Marks was accompanied by her husband, Peter, and Mr Martin was accompanied by Mr Gillham. The notes are at pages 727-32. They discussed her concerns about the way that the Trust had handled matters and Mrs Marks provided him with her file of correspondence. Mr Martin told her that he wanted to find a resolution of the matter. He agreed that a public apology should be made at the next Trust Board meeting and asked her to put together a form of words. She told him that there should be a full independent external investigation into the actions of Professor Trenchard and Mr Baines with a decision whether to pursue disciplinary allegations against them before her grievance was further considered. She described Mr Baines's personal involvement with her. How, if she was not nice to him and showed affection, he could "*make bad things happen*". He had made out that he had protected her; that she had tried to get out of the relationship and he had called her a whore and accused her of having an affair. She made it clear that Mr Baines acted out of spite and there is a note, presumably from Mr Martin, which describes this as "*abuse of power - totally unacceptable*".

174. She went on to describe how Mr Baines had initiated the allegations against her and that Professor Trenchard had not stopped what was happening. He had not thought as to why the Chair was asking him to behave in the way that he did. Mr Baines appeared to be running the process when Professor Trenchard should have told him to stay out of it. That he had not only carried out his own investigations but he had also met with the investigating officer. These were very clear and serious allegations that she was making against not only Mr Baines but also Professor Trenchard.

175. On 4 October, Mr Martin wrote to her (pages 733-4). He describes in the letter how he would undertake initial scoping of the documentary files to understand the nature of her grievance and to establish the appropriate action. He told her that he would keep her informed and update her on progress by 25 October and by then he should be able to agree terms of reference for any subsequent enquiries.

176. Mrs Marks had a pre booked holiday after the grievance meeting until 25 October. Mr Martin was aware of it. It is mentioned in the note of the meeting. Mrs Marks was hoping that she would be able to return to work on return from holiday and that Mr Martin would be able to resolve matters.

177. Although on the face of it Mrs Marks had been exonerated, no one had told the independent investigator. It can be seen that on 9 October, Louise Ludgrove was still in contact with Professor Trenchard about Sarah Carter. It says:-

> "*... Having forwarded Sarah's last email to you as part of submitting output from my investigation to you, unfortunately Sarah subsequently emailed me to ask me not to forward her email to the Trust.*
> ..."

178. On 24 October, Professor Trenchard wrote to Mrs Marks (Pages 771-2). The letter referred to the appointment of an independent mediator, Lee O'Bryan. Mr O'Bryan, who gave evidence to the tribunal, was in fact a former colleague of Mr Martin's at the Royal Mail. Mr Martin had been Operations Director at the same time as he had been HR Director. The instruction was for him to help "*with mediation to assist the return to work of a senior member of the Trust*". None of this had been discussed with Mrs Marks. In his letter, Professor Trenchard described three choices, which were;

178.1 Full immediate return to work, initially on a project basis working as directed by himself pending facilitating mediation;
178.2 A phased approached with initial project work from home agreed between them'
178.3 Exploration of secondment opportunities outside the Trust.

179. There was no reference to any investigation as discussed with Mr Martin and she was asked not to communicate with her colleagues in the Trust, other than himself "*until we have agreed a way forward*". She would remain on special leave. It was acknowledged by him that it had been anticipated that she would be returning to work on Monday 28 October, which had been agreed with Mr Martin.

180. On 29 October, Mrs Marks's solicitor, Mr Potter, wrote (pages 773-4). He referred to the discussions with Mr Martin and the letter from him of 4 October stating that an appropriate independent adviser would undertake an investigation. He also referred to the agreement that a public apology be issued at the next Board meeting, which was due to be heard on 30 October. Not surprisingly, Mrs Marks wished to return to her role and not do project work or secondments as directed in the letter. It was pointed out that Professor Trenchard was insisting on Mrs Marks's participating in mediation without any discussion, negotiation or agreement on this.

181. On 30 October, the Trust solicitors, DAC Beachcroft, wrote to Mr Potter (pages 775-7) now saying that an independent adviser, namely Lee O'Bryan had been appointed to carry out a "*desk top review*" which would involve an initial scoping of the documentary evidence in order to establish the way forward. It was described as a preliminary step in the grievance process being undertaken. This was done without discussion or agreement with the Claimant.

182. The position of the Trust was now very different from that described by Mr

Martin in his meeting with Mrs Marks on 2 October. There would be no apology at the Board meeting. The Trusts position re the allegations made against Mrs Marks was:

> "... *As the investigation ceased before any findings could be made, this restricts our client from exonerating your client against the allegations brought against her, particularly as the allegations have not been withdrawn by those who made them. Our client is, however, regretful at any upset and suffering that your client had experienced over the last few months, as Mick Martin has previously made clear when he met your client.*
>
> ..."

183. It goes on to say that any return to work must be "*by way of a mediated return*". In respect of a return to her previous role, it was said that the Trust had no issue with this "*in time*". It refers to relationships which needed to be repaired.

184. There was to be no public apology and she was to comply with mediation without any agreement with her. There was no mention of any investigation into her grievance.

185. The letter enclosed an unsigned and undated letter from Mr Martin on plain paper (page 777a) which proposed that her grievance was reviewed and investigated at stage 2 of the policy. Of course there had been no response to her grievance at all, other than her meeting with Mr Martin by that stage. The Trust policy allowed for extension of timescales to be agreed and he said that they had agreed an extension as a result of her holiday. Mrs Marks had never agreed any such extension.

186. Not surprisingly, Mrs Marks was very distressed about this communication and went to see her doctor on 1 November, who signed her off work with stress for a period of 2 weeks. Professor Trenchard wrote to her on 4 November. He reminded her about the Trust policy on managing sick absence. He invited her to attend a return to work meeting on 13 November. Mrs Marks was understandably confused as to what that meeting would be about as she had not been allowed to return to work despite her desire to do so.

187. On 6 November, Mrs Marks wrote to Mr Martin (pages 784-6) to highlight her concerns. She pointed out how Mr Martin had been keen to show support for her at his meetings with her and to apologise for what she had been put through. He had used language such as "*Helen centric*" relating an investigation process.

188. She expressed her disappointment that she had not been exonerated because the process had been terminated before it had been concluded. Therefore, serious allegations were being held in abeyance.

189. She was concerned that Professor Trenchard was continuing to have involvement in her case, despite raising serious allegations against him in her grievance. She pointed out that in the meeting, Mr Martin had been clear that she could come back to her post. She was dismayed that Professor Trenchard had no intention of allowing her to return to her post with immediate effect as he had proposed that she should undertake special projects or work from home or go off on secondment.

190. She also expressed her concern about Mr O'Bryan undertaking mediation as well as undertaking the investigation into her grievance. She said the two roles were incompatible. She suggested that if mediation was to take place, the organisation should approach ACAS and that they should jointly agree to an appropriate mediator.

191. She finally said that if she was not able to return to her substantive role and no apology was made, people might view her as being guilty and that her reputation would be damaged. Her solicitors also wrote on the same day to DAC Beachcroft raising their own concerns (pages 781-3).

192. On 7 November, she received a response (page 787). It was a short letter to say that he felt that he could not respond to the matters that she had raised. The matters raised would be dealt with as part of the grievance. In fact they were dealt with by DAC Beachcroft in their letter.

193. On the same day, DAC Beachcroft wrote to Mr Potter (pages 788-9). The Trust's position was that an independent investigation had not been concluded. That "*phrases such as 'exonerated' and not appropriate, relevant or accurate*".

194. The letter went on to say that:-

> "*... there remain a number of people working in the Trust who have raised concerns about the behaviour of your client. Our client is therefore of the view that independent mediation is the most appropriate way to address and build/re-build relationships, and our client would be more than happy to agree an alternative mediator, via ACAS as part of this process.*"

195. On 15 November, Professor Trenchard wrote to inform Mrs Marks of the appointment of an Interim Director of Workforce and Organisational Development. This was Lee O'Bryan, although Professor Trenchard did not tell her of this. He had undertaken an initial scoping of the documentary files relating to Mrs Marks's grievance. A copy of his review dated November 2013 is at pages 888-92. At no stage did he carry out any investigation himself and he did not speak to Mrs Marks. Apart from "scoping the review", which amounted to reading the file, Mr Martin had asked him to meet with Professor Trenchard. Apparently Mr Martin wanted his view on whether Professor Trenchard was a credible figure or if he may have targeted Mrs Marks in some way. This process was undertaken by Mr O'Bryan having a "*coffee*" in mid October on the basis of which he formed the view that Professor Trenchard "*was a credible and sincere person*". We have not seen which documents he had before him to form his opinion and the only discussions that he told us about was the coffee with Professor Trenchard. His conclusions were;

- 195.1 that the suspension was a robust but reasonable action;
- 195.2 he found no impropriety in Mr Baines's involvement;
- 195.3 he found no evidence of any sexual harassment;
- 195.4 he was not able to substantiate whether Mrs Marks was offered a companion/representative at the meeting on 31 July;
- 195.5 there was no evidence of regular suspension reviews as per the Trust's disciplinary policy;
- 195.6 it had been impossible for him to verify whether Mrs Marks had been told by Mr Majid that her suspension had been lifted and that there was no case to answer;
- 195.5 he could make no comment on the decision to cease the investigation;

196. In summary, he found that there had been some minor process failures but no evidence to support the substantive allegations that Mrs Marks had made. Although the review is dated November it is not clear as to when it was prepared and whether by then Mr O Brien had been appointed Interim Human resources Director. Mrs Marks was not sent the report until 24 December.

197. The respondents say that his appointment as Interim HR Director took place after he had undertaken this "*initial scoping*" of her grievance. His appointment therefore left him with three roles, which were;

197.1 Interim HR Director reporting to Professor Trenchard;
197.2 Mediator between Professor Trenchard and Helen Marks;
197.3 Investigator of her grievance against Professor Trenchard.

We find that he could not carry out the three roles without being conflicted.

198. On 28 November, Mr Potter wrote to DAC Beachcroft. He pointed out that in the letter; Mrs Marks had not been told who had been appointed as Interim Director in her place. Mr Potter raised concerns again about Mr O'Bryan being the person tasked to investigate the grievance as well as being put forward as the selected independent mediator. Now he was appointed as Interim Director. He made it clear again that the grievance:-

> "*... should be thoroughly investigated by an independent individual(s) external to the investigation. On the completion of the investigation we would expect a written report which would be shared with our client. At that stage our client would then make a decision as to whether to proceed into a grievance hearing.*
> ...".

199. On 5 December, Mrs Marks presented her original claim to the employment tribunal claiming sex discrimination.

200. On 6 December, Mr Martin wrote to Mrs Marks complaining that she had caused delays in the process (pages 825-6). In particular, he said:

200.1 She had not responded to his suggestion to move to stage 2 of the grievance procedure;
200.2 She had taken a 3 week holiday immediately after their meeting;
200.3 She had requested an independent review;
200.4 She had failed to seek an informal resolution.

201. He expressed a desire to support her return to work and told her that he was providing her with the review, even though the Trust had had this now for a number of weeks. It was not enclosed.

202. To make matters worse, he said that at the stage 2 hearing Professor Trenchard would present the management case.

203. Professor Trenchard continued in his communications with Mrs Marks, having written to her on 5 November about her return to work (pages 824-824a). He wrote to her again on 9 December about her return to work on 11 December saying that they would have a meeting to discuss her options. None of those options involved her being able to return to her previous position that was now being undertaken by Mr O'Bryan.

204. Mr Potter wrote to DAC Beachcroft on 11 December (pages 830-2) pointing out that despite the lodgement of her grievance on 17 September, no progress had been made. He pointed out that Mrs Marks was disappointed that Mr Martin's letter appeared to blame her for the delay when clearly the Trust was responsible for that delay. At this stage, the Claimant and her advisers had not seen the desktop review even. He finally pointed out that it was not appropriate for Mrs Marks to remain in a position where she was not allowed to return to work in a substantive role without conditions set by Professor Trenchard.

205. On 16 December, Jay Mistry (Senior Regional Manager of Monitor) wrote to Mr Martin about Mrs Marks's whistleblower concerns (pages 878a-c). It referred to a meeting with the Trust on 8 November to brief them. It suggested that the Trust should consider commissioning an independent governance review.

206. On 24 December, DAC Beachcroft wrote to Mr Potter (pages 884-7). Finally, they enclosed the notes of the 2 October meeting, which had not been provided before and a copy of the review. It was provided just before the Christmas break and we are satisfied done so at that time to cause further distress to Mrs Marks who would not be able to discuss the contents of it with her lawyers until after the new year holiday.

207. On 6 January 2014, Mr Potter wrote in response (pages 893-4). He reiterated that Mrs Marks wanted an independent investigation of her grievances. That her being off sick was no excuse for the delays. He complained that no progress had been made towards dealing with her grievance.

208. He pointed out that Professor Trenchard would not be an appropriate person to carry out the investigation or that he should present the management case. There were serious allegations about him and he would need to be a witness at any grievance hearing.

209. He described Mr O'Bryan's review as being "*woefully inadequate*". That the review did not even attempt to answer some of the questions that were highlighted in Mrs Marks's meeting with Mr Martin and Mr Gillham on 2 October.

210. He reiterated that Mrs Marks had done nothing wrong. There was no good reason why Mrs Marks could not return to her role as she had done nothing wrong and there was no pending enquiry into any allegations against her. .She had not seen any statements of allegations made against her and there was no basis for them preventing her returning to work.

211. Despite her lack of agreement to the stage 2 grievance hearing taking place, she was informed that she was required to attend a hearing on 22 January 2014. This was made clear in a further letter to Mr Potter on 10 January from DAC Beachcroft (pages 898-9). The management statement of Professor Trenchard was sent with that letter.

212. The meeting on 22 January could not take place because of the non-availability of her witness.

213. We note that Mr Martin had written to Monitor on 15 January (pages 908a-g). He said in his letter that they had commissioned an independent report which they had carefully considered, which was presumably the desktop review undertaken by Mr O'Bryan. He said that they were fully satisfied and confident

that it was carried out in good faith and that there was no evidence that Alan Baines had behaved as though he was not accountable to anyone and that the Trust's Chief Executive had colluded to allow this.

214. On 22 January, Mr Potter wrote again to DAC Beachcroft (pages 921-2). He complained that they continued to breach their own processes and Miss Miller, who was to be the independent HR adviser, was not in fact independent as she had a close association with DAC Beachcroft.

215. Mrs Marks again wrote to Professor Trenchard on 23 January about her return to work. She asked for a response to a number of questions, namely;

215.1 was she to be allowed to return to her substantive post with immediate effect without preconditions;

215.2 was the Trust going to conduct a proper, thorough and meaningful investigation into the matters she had raised;

215.3 was the Trust going to formally exonerate her;

215.4 was she to receive a public apology?

216. By now, Mark Todd had been appointed as Chairman. On 4 February, Guy Bredenkamp, Solicitor for DAC Beachcroft, wrote to Mr Potter. The position regarding mediation changed. He said:-

"...

Your client's position in relation to mediation at this stage is understood. However we would observe that, whether or not her grievance is upheld, a mediated or otherwise facilitated return to work process is likely to be helpful. We need not take this point any further at this stage but we would urge you to encourage your client to keep an open mind on that point.

..."

217. He went on to say:-

"...

To be clear, therefore, your client is of course exonerated in the sense that, following investigation, she has not been, and is not, subject to any disciplinary process. Our client does not accept, however, that she has been 'wronged' by having been subject to investigation in the circumstances. It is understood that that process had caused your client understandable distress and our client has expressed its regret for that."

218. At last though the Respondent was prepared to commission a full and independent investigation into the grievance, some 5 months now after the grievance had been presented.

219. On 6 February, Mr Potter received the terms of reference for the investigation into the grievance made. Those terms are at pages 948-9. Those terms of reference were limited. It would be an investigation into the "*decision making and behaviour of ex Chairman and Chief Executive since allegations were first raised*". There was no reference to the sexual harassment or discrimination occasioned by Mr Baines or an investigation into how the allegations came into being. It was still the case that Professor Trenchard would present the management case.

220. Mrs Marks considered her position carefully and decided to resign. The

reasons were;

220.1 She had lost all trust and confidence in the Trust as a result of the behaviour of Mr Baines and Professor Trenchard;

220.2 Her health had suffered and she was now suffering from severe depression;

220.3 She had lost the confidence to deal with serious cases that formed part of her role;

220.4 There was no consistent story from the Trust as to their version of events;

220.5 There was a clear unwillingness of the Trust to consider her allegations of sexual harassment;

220.6 The Trust would still not allow her to return to her previous role.

221. On 19 February, Mrs Marks tendered her resignation. It is at pages 952-4). This was accepted on 21 February (page 955).

222. The announcement of her departure was in distinct contrast to that of Mr Baines. Hers is at page 1171:-

"... thanking Helen for her contribution, and wishing her well"

The Law

The dismissal claim

223. This is made under the provisions of Section 94 of the Employment Rights Act 1996 (ERA). Section 95 provides:-

> ***95 Circumstances in which an employee is dismissed.***
> *(1) For the purposes of this Part an employee is dismissed by his employer if (and, subject to subsection (2)..., only if)—...*
>
> > *(c) the employee terminates the contract under which he is employed (with or without notice) in circumstances in which he is entitled to terminate it without notice by reason of the employer's conduct."*

224. It can be seen from this that the burden is on the Claimant to show that she was constructively dismissed. She must prove that the Respondent fundamentally breached her contract of employment, that she resigned in response to the breach and that she did not waive the breach or affirm the contract. Mr Sweeney for the Respondent said that there was no fundamental breach of contract and if there was the claimant affirmed the contract by delaying her resignation.

225. We were referred to the following cases by Miss Reindorf:-

- ***London Borough of Waltham Forest -v- Omilaju [2005] IRLR 35;***
- ***Lewis -v- Motorworld Garages Ltd [1985} IRLR 465;***
- ***Wright -v- North Ayrshire Council [2014] ICR 77'***
- ***Bournemouth University Higher Education Corp -v- Buckland [2010] ICR 908***
- ***Chindove -v- William Morris Supermarkets plc UKEAT/0201/13/BA.***

226. The Claimant says that the term breached is the implied term of trust and confidence. The test for whether that implied term has been breached is an objective one. The employee may resign in response to a cumulative series of acts which, taken together, amount to a breach of the implied term. The final act, or "*last straw*", which prompts the employee to leave, need not in itself amount to a fundamental breach of contract.

227. The repudiatory breach of contract in response to which the employee resigns need not be the effective cause of her resignation; it need only have played a part in the resignation. The repudiatory breach of contract cannot be cured while the employee is deciding whether to accept the breach. The question of whether the employee has affirmed the breach by delaying her resignation is to be decided by taking into account all the circumstances. This may include where the employee is off sick.

Direct sex discrimination

228. Section 13 of the Equality Act 2010 (EA) states:

> "***13 Direct discrimination***
>
> *(1) A person (A) discriminates against another (B) if, because of a protected characteristic, A treats B less favourably than A treats or would treat others*
> *...".*

229. Section 23 EA provides:-

> ***"23 Comparison by reference to circumstances***
>
> *(1) On a comparison of cases for the purposes of section 13 ... there must be no material difference between the circumstances relating to each case."*

Mr Sweeney reminded us that the less favourable treatment had to be because of the protected characteristic. He referred us to the case of **Madden v Preferred Technical Group CHA Ltd [2005] IRLR 46** which held that a finding that a claimant has been less favourably treated than an actual or hypothetical comparator does not mean that an inference must be drawn that it was on racial grounds.

He went on to refer us to a number of other cases including;

- **London Borough of Islington v Ladele [2009] IRLR 154**
- **Nagarajaran v London regional transport [1999] IRLR 572**
- **Shamoon v Chief Constable of the RUC [2003] IRLR 285**
- **Martin v Lancehawk t/a European Telecom Solutions UKEAT/0525/03**

He emphasised that what we needed to examine were the grounds for the treatment, not merely that it was unfavourable.

Harassment

230. Section 26 of the EA provides:-

> ***"26 Harassment***
> *(1) A person (A) harasses another (B) if—*

(a) A engages in unwanted conduct related to a relevant protected characteristic, and

(b) the conduct has the purpose or effect of—

(i) violating B's dignity, or

(ii) creating an intimidating, hostile, degrading, humiliating or offensive environment for B.

(2) A also harasses B if—

(a) A engages in unwanted conduct of a sexual nature, and

(b) the conduct has the purpose or effect referred to in subsection (1)(b).

(3) A also harasses B if—

(a) A or another person engages in unwanted conduct of a sexual nature or that is related to gender reassignment or sex,

(b) the conduct has the purpose or effect referred to in subsection (1)(b), and

(c) because of B's rejection of or submission to the conduct, A treats B less favourably than A would treat B if B had not rejected or submitted to the conduct.

(4) In deciding whether conduct has the effect referred to in subsection (1)(b), each of the following must be taken into account—

(a) the perception of B;

(b) the other circumstances of the case;

(c) whether it is reasonable for the conduct to have that effect."

231. Miss Reindorf referred us to the case of ***Smith -v- Ideal Shopping Direct Ltd UKEAT/0590/12/BA.*** The test for harassment is a mixed subjective and objective one. The complainant may have engaged in some banter, but it is still harassment if the conduct goes beyond what they were agreeing to, especially if it consists of deliberately insulting language. She reminded us that there can be no justification for harassment and no comparator is required.

232. Mr Sweeney referred us to the case of **Richmond Pharmacology v Dhaliwal [2009] IRLR 336.** We have to focus on the three elements of the claim i.e;

(1) unwanted conduct
(2) having the purpose or effect of either;
  (i) violating the Claimants dignity; or
  (ii) creating an adverse environment for her;
(3) on or related to the prohibited ground

Victimisation

233. Section 27 EA provides:-

"27 Victimisation

(1) A person (A) victimises another person (B) if A subjects B to a detriment because—

(a) B does a protected act, or

(b) A believes that B has done, or may do, a protected act.

(2) Each of the following is a protected act—
(a) bringing proceedings under this Act;
(b) giving evidence or information in connection with proceedings under this Act;
(c) doing any other thing for the purposes of or in connection with this Act;
(d) making an allegation (whether or not express) that A or another person has contravened this Act."

234. Again, there is no need for a comparator.

Burden of proof

235. Section 136 EA provides as follows:-

136 Burden of proof
(1) This section applies to any proceedings relating to a contravention of this Act.
(2) If there are facts from which the court could decide, in the absence of any other explanation, that a person (A) contravened the provision concerned, the court must hold that the contravention occurred.
(3) But subsection (2) does not apply if A shows that A did not contravene the provision."

236. Miss Reindorf referred us to the cases of:-

- ***Igen -v- Wong [2005] IRLR 258***
- ***Madarassy -v- Nomura International plc [2007] ICR 867***
- ***Hewage -v- Grampian Health Board [2012] ICR 1054***
- ***London Borough of Ealing -v- Rihal [2004] EWCA Civ 623***
- ***Lang -v- Manchester City Council [2006] ICR 1519***
- ***Shamoon -v- Chief Constable of Royal Ulster Constabulary [2003] ICR 337***
- ***Veolia Environmental Services UK -v- Gumbs UKEAT/0487/12/BA***
- ***King -v- Great Britain China Centre [1992] ICR 516***
- ***Network Rail Infrastructure Ltd -v- Griffiths-Henry UKEAT/0642/05/CK***
- ***The Solicitors Regulation Authority -v- Mitchell UKEAT/0497.12.MC***
- ***Birmingham City Council -v- Millwood UKEAT/0564/11/DM***

Mr Sweeney referred us also to;

- **Hammonds LLP v Mwitta [2010] UKEAT/0026/10**

237. The Claimant must prove on the balance of probabilities facts from which the tribunal could conclude, in the absence of an adequate explanation, that the Respondent has committed an act of unlawful discrimination. The burden will not shift on proof by the Claimant only of a difference in status and a difference in treatment between herself and a comparator, whether real or hypothetical. She must prove facts from which the tribunal could conclude that the reason for the difference in treatment was a relevant prohibited ground. If the Claimant proves such facts, the burden shifts to the Respondent to show that it did not commit those acts and to show that the treatment was not on the prohibited ground.

Jurisdiction

238. It is not suggested that the claims of unfair dismissal are out of time, only

some of the claims of discrimination. The Claimant presented her original claim of sex discrimination on 5 December so on the face of it any matters that arose before 6 September 2013 were presented out of time.

239. Section 123 of the EA provides:-

> ***"123 Time limits***
>
> *(1) ... proceedings on a complaint within section 120 may not be brought after the end of—*
>
> *(a) the period of 3 months starting with the date of the act to which the complaint relates, or*
>
> *(b) such other period as the employment tribunal thinks just and equitable. ...*
>
> *(3) For the purposes of this section—*
>
> *(a) conduct extending over a period is to be treated as done at the end of the period;*
>
> *(b) failure to do something is to be treated as occurring when the person in question decided on it."*

Conclusions

~~Unfair dismissal~~

240. We are satisfied that the Respondent has committed a fundamental breach of the contract of employment of the Claimant comprising the implied term of trust and confidence. We agree with Miss Reindorf that the Respondent's conduct towards the Claimant in the final year or so of her employment was an object lesson on how to breach the implied term of trust and confidence. The breaches are numerous. We are satisfied that Mrs Marks was subjected to sexual harassment and bullying by Mr Baines. He placed her under pressure to have a sexual relationship with him, acting in such a way as to make her fearful of displeasing him. He also accused her of having an affair with Professor Trenchard and on 13 March 2013 of being a "*whore*".

241. This has been overwhelmingly proved in our view from the text messages and the admissions he made in his evidence.

242. We do not accept that the discussions that they had about having a sexual relationship was done in a "*loving way*" nor in any event is that relevant.

243. It has been submitted by Mr Sweeney that the Claimant led Mr Baines. That she duped him. There is not a shred of evidence to suggest that at any stage she had indicated that she would be willing to enter into a sexual relationship with him. Indeed, the contrary has been shown.

244. We reject the argument that Mrs Marks was exploiting and manipulating Mr Baines in the relationship. We are satisfied that it was initially a consensual relationship. He was in a position of great power in the organisation. He used that power in this inappropriate relationship. In our view, it is not relevant what the Claimant's motive was for entering into her friendship with Mr Baines in the first place. It had no bearing on the conduct of Mr Baines, after Mrs Marks had ended it, which was wholly unacceptable.

245. We found that Mr Baines was a bully and a manipulator. He did not only manipulate Mrs Marks but also Professor Trenchard, Harinder Dhaliwal, Sarah Carter and Karen Herriman. He did not give truthful evidence to this Tribunal. We were able to examine what Mr Baines submitted to the preliminary hearing on 22 July 2014 and compare that to his witness statement to this Tribunal. There are many inconsistencies. An example of this related to the Callow Hall incident where he had made no mention of calling Mrs Marks a "whore". He also described mentioning the complaints of Harinder Dhaliwell and Sarah Carter to the CEO in their meeting on the 24 June "but left the matter there". That was untrue. He also lied at the time of the incident to both Mrs Marks and Professor Trenchard.

246. His behaviour after the Callow Hall incident was particularly unpleasant. He accused Mrs Marks of having an affair with Professor Trenchard, which was an accusation without foundation. He also admitted using the words "*whore*" in a text following the Callow Hall incident. It was meant in the context of her allegedly having a sexual relationship with Professor Trenchard and was designed by him to upset and demean Mrs Marks.

247. Whilst the Respondent says that they did not have an opportunity to take action to prevent the treatment because they were unaware of it, in our view that is entirely irrelevant. It has not been said by the Respondent that Mr Baines was acting outside the course of his employment and/or that they were not vicariously liable for his conduct. He was the head of the organisation and the submission is untenable.

248. After the Claimant ended the relationship and in the process of cooling it down, we are satisfied that Mrs Marks was subjected to spurious and unfounded allegations of bullying and harassment which were engineered by Mr Baines in an attempt to secure her dismissal.

249. We are satisfied that Mr Baines deliberately engineered the complaints against Mrs Marks in his discussions with Harinder Dhaliwal, Sarah Carter, Maura Teager and Karen Herriman. Professor Trenchard did not stop what was happening. He did not ask any questions of Mr Baines as to how he was behaving. He allowed Mr Baines to run the process and he should have told him to stay out of it.

250. The Claimant was subjected to an entirely unjustified suspension. In the email exchange between Professor Trenchard and Mr Baines, Mr Baines talks of dispensing with the services of Mrs Marks because *"she feels totally wrong to me now"*. We are satisfied that Mr Baines and Professor Trenchard took the decision to suspend Mrs Marks together and that they did so with a view of dispensing with her services shortly thereafter. The suspension was nothing to do with the carrying out of an investigation but was merely the first step in the process of getting rid of her.

251. The email from Mr Baines to Professor Trenchard on 1 August in which he states: "*over to the lawyers*" provides further support to this contention. There would be no reason to involve the lawyers if the matter was to be dealt with internally.

252. Professor Trenchard did not suspend Mrs Marks immediately once he had decided that suspension was the appropriate course, i.e. on Sunday 28 July 2013. He waited until it was more convenient to do so because he wanted her to

attend important meetings.

253. We are satisfied that he did not consider any alternative to suspension. His file note shows that he put no thought into that possibility, nor that suspension was necessary in the circumstances. His only rationale was;

> "*Can't have value being undermined by Director - especially HR who is driving them supposedly*".

254. In any event, the allegations made against her did not amount to proper grounds for suspension and were obviously trumped up by Mr Baines. He clearly should have asked questions as to how the allegations arose and not allowed himself to be used by Mr Baines to achieve his ends.

255. We are satisfied that Professor Trenchard and Mr Baines colluded in an attempt to dismiss the Claimant or alternatively obtaining her resignation.

256. In this respect, we particularly were able to rely on the email exchange on 29 July. As Mr Baines admitted under cross-examination, he is referring to Mrs Marks in that email exchange when he said:

> "*However many ... we dispense with this week we shall deal with it together*".

His claim that "*dispensing with*" simply meant placing her on suspension for some time was untrue.

257. There was no mention in Professor Trenchard's witness statement at all about this. He suggested that his response "*agreed and looking forward to it*" was a reference to restructuring the Board rather than the suggestion of dispensing with the services of Mrs Marks.

258. We reject this. It is unbelievable.

259. Professor Trenchard was complicit in obtaining the written statements from the complainants as a step in the process of securing evidence against Mrs Marks. Whilst he may not have known Mr Baines's motives, he was a willing participant in his plan.

260. He also allowed Mr Baines to be involved in the process by attending his own meetings with Karen Herriman and Louise Ludgrove. The Chairman's attendance at these meetings was inappropriate and there can be no reasonable explanation for it, other than they were acting in tandem.

261. The Claimant's suspension was imposed, conducted and pursued in a manner which was unfair and in breach of the Respondent's internal procedures.

262. Professor Trenchard had said that he was proceeding under the Dignity at Work Procedure and the Suspension Procedure. If he was proceeding under the Dignity at Work Procedure, there was no active complainant who had taken the decision to come forward under the policy. The informal stage of the procedure had not been undertaken. None of the alleged complainants had ever made any complaint to Mrs Marks about her behavior.

263. We are satisfied that at the suspension meeting, Professor Trenchard did

not tell Mrs Marks about her right of accompaniment and he was not accompanied himself. We do not believe him when he says that he wanted to protect her confidentiality. At that meeting, he should also have provided her with some details about the allegations. He provided none.

264. Mr Baines manipulated the suspension and investigation process to cause Mrs Marks pain. This is evidenced in his email to Professor Trenchard of 29 July; his visit and email to the Claimant of 7 August; his email to Professor Trenchard of 12 August; his communication to the Claimant of 13 August; his letter to the Claimant of 2 September; his letter to the Claimant of 4 September and his text message to the Claimant on 6 September. We are satisfied that his activities during this period were to ensure that the Respondent dispensed with the services of Mrs Marks; that she would be put under pressure to agree a negotiated exit from the organisation as she would not enter into a sexual relationship with him and indeed by then had ended her friendship with him. This is particularly evidenced in his email of 5 August when he described the "*emotional wilderness*" that he had been in since early June. We are satisfied that there was an implicit threat in that email as to what might occur if she did not treat him well.

265. He then visited her at home on 7 August. It matters not whether he suggested going upstairs to lie down. What he did during that meeting was to mislead Mrs Marks about his involvement and persuade her that Professor Trenchard was orchestrating the action against her.

266. He encouraged her to make a complaint about Professor Trenchard knowing full well that if she did so, it would make it impossible for her to return to the organisation. What happened after she made the complaint, i.e. she was never able to return to the Trust in her previous position, gives clear credence to this.

267. Mr Baines not only manipulated Mrs Marks but also Professor Trenchard. At the same time, he was telling Mrs Marks to come out fighting and "*get annoyed at being fitted up*, he was saying to Professor Trenchard in his letter of 12 August "*my antennae are sending me strong signals about this case. I feel now that it needs burying and bringing to a close swiftly or I can see a messy escalation ensuring*".

268. After the suspension was lifted, the Respondent refused to provide any reasons as to why it had and why the investigation was discontinued.

269. After the suspension was lifted, the Claimant was not allowed to return to work in her previous position. If there were no allegations being pursued against her, there was no reason for her not to be able to return to work. Instead, she was placed on "*special leave*". She was not in fact on special leave. The special leave procedures are for "*special*" events such as suffering bereavement. There is no provision for a situation such as Mrs Marks faced. In reality, her suspension was continued without any justification right up to her resignation.

270. The Respondent protected and defended Mr Baines and sought to obscure his wrongdoing, including in the way that it announced his departure from the Trust saying that he had retired and he left the Trust with "*love*". His departure led to the Respondent then claiming that they could not investigate his behaviour. In our view, there was no justification for this.

271. The Respondent ignored Mrs Marks's complaints of sexual harassment and discrimination for a period of 5 months. They delayed the process. They insisted on mediation. They refused to carry out any independent investigation into the conduct of Mr Baines, claiming they could not investigate him. They did not investigate the complaints made against Mrs Marks and how they came about. Despite failing to investigate them, they maintained the position that there was some substance to those complaints. Having agreed that the Claimant would receive an apology for her suspension and other treatment at a Board meeting, Mr Martin then reneged on that agreement.

272. The Respondent appointed Lee O'Bryan to carry out a mediation that the Claimant had not agreed to. He was not independent. He was a former colleague of Mr Martin from their time together at the Royal Mail. He then carried out a woefully inadequate review of the grievance by reviewing the papers and having a cup of coffee with Professor Trenchard. He was appointed as Interim HR Director at a time where there was no good reason why Mrs Marks could not have returned to her post. She was not consulted about the appointment.

273. When finally after months of prevarication and unreasonable delays in dealing with her complaints, they proposed terms of reference for the investigation which were wholly inadequate. There was no reference in the terms of reference to any investigation into the behavior of Mr Baines.

274. She resigned because of these matters and not for any other reason. We were satisfied that the terms of reference issue was the last straw that led to her decision.

275. We are satisfied that she did not delay too long. We take the following factors into account;

275.1 She had long service with the Trust;
275.2 She was a senior highly paid Director of the Respondent organisation;
275.3 She had the benefit of a pension, which would be severely affected if she left the Respondent's employment;
275.4 She was ill and suffering from stress throughout this period;
275.5 She had been placed on special leave, ie suspension during this period;
275.6 She genuinely wanted to return to work to her previous position.

276. The Respondents do not contend that they had a fair reason for dismissing the Claimant and therefore her claim of constructive unfair dismissal succeeds.

Direct discrimination and harassment

Jurisdiction

277. The Respondent has raised the issue of jurisdiction. It is agreed that the original complaint was received by the tribunal on 5 December 2013. It is said that any complaint therefore that arose before 6 September 2013 is out of time. The second complaint, and the amended grounds of complaint in respect of the first complaint, were presented to the tribunal on 28 May 2014.

278. We have considered the original ET1 and the amended grounds of

complaint. The original complaint complained of sex discrimination. We are satisfied that the amended particulars did not add additional claims. It merely further particularised the claims of sex discrimination against the Respondent.

279. In any event, we are satisfied that the Respondent was guilty of continuing acts of discrimination right up to the point of her resignation on 19 February as she continued to be kept on special leave and the Respondent continued with their refusal to carry out any independent investigation into her complaints.

280. If we were wrong in respect of that, we would say for the reasons that we have outlined above, that it would be just and equitable to extend time in this case.

Burden of proof

281. We have not had to concern ourselves with this. In our view, the evidence is clear that the Claimant has been able to establish beyond reasonable doubt that she has suffered;

281.1 direct discrimination;
281.2 harassment and bullying;
281.3 victimisation.

282. We are satisfied that the reason that she has received her less favourable treatment of bullying and harassment and the victimisation is because she is a woman.

283. It is clear to us that Mr Baines's pursuit of Mrs Marks was because she was a woman and because he wanted to have a sexual relationship with her. That when he realised that she would not have a sexual relationship with him, he treated her less favourably than he would treat others, in particular men.

284. The other men in this case, which include Professor Trenchard, Mr Martin and Mr Hall (all senior executives) then assisted Mr Baines in covering this matter up and preventing any proper investigation into his behaviour. They allowed him to retire with his good name in tact because he is a man. They treated Mrs Marks in the way that they did because she is a woman.

285. We are satisfied that the following matters amounted to less favourable treatment;

- Sexually harassing and bullying the Claimant
- Subjecting her to spurious and unfounded allegations of bullying
- Subjecting her to an unjustified suspension
- Professor Trenchard and Mr Baines colluding to make her leave the employ of the Respondent
- Conducting the suspension in an unfair manner in breach of the Respondents own procedures
- Mr Baines manipulating the suspension and investigation to cause her distress
- Mr Baines subjecting her to abusive text messages
- Suspending Mrs Marks compared to the manner Mr Baines and Professor Trenchard were dealt with when she raised complaints about them
- Protecting Mr Baines and obscuring his wrongdoing
- Refusing to explain her why her suspension was lifted and the investigation discontinued

- Refusing to exonerate her or issue an apology
- Seeking to impose conditions on her return to work
- Persistently ignoring her complaints
- Failing to investigate them at all and causing unreasonable delays

In respect of all these matters of less favourable treatment we are satisfied that they treated her like this because she was a woman. She would not have been treated in such a manner if she was a man. We in particular compared her treatment to the way the Trust treated both Mr Baines and Professor Trenchard. Neither were suspended or investigated despite serious allegations being made against them.

Harassment

286. We are satisfied in this case that the conduct to which Mr Baines subjected Mrs Marks was unwanted; that the purpose of that conduct was to violate her dignity and create an intimidating, hostile, degrading, humiliating and offensive environment for her. His behaviour could not, in our view, amount to simply a "lovers tiff" during some form of consensual relationship. His bombardment at times of the Claimant with texts, including accusing her of being a whore, was deliberately insulting and totally unacceptable.

287. The Claimant also succeeds with her claim under Section 26(3) EA. We are satisfied that because of her rejection of the unwanted conduct, namely sexual relations with Mr Baines, he embarked on a course of conduct that was designed to ensure that the Claimant left the Respondent's employment. We are satisfied that this is particularly evidenced by his "parking" of the complaints shortly after he had received what he considered a text that gave him hope that their relationship would continue from the Claimant immediately before he went on leave on 1 July 2013 and then his behavior when he returned from that leave knowing that his hopes of rekindling their relationship were not going to be satisfied.

Victimisation

288. It is not in dispute that there were a number of protected acts in this case. These were the Claimant's letters of 28 August, 6 and 11 September, the written grievance of 17 and 20 September and the grievance meeting on 2 Octobe4r.

289. We are satisfied that the Claimant suffered the following detriments as a result of her protected acts;

289.1 Mr Baines's text of 6 September when he called her "*you stupid woman*";
289.2 The Respondent protecting and defending Mr Baines and obscuring his wrongdoing;
289.3 The refusal to exonerate Mrs Marks;
289.4 The refusal to apologise for her suspension and their behaviour towards her;
289.5 The imposition of conditions about her return to work;
289.6 Placing her on special leave;
289.7 Ignoring her complaints against both Mr Baines and Professor Trenchard;
289.8 Deliberately delaying the process.

Discriminatory dismissal/dismissal by way of victimisation

290. Although we are satisfied that the discrimination that the Claimant suffered ultimately caused her resignation, this is not a discriminatory dismissal. Nor do we agree that her resignation was an act of victimisation in itself. As we have described above, the cause of her resignation was the conduct of the Respondent and Mr Baines during a period of 12 months prior to her resignation.

291. The issue of remedy is adjourned to 2 and 3 September 2015 and there will be a telephone case management discussion on 3 July 2015 at 9.30 am for me to give further directions in respect of this matter.

Employment Judge Hutchinson

Date 18 June 2015

JUDGMENT SENT TO THE PARTIES ON

22 June 2015

FOR THE TRIBUNAL OFFICE