Derbyshire Healthcare NHS
NHS Foundation Trust

Meeting of the Board of Directors

25 May 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 25 MAY 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 –	**-**	Richard Gregory
3.	1:30	Apologies for Absence		Richard Gregory
4.	1:30	Declarations of Interest	**A**	Richard Gregory
5.	1:30	Minutes of Board of Directors meeting held on 27 April 2016	**B**	Richard Gregory
6.	1:35	Matters arising – Actions Matrix	**C**	Richard Gregory
7.	1:40	Chairman's Verbal Update	**-**	Richard Gregory
8.	1:50	Acting Chief Executive's Report	**D**	Ifti Majid
OPERATIONAL PERFORMANCE, QUALITY AND STRATEGY				
9.	2:05	Integrated Performance and Activity Report - to follow	**E**	Carolyn Gilby Claire Wright Jayne Storey Carolyn Green
10.	2:15	Position Statement on Quality and Control of Infection Annual Report	**F**	Carolyn Green
11.	2:25	Board Committee Escalations from the Audit Committee, Mental Health Act Committee, Quality Committee, People & Culture Committee Ratified Minutes of meetings held in April (Quality Committee and People & Culture Committee) are included for information only	**G**	Committee Chairs
12.	2:35	Annual Report from the Audit Committee	**H**	Caroline Maley
13.	2:45	Approval of Trust Strategy	**I**	Mark Powell
3:00 B R E A K				
14.	3:15	Deep Dive - Neighbourhoods	**J**	Carolyn Gilby
GOVERNANCE				
15.	3:35	Governance Improvement Action Plan (GIAP) and Delivery Framework - GIAP Actions relating to Corporate Governance Framework	**K**	Mark Powell Samantha Harrison
16.	3:45	Monitor Compliance Return	**L**	Samantha Harrison
17.	3:55	Fit & Proper Person Declaration	**M**	Richard Gregory
18.	4:05	Register of Trust Sealings	**N**	Samantha Harrison
CLOSING MATTERS				
19.	4:10	Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework	**-**	Richard Gregory
20.	4:15	2016/17 Board Forward Plan	**O**	Sam Harrison

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

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 29 June 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.

Declaration of Interests Register 2016-17

NAME	INTEREST DISCLOSED	TYPE
Jim Dixon	Director – Winster Village Shop Association Director – Jim Dixon Associates Director – UK Countryside Tours Limited Patron – Accessible Derbyshire	(a) (a) (a) (d)
Carolyn Gilby	Nil	-
Carolyn Green	Nil	-
Richard Gregory	Director – Clydesdale Bank Plc (including Yorkshire Bank) Director – CYBG Plc (holding company of Clydesdale) NHS Providers Trainer/Facilitator for Board/Governor Development Member of Governwell, NHS Providers	(a) (a) (e) (e)
Phil Harris	Director – Phormative Ltd	(a, b, c)
Samantha Harrison	Nil	-
Ifti Majid	Nil	-
Caroline Maley	Director – C D Maley Ltd Trustee – Vocaleyes Ltd.	(a) (a, d)
Mark Powell	Nil	-
Jayne Storey	Nil	-
John Sykes	Independent Deprivation of Liberty mental Health Assessor undertaking assessments on BGHS patients at the request of Derbyshire County Council via my medical secretary	(b)
Maura Teager	Non-Executive Director – Ripplez social enterprise and NHS provider of the Family Nurse Partnership	(a)
Claire Wright	Nil	-

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

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

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Wednesday 27 April 2016

MEETING HELD IN PUBLIC
Commenced: 1pm Closed: 4.40pm

PRESENT:	Richard Gregory	Interim Chairman
	Jim Dixon	Deputy Chair and Non-Executive Director
	Caroline Maley	Senior Independent Director
	Phil Harris	Non-Executive Director
	Ifti Majid	Acting Chief Executive
	Claire Wright	Executive Director of Finance
	Dr John Sykes	Executive Medical Director
	Mark Powell	Director of Business Development & Marketing
	Jayne Storey	Director of Workforce OD & Culture
	Samantha Harrison	Director of Corporate Affairs & Trust Secretary
IN ATTENDANCE:	Anna Shaw	Deputy Director of Communications and Involvement
	Sue Turner	Board Secretary and Minute Taker
For item DHCFT 2016/051	Bev Green	Releasing Time to Care Lead (Service Improvement)
For item DHCFT 2016/051	Therese Vecsey	Senior Occupational Therapist
For item DHCFT 2016/051	Richard Holford	Student Occupational Therapist
For item DHCFT 2016/051	Members of the Mr Grundy's Group	
For item DHCFT 2016/062	Rubina Reza	Research and Clinical Audit Manager
For item DHCFT 2016/062	Ranjit Badhan	Research and Clinical Audit Co-ordinator
APOLOGIES:	Maura Teager	Non-Executive Director
	Carolyn Green	Director of Nursing & Patient Experience
	Carolyn Gilby	Acting Director of Operations
VISITORS:	John Morrissey	Lead Governor
	Carole Riley	Governor, Derby City East
	Chris Fitzclark	North Derbyshire Voluntary Action
	Pauline Gill	North Derbyshire Voluntary Action

DHCFT 2016/050	**INTERIM CHAIRMAN'S WELCOME, OPENING REMARKS AND APOLOGIES** The Interim Chairman, Richard Gregory, opened the meeting by welcoming all present.
DHCFT 2016/051	**SERVICE RECEIVER STORY – MR GRUNDY'S GROUP** Richard Gregory welcomed six service users from a group called Mr Grundy's who were accompanied by Senior Occupational Therapist Therese Vecsey and Richard Holford who is a student Occupational Therapist. Mr Grundy's has been running as a group for over a year as a community facility.

	Therese Vecsey explained that she became aware that through her assessments that there should be an occupational therapy focus within the recovery teams and there was a need for this type of group to help reduce social isolation. The group takes place on a Wednesday evening in the pub in the centre of Derby from which the group takes its name. The Board heard how the group was originally set up as a pilot scheme, is now permanent and has links into other groups and activities. There are several members in the group of various age and backgrounds who meet and share their skills and experiences and support each other. Taking part in different activities has encouraged them to progress with other social activities such as bingo, visits to the theatre, art and music classes etc. Friendships have developed between the members who also meet on other evenings. One member appreciated going to the theatre for the first time so much that he is now enjoying attending drama groups. Taking part in Mr Grundy's group gave him confidence and has opened up a brand new world to him. Members of the Board wondered if this was a model that could be set up in other areas. It was obvious that the success of the group could be attributed to the fact that they meet outside of a hospital environment. Members of Mr Grundy's group thought it should be an essential service as it has been a lifeline for them. It has helped some of them manage their mental health condition more efficiently. The Board recognised this was a very cost effective model and there were probably other venues in other areas that might be interested in providing space for a similar group. It would be ideal to roll out the ethos of what Mr Grundy's has started across Derbyshire. Richard Gregory gave thanks to the group for agreeing to tell their story which allowed the Board to hear at first hand the service this initiative provides. **RESOLVED: The Board of Directors expressed thanks to the Mr Grundy's group for sharing their experiences and appreciated the opportunity to hear at first hand the benefits they had received through this initiative.**
DHCFT 2016/052	**MINUTES OF THE MEETING DATED 30 MARCH 2016** The minutes of the meeting held on 30 March were accepted and agreed subject to the addition of the following sentence to the fourth paragraph of DHCFT 2016/043 Board Assurance Framework Update; "*It was also agreed that overall responsibility for the scrutiny of all risk systems, processes and procedures will be with the Audit Committee, which would be renamed Audit and Risk Committee and its terms of reference would be changed to reflect this revised responsibility.".*
DHCFT 2016/053	**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. **DCHFT 2016/005 Industrial Action:** John Sykes, Medical Director, informed the Board that around 20% of junior doctors had not participated in strike action and consultants, specialist doctors and advanced nurses were supplementing services. An incident room had been set up to run between the hours of 8am and 5pm and no incidents had taken place so far. Ifti Majid informed the Board that junior doctors had asked him to sign a letter on behalf of the Board to Jeremy Hunt in support of the junior doctors' strike. The Board discussed its support of junior doctors. Richard Gregory was of the opinion that Ifti Majid in his role as Accounting Officer should offer support to junior doctors in terms of morale and acknowledge the pressure they are under and should not become involved in

	negotiations. It was the responsibility of the BMA and the Government to make such decisions. **DCHFT 2016/042 Monitor Plan 2016/17:** Chair's Action to sign off the final Cost Improvement Plan has been completed. Richard Gregory confirmed his approval to proceed with the submission to Monitor via email on 14 April on the following basis: • Board considered the Project Vision system approach • There is still a gap of about £1.7m for 2016/17 • For that 2016/17 gap the Board discussed at the Board Development session on 13 April the mitigations including for example the diversion of some of the Finance Director's capacity to have additional oversight on some of the most high impact changes required • The Board also discussed progress for the 207/18 and beyond pipeline (virtual tender approach). Whilst it has not been possible to close the 2016/17 gap before submission, additional narrative to reflect the approach to mitigations for the 2016/17 CIP gap has been added to the Trust's updated submission to Monitor. The submission reflects true progress at this point in time and the challenges that are still ahead. **RESOLVED: The Board of Directors noted the issues raised under matters arising.**
DHCFT 2016/054	**<u>CHAIRMAN'S VERBAL REPORT</u>** Richard Gregory updated the Board on developments made in the last month. I. Richard Gregory, Ifti Majid and Mark Powell met with NHS Improvement (NHSI) (in its previous name, Monitor) to review the Governance Improvement Action Plan (GIAP). This was followed by a letter from NHSI that confirmed NHSI are supportive of the actions the Trust is taking and of the GIAP. II. Richard Gregory and Jim Dixon, Deputy Trust Chair, met with Peter and Helen Marks and offered them a unreserved apology and listened to their concerns with regard to issues relating to the recent employment tribunal. III. Richard Gregory also met with the Doctors and the Medical Staff Committee, MPs and the Lead Governor to discuss concerns relating to the employment tribunal. The GIAP was also discussed at this meeting and Richard Gregory was able to inform them of the progress the Trust was making. IV. Two meetings have been held with new Council of Governors' committees. The Nominations Committee approved the Non-Executive Directors (NEDs) appraisal template, although governors declined the opportunity to provide their input in the NEDs' appraisal process as they had not been asked to do this in the past. The Nominations Committee also approved the programme for the recruitment to fill three NED vacancies. Two meetings have now been held by the Governance Committee. V. The Trust's Constitution will be brought up to date and will be received by the Board and the Council of Governors. The Trust is also considering sourcing a governor to represent schools. Richard Gregory thanked Jayne Davies and Shirley Houston from the Involvement Team for their work in producing a comprehensive induction programme for new governors as well as a training programme that will run throughout the year for all governors. A number of new governors have been appointed and Richard Gregory has been impressed with the people who have joined.

	VI. Following the public disclosure of the investigation reports, the CQC is to receive information relating to the recent HR investigation. The Board had intended to release an over-arching report on this investigation to the governors. However, the identification of the individuals contained in the report compromises the Trust's policies. As a result, a summary of the work of the HR investigation team will be shared with the Lead Governor. VII. Richard Gregory held some very useful meetings with Staff Governors. Concerns have been raised by staff as a result of the identification of skill mixes and change in working patterns and staff governors were keen to understand that the right resource would be in place before changes are implemented. VIII. Staff have expressed concern that individuals could have been identified the recent Staff Survey. There was also an issue that middle managers could be seen as a barrier to teams speaking up. The People and Culture Committee is working in partnership with staff side to ensure managers are working with the same values as the Board. IX. Richard Gregory had the opportunity to meet with Dr Paula Crick, from the University of Derby and a member of the Council of Governors. Discussions centred around how the organisation could be more successful in securing newly trained mental health nurses and consider bursaries for students when they commence their academic studies. They also discussed opportunities for apprenticeships. X. A meeting was held with Angela Kerry from Derbyshire Mental Health Forum with a view to inviting her to support the Council of Governors. XI. Richard Gregory had also attended the first meeting of the System Leaders Group. Ifti Majid had chaired this meeting and Richard Gregory commended Ifti Majid's skills in chairing this very important and difficult first meeting. These were the highlights of some of the meetings Richard Gregory took part in over the last few weeks. Richard Gregory informed members of the Board that a series of questions had been received from Peter Marks relating to the Public Board meeting agenda. The questions raised by Peter Marks and the answers were outlined as below: Question 1: On Thursday 21 April 2016 an agenda was published without papers for the public Trust Board meeting on Wednesday 27 April 2016. This included Item I, Fit and Proper Person Assessment. This would appear to be in line with the expectation of the Trust's Governance Action Plan for a paper to be presented to the Board by the end of April 2016. The following morning, Friday 22 April 2016 the agenda had been changed and this item had been removed. I would be grateful if you could give an explanation as to why this item has been removed from the agenda for this meeting, both at the Public Board Meeting and by email. It would be unacceptable if such a matter of public interest is intended to be taken in private session. Response: *Unfortunately the agenda which was loaded onto the website was not the final version. The final version was uploaded on Friday 22 April following finalisation of the governance improvement action plan (GIAP) progress report which includes an update on fit and proper persons requirements. I can confirm that fit and proper persons requirements is not scheduled for discussion in the confidential section of the agenda.* *As outlined in the GIAP report, core 9, Fit and Proper Persons Test section, the detail included in the 'comments on progress column' highlights that the Trust has approved a fit and proper persons policy, self-declarations have been made by all Board members (at*

	the Board meeting in March 2016), and there is an internal process set up to proactively monitor compliance, hence the rag rating of 'on track'. There remains some documentary evidence outstanding (including return of DBS check documents) such that the Chairman is not therefore in a position to make a full declaration that all aspects of the policy are fully in place. The RAG rating will be discussed at the Board meeting as part of the GIAP agenda item. Confirmation that all directors comply with the fit and proper persons policy will be reported to the May public Board. In response to the questions in Peter Marks' second email of 25 April: Question 1: In the executive summary, under Key Tasks - Currently 'Off Track' or 'Some Issues', do you agree that it is misleading to describe the Director of Workforce OD and Culture as 'newly appointed' given that, although this specific role has only recently been created she has had professional responsibility for HR since November 2014? Response: *In response to this question I can confirm that the Director of Workforce OD and Culture was appointed on 25 January 2016 following discussion at the 23 December meeting of the Remuneration Committee.* Question 2: Why is action 6 in the Fit and Proper Person Test section not included in this section, as 'off track', given that these are the items that the Board is directed to as the main focus for discussion and assurance? *Response: This question is answered in the response to the first question regarding the status of progress with Fit and Proper Persons Requirements compliance.* Question 3: Why is action 6 in the Fit and Proper Person Test section (formal confirmation to Board by chair of full compliance with Fit and Proper Person requirements) rated "green" and on track, given this Board meeting is the last opportunity before the deadline of 30 April 2016 for this to be done and no such confirmation is given within the Board papers? *Response: Again, this question is answered in the response to the first question regarding the status of progress with Fit and Proper Persons compliance.* Question 4: Given that the report states that all required self-declarations are in place can you confirm that you are assured that all these self-declarations are correct and that all of the current Board members fulfil the requirement that they have not 'been responsible for, contributed to, been privy to or facilitated any serious misconduct or mismanagement (whether lawful or not) in the course of carrying out a regulated activity'? *Response: I am content that all self-declarations made are correct and the outcomes of the commissioned investigations undertaken within the Trust during 2015/16 have not indicated that any of the Board members of the trust are unfit.* Question 5: Given the Nolan Principles state that holders of public office are accountable to the public for their decisions and actions and must subject themselves to the scrutiny necessary to ensure this, will you agree to make public the individual reports from the Yates investigation of current Board members, particularly those that had direct involvement in the events surrounding the Helen Marks employment tribunal, ie Ifti Majid and Maura Teager? *Response: We are unable to disclose the individual reports due to issues of confidentiality with respect to staff named in the reports. However we are satisfied that the appropriate governance scrutiny is taking place.* **RESOLVED: The Board of Directors noted the Interim Chairman's verbal update.**

DHCFT 2016/056	**ACTING CHIEF EXECUTIVE'S REPORT** Ifti Majid presented his report which provided the Board with feedback on changes within the national health and social care sector as well as providing an update on developments occurring within the local Derbyshire health and social care community. The report also updated the Board on feedback from external stakeholders such as commissioners and the Trust's staff. Ifti Majid drew attention to the recommendations and 10 year vision of the Derbyshire Sustainability and Transformation Plan (STP) that was included as an appendix to his report. He also drew attention to the social capital project he was leading with the Health and Wellbeing Board (HWB). He explained that the community resilience strategy had been developed and approved by the HWB and he highlighted the key principles that were agreed with the other organisations the Trust was working in partnership with. New to Ifti Majid's report this month was the Listen, Learn and Lead matrix which set out the latest round of team visits by Directors. . This also formed part of the narrative of his report which listed key themes and staff concerns. The matrix also contained an action tracker which would show the outcomes and key actions and areas of responsibilities for delivering the actions. The Board considered this a very useful document and stressed the need for carefully documented feedback on the individual actions so they can easily be understood. The Board also discussed the need to support individuals within the HR team who are currently undertaking a high volume of work. **RESOLVED: The Board of Directors noted the contents of the Acting Chief Executive's report**
DHCFT 2016/057	**GOVERNANCE IMPROVEMENT ACTION PLAN AND DELIVERY FRAMEWORK** This was the first time the Board received had received the full update of the Governance Improvement Action Plan (GIAP) which was presented by Mark Powell. He updated the Board on the significant amount of work carried out in updating the tasks of the GIAP and explained that the purpose of the report was as follows: 1. To provide Board members with an update on progress of all tasks within the GIAP, including the identification of tasks that are off track 2. To receive assurances on delivery and risk mitigation through the updated GIAP, from Board Committees and lead Directors 3. To enable Board members to constructively challenge each other to establish whether sufficient evidence has been provided for completed actions 4. To decide whether tasks and recommendations can be closed and archived. The GIAP governance and delivery framework sets out a robust accountability process that includes lead Directors and Board/Board Committees. The Board noted that the main focus of attention during the last four weeks has been on tasks with a delivery deadline up to, and including the end of May. Due to the timing of meetings in April only the Quality Committee and People and Culture Committee have met to discuss and receive assurance on the tasks they have oversight for on behalf of the Board. It was also noted that the outcome of these meetings was presented in the 'comments on progress' column and in the updated RAG ratings sections in the GIAP. The Remuneration Committee and Audit and Risk Committee met on the day of Board and the following day respectively. Mark Powell described how weekly one to one meetings had been held with each lead

	Director to discuss the tasks/actions and to obtain assurance on task delivery and to agree associated evidence. This process would continue to evolve to ensure it is a meaningful approach and places focus on delivery and supports the foundation for sustainable change. The far right hand column of the GIAP would be used to reflect the rag rating that the Board has assured itself by. The Board was made aware of the challenging debate that took place at the People and Culture Committee as to whether Task HR2 was on track, when it was agreed that the task would be referred to ELT on 3 May for further consideration as the Committee was not assured that the resource plan was adequate. It was agreed that Mark Powell would provide an updated narrative in the GIAP and use the far right column to show the rag rating of the task once HR2 had been reviewed by ELT. The Board agreed that Tasks CG1, 7 and 9 would be identified in a paper to be received at the next meeting of the Board in May to allow the terms of reference to be reviewed by their respective Committees. Caroline Maley wanted to be clear on the process for completion and sign off. She was concerned that CG3 showed a completion and sign off date shown in the GIAP as 27 June and the Audit Committee would not meet until 19 July. It was agreed that Mark Powell would adjust the date for completion in the GIAP. Mark Powell encouraged the Board to feed comments back to him outside of the meeting that would be addressed at ELT and which would allow measures of outcomes to be developed and used as a barometer. The Board accepted the rating of blue (complete) for HR1, PC6, CG12, M2, M4 and M6. The Board confirmed it was satisfied with the level of assurance proposed on the tasks and issues contained within the GIAP. It was agreed that collective assurance from the Board committees would be captured in the GIAP to show robustness of the process which would also allow progress of the tasks to be reviewed by the internal auditors. **ACTION: GIAP will be updated to reflect the dates of Board committees where relevant. The timeline for completion of tasks CG1, 7 and 9 will be included of the next GIAP paper received in May.** **ACTION: Directors to provide Mark Powell with their comments on the GIAP to be addressed at ELT.** **RESOLVED: The Board of Directors:** **1) Reviewed the content of the report and the full GIAP** **2) Discussed the recommendations rated as 'off track' or 'some issues' and sought assurance on the mitigation provided from the Responsible Director, Individual Directors and/or Committee Chairs** **3) Discussed and approved the recommendations put forward as 'complete' for closure.**
DHCFT 2016/058	**<u>MONITOR COMPLIANCE RETURN</u>** Claire Wright presented to the Trust Board the key elements of the Quarter 4 compliance return for approval. The full content of the quarter 4 template had been sent to members of the Audit and Risk Committee for review and was scrutinised in the usual quarterly telephone call between Finance and Performance and Audit and Risk Committee members on 22 April. The Board noted that the reported FSRR for Q4 was an overall rating of 2 in the quarter, which had been driven by the expected deficit in the quarter. The year-to-date FSRR was a rating of 4 which was better than the plan and was as forecast. Claire Wright

pointed out that it was this year-to-date FSRR rating of 4, which the Trust would be monitored on by NHSI.

It was also noted that the content on financial performance in the quarterly return was consistent with the information contained in the Finance section of the Integrated Performance Report.

As the in-quarter FSRR is rated at only 2, additional detailed information was provided in the report to assure the Board of the regulatory impact.

The Board understood the need to be assured that the in-quarter position is not an ongoing trend and that NHSI would ask Claire Wright to confirm that the Trust would maintain the financial stability risk rating of at least 3 over the next 12 months in line with the Board confirmation in the return. It was noted that the quarterly ratings would need to be reviewed throughout the year.

At the request of Richard Gregory, Claire Wright described the detail behind the actual deficit performance in Q4. She also explained the various components of the ratings and their impact in the quarter. The overall year end forecast surplus of £1.8M surplus had been achieved, giving a risk rating of 4 for the year despite the rating of 2 in-quarter. Caroline Maley, Chair of the Audit and Risk Committee confirmed that this was discussed in detail in the quarterly telephone call that took place on 22 April.

The Board was confident that the report made the position very clear which enabled a good level of understanding to approve the recommendations. The 2016/17 forecast would also be discussed and reviewed by the Executive Leadership Team who would be tasked within the GIAP to report on the forecast through the Finance & Performance Committee. Claire Wright also assured the Board that any issues that might develop would be discussed with Caroline Maley and Ifti Majid.

The Board recognised that rapid progress was required to be made on 2016/17 CIP (Cost Improvement Programme). It was agreed that non-delivery of CIP projects would be declared at the Project Assurance Board and project managers would be held to account for their CIPs and this would be reported through the Finance & Performance Committee.

The Board was satisfied to accept Caroline Maley's assurance that appropriate plans were in place to ensure the ongoing compliance with existing targets and there were no matters arising in the quarter requiring an exception report to Monitor.

RESOLVED: The Board of Directors:

1) Discussed the governance statement and agreed that the Interim Chairman and Acting Chief Executive, on behalf of the Board of Directors, were able to sign the governance statement to confirm:

a) For finance, that:

- **The Board anticipates that the Trust will continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months**
- **The Board anticipates that the Trust's capital expenditure for the remainder of the financial year will not materially differ from the amended forecast in this financial return.**

b) For governance, that:
The Board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework;

	and a commitment to comply with all known targets going forwards. **Otherwise:** **The Board confirmed that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework Table 3) which have not already been reported.** **c) Consolidated subsidiaries:** **'Number of subsidiaries included in the finances of this return. This template should not include the results of your NHS charitable funds.'** **There are zero subsidiaries included in the finances of this return and only the finances of Derbyshire Healthcare NHS Foundation Trust are included.** **2) Approved the Q4 return to be appropriately signed and returned to Monitor by noon on 29 April 2016.**
DHCFT 2016/059	**<u>INFORMATION GOVERNANCE UPDATE</u>** In Carolyn Gilby's absence, Samantha Harrison presented this report which provided the Board with a performance update on the Trust's progress towards meeting the requirements of the 2015-16 Version 13 Information Governance Toolkit as well as the work of the Information Governance Committee and Information Governance breach monitoring. The Board was pleased to note the 97% compliance against the Information Governance Toolkit which placed the Trust as the highest scoring Mental Health and Community Trust for the third year running. The Board recognised and commended the work of Audrey Sirrel, Information Governance Manager who had since retired from the Trust. **RESOLVED: The Board of Directors:** **1) Acknowledged the successful completion of the IG Toolkit** **2) Acknowledged the progress made with the IG work plan**
DHCFT 2016/060	**<u>STAFF SURVEY RESULTS AND ACTION PLAN</u>** Jayne Storey presented to the Board the action plan that followed the annual NHS National staff survey results received in February 2016. The Board noted the value of the oversight that was evidenced in the discussion that took place on the Staff Survey Results and Action Plan at People and Culture Committee held on 20 April. The Trust's approach to internal communication, involvement and engagement with staff will be critical to deliver the desired participation and improve overall response rates. Our relationship with staff side to create true partnership will also assist in building relations across the Trust. The People Plan will be cross referenced with the Staff Survey plan and the GIAP. Proactive work will be undertaken to explore the results further in order to see improvement in the score and will be shared with the Engagement Group and escalated to the People and Culture Committee as appropriate. Progress on actions will be included in the People and Culture Committee forward plan. **RESOLVED: The Board of Directors:** **1) Received the staff survey action plan** **2) Agreed monitoring will be carried out through the People and Culture**

	Committee on a quarterly basis
DHCFT 2016/061	**ANNUAL REVIEW OF REGISTER OF INTERESTS** Samantha Harrison presented a report which provided the Trust Board with an account of directors' interests during 2015-16 which would appear in the Annual Report. Directors are responsible for disclosing any changes to the Register of Directors' Interests during the course of the year and the register would be the subject of a standing agenda item for each meeting. **ACTION: Board forward plan to be updated to reflect Review of Register of Directors' Interests as a standing agenda item.** **RESOLVED: The Board of Directors:** **1) Noted the declarations of interest as disclosed and requested that they be checked and recorded in the Register of Interests which is accessible to the public at the Trust Head Office and will be listed in the Trust's annual report and accounts for 2015-16.** **2) Recorded that all directors have signed as to compliance with the NHS Codes of Conduct and Accountability and Nolan principles; no relevant audit matters have been declared.**
DHCFT 2016/062	**CLINICAL AUDIT AND RESEARCH AND DEVELOPMENT DEEP DIVE** John Sykes and Rubina Reza provided the Board with a 'deep dive' report into the current Clinical Audit processes following the Audit and Risk Committee's escalation to the Board of the need for a deep dive into systems and process of clinical audit that the Audit and Risk Committee had a lack of assurance on. The Board noted that the lack of assurance around the effectiveness of the Research and Development Governance Committee had been raised and discussed at the Audit and Risk Committee and Quality Committee. Both these committees had raised concerns about the effectiveness of the Research and Development Governance Committee to supervise clinical audit and in the low attendance at the Research and Development Governance Committee meetings. Caroline Maley, Chair of the Audit and Risk Committee recognised there had been considerable improvement in the speed of completion of audits but there were issues around the capacity of the team to conduct clinical audits. As there have been problems with attendance at the Research and Development Governance Committee meetings, Rubina Reza explained that the committee was looking at proposing a review of clinical audits by email. This process also imposed a secondary reviewer and the committee had recorded and reported a number of audit proposals that have been scrutinised through this process. There are four levels of audit which are categorised and prioritised and the Trust has a higher completion rate than other organisations. Caroline Maley thought a weakness of email authorisation was that email does not have the same impact as verbal challenge in a meeting. Rubina Reza explained that there is robust challenge and this is recorded in the email trail which maintains the thread of comments. This process was tested and has now been adopted as a process and more confidence was felt in the process. The committee still meets but on a bi-monthly basis. The committee's terms of reference will now be amended to show that the Research and Development Governance Committee has adopted this new process. Rubina Reza pointed out that there are six members of the Research and Development Governance Committee. At the last Quality Committee Phil Harris suggested inviting

	someone from the University of Derby to sit on the Research and Development Governance Committee and this was being progressed. Discussions took place around linking clinical audit with the role of the Quality Leadership Teams (QLT) and the quality governance structure so that the QLTs should eventually be able to sign off audits. The Board considered this was the time to work with the QLTs to apply this process so that it becomes embedded. This will be part of the development programme of the QLTs with the Quality Committee acting as overseer. The Quality Committee will propose the process within the development of the QLT terms of reference and Quality Committee will seek this assurance on an ongoing basis. **RESOLVED: The Board of Directors noted the content of the report.**
DHCFT 2016/063	**BOARD COMMITTEE ESCALATIONS** In addition to the minutes of the meetings of the Board committees held since the last meeting, short assurance summaries were received from Committee chairs which supplemented minutes and identified key risks, successes and decisions made. The Board acknowledged that this was the first trial of the assurance summary template since Deloitte recommended reintroducing assurance summaries to supplement the minutes. However, the Board did not believe the summaries were fully effective and agreed that each matter escalated should specifically state why the committee felt the matter should be brought the Board's attention and it was suggested that additional detail be included to prompt explanation of why the Board should be requested to address a particular issue. **ACTION: Additional prompt to be included in the committee assurance summaries to ensure reason for matter being brought to the Board's attention is outlined** **RESOLVED: The Board of Directors noted the escalations and assurance summaries from the Board sub-committees.**
DHCFT 2016/064	**POSITION STATEMENT ON QUALITY** In the absence of Carolyn Green, Clare Grainger provided the Board of Directors with an update on the organisation's continuing work to improve the quality of the services it provides in line with the Trust Strategy, Quality Strategy and Framework and strategic objectives. The Board noted that the position statement set out: • Work being carried out to improve safety in our environments with the introduction of new training developed between the Trust and the police • The Safeguarding Children and Adults strategies for 2016 to 2019 received for information • An update on preparation work for the planned inspection which will take place in June by the Care Quality Commission • The Trust's commissioning for quality and innovation agreements 2016/17 • The Infection Control report will be received by the Board in May in line with Code of Practice requirements. **RESOLVED: The Board of Directors:** **1) Received the quality position statement and noted that the infection control**

	annual report will be presented in May in line with the code of practice requirements. **2) Noted the Safeguarding Children and Safeguarding Adults strategies provided for information.**
DHCFT 2016/065	**<u>INTEGRATED PERFORMANCE AND ACTIVITY REPORT</u>** The report provided the Trust Board with an integrated overview of performance as at the end of March 2016 with regard to workforce, finance and operational delivery. The report also included a first iteration of quality performance indicators which would be further developed through the quality dashboard which will be shown as an illustrative progress of trajectory. It was noted that in response to feedback received from members of the Board at the March meeting, the first steps have been made in starting to draw themes from across the component parts of the integrated report: Team hotspots for high agency usage, vacancy levels and sickness were identified and this information will be used in future reports along with additional triangulated analysis to analyse those teams' operational, financial and quality performance. Decisions are being taken to ensure there is a single Executive lead to draw the processes together with operational plan. Discussion took place on processes for the Board committees to review their ongoing hot spots. It was agreed that in order for the Board committees to be assured that there are plans in place to deliver services within an appropriate period of time, the agenda for each meeting should include an item to review and underpin the Committee's metrics. Richard Gregory did not believe full assurance was obtained with regards to ward safer staffing. In response, Ifti Majid proposed to resolve safer staffing levels with Carolyn Green and Carolyn Gilby with regards to Tansley and Hartington Wards. Mark Powell was not assured there were plans in place that were clear enough to demonstrate the Trust could achieve its set targets and he believed the Board should have sight of these plans. He stressed the need for when there is a red rating on the dashboard the Performance and Contract Operational Group (PCOG) should provide assurance to the Board that there are plans in place to turn the action green. This would assure the Board that PCOG was addressing the values and trends. **ACTION: Ifti Majid to address ward safer staffing levels in Tansley and Hartington Wards with Carolyn Green and Carolyn Gilby** **ACTION: Each Board committee agenda to include an item to review and underpin the Committee's metrics** **RESOLVED: The Board of Directors:** **1) Considered the content of the report and level of assurance received on the current performance across the areas presented.** **2) Discussed the format of the report and discussed any changes it required for subsequent iterations.**
DHCFT 2016/066	**<u>IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK</u>** There were no issues arising for inclusion or updating in the Board Assurance Framework.
DHCFT 2016/067	**<u>BOARD FORWARD PLAN</u>** The forward plan was noted and would be updated in line with today's discussions.

	RESOLVED: The Board of Directors noted the forward plan for 2016/17
DHCFT 2016/068	**<u>BOARD PERFORMANCE AND CONTENT OF MEETING</u>** Richard Gregory recognised that this was the first time the GIAP had been reviewed by the Board and asked that it be moved towards the end of the agenda. It was considered that more work was required to be carried out to develop the Integrated Performance and Activity Report. This item should be placed on the agenda after the Acting CEO report and be followed by the Quality Position Statement and Committee Assurance Summaries. This would ensure the first section of the agenda will cover the current position of the organisation. The Board committee minutes will be shown as an appendix to the assurance summaries. All reports submitted to the Board are to have more specific recommendations so it is made clear what is being asked of the Board. The agenda will be reviewed by Samantha Harrison with the Executive Leadership Team. Any other business and a review of the effectiveness of the meeting would be added as regular additional items, as well as the register of directors' interests.

The next meeting of the Board held in Public Session will take place at 1pm on Wednesday, 25 May 2016.

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

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - MAY 2016		
Date	**Minute Ref**	**Action**	**Lead**	**Status of Action**	**Current Position**	
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. Cover has gone well so far on previous occasions. Waiting times have been holding up well despite industrial action. Risks will be mitigated fairly across all provider units. Total walk out at the end of the month is unprecedented and will be discussed at ELT. Ifti Majid received a petition in support of junior doctors and he is more concerned about how we continue to support our doctors as a Trust and make sure we know the real link between staff morale and patient care. Richard Gregory and Ifti Majid will meet with junior doctors with John Sykes and other members of the Board to look at ways of finding mitigations. 27.4.2016 Around 20% of junior doctors had defied strike action and consultants, specialist doctors and advanced nurses were supplementing services. An incident room had been set up to run between the hours of 8am and 5pm and no incidents had taken place so far	Amber
30.3.2016	DHCFT 2016/039	Acting CEO Report	Sam Harrison	Sam Harrison to devise a process for delegated authority with the governance framework for the STP plan	Awaiting update from CCG on progress of the governance framework with the STP plan. Will be discussed at Chairs and CEO meeting on 5 May and SOD, consitution and SFI can be used to support STP. All organistions are going through the same process and flexibility for decision making will be followed up through ELT.	Amber
30.3.2016	DHCFT 2016/043	Board Assurance Framework Update	Claire Wright Sam Harrison Carolyn Green John Sykes	Delegation of governing risks will be captured in the Board sub-committee forward plans by the executive lead for each committee	Committee forward plans will reflect BAF risks delegated to each committee. High rated risks will be scrutinised by Audit Committee and other risks scrutinised by relevant committees. Committee forward plans will reflect timeline for deep dive of risks they are responsible for.	Amber
30.3.2016	DHCFT 2016/045	Strategy Update	Mark Powell Sue Turner	Approval of the Trust Strategy to be an agenda item for the June Board meeting	On June agenda. ACTION COMPLETE	Green
27.4.2016	DHCFT 2016/056	Acting Chief Executive's Report HR Capacity	Ifti Majid Mark Powell	Ifti Majid and Mark Powell to co-ordinate the support required for the HR Team.	Agreed specific focus for support from differing Directors - line management Jayne Storey, GIAP Mark Powell, CQC Carolyn Gilby ACTION COMPLETE	Green
27.4.2016	DHCFT 2016/057	Governance Improvement Action Plan & Delivery Framework	Mark Powell	GIAP will be updated to reflect the dates of the committees. Tasks CG1, 7 and 9 will be the focus of the next GIAP paper received in May	On agenda for May meeting and addressed in GIAP paper ACTION COMPLETE	Green
27.4.2016	DHCFT 2016/057	Governance Improvement Action Plan & Delivery Framework	All	Directors to provide Mark Powell with their comments on the GIAP to be addressed at ELT	Comments received through various Board and Executive forums, with agreed changes made to the GIAP. ACTION COMPLETE	Green
27.4.2016	DHCFT 2016/061	Annual Review of Register of Interests	Sam Harrison Sue Turner	Board forward plan to be updated to reflect Declaration of Directors' Interests as a standing agenda item	Forward Plan updated. May agenda now includes Declaration of of Directors' Interests ACTION COMPLETE	Green

27.4.2016	DHCFT 2016/063	Board Committee Escalations	Sam Harrison	Additional prompt to be included in the committee assurance summaries to ensure reason for matter being brought to the Board's attention is outlined	Assurance summaries have been revised and now include a column to list concern to escalate to the Board or Board Committee for action. ACTION COMPLETE	Green
27.4.2016	DHCFT 2016/065	Integrated Performance And Activity Report	Carolyn Gilby Carolyn Green	Review ward safer staffing levels in Tansley and Hartington Wards	Review of staffing levels took place 17 May. ACTION COMPLETE	Green
27.4.2016	DHCFT 2016/065	Integrated Performance And Activity Report	Committee Leads	Each Board Committee agenda to include an item to review and underpin the Committee's metrics.	Committee will agree agenda with the Board Secretary prior to each meeting.	Amber

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

Derbyshire Healthcare NHS Foundation Trust
Report to Public Board of Directors 25 May 2016

Acting Chief Executives Report to the Public Board of Directors

Purpose of Report:

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

National Context

1. NHS Improvement has launched a reminder about choice in mental health services following the initial requirement in 2014 for choice of provider and team. NHSI have developed an information leaflet for the public and a document for commissioners. Our Trust needs t review current practice to ensure we continue to comply with and actively promote the choice agenda in mental health.

2. The Local Government Association has published *Charting progress on the health devolution journey: early lessons from Greater Manchester*. This report details the meeting of a group of senior leaders from health and local government who met to discuss the early lessons emerging from Greater Manchester. Given the progression of the Sustainability and Transformation Plan and the submission of our 'short return' reported to the April Board it is essential that we learn from areas implementing new models of care elsewhere. The full report is available by following the link below

   Early Lessons from Greater Manchester

Local Context

3. Derbyshire County Council has published "Derbyshire Joint Strategic Needs Assessment: The State of Health and Social Care in Derbyshire 2015". This report reviews the position of Derbyshire County in regard to the various Outcomes Frameworks available for health and social care and highlights and compares information and data to the East Midlands and England as a whole. The information is key in supporting us as a Trust to better target our resources and plan our service developments as well as being an essential source of benchmarking information. The report can be accessed via the following link

   Derbyshire JSNA

4. Work on the Derbyshire Sustainability and Transformation Plan continues. NHS England have reviewed the plan and gave the following overview comments

   - There appears to be agreement and good understanding of the challenges and the vision and priorities to resolve them. There are good relationships and a history of

system working. This should be a strong foundation on which to build the detailed delivery plan. HEE concern about the absence of workforce reference and the importance this has against each of the three “levers”.

- The delivery plan needs to maintain the focus displayed in the submission. The Southern Derbyshire area has previously struggled with tracking progress of too many small projects, whereas Northern Derbyshire has focussed on a small number of large projects. These two approaches need to be reconciled to determine the best way forward. Lack of consideration/referencing for alignment/national drivers/reviews

- Emphasis on reducing variation would fit with Specialised Commissioning strategy. Particularly in relation to the specialist services listed in emerging priorities schematic.

We are building on these comments and the work streams are now developing clear plans that will be used bridge the identified health and wellbeing, quality and efficiency gaps. The mental health workstream is focussing on building capacity to reduce reliance on beds and developing the requirements in the 5 year forward view for mental health services. The Children’s service workstream includes CAMHS services as well as paediatrics, health visiting and school nursing and is looking to build on some of the successful integration that we have been involved in leading in the city.

5. Learning Disabilities Transforming Care - The Derbyshire County and Derby City Transforming Care Partnership Board has been established and reporting arrangements to Health and Wellbeing Boards, Governing Bodies and Partnership Boards identified and detailed within the plan. The Transforming Care Partnership Board brings together commissioners from local authorities, CCGs and Police to commission integrated approaches to delivering care and support to people with a learning disability in a place they call home. The Board covers all ages and incorporates the previous work undertaken by the Derbyshire Learning Disability Joint Commissioning Board (JCB) and the Derby City Transforming Care Joint Improvement Board.

   The Plan has been developed with stakeholders from across Derbyshire and Derby City. Both Derby City and Derbyshire County have well established Learning Disability Partnership Boards which act as a forum for co-production of local plans and ensure the inclusion of people with a learning disability and carers, providers and local communities.

   The full plan is lengthy but attached as appendix 1 is a plan on a page. For ease I have detailed a number of the key ambitions in the plan below:

   - Work as well as we can, as we would for a loved one / member of our own family with the money we have available.
   - Achieve the “I” statements and overarching principles detailed within the strategy
   - Develop one County/City 14+ at risk of admission to hospital/edge of care register
   - Integrate community pathways that support care closer to home, avoid unnecessary admissions to inpatient beds or high cost institutional care and

support people to remain in their own home.

- Prioritise and support successful discharge of those people remaining in independent sector hospitals
- Improve the process of care and treatment reviews and achievement of the recommendations and outcomes for individuals
- Expand local co-production and engagement with people with lived experience.
- Have in place a system to measure improvements in quality of life
- Address system-wide culture change – skilled and resilience workforce
- Support and nurture families
- Ensure that all children and young people are identified early, and that they, their families/carers are offered support (prevention and coping strategies) to achieve their full potential and prepare for an adult life that will be as independent as possible
- Develop robust infrastructure to enable the 'community' to flex to be there when needed
- Create an all age specialist health and social care model alongside all age integrated commissioning approaches,
- Develop a planned review of short-break options currently provided as established component of support plans
- Develop a menu of options for the provision of short-break support for people with complex health and social care support needs – and pathways in and out of short break facilities.

Within our Trust

6. Mental Health in the faith community – on Tuesday 17 May I was privileged to attend and speak at the Mental Health in the Faith Community, a full day conference arranged to support local faith leaders to understand more about the challenges of mental health, think about their role in recovery and social inclusion and particularly to think about the relationship between our new neighbourhoods and the established faith communities within them. The day was very well attended with great enthusiasm, commitment and a real sense of learning from each other.

7. Listen, Learn, Lead – Visits to our Teams across Derbyshire continue and can be seen in more detail in the ongoing feedback and actions tracker in appendix 2. Some of the key themes emerging from visits this months included:

    - How to make the Paris system most effective and easier to use for clinicians particularly when mobile
    - Neighbourhood accommodation issues, including car parking and over crowding
    - Relationships with hospitals outside of Derbyshire
    - The impact of changes in the mental health act on our older adult wards
    - Level of acuity on older adult wards due to success of rapid response team
    - Some concerns around staffing levels and effectiveness of escalation
    - The need for a clear trauma pathway fully funded

8. Raising of concerns – the increased visibility of myself and other Board members seems to have positively contributed to an increase in the number of people contacting asking to share thoughts, concerns or issues with me. All these calls, visits or meetings

are recorded; follow up actions agreed and passed on to the most appropriate person. Since the beginning of March 12 individuals or groups of individuals have been in contact the most common themes being:

- Speed of internal process in particular grievance, disciplinary and redeployment
- Bureaucracy and ideas for speeding up innovation
- Service development ideas
- Concerns about behaviour and values not being followed by colleagues
- Opportunities for career progression
- Sense of being treated unfairly or differently from others

I have purposely kept these themes very high level to ensure individuals or groups of staff are not able to be identified.

Strategic considerations

- This document is relevant to supporting the Board achieve all of it strategic objectives however the feedback from staff is particularly of note in supporting the Board be connected to service delivery
- The development of new models of care associated with Learning Disability services are key to delivery continuously improving the quality of our services – strategic objective 1

(Board) Assurances

- The Board can take assurance that Trust level of engagement and influence is high in the health and social care community
- The Board should be assured that the level of visibility of Executive Directors is increasing and having positive impacts
- Partial assurance should be derived around closing off actions linked to the listen learn lead matrix

Consultation

None

Governance or Legal Issues

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

Equality Delivery System

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

Recommendations

The Board of Directors is requested to note the contents of the update and agree to receive ongoing updates around the Sustainability and Transformation Plan

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

Joint Plan on a Page 2014-2017 to commission the range of local health, housing and care support services to meet the needs of people with a learning disability of all ages with behaviour that is challenging - based on the principle of an ordinary life for all citizens.

What is Challenging behaviour

- Challenging Behaviour is behaviour "of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion". (Challenging behaviour – a unified approach; RCPsych, BPS, RCSLT, 200
- The term "challenging behaviour" has been used to refer to the "difficult" or "problem" behaviours which may be shown by children or adults with a learning disability including:
  - Aggression (e.g. hitting)
  - Self injury (e.g. head banging)
  - Destruction (e.g. throwing objects)
  - Other behaviours (e.g. running away)
- Challenging behaviour can put the safety of the person or others at risk or have a significant effect on the person's every day life
- Note - this plan links to Countywide Autism Strategy.

How many people do we need to plan and buy housing and support for?

- Behaviour that challenges: is displayed by 10 to 15 per cent of adults who have a learning disability (see Emerson & Einfeld, 2011)
- In Derbyshire there are estimated to be 210 adults with a LD who display significant challenging behaviour.
- In Derby City there are estimated 70 adults with a LD who display significant challenging behaviour
- We will work with Children and Young peoples services including CAMHs to more accurately identify the number of people with behaviour that challenges.
- We will also identify those at risk of developing behaviour that challenges

What we will do

- Sign up across adult and childrens Health and Social Care commissioners to the Challenging Behaviour Charter
- Promote delivery of care/support at home or as close to home and provide more reliable support for families and carers
- Provide high quality person centred appraoches, prevention and early intervention services .
- Promote and prioritise joint investment in positive behaviour training to provide positive behaviour support for all ages
- Offer Personal Budgets and Personal Health Budgets
- Provide joint solutions to individual funding and risk sharing.
- Commissioners will review specialist learning disability health services against the national core service specification toolkit and develop new care pathways to strengthen health and social care responses for adults with a LD.
- Support communities and providers to manage the care of people with complex needs living in their local areas to stay living in their own home, to prevent unnecessary hospital admissions, unnecessary out-of-area packages and to support people to be moving back to their home area

What we will do

- The new pathways / offer will be defined to ensure that any inpatient services commissioned by the CCG's are only utilised after responsive intensive community interventions have been delivered and agreed jointly with Adult social care
- Introduce a Care coordination process for individuals who have complex needs.
- Design individual community appraoches that deliver;
- - a reduction in the prevalence and incidence of behaviour that challenges amongst people of all ages who have learning disabilities and / or autism
- - a reduction in the number of individuals placed in more restrictive settings which are inappropriate for their needs (for example, inpatient hospitals, 52-week school/ college placements or residential care homes), especially those that are out of area.
- - a reduction in the inappropriate use of psychoactive medication, restraint, and seclusion to manage behaviour that challenges
- Prioritise the management of and approaches to behaviour that challenges in quality montioring processes.
- Contunue to work closely with Housing colleagues to ensure access to a variety of accommodation.
- Develop future workforce plans, market management and community capacity building to support care closer to home.

What it will mean for the future

- People with a learning disability or autism and behaviour which challenges will be able to say:
- 1. My home is in the community;
- 2. I am treated with compassion, dignity and respect;
- 3. I am involved in decisions about my care and support;
- 4. I am safe and protected from avoidable harm, but also have my own freedom to take risks;
- 5. I am helped to live with my family or helped to keep in touch with my family and friends;
- 6. Those around me and looking after me are well supported;
- 7. I am supported to make choices in my daily life;
- 8. I get the right treatment and medication for my condition;
- 9. I get good quality general healthcare;
- 10. I am supported to live safely in the community;
- 11. Where I have additional care needs, I get the support I need in the most appropriate setting;
- 12. My care and support is regularly reviewed .

The joint plan will provide greater personalisation and a focus on community support that promotes independence from early childhood and throughout adult life. This will be achieved collaboratively across education, health, social care and housing with involvement of providers, partnership boards, families, carers, and self-advocacy groups.

Challenging Behaviour - National Strategy Group (CB-NSG) Charter Published 2009, Re-published 2013

Rights and Values:

1) People will be supported to exercise their human rights (which are the same as everyone else's) to be healthy, full and valued members of their community with respect for their culture, ethnic origin, religion, age, gender, sexuality and disability.
2) All children who are at risk of presenting behavioural challenges have the right to have their needs identified at an early stage, leading to co-ordinated early intervention and support.
3) All families have the right to be supported to maintain the physical and emotional wellbeing of the family unit.
4) All individuals have the right to receive person centred support and services that are developed on the basis of a detailed understanding of their support needs including their communication needs. This will be individually-tailored, flexible, responsive to changes in individual circumstances and delivered in the most appropriate local situation.
5) People have the right to a healthy life, and be given the appropriate support to achieve this.
6) People have the same rights as everyone else to a family and social life, relationships, housing, education, employment and leisure.
7) People have the right to supports and services that create capable environments. These should be developed on the principles of positive behavioural support and other evidence based approaches. They should also draw from additional specialist input as needed and respond to all the needs of the individual.
8) People have the right not to be hurt or damaged or humiliated in any way by interventions. Support and services must strive to achieve this.
9) People have the right to receive support and care based on good and up to date evidence.

Action to be taken:

1) Children's and adults' services will construct long term collaborative plans across education, social and health services and jointly develop and commission support and services to meet the needs of children and adults with learning disabilities, their families and carers.
2) Local Authorities and the NHS will develop and co-ordinate plans to:

- Reduce the exposure of young children with learning disabilities to environmental conditions that may lead to behavioural challenges.
- Promote the resilience of young children with learning disabilities who face such environmental conditions.
- Provide early intervention, support and services that will meet the individual needs (including communication needs) of young children who are showing early signs of developing behavioural challenges.

3) Active listening to the needs of the family will lead to the provision of appropriate and timely support, information and training.
4) People will be supported to have a good quality of life by individuals with the right values, attitudes, training and experience.
5) The NHS and services will proactively plan to ensure that people receive the same range, quality and standard of healthcare as everyone else, making reasonable adjustments when required. People will have an individualised health action plan and be supported to have access to annual health checks to ensure all health needs are met.
6) People and their family carers will receive support and services that are timely, safe, of good quality, co-ordinated and seamless. They will be proactively involved in the planning, commissioning and monitoring of support and services including both specialist and general services.
7) A person-centred approach that enables and manages the taking of risk will be used to ensure that people have access to family and social life, relationships, housing, education, employment and leisure.
8) Local authorities and the NHS will know how many children and adults live in their area and how many they have placed out of area. On the basis of information from person-centred plans all agencies will plan and deliver local support and services.
9) Services will seek to reduce the use of physical intervention, seclusion, mechanical restraint and the inappropriate or harmful use of medication with the clear aim of eliminating them for each individual.
10) All services and agencies will strive to improve continually, using up to date evidence to provide

Enc D

Listen Learn and Lead Action Tracker

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
03/05/2016	Cubley Court	Ifti Majid	Met with nursing and medical staff. Staffing levels remaining a concern in context of increased acuity due to DRRT keeping less well at home. Concerns that senior managers and clinical leaders are not visible enough on ward area though positive feedback for SLM. Some worries about the sense of 'blame culture', particularly linked to incidents and SIRI investigations. Very hot on unit in summer and staff wondered about summer uniforms. Concerns about the speed of Paris 'go live' and support during the DGO 'live' period, mixed views about approach taken but general feeling some reconfiguration needed to make easily usable for tasks such as admissions. Medical and nursing capacity eroded by changes around DOLS and MHA.	1. Ifti to do visit to London Road site. 2. Investigate possibility of summer uniforms (scrubs) 3. Further support re training on Paris in handovers etc to optimise use. 4. Possibility of formalising staff rotation scheme for those who want it. 5. Can physical healthcare diagnostic interventions, such as ECG, phlebotomy, be done by trained ward staff?	1. Ifti Majid 2. Carolyn Green 3. Carolyn Gilby 4. Jayne Storey 5. Carolyn Green	

Enc D

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
20/04/2016	South Derbyshire Community LD Service	Ifti Majid	Discussed the issues arising out of Aston Hall and the impact this was having within LD staff group. The team spoke about how responsive and visible the middle management and clinical leaders were in the service. Discussion about delays in recruitment and impact. Parking issues in Derby City particularly at St Andrews. Access to admin is a problem as means clinical staff spending time doing admin. Briefly discussed ET media coverage and financial impact. Discussed quality visits and LD service show case and great discussion around finances and opportunities	1. Exec team to consider radical options to support St Andrews staff 2. Consideration to be given to allowing a combined LD quality visit next year in the vein of showcase. 3. Workshop type discussion around financial efficiency opportunities	1. Ifti Majid 2. Carolyn Green 3. Claire Wright	
19/04/2016	Kingsway Campus Managers' Meeting	Carolyn Gilby	PARIS go live on the wards and the issues that had arisen. Other things discussed were the ESR reconfiguration and inaccuracy of IPR recording, the recent challenges on Cubley male and a long discussion regarding the current appraisal process and how it could be improved.	Peter Charlton was able to attend and resolve PARIS issues with the managers and share some benefits from the system which was welcomed.		

Enc D

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
11/04/2016	Cherry Tree Close	Ifti Majid	Staff asked specific questions around the money linked to HM and ST. Felt moment had passed but welcomed opportunity to discuss. Staff felt indignant that Trust isn't defending itself to negative press. Staff feel communication has improved and they feel able to raise concerns. Asked questions about Governor training and induction and plans to improve. Raised issue about the absence policy and how it promoted presenteeism. Concerned about speed of recruitment and if possibility of asking student nurses to sign on our bank within their first few weeks of commencing in training.	1. Inclusion of staff/consultation with staff at CTC to pick up any ideas about developing new absence policy. 2. Look into signing up student nurses in introductory week onto bank	1. Jayne Storey 2. Carolyn Green	Email reply from Ifti Majid with respect to actions and way to take forward.

Enc D

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
08/04/2016	Young Person's Substance Misuse Service	Jayne Storey	Passionate team - open dialogue – welcomed discussion. Angry recent media re: money paid due to senior managers - compared cost impact v junior doctors fighting for pay rise. Perception of leaving with good reference and pay off. AGM – Public face of the Trust, how do we justify the spend on buffet – wrong perception. Transparency of HR procedures – equitable for all – don't see adverts for secondments – just see people seconded into posts. No recognised training / professional qualifications for substance misuse team – just about to have first training in 3 years, no career progression as roles require qualifications not equivalent experience. Have raised with their Line Manager – as part of the training plan, but don't get feedback. Asked the question – How do we retain staff on the basis of the above?	1. Clear communications about this year's AGM and consideration about any hospitality. 2. Need to ensure that clarity is given in JDs around use of equivalent experience as universally acceptable substitute for formal training. 3. More communications around staff packages to support recruitment and retention	1. Sam Harrison (Anna Shaw) 2. Jayne Storey 3. Jayne Storey	

Enc D

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
04/04/2016	Occupational Therapy Team, Radbourne Unit	Ifti Majid	Very brief reference made to embarrassment around ET but staff specifically wanted to focus on Melbourne House and the security of their roles. Discussed the process with commissioners that was in place and expectations around letter of clarification that was expected. Talked about the confusion about letter sent in November that could be read as promising them a job on the Hub. Discussed significant improvements in care due to increased staff numbers in Unit.	1. Alert staff on Hub as soon as letter received from commissioners. 2. Independent review of letter sent in November		
04/04/2016	Chesterfield CMHT and North East CMHT Older Adult Team, Hartington Unit	Ifti Majid	Staff explained that the media coverage, and therefore the amount of discussion within staff groups less in North. Questions around financial affordability of the total cost of the ET and also staff wanted an understanding of why ST had left rather than process completed. Staff wanted to talk about the Neighbourhoods and the impact this was having on their ability to safely work with patients particularly around CAS/triage. Requesting support to pull CAS back to Hartington Unit due to economies fo scale.	1. Ensure agreement to recentralise CAS given on temporary basis	1. Ifti Majid	1. Action completed by Julia Lowes in email sent 4/4/16. Email sent by IM after a couple of weeks to understand current position

Enc D

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
30/03/2016	Workforce & Organisational Development Team	Carolyn Green	Detailed discussion around the outcome of the investigations, the way they had been handled and the method of communications or lack of with the team. Discussed historical culture in the team and previous leadership under past HR Director. Need to consider how the team is supported going forward to cope with past issues as well as moving forward. Team keen to move towards a consultancy, assurance function rather than at current where high expectation on delivery due to lack of management training.	1. Jayne Storey to attend regular team meetings 2. Short term support to discuss CQC visit expectations	1. Jayne Storey 2.Carolyn Green	Carolyn Green has emailed the team to thank them for the visit and propose the agreed actions

Enc D

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
23/03/2016	Learning Disability Team & Occupational Therapy Team	Ifti Majid	Team keen to hear summary of events and details around the outcome of the investigations. Team had specifically looked at well led review outcome from CQC to see what they needed to change as a result. Discussed perception around financial impact to the Trust due to the amount of money as well as reputational impact. Team would be supportive of more assertive response in the media. Discussed the issues the team had with accessing timely HR support. Team wondered about ability to access 360 appraisal process. Discussed the teams disappointment that the showcase had not been attended by commissioners.	1. Regular Director visits to the team meeting 2. Information about 360 degree appraisal system to be sent to the team	1. Ifti Majid 2. Jayne Storey	IM sent email to Team Leader following visit.

Enc D

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
21/03/2016	South Derbyshire Mental Health Team for Older People, Dale Bank View, Swadlincote	Carolyn Green	The team found it helpful to talk about the ET and their experiences when having issues raised by the community. It was a very difficult period and should a major event happen again, more directive advice would be appreciated. It was raised that although the ET aspect was important, and important to discuss. Key issues to the team were the neighbourhood model, release of vacancies to recruit to and the impact on team capacity, access to an all age crisis response service, exploring inter tem related challenges. Having capacity to meet demand and having access to more psychology or psychological therapy time to meet the needs of individuals in their care.	To feedback to the executive team on this visit, to consider the impact on capacity and demand in contracts negotiation and going forward. For the executive to consider feedback on solutions to issues raised	Carolyn Green	20-Apr-16
17/03/2016	Information Management Technology & Records	Ifti Majid	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.	1. Need to receive clarity about the recent changes in operational management	1. Carolyn Gilby	

Enc D

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
16/03/2016	Amber Valley CTLD, Rivermead	Carolyn Gilby	Team had questions about the recent press coverage and the amounts of money that had been lost to the organisation. There was concern regarding reputation and embarrassment regarding this. There was an expectation of better behaviour from Directors and disappointment as they set the tone for the organisation. In terms of moving forward they wanted to be forward focused and wanted the current acting CEO to be the new CEO as he was being open, honest and communicating well with the organisation.	1. The openness and good communication from the CEO to continue	1.Ifti Majid	
15/03/2016	IAPT Team, Ilkeston	Ifti Majid	New contract issues, capacity, covering whole of county and differences north/south. Multiple assessments and patient experience due to bouncing from service to service. Team interested in engaging in more detail with Directors around some of unique problems team face.	1. Specific Director visit to be arranged to team meeting	1.Ifti Majid	Meeting arranged

Enc D

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
15/03/2016	Estates Team	Claire Wright	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.	1. Further visit needs arranging to finish off discussion	1.Claire Wright	Date arranged
11/03/2016	Neurodevelopment Team	Mark Powell	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	No specific actions arising	N/A	Email sent to Team thanking them for visit

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
			each and every day.			
29/02/2016	Campus Care North, Hartington Campus	John Sykes	John Sykes visited the new neighbourhood teams in Chesterfield and spoke to service managers. Also visited wards at the Hartington Unit and spoke to ward nurses and individual CPNs. Carried out a separate meeting with general managers and met with individual consultants. Good overall support of the Board and the process we are following regarding the GIAP. Staff often asked how we were coping with the stresses given the level of external scrutiny and challenge from others. They also thought the Board needed to learn the lessons from what has happened and articulate these. "How are things going to be different?" There is considerable angst about the money that has been spent on this issue and the remedial processes. Generally there is no desire to prolong the process and spend any more money.		John Sykes	

Enc D

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
26/02/2016	Southern Derbyshire Crisis and Home Treatment Team	Mark Powell	1. The team would like to change their name from Crisis and Home Treatment to something akin to Assessment and Home Treatment. 2. 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. 3. 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 Trust's reputation. 4. The team wanted senior management to be aware of the ill feeling that some patients are expressing to them as employees of the Trust and that at times they are taking the brunt of this public ill feeling when they shouldn't be. 5. An issue was raised regarding a line in the Deloitte report regarding leadership being an issue in the team. 6. 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. I explained that the Trust was talking to commissioners about	1. Mark Powell to see whether a name change was possible. 2. Guidance to be sent to deal with ET questions (actioned 29/02/2016). 4. Senior management to be made aware of the ill feeling from patients to staff due to the public perception following media attention. 5. Mark to talk to Michelle about a line in the Deloitte report with regard to leadership being an issue - to understand context. 6. Carolyn Gilby to talk to commissioners with regard to the development of a community PD service. 7. Issue to be resolved re: staff from Melbourne House deployed to the Hub. 8. Short summary re: block contract payment to be sent (actioned 29/02/2016). 9. Current status of neighbourhoods to be sent.	1, 4, 5 & 6 - Mark Powell 7 & 9 - Carolyn Gilby	Actions and summary sent to Team 29/02/2016. 1. Further discussions required with commissioners 4. ELT made aware of this through Listen, learn, lead process 5. Action not complete 6. Proposal presented to Commissioners, but commissioners unwilling due to financial constraints to commission for 16/17 Mark Powell arranging a further follow up meeting with the team

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
			the development of a community PD service and that the service specification for this could be shared if required. 7. An issue was raised about staff from Melbourne House and then deployment to the Hub. 8. A question was asked about block contract payment and I explained about the 2 new proposed payment methods form 2017. 9. A question was asked about the current status of neighbourhoods as the team were unclear on this. 10. I asked if it was possible to come back to another meeting in 2 months' time and I think that the team were agreeable to this.			
23/02/2016	North Derbyshire Drug Service	Ifti Majid	Some discussion on negative publicity linked to ET and impact of cost on services however main areas of discussion from the Team lined to the upcoming tender, the lack of capacity in services and some of the good practice associated with court work and primary care liaison. Senior management visibility was commented upon - not Directors but upper middle management. Some concerns around the need to ensure managers from other	Are disciplinary and other processes being followed properly now?	N/A	

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
			sectors trained if going to manage our staff in partnership.			
23/02/2016	Bolsover Recovery Team	Ifti Majid	Significant discussion around reputation and financial cost of ET. Impact on social media and staff embarrassment. Trust culture of starting things but not finishing eg releasing time to care. Concern about the impact of neighbourhoods, will it give benefits expected. Some posts have been held too long linked to neighbourhoods. Problems with getting staff onto bank, even staff who just finished at Trust need to jump through hoops eg numeracy tests. Communication improved of late and staff do feel Directors keen to engage. Discussed and showed me the environmental problems in patient areas e.g. waiting room.	They have met with chairman, Richard Gregory, on these matters.	1.Ifti Majid 2.Ifti Majid	Feedback to Team within two weeks and to Board - extract from Board paper.....'*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'.*
16/02/2016	Radbourne Unit	Mark Powell	Spoke specifically with a couple of people, key messages from them was about focussing on patients and delivering services and need to move forward rather than focus on past.	No specific Actions	N/A	

Enc D

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team
15/02/2016	Radbourne Unit Acute Wards and Perinatal Service	Carolyn Gilby	Unit very busy, acuity on the unit, senior staff feeling regarding ET and 'pay out' in particular embarrassment and anger.	No specific Actions	N/A	

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 25th May 2016

Integrated Performance Report Month 1

Purpose of Report

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

Recommendations

The Board of Directors is requested to:

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

Executive Summary

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

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

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

The report continues to be in development and this month the workforce section includes a key to the KPI metrics. The other sections will include a key to their metrics in the next report.

Strategic considerations

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

Board Assurances

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

Consultation

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

Governance or Legal issues

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

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

Equality Delivery System

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

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

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

Challenges
- CIP forecast to under deliver and assurance required on forecast delivery
- Mitigations of Financial risks during 16/17.

Highlights
- Fully compliant with all NHSI targets
- New target Early Interventions in Psychosis added this month.

Challenges
- PbR clustering
- Outpatient Cancelations continue to be high due in part to industrial action, staff sickness and vacancies

Highlights
- Recruited to vacancies however delayed starts due to finishing qualification.
- Improving trajectories for appraisals despite small dip
- Above national benchmark for ratio of qualified nurses.

Challenges
- Commissioner Investment in services which now require recruitment services
- Agency spend adherence to the NHSI target has been breached

This is a report section in phased development, in line with FSR roll out.

Highlights
- Think Family / Safety planning on target to deliver. Training compliance improved in these areas.

Challenges
- Increased risks relating to financial position, lack of commissioned services and waiting times
- Flu vaccinations – CQUIN requirement this year with target of 45%

Enc E

FINANCIAL OVERVIEW – APRIL 2016

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Key Points
Governance	FSRR	Overall Financial Sustainability Risk rating	In mth/YTD	3	4	G	In April the FSRR is 4 which is better than plan and is forecast to be a 4 at the end of the year. Each of the quarters are also forecast to be a 4.
			Forecast	4	4	G	
		Debt Service Cover	In mth/YTD	2	3	G	
			Forecast	3	3	G	
		Liquidity	In mth/YTD	3	4	G	
			Forecast	4	4	G	
		Income and Expenditure Margin	In mth/YTD	2	4	G	
			Forecast	4	4	G	
		Income and Expenditure Margin Variance	In mth/YTD	4	4	G	
			Forecast	4	4	G	
I&E and profitability	Income and Expenditure	Underlying Income and Expenditure position £'000	In mth/YTD	-13	227	G 240	Surplus is better than plan in the month and due to changes in the run rate is forecast to achieve plan at the end of the financial year. The Normalised Income and Expenditure shows the financial performance adjusting for any non-recurrent costs or benefits that will not continue.
			Forecast	1,701	1,701	G 0	
		Normalised Income and Expenditure position £'000	In mth/YTD	-13	161	G 174	
			Forecast	1,700	1,985	G 285	
	Profitability	Profitability - EBITDA £'000	In mth/YTD	626	887	G 260	
			Forecast	8,944	8,944	G 0	
		Profitability - EBITDA %	In mth/YTD	5.5%	8.1%	G 2.6%	
			Forecast	6.5%	6.8%	G 0.2%	
Liquidity	Cash	Cash £m	In mth/YTD	10.229	12.397	G 2.168	Cash is currently above plan but is forecast to be below plan at year end due to the forecast release of some provisions.
			Forecast	12.323	11.525	R -0.798	
	Net Current Assets	Net Current Assets £m	In mth/YTD	3.122	5.580	G 2.458	
			Forecast	6.740	8.240	G 1.500	
	Capex	Capital expenditure £m	In mth/YTD	0.144	0.137	A -0.007	
			Forecast	3.450	3.450	G 0.000	
Efficiency	CIP	CIP achievement £m	In mth/YTD	0.358	0.142	R -0.216	CIP is currently behind plan and currently is forecast to underachieve by £1m.
			Forecast	4.300	3.364	R -0.936	
			Recurrent	4.300	3.243	R -1.057	

* Trend indicators will be reintroduced from month 2

OPERATIONAL OVERVIEW – APRIL 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%	97.65%	G	↑	Fully compliant with monitor targets. New target Early Interventions in Psychosis added this month.
			Quarter	95.00%	97.64%	G	↑	
		CPA Reviews in Last 12 months	Month	95.00%	95.76%	G	→	
			Quarter	95.00%	95.76%	G	→	
		Delayed Transfers of Care	Month	7.50%	2.38%	G	→	
			Quarter	7.50%	2.45%	G	→	
		Data completeness - Identifiers	Month	97.00%	99.43%	G	→	
			Quarter	97.00%	99.43%	G	→	
		Data completeness - Outcomes	Month	50.00%	94.34%	G	→	
			Quarter	50.00%	94.34%	G	→	
		Community Care Data Activity - Completeness	Month	50.00%	93.57%	G	→	
			Quarter	50.00%	93.67%	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%	75.80%	G	↓	
			Quarter	50.00%	75.52%	G	↓	
		18 Week RTT incomplete	Month	92.00%	95.79%	G	↓	
			Quarter	92.00%	95.43%	G	↓	
		Early Interventions New Caseload	Month	95.00%	172.70%	G	↑	
			Quarter	95.00%	172.70%	G	↑	
		Clostridium Difficile Incidents	Month	7	0	G	→	
			Quarter	7	0	G	→	
		Crisis Gatekeeping	Month	95.00%	98.88%	G	↓	
			Quarter	95.00%	99.27%	G	→	
		IAPT RTT within 18 weeks	Month	95.00%	99.80%	G	→	
			Quarter	95.00%	99.61%	G	→	
		IAPT RTT within 6 weeks	Month	75.00%	90.22%	G	↓	
			Quarter	75.00%	89.29%	G	↓	
		Early Intervention in Psychosis RTT Within 14 Days	Month	50.00%	90.91%	G		
			Quarter	50.00%	91.67%	G		

OPERATIONAL OVERVIEW – APRIL 2016

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Locally Agreed	CPA Settled Accommodation	Month	90.00%	97.52%	G	→	
			Quarter	90.00%	97.52%	G	→	
		CPA Employment Status	Month	90.00%	98.08%	G	→	
			Quarter	90.00%	98.08%	G	→	
		Data completeness - Identifiers	Month	99.00%	99.43%	G	→	
			Quarter	99.00%	99.43%	G	→	
		Data completeness - Outcomes	Month	90.00%	94.34%	G	→	
			Quarter	90.00%	94.34%	G	→	
		Patients Clustered not Breaching Today	Month	80.00%	79.23%	R	→	The PbR Advisor is working with teams offering training, support and advice.
			Quarter	80.00%	80.11%	G	→	
		Patients Clustered regardless of review dates	Month	96.00%	95.00%	R	→	
			Quarter	96.00%	95.01%	R	→	
		7 Day Follow-up - all inpatients	Month	95.00%	95.83%	G	→	
			Quarter	95.00%	96.58%	G	→	
		Ethnicity coding	Month	90.00%	90.78%	G	↓	
			Quarter	90.00%	90.78%	G	↓	
		NHS Number	Month	99.00%	99.96%	G	→	
			Quarter	99.00%	99.97%	G	→	
	Schedule 4	Consultant Outpatient Trust Cancellations	Month	5.00%	8.81%	R	↓	The main reasons given for cancellation were industrial action, difficulty getting locum cover for vacant posts and consultant sickness. An action plan for letters is being implemented. It has been agreed by commissioners that the 15 day target for letters will be reduced to 95%. This is currently being actioned via a contract variation and will be reflected in next months board report.
			Quarter	5.00%	7.95%	R	↓	
		Consultant Outpatient DNAs	Month	15.00%	14.78%	G	↓	
			Quarter	15.00%	14.83%	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%	92.60%	G	↑	
			Quarter	90.00%	93.96%	G	↑	
		Outpatient letters sent in 15 working days	Month	100.00%	97.33%	R	↑	
			Quarter	100.00%	97.82%	R	↑	
		Inpatient 28 day readmissions	Month	10.00%	7.46%	G	↑	
			Quarter	10.00%	5.26%	G	↑	
		MRSA - Blood stream infection	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Mixed Sex accommodation breaches	Month	0	0	G	→	
			Quarter	0	0	G	→	
		18 weeks RTT greater than 52 weeks	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Discharge Fax sent in 2 working days	Month	98.00%	99.06%	G	→	
			Quarter	98.00%	99.40%	G	→	

OPERATIONAL OVERVIEW – APRIL 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%	95.79%	G	↓	
			Quarter	92.00%	95.79%	G	↓	
		Mixed Sex accommodation breaches	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Completion of IAPT Data Outcomes	Month	90.00%	96.61%	G	→	
			Quarter	90.00%	96.61%	G	↑	
		Ethnicity coding	Month	90.00%	90.81%	G	→	
			Quarter	90.00%	90.81%	G	↓	
		NHS Number	Month	99.00%	100.00%	G	→	
			Quarter	99.00%	100.00%	G	→	
Other Dashboards	Health Visiting	% 10-14 Day Breastfeeding coverage	Month	95.00%	99.20%	G	→	
			Quarter	95.00%	99.20%	G	→	
		% 6-8 Week Breastfeeding coverage	Month	95.00%	98.60%	G	→	
			Quarter	95.00%	98.60%	G	→	
		% Still Breastfeeding at 6-8 Weeks	Month	65.00%	73.00%	G	→	
			Quarter	65.00%	73.00%	G	→	
	IAPT	Recovery Rates	Month	50.00%	54.20%	G	↑	
			Quarter	50.00%	54.20%	G	→	
		Partial and Full Recovery Rates	Month	65.00%	73.23%	G	↓	
			Quarter	65.00%	73.23%	G	→	
	Safer Staffing	Inpatient Safer Staffing Fill Rates	Month	90.00%	100.96%	G	→	Detailed ward level information
			Quarter	90.00%	100.96%	G	→	shows specific variances

WORKFORCE OVERVIEW – APRIL 2016

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance		Trend	Key Points
Workforce Dashboard	Monitor Key Performance Indicator (KPI)	**Turnover** (annual)	**Apr-16**	10%	**10.42%**	↘	G	↑	Annual turnover remains within the Trust target parameters and is below the regional Mental Health & Learning Disability average of 12.67% (as at February 2016 latest available data). Monthly sickness absence has decreased this month and is 0.85% lower than the same period last year, however the annual sickness absence rate continues to increase, running at an annual rate of 5.58% as at April 2016. The regional average annual sickness absence rate for Mental Health & Learning Disability Trusts is 5.03% (as at January 2016 latest available data). The budgeted vacancy rate this month is 17.30% compared to an average of 15.25% last year. Employees who have received an appraisal within the last 12 months has decreased slightly and historic Medical appraisals have now been included. Compulsory training compliance remains static and is above the 85% main contract non CQUIN.
			Mar-16		10.45%		G		
		Sickness Absence (monthly)	**Apr-16**	3.9%	**4.81%**	↘	R	↑	
			Mar-16		5.67%		R		
		Vacancies (budgeted full time equivalent)	**Apr-16**	10%	**17.30%**	↗	A	↑	
			Mar-16		16.24%		A		
		Appraisals (all staff - number of employees who have received an appraisal in the previous 12 months)	**Apr-16**	90%	**68.12%**	↘	R	↑	
			Mar-16		69.12%		R		
		Appraisals (medical staff only - number of employees who have received an appraisal in the previous 12 months)	**Apr-16**	90%	**69.37%**	↘	R	↓	
			Mar-16		71.05%		R		
		Qualified Nurses (to total nurses, midwives, health visitors and healthcare assistants)	**Apr-16**	65%	**66.89%**	↗	G	↑	
			Mar-16		66.41%		G		
	Other KPI	**Compulsory Training** (staff in-date)	**Apr-16**	95%	**88.58%**	↘	A	↑	
			Mar-16		88.59%		A		

Key:

Period Current month and previous month

Plan Trust target

↗ Variance to previous month

Achieving target/within target parameters

Approaching target/approaching target parameters

Not achieving target/outside target parameters

Trend based on previous 4 months

Turnover parameters (8% to 12%)

Vacancy parameters (10% to 20%)

QUALITY OVERVIEW – APRIL 2016

Enc E

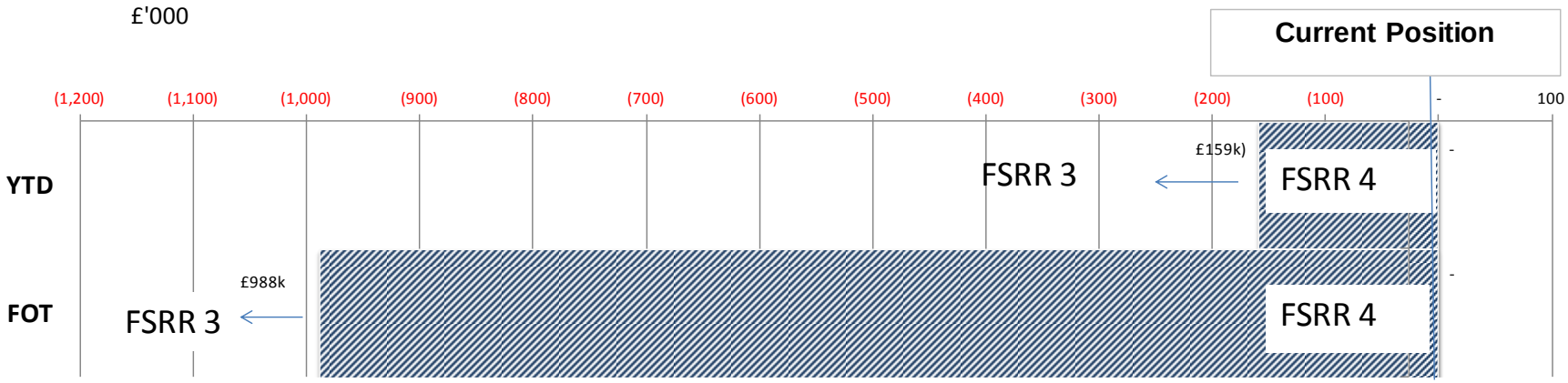
Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Quality	Quality Strategy	Percentage of current Inpatients with a recorded Capacity Assessment	Month	100.00%	16.31%	R	↑	Awaiting FSR roll out (data from PARIS)
			Quarter	100.00%	16.31%	R	↑	
		Percentage of all patients with a care plan in place which has been reviewed with 12 months	Month	90.00%	N/A	R		
			Quarter	90.00%	N/A	R		Awaiting FSR roll out
		Seclusion incidents	Month	20	18	G	↓	
			Quarter	60	37	G	↑	Restrictive practice reduction strategy, monitoring in place. 12 month average as a baseline.
		Physical Restraint incidents	Month	55	31	G	↓	
			Quarter	165	95	G	↑	
	CQUINs or contractual levy	Flu Jab Up-take	Month	45.00%	N/A	R		Flu remains unchanged. Think Family training increased by 27%, Safety Planning increased by 8%.
			Quarter	45.00%	N/A	R		
		Think Family Training	Month	90.00%	67.26%	R	↑	
			Quarter	90.00%	N/A	R	→	
		The safety plan training	Month	90.00%	49.97%	R	↑	
			Quarter	90.00%	N/A	R	→	
		The number of LD or Autism admissions without a CTR before admission	Month	0	4	R	→	
			Quarter	0	10	R	→	

taken average over previous 12 months to collect the baseline plan for seclusion and restraint

Financial Section

The FSRR in April is a 4 which is better than plan. The forecast is a rating of 4 as per the plan.

The headroom down to a FSRR of 3 in the month and forecast is £159k and £988k respectively. The headroom is shown in the graph below:



The FSRR for each of the quarters is shown in the table below:

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

Income and Expenditure and Profitability

STATEMENT OF COMPREHENSIVE INCOME — APR 2016

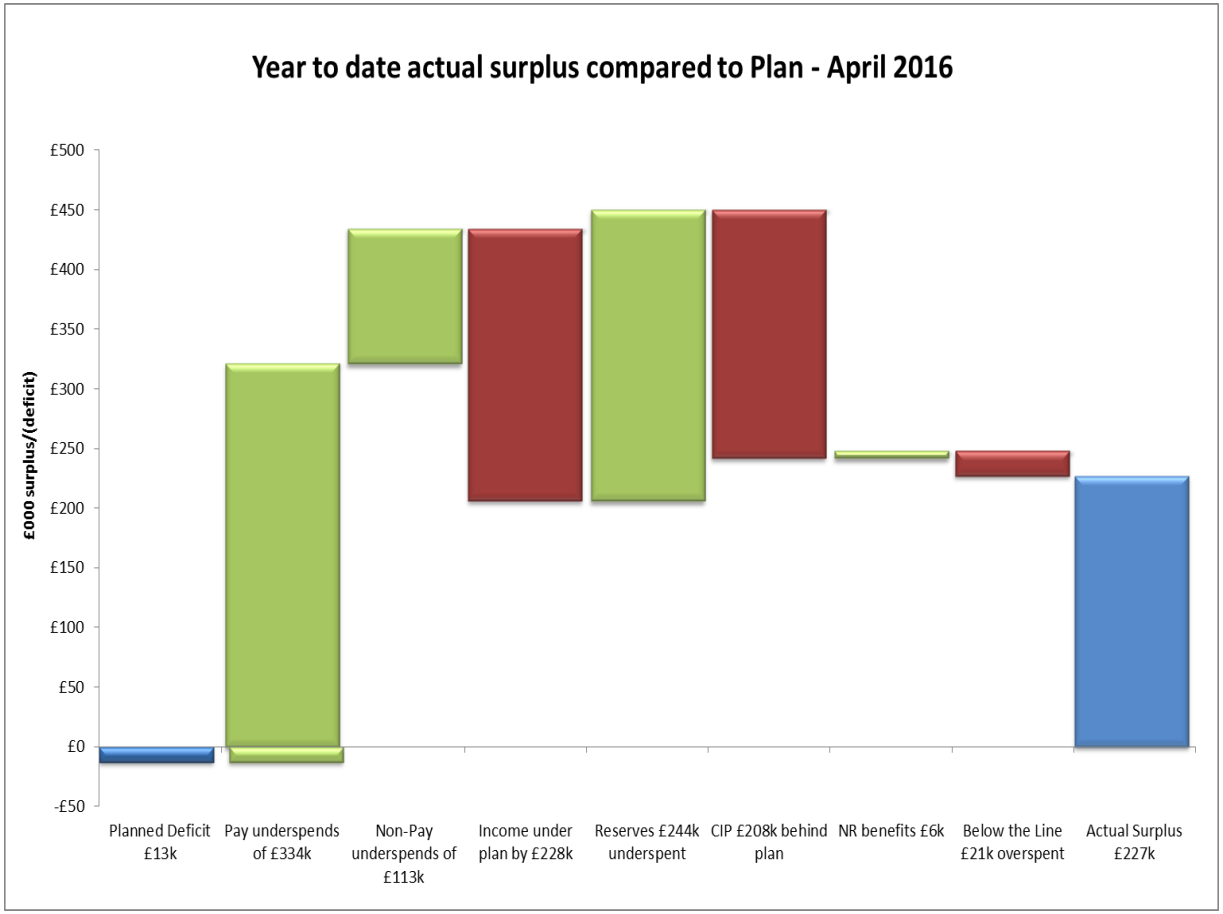
	Current Month			Year to Date			Forecast		
	Plan	Actual	Variance Fav (+) / Adv (-)	Plan	Actual	Variance Fav (+) / Adv (-)	Plan	Actual	Variance Fav (+) / Adv (-)
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical Income	10,473	10,217	(256)	10,473	10,217	(256)	126,576	122,867	(3,709)
Non Clinical Income	849	738	(112)	849	738	(112)	10,190	9,240	(950)
Pay	(8,478)	(7,946)	533	(8,478)	(7,946)	533	(101,492)	(96,796)	4,697
Non Pay	(2,217)	(2,122)	95	(2,217)	(2,122)	95	(26,330)	(26,368)	(38)
EBITDA	**626**	**887**	**260**	**626**	**887**	**260**	**8,944**	**8,944**	**0**
Depreciation	(295)	(313)	(18)	(295)	(313)	(18)	(3,534)	(3,533)	1
Impairment	0	0	0	0	0	0	(300)	(300)	0
Profit (loss) on asset disposals	0	0	0	0	0	0	0	0	0
Interest/Financing	(211)	(207)	5	(211)	(207)	5	(2,109)	(2,103)	5
Dividend	(133)	(140)	(7)	(133)	(140)	(7)	(1,600)	(1,607)	(7)
Net Surplus / (Deficit)	**(13)**	**227**	**240**	**(13)**	**227**	**240**	**1,401**	**1,401**	**0**
Technical adj - Impairment	0	0	0	0	0	0	(300)	(300)	0
UnderlyingSurplus / (Deficit)	**(13)**	**227**	**240**	**(13)**	**227**	**240**	**1,701**	**1,701**	**0**

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

Clinical Income is £256k less than plan in month and is forecast to be £3.7m worse by the end of the year of which a significant proportion is due to differences in planning assumptions. There is however forecast underperformances on activity related income.

Non Clinical income is less than plan in the month by £112k with a forecast outturn of £950k behind plan. £0.4m relates to a miscellaneous income target with no income forecast against it.

Pay expenditure is £533k less than the plan in the month and the year end position is £4.7m more favourable than plan which is due planning assumptions but also vacancies and recruitment.



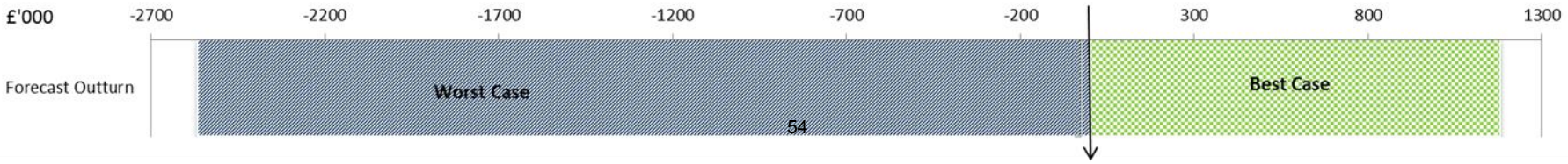
Summary of key points Enc E

Overall favourable variance to plan in the month of £240k which is driven by the following:

- Pay budget is significantly underspent which is mainly driven by vacancies across the Trust. Some of which is related to new service developments that are in the process of being recruited to. These also have associated non-pay underspends.
- Reserves are underspent in month as expenditure is now forecast to start form next month and spans across the financial year, so is in a different phasing to the original plan.
- This is helping to offset the CIP which is behind plan in the month.
- The forecast includes a set of assumptions based on knowledge and expectations at this point in time. At this early stage in the financial year there is a large performance range from worst-case to best-case outturn which is primarily dependant on the successful mitigation of emerging risks.

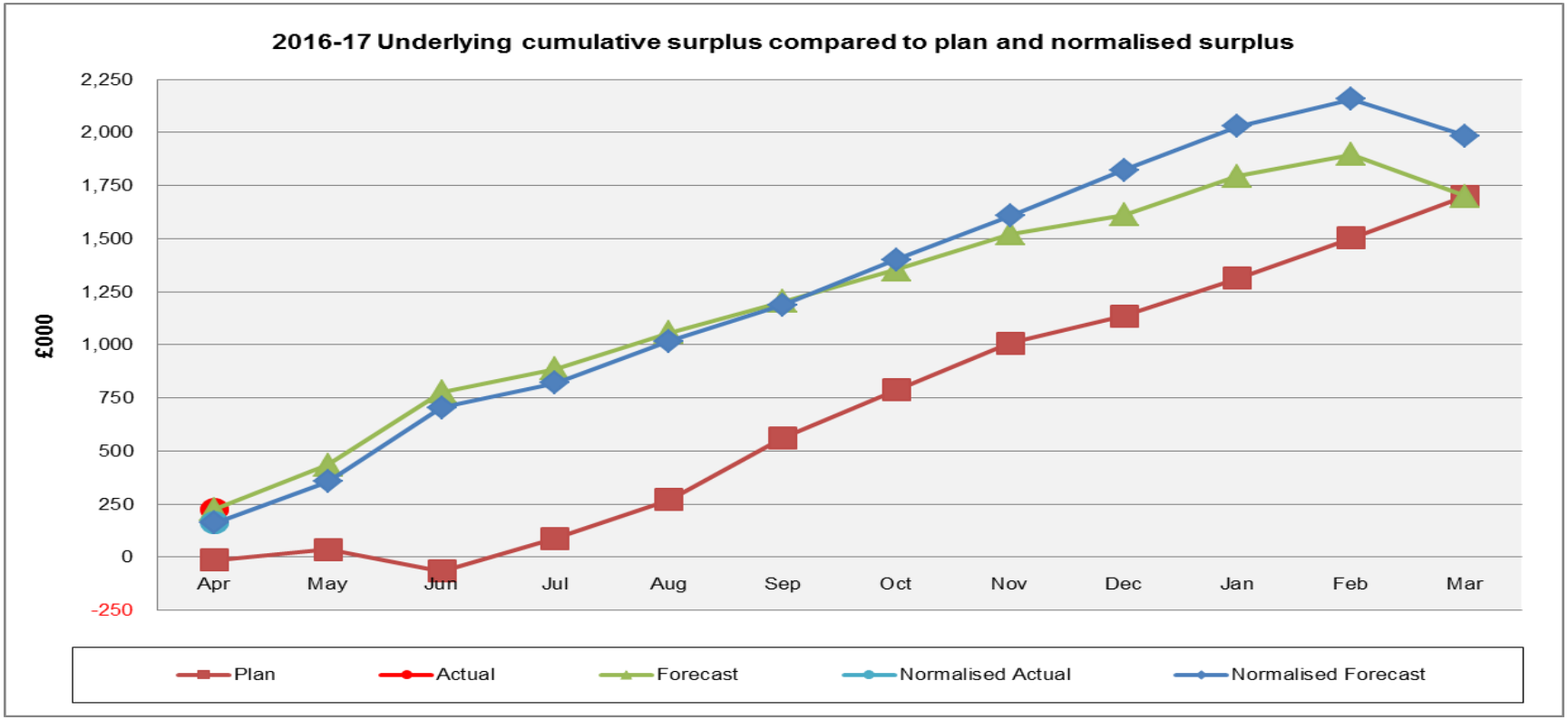
Forecast Range

Best Case	Likely Case	Worst Case
£1.2m Fav	Achieve plan	£2.6m Adv



Enc E

Normalised Income and Expenditure position

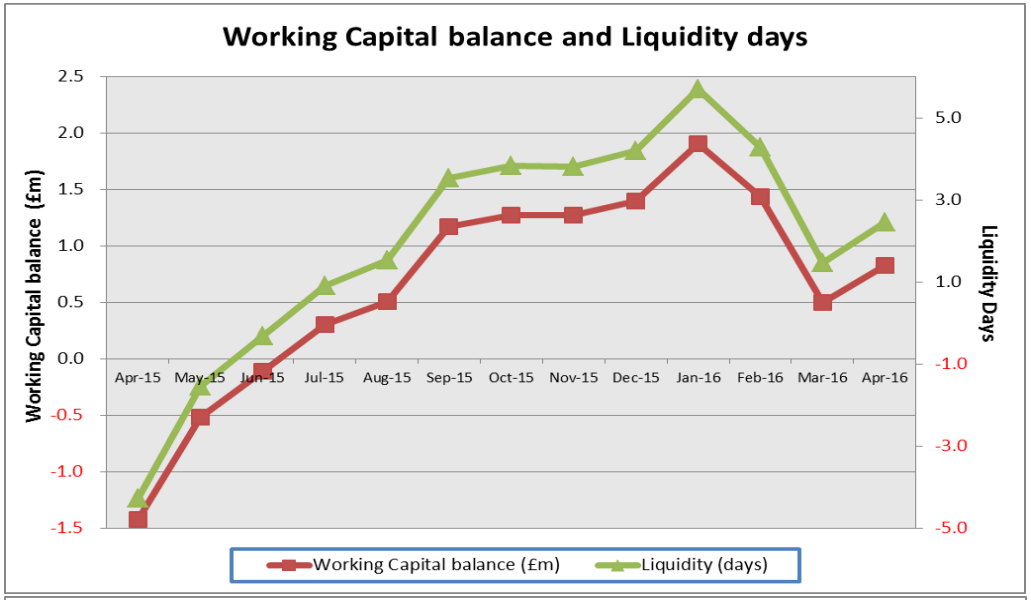


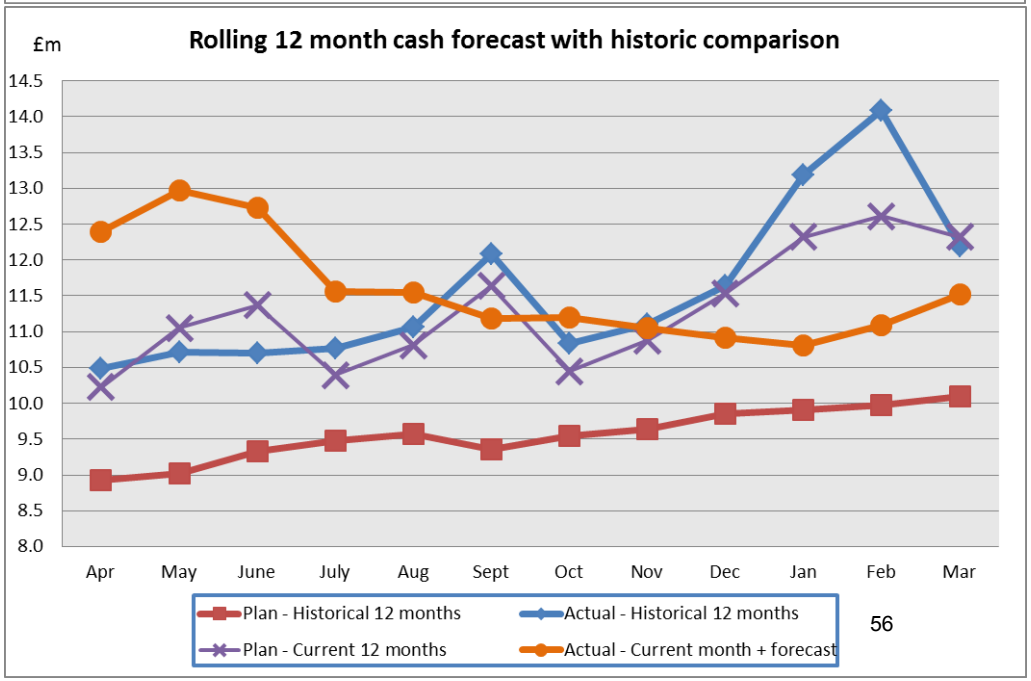
The normalised financial position is referring to the position removing any one off non-recurrent items of cost or income that is not part of the business as usual.

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

Liquidity

Enc E



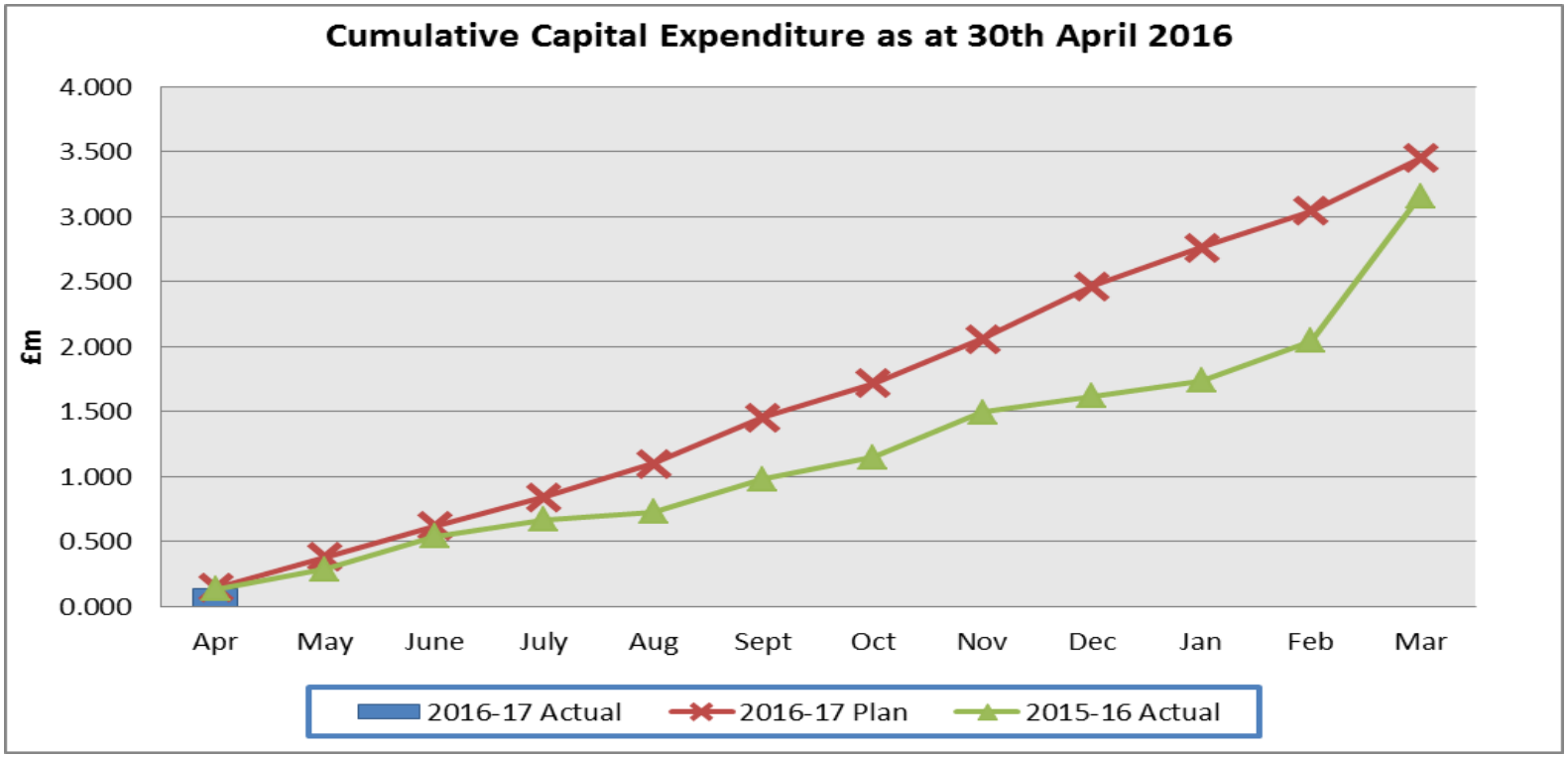


The first graph shows the working capital balance (net current assets less net current liabilities adjusted for assets held for sale and inventories) and how many days of operating expenses that balance provides.

During last financial year working capital continued to improve due to improved cash levels. The downward trend at the end of last financial year is reflective of the reduction in cash due to year end transactions. April is showing a further improvement.

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.

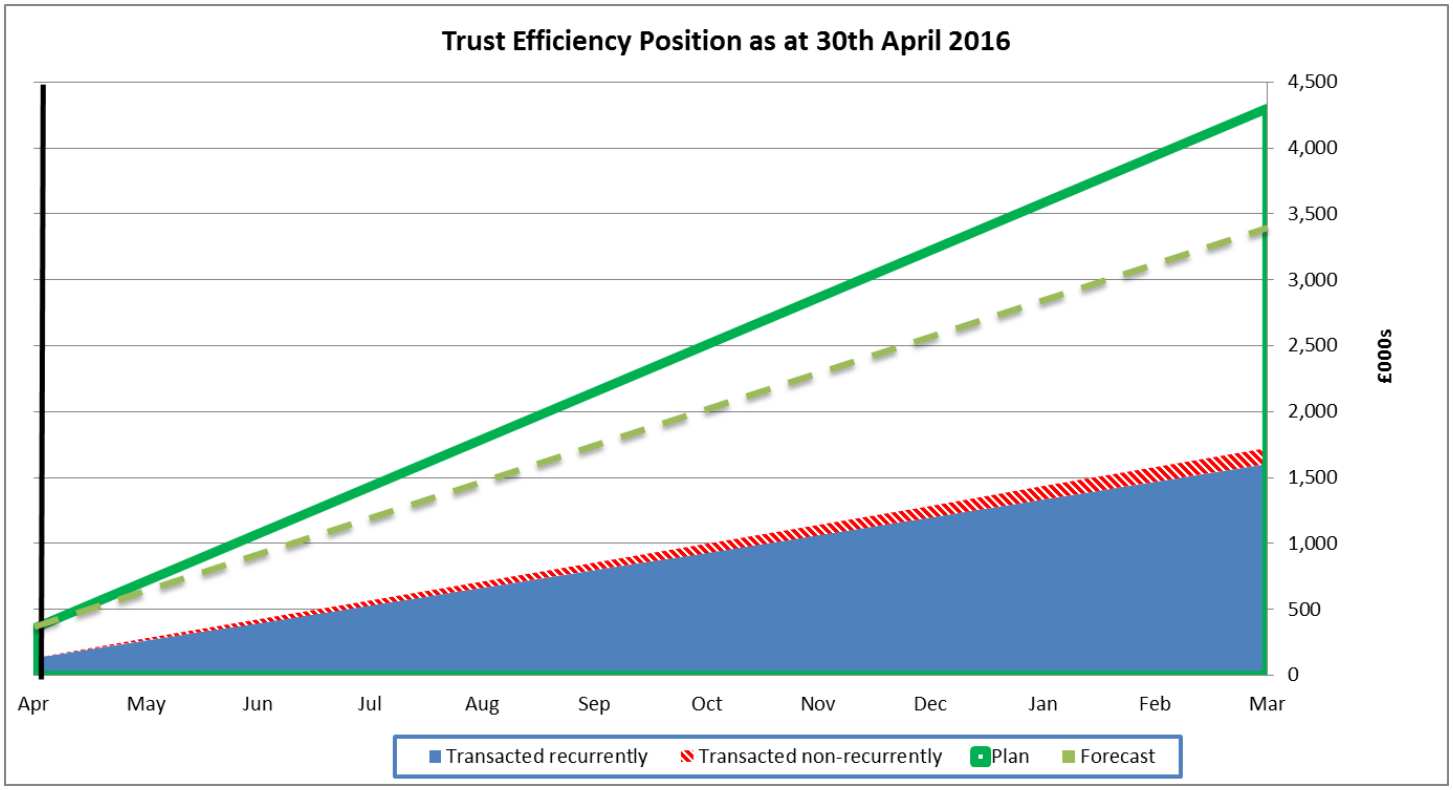
Cash is currently at £12.3m which was £2.2m better than the plan in the month. This is due to cash related Income and Expenditure surplus timing of payables and receivables.



Capital Expenditure is £6k behind plan year to date but is forecast to match the plan of £3.45m by year end..

The 2016/17 schemes are regularly reviewed by Capital Action Team (CAT) including the reprioritisation to fund any new schemes.

Cost Improvement Programme (CIP)



At the end of April there was a shortfall against the monthly plan of £216k. The full year amount of savings identified during April reporting is £1.7m.

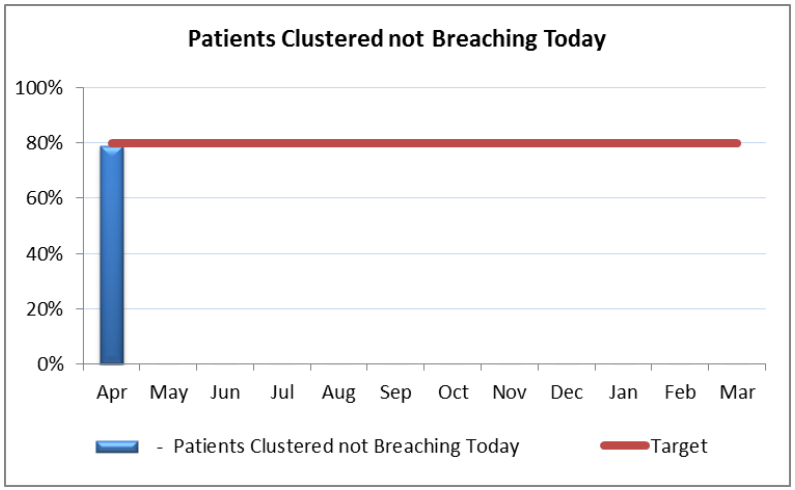
A further £0.5m has been assured and the forecast assumes further delivery which will amount to £3.3m leaving an unassured gap of £0.9m.

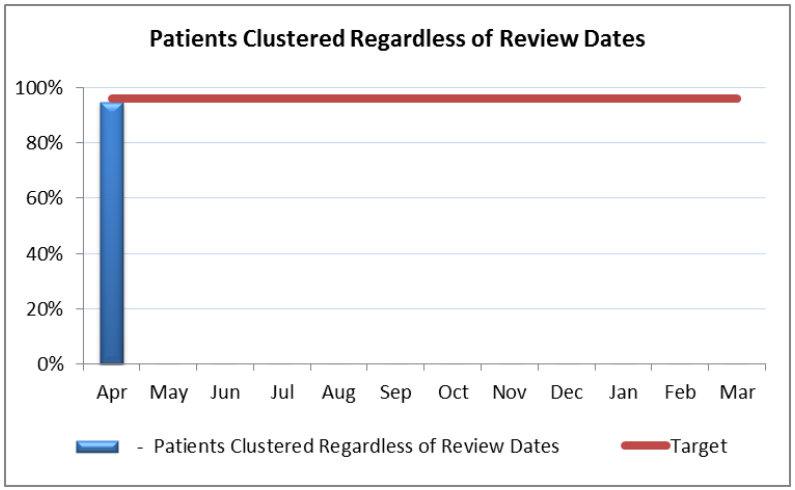
Programme Assurance Board continues to performance-monitor CIP delivery which is reported to Finance and Performance Committee who have delegated authority from Trust Board for oversight of CIP delivery.

Operational Section

Clustering

Enc E





The PbR Advisors, continue 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.

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

Feedback from Monitor Tariff Case Management and Compliance Manager, Pricing:

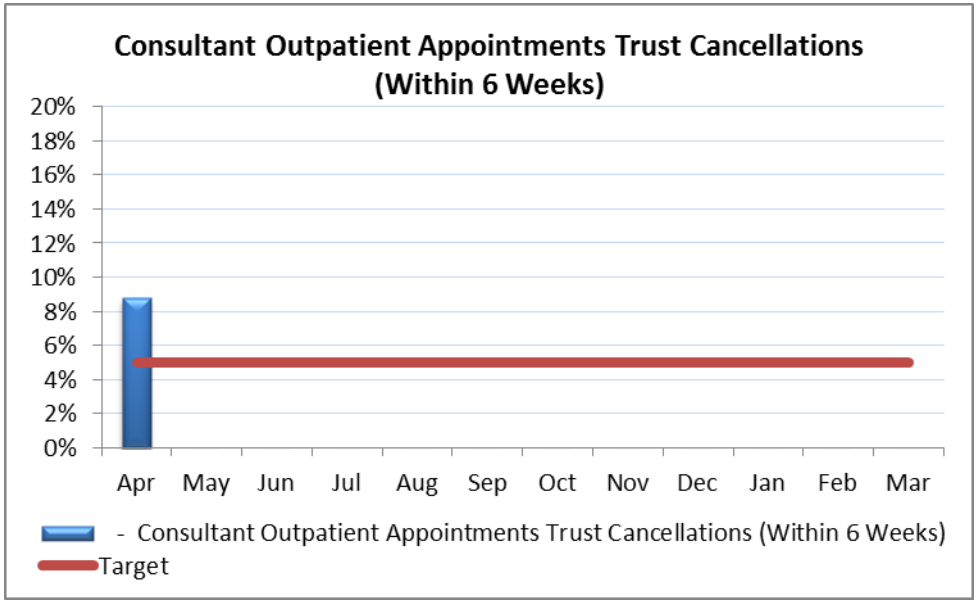
Compliance with Pricing Rules

The Trust is green on 8 of the 11 standards with the remaining 3 Amber for which resolutions are being explored:

The provider has adequate processes in place to cluster activity in line with the clustering tool?	The provider has access to the clustering algorithm in the system. However there is no regular formal audit or other internal consistency process in place. An audit of cluster 4 in December 2014 found an error rate of 91%.
Patients are re-clustered in line with clustering tool or when there is a significant change in need	The provider has access to clustering tool and re-clustering is a performance target. However there is no formal process in place to check re-clustering is operating correctly.
The arrangements for provision of service should support patient choice	There is some choice as patients can chose the area and possibly the team depending on the services they need - this is more limited for APC but there is some scope where there are issues with specific patients/clinician relationships.

Enc E

Consultant Outpatient Appointments Trust Cancelations (within 6 weeks)



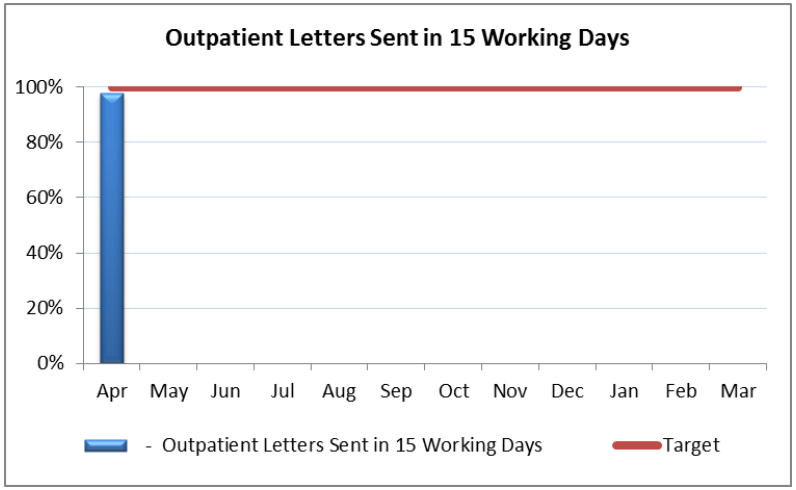
The main reasons given for cancellation were industrial action, difficulty getting NHS locum cover for vacant posts, consultant sickness and the cancellation of virtual clinics (no inconvenience to patients).

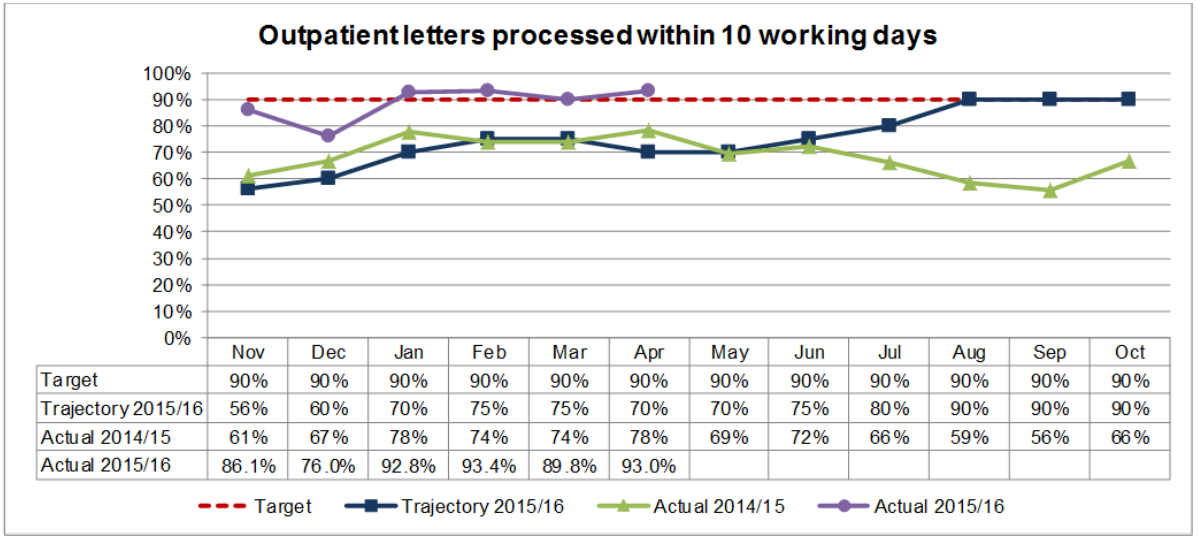
Commissioners are currently discussing the ongoing relevance of reporting on this target which is a local target not national.

Recent review of complaints has indicated a very low level of complaint in relation to this issue.

Outpatient Letters

Enc E





	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Trajectory 2015/16	56%	60%	70%	75%	75%	70%	70%	75%	80%	90%	90%	90%
Actual 2014/15	61%	67%	78%	74%	74%	78%	69%	72%	66%	59%	56%	66%
Actual 2015/16	86.1%	76.0%	92.8%	93.4%	89.8%	93.0%						

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

- It has been agreed by commissioners that the 15 day target for letters will be reduced to 95%. This is currently being actioned via a contract variation and will be reflected in next months board report.

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	101.2%	100.0%	100.0%	104.2%	No	None required
CHILD BEARING INPATIENT	113.1%	160.7%	100.0%	147.4%	Yes	We have broken the current fill rate tolerances due to vacancy, high observation levels to support mother with infant care and a phased return from long term sickness.
CTC RESIDENTIAL REHABILITATION	100.8%	99.5%	100.0%	100.0%	No	None required
ENHANCED CARE WARD	83.5%	102.7%	83.1%	112.3%	Yes	We still have vacancies for RNs and with the uplift of numbers from April the number has risen. We have a 0.8 nurse commencing in May and there is generic recruitment dates set. We are also in the process of putting out a separate advert for ECW only. We have 1 RN on long term sick and another just returned from Long term sick on a graduated return. We also have one RN who may slip into long term sickness after recent surgery. We continue to maintain cover from own staffing for Nurse in Charge and maintain a PMOVA team from own staff or by utilising staff from around Radbourne. We continue to struggle to cover Daytime bank shifts during the week.
HARTINGTON UNIT - MORTON WARD ADULT	103.1%	109.2%	66.1%	170.0%	Yes	The reason is we are currently carrying x 4.36 Band 5 vacancies on the ward and in addition to that x 1 band 5 is currently acting up into a Band 6 role on the ward. Thus we are having difficulty in having x 2 qualified staff on nights every night.
HARTINGTON UNIT - PLEASLEY WARD ADULT	119.3%	77.3%	125.0%	83.7%	Yes	The reason we are under on care staff during the day is because the shifts have been covered by qualified. This is because we had some short term sickness and annual leave during March and qualified staff have been prepared to work extra shifts. The reason we are over on Registered Nurses at night is because we are now in a position to start to rota 2 Registered Nurses on to nights as opposed to one.

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	80.0%	131.6%	57.6%	156.8%	Yes	There are currently 9.2 vacant Band 5 posts on Tansley Ward, during the rolling recruitment programme we have managed to recruit 5 x Band 5 nurses but all are currently students due to qualify in September. In addition to this we have 1 Band 5 nurse removed from clinical duty while a complaint investigation takes place. Given the current level of Band 5 availability we cannot fulfil the funded establishment of 3 registered nurses on day duty and 2 registered nurses on night duty. To cover the deficit our current Band 5 nurses have been working overtime to ensure the minimum staffing levels of 2 registered nurses on day duty and 1 registered nurse on night duty. In addition 2 of the Band 6 nurses are working clinically when not on the bleep and the manager is providing clinical leadership and support across the busiest parts of the day to maintain safe practice. Rotas have been reviewed by the Divisional Nurse to ensure that cover is provided to the optimum within the resources available. All posts are out to recruitment and we are planning for the number of preceptorship nurses due to commence in September/October.
KEDLESTON LOW SECURE UNIT	94.6%	96.7%	100.0%	105.0%	No	None required
KINGSWAY CUBLEY COURT - FEMALE	100.0%	95.9%	73.1%	110.8%	Yes	The broken tolerance is due to sickness of R/N's - they have now returned so this should now resolve.
KINGSWAY CUBLEY COURT - MALE	98.2%	98.3%	91.8%	102.0%	No	None required
LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP	102.2%	94.0%	91.3%	101.9%	No	None required
LONDON ROAD COMMUNITY HOSPITAL - WARD 2 OP	100.7%	97.1%	100.0%	95.8%	No	None required
RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT	96.6%	98.8%	100.0%	98.3%	No	None required
RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT	98.3%	105.4%	82.5%	148.8%	Yes	Ward 34 continue to have a high level of vacancies with staff being deployed from other areas to support, there is on going recruitment to address this.
RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT	92.3%	107.1%	109.3%	115.8%	No	None required
RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT	95.5%	98.4%	97.1%	107.3%	No	None required

Workforce Section

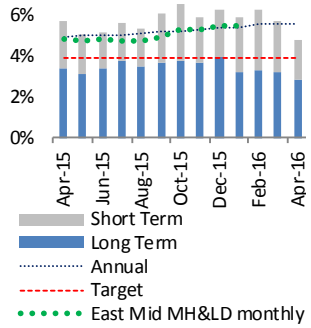
WORKFORCE DASHBOARD

Enc E

Wellbeing

Sickness Absence

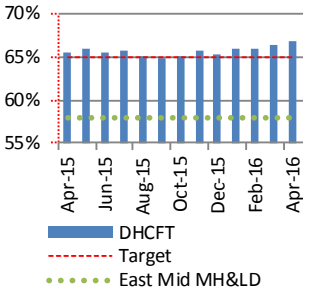
	Feb-16	Mar-16	Apr-16
(Monthly)	6.26%	5.67%	**4.81%**
		Target	3.90%



The Trust annual sickness absence rate is currently 5.58% (0.01% increase from last month). Anxiety/stress/depression/other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 23.3% of all sickness absence, followed by

Qualified Nurses

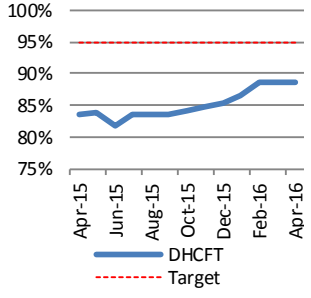
	Feb-16	Mar-16	Apr-16
health visitors and healthcare assistants)	66.04%	66.41%	**66.89%**
		Target	65%



Contracted staff in post qualified nurses to total nurses, midwives, health visitors and healthcare assistants remains within target at 66.89%. Vacancy rates can impact on this measure. The NHS average is 61.38% and the East Midlands Mental Health & Learning

Compulsory Training

	Feb-16	Mar-16	Apr-16
(Staff in-date)	88.48%	88.59%	**88.58%**
		Target	95%

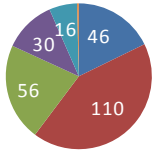


Compulsory training compliance remains static at 88.58%. Compared to the same period last year compliance rates are 5.16% higher. Compulsory training compliance remains above the 85% main contract

Motivation

Staff FFT Q4 2015/16 & Staff Survey 2015

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



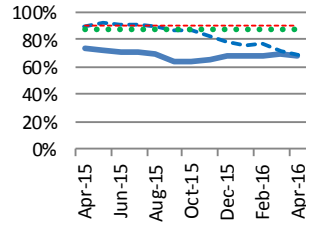
1 - Extremely Likely
2 - Likely
3 - Neither likely nor unlikely
4 - Unlikely

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

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

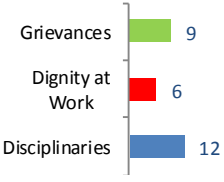
Appraisals

	Feb-16	Mar-16	Apr-16
(All staff)	67.82%	69.12%	**68.12%**
		Target	90%

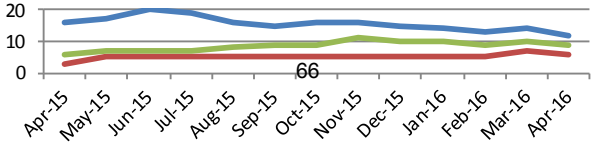


The number of employees who have received an appraisal within the last 12 months has decreased slightly during April 2016. Historic Medical appraisals have now been updated. According to the latest staff survey results, the national average for Mental Health & Learning Disability

Grievances/Dignity at Work/Disciplinaries as at 30/04/16



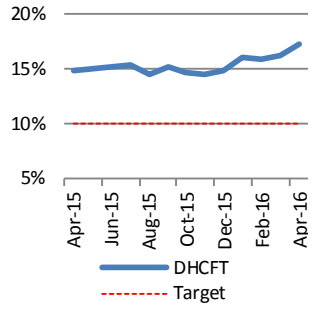
9 grievances lodged at the formal stage, 6 grievance investigations concluded and pending formal hearing. 6 dignity at work cases lodged, 3 case concluded and meeting scheduled for feedback. 12 disciplinaries in progress, 10 have



Attendance

Vacancy

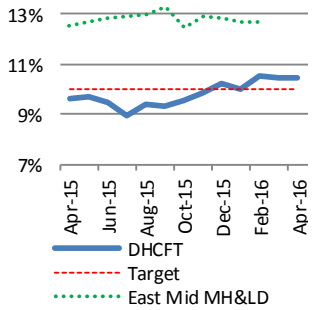
	Feb-16	Mar-16	Apr-16
(Budgeted full time equivalent)	15.91%	16.24%	**17.30%**
		Target	10%



The average budgeted vacancy rate for last year was 15.25%. Active recruitment during April 2016 was for 68 posts. 74.84% were for qualified nursing, 8.88% admin & clerical, 5.92% medical, 5.92% allied health professionals and 4.44% additional clinical services.

Turnover

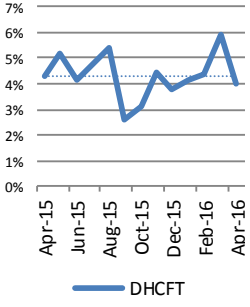
	Feb-16	Mar-16	Apr-16
(Annual)	10.54%	10.45%	**10.42%**
		Target	10%



Annual turnover remains within Trust target parameters at 10.42% and is below the average for East Midlands Mental Health & Learning Disability Trusts. The number of staff leaving remains static at an average of 21 per month. 20 employees left the Trust during April 2016 which included 9

Agency Usage

	Feb-16	Mar-16	Apr-16
(Spend)	4.39%	5.95%	**4.03%**



Total agency spend in April 2016 was 4.03%. Of total agency spend for all staff groups, Qualified Nursing represented 1.21%, Medical 2.07% and other agency usage 0.75%. Agency Qualified Nursing spend against total Qualified Nursing spend in April was 3.08%. Agency Medical spend against total Medical spend in April was 12.16%. In April the level of Agency expenditure exceeded the ceiling set by NHSI by £125k of

Quality Section

Strategic Risks (Board Assurance Framework)

Risk Description	Risk rating	Trend
Failure to achieve clinical quality standards	MOD	→
Failure to deliver the agreed transformational change at the required pace	HIGH	→
Risk to delivery of national and local system wide change.	HIGH	→
Failure to deliver short term and long term financial plans	EXTR	↑
Loss of public confidence due to NHS I enforcement actions and CQC requirement notice and adverse media attention	HIGH	→
Loss of confidence by staff in the leadership of the organisation at all levels	HIGH	→

Clinical Risks (Significant)

Risk Description	Risk rating	Trend
Long waiting lists due to difficulty in recruiting paediatricians	EXTR	→
Non-compliance with medicine management standards. Pharmacy on-call services	HIGH	→
Nursing vacancies, leadership and succession planning across Adult in-patient areas	HIGH	→
Lack of commissioned services: ADHD, patients discharged from prison	HIGH	↑
Waiting times for psychological assessment within neighbourhood teams	HIGH	↑
Lack of parking for clinicians at bases	HIGH	→

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 25 May 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 position statement sets out:

1. Safety through our infection control report
2. Caring through our work in community partnerships to promote Mental Health awareness
3. Responsiveness of our services. Trust wide review of our complaints and compliments and our findings, Our CAMHS national benchmark. How we discharge our duty of candour
4. Effectiveness. Our full achievement of all trust CQUIN's and our clinical strategy to apply for a Dept. of Health bidding round for a licence to provide patient activation measurement scales.
5. Well-led- Our CQC visit preparations and our progress on our Quality visits. An update on our preparation work for our planned inspection which will take place in June by the Care Quality Commission.

Strategic considerations

To give an insight into our clinical strategy e.g. bidding for personalised care rating scale to supplement our work toward our Quality priorities and innovations, to provide assurance level information on our services and their performance

(Board) Assurances

- Our compliance with the Health act and requirements under infection and prevention.
- Our compliance with the Duty of candour regulations for our being open and duty of candour regulations.
- Our achievement in full of our CQUINs, both in clinical improvement and in maintaining our income.
- Our performance in our complaints compliments and concerns performance of our teams
- Our preparations and CQC inspection readiness for our organisation

Consultation

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

Governance or Legal issues

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

Equality Delivery System

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

Recommendations

The Board of Directors is requested to:

1) Receive this quality position statement and note that the infection control annual report is presented within it line with the Health Act practice requirements.
2) Gain assurance and information on its content and seek clarity or challenge on any aspect of the report.

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

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

QUALITY POSITION STATEMENT

May 2016

1. SAFE SERVICES

1.1 Infection Control

The Infection Control annual report is included in the appendices.

2. CARING SERVICES

2.1 East Midlands Chamber – Mental Health in the Workplace

The East Midlands Chamber held an event on the 13 May 2016 which focused on Mental Health in the workplace. Our Executive Director of Nursing and Quality presented work on 'Delivering the Forward View: NHS planning guidance 2016/17 -2020/21. We talked about the importance of partnership working with employers to improve the mental health and wellbeing of the workforce in Derbyshire.

3. RESPONSIVE SERVICES

3.1 Compliments and complaints

The Patient Experience team is the central point of contact for people to provide feedback and raise concerns about the services provided by the Trust. The team sits within the Nursing and Patient Experience Directorate and is based at the Trust Headquarters. Staff have direct contact with the (Acting) Chief Executive and Executive Directors and liaise regularly with senior managers.

The team's aim is to provide a swift response to concerns or queries raised and to ensure a thorough investigation takes place when required, with complainants receiving comprehensive written responses including any actions taken.

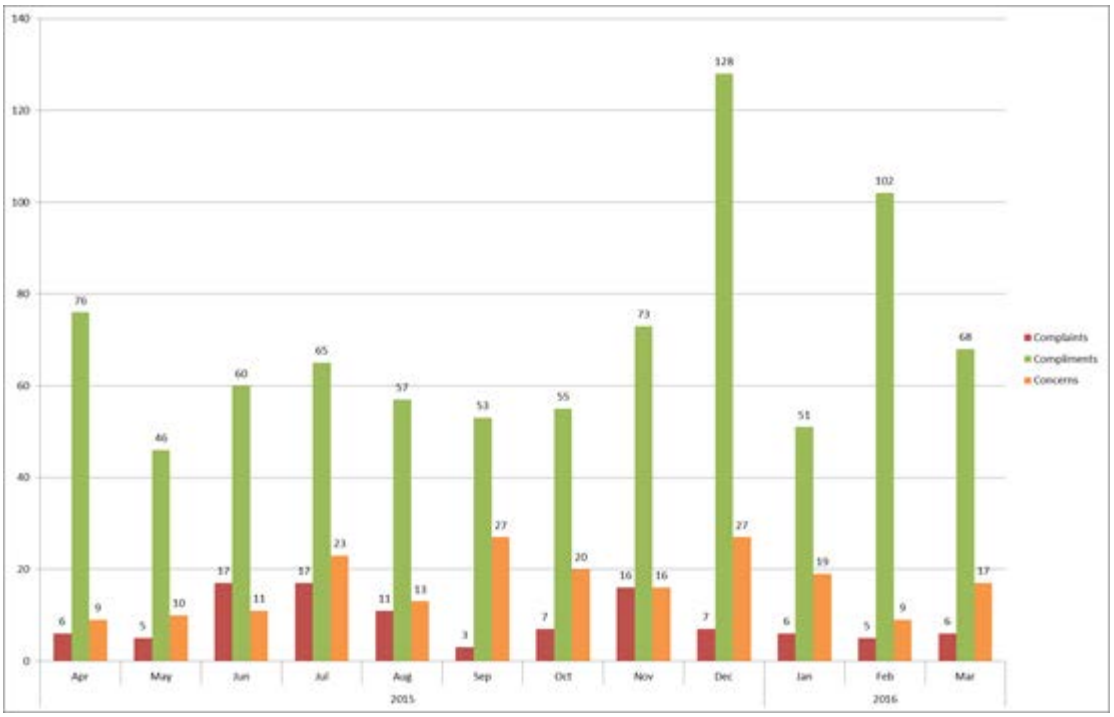
Learning from the feedback the team receives is essential and this is shared with staff through the Trust's *Practice Matters* publication.

During 2015/16 the Trust logged:

- 834 compliments
- 201 concerns
- 106 complaints

Complaints are issues that need investigating and require a formal response from the Trust. Investigations are coordinated through the Patient Experience Team. Concerns can be

resolved and require a less formal response; this can be through the patient experience team or directly by staff at ward or team level within our services.



Themes

During the year the Trust logged complaints, concerns and compliments by theme in order to use the information in a more meaningful way. Most of the issues commented upon in the compliments received were for the support/help provided 354, care 345 and general gratitude shown by staff 343 and 254 for the kindness shown by staff.

The top themes from complaints are as follows:

- Staff attitude – 39
- Availability of Services/Activities/Therapies – 26
- Assessment – 17
- Care Planning – 15
- Compassion – 14
- Medical Care – 14
- Information Provided – 13
- Engagement – 13
- Nursing Care – 11
- Medication – 11.

The top issues raised in the concerns are reported below:

- Availability of Services/Activities/Therapies – 62
- Staff attitude – 21
- Other care – 19
- Information Provided – 18
- Care Planning – 16
- Waiting Times – 16
- Other – 15
- Medication – 15
- Engagement – 13
- Assessment – 11
- Medical Care – 11.

During the year the Trust discussed five cases with the Health Service Ombudsman:

- Two investigations are underway
- One assessment is on going
- Two telephone discussions took place

3.2 How we discharge our CQC Regulation 20 for Duty of Candour

The Family Liaison Team consisting of two staff commenced in post in March 2015. 2015/16 has been their first year in operation. The aim of the Family Liaison team is to offer direct support to patients and their families alongside supporting staff to fulfil their Duty of Candour and offer assurances to the Trust that this has been completed.

Assurance

The Medical Director has overarching responsibility for ensuring the Trust fulfils Duty of Candour. A narrative on how we deliver our Duty of Candour, in relation to Serious Untoward Incidents, is included in the monthly Serious Incident (SI) Report which is reviewed by the Quality Committee and Trust Board.

Role of Family Liaison

Family Liaison offers direct support to family following a serious incident or the death of a loved one. This is alongside any support offered by clinical teams and staff investigating the incident. The work of the family liaison team extends under the principles of Being Open.

They also support staff undertaking serious incident investigations to engage with family. They ensure that Families and Patients are included where possible in reviews and their questions and concerns are addressed.

Family Liaison Process

Incidents graded moderate or above are reviewed by the Family Liaison and Investigation Facilitator (FLIF) to assess whether Duty of Candour is applicable, further information is gathered and support from clinical staff with specialist knowledge is sought at this stage if required. The Electronic Patient Record is reviewed and the clinical team is contacted to ascertain contact details for family and level of family involvement in the patients' care. This process would happen whether it is a serious incident or death and whether the incident meets the standards for duty of candour or being open. Support would also be offered to family if the incident is an expected death. Initial contact is made with family by letter or telephone. This is judged on an individual case basis. The purpose of the initial contact is to offer condolences or apologies on behalf of the trust and if there is to be an investigation inform them of the next steps. Family Liaison would ascertain family's wishes and keep them informed of the progress of the investigation and ensure that they are offered feedback.

Additional Support offered by Family Liaison

- Support Families who wish to make a complaint during an investigation
- Training for staff regarding engaging with family, being open and duty of candour
- Support Investigators to meet with Family
- Attend Coroners Court to support Family

Involvement in Serious Incident Process

FLIF sits within the serious incident group therefore is involved in the review of all Serious Incident. Where there is direct involvement any concerns/comments family has are fed directly into the group. This is supported by the Patient Safety Lead when the FLIF is absent.

Duty of Candour and Being Open

Occasionally it may be unclear in the first instance whether Duty of Candour or Being Open is applicable. We work with families in a compassionate and empathetic way in these circumstances to offer apologies and condolences in a meaningful way.

Incident Reporting Period April 2015 – March 2016

Number of Incidents reviewed	943
Total number of incidents open to Family Liaison	103
Number of incidents from 2015/16 remain open to Family Liaison	57
Initial Contacts	
Total number of Initial Contacts	87
No corroborated family information available/No appropriate to contact	57
Initial Contacts by Telephone	19
Initial Contacts by Letter	64
Initial Contacts by Meeting	2
Initial Contacts by Inquest	2
Follow Up Contacts	
Follow up telephone calls	53
Follow up letters	47
Number of Serious Incidents Family Liaison have supported through Complaints Process	4
Number of Meetings attended with investigators to support	12
Number of Inquests attended to support Family	3

Duty of Candour Trends

Of the 943 incidents reviewed 26 were classed as Duty of Candour. Of the 26 incidents 3 were as a result of the death of a patient, 7 were as a result of allegations made by patients, 3 were serious self-inflicted harm whilst an inpatient, 10 incidents related to patients suffering fractures (8 fractured neck of femur, 1 clavicle and 1 wrist), 1 incident required patient to have treatment by acute trust, 1 incident required the transfer of care of a patient to a higher intensity following an omission of medication, 1 incident related to errors with the transfer of a patients care between services.

Feedback from Family and Investigators

Verbal feedback has been collected however no written feedback from family has been received. So far, the verbal feedback received has been positive – family of Patient A following Inquest thanked Family Liaison for their supporting stating that it had been 'pitched right and you have offered support when it was needed', text received from family of patient B 'we are so thankful for your support it would have been a lot worse without you'.

"From an investigator's perspective, contact with the family is fundamental to the course of the investigation. Historically, this role has been carried out by the investigating team. However, the addition of the Family Liaison Facilitator's role has brought additional quality to the contact we have with bereaved families. This role offers accessibility, advocacy, consistency and compassion to people at perhaps the most tragic time in their lives and I think demonstrates our commitment to supporting them. Amy has also provided support to me as an investigator, in what is always a very difficult process. Much of this of course, is about having the right person in the role, and Amy brings all the skills, knowledge and compassion to the role to make it work."

Future Developments regarding Duty of Candour – What would I change?

Robust Recording of Family Liaison Activity

Further developments to the recording system to ensure there work undertaken by Family Liaison is fully captured, recorded and reported on. Work is already in progress regarding this. Following a Datix upgrade in March 2016 a specific module has been developed to record and an assessment of the suitability is to take place.

Greater Understanding and Further Embedding of Duty of Candour

Wider learning and development regarding embedding the process of duty of candour at a localised level ensuring there are assurances regarding steps taken when there an incident classes as duty of candour. Build on culture of openness and learning.

Referral Pathways for Family Members Children needing Support

Creation of robust referral pathways that Family Liaison can utilise to support families where needed.

4. EFFECTIVE SERVICES

4.1 Our quality and innovation agreements for 2015/16 were fully achieved Derbyshire Healthcare Foundation Trust: 2015/16 CQUIN achievement report

Indicator No	**N1a**			**Weighting**
Indicator name	**Physical healthcare Part one: Cardio Metabolic Assessment and treatment for Patients with psychoses**			**15%**
Date/period	**Rules for achievement of milestones**	**Date**	**Milestone weighting**	**Achieved Y/N**
Q1	Examine the evidence of the current national baseline from the National Audit of Schizophrenia 2014 (NAS) and the current evidence of implementation of the 2014/15 CQUIN, benchmark results against those of top performing providers. Produce report which sets out results, benchmarks and action plan to address those areas that are not doing so well and the necessary infrastructure and training for more rapid progress	20 June 2015	50%	Y
Q2				
Q3	Complete national audit	20 December 2015	50%	Y
Q4	Results from national audit		N/A	
		Total:	100%	

Indicator No	**N1b**			**Weighting**
Indicator name	**Physical healthcare Part two: Communication with General Practitioners.**			**10%**
Date/period	**Rules for achievement of milestones**	**Date**	**Milestone weighting**	**Achieved Y/N**
Q1	To examine the evidence of the baseline from the 2014/15 audit of care plans (a letter determining plan of care) and the current evidence of implementation of the 2014/15 CQUIN, benchmark our results against those of top performing providers. Produce report which sets out our results, benchmarks and action plan to address those areas that are not doing so well and the necessary infrastructure and training for more rapid progress. Audit of 100 sets of patient case notes to be completed	20 June 2015	50%	Y
Q2				
Q3	Complete re-audit. Audit report to be uploaded to CCG portal and report to November Physical Care Committee	20 Dec 2015	50%	Y
Q4				
		Total:	100%	

Indicator No	**N2**			**Weighting**
Indicator name	**To improve recording of diagnosis in A&E and a reduction in the rate of mental health re-attendances at A&E.**			**0.5%**
Date/period	**Rules for achievement of milestones**	**Date**	**Milestone weighting**	**Achieved Y/N**
Q1	To consider the current models of operation and formulate an implementation plan which supports delivery of this data, training and support. To explore alternative service models for urgent care to reduce hospital admissions. (commissioners and providers to develop plans collaboratively)	20 June 2015		Y
Q2	To present the implementation plan for local agreement together with baseline data if available.	20 December 2015	50%	Y
Q3				
Q4	Report against first year of implementation to demonstrate our contribution to preventing mental health re-attendances at A and E. Please note that some A and E attendances are appropriate and any appropriate re: attendances for emergency care and to harm.	March 2016	50%	Y
		Total:	100%	

Indicator No	**L1**	**Weighting**

Indicator name	**Suicide prevention**			**0.75%**
Date/period	**Rules for achievement of milestones**	**Date**	**Milestone weighting**	**Achieved Y/N**
Q1				
Q2	Report to commissioners which demonstrates roll out of Patient safety plan and the patient safety plan, training package.	August 2015	25%	Y
Q3	Report to commissioners demonstrating evidence of how the new collaborative approach and form has been developed and how it is working to benefit service users, using patient stories.	20 Dec 2015	25%	Y
Q4	Report to commissioners which demonstrate sustained implementation.	20 March 2016	50%	Y
		Total:	100%%	

Indicator No	**L2**			**Weighting**
Indicator name	**Think Family**			**0.5%**
Date/period	**Rules for achievement of milestones**	**Date**	**Milestone weighting**	**Achieved Y/N**
Q1	To establish the new Board level committee and leadership of safeguarding.		25%	Y
Q2	To devise strategies to prevent or minimise safeguarding issues, pilot them in organization Annual Safeguarding report to commissioners and Trust Board	September 2015	25%	Y
Q3	To roll out preventative strategies organization wide. Examples Family and Carer inclusive practice and Parenting work (CYIAPT) or other initiatives designed by team to Think Family	N/A	25%	Y
Q4	End of year report to commissioners. To report on the difference this approach is making, what teams do and what they want to do differently or any learning.	March 2016	25%	Y
		Total:	100%	

Indicator No	**L3**			**Weighting**
Indicator name	**Dementia and Delirium**			**0.5%**
Date/period	**Rules for achievement of milestones**	**Date**	**Milestone weighting**	**Achieved Y/N**
Q1				
Q2	To present the implementation plan of how we will work with the acute trust to contribute to the national cquin for dementia and delirium.	20 September 2015	50%	Y
Q3				
Q4	Report against implementation to demonstrate our contribution to the national cquin for dementia and delirium and propose any new working for 16/17.	20 March 2015	50%	Y
		Total:	100%	

All CQUINS were achieved and a thank you letter to all CQUIN leads and teams was sent to thank them for their contribution to patient care.

4.2 The Kings fund

The Kings fund published a report on Patient Activation Measures the Dept. of health released a bidding round for free licences to bidding bodies. The closing date for submission was 17 May 2016, and the Trust submitted a bid for the organisation named Shifting the Balance; helping you meet your wellbeing goal. DHCFT is the lead on planning and delivery of the project. Our organisation has a research and development department, is represented in our project team by our research manager who will be assisting in the project. We intend to use PAM licences embedded into our clinical pathway as part of care planning in key service areas; this would be through embedding licences into our Electronic patient record system PARIS and in our primary care interface services in SystemOne.

A quality circle approach was taken with junior staff that may not have experienced being a member of a bid development team, to develop skills, experience and knowledge of this group to invest in our future workforce.

Team developers:
Nicola Fletcher Occupational Therapist /Sara Bains Occupational therapist and Vanguard lead / Rubina Reza Research & Clinical Audit Manager / Rebecca Mace Nurse Service Manager / Anne Munnien Clinical Lead for Electronic Patient Records / Faith Sango - Assistant Director of Education / Mark Ridge Clinical lead / Transformation and operations

What we are doing

Our development and bidding team, await feedback form the bid in June, a roll out training in June and a phased implementation over the next 5 years. Progress to date on our preparation plans includes:

- A draft visit timetable has been formulated and this is in the process of being confirmed.

4.3 Child and Adolescent benchmarking data

CAMHS Benchmarking Indicator	DHCFT	National Average	Difference
% referrals accepted	81.0%	78.0%	3.0%
% patients assessed who go on to receive intervention	77.0%	73.0%	4.0%
Maximum waiting time for urgent appointment (days)	5	13	-8
DNA rate %	9.0%	11.0%	-2.0%
Number of contact s per member of staff	383	322	61
CAMHS staff per 100,000 registered population	26	61	-35
Sickness % rate	3.0%	4.0%	-1.0%
Patient satisfaction	76.0%	75.0%	1.0%
% SUIs investigated and completed within 45 days	100.0%	79.0%	21.0%

CAMHS services continue to be in the national news for pressure in the services and performance, our own organisation has received press coverage on a recent coroner's inquest in relation to a child death. We provided a full and comprehensive feedback to the inquest on our serious untoward incident findings and our areas to improve, in our service 24 months ago, in summing up the Coroner commented on the recommendations and improvements that had been put into place since the incident.

What we will do?

1. To continue to offer information and support the family if requested
2. Support the staff team in reflecting and learning and supporting them through this incident with learning rather than a blame based culture.

5. WELL LED SERVICES

5.1 Quality visits programme

The quality visit programme is underway with over half the visits now scheduled in. We have had good commitment from our governors to join the quality panel and also our commissioners. Teams are welcoming the opportunity to showcase their work and the panels are seeing some excellent examples of quality improvements.

5.2 Care Quality Commission planned inspection visit

Since the last quality position statement we have:

- Completed a session with our governors to ensure they are prepared for what to expect for our visit.
- The Care Quality Commission have undertaken 2 preliminary days where they have spoken to stakeholders, commissioners, mental health act panel members, our non-executive lead for quality and our clinical director.
- We have set out our first of the weekly briefing to staff updating them on our plans for our inspection visit.

Infection Prevention & Control

Annual Report – 2015/16

Report prepared by Hayley Darn, Nurse Consultant (lead for Infection Prevention & Control), on behalf of

Carolyn Green – Executive Director of Nursing & Patient Experience, Director for Infection Prevention & Control.

1.0 Introduction

1.1 Preventing the spread of infection has been a key focus in healthcare for a number of years, with a statutory requirement to fulfil mandated standards for all healthcare providers.

1.2 The Code of Practice: Prevention and Control of Healthcare Associated Infections (2010) provides the framework for the standards we are required to achieve, and this report will detail the actions and on-going work which underpins the achievement of this. The regulation of this activity falls as part of the inspection programme undertaken by the Care Quality Commission (CQC). Infection Prevention & Control considerations form part of the Trusts CCQ Preparedness work.

1.3 Preventing the spread of infection is an integral aspect of both patient safety and patient experience, providing assurance and a visible marker of standards and the quality of care service users should expect to receive. Derbyshire Healthcare NHS Foundation Trust is proud of the high standards we continue to achieve and the comparatively low rates of infection we see.

2.0 National context

2.1 Over the past five years, through sustained progress against challenging expectations, the rates of healthcare associated infection reported nationally have continued to fall (source Public Health England 2014). Recent focus on the impact of healthcare associated infection has now shifted somewhat from MRSA bacteraemia and *Clostridium difficile* to looking now at other emergent resistant organisms such as *Escherichia coli,* and the significant impact the communicable conditions such as Norovirus have on delivering healthcare. Cleanliness in healthcare facilities remains a high priority, with the well-established links between poor environmental standards and rates of infection. The emphasis on the speciality and related work is now much more proactive, rather than reacting to events after the fact. This has seen a

considerable focus now on ‘zero tolerance’ of healthcare associated infections, with healthcare associated infection now being seen as largely preventable.

3.0 Structures within Derbyshire Healthcare NHS Foundation Trust

3.1 The Chief Executive holds the responsibility for overall standards; however the Trust is required to designate a Director lead for Infection Prevention & Control (DIPC), Carolyn Green - Executive Director of Nursing & Patient Experience.

3.2 The Nurse Consultant (safety) is responsible for the day to day delivery of the plan of work and ensuring this meets the required standards. This role is both strategic and also involved in delivery of training, clinical advice and planning.

3.3 Since September 2013, an Infection Control Support Nurse (0.6wte) has been in post to assist the Nurse Consultant in the delivery of clinical support, advice, training and audit of standards.

3.4 The Head of Estates and Facilities oversees the maintenance, cleanliness and support services which are vital aspect of meeting high standards.

3.5 The programme of work is devised and delivered by the Infection Control Committee, which forms a key component of the Governance structure, along with reporting via Quality Leadership teams (QLT) as required.

4.0 Key achievements of 2015/16

4.1 Continued investment in the capital programme has seen sustained improvement in the care environment in a number of locations, through a dedicated capital expenditure allocation for Infection Control in 2014/15.

- Replacement furniture across areas in the inpatient wards at Hartington Unit
- Purchase of replacement pressure relieving mattress systems.

In addition, a replacement programme of 182 mattresses across the Radbourne, Hartington and Kedleston units has been undertaken during 2016, improving health and safety requirements as well as maintaining infection control standards.

4.2 The Infection Control team have been involved in the planning of the new of the seclusion suite at Radbourne Unit, as well as advising on refurbishments and the relocation of teams and services during the configuration of the Neighbourhoods.

4.3 Continued delivery of a training programme for those clinical and support staff who are identified as requiring the training (target group March 2016 was 1747 staff) saw a compliance position on 1st February 2016 at 87%. Training sessions are largely delivered in a ‘face to face’ taught session, in a variety of locations and via the ‘block’ training methodology. There is also an e-learning option for staff to access.

4.4 There have been 2 ward closures as a result of norovirus type illness during May 2015 (wards 33 &34 at Radbourne Unit). A full review was conducted and areas or practice including PPE stock levels were identified and the teams were supported to rectify. A risk assessment was submitted and review by the Infection Control Committee to ensure all risks associated with Domestic cover at bank holidays and out of hours were considered. Individual suspected cases have been well managed on wards with minimal clinical impact and no evidence of cross infection. Early identification and action remains key.

4.5 Surveillance of healthcare associated infections (HCAI alert organisms) have seen no cases of MRSA bacteraemia between April 2015 – March 2016 (0 reported in 2014/15) and 0 cases of *Clostridium difficile* in the same time period (0 in 2014/15).

4.6 Cleaning scores, measured against the national standards of cleanliness, have continued to meet the nationally defined 'excellent' standard in clinical areas across year (see detailed performance in the section 'Assurance').

4.7 Cleaning schedules remain consistent with national guidance, and are held at ward level for access by staff and patients / visitors.

4.8 Patient Led Assessment of the Care Environment (PLACE) inspections took place in Spring 2015, with continued strong performance. The 2016 inspection programme is underway at time of writing this report. The teams undertaking PLACE consist of Service User representatives, Estates, Nursing and Domestic Services as well as Infection Control representation. An action plan is drawn up after the assessments, which then feed into the allocation of capital funds, support for larger capital bids and in informing backlog maintenance priorities.

4.8 Continued development of the skills and leadership of the Infection Control Link Nurses programme brings a strong focus of clinical leadership and a conduit for information between the specialist team and clinical level. The link nurses meet twice a year to receive training and to share good practice. Recent focus has been on sharps safety and the planned launch of additional needle safety devices being rolled out in the coming months to clinical areas.

4.9 The cleaning schedules have been reviewed by the Hotel Services & Infection Control leads on behalf of the Infection Control Committee, and have been re-issued to the relevant clinical areas during February / March 2016.

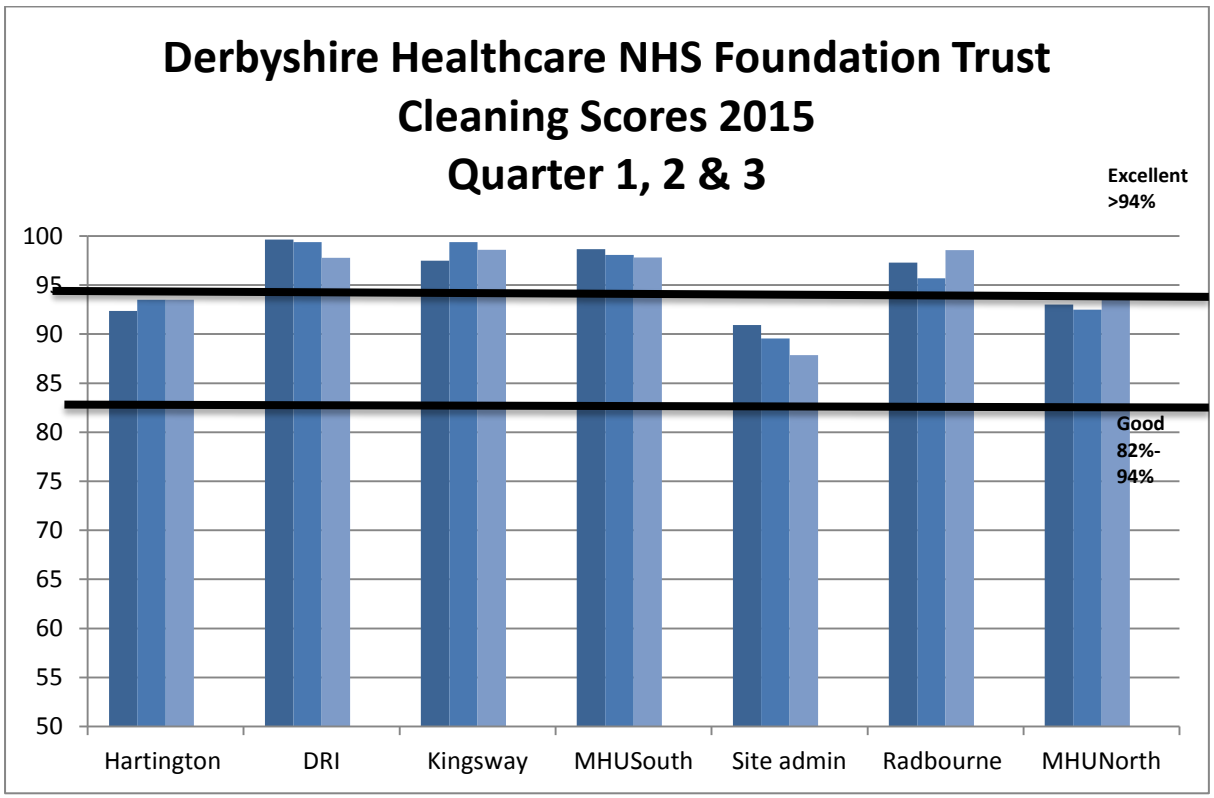
5.0 Assurances

5.1 The Facilities team continue to deliver high standards of cleanliness, and the graph below (Graph 1) demonstrates the performance from April 2015 until December 2015. The highest standards and greatest cleaning services input are delivered in inpatient wards and patient facilities. Services to admin bases and bases where

patients do not receive services have seen a reconfiguration of cleaning service, and the scores reflect their performance (MHU north, site admin).

The Hotel Services and Estates teams are undertaking a series of visits to the Community Mental Health units premises to ensure all environmental standards and being met and to check that all planned maintenance is in accordance with the proposed works schedule.

Graph 1: Performance against National Standards of Cleanliness



5.2 The Divisional Nurses rounds have continued to provide assurance of key standards in the inpatient wards, where on a twice yearly basis, representatives from Infection Control, Estates and Hotel Services join the Divisional Nurses to inspect the clinical areas from an environmental quality perspective. This provides a proactive way of looking at the environment, anticipating maintenance and quality issues at an early stage (and ensuring action is taken) and also the opportunity to seek informal feedback from patients on the wards as to the comfort and cleanliness of the wards.

5.3 Healthcare associated infection (HCAI) surveillance demonstrates our performance, as reported to the Commissioning organisation. We continue to show consistent performance here, with clinical focus on anticipation of possible infection risks and a swift, appropriate response, for example to suspected diarrhoeal illness. This has seen a significant emphasis on prevention of cross infection, and rising confidence in staff to deal with potential infection risks as they arise.

Table 2: Surveillance of healthcare associated infection (HCAI)

2015/16	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
MRSA bacteraemia (trajectory = 5)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Clostridium Difficile (trajectory = 10)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Outbreaks of infection (Norovirus type)	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

5.4 During 2015/16, there have been 2 ward closures as a result of diarrhoeal illness (suspected Norovirus). These were subject to full review by the Infection Control Committee, and local issues were addressed with the teams regarding swifter isolation of cases and also stock levels of PPE.

5.5 Clinical audit specifically to infection control has looked at 3 key areas during the year:

- Infection control general standards (hand hygiene, sharps, decontamination, equipment). Thematic review of the general infection control audit saw areas of work needed recording of cleaning of equipment. The audit tool has been revised and is now an electronic solution following feedback from Clinical teams and also from the Infection Control committee that the current system needed a refresh. Electronic system went live in April 2015, which will produce ease of recording and thematic review. The link nurses continue to undertake audits and have been involved in the revision of the tool.
- An audit of the Children's Specialist services including the Special Schools has been undertaken and raised a number of concerns regarding some of the working and care environments. A local 'risk register' is being developed with the support of the SLMs and the Head of Nursing.
- Audits of community mental health and substance misuse bases to ensure basic levels of PPE, sharps awareness and hand hygiene standards.

5.6 Clinical compulsory training continues to take place for those staff who are required to attend, as identified as part of the training framework, and administrated via the training passport system. Compliance is monitored via the Infection Control Committee at a strategic level, and attendance is managed by each of the Divisions. Frequency of attendance is currently agreed as every 2 years, and these are largely taught sessions via the 'block training' method. The compliance 'as at' 1st February 2016 was 87% (this is a rolling 12 month figure).

5.7 An influenza vaccination campaign was delivered for staff and patients who met the criteria. The final staff uptake figures remain low at around 22%. We delivered or had access in excess of 96 clinic sessions in a variety of locations. However, the sickness/ absence rate for staff reporting cold and flu like illness remained low during the winter months, accounting for less than 1% of sickness / absence compared to last year.

5.8 Hotel services continue to provide assurance on key service delivery areas, such as food hygiene, pest control, laundry and linen supplies, and the duty of care audits required under the NHS Waste Management regulations. A full review of the laundry contract has taken place as a joint venture, with a single provider in place. The kitchens at Kingsway site has had had environmental health inspection and was awarded 5star ratings by Derby City Council for the fourth year in succession. We await the Radbourne unit inspection; it currently holds the 5 star rating. This is a very public method of demonstrating quality, as it is used across all food preparation establishments. We continue to gain additional assurance by using an independent Environmental Health officer to undertake inspections and guidance, as well as the local authority inspections. Pest control contractors call outs totalled 35, with planned inspections of kitchen areas taking place as a preventative measure.

5.12 Estates continue to provide a monitoring system and maintenance programme to maintain safe water quality. Focussed work in ensuring proactive flushing records are maintained have been a recent focus of the Estates planned, proactive management.

5.13 Review of the DATIX Complaints system for 01/04/15 until 30/03/16 shows only 1 complaint related to cleanliness / infection risk, which has been dealt with by means of written response.

6.0 Next steps and priorities

6.1 The organisation continues to place prevention of infection, along with prevention of harm, as a central feature of clinical service delivery. A focus on continuing to equip the workforce is pivotal to this. The delivery of a compulsory training requirement means that staff are equipped to deliver care in a way that prevents the spread of

infection, and provides them with the clinical leadership to seek advice where required.

6.2 Continued focus on strong, visible clinical leadership will continue to see practice at the highest standards, with staff empowered to seek advice and support where needed. Strong leadership also brings consistency of standards.

6.3 Continued commitment in capital expenditure on the Estate will ensure that environmental risk is kept to a minimum (for example on-going replacement schedule for furnishings), upgrade of ward and community facilities reduces the risk of poor environment and enhances patient experience. Work is underway and requires continued commitment to support safe practice. Monitoring of external contracted services ensures the highest standards are achieved on our behalf. This is an important aspect of quality assurance.

6.4 On-going support for the delivery of high standards of hotel services, and specialist infection control advice when needed.

6.5 Commitment to working with other providers, to ensure we play our part as a health economy in reducing the burden of healthcare associated infections, such as Norovirus, *Clostridium difficile* and MRSA.

6.6 Ongoing support for the developmental work undertaken to meet Nutritional standards, much of which is reported via the Physical Care Committee, but crosses over with this work plan due to governance of food preparation and storage.

6.7 Completion and work on the NHS Premises Assurance Model framework, currently being led by Estates & Facilities.

7.0 Potential risks in delivery

7.1 Operational support for the infection control support nurse role is pivotal in the ability to deliver the programme of work and level of clinical support and responsiveness needed to meet clinical demand.

7.2 The low uptake of the influenza vaccination by staff should be considered as a key protective and public health responsibility of the organisation, and requires support to improve uptake.

7.3 Continued operational support to achieve compliance with compulsory training.

7.4 Failure to achieve full compliance with requirements of the European Sharps safety directive due to problems with procurement of appropriate sharps safety devices.

7.5 Any impact on ability to deliver cleaning services to the current high standard in the inpatient areas and clinical bases would have an impact on existing infection control standards.

7.6 The organisation needs to ensure that we maintain monitoring of externally provided contracts, such as laundry, cleaning (north county units), pest control and maintenance to ensure that that standards are not allowed to slip in challenging operating environments.

7.7 The organisation needs to remain focussed that Hotel Services remain equipped to be able to continue to maintain the high standards of cleanliness we currently achieve.

Hayley Darn

31st March 2016.

Board Committee Summary Report to Trust Board
Audit Committee - meeting held on 28 April 2016

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee) and for what action
GIAP	Review of actions for oversight by the Audit Committee	Committee discussed and approved completed actions as outlined. CG12 – assurance reports from Committees - noted that although marked as complete there was further work to refine the format to ensure fitness for purpose – Committee agreed to amend status to amber (some issues).	Demanding timescales particularly relating to review of corporate governance framework – a programme for delivery will be presented to May Audit Committee and May Trust Board.	SH and CM to review actions in detail Exception/highlight reporting only to future meetings Deadline dates for actions to be aligned to dates of Audit Committee meetings. Progress and oversight will be undertaken by the Committee at each meeting	None
Going Concern Assessment	In-quarter score FSRR of quarter 4 is 2. CW updated on discussions at Board where CW provided assurance on ongoing position.	Assurance given on going concern assessment. This was supported by External Audit, pending their ongoing audit work. The Committee was assured on the going concern assumption.	None identified	Further reports to include reference to cash and headroom as suggested as good practice by internal auditors.	None
2015/16 NHS SBS ISAE3402 Effectiveness	Assurance report on SBS services was discussed. All controls had been tested	The report gives assurance that there is no material impact to the Trust.	None	Report received and noted	None

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee) and for what action
of Controls Reports	with no material exceptions noted.				
Review Draft Annual Accounts	The draft accounts were reviewed page by page and amendments raised by Committee members were noted by R Leyland for incorporation into final draft.	Draft accounts were submitted on Thursday 21 April, prior to the Friday deadline. R Leyland confirmed that the accounts followed Monitor's Annual Reporting Manual (ARM) report requirements.	None identified	Updates and clarifications noted. Final draft of annual accounts to be scheduled for approval at 24 May Audit Committee.	None
Review Draft Annual Report, Quality Report, and Draft Annual Governance Statement	Remuneration report Annual Report and Accounts Annual Governance	SH to review Remuneration Committee narrative on activity during the year. CW/SH/AS to review commentary on remuneration report. AS/SH to meet with Grant Thornton to clarify compliance with ARM – and for all remuneration issues to be covered in one place Reviewed page by page Issues of accuracy, query and comments were noted by AS/SH to be incorporated into the final draft of the report. Updates noted by Rachel Kempster for incorporation	For all sections : Clarification with contributors on areas of content and seeking outstanding content by Audit Committee deadline (19 May)	Comments discussed, noted and agreed. Final draft of annual report to be scheduled for approval at 24 May Audit Committee.	None

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee) and for what action
	Statement Quality Account	into final draft Updates and comments noted by Claire Grainger for incorporation into final draft			
Audit Committee Self-assessment/effectiveness review	Summary of Committee effectiveness against the HFMA audit committee checklist as facilitated by Internal Audit	Assurance given on Committee effectiveness through summary results of self-assessment from members and the chair against the HFMA Audit Committee checklist.	None	Report received and noted	None
Annual Report from the Audit Committee to the Board	Annual report/review of the activities of the Audit Committee following the NHS Audit Committee Handbook guidelines	Discussed and agreed that the report fairly reflects the remit and activities of the Audit Committee. Assurance that the Committee is effectively fulfilling its role as measured against its terms of reference.	None	Agreed to be forwarded to Trust Board as part of assuring reporting from Board Committees and also to be presented to June Council of Governors meeting	None
2015/16 F&P Committee Year-end Report	Report reviewed, noted to have been agreed by F&P chair out of meeting. Considered confirmed and noted.	Assurance that Committee is performing effectively as measured against its terms of reference.	None	Reports from other committees to be scheduled at next meeting	None
Review assurances from other	Assurance summaries from other Board committees were discussed and noted.	Assurance was received on the focus of discussions and where assurances and	None	Agreed that purpose/format of the assurance summaries are to further reviewed by	None

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee) and for what action
Committees		escalations were identified.		ELT	
Exception Reporting	No exceptions to report on:- • Losses and Compensations • Hospitality and Sponsorship • Debtors and Creditors	None	None	Agreed SH to review exception reporting for these areas and schedule for one/twice per year as appropriate	None
Internal Audit Charter	The charter for conduct of internal audit function was presented	The charter was received and noted to be industry standard.	None	Report noted.	None
Draft Internal Audit Annual Report	Internal audit work carried out for the year ended 31 March was presented.	Overall opinion generally satisfactory with some improvement required. This opinion will be reflected in the Annual Governance Statement	None	Report noted	None
Update on External Audit Progress	The 'Informing the Risk Assessment' report was discussed Progress with the audit	The Committee confirmed agreement with responses in the report which had been obtained from Trust management Audit Team currently on site – no issues to report	None	Report noted	None
2016/17 Forward Plan	Forward plan for Committee business was reviewed	This programme covers key areas of Audit Committee business and will be updated as Audit Committee terms of	None	This was agreed and will be reviewed on an ongoing basis	None

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee) and for what action
		reference are updated.			
Meeting Effectiveness	Review of meeting including agenda items, level of challenge/scrutiny, focus of debate on assurance, appropriateness of papers etc	Noted to be a lengthy meeting but that detailed review of annual report and accounts was valuable.	None	N/A	None

Board Committee Summary Report to Trust Board
Mental Health Act Committee meeting held on11 May 2016

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee) and for what action
Review of actions	Updates on progress	Assurance received on completed actions and updates given on outstanding areas.	None	Agreed to escalate one action.	Escalate for Chair: Chair discussion the issue of Hartington Unit as place of safety
CC Visit Report and CQC Visit plan	Review of CQC report re unannounced visit to Cherry Tree Close and Hartington Unit.	Limited assurance received. Some progress and areas of good practice identified, but further work required to ensure compliance. JS updated on initiatives underway to address requirements as part of action plan. Need evidence to demonstrate progress against action plan.	Potential breach of Human Rights Act if policies not followed.	Agreed that paper to June meeting from named action plan leads to confirm action taken or identify where there are issues with progress.	None.
Section 12 Doctors Service Update	Discussion on availability of Section 12 approved doctors during working hours.	Governance around Section 12 has improved following an internal audit report. Pilot of new scheme to be run over a one month period. Timelines and success criteria to be identified and feedback to come back to MHA Committee.	Delayed assessments could increase risk in vulnerable individuals.	Proposal approved for implementation of the pilot.	None.

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee) and for what action
Review of policies required by the revised Mental Health Act 1983: Code of practice	Review of policies, procedures and guidance required to be in place under the MCA Code of Practice	Some gaps in assurance. Noted policies in place and those not yet completed.	Non-compliance with MHA Code of Practice	John Sykes to liaise with Rachel Kempster and all identified leads to ensure completion of all outstanding policies by 3 June meeting.	None
MHA Section 132 Rights Policy and Procedures	Review of updated/revised policy	The Committee discussed aspects of the policy and clarified points of query.	Non-compliance with MHA Code of Practice	Approved in principle subject to amendments noted – JS to liaise with C Henson to finalise.	None.
MHA 1983 Hospital Managers Scheme of Delegation policy and Procedures	Review of updated/revised policy	To come back to the Committee in June.	Non-compliance with MHA Code of Practice	J Davies to advise on issue of delegation to associate hospital managers and policy to be amended to accurately reflect this. Additional update from J Sykes.	None.
Locking of Doors on open Ward All units policy and procedures	Review of policy with updates/revisions	Content agreed subject to typographical errors and clarification in monitoring section regarding review of lock down.	Non-compliance with MHA Code of Practice	To be reviewed and to come back to Committee on 3 June.	None.
Protocol for Conveyance of Services Receivers	The policy was reviewed.	Assurance received on arrangements in place for conveyance. Amendment to be made re reference to old name of the Trust.	None.	Policy adopted.	None.

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee) and for what action
Forward plan	Noted.	Annual work plan to be further developed. Noted that scheduled meetings should not be cancelled in future.	Risk of inadequate oversight and assurance of MHA compliance issues	JS and SH to review work plan for next meeting.	None.

Board Committee Summary Report to Trust Board
Quality Committee - meeting held on 12 May 2016

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Clinical policy management	Significant improvement in policy governance	Good assurance	Maintaining performance	Assurance received	None
Governance Improvement Action Plan	Arrangements by which GIAP is implemented and delivered. Role of QC with respect to actions for which is has oversight was reviewed Terms of reference reviewed with review and challenge.	QC to ensure and be assured that actions for which they have oversight are completed within required timescales.	None currently identified.	Evidence presented and agreed. Quality Committee Group TOR presented and agreed.	None
Suicide Prevention Strategy	Scrutiny and challenge on the Strategy and training. Removal of name of provider due to SFI's and breaching Checking children commissioning implementation and impact. To be changed to comply with clinical supervision policy To adapt in line with ligature policy.	Assurance on the development of key clinical strategy now in place linking into partners.	Door closures solutions to be further explored Increasing assurance on ligature reduction Environmental risk work to be reduced, with heads of nursing education	Endorsed and assured on progress To inform	None

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Ligature Audit and Estates Capital Improvement Progress	Paper reviewed Assurance on potential strategy Care planning and clinical record audit and personalised work measures of performance	Strategy – clinical priority area	9 months lead in time Feasibility study and cost as an action.	Require a feasibility study and costing. Including the risks of not doing it.	None
Patient Experience Annual Report	Reviewed patient experience report. Information on management of professional misconduct on abruptness. Information for service receivers and carers agreed by Executive Director of Nursing	Increasing assurance, in patient experience	Consider student nurse impact on reduction in medicine incidents	Assurance received and feedback preceptorship. Ward to Bard group. Approved, increasing assurance.	None
Care Planning and Person Centred Care Project	Paper presented and discussed	Increasing assurance, in this quality priority area.	Meeting and care planning.	To involve newly qualified nurses, in proposed developments.	None
Community Capacity, Mental Health and Community Paediatric Model	Reports received to detail clinical risks Full exploration of the paper and the risks	Gaps and assurance in paediatric waiting list management. Mitigation plan and improvement plan presented for assurance.	Responsiveness and waiting time. Patient experience and access.	Partial assurance received; require improved performance in this area. ELT to monitor performance via PCOG. Addition of this significant	Risk escalation through Board from committees already in place through integrated performance report

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
				risk to the BAF. Request a paediatric clinical strategy for transformation of this service offer and brief next month with estimated date of completion.	
		Mental Health Community Teams waiting time variations.	Responsiveness and waiting time. Full compliance with Safeguarding CQC systems report, care coordinator on discharge. Patient experience and access risks and concerns Challenges by chair on nurse recruitment impacting on these issues. Proactive recruitment/ rolling programme, central and local. Challenge on caseload balance and to give further assurance, in 3 month to the comittee to gain greater assurance.	Partial assurance received; require improved performance in this area. ELT to monitor performance via PCOG. Addition of this significant risk to the BAF. An up-date on mental health practice / capacity and demand.	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Facilitating a Maastricht Approach	The project was reviewed and end of project evaluation	Assurance on project completion Outcome of pilot and learning was achieved	Learning from the pilot, but not financially viable for quality outcomes	Project completion	None
Positive and Safe Policy	Policy reviewed on development and learning from serious incidents and staff support	Policy ratified	None	Roll out and policy implementation authorised.	None
Clinical Audit Framework Policy and Procedures	Policy review with attended.	Policy ratified	None	Roll out and policy implementation authorised.	None
Any other business and effectiveness	Group discussion				None

Board Committee Summary Report to Trust Board
People & Culture Committee
18 May 2016

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee) and for what reason
GIAP W1 Freedom to Speak Up Action Plan – Raising Concerns Policy	Action plan developed in Feb 2015 – and reviewed Carina Gaunt – Speak up Guardian - Podcast Jim Dixon – NED lead Update to Whistleblowing Policy	**Limited Assurance** Role and responsibility / training / support for Speak up Guardian/NED lead	Previous actions not progressed fully- Superseded with GIAP actions Impact on individuals - additional support required	SH to revisit plan and on forward plan for June PC&C Consider involvement of staff governor / staff side SH	Audit and Risk Committee - oversee processes and effectiveness **Limited assurance** – to Board – May
GIAP PC3 Internal Comms Plan including staff feedback	Sharing extracts from comms plan and strategy	**Partial assurance** Re-iteration of comms mechanisms	Alignment of communications & engagement agenda Capacity of comms team to support people plan delivery	Review of existing mechanisms and feedback - AS AS (comms) to revisit plan in line with SW (engagement) – include time frames - Engagement group	Board – **Partial assurance** on plan – Some issues ELT - re-prioritise comms activity or additional resources
GIAP PC5 Review of Trust Values including engagement plan	Re-cap on the engagement / cultural change programme Be balanced – don't walk past good stuff – recognise and celebrate	**Positive Assurance** Engagement Group to meet and lead the engagement plan	Pace v embedding sustainable culture change Comms resource risk	Tools to measure behaviour change to be considered and agreed Visuals / comms support	**No escalation**

GIAP WOD3 HR and OD Development Plan	High level over view of teams development plan	**Positive assurance**	Growing confidence	Development plan to be delivered	**No escalations**
GIAP WOD6 HR and OD Pulse Check	Verbal update on the 'teams' feelings and impact on productivity	**Positive assurance**	Capacity to ensure delivery of development plan	To be tracked on a monthly basis – update to PC&C	**No escalations**
GIAP WOD7 Monitoring of adherence to the grievance, disciplinary, whistleblowing policies	Verbal update offered on tracker and progress	**Partial assurance** Challenge on how we will ensure adherence? Recognised the training needs of managers	Assurance of adherence to policy	NED to review 'automated tracker' Consider the monitor and adherence to policy Internal audit to review some cases	**Escalation to Board** **Assured** via tracker system **Limited assurance** - No formal system in place to adherence to policy /process
GIAP CQC2 Recruitment of operational vacancies and communications plan	Paper revisited from previous month - with trajectory	**Positive assurance** on plan Concern as to the confidence factor of the delivery of the plan	Risk to absorbing new staff into teams - preceptorship Challenging trajectory Local and national context –of challenges of environment	Track and present progress report back in Sept to PC&C Consider both the internal and external mechanisms for comms – recruitment – consider social media	**No escalations**
Terms of Reference	Re-visited in line with GIAP /	Standardisation – re. Membership needed Delivery of GIAP	Capacity of NED's to attend committees	SH to update in line with other Committees	No escalation
Resource Plan Update	Update shared 4/6 roles appointed and in post 2 out to advert - 1 confident in recruitment in next 10 days	**Partial assurance** Progress external recruitment	Ensuring effective induction period v delivery	Progress external recruitment	Board – **Partial assurance**

Draft People Plan	Discussion as to progress on the plan	**Limited assurance** Agreed on the principles of the plan Clarity of ownership Prioritisation KPI's	Capacity to re-frame to meet expected timescales Who owns the plan?	Consider review of the plan to identify the priorities – assurance / gaps / mitigation plan Achievements /exceptions /risks to be identified (mitigations)	**Board - Limited assurance**
Sickness and Absence Deep Dive	Discussion on data provided and possible impact on quality	**Positive assurance** Re-visit through the supporting groups and HR metrics	Risk that interventions don't impact on absence rates	Mindful, Health and Well-being group tasked with monitoring and reporting back to PC&C	**No escalation**
HR Metrics	Discussion on data- and progress made	**Positive assurance** on progress and refinement	None identified	None	**No escalation**
Any other business	None				
Identified Risks	Capacity in timeframes due to competing priorities				
Meeting Effectiveness	Recognise the time GIAP requires and consider approach / time given to other items				

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, 14 April 2016

PRESENT:	Maura Teager	Chair and Non-Executive Director
	Phil Harris	Non-Executive Director
	Carolyn Green	Director of Nursing and Patient Experience
	Carolyn Gilby	Acting Director of Operations
	Samantha Harrison	Director of Corporate Affairs and Trust Secretary
	Wendy Brown	Clinical Director
	Emma Flanders	Lead Professional for Patient Safety
	Sarah Butt	Assistant Director of Clinical Practice and Nursing
	Rachel Kempster	Risk & Assurance Manager
IN ATTENDANCE:	Sue Turner	Board Secretary and Minute Taker
	Rubina Reza	Research & Clinical Audit Manager
For item QC/2016/059	Mark Powell	Director of Business Development & Marketing
For item QC/2016/061	Andrew Coburn	Legal Services Manager
For item QC/2016/064	Liam Carrier	Workforce Systems & Information Manager
For item QC/2016/065	Brenda Rhule	Acting Divisional Nurse
For item QC/2016/067	Philomena O'Hanlon	Nurse Consultant Dementia Care
For item QC/2016/070	Peter Charlton	General Manager, IM &T
For item QC/2016/072	Hayley Darn	Nurse Consultant
APOLOGIES:	Dr John Sykes	Executive Medical Director
	Petrina Brown	Consultant Clinical Psychologist
	Clare Grainger	Head of Quality & Performance
	Richard Morrow	Head of Nursing Radbourne Campus and Children's and CAMHS
	Sangeeta Bassi	Chief Pharmacist
	Pam Dawson	Carer Forum

QC/2016/056	**WELCOME AND APOLOGIES** The Chair, Maura Teager, opened the meeting and welcomed everyone.
QC/2016/057	**MINUTES OF THE MEETING DATED 10 MARCH 2016** The minutes of the meeting, dated 10 March 2016 were accepted and agreed, subject to the removal of Claire Wright, Executive Director of Finance in the list of attendance. Maura Teager explained that as a result of a recent review of executive directors' attendance at board committees Claire Wright is no longer required to be member of the committee and Maura Teager thanked her for the significant contribution she had made to the committee's agenda.
QC/2016/058	**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/2016/059	**GOVERNANCE IMPROVEMENT ACTION PLAN** Mark Powell's report 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 improvements have been made. The paper also explained the role of the Quality Committee with respect to its oversight of GIAP actions and provided an overview of the actions the Committee is responsible for seeking assurance on delivery. Carolyn Green's paper summarised the proposed activity for the Quality Committee over the next twelve months. It also set out the key named quality issues required in delivering the targeted requirements and provided evidence of the model. The appendices set out work completed to date and the next steps with the key priorities and risks to be considered. Carolyn Green referred to the introduction of the Quality Governance Group outlined in her paper and informed the Committee that the terms of reference for the group will be received at next month's meeting. She also pointed out that chairs of the Quality Leadership Teams will present their dashboard against performance targets and QLTs will be coached and developed against their performance matrix. Maura Teager sought clarity around the style of writing of the QLT minutes/action notes and it was agreed that the format of these would be discussed and agreed by the QLT chairs. The Committee noted the six tasks it is responsible for delivering and was content that actions contained in the GIAP can be progressed within the agreed timeline. It was understood that the GIAP will be captured in the forward plan and be received at each meeting of the Committee and evidence of progress of each task will be reported to the Board each month by Mark Powell. The Committee's assurance summary will supplement the minutes to be submitted to the Board and will also show progress of actions. **ACTION: Forward plan to show GIAP as agenda item at each meeting.** **RESOLVED: The Quality Committee received the Governance Improvement Action Plan and was assured that actions outlined in the GIAP will be delivered within the timeframes agreed.**
QC/2016/060	**<u>SERIOUS INCIDENT REPORT</u>** Emma Flanders, Lead professional for Patient Safety, provided the Quality Committee with information relating to all Serious Incidents (SIs) occurring during March 2016. The committee was pleased to hear that all actions resulting from SIs were complete and the SI group will continue to sustain the achievement of having no actions overdue for more than three months. Although this may change from time to time depending on the flow of incident reports creating peaks and lulls in incident recommendation implementation. A review of community suicides from 2011 showed no significant changes and findings were in line with national trends. The report also showed fewer incidents reported during 2015/16, compared to 2014/15. Reference was made to the safeguarding children updates for March. It was noted that a summary of safeguarding incident ADS14 would be scrutinised by the Trust's Safeguarding Committee and the Trust's Board would be briefed in confidential session with regards to this historical case which was not open to the Trust at the time of the incident. The paper also contained a report on the audit of Datix actions. The committee noted that the level of participation in the audit was disappointing (47%) and requested that this audit be repeated in six months' time and the results submitted to the committee in October and this would also be reflected in the forward plan. Emma Flanders informed the committee that the Trust was supporting a review of deaths and SIs carried out in police custody and terms of reference were being

	written in response to this consultation and potential future requirements. The committee reviewed the actions from the SIRI Reports which showed the follow up of completed actions to produce information on methods of consultation and evidence of changes of practice. The review was a pilot of a revised model of checking whether improvements are sustained, the methodology for this work and the performance in the recommendations showed areas for improvement with a level of participation (47%). The committee supported the suggestion that guidance to investigators should be reviewed to strengthen the message that a draft action plan should form the basis of discussions with both families and teams (as appropriate) to maximise their contribution and engagement in the final plan. In summary, the committee accepted the report and was pleased to note the reduction in overdue actions but discussed the challenges of sustaining this level of performance that will be sensitive to any peaks in activity. . **ACTION: Forward plan to reflect re-audit of Datix actions to take place in six months with results submitted at October meeting.** **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/2016/061	**<u>SECTION 28 REPORT</u>** Andrew Coburn presented his report which updated the committee on the number of inquests and the level of Trust involvement in the past financial year. The report also considered the known inquests for the next financial year before providing a comparison table of the number of Prevention of Future Death Reports written by the all Coroners in England to all Mental Health Trusts. It was recognised that supporting inquests was a significant consumer of the Trust's resources. It was noted that in total there were 37 concluded inquests for the financial year 2015/16. Four of which the Trust representatives did not attend and we are still awaiting the formal outcome from the Coroner's office, as such these numbers do not reflect the true number of conclusions reached by the coroner. In addition, the Trust attended two inquests which were adjourned during oral evidence so that more evidence could be sourced. Another three week long inquest is listed for later in the year of a historical complex intra mental health trust case. The committee understood these factors helped explain why a marginally smaller number of inquests have been concluded this year versus previous years (circa 40 on average]) Andrew Coburn informed the committee he was working with coroners to establish ways to reduce the pressures on consultants to attend inquests and was exploring the possibility of speciality doctors attending in their place to give accounts for Trust practice, when involvement is limited and not directly related to death. This model will be further explored with the medical team to develop an analysis of the impact of this proposed change to the model. The committee discussed aspects of the changes in relationship and expectation between regulators (CQC) and the Coroner's office in the Memorandum of Understanding. It was recognised that in addition to the increased scrutiny applied to the Trust in the process, it would also increase the pressure on our resources when responding to Section 28 reports as well as exchanging information when the Coroner's office and the CQC have differing response timescales. The Trust has always worked to maintain a good relationship with the coroner's office and the committee was provided with feedback on our collaborative approach to working with them.

	The committee considered the report extremely helpful and received a high level of assurance that the Trust was operating in a transparent and effective manner with the Coroner's office. Trust teams learning from deaths of services users were actively engaged in the process, attendance was solid and support to staff attending with preparation and a letter post attendance had all been strengthened. Staff had fed back that they felt supported in preparing to give their evidence. It was noted the attendance of the family liaison team at inquests to support families had been an invaluable development over last year and this approach will continue. The committee was concerned about the significant capacity pressure and emotional impact and the sustained the risks in releasing staff to attend and prepare for inquests and recognised there is a real need to support staff to recover from the distressing effects of participating in inquests. **RESOLVED: The Quality Committee considered the report and noted the potential for statutory timescales to be truncated by the Trust's regulatory body and received assurance on the Trust's performance in comparison with other organisations and on support to staff.**
QC/2016/062	**<u>RISK ESCALATION REPORT</u>** Rachel Kempster presented the Quality Committee with a summary of current 'Top (High Level) Risks', to ensure the committee is aware of the Trust's most significant risks at a strategic and operational level. The report identified risks currently rated as high or extreme on the Trust's risk register which were identified through the strategic and operational risk processes and escalation. The report also identified emerging themes from risks currently graded as moderate. The committee noted that a summary of risks rated as high or extreme on the Trust's risk register was presented to the Board in March as part of the regular Quality Position Statement Report. The committee also noted following themes are emerging through the high and moderate risks currently recorded on the Trust's risk register: • Staffing levels and capacity, particularly access to paediatricians and psychologists • Migration from paper/Care Notes to full EPR (PARIS) • Meeting medication standards • Car parking, particularly St Andrews house and Radbourne Unit • Commissioning risks • Work related stress The strategic risks held on the Risk Register were noted by the committee and it was understood that five out of the six risks were rated as high and would be scrutinised by the Audit Committee. The current Board Assurance Framework (BAF) was not provided at the meeting and would be circulated outside of the meeting to members of the committee by Rachel Kempster. The BAF would also accompany further risk escalation reports. Discussions were being held with Caroline Maley, Chair of the Audit Committee as to where risks would be scrutinised should they also be scrutinised by the relevant committees? Rachel Kempster explained the agreed process that is in place for risk mitigation. The committee should take assurance that risks are reviewed and actioned. It was agreed that the report would come the committee every other month and this would be reflected in the forward plan. **ACTION: Risk Escalation Report to be received by the committee on a bi-monthly basis and will be reflected in the forward plan.**

	The committee was assured that the report showed the Trust's most significant risks at a strategic and operational level and that it identified risks currently rated as high or extreme on the Trust's risk register as identified through the strategic and operational risk processes and escalation. These risks have detailed minimisation and mitigation plans and key risks will be reviewed by the Quality committee in future meetings, in line with monitoring BAF 1a risk, providing scrutiny and level of assurance in the quality of care. **RESOLVED: The Quality Committee** **1) Agreed to a bi-monthly report, providing a summary of 'top (high level) risks' and a summary of emerging themes identified through moderate graded risks** **2) Agreed for a summary of this paper to be included in the regular integrated performance dashboard and referenced as required into the Quality Position Statement escalated to Board**
QC/2016/063	**CLINCIAL AUDIT AND RESEARCH AND DEVELOPMENT GOVERNANCE** Rubina Reza presented a report which provided the Quality Committee with an update on Clinical Audit Project status and Research & Development Governance Committee meetings In December 2015 an improvement trajectory was presented at the request of the Quality Committee to demonstrate increased sign-off of delayed projects by the end of March 2016. This report demonstrated an actual improved position in line with the estimated trajectory with an increase in signed off projects from the 16 reported in December to 32 signed off projects at the end of March 2016. The committee was concerned that over 2015/16 attendance at the R&D Governance Committee meetings has not improved neither has the committee succeeded in securing new members. This resulted in a process being established to review and seek approval for new projects via email and the use of Skype at R&D Governance Committee meetings. The meetings would also be rescheduled to take place on a bi-monthly basis in the hope this would relieve the time pressures on clinical staff and increase attendance. It was noted that strong advertising had taken place to increase membership of the R&D Governance Committee and Maura Teager suggested that they also consider inviting representatives from the University of Derby to join the committee as associate members. The committee acknowledged the increased level of assurance on completion of audits and that this had been strengthened by the engagement with the Quality Leadership Teams. Concerns remained regarding membership and attendance at the R&D Governance Committee meetings and the use of virtual tools was seen as a positive idea. **RESOLVED: The Quality Committee noted the content of the update report.**
QC/2016/064	**STAFF FRIENDS AND FAMILY TEST** In the absence of Jayne Storey, Liam Carrier, Workforce Systems & Information Manager, presented the latest Staff Friends and Family Test results (Staff FFT) and report which focussed on hot spots within the Trust. This was the third publication of the Staff FFT results received by the Quality Committee and members of the committee were concerned to note a further decline to the lowest results so far received for recommending the Trust to friends and family if they needed care or treatment and as a place to work. Also, compared to the national picture, the Trust was running below the national average result.

	The majority of those who completed the survey also submitted written comments and these were included in the report, although the comments were a small number of the Trust headcount. The committee was concerned to read the many negative comments made by staff and that some of these comments related to effects the recent press coverage had on staff morale. Other key themes showed that staff were unhappy with the level of clinical pressure and capacity to deliver services, the effects of transformation, management behaviour and lack of training. The committee noted that these issues would be addressed at TOMM (Trust Operational Management Meeting) and will be driven through to the People & Culture Committee with a defined action plan against all issues raised. In addition, Jayne Storey and the Communications Team would work on a message to issue to staff to show how the Trust is responding to the staff feedback, reflecting and learning and responding to some of the specific detail in the survey. The Quality Committee considered that the significant reduction in staff morale may have a detrimental impact on clinical services and standards and this should be closely monitored and a solutions focused approach would be continuously adopted. The Quality Committee would work closely with the People & Culture Committee to ensure the development of an effective work plan to address management training support. **RESOLVED: The Quality Committee:** **1) Considered the report** **2) Scrutinised the contents** **3) Agreed to work closely with the People & Culture Committee to ensure the development of an effective work plan to address management training support.**
QC/2016/065	**<u>UPDATE ON CHESTERFIELD CENTRAL NEIGHBOURHOOD TEAM</u>** Acting Divisional Nurse, Brenda Rhule provided the Quality Committee with a verbal update on a service receiver concerns around the level of cases carried by the Chesterfield Central Neighbourhood Team. This followed an initial review which had been reported to the committee to ensure sustained oversight and closure of the local intelligence which was shared with the committee along with details on the audit of case notes and care planning recently carried out at St Mary's Gate. The committee was pleased to note that care plans, risk assessment and family and carers information had been well completed but there were concerns that some doctors were still using paper records rather than the EPR (Electronic Patient Records) system. Discussions centred around the patient safety risks, repetition of recording and impracticalities of using paper records. The committee suggested that files display a notice that the file was closed and reference should be made to the PARIS system. It was agreed that further exploration of this issues and a directive would be made from the Medical Director to promote full compliance with the EPR system and to take a solutions approach to support clinicians in a safe roll out of EPR. This would be led through the Full Service Record Group. **ACTION: A directive to ensure full service record compliance with the roll out of EPR will be led by John Sykes through the FSR Group and followed up through a report to –the next meeting in May in detail to enable the Quality committee to be appraised and assured on progress** **RESOLVED: The Quality Committee noted the verbal update on the Chesterfield Central Neighbourhood Team and had an increased level of assurance that this issue is resolving and will be managed as a business as usual improvement work by the Neighbourhood Lead professional/ Head of Nursing.**

QC/2016/066	**QUALITY REPORT** The first draft of the Quality Report for 2015/16 was received by the Quality Committee prior to the final version publication date of 30 June 2016 and reflected items that have been received through this committee throughout the year and the Quality Position Statement provided to the Trust monthly Board meetings. It was noted that the draft version would be shared with the Trust's service user groups, carers' forums, governors, and third parties which includes the lead commissioner, Hardwick Clinical Commissioning Group. Governors also had the opportunity to discuss the draft at the first meeting of their Governance Committee held on 12 April in order to agree a prepared response from governors and this will be included along with other third party comments in the final version of the Quality Report. The committee considered the uptake of staff participating in the seasonal flu vaccinations could be significantly increased with the use of an incentive and that this proposal would need to be agreed as part of the 2016/17 flu vaccination campaign. The committee acknowledged the significant work and good practice identified in the Quality Report and agreed that the report made clear the risks and challenges that staff faced in providing clinical services. **ACTION: Flu vaccination incentive scheme to be considered and agreed as part of the 2016/17 flu vaccination campaign.** **RESOLVED: The Quality Committee considered the draft Quality Report, challenged its content, gave feedback on areas to improve and received assurance on the process for its development, that it was representative of the quality position and expected the next iteration of the document to be received.**
QC/2016/067	**MANAGING FRAILTY** Nurse Consultant in Dementia Care Philomena O'Hanlon provided a report that contained an overview of training content and objectives in relation to a new e-learning course, supporting the identification of frailty as a clinical syndrome within the health population. This will be accessible to Trust employees working with relevant specialities. The committee confirmed its support for the frailty e-learning training and agreed that John Sykes would ensure e-learning training would be addressed at the People & Culture Committee and ensure the training is aimed at all qualified staff and carers and also be part of physical healthcare training. **ACTION: John Sykes to work with the Communications and Education Team to promote uptake for the training and include the frailty e-learning programme in the ESR training directory to support the development of the Neighbourhood model.** **RESOLVED: The Quality Committee reviewed the frailty e-learning training material and supported its application on to e-learning programme**
QC/2016/068	**INTERIM POLICY GOVERNANCE REPORT** Risk Assurance Manager, Rachel Kempster presented an interim amendment to the 'Policy on Procedural Documents' to allow a controlled process of extensions to be applied to policies nearing the completion of their review requiring a short extension period to complete. Rachel Kempster was liaising with another Trust to establish how they review policies

	that are in need review and establish any improvement areas that could be garnered to ensure strong policy governance. She asked the committee to adjust the Policy on Policies that the Quality Committee leads upon either in agreement with the director responsible or policy lead to allow just one agreed extension of the policy expiry date to include that there is no risk attached to this extension and that the policy will be ratified within the extension period. Rachel Kempster informed the committee that since March, 18 policies were shown as having passed their allocated expiry date. For a small number of these policies, especially those requiring input from multiple individuals or groups, there was clear evidence that the policy was near to being finalised and would benefit from a short extension to allow this to be completed. As the overall review and governance of policies has been significantly tightened over the last two years, with substantial and sustainable improvements in performance of policy management with tracking and number of policies out of date, Rachel Kempster requested that the Quality Committee allow short extensions to policy review dates, provided there is minimal risk in terms of risk, legal and practice implications. It was proposed that extensions be authorised by either the Director Sponsor or the Trust's policy lead, provided the extension date and rationale are clearly recorded on the policy document. The Quality Committee agreed that only one such extension be granted per policy and generally for definitely no more than six months from the expiry date and preferably within three months. Policies not reviewed, ratified and uploaded to Connect within this timescale will continue to be reported as overdue for review, as will policies where there is either risk associated with the delay or there is limited evidence that progress is in hand. **RESOLVED: The Quality Committee** **1) Agreed to allow a controlled process of extensions to be applied to policies nearing the completion of their review, and requiring a short extension period to complete.** **2) Agreed for the 'Policy on Policies Document' be amended to reflect these changes.** **3) Agreed to a more detailed report on overall Policy Governance to be provided as per the Quality Committee's forward plan in May 2016.**
QC/2016/069	**<u>NICE GUIDELINES REPORT</u>** Rachel Kempster provided the Quality Committee with an update on progress on plans for improving the Trust's systems and processes for monitoring the effectiveness of implementation of NICE guidance and advice. The committee noted that 257 NICE guidelines listed for the Trust have been assessed for relevance and 119 were deemed relevant to core business of the organisation. A further 15 guidelines have been issued by NICE during February which require assessing for relevance and this is in the process of being completed. The Quality Leadership Teams (and their Clinical Reference Groups – CRG's), plus other key groups such as the Physical Care Committee, have been tasked to review the list of guidance which may be relevant to the core business of the Trust, to agree those which are actually relevant, to prioritise these and to nominate a lead reviewer for each. This has been partially completed. These oversight groups are requesting lead reviewers to complete a pro-forma to identify current service provision against the guidance, gaps in provision and actions to be taken, for review and agreement by the relevant oversight group. This is a significant task facing all oversight groups and is still in the early stages of completion. NICE guidelines relevant to specific care pathways will be reviewed by the relevant QLT, until the process is fully established within the QLT.

	The committee was made aware that Microsoft SharePoint technology had been designed to provide a centralised database held on Connect to support the monitoring of compliance with NICE guidance and advice. This database was ready to be populated with completed pro-forma information and would be completed by the end of April 2016. The committee recognised the impact on capacity to progress the completion of a gap analysis for all 119 relevant guidelines, and for new guidelines deemed relevant going forward and fully supported the recommendation that each group propose a plan to completion to which they would be held to account through the Quality Committee. The committee looked forward to receiving a further progress report in June. **RESOLVED: The Quality Committee** **1) Agreed the progress reported and plans to improve allocation and review of NICE guidance** **2) Agreed to a further report on progress in June 2016, to allow the report to be compiled**
QC/2016/070	**SINGLE PATIENT CARE SYSTEM** Discussions regularly take place during SI cases around the use of a single patient care system and the General Manager for IM and T, Peter Charlton attended the meeting to talk about the different systems used for IAPT patients and Children and Young People's services. This issue is a recommendation from a historical serious incident, to ensure that there is a single electronic patient record system to access a full patient record. AC male to have access to records and care plans across clinical services (AC female). The committee acknowledged that PARIS is the Trust's primary source of information and clinicians and consultants were working with Peter Charlton to develop a solution. In the AC (male) case when EPR for inpatient services and campus go full live, this recommendation will be achieved, However, in the case of AC (female) further development work will be required to integrate with other systems. The committee noted the 6 month lead time to develop the system and supported this approach. It was agreed that a formal written paper on the single patient care system would be received at the May meeting and Peter Charlton was asked to contribute to the paper and prepare a summary to the report. It was noted that should services such as substance misuse be tendered and the Trust would no longer be the lead provider there were potential risks to AC (female) that the integration of information and care, may never be achieved. Carolyn Green asked Wendy Brown to arrange for the ACDs to attend the full service record meeting to enable increased clinical leadership by ACD's and improved involvement and ideas generation on how an integrated single patient care system can be driven forward. **ACTION: Peter Charlton to contribute and prepare a summary for the formal written paper on single patient care system which will be received by the committee at the May meeting.** **ACTION: John Sykes/Wendy Brown to arrange for ACDs to attend the service record meeting and engage with the implementation of an integrated single patient care system.** **RESOLVED: The Quality Committee noted the progress made to date to develop a cross organisational information system, however there were still**

	areas of limited assurance.
QC/2016/071	**<u>IMPROVEMENTS TO DATA QUALITY IN INTELLIGENCE MONITORING</u>** Carolyn Green gave a verbal update on improvements being made to data quality in intelligence monitoring. She informed the committee that so far all reports have been factually correct. However, the current report showed that a high number of people who are in employment have a mental health problem which implied our performance has decreased or a data entry performance issue in transition to FPR. The committee was assured that the Trust was supporting employment prospects of its service users and was reminded that the service user story presented at the March Board meeting illustrated how the Trust was working with and helping people who are out of work and getting them back to work through apprenticeships and internships. Carolyn Green also drew attention to the fact that the number of people under aspects of DOLs or the Mental Health Act were rated as moderate currently for this time period. Existing mitigation plans were our developments of a suicide strategy and safety plans were put in place to improve patient care and have an impact on these performance levels. Carolyn Green proposed to raise both these matters as aspects of risk within our intelligence monitoring during the forthcoming CQC inspection. **RESOLVED: The Quality Committee noted the improvements being made to data quality in intelligence monitoring.**
QC/2016/072	**<u>ANNUAL INFECTION CONTROL REPORT</u>** Nurse Consultant, Hayley Darn's paper summarised the activity of infection control over the preceding 12 months. The report showed that performance against key standards of infection prevention and control and related activities remain consistently high with those of the previous year and we have maintained our five-star rating on kitchens by Derby City Council for the fourth year in succession. Hayley Darn commended the work of the estates and hotel services teams in ensuring the highest standards in food hygiene, pest control, laundry and linen supplies in inpatient wards and patient facilities. Concern was raised by the committee in the low uptake by staff in the influenza vaccination campaign (around 22%) and discussed how to incentivise staff to be vaccinated. It was suggested that staff would be more inclined to be inoculated if the vaccination programme was facilitated on the wards rather than at the designated clinics. The committee agreed that this matter should be addressed as a programme of work through the People & Culture Committee by John Sykes to discuss how to incentivise this initiative. The committee acknowledged the good operational engagement and collaborative work with the estates and hotel services in maintaining such high levels of hygiene standards. **ACTION: Hayley Darn to raise influenza vaccination initiative with John Sykes for the matter to be addressed as a programme of work through the People & Culture Committee.** **RESOLVED: The Quality Committee** **1) Noted the reporting of key areas, such as surveillance of healthcare**

	associated infections – alert organisms, outbreaks of infection, staff training. **2) Received high levels of assurance on standards of cleanliness of clinical areas and food preparation areas** **3) Approved the report in preparation of presentation to the Trust Board of Directors as per forward plan.**
QC/2016/073	**NICOTINE MANAGEMENT POLICY** Hayley Darn presented the refreshed Nicotine Management Policy to the committee for formal approval. The committee agreed to the policy being ratified. **RESOLVED: The Quality Committee agreed to ratify the Nicotine Management Policy.**
QC/2016/074	**VIOLENCE AND AGGRESSION PREVENTION AND MANAGEMENT POLICY AND PROCEDURE** The committee received the Violence and Aggression Prevention and Management Policy and Procedure for review. It was understood that the policy had been considerably re-written in line with national and local requirements and Code of Practice changes and would be submitted to the next meeting in May for formal ratification. **ACTION: Violence and Aggression Prevention and Management Policy and Procedure to be an agenda item for next meeting in May.** **RESOLVED: The Quality Committee noted the requirements relating to the Violence and Aggression Prevention and Management Policy and Procedure**
QC/2016/075	**ITEMS INCLUDED FOR INFORMATION** The following items were received and noted by the committee: • Quality Leadership Team draft minutes • CQUIN Agreements • Committee meeting dates for 2016/17
QC/2016/076	**FORWARD PLAN** The forward plan would be updated to show the GIAP addressed by the committee at each meeting.
QC/2016/077	**ITEMS ESCALATED TO THE BOARD OR OTHER COMMITTEES** • Pressure and capacity issues regarding staff preparation and attendance at Coroners Inquests and implications of CQC/Coroners Memorandum of Understanding Section 28 reports • The potential to introduce an Incentive Scheme to increase uptake of flu vaccination to be brought to the Board's attention and to be progressed at the People & Culture Committee • Positive progress with the completion and signing off of clinical audit projects • Feedback from Staff Friends and Family Test showed a significant reduction in staff morale which may have a detrimental impact on clinical services and standards • Concern that doctors and consultants are not recording case notes in EPR and

	the requirement for greater assurance on the transition phase and safeguards to ensure contemporaneous record keeping in an electronic form.
QC/2016/078	**ANY OTHER BUSINESS** Maura Teager informed the committee that since Derbyshire Voice withdrew from Derbyshire's mental health engagement service earlier this year, Hardwick CCG had selected NDVA (North Derbyshire Voluntary Action) to support the new interim arrangement as a suitable interim support provider. NDVA now holds the contract and will be providing support to the service user involvement group during this time, the Derbyshire Mental Health Alliance has been set up and their representatives Chris Fitzclark and Ruth Hindle will now attend meetings of the committee from May onwards.
QC/2016/079	**EFFECTIVENESS OF THE MEETIING** The meeting overran due to the complexity and number of agenda items which prompted good discussion. The meeting was challenging and good scrutiny of information took place.

Date and Time of next meeting: The next meeting of the Quality Committee will take place on:
Thursday, 12 May 2016 at 2.15 pm
Venue: Meeting Room 1 – Albany House, Kingsway, Derby

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

Thursday, 20 April 2016

PRESENT:	Richard Gregory	Chairman
	Phil Harris	Non-Executive Director
	Mark Powell	Director of Business Development & Marketing
	Jayne Storey	Director of Workforce, OD & Culture
	Sam Harrison	Director of Corporate Affairs & Trust Secretary
	Dr John Sykes	Executive Medical Director
	Carolyn Gilby	Acting Director of Operations
IN ATTENDANCE:	Sue Turner	Board Secretary & Minute Taker
	Lee Fretwell	Chair, Staff Side
	Richard Eaton	Communications Manager
APOLOGIES:	Rose Boulton	Principal Workforce & OD Manager
	Liam Carrier	Workforce Systems & Information Manager
	Anna Shaw	Deputy Director of Communications
	Robert Quick	Governor, North East Derbyshire

P&C/2016/024	**WELCOME AND APOLOGIES** The Chair, Richard Gregory opened the meeting and welcomed everyone. Richard Gregory suggested that in addition to governor representation on the committee provided by Robert Quick, a staff governor representative would also be invited to attend. **ACTION: Staff governor attendance at committee meetings to be arranged.**
P&C/2016/025	**MINUTES OF THE PREVIOUS MEETING, ACTION MATRIX** Minutes of the meeting held on 17 March 2016 were approved with the following amendments: **P&C/2016/013 Mindful Health & Wellbeing Board Terms of Reference:** The final paragraph of this item "The Trust's Health & Wellbeing Strategy was also discussed and Rose Boulton agreed to update this and bring to the next meeting for approval." would be substituted with *"The Health and Wellbeing Strategy would be updated by Rose Boulton and submitted to the committee at the June meeting. This would be reflected in the forward plan."*. The corresponding action for this item would be corrected to read as follows: **ACTION: Mindful Health & Wellbeing Board Terms of Reference to be updated in line with Trust standard. Health & Wellbeing Strategy to be updated and submitted to the committee in June and reflected in the forward plan.** **P&C/2016/019 Operational Update:** The third bullet point **"**Staffing is a concern. The numbers of preceptors going forward is an issue. There is a need to look at the retirement profile of the workforce and do some forward planning." would be

	corrected to read *"Staffing is a concern. The numbers of preceptors going forward is an issue. There is a need to look at the retirement profile of the workforce and feed this into the workforce plan.".* The penultimate sentence would also be corrected to state that Lorraine Statham and not Rose Boulton would liaise with the Royal Derby with regard to the work they were carrying out around workforce planning, if appropriate.
P&C/2016/026	**MATTERS ARISING** **P&C/2016/016 Freedom to Speak Up Action Plan:** Lee Fretwell informed the committee that open surgeries with representation from Staff Side would be set up to listen to staff concerns. He also pointed out that staff were feeling more confident in communicating with the Acting CEO about raising concerns. Jayne Storey outlined the mechanism recently put in place to "listen, learn and lead" which forms part of the Acting CEO's report to the Board and she would discuss developing this process further with him to ensure that we continue to build relationships with staff, and demonstrate we are both listening and acting on feedback and concerns. **P&C/2016/018 2015 Staff Survey:** The committee considered the fact that staff did not feel the staff survey was an entirely anonymous system. The committee discussed how the survey is managed via an external agency and it was agreed that the staff completion rate could be improved if Staff Side were to validate the anonymity of the survey so staff can understand that individuals are not identifiable internally. **ACTION: Lee Fretwell would issue an email to staff to validate the anonymity of the staff survey.** **P&C/2016/019 Operational Update:** Lee Fretwell informed the committee that the future workforce plan would need to consider the impact of the recent re-tender of children's services as well as future tenders. Jayne Storey confirmed it would be part of the workforce planning process.
P&C/2016/027	**GOVERNANCE IMPROVEMENT ACTION PLAN** Mark Powell presented his paper which set out the arrangements by which the Trust's Board would be assured that the GIAP was systematically implemented, delivering the agreed key outcomes so that it could demonstrate to all key stakeholders that the required improvements have been made. The paper also briefly explained the role of the committee with respect to its oversight of GIAP actions and provided an overview of the actions that this committee is responsible for seeking assurance on delivery. The purpose of the paper was 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. Out of the 140 tasks on the GIAP this committee has 39 task actions and the following actions were reviewed: I. **HR2 R25 Resource Plan:** The committee was assured that a Resource Plan had been developed and set out the status of the recruitment of the five roles identified to support the transformation of HR and related functions. However, following discussions, the committee raised concerns in regards to the number of resources identified and felt that given the needs of the function and GIAP, insufficient resources had been identified. The committee considered six-month contracts insufficient to enable the plan to be delivered and asked Jayne Storey

to revisit this aspect of the resource plan at ELT. The committee agreed to categorise this action as **Amber** and noted that an updated plan will be received at the next meeting.

II. **ACTION: Jayne Storey to revisit the resource plan at ELT in terms of the capability required and the duration of the contracts. W1 Delivery of Freedom to Speak Up Action Plan:** The Freedom to Speak Up Action Plan was approved by the committee in February and understood it would be updated in line with the national policy. The committee was assured that in the meantime the Trust is covered by the existing policy. Sam Harrison would take this forward and present back at the May Committee

III. **HR5 R35 Measures of efficiency and impact on HR:** The committee was pleased to see the vacancy monitoring and time to recruit included in the timeline of recruitment measures and considered this would be a good measure to gauge recruitment time to hire. . Quality of staff appraisals would also be monitored through this process and would be part of the OD Project Manager's remit. The committee was satisfied that a functional set of measures has been set in place and agreed this task was on track and agreed to turn this action **Green**.

PC4 Development of the People Strategy: The committee recognised the strategic intent of the People Strategy and understood it will contain a number of key themes which would be the building blocks to support the achievement of the Trust's mission, vision and values and each block would be supported by a logical sequence of activities contained within the People Plan. Jayne Storey asked the committee to accept that the People Strategy was a work in progress and the timescale for its completion would be synchronised with the Trust Strategy. The People Strategy would be shared with Governors, together with the Trust Strategy at the next meeting of the Council of Governors on 1 June. The People Strategy would also be the subject of a Board Development session and leadership meeting in May. The committee discussed the values element of the People Strategy and questioned whether these should be refreshed or re-written. It was agreed that the Communications Team would conduct a poll to establish whether staff feel the Trust's values need to change. In addition, it was proposed that a podcast be prepared to show Lee Fretwell and Jayne Storey discussing their views on the values to encourage a bottom up / partnership approach to setting the Trust's renewed values.

The committee discussed organisation capability and enabling people to reach their potential. When asked by Richard Gregory if there was a plan to extend 360 degree appraisals for middle managers, Jayne Storey responded that the People Strategy was supported by the People Plan which contained all these issues. Levels of and hierarchy of management will be looked at and would be reviewed as part of the organisation design action on the people plan.

The GIAP has been mandated to state that the People Strategy is being refreshed, although it is not yet complete. The committee agreed that the People Plan will be in place by the end of May and understood that the completion of the People Strategy itself was a more lengthy process and would be in line with the Trust Strategy

ACTION: Lee Fretwell and Jayne Storey to work with the Communications Team to produce a podcast to establish staff engagement in the Trust Values.

ACTION: Communications Team to conduct a poll to establish staff opinion on whether the Trust's values need to change

ACTION: Completed People Plan to be presented to the next meeting in May.

IV. **GIAP item FF1 (3) Fit and Proper Person Policy:** All current directors have to comply with all aspects of the policy evidence is to be made available in a revised file structure. Sam Harrison, Director of Corporate Affairs informed the committee she was working closely with the HR team to ensure all required checks are carried out and evidenced within the files. There are some outstanding areas of evidence which would be required to give assurance to the chairman to make a formal declaration of confirmation to the Board full compliance with Fit and Proper Persons Requirements. Sam Harrison reiterated that all required policies and self-declarations are in place and she believed the Trust was on track to meet this task.

V. **CQC2 Operational Recruitment Plan:** Carolyn Gilby presented a paper that outlined plans and strategies to improve success in recruiting staff in the context of a national shortage of nurses and medical staff. She asked for the committee's support to progress the proactive initiatives contained in the recruitment plan and to fast track recruitment to fill the high level of vacancies and align the Operation Recruitment Plan with the People Plan. The committee was assured that the recruitment plan can commence but was realistic about the capacity of the HR department. Jayne Storey to seek assurance from the team and if needed additional capacity would consider within the revised resource plan

The Committee acknowledged that certain policies that have not been ratified have had an impact on recruitment and it was agreed this this would be raised at TOMM (Trust's Operational Management Meeting) on 22 April by Carolyn Gilby. Phil Harris suggested applying a temporary waiver to the relevant policies which would allow them to be revisited in three or six months' time. This would overcome the issue of waiting for the relevant policies to be ratified. Sam Harrison agreed to look into the possibility of apply a temporary waiver to policies that affect recruitment process.

Carolyn Gilby informed the committee that capacity issues in the HR team to implement the recruitment changes would be discussed at TOMM (Trust's Operational Management Meeting) on 22 April and she would provide a post meeting note that would update the committee on the actions agreed at TOMM.

The committee hoped to receive assurance that component parts of the Operational Recruitment Plan could be put in place ready to commence on Friday, 22 April and was realistic and understood the issues that the HR team were facing.

Post Meeting Note:

- Jayne Storey will take the additional resource request to ELT
- A flowchart to support the changes will be in place for 3 May
- Policy changes to be made and agreed at policy development group
- HR can support the new processes from 9 May and so they will start then
- Ops continue with recruitment is usual way until then
- eDBS project is revisited by HR/IM&T/OPs at the next TOMM meeting 27 May
- Staff side chair was at the meeting, has the paper and was part of the P&CC discussion and can share this with staff side colleagues
- Review new processes to ensure improvements using a basic KPI e.g. timescale of recruitment process

	Carolyn Gilby would provide an update on progress at the next meeting in May. The committee discussed blue and red actions shown on the GIAP and agreed that items would be scrutinised line by line each quarter, commencing at the June meeting. **ACTION: Line by line scrutiny of the GIAP will be an agenda item for June meeting and will feature quarterly on forward plan.** **RESOLVED: The People & Culture Committee received partial assurance that actions outlined in the GIAP have been delivered within the timeframes agreed.**
P&C/2016/028	**STAFF SURVEY AND ACTION PLAN** Jayne Storey presented her report that contained the action plan that was formulated following the annual NHS National staff survey results in February 2016. The committee discussed the challenges that the Trust would be facing over the next 12 months and was assured that a number of these areas have been identified within the GIAP. Members of the committee felt content that the proposed survey action plan supported the People Strategy and People Plan and would be shared with the Engagement Group and demonstrated a positive partnership with staff side. It was also noted that the results of the Staff Survey and Action Plan would be received by the Trust Board on 27 April. The committee agreed that progress on actions would be monitored on a quarterly basis and this would be captured in the committee's forward plan. **ACTION: Forward plan to reflect a quarterly review of the Staff Survey Action Plan.** **RESOLVED: The People & Culture Committee** **1) Received the draft staff survey action plan** **2) Recognised that further refinement was required and that it would be presented at the Trust Board in April.** **3) Agreed that progress of actions contained in the action plan would be reviewed by the committee on a quarterly basis.**
P&C/2016/029	**HR METRICS** Jayne Storey presented the latest key Workforce KPI Dashboard metrics at Trust level, together with the next steps. This was the third time this HR metrics have been presented to the committee. The committee recognised that the metrics were refined each month and will be further developed to identify hot spots in each service line. **RESOLVED: The People & Culture Committee considered the HR metrics and was satisfied with the content and style.**
P&C/2016/030	**OPERATIONAL UPDATE** Carolyn Gilby provided a verbal operational update and informed the committee that a contract had now been agreed with commissioners with regard to Melbourne House and she was developing a process to temporarily redeploy staff into substantive posts.

	RESOLVED: The People & Culture Committee noted the information within the verbal operational update report.
P&C/2016/031	**RESEARCH & DEVELOPMENT STRATEGY UPDATE** John Sykes offered a verbal updated on the Research and Development Strategy. John Sykes informed members of the committee that a presentation on the values of compassionate management and clinical care had been made at the Board Development session on 13 April. He explained that Professor Paul Gilbert was conducting a study into compassionate management and leadership styles and could be invited to attend the next meeting of the committee to discuss what is required for a training programme to be developed. It was agreed that Jayne Storey would meet Paul Gilbert to discuss how the compassionate model could be developed into a training programme. **ACTION: Jayne Storey to develop compassionate management training with Paul Gilbert.** **RESOLVED: The People & Culture Committee received and noted the information within the verbal Research & Development Update report.**
P&C/2016/032	**WORKFORCE PLAN** Jayne Storey presented the proposed methodology and timeline for the construction of the 2016 workforce plan. The committee received positive assurance on the workforce plan. It was noted that consultation will take place with general managers to ascertain overall direction, with input from management groups across the Trust and the Workforce sub-group of the People and Culture Committee will be used as a line of consultation and a mechanism for refining the plan. A draft plan will be produced for consultation by mid-May with the final plan in place by mid-June. **ACTION: Draft workforce plan will be received by the committee in May and the Final plan to be submitted to the June meeting. This timeline will be reflected in the forward plan.** **RESOLVED: The People & Culture Committee:** **1) Noted the contents of the report** **2) Approved the methodology and timeline for the production of the workforce plan**
P&C/2016/033	**TERMS OF REFERENCE** The following Terms of Reference were ratified by the committee: Updated Engagement Group Terms of Reference were ratified subject to the minor amendments as follows; the removal of the word internal when referring to the Communications team. The core membership will include a nominated member of the Nursing Directorate and a nominated member of the Medical Directorate. Education Training and Development Group Terms of Reference were ratified subject to the membership being amended to include nominated representatives from the Nursing Directorate, Psychology, AHPs and Administrative staff. The committee requested that Paula Crick, Voluntary Sector Governor from the University of Derby

	be invited to become a member of the Group. The first meeting is to be scheduled and held within four weeks. Workforce Group Terms of Reference were ratified. Updated Mindful Health and Wellbeing Group Terms of Reference were ratified with the first meeting to be scheduled and held within four weeks. **RESOLVED: The People & Culture Committee ratified the above Terms of Reference.**
P&C/2016/034	**SICKNESS AND ABSENCE DEEP DIVE** Due to the large number of agenda items it was agreed to defer this item to the next meeting in May.
P&C/2016/035	**STRESS LEVELS IN THE COMMUNITY TEAMS** The committee agreed to discuss this item at the next meeting in May.
P&C/2016/036	**REINSTATING THE SCHWARTZ ROUNDS** Jayne Storey proposed that the reinstating Schwartz rounds be part of the Health and Wellbeing strategy going forward and would be addressed by the Health and Wellbeing Group.
P&C/2016/037	**ANY OTHER BUSINESS** **Addendums to existing appraisal policy:** Jayne Storey informed the committee that the Appraisal Policy is to be reviewed in line with the Policy reviews, however in the immediate term an addendum would be added to reflect nurse re-validation process. Hayley Darn as lead for the re-validation would take this forward. This information would also be shared with JNCC/Policy group. **ACTION: JNCC/Policy Group to be made aware that the Appraisal Policy is to be re-evaluated and an appendix would be added to include nurse re-validation.**
P&C/2016/038	**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/2016/039	**ITEMS ESCALATED TO THE BOARD** The Committee agreed that HR capability and capacity will be escalated to ELT
P&C/2016/041	**IDENTIFIED RISKS** The committee identified the key risks as follows: Resources / capacity and the length of time resources are contracted for.
P&C/2016/042	**EFFECTIVENESS OF THE MEETING** The committee recognised the full and complex agenda at today's meeting and some difficult issues were discussed in detail. It was agreed that Phil Harris would chair the May meeting as Richard Gregory would be on holiday and a Non-Executive Director would be invited to attend the to ensure the committee would be quorate.

Date and Time of next meeting: The next meeting of the People & Culture Committee will take place on **Wednesday, 18 May 2016 at 2.00 pm in *Meeting Room 2 – Albany House, Kingsway, Derby.***

Derbyshire Healthcare NHS
NHS Foundation Trust

Audit Committee

Annual Report

April 2016

Better together

AUDIT COMMITTEE
Annual Report 2015/16

1. Introduction

The purpose of the report is to formally report to the Board of Directors on the work of the Audit Committee during 2015/16.

2. The Committee

The Audit Committee is responsible for ensuring the establishment and maintenance of an effective system of integrated governance and internal control, across the whole of the organisation's activities in support of the organisation's objectives. It achieves this by:

- Ensuring that there is an effective internal audit function providing appropriate independent assurance to the Audit Committee, Chief Executive and Board
- Reviewing the work and findings of the external auditor
- Reviewing the findings of other significant assurance functions, both internal and external to the organisation
- Reviewing the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work
- Requesting and reviewing reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control
- Reviewing the Annual Report and financial statements (as a delegated responsibility of the Board) and ensuring that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

2.1 Membership of Audit Committee

Our Audit Committee comprises:

Non-Executive Directors

- Caroline Maley – Non-Executive Director (Chair)
- Phil Harris – Non-Executive Director
- Tony Smith – Non-Executive Director

Non-Executive Directors' attendance at the Audit Committee during the year was as follows:

	Possible attendances	Actual
Caroline Maley	7	7
Phil Harris	7	6
Tony Smith	7	7

3. Internal Audit

Much of the Committee's work is supported by the programme of work for the internal audit service, which is provided by PricewaterhouseCoopers LLP (PwC). The service is provided within an agreed workplan, prepared in consultation with the Executive Leadership Team

and approved by the Committee, which over a three-year cycle seeks to ensure that all areas of risk that could have significant impacts are subject to reviews, both for the design of controls and their effective implementation in practice.

Each review report by Internal Audit, together with the responses and action plan from Trust management, are laid before the Committee. During the year, the Committee has considered eleven internal audit reviews resulting in the identification of 2 high, 15 medium and 19 low risk findings to improve weaknesses in the design of controls and / or operating effectiveness. The two high risk finds are outlined as below and are detailed in the Trust's Annual Governance Statement.

- **ICT Infrastructure Resilience and Recovery (Recovery Requirements within the GEM Contract)**

Approximately 95% of the Trust's IT systems are outsourced to the third party Greater East Midlands Commissioning Support Unit (GEM). Within the GEM contract, for the highest priority incidents, there are no Service Level Agreements (SLAs) for recovery of key IT systems. For major incidents affecting critical systems, the GEM contract does not include specified recovery time objectives (RTO), and no recovery points objectives (RPO).Without agreed SLAs for the recovery of the Trust's critical IT systems, there is a risk that those IT systems will not be recovered in time to prevent significant impact to the Trust's key operations and stakeholders.

The Committee received assurance from senior managers that the recommendations within the report have been completed.

- **HR Processes (Data Quality - Safe Staffing)**

The audit reviewed whether safe staffing data was correct for 25 shifts. Six shifts were incorrectly stated and therefore reported incorrectly to NHS England and the Board of Directors. The majority of errors occurred as the ward manager did not understand that bank and agency staff should be presented in the data submitted. Consequently, in the majority of cases, the Trust underreported their performance.

The Committee received assurance from senior managers that the recommendations within the report have been addressed.

The Head of Internal audit opinion is as follows:

Governance, risk management and control in relation to business critical areas is generally satisfactory. However, there are some areas of weakness and noncompliance in the framework of governance, risk management and control which potentially put the achievement of objectives at risk. Some improvements are required in those areas to enhance the adequacy and effectiveness of the framework of governance, risk management and control.

In March 2016, an independent review was undertaken by PwC of the effectiveness its service to the Trust, and suggestions for improvement. The review was largely positive with some areas noted for improvement. These include that timing of reports should be more balanced across the year, continuing the move away from technical audits and improving the focus on 'what's new' section of report to outline industry insights and emerging friends.

The internal audit contract having previously been extended for a further two years, will run to November 2016. The Committee would like to thank PwC for their approach to internal audit work through the year, and also the support that they have provided to the Committee.

4. External Audit

Grant Thornton continued to serve as the External Auditors for the year.

The Committee has continued to be supported in its work by the External Auditors, who attend all scheduled meetings of the Committee and have unrestricted access to the Committee's Chairman. Although the outcomes of the external auditor's work are published with the Annual Accounts, work is undertaken throughout the year to support their final opinions and to ensure that the audit process is effective. As is established practice, the Committee will be reporting to Council regarding the conduct of the Audit; however, we can report to the Board that External Auditors have identified a significant risk regarding their value for money audit (which assesses whether the audited body had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people). This risk is in relation to governance and arises from Monitor's governance risk rating for the Trust being red and the Trust being subject to enforcement action.

The Committee assesses the effectiveness of the external audit process by undertaking the self-assessment each year and by meeting with auditors in private. Auditors attend every meeting of the Audit Committee, and the Trust's compliance with the audit plan approved by the Committee is monitored**.**

The external audit firm, Grant Thornton, was appointed on 1 November 2012 following an open tender process in the summer of 2012. The contract awarded was for an initial term of three years. The total value of the three year contract was £116,560 + VAT. In adherence with all requirements, including approval by the Council of Governors, this contract was subsequently extended for a further two years.

The value of the 2015/16 accounts work is £38,850. Grant Thornton did not provide any non-audit services during the year.

5. Local Counter-Fraud service

The Trust's counter fraud service is provided by an external organisation named 360 Assurance. They provide our Local Counter Fraud Specialist (LCFS), who works with us to devise an Operational Counter Fraud Work Plan for the year, which is agreed by our Audit Committee. The plan is designed to provide counter-fraud, bribery and corruption work across generic areas of activity in compliance with NHS Protect guidance and Provider Standards.

The Trust has agreed to take all necessary steps to counter fraud affecting NHS-funded services and will maintain appropriate and adequate arrangements and policies to detect and prevent fraud and corruption. We have a Counter Fraud, Bribery and Corruption Policy and a Raising Concerns at work (Whistleblowing) policy and procedures in place which are communicated to staff – for example, through Trust information systems, newsletters and training.

During 2015/16 the Trust used 65 days of counter fraud activity, across the following areas:

- Strategic governance (assessment and reporting) – 15 days
- Inform and involve (awareness training, publicity, liaison)– 17 days
- Prevent and deter (issue alerts, review policies, provide guidance)– 24 days
- Hold to account (investigations) – 9 days

- Total – 65 days.

The Trust's Audit Committee receives regular updates from the Local Counter Fraud Specialist in order to gain appropriate assurance around our counter fraud work programme.

The Local Counter Fraud draft annual report concluded that the Audit Committee could be assured that the Trust's counter fraud, bribery and corruption arrangements are embedded, that there is a strong anti-fraud, bribery and corruption culture within the Trust and that the Counter Fraud service delivered by 360 Assurance (as positively commented upon by NHS Protect in their inspections is efficient and effective.

The Local Counter Fraud contract having been extended for a further two years, will run to November 2016. The Committee would like to thank 360 Assurance for their approach to their work through the year, and also the support that they have provided to the Committee.

6. Other sources of assurance

The Committee adopted a process of "Deep Dive" review of the BAF risks, which proved invaluable in providing assurance over controls and gaps in assurance with a focus on action plans to improve. This approach has informed and supported our overall review of the BAF prior to submission to Board.

The Annual Governance Statement has been subject to scrutiny and challenge by the Audit Committee to ensure that it meets the requirements as set out for this report. The Committee is assured that the report is balanced and fair.

External Auditors of NHS Shared Business Services (SBS) have given an unqualified opinion on all 24 controls within the International Standard on Assurance Engagements (ISAE) No. 3402. This assurance was presented to the Audit Committee in April 2016.

7. Review of our effectiveness and impact

We have considered the overall impact and effectiveness of the Committee's work, as is recommended in the *Audit Committee Handbook*. Overall, we consider that the Committee is effective, in that it has maintained good oversight of the systems and controls in place for the Trust. As part of the outcome of the audit committee effectiveness process, members again noted that clarification was required about the interaction between the Committee and the Council of Governors. The Audit Chair's views were also benchmarked against over 30 other Audit Committees, and this highlighted the need to clarify the responsibility for the oversight of risk management. The Board agreed at the March meeting that the Audit Committee will take overall responsibility for the oversight of risk management, and will be renamed the Audit and Risk Committee.

8. Objectives of the Committee

For 2015/16, the Committee set the following objectives:

- To promote good governance by ensuring greater clarity and cohesion between board committees
- To continue to engage more deeply with the clinical audit programme to improve integration of its activities

- To apply rigorous challenge to the Board Assurance Framework through a “deep dive” approach and through close collaboration with other board committees
- To clarify the role of the Committee and the Council of Governors, and improve relations with the Council of Governors
- To keep a focus on and be assured on the quality of data.

During the self-assessment of the Committee’s effectiveness, the Committee reviewed these objectives and concluded that they had been largely met, but in particular noting the improvement in the engagement with clinical audit, and the BAF deep dive approach which was used during the year to gain assurance on the controls and gaps in assurance relating to each of the strategic risks. The Committee also noted that actions from the 2015 self-assessment had been addressed (seeking assurances from third party providers; gaining clarity on the policy for non audit work delivered by external audit; improving meeting discipline around summarising and confirming actions in the meeting).

For 2016/17 the Committee had set as its objectives:

- To promote good governance by ensuring greater clarity and cohesion between Board committees
- To ensure that the Committee has a formal process for the interaction with Governors
- To apply clarity to the oversight of Risk within the Board Committee structure.
- To consider the implications of non-audit work carried out by the auditors.
- To ensure robust Governance processes are in place to enable Audit Committee to seek the appropriate assurance over systems, controls and processes
- To ensure that the Board and Council of Governors are provided with the appropriate training to ensure knowledge of Audit and the role of the Audit Committee.

9. Conclusion

Having considered the other documents that are being presented to the Board in connection with the Annual Report and Accounts, the Audit Committee is of the opinion that this report is consistent with them. Having made reasonable enquiry, we report to the Board that:

- The Board can have reasonable assurance regarding the contents of the Annual Report, Financial Statements, and Quality Report for the year ended 31st March 2016
- The Annual Governance Statement appears to be consistent with the internal controls environment that existed in the Trust during the year
- There is reasonable assurance that the statements made by the Board in the Letter of Representation to the Auditors are appropriate.

The Annual Report and Accounts will be signed prior to the submission deadline on 27 May 2016 and be adopted on behalf of the Board. The letter of representation will also been signed by the Chair of the Audit Committee and the Director of Finance.

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 25 May 2016

The Trust Strategy 2016-21

Purpose of Report

The purpose of this report is to present the Trust Strategy 2016-21 to the Board for approval. The DRAFT strategy was presented in April and feedback received. Revisions based on feedback have been incorporated in the final document.

The report also contains the following documents for the Board to note and provide feedback:

- 'Plan on a Page' - *Appendix B*.
- Measuring Success – initial thoughts - *Appendix C*.
- A brief communications plan – *Appendix D*
- Outline details of the Strategy Implementation Process - *Appendix E*

Executive Summary

The Board of Directors committed to developing a new Trust Strategy and regular updates have been received over the past few months, with the DRAFT strategy being presented in April 2016.

Following feedback from the Board further updates have been made to the final version (Appendix A):

- Reference to the use of external reports, in particular the CQC Focused Inspection.
- Updated references to the emerging Sustainability and Transformation Plan
- Changes to wording to reflect links to the developing People Strategy and results from the staff survey.

The strategy clearly sets out the direction of travel over the next five years in-line with national and local plans. Key areas within the plan are:

1. Introduction and background: This section includes information on what a strategy is, why we need one, how it has been developed and the drivers of change. It further goes on to explain the wider national and local planning environment, showing how our strategy fits within that context. There is also information about the Trust and high level demographic data about our populations.

2. Creating our vision: This section clearly articulates the vision, values and strategic priorities of the Trust. There is also information about our services and the different areas we work within i.e. 'place', Derbyshire wide or outside of Derbyshire.

3. Achieving our vision: This section gives further details on each of the four strategic priorities and what they actually mean together with what we want to achieve. The

four priorities are:

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

This section also looks at how it 'feels' for a service receiver and everyone employed by the Trust in 2016 and what we aspire to in 2021.

As outlined to the Board in April further work has taken place to develop the following:

- 'Plan on a Page' – this provides a summary of the key areas of the strategy - *Appendix B*.
- Measuring Success – initial thoughts are outlined in *Appendix C*. The proposal is aligned to the integrated performance reporting mechanism and is based on the four strategic objectives. Further, more detailed KPI's will be developed as part of the strategy implementation process.
- A brief communications plan has been developed to ensure that people are aware of the strategy and what it means for them – *Appendix D*
- The Strategy Implementation Process which aligns business planning, transformational change and efficiency. It also aligns to the emerging STP providing a mechanism for delivery. See *Appendix E*

Strategic considerations

Strategic considerations have been highlighted in previous briefings. These have been taken into account in the writing of the strategy. It should also be noted that there is a clear link to the wider system transformation and the emerging Sustainability and Transformation Plan (STP).

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

Board Assurances

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

Consultation

As previously highlighted in January, March and April 2016, this plan has been developed following staff, service receiver and governor engagement events, updated with feedback from Executive Directors and Commissioners

Governance or Legal Issues

There are no governance or legal issues associated with the actual strategy document. However, as the implementation process commences governance and legal issues are likely to arise and will be reported accordingly.

Equality Delivery System

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

Recommendations

The Board of Directors is requested to:

1. Approve the Trust Strategy 2016-21
2. Approve the content of the 'Plan on a Page'
3. Note the contents of the proposed communications plan and provide feedback
4. Note the suggested performance monitoring dashboard and provide feedback
5. Note the outline timetable for strategy implementation

Report presented by: **Mark Powell, Director of Business Development and Marketing**

Report prepared by: **Lynn Wilmott-Shepherd, Associate Director of Strategy and Business Development**

Derbyshire Healthcare NHS
NHS Foundation Trust

Trust strategy

2016-2021

Background and context

- **What is a trust strategy?**

Our strategy has been developed to meet the needs of our service receivers and to help staff understand their role in achieving the vision. It sets out the direction of travel for Derbyshire Healthcare NHS Foundation Trust for the next five years within the context of the wider health and care agenda, both nationally and locally.

The strategy aims to provide a clear and concise vision for the future in order to deliver a *"…proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services" (Five year forward view for Mental Health - February 2016, NHS England).*

This strategy also outlines our plans for what we need to do to ensure that our vision is realised for the benefit of our service receivers.

- **Why update it now?**

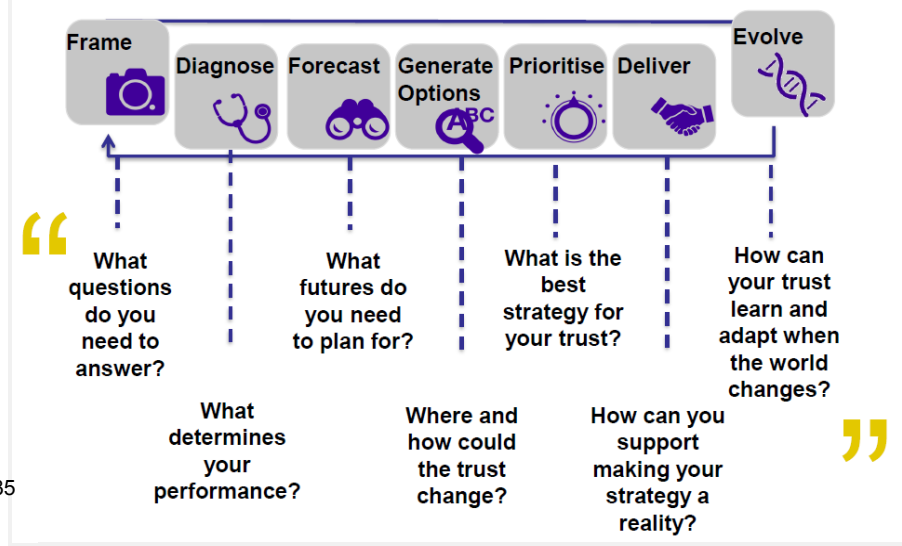
Our current strategy has helped us develop our services up to 2016. However, we now need to rethink how the Trust develops over the next five years in a changing health and care environment. There are many reasons why we need to change and examples of these are set out on page 8 (Drivers of Change). However, an important influence on the changes we need to make come from service receiver feedback and listening to our staff. At a national level we have to ensure we meet the requirements of the *NHS Constitution* and the important guidance called *Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21 (Dec 15).* As part of the national guidance we are developing a system wide (Derbyshire and Derby City) Sustainability and Transformation Plan (STP) which means that this is an opportune time to rethink how we move forward and how we work together with our service receivers, our staff and our system partners to achieve our vision (see page 2 and diagram on page 3).

- **How has the trust strategy been developed?**

We have considered our health economy environment, our current performance, what services are core and which are strategically important to us (core plus). We have consulted with our staff, stakeholders, commissioners, governors and Trust Board members to gather ideas for strategic direction and these are detailed in this document. We have circulated the draft content to our staff to ensure that it clearly represents the views of the whole organisation.

We have also aligned the strategy to a number of external reports and recommendations including the recent Care quality Commission (CQC) Focused Inspection.

We have also followed the seven stages detailed in the monitor "Strategy in Practice- Workbook" as a guide for the process. This gave a structure to the process providing templates and strategic challenge to our final document.

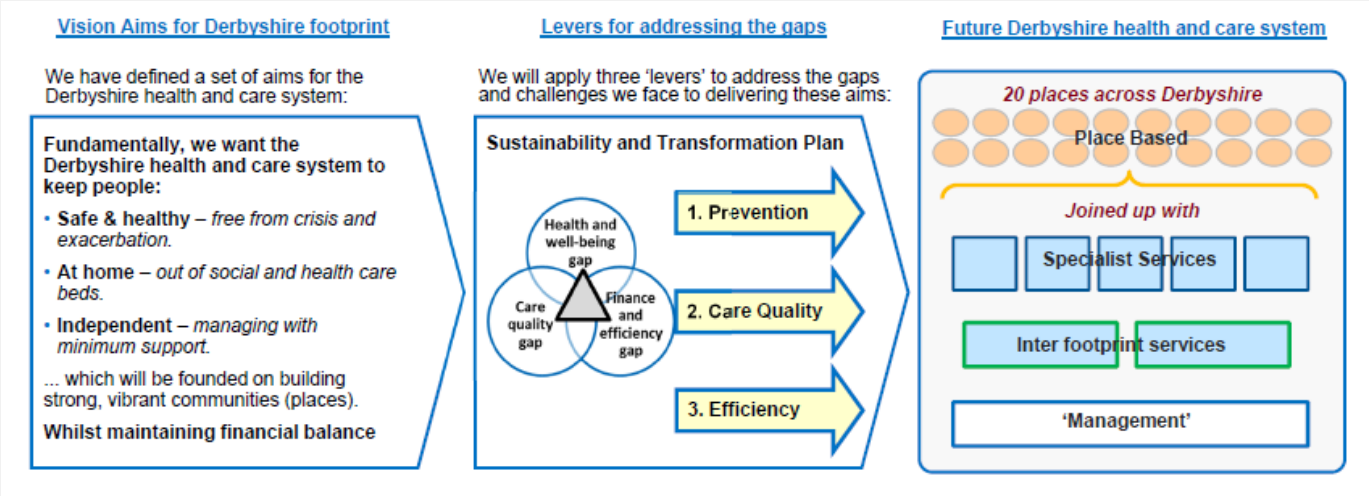


Background and context - Putting our Strategy in the context of system wide planning

Developing the Sustainability Transformation Plan

In response to the *NHS Shared Planning Guidance* (December 2015) it was agreed by health and care leaders across both City and County that all parties would contribute to the Sustainability Transformation Plan (STP) making it a truly system wide plan. The 12 organisations (NHS and Local Authority) agreed to create an ambitious local blueprint for accelerating the implementation of the Five Year Forward View (5YFV). The STP will be a place-based, multi-year plan built around the needs of local populations. This plan will be completed by 30 June 2016 and implemented from October 2016.

The STP is being developed based on the needs of local citizens and communities. Clinicians, professionals, staff and wider partners are central to the development of the STP. The Trust strategy needs to be in-line with the emerging system wide plan and be flexible in its approach. The strategy is aimed at providing the framework for the next five years whilst recognising that the health and care landscape will change for providers, commissioners and service receivers. A key feature of the STP will be the move towards 'place based systems of care'. The emerging STP can be diagrammatically shown as:



Moving to Place Based Systems of Care

The move towards place based systems of care will enhance the concept of 'the team around the person' leading to a more integrated service, a reduction in duplication and greater efficiency. For a **defined geographical community with similar characteristics** all services – primary care, mental health, community services, social care and third sector sectors will operate as a **single team to wrap care around a person and their family.** There will be an equal focus to **empowering citizens** to self care and participate in shared decision making and promoting healthy lifestyles and well being, as there is to providing direct care. Links with the local community will be fostered, recognising that communities have a range of complex and inter-related needs, but also have **assets at the social and community level** that can help improve health and strengthen resilience to health problems. This integrated approach will meet the specific needs of local communities it will be **not one size will fit all** and will recognise that different communities will start with different services and facilities (including general practice).

Background and context

How will the Trust Strategy be implemented?

Sustainability and Transformation Plan (STP - Derbyshire wide)

This outlines system level objectives in-line with the Five Year Forward View and national level planning documents

Derbyshire Healthcare NHS Foundation Trust Strategic Plan

2016-21

Our Trust Strategy clearly outlines how we are contributing to the STP and the changes that we need to make in order to achieve our own vision working with our partners

Supporting Strategies

- Quality

- People

- Information Technology

- Estates

These 'enabling' strategies will clearly outline how we will change our structures and processes in order to meet our vision. These will set-out how we will make the changes and how things will 'look different' in 2021

Annual clinical/operational business plans

- Sets objectives for services and corporate areas each year of the strategy

- Annual clinical/operational business plans will enable teams and individuals to see how they are contributing to the overall strategy.
- Team and personal objectives will be aligned to the plans.
- Plans will allow us to track our progress.

Derbyshire Healthcare NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust (DHCFT) is a provider of community, children's and mental health services across the city of Derby and wider county of Derbyshire. We also provide a range of children's physical and mental health services in Derby and specialist services across the county including substance misuse, eating disorders and learning disabilities.

The Trust provides services to a diverse population, including areas of wealth alongside significant deprivation. The Trust's catchment includes both city and rural populations, with 71 languages being spoken.

Successful partnership working is key to the delivery of many of our services. The Trust works in close collaboration with our commissioners and fellow providers of local healthcare services, together with local authority colleagues at Derby City Council and Derbyshire County Council, and voluntary and community sector organisations.

Our services

The Trust started to restructure its clinical services during 2015/16, following a large scale transformation programme that commenced in July 2013, when nearly 500 people took part in sessions to define how our services across Derbyshire might look in the future. From there, a vision was developed:

- Services will be wrapped around the needs of the patient and their community, they will be easy to access and re-access. The way in which we deliver care will be in line with an individual's needs and not simply dictated by how the service pathway is designed. We will not 'discharge' patients but will support their transition between services based on the individual's needs.
- Models of care will be service receiver needs led, not simply diagnostically led. Services will interconnect with other organisations to ensure that care is delivered in a truly integrated co-produced way.
- We will have fewer beds and instead care for service receiver within their communities as much as possible; services will support and enable the development of community, family and service receiver resilience. Our workforce will be flexible to support the service receiver's journey.

To date, hundreds of staff, service receivers, carers and external partners have been involved in deciding how this vision could be achieved. This has resulted in the identification of:

- A neighbourhood-based, needs-led approach to our community mental health services, with neighbourhood team members working closely with each other and other local health professionals, wrapping care around the person to keep them at home as long as possible. The teams draw on local community resources to help people rebuild their lives after an episode of mental ill health; and
- A campus based approach where our inpatient mental health services and the wider teams that support inpatients will focus on delivering high-quality care, as well as support within the community to prevent hospital admissions.

Enc I

Derbyshire Healthcare NHS Foundation Trust (Continued)

86,062 service users seen

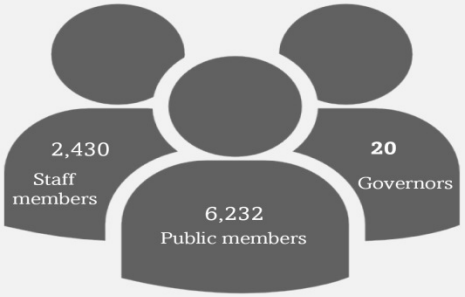
311 inpatients beds

Number of staff **2,383**

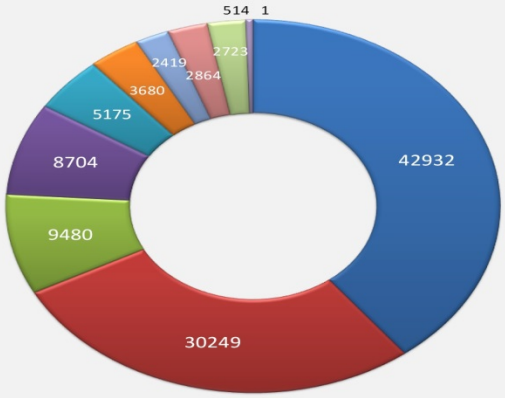
- 181 Scientific and technical
- 405 Additional clinical services
- 491 Administrative and clerical
- 133 Estates and ancillary
- 882 Nursing and midwifery
- 146 Medical
- 137 Allied health professionals
- 8 Students

The Trust cared for **3,755** babies born in Derby City

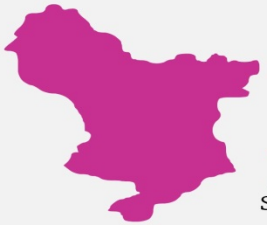
8,662 members



108,741 service users open to Derbyshire Healthcare services on 31 March 2016



5 years ago we were licensed as an NHS Foundation Trust



1,014 Square miles covered

£ 130 million Annual operating income

During **2015/16** we reported an overall financial surplus

Our communities

Derby City perspective

Derby City public health profile summary: Source narrative from Public Health England published June 2015.

Derby at a glance:

Health in summary - The health of people in Derby is generally worse than the England average. Deprivation is higher than average and about 23.8% (12,100) children live in poverty. Life expectancy for both men and women is lower than the England average.

Living longer - Life expectancy is 12.4 years lower for men and 8.9 years lower for women in the most deprived areas of Derby than in the least deprived areas.

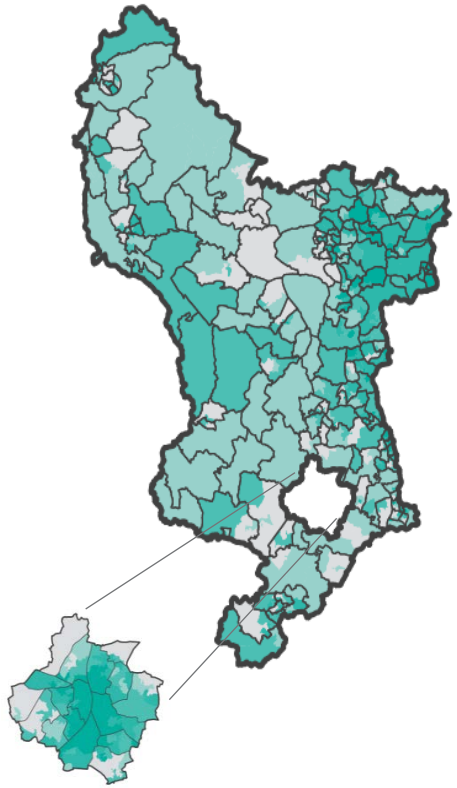
Child health - In Year six, 20.5% (545) of children are classified as obese. The rate of alcohol specific hospital stays among those under 18 was 44.1*. This represents 25 stays per year. Levels of teenage pregnancy, GCSE attainment, breastfeeding and smoking at time of delivery are worse than the England average.

Adult health - In 2012, 24.3% of adults are classified as obese. The rate of alcohol related harm hospital stays was 801*, worse than the average for England. This represents 1,856 stays per year. The rate of self-harm hospital stays was 291.0*, worse than the average for England. This represents 760 stays per year. The rate of smoking related deaths was 303*. This represents 374 deaths per year. Estimated levels of adult smoking are worse than the England average. The rate of sexually transmitted infections is worse than average. The rate of people killed and seriously injured on roads is better than average.

Local priorities - Priorities for Derby include reducing inequalities, giving children the best start, risky behaviour change and substance misuse.

* *Mental health locality profiles - Derby City overview (East Midlands Public Health Observatory)*

Deprivation in Derbyshire: darker wards represent areas of higher deprivation.



Source: Derby City and Derbyshire County 2014 Public Health Profiles

Our communities

Derbyshire County perspective

Derbyshire public health profile summary: Source narrative from Public Health England published June 2015.

Health in summary - The health of people in Derbyshire is varied compared with the England average. Deprivation is lower than average, however about 16.3% (21,900) children live in poverty. Life expectancy for both men and women is similar to the England average.

Living longer - Life expectancy is 7.9 years lower for men and 5.8 years lower for women in the most deprived areas of Derbyshire than in the least deprived areas.

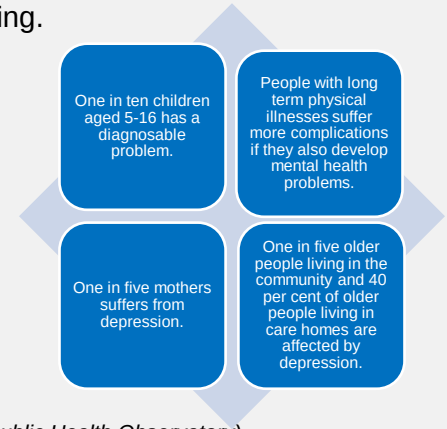
Child health - In Year 6, 17.1% (1,258) of children are classified as obese, better than the average for England. The rate of alcohol-specific hospital stays among those under 18 was 45.4*. This represents 70 stays per year. Levels of GCSE attainment, breastfeeding and smoking at time of delivery are worse than the England average. Levels of teenage pregnancy are better than the England average.

Adult health - In 2012, 24.7% of adults are classified as obese, worse than the average for England. The rate of alcohol related harm hospital stays was 718*, worse than the average for England. This represents 5,632 stays per year. The rate of self-harm hospital stays was 274.2*, worse than the average for England. This represents 2,076 stays per year.

The rate of smoking related deaths was 283*. This represents 1,301 deaths per year. Estimated levels of adult excess weight are worse than the England average. Rates of sexually transmitted infections and TB are better than average. Rates of statutory homelessness, violent crime, long term unemployment and drug misuse are better than average.

Local priorities - Priorities for Derbyshire include reducing smoking in pregnancy, reducing inequality in life expectancy and healthy life expectancy within the area and increasing breastfeeding.

In England:



* *Mental health locality profiles - Derbyshire overview (East Midlands Public Health Observatory)*

Drivers for change

We have assessed the internal and external drivers for change in the development of this strategy. Examples of the drivers for change are listed below.

Internal	Our service receivers and families
• Need for clear direction - clear message to all staff, service receivers, partners and stakeholders. Promote a can do and creative approach in setting mutual expectations. • A strategy that assists with decision making. • Understand the direction of travel – how we can change to work in a changing health and care system. • Changing the culture of our organisation and our workforce. Embedding a listening, learning and solutions focused approach to all aspects of the organisation. • Managing and reducing the demand for our services. • Developing appropriate partnerships and collaboration.	• Services that put people at the centre – joined up and easy to access. • 'I tell my story once'. • Local services where possible. • Services within my own home where possible. • People that understand me and my needs. • Choices for service receivers and their carers. • Developing and embedding family and care inclusive practice. • Developing and setting mutual expectations. • 'Nothing about me, without me'.
System Level	**National**
• System wide sustainability – meeting the 'three gaps' - health and wellbeing, care and quality and finance and efficiency. • Greater alignment of physical and mental health – parity of esteem. • More integrated services – 'I tell my story once'. • Developing seven day services. • Delivering high quality services. • Increasing demand for services linked to demographic change e.g. ageing population. • Delivering financial sustainability – the £505m health and care gap.	A number of documents have been produced by NHS England, Monitor and other national bodies which either provide guidance or are clear on the things we must do over the next five years. Examples of important documents are: • Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21 (December 15). • Five Year Forward View for Mental Health (February 2016). • NHS Constitution. • NHS Outcomes Framework. • Carter Review (February 2016). • National Standard Contract and National tariff • National 'must do's'. • The 'three gaps' - health and wellbeing, care and quality, and finance and efficiency .

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N.B. *Documents available via NHS England or NHSI/Monitor website*

Our vision, values and strategic objectives

'To work collaboratively across organisational boundaries in order to deliver care in the most clinically appropriate setting: services will be wrapped around the needs of the service receiver and their community, they will be easy to access.'

We are proud of the services we offer and these need to be underpinned by our values. We need to ensure that we live our values and that they underpin everything we do. The values we will live by are:

- We put our service receiver at the centre of everything that we do – we are **respectful** and **responsive**
- We focus on our people – we work with **integrity** and **trust**
- We involve our people in making decisions – we encourage a culture of **honesty** and **openness**
- We will aspire to deliver excellence – we work in **partnership** with service receivers and stakeholders. We will enable teams to be **effective** and **efficient**.

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

Our Vision

Derbyshire Healthcare NHS Foundation Trust in 2021

Following consultation in 2013 (see page 4) we commenced our transformation journey which has resulted in changes during 2015/16. These changes will continue to evolve and further develop in line with the emerging whole system Sustainability and Transformation Plan (STP). The following table shows the services we consider to be 'core' and those we want to work with partners to deliver i.e. develop services in a different way as part of a whole system approach and in response to the changing health and care landscape:

Develop services to new markets when:	Highly specialist services (wider than Derbyshire footprint)	Core services – specialist (wider footprint)	Secondary Care Point of Access and primary care integration support	Place based
Tertiary or highly specialist Services outside Derbyshire that add a clear clinical synergy or operational efficiency		**Campus** • Forensic inpatient services • Enhanced Care Unit • Adult Mental Health Inpatient services • Inpatient services • Rehabilitation Inpatient services • Older People's inpatient services*		• Revised urgent and Long Term Conditions (LTC) primary care offer • Core integrated care team components (District nursing, community matron, social worker) health visiting, school nursing, nursing home support*
Secondary services outside of Derbyshire that add a clear clinical synergy or operational efficiency	• Perinatal services • Forensic services • Eating disorder services	**Central Services** • Early intervention services • Criminal Justice and Diversion • Crisis and Home Treatment services • Dementia Rapid Response • Memory Assessment Services • Assessment and Treatment Services Learning Disabilities Services • Liaison services (RAID) • Child and Adolescent Mental Health Liaison (CAMHL) services • Child and Adolescent Mental Health Services (CAMHS) and children's services • Specialist Substance Misuse Services (High Intensity) • Psychotherapy services • Neurological pathways		• Primary mental healthcare for Improving Access to Psychological Therapies (IAPT) • Dementia support workers • Community hub staff etc
		Neighbourhood • Mental Health Neighbourhood Teams • Learning Disability Community Teams* • Step 2 (low intensity) substance misuse services • Eating disorder community services • Autistic Spectrum Disorder Services • CAMHS community teams* • Personality disorder services		

*** Where commissioned**

Achieving our vision

What we need to achieve

"Transform services to improve access, quality and affordability"

Meet our strategic priorities

1. **Quality** – provide good care to our service receivers and families, developing the use of clinical and patient reported outcome measures, to test and measure how effective our services are. Work to achieve at least a ' good' rating with the Care Quality Commission (CQC).
2. **Partnerships** – develop partnerships which enhance service delivery and foster a system wide approach in line with the STP.
3. **People** – our people and organisational development strategy will enable us to create the cultural change that is required for the next five years.
4. **Transformation** – our plans will be both internally and externally focused, aimed at ensuring a sustainable long-term future for the organisation and the health and care economy in which we work.

Develop our core services (in line with the mental health Taskforce recommendations)

- **Campus** – inpatient services will be developed in our highly specialist areas. These may be in partnership with other trusts, private providers or the third sector at a local, sub-regional or regional level.
- **Central services** – specialist community based services will continue to develop and may be in collaboration with partner organisations. Where necessary we will work with other organisations to provide additional community based support e.g. social care, voluntary sector etc.
- **Neighbourhood** – these teams will be aligned to GP practices providing specialist support. They will work closely with Community Support teams to ensure service receivers receive the best possible care and focus on symptom and social recovery.

N.B. *We will seek new business in neighbouring counties in all these areas, where there is real synergy and added value*

National 'must do's'

- **Focus on quality** – achieving the best results for service receivers within the resources available. Reducing variation in services and achieving 'good' or 'outstanding' in the Care Quality Commission ratings. Services will be delivered services seven days a week.
- **Focus on access** – meet the access standards for Improving Access to Psychological Therapies (IAPT) and Early Intervention. Improve access to other services.
- **Focus on finance** – rise to the efficiency challenge both internally and working with system partners to implement the Carter Review recommendations.

What we need to achieve - quality

- We will continue to change the balance of power in our clinical services and embed a contemporary health service based upon **empowerment, informed decision making and choice**.
- We will continue to embed a **quality impact assurance process** to ensure that wherever possible, efficiency changes improve or enhance service quality.
- We will reduce the use of restrictive practice in services in line with our **Positive and Safe** Strategy and develop trauma informed services.
- We will continue work in the **Research and Development Centre** to help in the reduction of self-harm and suicide. We will implement the Suicide Strategy. We will reflect on our care delivery learn the lessons, and adopt our knowledge and systems from this learning.

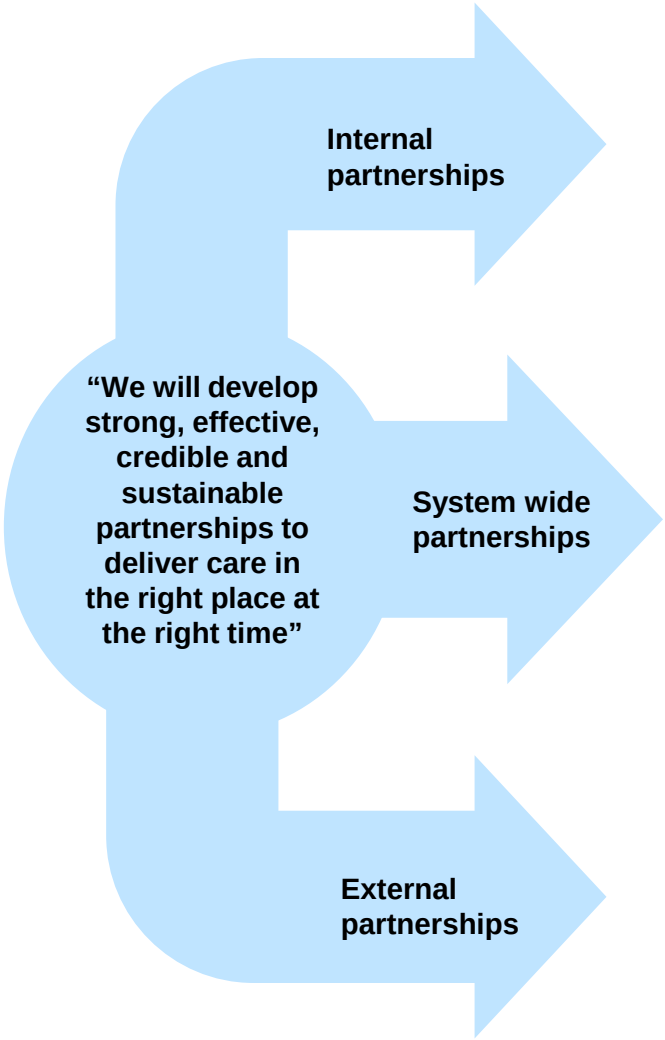
- We will redefine our **clinical leadership, ownership and performance management** through a model of earned autonomy for quality improvement. This will provide a 'golden thread' of quality between service areas and the Board.
- We will aim to improve our performance and then maintain our compliance with **CQC clinical quality standards** and embed them into the fabric of our organisation and specifically set and deliver on agreed mutual expectations for our service receivers and families.
- We will eliminate **unwarranted variation** in the delivery of clinical services.
- We will use data and analysis to understand the **mortality gap** affecting those with serious and enduring mental ill health, working in an integrated way with our physical health and care partners.
- We will continue to develop our clinical interventions and embed our approach to **treating people in their community as close to home as possible**.

- We will deliver a consistent accessible and quality service **seven days a week**
- **Think! Family** – we will work with the whole family and our partners, to co-ordinate all aspects of the support necessary to address their needs.
- We will deliver a **person centred and recovery-focused approach** to care and safety planning. New models of care will emphasis patient choice and decision making.
- We will **champion an inclusive and integrated approach** to health aiming to eliminate stigmatisation, prejudice and neglect.
- We will work in partnership with health and care, to develop **prevention, early detection, diagnosis and treatment** of mental illness for all ages.

Achieving our vision

What we need to achieve - partnerships

Partnerships will be an increasingly important way to deliver access to high quality patient care in a financially sustainable environment.



Examples of internal partnerships

- Joint working across pathways both physical and mental health – 'I tell my story once – I know what to expect from my care' .
- Co-ordination of care across age and divisional boundaries.
- Sharing of resources i.e. staff working across inpatient/community, technology etc. Following the service receiver.
- Sharing learning – what works and what needs to be done differently to develop solutions.

Examples of system partnerships

- Derbyshire wide Estates Strategy working with other trusts, the councils and commissioners to deliver the recommendations of the national Carter Review Derbyshire wide approach to 'back office' functions – working together to stop duplication .
- System level approach to leadership development and workforce organisational development – a shared approach allowing greater flexibility across organisations.
- Working with other providers and commissioners to deliver a joined-up approach to care – including voluntary sector, Fire and Rescue, Police and private sector where appropriate.
- Joint innovation bids and projects.

Examples of external partnerships

- Collaborate with trusts from outside of Derbyshire to develop centres of excellence
- Work in partnership with voluntary sector organisations to deliver parts of the pathway.
- Private sector joint ventures where this adds value to our service receivers.
- Links to Health Science Networks for innovation projects.
- Joint working with Derby University on research and grant funding.
- Joint working with the Chamber of Commerce to enhance work-place health and wellbeing .
- Work with National bodies such as NHS England, NHS Improvement and CQC.

What we need to achieve - people

"We will develop our people to allow them to be innovative, empowered, engaged and motivated. We will retain and attract the best staff"

Developing our people – the individual

- We will have regular, **meaningful appraisals** helping us to see where we contribute to the overall Trust strategy. A **personal development plan** will empower us to learn and innovate.
- We will be **empowered** to make decisions at the lowest appropriate and safe, level reducing the time to get a decision and encouraging people to work at the top of their license.
- We will be open, reflective and questioning – constructive feedback and challenge will be the norm.
- We will **ensure that rewards are appropriate** and seek to retain staff.
- **Our well-being** is important – we will work with occupational health to develop a well-being programme to look after peoples physical and mental health.

Developing our people – the team

- **Developing people to deliver excellence** – access to the right training and development in order to maintain and enhance skills for the individual and team.
- **Developing a productive and efficient environment** – we will continue working towards having the most appropriate number, and mix of staff skills within teams to deliver both quality, empowerment and efficiency.
- **Providing appropriate and effective technology to deliver a safe service** – we will work towards having a fully operational electronic patient record, redesign and redevelop any functionality required to meet this shared goal.

Developing our people – the organisation

- **Culture Change** – develop an environment which encourages inquisitive enquiry, inclusivity, challenge, creativity and a can do attitude and embraces innovation and cross-boundary working.
- **Leadership development** – strong and credible leaders at all levels across the organisations who feel supported to be brave. Working with EMLA, the national leadership academy and HEE.
- **Talent management** – identify and develop our leaders and core staff of the future, working in partnership with the health and care community in Derbyshire, underpinned by strong workforce planning and profiling processes.
- **Systems and processes** – build strong foundations to support people with the right policies, procedures, systems and processes.
- **We will become a learning organisation –** learning from successes and incidents, encouraging individuals to share learning and supporting people where necessary.

What we need to achieve – transformation (for financial sustainability)

"We will transform services to achieve long-term financial sustainability"

Transform our services

- Services will be planned in such a way that they **deliver the vision** for our people using them in 2021 – we will work across boundaries, linking physical and mental health.
- We will review **clinical and operational best practice** to ensure that services meet the needs of service receivers and their carers, who access our services
- Transformation will be have **quality, access and affordability** at the heart of service change.
- We will use sound clinical evidenced based practice and business principles to achieve the transformation of our services – **clinically led and managerially supported changes.**
- We will work with our **partners** to deliver joined-up care.

Create a culture of continuous improvement

- We will all be **encouraged to contribute ideas** which will help transform services to meet our vision.
- **Thinking differently** - there are no wrong ideas – we will develop a culture of innovation and embracing change.
- We will **continuously review our everyday working practices** to ask if we are doing things in the most efficient and effective way. Is what we are doing enhancing people's care and their experience?
- We will adopt **'lean principles'** – getting things right first time, working with partners to stop duplication, no waste and no wasted time.
- Everything we do will put the **person at the centre.**

Manage our finances

- **Potential savings** for the next five years are **around £15.5m** this is based on economic assumptions for pay and non-pay inflation and the potential efficiencies that will be required nationally.
- We will continue to plan to **achieve a similar level of overall surplus** as in the 2016/17 financial plan, following NHS guidelines.
- We will work with commissioners and stakeholders to implement **modernised methods of payment** for mental health services.
- We will continue to work with **operational and clinical teams** to ensure everyone can make financially well-informed decisions.

Our services in 2016 – a service receiver's perspective

Our Vision – 'To work collaboratively across organisational boundaries in order to deliver care in the most clinically appropriate setting: services will be wrapped around the needs of the patient and their community, they will be easy to access.'

If I need rehabilitation for either my physical or mental health I cannot always get support in my own home.

The team supporting me do not always work together so I often tell my story several times. I do not always know where to go and who to talk to.

My care can be different at the weekends and in the evening – it is not the same across the seven days.

I do not feel that services are joined up and that professionals are working together to make it easier for me – they seem to make it hard.

Services can be different depending where I live.

I often have to wait a long-time to see someone.

If I am a carer I am not always supported to be fully involved and I do not get a break if needed.

I do not have one person who knows me and is my main point of contact. I have different people co-ordinating my care if I am in hospital or in the community.

If I have a mental and physical illness I have to deal with different people who do not seem to co-ordinate my care.

I sometimes go to hospital when I could be supported in the community because services are not available 24/7.

I do not always have access to information about my condition and so cannot always help myself.

My local community does not always support me as they do not understand my condition.

I may not get an early assessment for dementia and so will not be able to access support.

Our services in 2021 – a service receiver's perspective

"Transform services to improve access, quality and affordability"

If I need rehabilitation for either my physical or mental health I can get support in my own home.

The team supporting me always work together so I tell my story once. I always know where to go and who to talk to.

I will know where to go and who to talk to. Services are joined up and I feel all professionals are working together to make it easier for me.

My care is the same at the weekends and in the evening – it is available across the seven days.

Services are the same wherever I live.

I can access services quickly and easily.

If I am a carer I am always supported to be fully involved and I get a break if needed.

There is one person who knows me and is my main point of contact. I have one person co-ordinating my care whether I am in hospital or in the community.

I only go to hospital when I really need to. Where possible I am supported in the community because services are available 24/7.

I always have access to information about my condition which allows me to take control and help myself.

My local community always supports me as they try to understand my condition.

I can get an early assessment for dementia from my GP and so am able to access support.

If I have a mental and physical illness I deal with the same person who understands me and co-ordinates my care.

Achieving our vision

Our services – a staff perspective

	Working in 2016
Working practices	• I work within a defined team – campus, neighbourhood or central services. • I do not follow my service receivers if they access a different service to the one I work in. • Not all services are available seven days a week – some colleagues work seven days, others do not. • If my service receivers access physical services I do not know. • My work life balance is not always as good as it should be.
Training, organisational development and rewards	• I receive mandatory training for my job but I do not feel I receive all the training I need. • I do not always receive regular appraisals or a personal development plan. • I am not always encouraged to put forward ideas. • I do not always feel I am listened to. • I do not always feel valued. • I have no really clear plan of my future career – some colleagues do, but talent management is not consistent.
Things to help me do my job	• I have a base office or ward. • I have access to a computer – often shared. • I usually return to base to get to know my schedule if I work in the community. • I cannot access service receiver records from other health and care organisations so I do not always know the full picture – I have to rely on the service receiver telling me their story, often repeatedly.

	Working in 2021
Working practices	• I work flexibly following my service receivers across boundaries i.e. the community to the ward etc. • I work in a multi-disciplinary team and we work flexibly. • I am part of a 24/7 rota which I know in advance so I can plan my life. • I am aware of my service receivers when they access physical healthcare – I have a full picture. • I have a good work life balance.
Training, organisational development and rewards	• I work totally flexibly and my training means I feel fully competent. I receive all the training I need. • My appraisal links to the Trusts strategy and business unit objectives. I know exactly what my contribution is to the success of the Trust. • My colleagues and I continuously improve the way we work. We share learning and contribute towards being a learning organisation. • I am rewarded for what I do and feel the Trust really wants to retain my skills – I feel valued. • There is a clear talent management plan and I can see where I am heading. My manager regularly talks through my career and learning plans.
Things to help me do my job	• I have excellent information technology allowing me to work across organisations, from the community and from home. • I have more time to work clinically because I do not have to keep returning to base. • I can access my Service Receivers records, securely, from other organisations so I know their full story and they only tell their story once.

Appendix B

Our Vision

'To work collaboratively across organisational boundaries in order to deliver care in the most clinically appropriate setting: services will be wrapped around the needs of the patient and their community, they will be easy to access.'

Our Strategic Priorities

1. We will deliver **quality** in everything we do providing safe, effective and service receiver centred care

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

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

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

Our Values

- We put our patients at the centre of everything that we do – we are **respectful** and **responsive**
- We focus on our people – we work with **integrity** and **trust**
- We involve our people in making decisions – we encourage a culture of **honesty** and **openness**
- We aspire to deliver excellence – we work in **partnership** with service receivers and stakeholders. We will enable teams to be **effective** and **efficient**.

Outcomes

- **Service Receiver perspective**
  - Service receivers are informed and knowledgeable about prevention and care
  - Carers are involved and informed
  - Community services are easily accessible via one route and one person co-ordinates care
  - Services available 7 days a week
  - A choice of treatments are available
  - GPs fully involved in initial assessments for dementia or mental health
  - Physical and mental health services are aligned
- **Staff perspective**
  - Multi-disciplinary, multi-agency working across age groups
  - 24/7 rota with time to plan work/life balance
  - IT equipment and solutions will enable agile working and more time to work clinically
  - Emphasis on continuous improvement and supporting organisational development and training

Changes we will see

- Services will deliver high quality, safe and effective care in partnership with those who use them, linking different agencies "I tell my story once"
- Improved service receiver and carer satisfaction
- Better access to services
- Improved health and well-being
- Better management of both mental and physical health.
- Increased quality of life
- Increased staff satisfaction
- Fewer beds; instead patients will be cared for within their communities as much as possible
- Workforce will be flexible to support the service users' journey.
- A system wide approach – increased community resilience
- A financially sustainable organisation and health/care economy

Measured using the following success criteria

- Achieving at least a 'good' rating with CQC
- Achieving high levels of service receiver satisfaction on services delivered in partnership
- Achieving high levels of staff satisfaction in the annual staff survey
- Achieving statutory financial targets

Measuring Success - Initial thoughts **Appendix C**

The following represents some ***initial thoughts*** on the measures that might be developed and used to provide the Trust Board with assurances that the strategy is being delivered. More detailed metrics will be developed as part of the strategy implementation process. Where possible measures are in line with the Integrated Performance Report.

1. **Quality** – provide good care to our service receivers and families, developing the use of clinical and patient reported outcome measures, to test and measure how effective our services are. Work to achieve at least a ' good' rating with the Care Quality Commission	2. **Partnerships** – develop partnerships which enhance service delivery and foster a system wide approach in line with the STP
• Achievement of at least 'good' in CQC ratings • Reduce restrictive practice in services in line with our Positive and Safe Strategy • At least X% of teams will have gained earned autonomy • A reduction of X years in the mortality gap for people with a serious mental illness compared to the rest of the population • An increase of X% in service receiver and carer satisfaction	• Derbyshire Healthcare FT is viewed as a key partner in the system wide transformation • Service receiver feedback shows high levels of satisfaction with services delivered in partnership • Partnerships result in improved efficiency • Year on year increase in the number of Partnerships with NHS, voluntary and other public/private bodies
3. **People** – our people and organisational development strategy will enable us to create the cultural change that is required for the next five years	4. **Transformation** – our plans will be both internally and externally focused, aimed at ensuring a sustainable long-term future for the organisation and the health and care economy in which we work.
• 90% of staff receive a meaningful appraisal • Staff turnover is reduced to X% • Sickness levels are below X% • X% of leaders receive leadership training • Year on year improvement in staff survey results	• Achievement of all statutory financial targets • Cost improvement plan delivered • System control total delivered • Overall surplus achieved • X% staff have undertaken finance training

Appendix D

Brief Communications Plan – Trust Strategy 2016-21

With regard to 'launching' the strategy the following actions will be taken:

- On 1 June
  - message from Ifti/Richard to launch strategy and key themes (include offer for Mark, Lynn or Jenny to go out to teams and discuss)
  - screensaver to go live
  - printed copies to be available and shared with teams
- Podcast in June Monthly Connect
- 'What does it mean for me' – brief statements from individual staff and teams
- Meetings with Teams scheduled throughout June, July and August
- Payslip attachment in June – summary 'Plan on a Page'
- Feature in June Members' News and Connections magazine (scheduled for late May at present)
- Write to partners to thank everyone for input, share link to strategy online and include summary plan on page version
- Share final version and 'Plan on a Page' with Commissioners
- Work with Governors to share development and content with their members

Appendix E

Strategy Implementation Process

The new Trust Strategy 2016-21 requires implementation and it is important that we develop the detailed business plans to support its delivery. There is also a requirement to think more radically about how we transform our services in order to deliver quality services in a sustainable way.

Where we have been truly transformational and have changed the way we deliver services, enhancing quality and patient experience, whilst at the same time reducing costs is when we have had to submit a competitive tender. This has meant that we have competed with other organisations and had to 'think differently' about the way we deliver our services.

In order to help teams 'think differently' we are looking to recreate a tender type process as we commence the implementation of our strategy. This is intended to help us prepare for the changes we need to make to our services over the next 5 years. The objectives of the process are to:

- Transform services so that they meet the needs of our service receivers and their families/carers in line with the Trust Strategy and the STP
- Create a 'competitive environment' which will encourage teams to think differently about how our services look and how they are delivered
- Encourage teams to think across boundaries and challenge the status quo – do we need to deliver all parts of a pathway? Could we partner with other organisations?
- Reduce variation and duplication
- Be efficient and effective – provide cost effective quality services
- Provide a robust Clinical/Operational Business Plan (including CIP plan) for the next 5 years which will help us deliver the strategy.

The timelines are extremely tight and will need to be strictly adhered to. Commissioners will be involved at all stages to ensure alignment to system level thinking.

Key timelines are outlined below:

Milestones	Date
Updated guidance issued to managers and teams at Leadership Event	24/05/16
Familiarisation of the process via guidance and initial thoughts discussed in teams etc	3 weeks
'Strategy Implementation' Event – greater explanation of the process, the objectives and the parameters – what are we expecting, what is required, timescales etc	15/06/16
Deadline for receipt of clarification questions from teams	22/06/16
Teams submit 'Outline Solutions' (options considered) to panel consisting of Executive Directors, Senior Managers, commissioners etc	w/c 11/07/16
Competitive Dialogue commences – developing a revised service specification and service model with Commissioners, service users, carers, families and potential partners (including panel)	18/07/16
Competitive Dialogue closes	22/08/16
Invitation to submit 'Proposed Solution'	22/08/16
'Bidder' clarification questions	22/08/16
Deadline for receipt of clarification questions from Bidders	30/08/16
Deadline for receipt of Proposed Solution	05/09/16
Presentations of the proposed solution to the panel	w/c 12/09/16
Sign-off by panel – may include presentations, further clarification etc	19/09/16
Agreement to go ahead 'Contract award'	26/09/16
Business Plan deadline	30/09/16
Mobilisation i.e. get ready to commence new services or commence stage 1 etc (6 months).	1/10/16
Deadline for current management structure Business Plans, reflecting the need for matrix working and realignment of teams to 'places' etc	1/11/16
Services Commence	01/04/17

Each milestone from the above table is explained in further detail below.

Milestones	Explanation
Guidance issued to managers and teams	• Information contained in this introductory pack
'Strategy Implementation' Event – greater explanation of the process etc	• A 'one-off' event with managers and key people within the teams and supporting services (finance, HR, Estates, information, quality, transformation, business development etc.)
Deadline for receipt of clarification questions from teams	• Teams will be asked to submit any questions they may have. The deadline will be strictly adhered to and no further questions can be submitted after this time.
Teams submit 'Outline Solution' to panel consisting of Executive Directors, Senior Managers, commissioners etc	• This will be initial thoughts on what the service will look like going forward • Ideas that have been generated will be discussed and initial thoughts will be outlined – option appraisal and recommendations • The aim will be to get agreement that the outline is an acceptable way forward meeting both Trust and system-wide objectives • This session will 'Confirm and Challenge' initial options to allow agreement on the way forward
Competitive Dialogue commences – developing a revised service specification and service model with Commissioners, service users, carers, families and potential partners (including panel)	• This will involve developing the service specification and discussing/agreeing the outline with commissioners • The outline model will be developed and potential partners identified • Analysis will underpin the model – data, finance, benefits etc • Throughout this time there will be the opportunity to clarify questions and have on-going dialogue with panel members
Competitive Dialogue closes	• This will be the close down of further conversations
Invitation to submit 'Proposed Solution'	• An invitation confirming deadlines for submission will be issued
'Bidder' clarification questions	• Further questions may be submitted
Deadline for receipt of clarification questions from Bidders	• This will be the close down of further questions
Deadline for receipt of Proposed Solution	• Final deadline for receipt of models, service spec etc • This will include the Business Case proposal and the Service Specification
Sign-off by panel – may include presentations, further clarification etc	• Further details of the process will be agreed • This may include final presentations

Milestones	Explanation
Agreement to go ahead 'Contract award'	• Agreement in writing from the panel that the new service design is acceptable and should commence
Business Plan deadline	• The Business plan detailing 18 months of the 'how' together with KPI's etc will be completed for the new service
Mobilisation i.e. get ready to commence new services or commence stage 1 etc (6 months)	• This will involve a full project structure which will span more than one year
Deadline for current management structure Business Plans,	• These will reflect the need for matrix working and realignment of teams to 'places' etc • Each of the current Service Lines will have a plan which clearly shows the 'cross area' working etc
Services Commence	• Start date

For a copy of the full pack please contact lynn.wilmott-shepherd@derbyschft.nhs.uk

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 25 May 2016

Neighbourhood Directorate Performance Report

Purpose of Report
The Board have requested a 'deep dive' of the performance of the Neighbourhoods. This report has been produced to enable the Directors to review the performance of this Directorate since its inception on 1 April 2016.

Executive Summary
Neighbourhood Services were launched on 1 April 2016. This service comprises mental health community services for people over the age of 18, in essence what was older people's community mental health teams and the Recovery and Pathfinder teams. The Neighbourhoods are 8 geographically-focused teams primed to lead and evolve in response to shifts in health and social care culture. The Neighbourhoods also manage and deliver older people's day hospital services and the emergent Dementia Rapid Response Team.

Strategic considerations
- To maintain a high level of operational performance

(Board) Assurances
- Operational performance

Consultation
- This report is not being considered at any other committee or meeting

Governance or Legal issues
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Equality Act 2010
- Health and Safety at Work etc Act 1974

Equality Delivery System
This report is not requesting the Board agree to any service delivery changes that have an impact on any particular protected group. The Report details current performance against a range of performance criteria and the Board may wish to explore the impact of any variance in performance on particular groups.

Recommendations
The Board of Directors is requested:
1) To acknowledge the current performance of the Directorate
2) To note the actions in place to ensure sustained performance

Report presented by: **Carolyn Gilby**
Acting Director of Performance

Report prepared by: **Claire Biernacki**
Acting General Manager, Neighbourhood

Derbyshire Healthcare NHS FT Neighbourhood Performance Report Based on April 2016 Information

Introduction

This Neighbourhood performance report is organised into the following sections:

1. Performance dashboard
2. Workforce dashboard
3. Activity
4. Caseload
5. Current waiting times
6. Friends and family test
7. Compliments
8. Complaints
9. Incidents
10. Conclusion

1 Performance dashboard

	Apr, 2016		
	No.	%	Target
Monitor Targets			
CPA review in last 12 Months	2,814	95%	95%
Mental health services dataset - identifiers	15,646	100%	97%
Mental health services dataset - outcomes	2,814	95%	50%
18 week referral to treatment < 18 weeks - incomplete	532	96%	92%
Locally Agreed			
CPA settled accommodation status recorded	2,814	98%	90%
CPA employment status recorded	2,814	99%	90%
Mental health services dataset - identifiers	15,646	100%	99%
Mental health services dataset - outcomes	2,814	95%	90%
Patients clustered not breaching today	14,347	79%	80%
Patients clustered regardless of review dates	15,095	95%	96%
Ethnicity recorded	15,646	91%	90%
NHS number recorded	4,473	100%	99%
Schedule 4 Contract			
Consultant outpatient appts cancelled by Trust	4,431	9%	5%
Consultant outpatient appts DNAs	2,913	15%	15%
Outpatient letters sent in 10 working days	1,900	95%	90%
Outpatient letters sent in 15 working days	1,900	99%	100%

Narrative:

The CPA target is currently being met but operational managers monitor closely as there have been times when it has dipped in the past few months. It is an element of performance that can quickly slip and we are working to be proactive rather than reactive.

Ensuring Clusters are appropriate value and reviewed within target is an ongoing piece of work. We have undertaken a significant amount of cleansing as neighbourhoods moved to Paris, but there are two issues that are difficult to resolve. Firstly some people are correctly clustered as 1-3, where they were referred but don't reach threshold for service when assessed. In these cases we are working to ensure these people are discharged in a timely manner.

Secondly there are a proportion of out of date clusters held within the Memory Clinic service. This service undertakes memory monitoring for people diagnosed with dementia, in the North of the County, who are prescribed anti-dementia medication. Due to the significant increase of people in this cohort, as a result of a commissioned Dementia diagnosis service, seeing people within the cluster timeframe is not achievable. We are in discussion with commissioners about this issue. This second cohort accounts for 9% of our clusters overdue, and we would be within target otherwise.

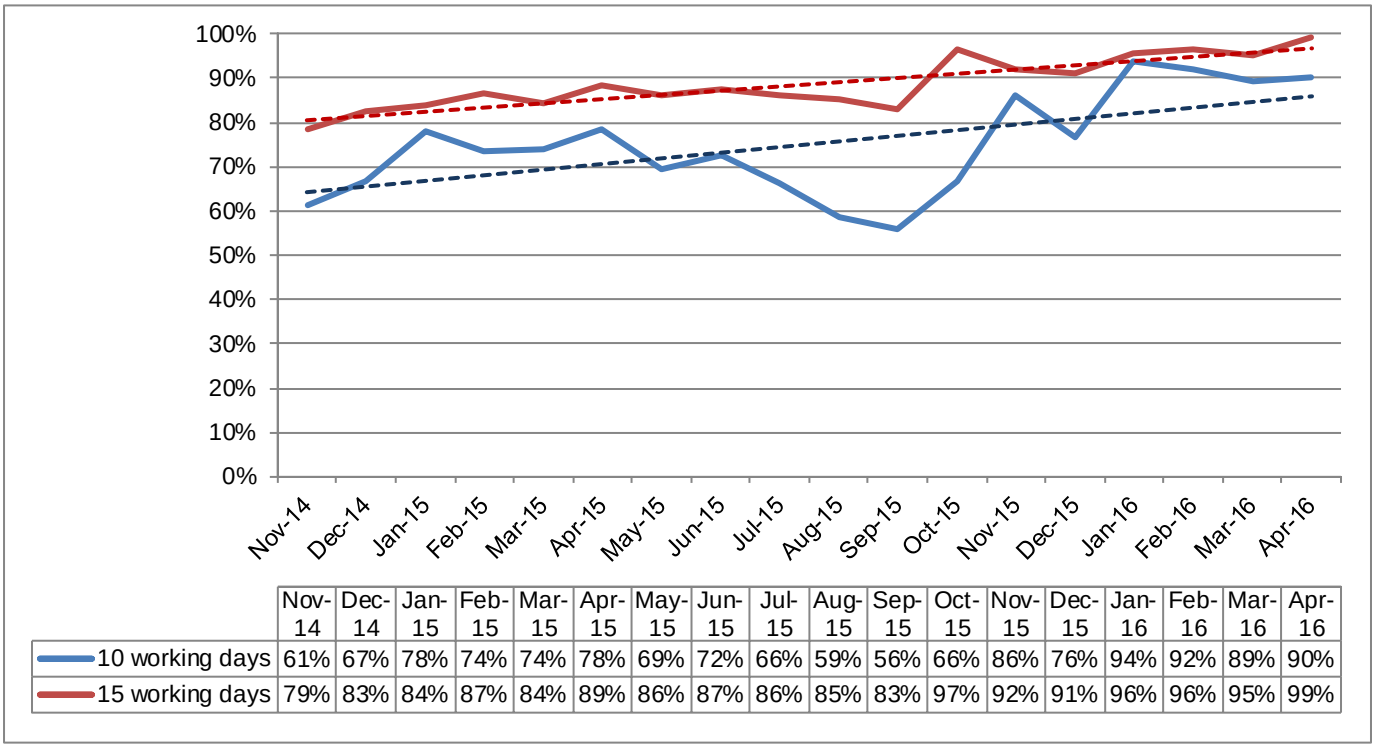
The outpatient appointments cancelled by Trust have been impacted on as a result of this years' Jnr Dr industrial action. At these times the approach has been to keep disruption to clinical activity

at a minimum, while at the same time patients with the highest level of need have been prioritised. Where this prioritisation has allowed, consultants have picked up clinics, however cover to inpatient areas has taken precedence.

The table below identifies the clinics cancelled by reason. The other high cancellation number is related to locum posts that have unexpectedly become vacant and reflects the gap in securing alternative cover to posts:

Reason	n
Clinic Closed	5
Clinician Must Attend Training	1
Industrial Action	86
Virtual Clinic	16
Locum dental appointment	8
Consultant annual leave	6
Locum left - unable to get cover	48
Consultant sickness	20
Grand Total	**190**

Outpatient letters has seen good improvement over the past few months and is something we have been working on. ACDs work with the consultants in their areas to avoid the use of inappropriate Clusters (clusters 1-3) and to develop systems which support them to keep Clusters up to date. Trainee doctors and locum doctors are a source of error in clustering due to their frequent movement in and out of posts within the Trust. We are looking at how we can develop our systems to ensure that these groups will be trained in clustering and this should be supported by their clinical supervisors.



	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
10 working days	61%	67%	78%	74%	74%	78%	69%	72%	66%	59%	56%	66%	86%	76%	94%	92%	89%	90%
15 working days	79%	83%	84%	87%	84%	89%	86%	87%	86%	85%	83%	97%	92%	91%	96%	96%	95%	99%

2 Workforce

Dashboard:

	Apr, 2016		
	Actual	Target	
Headcount	416		
Whole time equivalent	355.79		
Appraisal Completion	79%	90%	
Compulsory Training	88%	85%	

Supervision:

	Team	Staff	Managerial % Supervisions Completed	Clinical % Supervisions Completed
Neighbourhood	Amber Valley Neighbourhood	36	61.1%	46.2%
	Bolsover+CC Neighbourhood	31	54.1%	51.1%
	Cfd Central Locality - Adult	2	50.0%	90.9%
	CfldCentral Neighbourhood	41	63.4%	77.1%
	County South Older People Day Hospital DH	5	85.2%	39.0%
	Dementia Rapid Response	15	33.3%	61.6%
	Derby City Neighbourhood - Team A	70	74.3%	78.0%
	Dovedale Older People Day Hospital DH	7	75.1%	27.3%
	Erewash Neighbourhood	30	81.3%	68.7%
	HP+NthDales Neighbourhood	44	50.0%	64.1%
	KillNthCfld Neighbourhood	32	61.7%	72.7%
	MAS North	6	66.7%	81.5%
	MAS South	6	66.7%	50.0%
	Medics Neighbourhood City	12	16.7%	0.0%
	Medics Neighbourhood Nth	5	20.0%	0.0%
	Medics Neighbourhood Sth	4	0.0%	0.0%
	Psychology Neighbourhood	29	48.3%	55.0%
	Resource Ctr Outpatient	2	75.8%	N/A
	Sth DD Neighbourhood	34	38.2%	27.9%
	Trust Wide Discharge Liaison Team OP	3	33.3%	33.7%
	Total	**414**	**57.7%**	**57.4%**

Narrative:

The consultation process prior to the launch of Neighbourhoods saw all staff being offered 1-1 consultation with managers. This was extremely time intensive and has impacted on the managers' ability to undertake appraisals in a timely manner. However it is a priority going forward for all managers to work towards the target and ensure all staff have an appraisal date booked.

Supervision rates have seen improvement over the year; however we are still below target. We are currently working hard on our supervision trees – ensuring that clinical supervision is achievable within the management lines and reporting resource that we have. For example in bringing the Neighbourhood teams together some managers, at this stage of the process, have upwards of 20 reports within their tree and this is not considered sustainable. Work has commenced to reorganise and ensure a robust and sustainable approach is embedded.

At the commencement of Neighbourhoods and with some concern about the high level of caseload and gaps in funding for the service we have undertaken a review of absence due to work related stress and have assured ourselves that absence, although high is not related to work related stress to any significant degree.

During the financial year 2015/16 there were 3 community team nursing and OT staff off work with work-related stress which equates to 1.8% of the total nursing and OT staff with caseloads.

The caseloads of the 3 staff members were as follows:

Community Team	Caseload
Derby City Team 1 (OT)	32
Bolsover and Clay Cross	35
Bolsover and Clay Cross	59

Average caseload size

The average caseload across the whole patch is 48 per wte.

3 Activity

	Apr, 2016
Attended Activity	14,236
1st Appointment	596
Follow-Up	13,640
Non-Attended Activity	1,544
Cancelled by Client	359
Cancelled by Trust	43
DNA	965
To Be Attended	177

Narrative:

In April the DNA rate was 6%. The DNA rate is something we have been working on over the last few months. We have introduced the text reminder system but disappointingly this has not had the positive impact expected. Medics continue to support clinical risk management by contacting patients who DNA, however given the number of locums and changes to posts over the past year there is some ongoing difficulty in ensuring a consistent response. Medical management is used to drive consistency in this area.

4 Caseload

The average caseload across the whole patch is currently 48 per wte.

Erewash CCG	Caseload	Nurse CPC wte	OT CPC wte	Total CPC wte*	Caseload per wte
Erewash Adult Recovery	433	5.51	1.52	6.27	69
Erewash Older People CMHT	326	10.47	1.56	11.25	29
Total	**759**	**15.98**	**3.08**	**17.52**	**43**
Actual wte required for max. 35 caseload per wte				21.69	
Difference				**-4.17**	

Hardwick CCG	Caseload	Nurse CPC wte	OT CPC wte	Total CPC wte*	Caseload per wte
Bolsover & Clay Cross Adult Recovery	546	8.62	1.87	9.56	57
County North East Older People CMHT	360	9.53	1.6	10.33	35
Total	**906**	**18.15**	**3.47**	**19.885**	**46**
Actual wte required for max. 35 caseload per wte				25.89	
Difference				**-6.00**	

North Derbyshire CCG	Caseload	Nurse CPC wte	OT CPC wte	Total CPC wte*	Caseload per wte
Chesterfield Central Adult Recovery	619	11.26	2.63	12.58	49
High Peak & North Dales Adult Recovery	447	8.92	2.47	10.16	44
Killamarsh & North Chesterfield Adult Recovery	614	8.88	2.39	10.08	61
Chesterfield Older People CMHT	306	7.89	1.5	8.64	35
Dales North Older People CMHT	159	2.8	0.2	2.90	55
High Peak Older People CMHT	349	4.09	0.2	4.19	83
Total	**2494**	**43.84**	**9.39**	**48.54**	**51**
Actual wte required for max. 35 caseload per wte				71.26	
Difference				**-22.72**	

South Derbyshire CCG	Caseload	Nurse CPC wte	OT CPC wte	Total CPC wte*	Caseload per wte
Amber Valley Adult Recovery	598	8.72	1	9.22	65
County South & Dales Adult Recovery	531	9.48	1	9.98	53
Derby City Adult Recovery 1	671	14.49	0.76	14.87	45
Derby City Adult Recovery 2	764	12.8	1.5	13.55	56
Amber Valley Older People CMHT	456	10.61	1.11	11.17	41
County South Older People CMHT	239	7	1.11	7.56	32
Dales South Older People CMHT	65	2	0.2	2.10	31
Derby City Older People CMHT	504	11.49	2.4	12.69	40
Total	**3828**	**76.59**	**9.08**	**81.13**	**47**
Actual wte required for max. 35 caseload per wte				109.37	
Difference				**-28.24**	

National guidance on caseload sizes

NICE will no longer be publishing the guidance on mental health community team staffing, the previous guidance published by the Department of Health is as follows:

"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*

This financial year the commissioners have funded an additional 18.3 wte care coordinator posts which should help to reduce caseload sizes. To achieve a maximum caseload size of 35 per whole time equivalent care coordinator we would need a further 43 wte posts.

Agency Use:

The planning phase for Neighbourhoods included use of agency staff in order to manage the shifts of resource between teams as a result of the move. This was planned to be achieved within budget and with an associated recruitment plan, with planned trajectories in place. The recent national focus on this area has accelerated our activity to move to a no agency position.

Within the medical staffing there is an ongoing issue with recruitment, with some areas being traditionally difficult to recruit to and the situation with agency and NHS locum supply becoming increasingly challenging. We have had situations for example where a simple request to an agency to enquire whether a locum consultant would consider moving to a pay level within framework led to that consultant abruptly leaving. We are working to ensure medical vacancies are swiftly turned around, however this is also challenging as the role of the Royal College can sometimes delay process, particularly where new job descriptions are required.

5 Current waiting lists

Service Line	Team	External Waits			Internal Waits			
		Number Waiting	Average Wait (Wks)	Longest Pathway Wait	Number Waiting	Average Wait (Wks)	Longest Wait	Referral Type
Derby City	Derby City - Community	172	13	53	335	14.49	110.14	Community
	Dovedale Older People Day Hospital	4	12.79	27.29	121	11.14	42.29	Day Hospital
	Derby City - Outpatients	141	9.66	50.86	453	18.26	254.43	Outpatients
	Midway Older People Day Hospital				64	6.22	15.86	Community
	Derby City - OT				8	5.64	12.86	Community
	Derby City - SPOA	180	4.65	27.29	218	3.6	27.29	Community
	Trust Wide Discharge Liaison Team (Older People)	6	3.76	14	18	1.58	3	Community
	Dementia Rapid Response	2	0.65	1	8	3.09	9.14	Community
North Derbyshire	Bolsover & Clay Cross - OT	2	14.15	15	49	3.67	6.71	Community
	Chesterfield Central - Community	43	10.91	27.14	101	11.21	61.29	Community
	Killamarsh & North Chesterfield - Outpatients	22	8.69	18.14	164	10.72	102.29	Outpatients
	High Peak & North Dales - OT				5	8.37	23.14	Community

Service Line	Team	External Waits			Internal Waits			
		Number Waiting	Average Wait (Wks)	Longest Pathway Wait	Number Waiting	Average Wait (Wks)	Longest Wait	Referral Type
	Bolsover & Clay Cross - Outpatients	51	8.29	26.29	235	6.58	68	Outpatients
	Bolsover & Clay Cross - Community	15	7.93	19	72	12.98	61	Community
	Chesterfield Central - Outpatients	47	6.91	29.14	169	7.19	44.86	Outpatients
	High Peak & North Dales - Outpatients	45	6.9	34.43	161	9.06	63.14	Outpatients
	Killamarsh & North Chesterfield - Community	13	5.91	11	69	10.43	51	Community
	High Peak & North Dales - Community	122	5.65	42.86	190	6.32	60.57	Community
	MAS North - Memory Clinic	4	5.39	9	136	17.31	69.86	Outpatients
	MAS North - MAS	66	5.33	51.29	212	11.02	49.86	Outpatients
	Bolsover & Clay Cross - Assertive Outreach				1	5.14	5.14	Community
	Bolsover & Clay Cross - SPOA	89	4.5	23	108	2.11	6.71	Community
	Chesterfield Central - OT				5	3.83	6.29	Community
	Chesterfield Central - Assertive Outreach				8	3.73	5.29	Community
	Chesterfield Central - SPOA	65	3.58	14	93	3.28	7	Community
	Killamarsh & North Chesterfield - OT				25	3.09	10.29	Community
	Killamarsh & North Chesterfield - SPOA	30	2.38	5	34	2.36	5	Community
	High Peak & North Dales - SPOA	10	1.69	3.86	12	1.93	6.29	Community
South Derbyshire	South Derbys & South Dales - Community	145	11.78	40.29	276	12.99	113.14	Community
	MAS South - MAS	243	9.41	34	277	9.11	61.14	Community
	Amber Valley - Outpatients	48	8.86	24.43	155	9.36	65	Outpatients
	South Derbys & South Dales - Outpatients	29	7.63	36.43	119	13.52	86.43	Outpatients
	Amber Valley - Community	174	7.47	52	265	10.11	87.43	Community
	Erewash - Outpatients	67	7.33	26.29	187	11.02	73.14	Outpatients
	Erewash - MAS	47	6.29	12.14	67	7.61	24.14	Outpatients
	South Derbys & South Dales - OT				10	6	6	Community
	Erewash - Community	121	5.52	26.14	199	7.41	53	Psychotherapy
	Amber Valley - Assertive Outreach				2	3.29	3.29	Community
	Erewash - Assertive Outreach				2	3.29	3.29	Community
	Amber Valley - OT				5	3.09	5.29	Community
	South Derbys & South Dales - Assertive Outreach				5	2.72	4.86	Community
	South Derbys & South Dales - SPOA	21	2.58	9.14	23	1.95	5.14	Community
	Erewash - SPOA	1	2	2	2	2.15	2.43	Community
	Erewash - OT	1	0.86	0.86	13	3.29	14.43	Community
	Amber Valley - SPOA	3	0.14	0.14	4	1.71	6.43	Community

Narrative:

The move to Neighbourhood ways of working has been supported by numerous departments within the Trust.

The move of Neighbourhoods in Paris was a significant undertaking and an excellent example of inter-departmental working. As a result the move has been relatively straightforward. However we are continuing to work closely with the IT department as we move towards greater transparency of waiting lists within our systems. There is a requirement, from commissioners, that we demonstrate wait times both internally and externally and there are several layers to this in clinical practice, so establishing the best way to deliver this transparency is an ongoing piece of work. Regular meetings between Neighbourhood operational staff and IT staff have been set up to enable this.

6 Friends and family test

Date Completed	Likelihood of using Service	Comments	Team
18 Apr 2016	likely	supported me with injured hand	Amber Valley Older People CMHT
18 Apr 2016	extremely unlikely		Derby City Adult Recovery 2

- Only 2 friends and family tests have been completed relating to Neighbourhood teams since its inception on 1st April 2016.
- Generally the level of feedback received across the Trust is low.
- Patient Experience Team to be requested to develop a strategy for increasing the level of friends and family test feedback received across the Trust

We are aware that this is an area for focus as neighbourhoods progress and are keen to enable better gathering of information, this in turn will propel our service development.

7 Compliments

There were 16 compliments received in April relating to Neighbourhood services, as follows:

Ward or Team	Description
Dementia Rapid Response Team	Letter from student social worker: *"Thank you so much for everything. You all have made me feel so incredibly welcome and I could not be more grateful. I've thoroughly enjoyed every day that I have spent here and I hope to one day be a part of a team as supportive as yours. The work you all undertake on a daily basis is nothing short of inspiring."*
Dementia Rapid Response Team	*The Dementia Team are amazing, they help us and give us guidance. I would very highly recommend this team.*
Dementia Rapid Response Team	Care home patient: *"very friendly and approachable, nothing too much trouble, very helpful with advice."*
Dementia Rapid Response Team	*"The team came very quickly when we needed them. Very supportive, friendly team."*
Neighbourhood - Amber Valley	Letter from carer: *"I am a carer for my wife, who has Dementia. A member of the CMHT has recently completed a "life history" project with her. The document outlines stages and events through her life and is so well and sensitively done that it has already brought a mixture of emotions (humour, joy, sadness) to all who know her. Practically it encouraged J to use communication and is important in giving professionals who work with her a better understanding of the person they are involved with. It is such a good thing to have that I wanted to say thank you to the team and particularly BH who has been so professional and sensitive throughout the process."*
Neighbourhood - Amber Valley	Card received: *"Dear Dr D. Thank you for your letter and your kind thoughts for me. My chest infection is much better. I think the antibiotics and steroids made me feel worse than the infection. it was very thoughtful of you to think of me in your very busy clinic. I will always let you know if I cannot attend an appointment, unless there is a good reason why I can't. I know there are lots of people waiting to see you."*
Neighbourhood - Chesterfield Central	Son and daughter sent card and tin of biscuits in to thank JM for her care and understanding of their mother when she cared for her.
Neighbourhood - Chesterfield	Family thanked AH for her kind, considerate care of their mother. They sent a thank you card and typed letter thanking for kindness and support provided to all the family.

Ward or Team	Description
Central	
Neighbourhood - Chesterfield Central	Father of 3 patients telephoned to give feedback re the consultant psychiatrist: *"RPR has done more for me and my family than anyone else. I will never be able to thank him enough. He is helpful, caring, supportive, listens and does not rush".*
Neighbourhood - Chesterfield Central	Plastic bobbing head Queen Elizabeth desk toy given as a gift to lead nurse JD by service user.
Neighbourhood - Chesterfield Central	Box of milk tray received by lead nurse JD as a gift from service user to show his appreciation for the care and support that he receives
Neighbourhood - Chesterfield Central	Card and Tassimo coffee machine and hamper of treats given by patient's relative following the death of the service user: *"To all of the mental health team, thank you for doing everything you could to help and care for JG over the years. Enjoy your coffee machine and treats to show our appreciation...Thank you"*
Neighbourhood - Derby City	Email from Dr to LM following an investigation into an incident: *"I would like to take this opportunity to thank you and Dr R for making this process so objective and constructive and as painless as possible."*
Neighbourhood - Derby City	Letter handed to Care Coordinator: *"C is a good time keeper, shows great support. She phones when she is going to be late, I feel I can talk about my medication and any health problems to C and she is very good and understands me."*
Neighbourhood - Killamarsh & Chesterfield North	Letter received from service user expressing thanks for how 2 staff members had stayed with him until he received treatment for an infected fracture. They had visited him at home to find his leg badly infected. They had taken him to hospital for treatment and stayed late into the evening to ensure that he was all right and to make sure he received all that he needed.
Neighbourhood - Killamarsh & Chesterfield North	Handmade thank you card

8 Complaints

There were 5 complaints received in April relating to Neighbourhood services, with themes of travelling distance, care and treatment and waiting times.

9 Incidents

There have been 40 incidents reported in April 2016 relating to the Neighbourhood:

Category	Insignificant	Minor	Moderate	Major	Catastrophic	Total
Medication	1	7	1			9
Death					8	8
Self-harm		3	3			6
Other	1	2	1			4
Referral, intervention, transfer and discharge			2	1		3
Medical equipment/device	1	1				2
Allegation (inc. risk of abuse or neglect)			1	1		2
Medical issue			1			1
Drug use (illicit)			1			1
Accident		1				1
Abuse/aggression - other party to patient		1				1
Fire		1				1
Homicide					1	1
Grand total	3	16	10	2	9	40

Medication incidents:

Administration - Incorrect storage for drug/medication	3
Administration - Other medication incident	3
Prescribing - Dose or strength was wrong or unclear	1
Prescribing - Missing/Lost record	1
Prescribing - Other medication incident	1

Deaths:

Death unexpected - medical condition/ natural causes	4
Death unexpected - other	2
Expected - end of life pathway	1
Suspected suicide - other	1

10 Conclusion

Neighbourhood services are at the first stage in their development and to achieve the kind of outcomes envisaged; delivering better services in a more efficient and effective manner, we will be working in new and innovative ways. Ensuring targets and activity data remain at a good standard, and improve where needed is a key goal, together with ensuring the people delivering services in neighbourhoods are supported well in doing so.

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 25 May 2016

Governance Improvement Action Plan – Full Report

Purpose of Report

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

Therefore, the purpose of this paper is as follows;

1. To provide Board members with an update on progress of all tasks within the GIAP, including the identification of tasks that are off track, including those that the Board has responsibility for oversight

2. To receive assurances on delivery and risk mitigation through the updated GIAP, from Board Committees and lead Directors

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

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

Executive Summary

The GIAP governance and delivery framework sets out a robust accountability process that includes lead Directors and Board/Board Committees.

The month of May is the second monthly cycle of this accountability process, culminating in this report. The full GIAP accompanying this report provides Board members with an up to date position of the totality of the plan.

It is worth noting the following;

- The main focus of attention during the last 4 weeks has been on tasks with a delivery deadline up to, and including the end of May. The Board should be aware that there has been limited opportunity to look beyond this in any great detail.

- Owing to the timing of meetings in April only Quality Committee and People and Culture Committee have met to discuss and receive assurance on the tasks that they have oversight for on behalf of the Board. Board members will see the outcome of these meetings presented in the 'comments on progress' and in the updated RAG ratings sections in the GIAP.

- Remuneration Committee and Audit Committee meet on the day of Board and the day before respectively.

At the time of writing this report, weekly one to one meetings continue with each lead Director to discuss their tasks/actions, for assurance to be sought by the Responsible Director on task delivery and to agree associated evidence. This process continues to evolve to ensure that it is a meaningful approach and places focus on delivery 'and' supports

the foundation for sustainable change.

Board Members will see that the far right hand BRAG rating column has been completed by the Responsible Director on the GIAP this month. This has been completed based on the information, evidence and assurance provided to date and is subject to challenge/further discussion.

The purpose of this rating is to provide a mechanism by which the Board is assured on delivery of the overall recommendation (and not just specific tasks). This method of rating will be become more objective once it is aligned to an agreed set of measures and documentary evidence. A draft set of measures and proposed documentary evidence is included in with this report for Board to discuss, suggest changes and approve where possible.

To focus the Board's attention, a number of specific areas have been identified for discussion. These have been identified from the Board BRAG rating column.

Board RAG Rating - 'Off Track'

- *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.*

This remains off track for a second month.

Board RAG Rating - 'Some Issues'

- *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.*

- *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.*

- *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.*

- *CorpG1, 2, 4,7 9 and 12 - Governance Framework review* ***(Trust Board agenda item)***

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

- *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*

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 not been discussed at any other meeting

Governance or Legal issues

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

Recommendations

The Board of Directors is asked to;

1. Review the content of this paper, full GIAP (attached) and seek assurance where required

2. Discuss the recommendations rated as 'off track' or 'some issues' and seek assurance on the mitigation provided from the Responsible Director, Individual Directors or Committee Chairs

3. Discuss, make suggested changes and/or approve KPI's and documentary evidence

4. Agree at the end of the Pubic Board meeting whether any further changes are required to the GIAP following presentation of papers, outcomes of item specific discussions and/or other assurances provided throughout the meeting

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

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

Core 1 - HR and Associated Functions	target	Monthly rolling/Annual	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Documentary evidence of demonstrable outcomes
1) Sickness absence rate	3.90%														1) Positive assurance received from internal audit on a number of audits related to the delivery of the GIAP 2) Revised HR model in place 3) HR team metrics in place with evidence of improvement 4) Improvement in organisational HR metrics evidenced through Integrated Performance report 5) Trust Board minutes 6) P&CC minutes
2) Vacancy rates	10%														
3) Staff appraisals	90%														
4) Staff turnover	10.00%														
5) Mandatory training	95%														
6) Agency spend	£3 m														
7) Time to recruitment	TBC														
Core 2 - People and Culture Committee															
1) Improvement in monthly Pulse Check scores	TBC														1) P&CC minutes 2) Evidence of the delivery of the People plan 3) External assurance of the effectiveness of the People and Culture Committee 4) Evidence of the delivery of the Communications Plan
2) People plan metrics to be reflected once agreed	TBC														
Core 3 - Clinical Governance															
1) Trust Policies that are in date	100%														1) Revised Policy for Policies 2) Internal Assurance report on policy compliance 3) External Assurance report on effectiveness of QLTs 4) Quality Committee TOR
2) Reduce the overall number of Trust policies	10%														
Core 4 - Corporate Governance															
1) 100% of Board Committee ToRs reviewed annually	100%														1) Well led External review 2) Committee's TOR 3) Completed actions matrix 4) Board Development programme agendas 5) 360 feedback reports and associated actions
2) 90% papers circulated 5 days prior to meeting	90%														
3) 80% of actions on the Integrated action matrix are on track	80%														
Core 5 - Council of Governors															
1) All new Governors completed induction	100%														1) Well led External review 2) Engagement Policy

2) 90% positive feedback received on the induction	90%														3) Code of Conduct 4) Lead Governor role description
Core 6 - Role & Responsibilities of Board Members															
1) Each Board member has attended 80% of the Board Development programme	80%														1) Board Development programme agendas 2) 360 feedback reports and associated actions 3) Succession plans 4) Well led External review 5) Board Effectiveness Review
2) 100% of Board Members have undergone a 360 appraisal	100%														
3) Exec Directors have attended at least 80% of the executive development sessions	80%														
4) All Directors 100% compliance with their training requirements	100%														
Core 7 - Workforce and OD															
1) Improvement of the following Staff Survey Results KF 14, KF 27, KF 15, KF 21	TBC														1) Board and Committee minutes 2) HR SLA delivery 3) Staff Survey
2) 90% of Managers trained on HR policies before 31st December	90%														
3) Improvement in monthly HR team Pulse Check scores	TBC														
Core 8 - Raising Concerns															
1) Managers completing Grievance, Disciplinary, and Whistleblowing policies training	TBC														1) Raising Concerns policy and process approved by Board 2) Freedom to Speak up action plan 3) Internal Audit assurance on compliance with the Whistleblowing policy
2) 100% compliance against the whistleblowing policy	100%														
3) Improve scores in the following staff survey questions Q13a, Q13bm, Q13c	TBC														
Core 9 -Fit and Proper person Test															
1) All Directors are fully compliant with the Fit and Proper person test	100%														1) Board Minutes 2) Fit and Proper person evidence files
2) 100% of Directors personal files evidence fit and proper persons requirements	100%														
Core 10- CQC															
1) Recruitment trajectory (reduction in operational vacancies)	TBC														1) P&CC minutes
Core 11 - NHS improvement															
1) 80% of Actions are on Track or Completed	80%														1) External assurance reports on the GIAP and governance Framework 2) Enforcement notice removed 3) External well led governance review 4) Board minutes
2) 80% of rag ratings in the Board Assurance Colum are on Track or Completed	80%														
3) 80% of deliverables are presented to committees within timeframes	80%														

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
	CORE 1- REUNIFICATION OF THE HR AND ASSOCIATED FUNCTIONS									
HR2	Ensure external resources for the newly appointed Director of Workforce, OD and Culture are obtained in order to drive the transformation of HR and related functions through a combination of coaching, buddying, and mentoring support.	1) Develop and agree a plan which identifies additional resources to ensure successful delivery of HR, Workforce and OD GIAP actions	18th March 2016	**Some Issues**	A resource plan will identify costs	Director of Workforce, OD and Culture	People and Culture Committee	20th April 2016	1) A plan setting out resource requirements to deliver the GIAP was agreed by ELT 2) Internal process for approval/adverts in progress 3) CV's received from agencies with interviews planned for mid to late April 4) An exception report was presented to People and Culture Committee on 20.4.16 by the Director of Workforce, OD and Culture explaining the delay in the delivery of the agreed resource plan. The report set out the timeframes for recruitment of the agreed posts, with assurances given that all posts would be appointed to, except 1, by the end of April. The Committee were assured that progress was being made, but were not fully assured, hence the rating of 'some issues' 5) Members of P&CC also reviewed the assurance provided for the resource plan itself and challenged whether the plan included enough resource to deliver the totality of the actions within GIAP. The Committee was not assured about the level of resource that had been agreed and requested that ELT reviewed the plan. It was agreed that 'some issues' was the correct rating for this. 6) Following the request from P&CC, a revised HR resource plan was presented to, and agreed, by ELT on Monday 25th April. 7) 7 of the 8 posts will have been recruited and in post by the 31st May. the final one is currently out for advert which closes on the 10th May. 8) Two posts have been removed from the plan as they are considered BAU and are acting up positions. 4 of the 6 posts have currently been recruited to. Of the remaining 2 posts 1 will be recruited by the end of May and 1 will not.	**Some Issues**
		2) Deliver the Resource Plan	31st March 2016	**Some Issues**		Director of Workforce, OD and Culture	People and Culture Committee			

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
HR3	Undertake an exercise to update the model for HR. Utilising the model as a guide, expertise and best practice across the LHE, and beyond. As a priority the Trust should focus on establishing clear foundations, utilising key building blocks to create sustainability in the long term.	1) In consultation with the team develop and deliver the new model for HR	30th June 2016	**On Track**	External support may be required on both the developmental and delivery stages	Director of Workforce, OD and Culture	People and Culture Committee	19th October 2016	1) A customer survey will be distributed to all Band 7's within the organisation week commencing 9th May. From the results and feedback of the survey the team will consider the HR model and areas of focus. In addition the team will also develop a customer charter and a service level agreement. 2) The customer survey was sent out to staff and closes on the 20th May. To date 50 responses have been received. 3) A paper setting out the new model for HR will be presented at June's P&CC	**On Track**
HR4	Define a new structure for HR and its related functions with a priority on operational efficiency and strategic impact taking into account the refreshed People Strategy and revised model for HR and related functions.	1) Develop and implement a new structure for HR and its related functions with a priority on operational efficiency and strategic impact	30th June 2016	**On Track**	External support may be required on both the developmental and delivery stages	Director of Workforce, OD and Culture	People and Culture Committee	19th October 2016	1) Work is currently underway to define a new structure of working which allows for further cohesion between the OD and HR functions. 2) There are no plans to change the HR structure in the short term. 3) A paper will be presented to People and Culture Committee on the 16th June 2016	**On Track**

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
HR5	As part of the development of the People strategy and developing the model for HR, the function should define how it measures and evaluates the impact of HR, particularly around securing organisational development. A clear set of metrics demonstrating the impact of the function should be a focus on the newly created People and Culture committee.	1) Develop a suite of metrics to measure impact of interventions at an organisation and service line level	30th June 2016	On Track	None Required	Director of Workforce, OD and Culture	People and Culture Committee	6th July 2016	1) Progress against this action has been delayed due to annual leave and sickness. 2) Functional HR metrics presented at People and Culture Committee on the 20.4.16 for Committee discussion. Feedback was provided by the Committee and the metrics were agreed. The Committee noted that the timeframe for delivery had not been met, but was assured by the proposed metrics and agreed that this was now back on track. It was agreed that the metrics will be included within the HR model proposal due by the end of June 2016 and used to monitor effectiveness 3) Metrics to be populated in May and adopted in June	Some Issues
		2) Develop an internal suite of metrics to measure functional effectiveness	31st March 2016	On Track		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	1) Terms of Reference Developed	29th January 2016	Completed	None Required	Director of Workforce, OD and Culture	People and Culture Committee	27th January 2016	1) TOR for P&CC agreed in February 2) TOR of P&CC sub committees were presented in March but not approved. Revised TOR will be re-presented for approval by P&CC committee in April 3) Revised TOR for sub groups were approved at P&CC 20.04.16	On Track
		2) Terms of Reference approved by Board	29th January 2016	Completed						
		3) First Committee meeting	17th February 2016	Completed						

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
PC2	Develop and undertake a clear programme of work around culture, utilising the expertise of other NHS Trusts in the LHE, and where necessary beyond, to inform the programme of activities.	1) Develop a programme of work against the delivery of the people strategy	30th June 2016	On Track	Resources required to be identified within People plan.	Director of Workforce, OD and Culture	People and Culture Committee	17th March 2017	1) People Strategy on the agenda for the people committee in April. 2) An externally facilitated Board development session was held on the 13th April 2016 at which the Board discussed the values 3) The People strategy framework was presented to People and Culture Committee on the 20.4.16 4) P&CC requested a fully detailed People Plan to be presented at its May meeting. This plan will outline a work programme which underpins this key recommendation 5) A survey has been distributed to all staff asking them if we should refresh the Trust Values, the feedback of the survey will be discussed at the Board Development Session 11th May 2016 6) The Survey results were discussed at the Board Development session and at People and Culture Committee in May. Based on the feedback from the survey and other feedback from engagement events, it has been agreed that the values will be refreshed and not rewritten as part of the new Trust Strategy. 7) Health and Well- Being events already happen within the organisation and a paper highlighting this will be presented to the Committee in June. A further comprehensive plan will be presented at the July Committee meeting which will align to the People Plan.	On Track
		2) Develop a clear plan which outlines an on-going focus on pulse surveys to enable targeted activity	31st July 2016	On Track		Director of Workforce, OD and Culture				
		3) Based on Pulse Checks develop a focused coaching within teams	31st August 2016	On Track		Director of Workforce, OD and Culture				
		4) Implement events focused on staff health and well-being	30th June 2016	On Track		Director of Workforce, OD and Culture				
		5) Ensure there is an agreed approach to extensively share good practice and innovation	30th June 2016	On Track		Director of Workforce, OD and Culture				

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
		6) Develop and implement a leadership development programme	31st July 2016	**On Track**		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.	1) Develop a comprehensive internal Comms plan, which clearly articulates engagement approaches both formal and informal	31st May 2016	**Completed**	Comms resource may be required	Director of Corporate Affairs	People and Culture Committee	8th June 2016	1) CEO Report to Board has been enhanced to include more detailed information about stakeholder engagement and it now includes a detailed section called listen, learn, lead. This summarises feedback from staff and provides evidence of where action has been taken in response to this feedback. 2) May's People and Culture Committee received an internal Comms plan. It was agreed that the plan would be further developed in line with the engagement plan and supported by the Engagement group of People and Culture. The Committee also requested further action and clarity on how staff feedback was going to be recorded and then how it could be used in a positive way.	Some Issues
		2) Develop a clear system to record feedback received from staff	31st May 2016	**Some Issues**		Director of Corporate Affairs	People and Culture Committee			

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
PC4	Prioritise the development of the People Strategy and ensure the agenda and focus of the newly formed People and Culture Committee is clearly aligned the Trust's overall strategy.	1) Refresh People Strategy including reporting metrics	29th April 2016	Off Track	Identified within the resource plan	Director of Workforce, OD and Culture	People and Culture Committee	6th July 2016	1) People Strategy to be presented to P&CC in April. 2) A draft People Strategy framework and plan was presented to People and Culture Committee on the 20.4.16. The Committee acknowledged progress and discussed the draft documents, agreeing that the content was good, but that the People Plan (implementation) was not complete. The Committee was therefore not assured and agreed that a completed People Plan was required at its May meeting for approval. 3) A revised people plan was discussed at the People and Culture Committee in May, it was agreed that there was limited assurance on the plan but agreed the principle actions. The Committee requested, at its June meeting, a revised plan to be developed which would provide clarity on ownership of actions, clearly defined KPIs, timescales and deliverables.	Off track
		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	Off Track		Director of Workforce, OD and Culture	People and Culture Committee			
	Undertake an exercise to refresh the Trust values. As part of this exercise engage with staff to ensure that values are meaningful and expected behaviours are clear. Prelaunch revised values across the Trust.	1) HR and OD to undertake a review of the Trust values	31st May 2016	Completed		Director of Workforce, OD and Culture	People and Culture Committee		1) An externally facilitated Board development session on Trust values took place on the 13th April 2016, and was discussed by ELT on the 18th April 2016. A further discussion is planned for Board in April to agree next steps. 2) As part of the review of the Trust values the Director of workforce, OD, and Culture has delivered a podcast to staff explaining this specific part of the GIAP. This has	

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
PC5		2) Set a programme of engagement with staff to consultant on the refresh of the values	31st May 2016	Completed	Investment in external consultants to support culture change programme	Director of Workforce, OD and Culture	People and Culture Committee	10th August 2016	this specific part of the GIAP. This has been supplemented with a short organisational survey distributed via the intranet to seek staff's views on whether the current values are still valid, valid with small changes or whether a full re-write of them is required. 3) A Board discussion took place on the 27th April which focused on the feedback from the Board Development session and reflections on the Trust values. Board members agreed to wait for feedback on the survey before agreeing next steps. 4) A survey has been distributed to all staff asking if we should refresh the Trust Values. Intranet survey results will be discussed at the Board Development Session 11th May 2016 5) The People and Culture Committee received positive assurance on the review of the Trust values and the approach taken to refresh the Trust values in the new Trust Strategy.	On track
		3) Ensure a comprehensive Comms plan in place to ensure values are visible across the Trust; and	30th June 2016	On Track		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	On Track		Director of Workforce, OD and Culture	People and Culture Committee			
	CORE 3 CLINICAL GOVERNANCE									

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
ClinG1	Refresh the role of Quality Leadership Teams to increase their effectiveness as core quality governance forums.	1) Agree and implement a QLT forward plan process to ensure all required papers are received at each meeting	30th April 2016	Completed	Resource required to support time out days for QLT and CRG leadership teams	Director of Nursing	Quality Committee	6th October 2016	1) April Quality Committee received a paper outlining the process on this action and also included Model Quality Leadership team - forward plan, a template issue log and a template agenda for the QLT meetings. The Committee were assured by the proposed programme of work.	On Track
		2) Develop and implement a standard escalation template to be used by QLT's	30th April 2016	Completed		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	Completed		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	On Track		Director of Nursing	Quality Committee			
ClinG2	The Trust would benefit from a robust and thorough policy review programme.	1) Undertake a review of Trust policies in order to; a)Revise the number of policies; b) update to ensure for plain English; c) ensure consistency and clarity in how policies are presented , e.g. managers guide, policy or procedure.	31st December 2016	On Track	Resource will be required to increase capacity within the risk management function	Director of Nursing	Audit and Risk Committee	10th January 2017	1) Extra resource to support this action was approved by ELT 2) A member of staff has been seconded to the role for 6 months in order to review policies	On Track
ClinG3	Increase the effectiveness of the Quality Committee by ensuring clear alignment of the committee with the quality strategy and associated objectives, and ensuring a clear focus on seeking assurance.	1) Board Development to focus on NED challenge of overdue actions and reports (see RR2)	31st March 2016	Completed	Resource identified in Board Development RR2	Director of Corporate Affairs	Board of Directors	3rd November 2016	1)As part of the first task the Board Development programme was agreed at March Board meeting. This includes a session in June on holding to account 2) The Quality Committee approved the TOR at its meeting in May. Before this can be approved as completed there is requirement to ensure the agenda of Junes meeting is reflective of, and aligned to the Quality Strategy	On Track
		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	On Track		Director of Corporate Affairs	Audit and Risk Committee			

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
		3) Introduce a Quality Governance Group that will report to Quality Committee	31st July 2016	**On Track**		Director of Nursing	Quality Committee			
		4) Ensure that Quality Committee agenda is structured so that it focuses on topics to deliver quality strategy and goals.	30th June 2016	**On Track**		Director of Nursing	Quality Committee			
	CORE 4; CORPORATE GOVERNANCE									
CorpG1	The Trust should consider how its governance arrangements could better match its strategy and plans.	1) Develop and approve a Corporate Governance Framework which supports the delivery of the Trust strategy ensuring that the Board of Directors and Board Committee agendas adequately reflect the strategic objectives of the Trust	31st May 2016	**Some Issues**	None Required	Director of Corporate Affairs	Board of Directors	29th June 2016	1) The key tasks associated with the development of the Corporate Governance Framework identified in the GIAP have been reviewed by the new Director of Corporate Affairs. There is a concern about the timeframes for delivery. This is being raised as a significant issue to Trust Board ahead of the 31st May delivery date. In order to successfully deliver and embed these key recommendations, an extended timeframe will need to be agreed. A plan will be presented to May's Board meeting setting out how all or parts of CG1, 2, 4, 7, and 9 will be delivered along with clear timeframes 2) The Corporate Governance Framework has been discussed informally by ELT, and a Discussion Paper was presented to the Board Development Session 11 May 2016. From the feedback received from the Board Development session an updated Governance Framework is being presented to the Audit Committee and the Board for discussion.	**Some Issues**

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
CorpG2	The Governance Framework should be updated to give greater clarity regarding roles of key individuals and governance forums, including: all EDs, the SID and Vice Chair, PCOG, QLTs and the Safeguarding Committee.	1) Develop and approve a Corporate Governance Framework	31st May 2016	**Some Issues**	None required	Director of Corporate Affairs	Board of Directors	29th June 2016	1) The key tasks associated with the development of the Corporate Governance Framework identified in the GIAP have been reviewed by the new Director of Corporate Affairs. There is a concern about the timeframes for delivery. This is being raised as a significant issue to Trust Board ahead of the 31st May delivery date. In order to successfully deliver and embed these key recommendations, an extended timeframe will need to be agreed. A plan will be presented to May's Board meeting setting out how all or parts of CG1, 2, 4, 7, and 9 will be delivered along with clear timeframes 2) The Corporate Governance Framework has been discussed informally by ELT, and a Discussion Paper was presented to the Board Development Session 11 May 2016. From the feedback received from the Board Development session an updated Governance Framework was presented to the Audit Committee and to the Board for discussion.	**Some Issues**
CorpG3	The Board and its committees need to have a greater focus on capturing, recording and holding to account for agreed actions.	1) Board Development programme to be updated to include a session on holding to account which will include holding to account for agreed actions.	30th June 2016	**Completed**	External Support needed in order to facilitate Board Development session	Director of Corporate Affairs	Audit and Risk Committee	29th June 2016	1) Board Development programme agreed at March Board meeting. This includes a session in June on holding to account. 2) The Corporate Governance Framework has been discussed informally by ELT, and a Discussion Paper was presented to the Board Development Session 11 May 2016. From the feedback received from the Board Development session an updated Governance Framework is being presented to the Audit Committee and Board for discussion. The Discussion paper also considers ED attendance, Minutes of committee meetings, and the action log process.	On Track
		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	**Completed**		Director of Corporate Affairs	Audit and Risk Committee			

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
CorpG4	Review the operation of all committees seeking to minimise duplication, revising membership, ensuring a focus on capturing and tracking actions, and increasing contribution to the debate. -a review of forward plans against ToR to ensure clarity of purpose; -minimise duplication of papers; -committee chairs should also meet quarterly to ensure effective co-working; -ensure robust attendance of all key EDs at committee meetings; -ensure a consistent focus on summarising debate and capturing actions. (feedback on this should be sought in annual effectiveness reviews); -review appropriateness of membership and provide a focus on members and attendees contributing equitably and effectively; and -timely submission of papers and consistent use over cover sheets	1) Undertake a comprehensive review of the Board Committee structures including TOR	31st May 2016	**Some Issues**	None Required	Director of Corporate Affairs	Audit and Risk Committee	29th June 2016	1) ED attendance at Committees reviewed at ELT and will be reflected in revised TOR 2) The key tasks associated with the development of the Corporate Governance Framework identified in the GIAP have been reviewed by the new Director of Corporate Affairs. There is a concern about the timeframes for delivery. This is being raised as a significant issue to Trust Board ahead of the 31st May delivery date. In order to successfully deliver and embed these key recommendations, an extended timeframe will need to be agreed. A plan will be presented to May's Board meeting setting out how all or parts of CG1, 2, 4, 7, and 9 will be delivered along with clear timeframes 3) The Corporate Governance Framework has been discussed informally by ELT, and a Discussion Paper was presented to the Board Development Session 11 May 2016. From the feedback received from the Board Development session an updated Governance Framework is being presented to the Audit Committee and Board for discussion. The Discussion paper also considers ED attendance, Minutes of committee meetings, and the action log process.	**Some Issues**
		2) Arrange for Committee Chairs to meet on a quarterly basis	31st March 2016	**Completed**		Director of Corporate Affairs	Audit and Risk Committee			
		3) Review ED attendance at Committees	27th January 2016	**Completed**		Director of Corporate Affairs	Audit and Risk 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	**Completed**		Director of Corporate Affairs	Audit and Risk Committee			

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
		5) Embed a process for the yearly review of the effectiveness of Board Committee against TOR	30th June 2016	**Completed**		Director of Corporate Affairs	Audit and Risk Committee			
CorpG5	Undertake a review of the Finance and Performance Committee outlined below -a review of forward plans against ToR to ensure clarity of purpose; -minimise duplication of papers; -committee chairs should also meet quarterly to ensure effective co-working; -ensure robust attendance of all key EDs at committee meetings; -ensure a consistent focus on summarising debate and capturing actions. (feedback on this should be sought in annual effectiveness reviews); -review appropriateness of membership and provide a focus on members and attendees contributing equitably and effectively; and -timely submission of papers and consistent use over cover sheets	1)Undertake a comprehensive review of the Committee aligned to the TOR of the Committee	31st May 2016	**Completed**	None Required	Director of Corporate Affairs	Audit and Risk Committee	29th June 2016	1) Updated TOR were approved at the Committee meeting on the 28th March 2) The TOR were updated to reflect the well led findings, Trust Board forward plan updates, creation of People and Culture committee and general refresh 3) As part of the Committees annual report on its work the committee has also reviewed its effectiveness.	**On Track**
		2) Finance and Performance Forward Plan approved by F&P	31st May 2016	**Completed**		Director of Corporate Affairs	Audit and Risk Committee			
		3) Embed a process for the yearly review of the effectiveness of Board Committee against TOR	31st May 2016	**Completed**		Director of Corporate Affairs	Audit and Risk Committee			
CorpG6	The Audit Committee should reaffirm its role in seeking assurance over systems, controls and processes and not matters of operational or managerial detail.	1) Ensure processes are in place for Audit Committee to undertake a review of its effectiveness	30th April 2016	**Completed**	None Required	Director of Corporate Affairs	Audit and Risk Committee	27th April 2016	1) Committee Terms of Reference have been reviewed in line with Best Practice.	**On Track**
		2) Review reporting and monitoring process to ensure Audit Committee is receiving required assurance on systems, controls and processes	30th April 2016	**Completed**		Director of Corporate Affairs	Audit and Risk Committee			
		3) Review Audit committee TOR in line with best practice from across the NHS	30th April 2016	**Completed**		Director of Corporate Affairs	Audit and Risk Committee			

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
CorpG7	In light of the changing governance and accountability structures (such as neighbourhoods, campuses and QLTs), an accountability framework should be designed to fully engage staff in how these changes will affect ways of working, performance management structures and desired behaviours moving forward.	1) Aligned to the Corporate Governance Framework develop and approve an organisational accountability framework	30th June 2016	**Some Issues**	None Required	Director of Operations	Audit and Risk Committee	19th July 2016	1) The key tasks associated with the development of the Corporate Governance Framework identified in the GIAP have been reviewed by the new Director of Corporate Affairs. There is a concern about the timeframes for delivery. This is being raised as a significant issue to Trust Board ahead of the 31st May delivery date. In order to successfully deliver and embed these key recommendations, an extended timeframe will need to be agreed. A plan will be presented to May's Board meeting setting out how all or parts of CG1, 2, 4, 7, and 9 will be delivered along with clear timeframes 2) The Corporate Governance Framework has been discussed informally by ELT, and a Discussion Paper was presented to the Board Development Session 11 May 2016. From the feedback received from the Board Development session an updated Governance Framework is being presented to the Audit Committee and Board for discussion.	**Some Issues**
		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	**Some Issues**		Director of Corporate Affairs	Audit and Risk Committee			

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
CorpG8	The Board needs to introduce an integrated performance report which encompasses key operational, quality, workforce and finance metrics	1) The Trust will revise the integrated performance report which will include: •key operational metrics; •a workforce dashboard; •the Quality Dashboard, updated to show the refreshed Quality Priorities; •a finance dashboard; and •a summary of performance of groups to highlight any underlying themes.	31st May 2016	**Completed**	None Required	Director of Operations	Board of Directors	25th May 2016	1) New Integrated Performance Report presented to Board in March 2) Quality Metrics required to complete the report by the end of May 3) Quality Metrics were presented to Board as part of the Integrated performance report in April. It was agreed that further work would be undertaken to refine the metrics and would be included in the May report to the Board 4) A Local operating procedure is being drafted which outlines the process and responsibilities for the Integrated Performance report. It has been agreed as part of the development of the LOP that PCOG will take a formal role in pulling together all the relevant information and presenting to the relevant Directors for sign off.	On Track
	Formalise the role of PCOG as a key forum in the Trust's governance structure	1) As part of the Governance Framework review the Trust will formalise the role of PCOG	31st May 2016	**Some Issues**		Director of Operations	Audit and Risk Committee		1) See CG1 for task 1 2) Actions matrix has been introduced with further development required 3) Escalation to ELT being provided by Director of Operations	

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
CorpG9		2) Increasing ED attendance at PCOG	31st May 2016	Some Issues	None Required	Director of Operations	Audit and Risk Committee	19th July 2016	4) PCOG has placed greater emphasis on its role in providing an oversight of performance and Contracting operational performance and issues. 5) The TOR of PCOG will be refreshed to place greater emphasis of the oversight of the Integrated performance report and to reflect attendance at the group. It has been agreed that not all ED need to be in attendance and deputies with operational oversight are better placed to be on the group, when the deputies are unable to attend the ED should attend in there place. 6) The TOR of TOMM will also be refreshed to ensure there is clarity of roles and responsibilities between the groups 7) Action tracker is now in place and is aligned to the minutes 8) The General Managers of Campus and Neighbourhoods form part of the membership of PCOG which provide oversight of the move to the Neighbourhood Model 9) The review of PCOG will now be aligned to the delivery of the Accountability Framework and will be delivered in July 2016	Some Issues
		3) Improving the quality of minutes and action trackers and the timeliness of papers to this forum.	31st May 2016	Some Issues		Director of Operations	Audit and Risk Committee			

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
		4) Clarifying the role of PCOG in light of the move to neighbourhoods and campuses	31st July 2016	**On Track**		Director of Operations	Audit and Risk Committee			
CorpG10	Further improve the function of the ELT by improving the timeliness of papers and quality of debate.	1) Ensure ELT agenda focuses on agreed key priorities and items appropriately escalated through the Governance Structures. Agenda and papers will be circulated on a Thursday	31st March 2016	**Completed**	None Required	Acting Chief Executive	Board of Directors	30th April 2016	1) ELT agenda completed and sent out on a Thursday 2) Revised agenda reflects the focus on agreed key priorities and principles.	**Complete**
	The Board needs to address the quality of debate and dialogue, focussing on increasing contributions across all BMs, displaying greater leadership and vision, ensuring an appropriate balance between strategic and operational debate, and pushing for increased momentum around key issues.	1) Ensure a Board development programme which is linked to the Trust Strategy	31st March 2016	**Completed**		Director of Corporate Affairs	Board of Directors		1) Board development programme approved at the Board meeting in March 2) 360 degree appraisals have commenced for 2016. The Council of Governors Noms and Rems Committee agreed the paper work and framework, but have agreed given the current environment that Governors will not comment on the NED appraisals this year, as they will hold the NEDs to account through their task and finish group 3) Board forward plan was approved at the	

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
CorpG11		2) Ensure all Board Members have completed 360 appraisals which focus on development	31st March 2017	**On Track**	None Required	Director of Workforce, OD and Culture	Rem Com/ Nominations and Remuneration Committee (CoG)	1st April 2017	meeting in March which includes a balance of operational and strategic items 4) The agenda will continue to be reviewed by the Director of Corporate Affairs as well as ELT to ensure the plan remains balanced	On track
		3) Ensure that there is the appropriate balance of strategic and operational items on the Board Agenda	30th September 2016	**Completed**		Director of Corporate Affairs	Board of Directors			
CorpG12	Reintroduce short summary reports from committee chairs to the Board to supplement minutes. These should identify key risks, successes and decisions made / escalated from the meeting.	1) Reintroduce short summary reports from committee chairs to the Board which identify key risks, successes and decisions made / escalated from the meeting.	30th April 2016	**Some Issues**	None Required	Director of Corporate Affairs	Audit and Risk Committee	29th May 2016	1) Summary reports will be presented at the Board meeting in April 2) Summary reports from Board Committees were provided for April's Board meeting. It was agreed that further development and understanding of their purpose was required to ensure that they are an effective tool in the governance and assurance process. Board members agreed that there remained 'some issues' which required resolution for May's Board meeting.	Some Issues
CorpG13	The Board should re-establish the Board Assurance Framework as one for all risks including risks which it is involved in and when that risk has an element of confidentiality how it is handled. It should write and implement a plan for BoD development which includes these objectives.	Develop and Agree BAF 16/17	31st March 2016	**Completed**	None Required	Director of Corporate Affairs	Audit and Risk Committee	31st March 2016	1) Board has agreed 16/17 BAF at march Board meeting 2) Board has agreed timetable for BAF deep dives 3) Once the new Trust Strategy has been formally approved, the BAF will need to be refreshed.	On Track

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
		Schedule BAF Deep dive reviews for Board Committees	31st March 2016	**Completed**		Director of Corporate Affairs				
CORE 5- COUNCIL OF GOVERNORS										
CoG1	The relationship between the BoD and the CoG is poor. Both parties should adopt a conciliatory approach rather than continuing with the antagonism which inflicts the current relationship.	1) The Board and Council of governors will co-write a policy on how the Board and council of governors will work in partnership	30th June 2016	**On Track**	None Required	Director of Corporate Affairs	Board of Directors & Council of Governors	1st April 2017	1) Council of Governors have approved a new meeting structure which include a more robust and effective Nomination and Remuneration Committee 2) Council of Governors have approved an expanded lead Governor job description and appointed to it 3) Code of Conduct to be reviewed at 12th April meeting 4) CoG is due to meet on the 1st June and will review tasks that it has oversight for.	**On Track**
		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	**On Track**		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	**On Track**		Director of Corporate Affairs	Board of Directors & Council of Governors			
CoG2	**Deloitte 12** - Formal training should be required for all current members of the CoG and to future members as they join. This training should include the role of the Governors, the context of organisational governance and the personal conduct expected of Governors. **CQC 3** - The trust should ensure that all board members and the council of governors undertake a robust development plan	1) Develop a new induction programme for the Council of Governors and roll out its delivery	31st May 2016	**On Track**	Requirement for external governance training	Director of Corporate Affairs	Council of Governors	1st April 2017	1) A new induction programme has been developed and will be used to induct all new Governors in May 2) A new development programme has been developed and will be discussed at the Governance Committee of Council of Governors on the 12th April 2016 3) The CoG Governance Committee on the 12th April 2016, discussed and approved the Governor Development programme and the first session is due to take place on the 22nd April 2016 focusing on Trust Strategy and GIAP 4) CoG is due to meet on the 1st June and will review tasks that it has oversight for.	**On Track**
		2) Develop a CoG development plan for 2016/17 to include Governwell and other external training	30th April 2016	**On Track**		Director of Corporate Affairs	Council of Governors			

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
		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 2016	**Completed**		Director of Corporate Affairs	Council of Governors			
CoG3	Prioritise the recruitment to the Council of Governors, ensuring that the role of the governor and vacancies are publicised.	1) Chairman will engage stakeholders to ensure representation on the Council of Governors	31st May 2016	**On Track**	Electoral reform services will manage the Governor Elections	Director of Corporate Affairs	Council of Governors	21st July 2016	1) The Chairman has written to all stakeholders to ensure they have identified someone in the organisation to represent them. The local police constabulary has written to decline representation. This will be discussed at the Governance Committee of CoG 2) Following the nomination process in Feb/March 16 we now have six new governors who were elected unopposed These are: Bolsover Chesterfield North Derby City East Derby City East Erewash North Surrounding Areas This leaves us with the following: Upcoming elections (close on Tuesday 3 May): High Peak (two candidates) Nursing and Allied Professions – staff (three candidates) Remaining vacancies: Amber Valley North Chesterfield South Voluntary sector (appointed) x 2 Derbyshire Constabulary (opted out)	**On Track**
		2) Hold Governor elections	31st May 2016	**On Track**		Director of Corporate Affairs	Council of Governors	22nd July 2016		
	CORE 6- ROLE AND RESPONSIBILITIES OF BOARD MEMBERS									

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
RR1	Implement proposals to improve succession planning at Board level, including ensuring that Governors are adequately engaged in this process. Alongside this, develop processes for succession planning for Senior Leader positions	1) Develop and approve Board level, key divisional and corporate leaders succession plan	30th September 2016	**On Track**	None Required	Director of Workforce, OD and Culture	Rem Com	1st April 2017		**On Track**
		2) Implement and embed succession plan	31st March 2017	**On Track**		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)	1) Develop a Board Development plan for 2016/17	31st March 2016	**Completed**	External resource will be required to facilitate Board Effectiveness sessions	Director of Corporate Affairs	Board of Directors	1st April 2017	1) Board Development programme agreed at March Board meeting 2) An externally facilitated Board development session focusing on the Trust's values took place on the 13th April 2016, with a further discussion planned for Board in April 3) Board Development holding to account sessions planned for 15th June	**On Track**
		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	**On Track**		Director of Corporate Affairs	Board of Directors			
RR3	**Deloitte 6** - Complete the full process of 360 feedback for all BMs and utilise the outcome to set clear objectives in relation to portfolio areas (for EDs) as well as in relation to the role of the corporate director and contribution to the Board. **CQC 8** - The trust should introduce and effectively monitor 360 degree feedback all senior managers and directors.	1) Develop a 360 feedback process for BM's with forms and expectations on what and how to feedback	30th June 2016	**On Track**	Support required from external organisations	Director of Workforce, OD and Culture	Rem Com/ Nominations and Remuneration Committee (CoG)	1st April 2017	1) Board development programme approved at the Board meeting in March 2) 360 degree appraisals have commenced for 2016. The Council of Governors Noms and Rems Committee agreed the paper work and framework, but have agreed given the current environment that Governors will not comment on the NED appraisals this year, as they will hold the NEDs to account through their task and finish group 3) Board forward plan was approved at the meeting in March which includes a balance of operational and strategic items 4) The agenda will continue to be reviewed by the Director of Corporate Affairs as well as ELT to ensure the plan remains balanced 5) 360 feedback has been completed for 3 NEDs and 1 ED 6) A paper detailing the process for 360 feedback for senior managers will be presented to the People and Culture Committee in June	On Track
		2) Implement 360 degree feedback for all BM's	30th September 2016	**On Track**		Director of Workforce, OD and Culture	Rem Com/ Nominations and Remuneration Committee (CoG)			
		3) Integrate 360 feedback into BM's appraisal objectives and personal development goals	31st March 2017	**On Track**		Director of Workforce, OD and Culture	Rem Com/ Nominations and Remuneration Committee (CoG)			
		4) Implement 360 degree feedback for all senior managers	31st March 2017	**On Track**		Director of Workforce, OD and Culture	Rem Com			

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
		5) Integrate 360 feedback into senior manager appraisal objectives and personal development goals	30th September 2017	**On Track**		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.	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	**Completed**	Support required from external organisations	Acting Chief Executive	Rem Com	1st April 2017	1) A paper setting out an ELT development programme will be presented the Remuneration Committee on 27.04.16 for consideration and approval	On Track
		2) Implement development programme and monitor effectiveness through 360 feedback	31st March 2017	**On Track**		Acting Chief Executive	Rem Com			
RR5	The trust should ensure that training passports for directors reflect development required for their corporate roles.	1) Training requirement for all ED's and NEDS are agreed by CEO and Chair, with passports updated accordingly	30th June 2016	**On Track**	Resource may be required for individual development	Acting Chief Executive / Chairman	Rem Com	5th October 2016	1) An assurance paper will be presented to the Remuneration Committee in October	**On Track**
		2) Developmental training requirements are discussed and agreed with Board members in their Appraisals	31st May 2016	**On Track**		Acting Chief Executive / Chairman	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	**On Track**		Acting Chief Executive / Chairman	Rem Com			
CORE 7- HR AND OD										
	DR34- Define and agree a process to regularly monitor the consistent application of HR policies and procedures for the full range of Employee Relations cases. **CQC 1** - The trust must ensure HR policies and procedures are followed and monitored for all staff	1) To undertake a review of HR policies and procedures to ensure all are in date and are compliant with expected HR practice	30th September 2016	**On Track**		Director of Workforce, OD and Culture	People and Culture Committee		1) Principal ER manager role has been advertised and is due to close on the 27th April. Post appointed to. 2) Director of Workforce, OD and Culture is meeting with internal audit week commencing the 9th May. It will be suggested that Internal Audit should review the Disciplinary and Health Attendance Policies 3) Internal audit scope being agreed to audit specific policy compliance	

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
WOD1		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	On Track	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	18th January 2017	audit specific policy compliance	On track
		3) A training programme on HR policies and process is designed, available and accessible	31st December 2016	On Track		Director of Workforce, OD and Culture	People and Culture Committee			
		4) HR function to Audit compliance against two selected HR policies	30th June 2016	On Track		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	On Track		Director of Corporate Affairs	Audit and Risk Committee			
	The trust should ensure that recruitment processes for all staff are transparent, open & adhere to relevant trust policies	1) Review and ensure that Trust recruitment and acting up policies are fit for purpose	30th June 2016	On Track		Director of Workforce, OD and Culture	People and Culture Committee		1) An audit of the recruitment processes took place in 2015 which only identified one area of low risk. This is to be considered as part of the wider HR policy review which will take place before September 2016	

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
WOD2		2) Agree a plan and deliver recruitment training to all appointing officers	31st March 2017	**On Track**	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	15th July 2016		**On track**
		3) Deliver a peer audit of recruitment policies compliance to demonstrate improvement	31st December 2016	**On Track**		Director of Workforce, OD and Culture	People and Culture Committee			
WOD3	Address the relationship issues identified within the function, and alongside this agree a development programme for HR and its related functions that starts by building relationships at a senior level before seeking to develop an effective and efficient function.	1) Develop and implement a HR and related function Development programme, which includes building good working relationships	31st May 2016	**Completed**	External resource and support required	Director of Workforce, OD and Culture	People and Culture Committee	15th March 2017	1) A high-level paper outlining the development for the HR team will be presented to the P&C committee in May 2) A Paper was delivered to People and Culture in may which outlined the approach and broad areas of development for the HR team.	On Track
		2) Implement Development Programme	31st May 2016	**Completed**		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.	1) A training programme on HR policies and process is designed, available and accessible	31st December 2016	**On Track**	Additional capacity to develop core management training is required	Director of Workforce, OD and Culture	People and Culture Committee	15th January	The Post of Management Trainer has been advertised	On Track
WOD5	Consider a range of development interventions for the operational HR team to ensure employment law risks are mitigated.	1) As part of the wider HR development programme (WOD 3) deliver specific interventions on employment law	30th September 2016	**On Track**	Specialist HR Employment law specialist request	Director of Workforce, OD and Culture	People and Culture Committee	19th October 2016		On Track

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
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	1) Introduce a monthly pulse check for the HR team	31st May 2016	**Completed**	None required	Director of Workforce, OD and Culture	People and Culture Committee	17th July 2017	1) At the HR team meeting it was agreed to use emoji's as a pulse check for the team. The Process will be outlined to the People and Culture Committee verbally at its meeting in May 2) A Paper was delivered to People and Culture in May which outlined the approach and broad areas of development for the HR team.	**On Track**
		2) Integrated Team meeting implement	30th June 2016	**On Track**		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.	1) Implement a proactive system which monitors adherence to the grievance, disciplinary, whistle-blowing policies, including a robust case tracking system.	31st May 2016	**Some Issues**	Resource Plan	Director of Workforce, OD and Culture	People and Culture Committee	19th October 2016	1) the Director of Workforce, OD and Culture has provided assurances that there is a proactive system which monitors adherence to the grievance, disciplinary, whistle-blowing policies, including a robust case tracking system is already in place. An internal audit is due which will review the case tracker. 2) Internal Audit scoping meeting to take place on 12th may 3) Case tracker to be presented at the People and Culture Committee in May 4) The People and Culture Committee understood the tracking system, but the committee were not assured that adherence to the policy was being monitored through the process outlined. 5) In order to provide assurance it has been agreed to internally audit the case tracker. The scope is currently being developed with internal audit team.	**Some Issues**
		2) Internal audit compliance against named policies and the defined timescales against cases identified on the tracker.	30th September 2016	**On Track**		Director of Workforce, OD and Culture	Audit and Risk Committee			

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
		3) Ensure the backlog of cases made known to the CQC at the time of the inspection are concluded.	30th June 2016	On Track		Director of Workforce, OD and Culture	People and Culture Committee			
WOD8	The trust should continue to make improvements in staff engagement and communication	1) Develop a clear staff engagement plan that takes account of listen, learn and lead, wider open staff forums and enhances existing good practice	30th June 2016	On Track	1) Resource may be required for Pulse Check	Director of Workforce, OD and Culture	Board of Directors	1st April 2017	1) Director of Workforce and OD to meet with Director of Corporate Affairs to discuss the engagement plan	On Track
		2) Publish and implement agreed engagement plan	31st December 2016	On Track		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	On Track		Director of Workforce, OD and Culture	People and Culture Committee			
	CORE 8- RAISING CONCERNS AT WORK									

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
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	1) Freedom to speak up action plan will be refreshed and approved	31st March 2016	**Completed**		~~Director of Workforce, OD and Culture~~ Director of Corporate Affairs	People and Culture Committee	1st April 2017	1) Action plan agreed in Feb 2016 by ELT 2) National Whistleblowing Policy published 1st April 2016 3) Revised action plan and National Policy to be presented to April P&CC 4) At the P&CC on 20.04.16 Committee members were assured that a policy and plan were in place and acknowledged the requirement to update this following a national policy being released. It was agreed that an updated plan would be brought to May's P&CC. 5) The People and Culture Committee considered a revised plan in May, the Committee received limited assurance on the plan and noted that there was a lack of clarity around role and responsibility / training / support for Speak up Guardian/NED lead. It was also noted that there should be engagement from staff and staff side on the plan. It was agreed that the Director of Corporate Affairs would present a clearer plan to the June Committee meeting.	**Some Issues**
		2)Freedom to Speak up action plan will be delivered and monitored through the People and Culture Committee	31st March 2017	**On Track**		~~Director of Workforce, OD and Culture~~ Director of Corporate Affairs	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**		Director of Corporate Affairs	Board of Directors		1) Fit and Proper Persons Policy approved by Board in February, with further amendments agreed in March 2) Board forward plan now includes an annual review of the Fit and Proper Persons Policy and its implementation 3) P&CC received a verbal update from the Director of Corporate Affairs on the monitoring and filing system for Fit and Proper Persons information for each Director. The Committee were assured	
		2) Ensure that HR maintain the Fit and Proper Persons tracker	30th April 2016	**On Track**		Director of Workforce, OD and Culture	Board of Directors			

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
FF1		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	**On Track**	None required	Director of Corporate Affairs	People and Culture Committee	29th June 2016	that it was in place and recognised that the Board of Directors would receive a full compliance declaration at its May meeting. 4) A paper will be presented to Board in May by the Chairman in which he will declare that all Directors are fully compliant	**On Track**
		4) Ensure that all current Directors comply with all aspects of the policy and that evidence is available in revised file structures	31st May 2016	**On Track**		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	**Completed**		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	**Completed**		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	1) The CQC targeted report is used as a key guide in Trust strategy development days	30th June 2016	**On Track**	None Required	Director of Business Development	Board of Directors	29th June 2016	1) During its development the new Trust Strategy has considered the outcome of the CQC inspection as part of the development of strategic priorities, particularly with reference to 'our people'	On Track

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
CQC2	The trust should continue to proactively recruit staff to fill operational vacancies.	1) Develop and agree a proactive operational recruitment plan, including in reach to the local University and wider health community	30th April 2016	Completed	None Required	Director of Operations	People and Culture Committee	18th January 2017	1) P&CC received an operational recruitment plan paper from the Director of Operations at its meeting on the 20.04.16. The Committee were assured that the actions identified in the plan were the right ones, but requested a clear improvement trajectory and sought further assurance by the end of the week that there was enough capacity within the Trust to be able to deliver the plan. It was agreed that confirmation of this would be circulated to all Committee members by cop Friday 22nd April. This remains 'on track' pending confirmation of capacity to deliver the plan. 2) Confirmation was sent to Committee members to confirm that HR had the capacity to deliver plan in the timeframes suggested. This action has now been completed 3) People and Culture Committee in May received an updated recruitment plan. The Committee were assured by the paper and the suggested trajectory. It was agreed that an update paper would be provided to the September meeting of P&C and the Trajectory would be added to the GIAP KPIs	On track
		2) Implement the recruitment plan and monitor effectiveness against an agreed vacancy rate trajectory	31st December 2016	On Track		Director of Operations	People and Culture Committee			
		3) Develop and implement an internal communications plan which supports pro-active recruitment	31st May 2016	Completed		Director of Corporate Affairs	People and Culture Committee			
	CORE 11- MONITOR ENFORCEMENT UNDERTAKINGS									
	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	1) Governance Improvement Action plan approved by Board of Directors	30th March 2016	Completed	Programme Manager to be appointed PMO admin support	Responsible Director	Board of Directors		1) GIAP and Governance and delivery Framework agreed by Board in March 2) GIAP delivery framework implemented during April, with updates made to the plan	

	Issue Raised/ Action	Key Tasks	Key Task Date	Progress Rag Rating	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	Board Assurance Rag Rating
M1	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	2) GIAP and Governance and Delivery Framework sent to Monitor	18th March 2016	**Completed**	appointed responsible Director identified	Responsible Director	Board of Directors	31st March 2017	accordingly	On Track
		3) Governance and Delivery Framework developed and approved	30th March 2016	**Completed**		Responsible Director	Board of Directors			
		4) Governance Action plan delivered	31st March 2017	**On Track**		Responsible Director	Board of Directors			
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	**On Track**	External Assurance from professional service consultancy e.g. Deloitte resource will be required	Acting Chief Executive	Board of Directors	31st March 2017	1) A scope of work is being agreed with internal auditors to provide assurance in a number of specific areas of the plan.	On Track
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	**On Track**	None Required	Acting Chief Executive	Board of Directors	31st March 2017	1) April reports provided to NHSI and CQC	On Track

Derbyshire Healthcare NHS Foundation Trust
Report to Trust Board 25 May 2016

Governance Improvement Action Plan (GIAP)

Actions relating to the Corporate Governance Framework

Purpose of Report:
To update the Trust on progress with GIAP Actions relating to the Corporate Governance Framework

Executive Summary

- There are several interrelated actions within the GIAP which require the Trust's Corporate Governance Framework and accompanying documents to be refreshed and updated to ensure robust governance arrangements are embedded within the organisation.
- The Board agreed at their meeting on 27 April 2016 that future reporting on GIAP progress should include items by exception, that is, are not on target to meet the originally stated target completion date.
- As previously reported to the Board, it was flagged at an early stage that the timeline outlined on the GIAP for completion of the tasks to redevelop the Corporate Governance Framework were not feasible due in part to the required sign-offs from Board Committees for their individual terms of reference. A revised timeline is attached which proposes revised date for the Corporate Governance Framework to be submitted to the Board, namely 27 July 2016.
- The attached narrative was presented to the Board Development Session on 11 May 2016 and the updates and responses to the various GIAP actions were considered and additional comments noted and incorporated.
- The overseeing Committee for the GIAP actions relating to the Corporate Governance Framework is the Audit and Risk Committee. The attached update was discussed at the Audit and Risk Committee on 24 May and a verbal update on discussions will be given at the Board meeting.

Strategic considerations

- The Corporate Governance Framework is an essential document for the Trust which outlines the decision making and assurance arrangements for the Trust to effectively delivery its Strategy. Review of the Corporate Governance Framework is a requirement outlined in the Governance Improvement Action plan.

Board Assurances

- The Committee can receive assurance from the updates provided on the GIAP actions as outlined.

Consultation

- Following the advisory internal audit undertaken by PWC during 2014 on the Trust's governance framework a piece of work was undertaken during 2014/15 to review the existing governance framework. This was developed with the involvement of several Board members and was presented in draft form to the Board of Directors on 29 April 2015. The framework was not approved at this time, pending a further review of governance arrangements and the subsequent review of Trust governance arrangements led by Deloitte LLP undertaken in the latter part of 2015.
- Recommendations arising from the Deloitte review relating to the Corporate Governance Framework are incorporated in the Trust's GIAP as part of a wider programme of actions. The actions relating to the Framework are assigned to the Audit and Risk Committee for review of progress, and assurance on delivery and outcomes.
- The updates on the actions relating to the Framework were discussed at the Board Development Session on 11 May.
- The attached update on progress with actions and plans for the redevelopment of the Corporate Governance Action Plan is to be discussed at the Audit and Risk Committee on 24 May 2016.

Governance or Legal Issues

- The Corporate Governance Framework is an essential document for the Trust which outlines the decision making and assurance arrangements for the Trust to effectively delivery its Strategy. Review of the Corporate Governance Framework is a requirement outlined in the Governance Improvement Action plan.

Equality Delivery System

- None

Recommendations

The Trust Board is requested to:

1) Note and receive assurance from the update on progress on the GIAP tasks as outlined.

2) Receive a verbal update from the Audit and Risk Committee who are the overseeing Committee for these actions.

3) Consider and confirm if appropriate those actions which are proposed as complete (CG4,2) (CG4,4) (CG4,5), following assurances received from the Audit and Risk Committee (as appropriate).

4) Consider and agree the revised timeline (27 July) for the full Corporate Governance Framework to be submitted to the Trust Board, following review at the 19 July Audit and Risk meeting.

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

GIAP Actions relating to Corporate Governance Framework

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

CG1: The Trust should consider how its governance arrangements could better match its strategy and plans.

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

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

The proposed corporate governance framework helps deliver the Trust strategy by providing a structured approach to seeking assurance on progress in key areas and ensuring there are rapid and effective mechanisms to escalate risks to the delivery of strategic objectives. The BAF is the tool used to identify risks to achieving strategic objectives and relevant Committees are assigned BAF risks to carry out appropriate review of mitigating actions taken, gaps in control and assess the ongoing likelihood and impact of the risk. The Audit and Risk Committee takes an oversight role on the Board Assurance Framework and scrutinises red rated risks directly through scheduled deep dives. Terms of reference of all Board Committees are to include reference to their role in providing assurance on the delivery of Trust Strategy.

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.*

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

1) Develop and approve a Corporate Governance Framework

The revised corporate governance framework will clearly outline the role of the Board and its Committees. A timeline is in place to update the Standing Orders, Standing Financial Instructions and Scheme of Delegation involving the Audit and Risk Committee. Revised structures for forums reporting into Board Committees are being developed and will be included in the final corporate governance framework.

***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.*

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

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

All Board Committee terms of reference have been or are in the process of being reviewed and approved by their own Committee and will then be reviewed collectively by the Audit and Risk Committee. There has been considerable focus on the role of the Quality Committee, both to ensure that this is aligned with other Committees and with the revised remit of the Audit and Risk Committee, and with the creation of the People and Culture Committee. The Quality Committee terms of reference and workplan are aimed to focus on the delivery of the Quality Framework and ensure that business of the Committee is focussed on seeking assurance for the Board on these issues. The Committee structure reporting into the Quality Committee has also been reviewed and will be strengthened over forthcoming months to ensure the Quality Committee have a manageable and appropriate focus for their agenda.

***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

Key tasks identified to address the action as outlined are as follows:

1) Undertake a comprehensive review of the Board Committee structures including TOR:

The Board Committee structure has been reviewed in the context of current priorities and following annual review of effectiveness of each Committee. Through informal discussion with Executive Directors it is recognised that there is potential to reduce the number of Board Committees, specifically to consider whether the Safeguarding Committee and Mental Health Act Committee should remain as Board Committees.

It is proposed that these two Committees remain as Board Committees for the following reasons:

- The Quality Committee has undergone a thorough review of both its terms of reference and also the supporting and reporting structures that lie beneath it. Future plans include the establishment of a Quality subcommittee which will focus on a variety of operational issues, and allow the Quality Committee to retain its focus on seeking assurance, oversight and considering escalated issues. As the subcommittee and associated Quality Leadership Teams are not yet fully developed, and the revised focus of the role of the Quality Committee is yet emerging, it is proposed that it would not be appropriate at this time for the Safeguarding Committee to be subsumed within the remit of the Quality Committee. In addition, it is recognised that the Safeguarding Committee has a challenging strategic agenda and that its status as a Board Committee was supported by the CQC in their last safeguarding inspection.

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

It is proposed that arrangements for Board Committees be reviewed in 9 months (December 2016) to establish whether either of both of the Mental Health Act Committee and Safeguarding Committee may be incorporated into the work of the Quality Committee.

- Oversight of risk – as part of the review of roles and responsibilities of Board Committees the role for oversight of risk management has been reviewed. It is proposed that the Audit Committee is renamed as the Audit and Risk Committee to reflect the aim that it is this Board Committee which will have overall oversight of Risk issues within the Trust. As outlined in the terms of reference, this will encompass seeking assurance on the effectiveness of the Trust's risk management strategy, oversight of the Board Assurance Framework and seeking assurance from other Board Committees, notably the Quality Committee, that there are robust procedures in place to monitor and scrutinise clinical and other operational risks. The Audit and Risk Committee will seek to ensure that the Trust has in place a culture which supports effective risk management, mitigation and organisational learning and that this is embedded in the organisation.

Terms of reference for all Committees have been or are in the process of review. The timeline for completion of this approval programme is outlined below. As part of the review, all terms of reference will be aligned for layout, consistency of content and all include reference to conducting a review of meeting effectiveness both at the end of each meeting and on an annual basis against the terms of reference. Each Committee will also produce a workplan which is laid out to illustrate how the remit, as specific by the terms of reference, will be covered in Committee business throughout the year. All Committees within their terms of reference are encouraged to refer issues between Board Committees where appropriate and to escalate items of both positive assurance and risk to the Trust Board. An assurance and escalation grid has been developed and has been implemented from 1 April 2016. The terms of reference have been reviewed with a view to reaffirming focus on the assurance role of Board committees, avoiding duplication and ensuring focus on the key purpose of each Committee in support of delivering the Trust's strategic objectives.

2) Arrange for Committee Chairs to meet on a quarterly basis

Dates for Committee chairs to meet have been established as part of regular meetings with the Chair. These meetings will aim to provide a forum for review of cross-committee working and common themes, such as risk, assurance and escalation to be considered collectively. The meetings will be supported by the Director of Corporate Affairs and Board Committee chairs will feed back into their respective Committees. Initial meetings will include identifying the remit of this forum, which may include input from external sources and review of good practice to identify effective co-working.

ACTION COMPLETE

3) Review Executive Director attendance at Committees

The Executive Leadership Team in association with chairs of Board Committees have reviewed the membership of Board Committees and have clarified the membership and attendance requirement by Executive Directors, as below:

Committee	Director Member/Attendee	ELT Lead
Quality	Director of Nursing Medical Director Director of Operations	Director of Nursing
Finance and Performance	Director of Finance Director of Business Development Director of Operations Medical Director	Director of Finance
Mental Health Act	Medical Director Director of Corporate Affairs	Medical Director
People and Culture	Director of Workforce Medical Director Director of Operations	Director of Workforce
Audit and Risk	Director of Finance Director of Corporate Affairs	Director of Corporate Affairs
Safeguarding	Director of Nursing Director of Workforce Director of Operations	Director of Nursing
Remuneration	Chief Executive Director of Workforce Director of Corporate Affairs	Director of Corporate Affairs

Following discussion at the Board Development Session it was proposed that the terms of reference of the Audit and Risk Committee be amended to reflect that Executive Directors who were not in the core membership were expected to attend the Committee if requested.

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

The Board and Board Committees have historically had comprehensive minutes, with comments and scrutiny attributed to individuals and clear actions highlighted both in the minutes and in action grids. The Executive Leadership Team has considered the use of action notes, but it is acknowledged that as part of ongoing scrutiny and review by external parties it is important that extensive and detailed minutes are recorded of the Trust Board and Board Committees. In addition to the minutes recorded for each meeting, there is a summary actions grid which is used to ensure that actions are clearly allocated to lead directors and that progress on completion can be followed up effectively.

Actions arising from meetings are collated in an ongoing actions grid for each meeting with an assigned lead (who was present at the meeting). These are actively followed up by the Board Secretary who minutes all Board Committee meetings. In addition the actions grids are reviewed, currently weekly, by the Executive Leadership Team. Exceptions and issues are raised and updates noted for the grids. All actions that are complete are archived following reporting of their completed status to their respective Committee.

The use of the assurance reporting grid, produced by each Committee, usually in real time during the meeting, has helped to focus on agreeing and summarising each discussion point and identifying assurance, risks and actions arising. This approach also ensures clarity for all members present on what has been agreed for consistent and accurate onward cascade of communication to wider teams.

ACTION COMPLETE

5) Embed a process for the yearly review of the effectiveness of Board Committee against Terms of Reference

Each Committee has an annual workplan which maps out the assurances and reporting the Committee will consider in order to meet its terms of reference. As part of this, each Committee has scheduled in its workplan, following the end of the financial year, a report to review effectiveness of the Committee against its stated terms of reference. The report will be considered both by the Board Committee itself and the Audit and Risk Committee.

ACTION COMPLETE

Timeline for Completion of Corporate Governance Framework

To complete the review of the Corporate Governance Framework, including its component elements, requires sign off by a range of Committees and the Board. The timeline below illustrates when the various components can be scheduled for discussion and approval:

	Component of Corporate Governance Framework	**Forum for discussion/approval**	**Date**
1	Board Roles and Responsibilities	Board Development Session	15 May 2016
2	Structure, process, Assurance and Escalation	Board Development Session	15 May 2016
3	Scheme of Delegation: Part One - Decisions Reserved for the Board	Audit and Risk Committee	19 July 2016
4	Responsibilities Delegated to Board Committees: Terms of Reference 4a: Audit and Risk	Audit and Risk Committee	24 May 2016
	4b: Finance and Performance	Finance Committee	APPROVED 29 March 2016
	4c: Quality	Quality Committee	APPROVED 12 May 2016
	4d: Mental Health Act	Mental Health Act Committee	3 June~~11 May~~ 2016
	4e: Safeguarding	Safeguarding Committee (to be approved out of Committee)	5 August 2016
	4f: Remuneration	Remuneration Committee	25 May 2016
	4g: People and Culture	People and Culture Committee	APPROVED 17 February 2016
	Appendix A – Board Committee Assurance Summary report template	Board Development Session	11 May 2016
	Appendix B – Board Front Sheet Template	Board Development Session	11 May 2016
	Appendix C – Standing Orders	Audit and Risk Committee	19 July 2016
	Appendix D – Standing Financial Instructions	Audit and Risk Committee 19 July	19 July 2016
	Full Corporate Governance Framework	Public Board Meeting	27 July 2016

The Board is asked to:

1) Note and receive assurance from the update on progress on the GIAP tasks as outlined.

2) Consider and confirm as appropriate those actions which are proposed as complete, as discussed at the Audit and Risk Committee on 24 May 2016 - verbal update to be given (CG4,2) (CG4,4) (CG4,5).

3) Consider and agree the revised timeline (27 July) for the full Corporate Governance Framework to be submitted to the Trust Board.

Derbyshire Healthcare NHS Foundation Trust
Report to Trust Board 25 May 2016

Annual Plan Governance Statements 1 & 2, 2015/16 submission

Purpose of Report

This paper supports the requirement for the Board to submit Governance Statements one and two to Monitor by 31 May 2016.

Recommendations

The Board of Directors is requested:

1) **To agree that the Trust is unable to confirm the following governance statements:**

   Statement 1: Following a review for the purpose of paragraph 2(b) of license condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the license, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

   Statement 2: The board declares that the Licensee continues to meet the criteria for holding a license.

2) **To note that the statements will need to be appropriately published in accordance with general condition G6, paragraph 4:** *"The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to Monitor in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it."*

Executive Summary

The Board has considered its compliance with the license conditions on a quarterly basis through the year when certifying the compliance return to Monitor. Assurances have been provided through the Trust's governance arrangements and systems of internal control (as described in the Annual Governance Statement in the Annual Report), and the Audit Committee's independent oversight of the effectiveness of those systems. The Trust was subject to enforcement action (under section 106) on 25 February 2016 and as such the Board is not able to positively certify against the declarations.

As required in the compliance return, explanatory information is required to be provided in the event that confirmation of systems of compliance with license conditions cannot be confirmed. Explanation is proposed as follows:

'On 25 February 2016 Monitor took enforcement action pursuant to its powers under section 106 of the Health and Social Care Act 2012. This was on the grounds of breaches relating to governance (namely breaches of license conditions) that were highlighted as part of an Employment Tribunal involving the Trust's Board, and a subsequent Employment Tribunal investigation. Reviews by Deloitte LLP on governance arrangements and HR related functions and a CQC Focused Inspection on the well-led domain identified actions to be undertaken by the Trust to make improvements in corporate governance arrangements. Enforcement undertakings agreed by the Trust and Monitor include the development and implementation of a Governance Improvement Action Plan to agreed timescales and through ongoing oversight by NHS Improvement.'

At their quarterly Council meetings the Governors take the opportunity to question the directors on the Trust's performance and current governance rating and will be kept updated on progress against the Governance Improvement Action Plan.

It is therefore recommended that the Board approves the signing-off of the declarations (GS6) as 'not confirmed'.

Strategic Considerations

Statements 1 and 2: Declarations required by General Condition 6 – compliance with license conditions (G6).

In accordance with the Monitor Risk Assessment Framework (introduced in October 2013 and updated in March 2015), the Board is required to self-certify against the Trust's license conditions. The self-certification is in template form provided by Monitor and is in two parts: that the Trust took all such precautions as were necessary in order to comply with the license conditions; and that the criteria for licensing continue to be met. The template provides for either a 'confirmed' or 'not confirmed' declaration.

Consultation

There has been no consultation prior to the Board of Directors being asked to confirm these declarations.

Governance or legal issues

As part of APR planning NHS Foundation Trusts are required to make certain declarations to Monitor. The full list of six declarations is detailed below for context.

Declarations 1& 2: *Systems for compliance with license conditions – in accordance with General Condition 6 of the NHS provider license*

Declaration 3: *Availability of resources and accompanying statement in accordance with Continuity of Services condition 7 of the NHS provider license*

Declaration 4: *Corporate Governance Statement – in accordance with the Risk Assessment Framework*

Declaration 5: *Certification on AHSCs and governance – in accordance with Appendix E of the Risk Assessment Framework*

Declaration 6: *Certification on training of Governors – in accordance with s151(5) of the Health and Social Care Act*

Declarations 1 and 2 above are set out in this document, and are required to be returned to Monitor by 2 May 2016.

Declaration 3 is part of the APR financial template, and has already been submitted to Monitor.

Declarations 4, 5 and 6 above are set out in a separate document which is required to be returned to Monitor by 30 June 2016.

There are no legal issues arising from this report.

Equality Delivery System

This report has a neutral impact on REGARDS groups.

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

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 25 May 2016

Fit and Proper Persons Test Policy and Chairman's Declaration

Purpose of Report

To present the Chairman's declaration that all Trust Board directors meet the fitness test and do not meet any of the 'unfit' criteria as per the Fit and Person's Test regulations (Health and Social Care Act 2008 Regulation 2014).

Executive Summary

The Health and Social Care Act The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 introduced a 'fit and proper person test' for NHS bodies. At its meeting on 30 March 2016 the Trust Board approved a fit and Proper Persons Test policy (Appendix 1) which outlines how the Trust will meet the requirements placed on NHS providers which came into force on 1 October 2014 for all NHS bodies and for all providers on 1 April 2015.

Under the regulations, all provider organisations must ensure that Director level appointments meet the 'Fit and Proper Persons Test' and the regulations place a duty on NHS providers not to appoint a person or allow a person to continue to be an Executive Director or equivalent or Non-Executive Director under given circumstances. The regulations have been integrated into the Care Quality Commission's (CQC's) registration requirements, and falls within the remit of their regulatory inspection approach.

It is the responsibility of the Chair to discharge the requirement placed on the Trust to ensure that all directors meet the fitness test and do not meet any of the 'unfit' criteria. Work has been undertaken within the Trust to establish processes to ensure that the appropriate checks are made on appointment of director level posts, that relevant checks and supporting information relating to existing post holders has been provided and there are proactive processes set in place to ensure the ongoing review and monitoring the filing system for all directors. Self-declarations have been also made by all Directors at the 30 March Confidential Trust Board Meeting.

DECLARATION:

I hereby declare that appropriate checks have been undertaken in reaching my judgment that I am satisfied that all Directors of the Trust, including Non-Executive Directors, and Executive Directors (including voting, non-voting and Acting) are deemed to be fit and that none meet any of the 'unfit' criteria. Specified information about Board Directors is available to the CQC on request.

In making this declaration, this meets the requirements as stated in the Trust's Governance Improvement Action Plan which outlines at FF1 (4) that the Trust should:

- Ensure that all current directors comply with all aspects of the policy and that evidence is available in revised file structures

And also FF(5) that there should be:

- Formal confirmation to the Board by the Chair of full compliance with fit and proper persons requirements.

Strategic considerations

- This declaration confirms that the Trust meets the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 'fit and proper person test' for NHS bodies.
- It is an element of NHS Improvement's Code of Conduct for NHS Trusts (Reference B.2.2) for which the Trust must 'comply or explain' within the Annual Report and Accounts

Board Assurances

- The Board can receive assurance that due process has been followed to ensure that all relevant post holders meet the fitness test and do not meet any of the 'unfit' criteria.
- That comprehensive files have been established for each relevant post, evidencing compliance and that proactive processes have been set in place to monitor the filing system.

Consultation

- The Confidential Trust Board discussed the Fit and Proper Persons Test policy at its meeting in January 2016 and approved it at its 30 March meeting.
- Updates on progress towards ensuring full compliance with the GIAP requirements relating to the FPP Test were included in the GIAP report to the Public Board in April 2016.

Governance or Legal Issues

- It is a requirement of the The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that NHS bodies undertake a 'fit and proper person test'.
- The regulations have been integrated into the CQC's registration requirements, and falls within the remit of their regulatory inspection approach.

Equality Delivery System

- None

Recommendations

The Board of Directors is requested to:

1) Note the work undertaken to ensure that robust processes have been undertaken to evidence that
2) Note the Chairman's declaration that that all directors meet the fitness test and do not meet any of the 'unfit' criteria.
3) Confirm that GIAP elements FF1 (4) and FF1 (6) are now complete.

Report presented by: Richard Gregory, Chairman

Report prepared by: Samantha Harrison, Director of Corporate Affairs

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 25 May 2015

Register of Trust Sealings 2015-16

Purpose of Report

This report provides the Trust Board with an account of the authorised use of the Foundation Trust Seal during 2015-16.

Executive Summary

- In accordance with the Standing Orders of the Board of Directors the Foundation Trust Seal is affixed to legal transactions, including deeds, transfer and letting of contracts over £100,000.
- These transactions will apply where the Board has previously approved the business through the Capital Expenditure Plan or the Estates and Agile Working Strategy.
- There is one entry on the Register of Trust Sealings for 2015/16. The Trust Seal was affixed to the contract for the provision of an integrated public health system for children and young people in Derby City on 30 December 2015 (seal number DHCFT41).

Governance or Legal issues

The affixing of the seal is consistent with the Board's responsibilities outlined within the Standing Orders of the Foundation Trust.

Equality Delivery System

This report has a neutral impact on REGARDS groups

Recommendations

The Board of Directors are requested to note the authorised use of the Foundation Trust Seal during 2015-16.

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

Report prepared by: **Sue Turner**
Board Secretary

2015-2016 Board Annual Forward Plan

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

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	Apr-16	May-16	Jun-16	Jul-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
SH	Committee Reports (following every meeting) - Audit - Finance & Performance - Mental Health Act - Quality Committee - Safeguarding -People Committee	Strategic Outcome 3	X	X	X	X	X	X	X	X	X	X	X
MP	Governance Improvement Action Plan	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X	X
SH	Fit and Proper Person Declaration	Licence Condition FT4		X									X
OPERATIONAL PERFORMANCE													
CG, CW, JSt, CG	Integrated performance and activity report to include Finance, Workforce, performance and Quality Dashboard	Licence Condition FT 4 Strategic outcome 1 Strategic Outcome 3	X	X	X		X	X	X	X	X	X	X
QUALITY GOVERNANCE													
CG	Position Statement on Quality (Incorporates Strategy and assurance aspects of Quality management)	Strategic Outcome 1 CQC and Monitor		X	X		X	X	X	X	X	X	X
CG/ JSy	Safeguarding Children Annual Report	Children Act Mental Health Standard Contract						X					
CG/ Jsy	Safeguarding Adult Annual Report	CQC Mental Health Standard Contract						X					
CG	Control of Infection Report	Health Act Hygiene Code		X									
CG/ JSy	Integrated Clinical Governance Annual Report including MHA/Governance/Complaints and Compliments/SIRI's/Patient Safety/NHS Protect (LSMS) and Emergency Preparedness/H&S (including H&S and Fire Compliance and Associated Training)	CQC and H&S Act							X				
CG	Annual Community Patient Survey	Clinical Practice CQC							X				
JSy	Re-validation of Doctors	Strategic Outcome 3			X								