Derbyshire Healthcare NHS
NHS Foundation Trust

NOTICE OF BOARD MEETING
THURSDAY 30 JUNE 2016
TO COMMENCE AT 1.00 PM IN TRAINING ROOMS 1 & 2, FIRST FLOOR
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 25 May 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.	2:00	Integrated Performance and Activity Report	**E**	Carolyn Gilby Claire Wright Jayne Storey Carolyn Green
10.	2:10	Trust Compliance – Accessible Information Standard	**F**	Carolyn Gilby
11.	2:20	Position Statement on Quality	**G**	Carolyn Green
12.	2:30	Revalidation of Doctors	**H**	John Sykes
13.	2:40	Compliance Return – Governance Statements 4, 5 & 6 including Delegated Authority	**I**	Samantha Harrison
14.	2:50	Board Committee Escalations from the Audit & Risk Committee (24 May), Quality Committee (23 June), People & Culture Committee (16 June) Ratified Minutes of meetings held in May (Quality Committee, People & Culture Committee), Mental Health Act Committee, and ratified minutes of Audit & Risk Committee held in April) are included for information only	**J**	Committee Chairs
3:00 B R E A K				
15.	3:15	Deep Dive – Vacancies, Sickness and Recruitment	**K** **to follow**	Jayne Storey
GOVERNANCE				
16.	3:35	Report from Council of Governors meeting	**L**	Richard Gregory/ Samantha Harrison
17.	3:45	Governance Improvement Action Plan	**M**	Mark Powell
CLOSING MATTERS				
18.	3:55	Any other business	**-**	Richard Gregory
19.	4:00	Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework	**-**	Richard Gregory
20.	4:05	2016/17 Board Forward Plan	**N**	Samantha Harrison
21.	4:10	Meeting effectiveness	**-**	Richard Gregory

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 27 July 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 25 May 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
	Maura Teager	Non-Executive Director
	Ifti Majid	Acting Chief Executive
	Claire Wright	Executive Director of Finance
	Carolyn Green	Director of Nursing & Patient Experience
	Carolyn Gilby	Acting Director of Operations
	Dr John Sykes	Executive Medical Director
	Mark Powell	Director of Business Development & Marketing
	Jayne Storey	Director of Workforce OD & Culture
	Samantha Harrison	Director of Corporate Affairs & Trust Secretary
IN ATTENDANCE:	Anna Shaw	Deputy Director of Communications and Involvement
	Sue Turner	Board Secretary and Minute Taker
	Hayley Darn	Nurse Consultant
For item DHCFT 2016/070	Bev Green	Releasing Time to Care Lead (Service Improvement)
For item DHCFT 2016/070	Sharon Trott	Senior Nurse/PMVA Instructor
For item DHCFT 2016/007	Claire Biernacki	General Manager, Neighbourhoods
For item DHCFT 2016/051	Rais Ahmed	Consultant Psychiatrist and Associate Clinical Director
For item DHCFT 2016/062	Kath Lane	Acting Deputy Director of Operations
For item DHCFT 2016/062	Mark Broadhurst	Consultant Psychiatrist and Associate Clinical Director
APOLOGIES:	None	
VISITORS:	John Morrissey	Lead Governor
	Carole Riley	Governor, Derby City East
	Chris Fitzclark	North Derbyshire Voluntary Action
	Pauline Gill	North Derbyshire Voluntary Action
	Dr Mike Skelton	Consultant Psychiatrist
	Winston Samuels	Member of the public

DHCFT 2016/069	**INTERIM CHAIRMAN'S WELCOME, OPENING REMARKS AND APOLOGIES** The Interim Chairman, Richard Gregory, opened the meeting by welcoming all present.
DHCFT 2016/070	**SERVICE RECEIVER STORY** Senior Nurse, Sharon Trott introduced Marilyn and Bill who kindly agreed to come to talk to the Board about their recent experience of care on Tansley Ward following Marilyn's

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	recent admission to hospital on Section 2 of the Mental Health Act. Marilyn was admitted to Tansley Ward in April. Her mental state had recently deteriorated at home where she was experiencing an acute manic episode. Marilyn's GP made an urgent referral to the Pathfinder Service and she was admitted to Tansley Ward before her condition could be assessed. On admission to the ward Marilyn presented with symptoms of an acute manic episode. She posed a risk to herself and was unable to comprehend instructions given to her by the nursing team to manage her distress or maintain her safety. She was less agitated when supported by two nurses who were trying to develop a trusting and therapeutic relationship. Due to there not being any available female single rooms on either the ward or the unit, staff made the decision to temporarily close the female lounge and turned this over to Marilyn's care as a safe environment in which she was also able to eat and sleep. This also provided a low stimulus environment and allowed time and space for her family to visit while Marilyn's privacy and dignity was maintained. Gradually Marilyn's mental health improved and she was able to return to a dormitory and her support and observation levels were reduced. Marilyn's husband Bill and her family were very supportive and played a large part in her care and treatment. They visited regularly and attended reviews. As her mental health started to improve Marilyn's sleep pattern improved however as her diet and fluid intake was still not satisfactory, she was prescribed supplements and was encouraged by the nursing team. Her husband Bill wanted to be part of this and after discussion with Liz Bates the team were able to facilitate time with Marilyn and Bill so they were both able to eat together on the ward. Bill requires a Gluten free diet this was ordered for him from the kitchens. Marilyn appreciated having the privacy of the female lounge and having her immediate family around her which definitely helped her recovery. Carolyn Green was pleased that the staff had taken the decision to care for Marilyn in this way although this was a technical breach of the Trust's gender sensitive policy. If Tansley Ward was not a dormitory ward a single room could have been provided as this would have helped Marilyn to recover just as quickly. One of the common requests from patients is to have a single room, although some prefer the company that a dormitory provides. This is clearly a challenge to the Trust as not all wards or units have the footprint this would require. Marilyn's recovery continued to progress and she began to take day leave with her family. She has now progressed sufficiently to take leave with her family and feels much better. When asked by Ifti Majid how the ward manages the aspects of different stages of people's recovery, Sharon Trott replied that they make sure they are aware of people like Marilyn who might be distressed by some of the behaviour of other patients. They also look at the mix of admissions when they arrive on the ward and always try to calm the ward environment so as not to destabilise patients who are already recovering. The Board recognised that it is sometimes necessary to break the rules to do the right thing and it is important to empower staff to make sensible and pragmatic decisions even when there is a risk associated with it. Richard Gregory thanked Marilyn and Bill for telling their story. He explained that the Board receives a lot of reports about the services it provides but nothing is as powerful as hearing stories first hand from service receivers. He and the Board were thankful to hear what Sharon Trott and the team did to respond to Marilyn's needs. **RESOLVED: The Board of Directors expressed thanks to Marilyn and Bill for sharing their experience and appreciated the opportunity to hear at first hand the**

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	service the Trust had provided.
DHCFT 2016/071	**MINUTES OF THE MEETING DATED 27 APRIL 2016** The minutes of the meeting held on 27 April were accepted and agreed subject to the correction to item DHCFT2016/058 Monitor Compliance Return. The last sentence of the first paragraph would be amended to read *"The full content of the quarter 4 template had been sent to members of the Audit & Risk Committee for review and was scrutinised in the usual quarterly telephone call between the Finance team and the Chair of the Audit & Risk Committee."*
DHCFT 2016/072	**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 although the BMA had urged junior doctors not to negotiate with the Trust, it was clear that the Trust had maintained good relations with junior doctors.
DHCFT 2016/073	**CHAIRMAN'S VERBAL REPORT** Richard Gregory updated the Board on developments during the last month. A second meeting would take place next week with NHS Improvement (NHSI) on the Governance Improvement Action Plan. The first meeting was successful and Richard Gregory and Ifti Majid are heading into next week's meeting with confidence. The meeting of the Council of Governors is taking place on 1 June and Richard Gregory was looking forward to a better representation of governors due to the recent elections. New governors that have recently been elected will also take part in their induction on 31 May. Thanks were given to Jayne Davies and Shirley Houston of the Engagement Team for the development of the induction programme. Prior to the meeting of the Council of Governors on 1 June the Non-Executive Directors and governors will meet informally. **RESOLVED: The Board of Directors noted the Interim Chairman's verbal update.**
DHCFT 2016/074	**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 links contained in his report, the first of which was one published by the Local Government Association charting progress on the health devolution journey and the Derbyshire Joint Strategic Needs Assessment issued by Derbyshire County Council. Work on the Derbyshire Sustainability and Transformation Plan continues and Ifti Majid explained how this was driving forward person-centred planning. This is very much about supporting people to live at home or in a place they choose to call home and will also avoid high cost institutional care. Ifti Majid felt privileged to attend and speak at the Mental Health in the Faith Community

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	conference arranged by the Trust's Chaplaincy 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 by different representatives from Derbyshire and was held with great enthusiasm, commitment and with a real sense of learning from each other. This was the second time that Ifti Majid's report included the Listen, Learn and Lead matrix which set out the latest round of team visits by Directors. This exercise provides increased contact with the Directors and the teams and has helped staff feel able to raise concerns since its initiation in March. The matrix contains an action tracker and Ifti Majid hoped it illustrated some of the issues being raised and would help to resolve some of the issues staff are struggling with. The Board recognised Caroline Maley's concern that the action tracker was evolving into a list of issues and would consider a different approach to capturing actions in the future. **RESOLVED: The Board of Directors noted the contents of the Acting Chief Executive's report**
DHCFT 2016/075	**INTEGRATED PERFORMANCE AND ACTIVITY REPORT** This report provided the Trust Board with an integrated overview of performance as at the end of April 2016 with regard to workforce, finance and operational delivery and quality performance. Carolyn Gilby described how the workforce, operational and finance functions had met to establish themes that were emerging from the data contained in the report. Overall medical staff sickness and staff vacancies had impacted on outpatient clinics and this had resulted in a breach in the ceiling of the NHSI spend on agency staff. The Board noted that there was not a specific reason identified for staff sickness but this, together with the level of vacancies, had affected staffing levels. Discussions were taking place in the Performance Overview Group to establish how to support staff and the People & Culture Committee would be addressing plans to improve the process for recruitment of additional staff. Claire Wright highlighted the key messages emerging from the report relating to Finance. She explained that the performance for month one was better than planned but she was expecting the run-rate to change to achieve a control total surplus of £1.7m. She also described how the report showed some of the ranges of key assumptions and that one of the biggest challenges was around the Cost Improvement Programme (CIP). This was planned at £4.3m for the year but was now expected to achieve £3.3m and it would be a challenge to achieve this. Richard Gregory pointed out that challenges associated with the CIP had been the subject of discussion during the confidential session of the Board held earlier today. The other key challenge would be in mitigating other financial pressures which would be the subject of an extraordinary meeting of the Finance & Performance Committee on 23 June when a number of proposals will be addressed to provide assurance to the Board to complete the compliance statement for NHSI in July. Ifti Majid considered the report showed strong and sustained performance around operational KPIs. Although there are issues around staffing levels within the workforce he considered that staff appraisals would improve morale and performance overall. Mark Powell observed that the Board's Committees should take oversight of the different aspects of the dashboard to ensure plans were in place to deliver the targets. It was understood that most of the red targets related to quality targets that were introduced in April. Carolyn Green drew attention to the metrics contained in the quality overview (flu jab uptake, Think Family training, safety plan training and the number of learning disability or autism cases within a CTR before admission) to assure the Board that there

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	is a positive and safe strategy in place and all CQUINS have an improvement plan which is monitored by the Quality Committee. The Board was pleased to note that safer staffing levels at the Hartington Unit and Radbourne Unit were being addressed and that recruitment was improving, and that both these units have a low level of bank and agency staff. It was also noted that ongoing work was taking place with universities to recruit graduate nurses. Caroline Maley was pleased to see that the dashboard showed an improvement in the output of patient letters. She made a request that the workforce dashboard be spread across three pages rather than one. She considered that an awareness of high operational risks was good to see in the quality section and she asked that these be linked with the BAF (Board Assurance Framework) risks. Carolyn Green responded that all risks had been included in the Clinical Risk Register and a narrative would be included in future reports to indicate this. It was also agreed that the dashboard would indicate when these risk ratings would return to normal status. She also intended including a new addition in the quality and operational section of the report that would record supervision requirements. **RESOLVED: The Board of Directors scrutinised the content of the report and obtained assurance on the current performance across the areas presented.**
DHCFT 2016/076	**POSITION STATEMENT ON QUALITY** Carolyn Green presented her report which provided the Board of Directors with an update on the Trust's continuing work to improve the quality of services it provides in line with the Trust's Strategy, Quality Strategy and Framework and strategic objectives. The Board noted that the position statement set out: 1. Safety through the infection control report 2. Caring through the Trust's work in community partnerships to promote Mental Health awareness 3. Responsiveness of services Trust-wide including the review of complaints and compliments findings and the CAMHS national benchmark. Details of how the Trust discharges the duty of candour were also noted. 4. Full achievement of all Trust CQUIN's and the clinical strategy to apply for a Department of Health bidding round for a licence to provide patient activation measurement scales. 5. Care Quality Commission visit preparations for the planned inspection in June and progress on Quality visits. Carolyn Green drew attention to the responsiveness of services section of the report and assured the Board that serious untoward incidents were robustly reviewed and monitored by the Quality Committee and further assurance could be obtained through the benchmarking data contained in the report. It was noted that the report provided specific assurance on the Trust's Duty of Candour. Maura Teager also pointed out the work recently undertaken by John Sykes to support areas under particular pressure. Richard Gregory asked how many complaints had been found in favour of the service receiver. Carolyn Green explained that this was not included in the Quality Position Statement but was reviewed at the last meeting of the Quality Committee. The main

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	theme arising from complaints continued to be obtaining access to our services and therapies, particularly in paediatric care. The Board considered the report provided a good level of assurance, in particular the Infection Control Report. **RESOLVED: The Board of Directors:** **1) Received the Quality Position Statement and noted that the Infection Control Annual report was presented in line with the Health Act practice requirements.** **2) Gained assurance and was informed by the content.**
DHCFT 2016/077	**BOARD COMMITTEE ESCALATIONS** Short assurance summaries were received from Committee chairs which identified key risks, successes and decisions made. Each summary was scrutinised and escalations were noted, although it was agreed that some escalations were purely to draw the Board's attention to particular issues. Ifti Majid drew attention to the escalation from the Mental Health Act Committee that the Emergency Department at Chesterfield Royal Hospital was not considered to be a place of safety. It was understood that this was a long standing issue and was not peculiar to Chesterfield. This matter would be progressed by John Sykes through the Crisis Care Concordat. Limited assurance was received by the People & Culture Committee concerning the timeframe around actions contained in the Governance Improvement Action Plan (GIAP) especially around the compliance of policies. Solutions would be revisited when the GIAP is scrutinised line by line at the next meeting of the Committee in June and assurance is to be provided to the Board that policies are being adhered to. Limited assurance was also obtained on the People Plan and it was noted that this would be addressed later in agenda item 15, Governance Improvement Action Plan and Delivery Framework. It was understood that the format of the assurance summaries was still evolving and in future matters escalated to the Board would be distinguished between escalations for action by the Board and matters that purely alerts for Board awareness. **ACTION: A dynamic process will be developed to provide assurance to the Board that policies are being adhered to.** **RESOLVED: The Board of Directors noted the escalations and assurance summaries from Board Committees.**
DHCFT 2016/078	**ANNUAL REPORT FROM THE AUDIT & RISK COMMITTEE** Caroline Maley as Chair of the Audit & Risk Committee presented the 2015/16 Audit & Risk Committee Annual Report. She explained that the report was reviewed by the Committee at the April meeting in order to finalise and agree the report for submission to today's Trust Board meeting. The report summarised how the Committee had discharged its remit during 2015/2016 which resulted in the approval of the Trust's Annual Report and Accounts and she gave thanks the Quality and Communication teams for their valuable input. The report would also be presented to the Council of Governors at the next meeting on 1 June to explain the responsibilities of the Committee. **RESOLVED: The Board of Directors received the Annual report from the Audit and Risk Committee.**

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DHCFT 2016/079	**APPROVAL OF THE TRUST STRATEGY** Mark Powell presented the Trust Strategy 2016-21 to the Board for approval. The draft strategy was presented to the Board in April and had been revised based on feedback received from directors which has been incorporated in the final document. The Board recognised that the strategy had been presented to the Council of Governors and considered that the strategy was extremely comprehensive. It was noted that more emphasis could be made on the collaboration with the STP programme in Appendix C. It was also considered that encouraging the 'Listen, Learn and Lead' culture could be included in the strategy especially as staff governors had expressed concern that staff were being asked to work in new areas without there being an adjustment to staff resource. The Board approved the Trust Strategy and Ifti Majid was given Chief Executive Action to ensure the changes suggested by the Board would be implemented. **ACTION: Ifti Majid was given authority via Chief Executive Action to ensure the changes to the Strategy suggested by the Board would be implemented.** **1) RESOLVED: The Board of Directors:** **2) Approved the Trust Strategy 2016-21** **3) Approved the content of the 'Plan on a Page'** **4) Noted the contents of the proposed communications plan** **5) Noted the suggested performance monitoring dashboard and provide feedback** **6) Noted the outline timetable for strategy implementation**
DHCFT 2016/080	**DEEP DIVE – NEIGHBOURHOODS** The Board requested a 'deep dive' of the performance of the Neighbourhoods. This report was presented by senior members of the team and enabled the Board to review the performance of this Directorate since its inception on 1 April 2016. The operational and members of the clinical leadership teams gave a summary of the positive work and challenges of the Trust's remodelling to a new neighbourhood framework. The main points captured by the Board were as follows: • The model is new and the teams are in transition, and require operational and emotional support as part of a significant change management programme, it is very early days in the change • Some new ideas and innovations are blossoming in working with GP's and the link model • Some teams are embracing the single point of access and the benefits and others are working though the issues of change • Community capacity in community teams is a known pressure and risk, which was a significant issue in this year's contracting round. Although significant investment in funding was achieved and approximately £1m additional

	investment received, this was less than the services required and represented one third of what the Trust requested. Under the existing model for case load sizes, teams will not be able to manage the demand of case sizes without the investment. This financial year the commissioners have funded an additional 18.3 whole time equivalent care co-ordinator posts which should help to reduce caseload sizes. It was noted that in order to achieve a maximum caseload size of 35 per whole time equivalent, care coordinators the team would need a further 43 whole time equivalent posts. • It is envisaged that an improvement in recruitment will help reduce waiting lists. The team are trying to find a balanced and fair universal wait list plan. It is also recognised that waiting lists are growing daily. • Clinical variation is an area of development. Clustering is a concern in the north of the county particularly in the dementia monitoring service where demand for the service far outstrips capacity. Work is being undertaken with commissioners to deliver care from primary care bases and explore solutions this piece of work is on-going. • Outpatient appointments have been affected by strike action this year and the report showed that the loss of outpatient appointments has impacted on the teams and the operational performance as detailed in the report. The performance data demonstrates a good improvement in outpatient letters which continues on an upward trajectory. • Wider aspects of performance are staff appraisals which are angoing challenge and positive strides are being taken to work towards a three month trajectory. Appraisals performance will also improve with the appraisal links to the revalidation of nurses and the same quality of appraisals will be carried out for registered nurses; however this will not assist with the AHP or support workers' performance which also requires attention. • There are a lower number of people absent from work with stress related issues in Neighbourhoods even though the Staff Family and Friends Test indicates high absences due to work related stress. It was noted that Sue Walters the Trust's newly appointment Senior Staff Engagement Lead would work with teams to analyse and recommend a management approach for managing stress levels within the teams. • Ongoing work was taking place to improve DNAs (Did not Attend) and a text reminder system has been developed and new themes have emerged through follow up calls of DNAs carried out by medical staff. When asked how the Board could help the Neighbourhood teams, Kath Lane replied that she had noticed that where Neighbourhoods had been set up into one base they were working significantly better than where neighbourhoods were spread across estate with facilities where teams could offer group work and support in line with the shared care and self-care models. Developing the new model estate was a significant factor in how quickly things can move forward into new models. It was recognised that the Trust was trying to make the best use of estate throughout the whole of Derbyshire and money had been set aside in the capital programme for this purpose. However, this was reliant on the availability of estate in the right place at the right time with the right group work facilities. It

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	was emphasised that setting Neighbourhoods into key locations was one of the key priorities in the STP work stream. Claire Wright would consider the possible STP solutions that could assist the Neighbourhoods with the building requirements that may be available when considering the wider Derbyshire estate. Rais Ahmed was of the opinion that the Board could help with staffing levels by providing and agreeing funding to increase the number of permanent staff; examples would be occasions when it is required to breach the agency cap and framework rates. This would also reduce the level of bank and agency staff. He felt it would also help to have some flexibility to enable posts to be filled. Richard Gregory pointed out that the Trust was trying to observe the governance edict on bank and agency staff while still providing quality of service to patients. The Board will take action and raise this issue with NHSI in a drive to engage their support for the Trust to deliver a quality service whilst adhering to NHSI KPIs. This would be to explore any system or national in-built delays to recruitment. The Board acknowledged the progress made by the Neighbourhood team and thanked them for providing such an informative report. **ACTION: Building requirements of Neighbourhood teams in STP developments and as part of the Estates strategy to be considered by Claire Wright.** **ACTION: Ifti Majid and Richard Gregory to consider raising with NHSI systemic issues and explore any system or national in built delays to recruitment.** **RESOLVED: The Board of Directors:** **1) Acknowledged the current performance of the Directorate** **2) Noted the actions in place to ensure sustained performance** **3) Claire Wright to consider the building requirements of Neighbourhood teams in STP developments and as part of the Estates strategy** **4) Ifti Majid and Richard Gregory to consider raising with NHSI systemic issues and explore any system or national in built delays to recruitment.**
DHCFT 2016/081	**GOVERNANCE IMPROVEMENT ACTION PLAN AND DELIVERY FRAMEWORK** Mark Powell presented his report which provided Board members with an update on progress of all tasks within the GIAP, including the identification of tasks that are off track, including those that the Board has responsibility for oversight. It was pointed out that there is a draft outline of KPI documentary evidenced in the GIAP and at the end of the meeting the Board should asses if there have been any decisions taken that would affect the plan. Mark Powell expressed concern that when 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) was revised at by the People & Culture Committee the task had remained off track for the second month. The Board was pleased to note that the Committee had carried out robust discussion and that Mark Powell would spend time with Jayne Storey to provide support in addressing the challenging timeframes contained in the task. Ifti Majid is comfortable that Jayne Storey is aware of what is required by the Committee. It was considered that the additional

	resource being provided to the HR team will allow Jayne Storey to develop the People Plan further. The Board considered the rating of the remaining tasks listed in the report and noted that CorpG1, 2, 4, 7, 9 and 12 (Governance Framework review) was the subject of the next report on the agenda. The Board acknowledged that the report showed that the right focus was being applied to the issues and tasks. The GIAP now has a Board assurance rating column and this has been updated based on assurance provided from the Board's Committees. Mark Powell was asked to produce a mechanism that would provide the Board with a subjective view of each task. Governors will also be asked to focus on the embeddedness of the outcomes in the GIAP at the meeting of the Council of Governors on 1 June. Mark Powell asked Board members to provide him with documentary feedback on the draft KPIs by the end of next week which would enable him to populate the GIAP for the next Board meeting in June. **ACTION: A rating mechanism will be produced by Mark Powell that will provide the Board with an objective view of each recommendation.** **RESOLVED: The Board of Directors:** **1) Reviewed the content of the paper, the full GIAP and sought assurance where required** **2) Discussed the recommendations rated as 'off track' or 'some issues' and was assured by the mitigation provided from the Responsible Director, Individual Directors or Committee Chairs** **3) Discussed and suggested changes and would provide documentary feedback on the KPIs** **4) Agreed 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**
DHCFT 2016/082	**GIAP ACTION RELATING TO CORPORATE GOVERNANCE FRAMEWORK** Samantha Harrison presented her report that updated the Trust on progress with GIAP Actions relating to the Corporate Governance Framework. As previously reported to the Board, 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 was shown in the report which proposed a revised date for the Corporate Governance Framework and it was agreed this would be to be submitted to the Board at the meeting on 27 July. **RESOLVED: The Board of Directors** **1) Noted and received assurance from the update on progress on the GIAP tasks as outlined.** **2) Agreed the revised timeline (27 July) for the full Corporate Governance Framework to be submitted to the Trust Board, following review at the Audit and Risk Committee on 19 July.**
DHCFT 2016/083	**MONITOR COMPLIANCE RETURN** Samantha Harrison's paper supported the requirement for the Board to submit Governance Statements one and two to Monitor by 31 May 2016. She drew attention to the narrative contained in the paper that explained why the Trust was currently in breach

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<tr><td></td><td>of its licence. .

The Board agreed to the recommendations contained in the paper and agreed that the Trust was unable to confirm the following governance statements:

Statement 1: Following a review for the purpose of paragraph 2(b) of licence 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.

RESOLVED: The Board of Directors:
1) Agreed the response to governance statements 1 and 2 set out above.
2) Noted 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.”</td></tr>
<tr><td>DHCFT 2016/084</td><td><u>FIT AND PROPER PERSON DECLARATION</u>

The purpose of the paper was to support the Chairman’s responsibility to declare 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) and in line with the Trust’s Fit and Proper Persons Test Policy.

It is the responsibility of the Chairman to discharge the requirement placed on the Trust and Richard Gregory declared that appropriate checks have been undertaken in reaching his judgment that he is 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.

RESOLVED: The Board of Directors:
1) Noted the work undertaken to ensure that robust processes have been undertaken to evidence that the Chairman’s declaration that that all directors meet the fitness test and do not meet any of the ‘unfit’ criteria.
2) Confirmed that GIAP elements FF1 (4) and FF1 (6) are now complete.</td></tr>
<tr><td>DHCFT 2016/085</td><td><u>REGISTER OF TRUST SEALINGS</u>

The Register of Trust Sealings provided the Trust Board with an account of the</td></tr>
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	authorised use of the Foundation Trust Seal during 2015-16. It was noted that there was 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. **RESOLVED: The Board of Directors noted the authorised use of the Foundation Trust Seal during 2015-16.**
DHCFT 2016/086	**BOARD FORWARD PLAN** 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 2016/087	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK OR GIAP** It was agreed that no further changes were required to the GIAP following presentation of papers or specific discussions. The Board noted that the Finance BAF risk had increased from high to extreme.
DHCFT 2016/088	**BOARD PERFORMANCE AND CONTENT OF MEETING** Richard Gregory considered that challenging discussions had taken place during the meeting which enabled the Board to work effectively as a Board of Directors. It was recognised that during discussions on the Board assurance summaries, too many issues were escalated and that some issues were escalated for the Board to merely note. Richard Gregory felt the deep dive gave the Board a real sense that the Neighbourhood team were very joined up.

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

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

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				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - JUNE 2016	
Date	**Minute Ref**	**Action**	**Lead**	**Status of Action**	**Current Position**
25.5.2016	DHCFT 2016/077	Board Committee Escalations - People & Culture	Jayne Storey	A dynamic process will be developed to provide assurance to the Board that policies are being adhered to	The ER tracker continues in its development, training is being developed to ensure all managers are equipped to understand and follow policies. Principle HR Managers are aligned to Service Areas to ensure a closer relationship. Regular meetings take place with staff side to pick up concerns.
25.5.2016	DHCFT 2016/079	Trust Strategy	Ifti Majid	Ifti Majid was given authority via Chief Executive Action to ensure the changes to the Strategy suggested by the Board would be implemented	All updates have been made to the final strategy document
25.5.2016	DHCFT 2016/081	GIAP	Mark Powell	A rating mechanism will be produced by Mark Powell that would provide the Board with an objective view of each recommendation.	Populated KPI and outcome provided as part of the GIAP report

	Action Ongoing/Update Required	**ORANGE**
	Resolved	**GREEN**
	Action Overdue	**RED**

Derbyshire Healthcare NHS Foundation Trust
Report to Public Board of Directors 30 June 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 guide on good governance expectations for provider organisations and local health economies. NHSI are clear about their expectations of providers to include
   - Implement system improvements – providers are expected to implement their share of local plans to improve the quality and sustainability of care and to ensure that their organisational plans are aligned to these local plans.
   - Work collaboratively with local health and care organisations – providers are expected to work with partners to build a shared understanding of patient needs and system challenges, and design improvements to meet them. For example this might be through a new care model, through information sharing to support improvements to services, or through the development of a Sustainability and Transformation Plan.
   - Engage in local decision-making - providers are expected to work with local partners to improve local services for patients where possible and appropriate. This may be through shared or joined up planning and decision-making arrangements. Where these forums exist, such as in devolved areas, providers are expected to take part if possible and appropriate.

   NHSI have detailed their expectations of providers working together
   - Scope: There should be a clear and appropriate scope of issues under consideration.
   - Level: Decisions should be taken at the most appropriate level (for example provider, groups of providers, commissioners).
   - Engagement approach: The manner of engagement must be constructive and effective.
   - Rationale: There should be clear consideration and articulation of why decisions are in the interest of patients and organisations.
   - Accountability: There must be clear lines of accountability for decisions and actions taken, taking into account providers' legal responsibilities and internal governance.

   The Chief Executive Core group are considering this guidance

2. An expert advisory group, chaired by NHS National Director of Patient Safety, Dr Mike Durkin, has published a report making a series of recommendations to the government on the scope and the principles of the Healthcare Safety Investigation Branch (HSIB).

   As announced by Jeremy Hunt last year, the patient safety investigation function will offer support and guidance to NHS organisations on investigations, and carry out certain investigations itself to support learning and improvement. The Health Service Journal has announced that Keith Conradi, the former chief inspector at the Air Accident Investigation Branch is the Secretary of States preferred candidate for the Chief Investigator of the HSIB

3. On 3 June the NHS Equality and Diversity Council is published the inaugural report of the NHS Workforce Race Equality Standard (WRES), showing results of the experiences of BME and white staff from the staff survey 2015 at every NHS trust across England.

   This is the first time the WRES data has been collected and published nationally. The report looked at four indicators across acute trusts, ambulance trusts, community provider trusts, and mental health and learning disability trusts. The results show a picture of variation across the health service with some trusts making progress, whilst others still have a considerable way to go.

   There are 8 indicators in total. One indicator looked at the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months. 78% of all mental health and Learning Disability Trusts showed a higher percentage of BME staff being harassed, bullied or abused by staff in comparison to White staff.

   Whereas a much higher proportion of BME staff report harassment, bullying or abuse by staff in the last 12 months compared to White staff, the levels of harassment, bullying, or abuse from patients relatives or the public are similar for White and BME staff. In 80% of Mental Health and Learning Disability Trusts, BME staff do not believe that their organisation offers equal opportunities for career progression or promotion in comparison with White staff. Most mental health and Learning Disability Trusts (73%) report a higher proportion of BME staff having personally experienced discrimination from a manager, team leader or colleague than White staff

   The People and Culture Committee should review the information associated with our submission, comparing our results with the average for similar Trusts and understand how we can improve learning from the best in class.

Local Context

4. Work towards the next milestone for the Derbyshire Sustainability and Transformation Plan continues with the more complete plan submission due to NHS England at the end of June. The requirement is for a 30 page document to detail the three gaps identified in the 'short submission' and describe 5 or 6 key actions that the health economy will be using to close those gaps.

   On 27 May I represented the Derbyshire Providers on the NHS England STP assurance call. The key issues/themes emerging from the call were

- Supported engine room approach.
- Including the Social Care challenge is commendable. However if it's included it must be balanced on both sides of the plan i.e. if it's included then there must be clear plans for how it will all be addressed, and the STP governance arrangements must have full oversight and accountability for delivering those plans.
- A balanced plan must be submitted. 3-5 priorities unlikely to deliver a balanced plan in isolation. 'Don't forget about CIPs/QIPPs'.
- Need a compelling case for a system control total. A control total in itself won't deliver a saving.
- No additional support for structural deficits such as PFI. It's part of the system challenge.

The next submission will be presented in full to the July public Board of Directors meeting

5. At the Board of Directors in May I provided a briefing on the Learning Disability Transforming Care Partnership plan. We have now received feedback from NHS England on our plan and I am delighted it has been rated as 'met requirement'

Within our Trust

5. On 6 June the Care Quality Commission (CQC) commenced our planned comprehensive inspection. The inspection team will continue to seek information over the next few weeks prior to consolidating their findings and collating their final report. I have briefed staff and stakeholders on progress and at the time of writing we continue to work with the CQC during this process. I anticipate that it may be the autumn before we receive the final report and findings from CQC. I will keep the Board updated in the intervening period.

6. 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 the appendix. This month the tracker has been amended to show those new visits that have occurred since the last Board (marked "New") Those visits with actions ongoing (yellow) and those visits with actions completed or no actions required (green) once a visit has been rated green it will be placed on the archive file from now on. Some of the key themes emerging from visits this month included:
   - How to make the Paris system work better for inpatient services
   - Differences in how crisis team operates
   - Move to neighbourhoods and impact on space
   - Questions around the CQC visit & request to see the CQC presentation
   - The need for a clear trauma pathway, fully funded
   - Finding a solution to keep the Primary Mental Health Worker role within CAMHS service

7. There have been two Acting CEO/Chair listening sessions during the month at the Radbourne Unit and the Hartington Unit. These visits were very poorly attended, nobody attended the Radbourne session probably due to half term and ward pressures. At the Hartington Unit the Acting CEO visited all the wards and staff took the opportunity to talk about some of the staffing issues particularly around

band 5 nurses, concerns around the need for time to complete supervision and general acuity levels on the Unit. A few patients mentioned their concern about smoking but were reassuring in that they spoke about how they were being supported. A further patient mentioned how much he enjoyed the activities in the Hub.

Strategic considerations

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

1) Note the contents of the update
2) Agree to receive ongoing updates around the Sustainability and Transformation Plan

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

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

Date	Name of Team	Name of Visiting Director	Summary of Visit	Action Required	Responsible Lead for Action	Date Actions Fed Back to Team	Status
26/05/2016	Derby City CTLD Health Workers	Claire Wright	Discussed team bases including council house approach to desk use and parking. Discussed parking and rotational staff and working across different bases and impacts on "teamness" and governance. Discussed parking problems and impact on morale/feeling valued as well as productivity. Discussed values and need for the Trust as a whole to act in accordance with values. Felt strongly that patient should remain at centre of values. Discussed impact on clinical time of admin staff having been CIPd. staff said they felt well supported by managers across levels.	None specific	N/A		**Complete**
23/05/2016	CAMHS Leadership Team	Ifti Majid	Spoke about the upcoming CQC visit. The Team shared their plans and spoke of looking forward to sharing their innovations. Talked about organisational communication having improved over the last few months. Discussed issues with transition and the fragmentation that occurs. Discussed the children's transformation process towards pathways and they shared a presentation describing the plans. Discussed some of their feedback around HR issues particularly the use of temporary contracts that had caused some difficulties. The Team shared some of their concerns around PARIS and the fact they felt they were having to develop a number of work arounds due to it not linking with the outcomes framework. Finally we discussed that CAMHS staff did feel somewhat marginalised in the Organisation at times	1. Share CQC presentation	1. Ifti Majid	03/06/2016	**Complete**
18/05/2016	South CAMHS Team Meetin	Mark Powell	- Primary Mental health Worker role – issues regarding proposed service cessation – I will discuss this with colleagues and come back to you with an update - Speed of Transformation work - Requirement for more senior School input - Not enough staff / CIP challenge - Working environment / reception area / privacy – linked to Bank Gate opportunity – I will discuss this with colleagues and come back to you - Mix of adult/young people in the centre – as above - CAMHS into neighbourhood model – is there anything specific that you would like me to explore with this one? - Consultant recruitment (on-call, pressure in teams, underfunded, caseloads)	1. Supporting the team to find a solution to keeping the Primary Mental Health Worker role 2. Supporting the team in their discussions regarding working environment and also the appropriateness of the facility for their service users 3. For me to attend a future team meeting	Mark Powell	PMHW role funding has been extended until the end of March 2017, pending further discussions taking place with commissioners about future funding MP held meeting with colleagues to discuss issues raised regarding office space and environment. Its clear that this has been discussed at length in the past with operational policies being agreed by managers to address the issues raised, which MP will feedback. Future attendance at team meeting being arranged.	**Complete**
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		**Action Ongoing**
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	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	1. Ifti Majid 2.Carolyn Green 3.Claire Wright		**Action Ongoing**
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			**Complete**

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.	**Action Ongoing**
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	1.Clear communications about this years 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		**Action Ongoing**
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.Independant review of letter sent in November		November	**Complete**
04/04/2016	Radbourne Unit Leadership Team	Ifti Majid	Discussed some innovation such as the care booklet. Long discussion around the trauma pathway as opposed to the personality disorder pathway, some 13 pts in the unit who may have been able to be kept out with a more developed team. Crisis Team caseload discussed, differences north/south in team makeup. Discussed ideas to incentivise neighbourhoods to keep more people at home. LoS figures not as recognised by one of the consultants, 28/7 re-admissions increased a little maybe due to pressure to discharge. Discussion around how to make PARIS more user friendly for the wards.	None required	None required		**Complete**
04/04/2016	High Peak Older Adults Team	Ifti Majid	Started with discussing move to neighbourhood, a cause for concern for many staff in team, worries about space, impact on OA speciality and clinical space. That said they talked about the plans in place to resolve some of the issues. Discussed relationship with Stepping Hill and DCHS, sometimes struggle to get people admitted to Stepping Hill. Discussed some concerns around the MAS process in particular differences across the County	1. SPOE Numbers - PARIS not generating correct SPOE number for High Peak 2.Need to be able to filter duty desk to High Peak only 3.Some personnel changes still needed on system	1- 3 Carolyn Gilby		**Action Ongoing**
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 of 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	**Complete**
30/03/2016	Workforce & Organisational Development Team	Carolyn Green	Detailed discussion around the outcome of the investigations, they way that 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 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	**Complete**
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.	**Complete**

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	**Complete**
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		**Action Ongoing**
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	Not required.	**Complete**
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	**Complete**
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 diarised	**Complete**
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 each and every day.	No specific actions arising	N/A	Email sent to Team thanking them for visit	**Complete**
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	Not required.	**Complete**

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 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	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 7. A paper is going to TOMM, 27/05/16, for consideration and further feedback will be available via Tim Slater and Hannah Burton following this. 9. Neighbourhoods went live on the 1st of April and currently are about the integration of the Adult and OA teams. Claire Biernacki invited to attend a team meeting for further clarification if required. Mark Powell arranging a further follow up	**Action Ongoing**
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		**Complete**
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 e.g. 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 e.g. 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'.*	**Complete**
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		**Complete**
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		**Complete**

Public Session

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

Integrated Performance Report Month 2

Purpose of Report

This paper provides the Trust Board with an integrated overview of performance as at the end of May 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 and monitoring of supervision uptake and compliance, as a key quality metric, has been included.

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

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

Strategic considerations

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

Board Assurances

This report should be considered in relation to the relevant risks in the Board Assurance Framework.
As an integrated performance report the content of this report provides assurance across several BAF risks related to workforce, operational performance, quality performance, financial performance and regulatory compliance.
This montgh w have been focusing on our comprehensive CQC inspection and learning from their feedback and our analysis of other high performing FTs integrated quality reports.
We are redesigning our performance report to consider historical and run rate performance in

quality and operational metrics to be included as soon as we can establish automated, validated data collection, in real time.
Gap in assurance, we need to report on our seclusion data but this requires further validation, there may be additional seclusion events which would alter our historical data and position.

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

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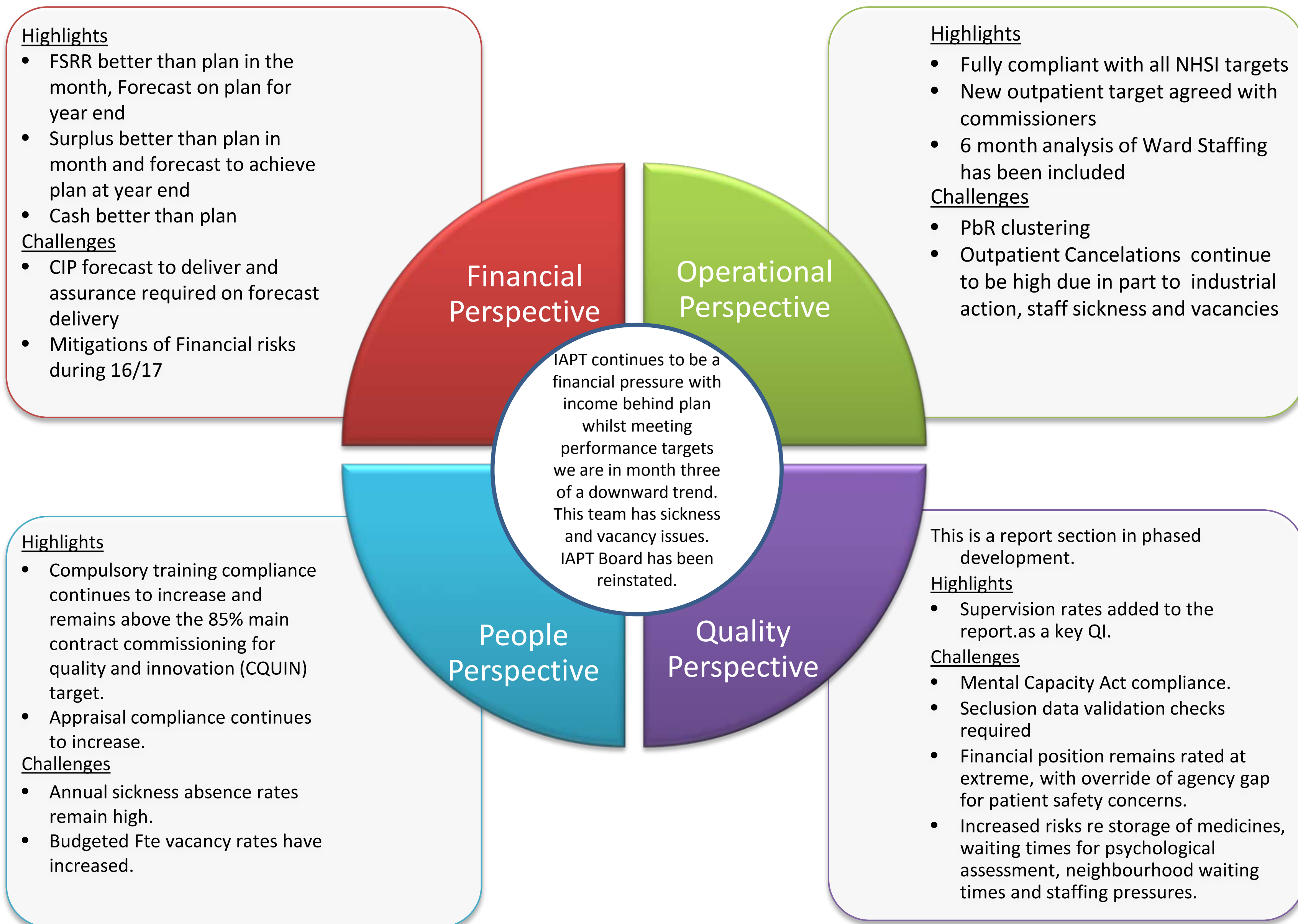

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FINANCIAL OVERVIEW – MAY 2016

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Governance	FSRR	Overall Financial Sustainability Risk rating	YTD	3	4	G	⇨	As at the end of May the FSRR is 4 which is better than plan and is forecast to be a 4 at the end of the year. Each of the quarters are also forecast to be a 4.
			Forecast	4	4	G	⇨	
		Debt Service Cover	YTD	2	3	G	⇨	
			Forecast	3	3	G	⇨	
		Liquidity	YTD	3	4	G	⇨	
			Forecast	4	4	G	⇨	
		Income and Expenditure Margin	YTD	3	4	G	⇨	
			Forecast	4	4	G	⇨	
		Income and Expenditure Margin Variance	YTD	4	4	G	⇨	
			Forecast	4	4	G	⇨	
I&E and profitability	Income and Expenditure	Underlying Income and Expenditure position £'000	In-Month	49	145	G	⇩	Surplus is better than plan in the month and due to changes in the run rate is forecast to achieve plan at the end of the financial year. The Normalised Income and Expenditure shows the financial performance adjusting for any non-recurrent costs or benefits that will not continue.
			YTD	36	372	G	⇧	
			Forecast	1,701	1,701	G	⇨	
		Normalised Income and Expenditure position £'000	In-Month	49	125	G	↘	
			YTD	36	312	G	⇧	
			Forecast	1,701	1,957	G	↘	
	Profitability	Profitability - EBITDA £'000	In-Month	650	712	G	⇩	
			YTD	1,276	1,598	G	⇧	
			Forecast	8,944	8,936	R	⇨	
		Profitability - EBITDA %	In-Month	5.7%	6.5%	G	↘	
			YTD	5.6%	7.3%	G	↘	
			Forecast	6.5%	6.8%	G	⇨	
Liquidity	Cash	Cash £m	YTD	11.054	12.976	G	⇧	Cash is currently above plan but is forecast to be below plan at year end due to the forecast release of some provisions.
			Forecast	12.323	11.525	R	⇨	
	Net Current Assets	Net Current Assets £m	YTD	3.376	5.781	G	⇧	
			Forecast	6.740	8.239	G	⇨	
	Capex	Capital expenditure £m	YTD	0.381	0.255	R	↘	
			Forecast	3.450	3.450	G	⇨	
Efficiency	CIP	CIP achievement £m	In-Month	0.358	0.170	R	↗	CIP is currently behind plan and currently is forecast to achieve plan at the end of the financial year.
			YTD	0.717	0.322	R	↘	
			Forecast	4.300	4.300	G	⇧	
			Recurrent	4.300	4.169	R	⇧	

Key:

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

Plan In-month or Year end Trust plan

Green: Achieving plan/within parameters
Amber: Slight variance to plan/within paramenters
Red: Not achieving plan/outside parameters

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

OPERATIONAL OVERVIEW – MAY 2016

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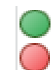
Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	NHSI	CPA 7 Day Follow-up	Month	95.00%	98.67%	G	↑	Fully compliant with NHSI targets.
			Quarter	95.00%	96.84%	G	→	
		CPA Reviews in Last 12 months	Month	95.00%	95.86%	G	→	
			Quarter	95.00%	95.63%	G	→	
		Delayed Transfers of Care	Month	7.50%	2.08%	G	→	
			Quarter	7.50%	2.11%	G	→	
		Data completeness - Identifiers	Month	97.00%	99.42%	G	→	
			Quarter	97.00%	99.51%	G	→	
		Data completeness - Outcomes	Month	50.00%	94.25%	G	→	
			Quarter	50.00%	94.35%	G	→	
		Community Care Data Activity - Completeness	Month	50.00%	93.82%	G	→	
			Quarter	50.00%	93.69%	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%	76.01%	G	→	
			Quarter	50.00%	75.94%	G	↓	
		18 Week RTT incomplete	Month	92.00%	94.99%	G	→	
			Quarter	92.00%	94.62%	G	↓	
		Early Interventions New Caseload	Month	95.00%	165.20%	G	↓	
			Quarter	95.00%	165.20%	G	↑	
		Clostridium Difficile Incidents	Month	7	0	G	→	
			Quarter	7	0	G	→	
		Crisis Gatekeeping	Month	95.00%	98.88%	G	→	
			Quarter	95.00%	99.01%	G	→	
		IAPT RTT within 18 weeks	Month	95.00%	99.63%	G	→	
			Quarter	95.00%	99.67%	G	→	
		IAPT RTT within 6 weeks	Month	75.00%	90.88%	G	→	
			Quarter	75.00%	91.12%	G	↓	
		Early Intervention in Psychosis RTT Within 14 Days	Month	50.00%	92.86%	G	↑	
			Quarter	50.00%	87.50%	G		

Key:

Period Month Current Month

Quarter Current Quarter



Achieving target

Not achieving target

Trend compared to previous month/quarter

OPERATIONAL OVERVIEW – MAY 2016

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Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Locally Agreed	CPA Settled Accommodation	Month	90.00%	97.37%	G	→	
			Quarter	90.00%	97.23%	G	→	
		CPA Employment Status	Month	90.00%	97.93%	G	→	
			Quarter	90.00%	97.97%	G	→	
		Data completeness - Identifiers	Month	99.00%	99.42%	G	→	
			Quarter	99.00%	99.51%	G	→	
		Data completeness - Outcomes	Month	90.00%	94.25%	G	→	
			Quarter	90.00%	94.35%	G	→	
		Patients Clustered not Breaching Today	Month	80.00%	81.33%	G	↑	The PbR Advisor is working with teams offering training, support and advice.
			Quarter	80.00%	80.84%	G	→	
		Patients Clustered regardless of review dates	Month	96.00%	95.17%	R	→	
			Quarter	96.00%	95.11%	R	→	
		7 Day Follow-up - all inpatients	Month	95.00%	97.78%	G	→	
			Quarter	95.00%	96.82%	G	→	
		Ethnicity coding	Month	90.00%	90.48%	G	↓	
			Quarter	90.00%	90.41%	G	↓	
		NHS Number	Month	99.00%	99.97%	G	→	
			Quarter	99.00%	99.98%	G	→	
	Schedule 4	Consultant Outpatient Trust Cancellations	Month	5.00%	5.11%	R	↑	The main reason given for cancellation was when the clinican was absent from work.
			Quarter	5.00%	7.12%	R	↓	
		Consultant Outpatient DNAs	Month	15.00%	14.35%	G	→	
			Quarter	15.00%	14.37%	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%	92.90%	G	→	
			Quarter	90.00%	92.99%	G	↑	
		Outpatient letters sent in 15 working days	Month	95.00%	96.94%	G	→	A revised 15 day target of 95% for outpatient letters has been agreed with the commisioners.
			Quarter	95.00%	96.72%	G	→	
		Inpatient 28 day readmissions	Month	10.00%	7.41%	G	→	
			Quarter	10.00%	7.67%	G	↑	
		MRSA - Blood stream infection	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Mixed Sex accommodation breaches	Month	0	0	G	→	
			Quarter	0	0	G	→	
		18 weeks RTT greater than 52 weeks	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Discharge Fax sent in 2 working days	Month	98.00%	100.00%	G	→	
			Quarter	98.00%	99.60%	G	→	

OPERATIONAL OVERVIEW – MAY 2016

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Fixed Submitted Returns	18 weeks RTT greater than 52 weeks	Month	0	0	G		
			Quarter	0	0	G		
		18 Week RTT incomplete	Month	92.00%	94.99%	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%	95.99%	G		
			Quarter	90.00%	96.28%	G		
		Ethnicity coding	Month	90.00%	90.36%	G		
			Quarter	90.00%	90.93%	G		
		NHS Number	Month	99.00%	100.00%	G		
			Quarter	99.00%	100.00%	G		
Other Dashboards	Health Visiting	% 10-14 Day Breastfeeding coverage	Month	98.00%	100.00%	G		
			Quarter	98.00%	99.80%	G		
		% 6-8 Week Breastfeeding coverage	Month	98.00%	98.90%	G		
			Quarter	98.00%	99.10%	G		
	IAPT	Recovery Rates	Month	50.00%	51.92%	G		
			Quarter	50.00%	51.92%	G		
		Reliable & Recovery Rates	Month	65.00%	70.77%	G		
			Quarter	65.00%	70.77%	G		
	Safer Staffing	Inpatient Safer Staffing Fill Rates	Month	90.00%	105.2%	G		Detailed ward level information shows specific variances
			Quarter	90.00%	101.0%	G		

Key:

Period Month Current Month
Quarter Current Quarter

Achieving target
Not achieving target

Trend compared to previous month/quarter

WORKFORCE OVERVIEW – MAY 2016

Category	Sub-set	Metric	Period	Plan	Actual	Variance		Trend	Key Points
Workforce Dashboard	Monitor Key Performance Indicator (KPI)	**Turnover** (annual)	**May-16**	10%	**10.44%**	↗	G	⬇ (green)	Annual turnover remains within the Trust target parameters and is below the regional Mental Health & Learning Disability average of 12.16% (as at March 2016 latest available data). Monthly sickness absence has increased compared to the previous month, however it is 0.13% lower than the same period last year. The annual sickness absence rate continues to increase, running at an annual rate of 5.54% as at May 2016. The regional average annual sickness absence rate for Mental Health & Learning Disability Trusts is 5.04% (as at February 2016 latest available data). The budgeted vacancy rate this month has increased by 0.45% to 17.75%. The number of employees who have received an appraisal within the last 12 months has increased by 1.47% and historic Medical appraisals have now been included. Compulsory training compliance has increased by 2.29% and remains above the 85% main contract non CQUIN.
			Apr-16		10.42%		G		
		Sickness Absence (monthly)	**May-16**	3.9%	**4.87%**	↗	R	⬆ (red)	
			Apr-16		4.81%		R		
		Vacancies (budgeted full time equivalent)	**May-16**	10%	**17.75%**	↗	A	⬆ (red)	
			Apr-16		17.30%		A		
		Appraisals (all staff - number of employees who have received an appraisal in the previous 12 months)	**May-16**	90%	**69.59%**	↗	R	⬆ (green)	
			Apr-16		68.12%		R		
		Appraisals (medical staff only - number of employees who have received an appraisal in the previous 12 months)	**May-16**	90%	**84.82%**	↗	R	⬆ (green)	
			Apr-16		81.08%		R		
		Qualified Nurses (to total nurses, midwives, health visitors and healthcare assistants)	**May-16**	65%	**67.50%**	↗	G	⬆ (green)	
			Apr-16		66.89%		G		
	Other KPI	**Compulsory Training** (staff in-date)	**May-16**	95%	**90.87%**	↗	A	⬆ (green)	
			Apr-16		88.58%		A		

Key:

Period Current month and previous month
Plan Trust target
↗ Variance to previous month

(green) Achieving target/within target parameters
(amber) Approaching target/approaching target parameters
(red) Not achieving target/outside target parameters

⬇⬆ Trend based on previous 4 months
Turnover parameters (8% to 12%)
Vacancy parameters (10% to 20%)

QUALITY OVERVIEW – MAY 2016

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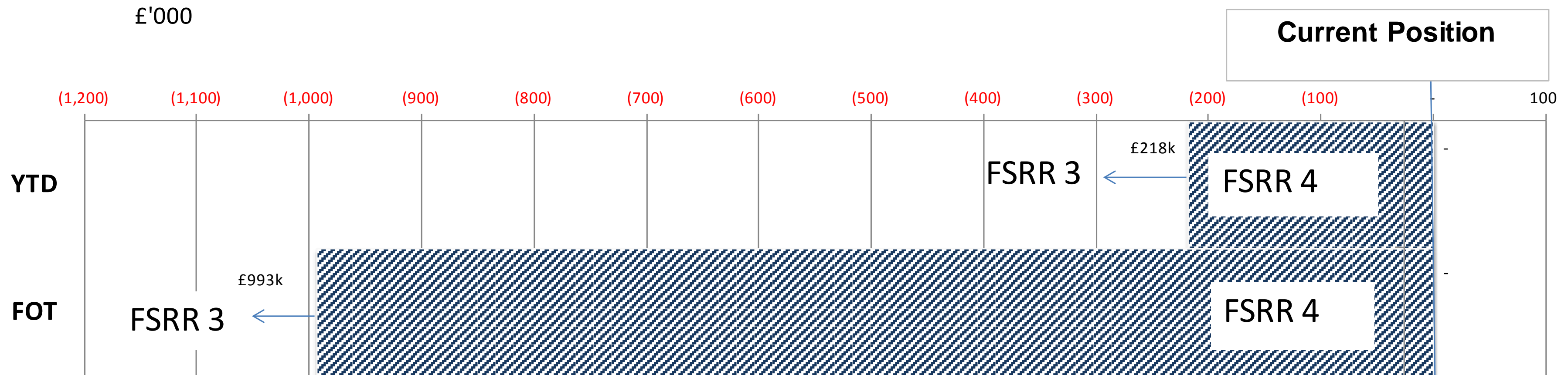
Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Quality	Quality Strategy	Percentage of current Inpatients with a recorded Capacity Assessment	Month	100.00%	54.00%	R	↑	Awaiting FSR roll out (data from PARIS).Paper records, still in use. Increased from 16% last month Seclusion data requires rechecking and data validation checks. Restrictive practice reduction strategy, monitoring in place. 12 month average as a baseline., ongoing action plan still in implementation phase
			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		
		Seclusion incidents	Month	20	21	R	↓	
			Quarter	60	40	G	↓	
		Physical Restraint incidents	Month	55	17	G	↑	
			Quarter	165	80	G	↑	
	CQUINs or contractual levy	Flu Jab Up-take	Month	45.00%	N/A	R		Flu remains unchanged. Safety Planning training increased by 25%
			Quarter	45.00%	N/A	R		
		Think Family Training	Month	25.00%	54.87%	G	↓	
			Quarter	25.00%	N/A			
		The safety plan training	Month	50.00%	75.87%	G	↑	
			Quarter	50.00%				
		The number of LD or Autism admissions without a CTR before admission	Month	0	2	R	→	
			Quarter	0	12	R	→	
	Quality Strategy	Clinical Supervision	Month	100	34.31%	0.00%		
		Management Supervision	Month	100	51.40%			
		Safeguarding Supervision	Month	100	30.70%			
		Professional Supervision	Month	100	13.90%			

Financial Section

Governance – Financial Sustainability Risk Rating (FSRR)

The FSRR at the end of May 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 £218k and £993k 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 — MAY 2016

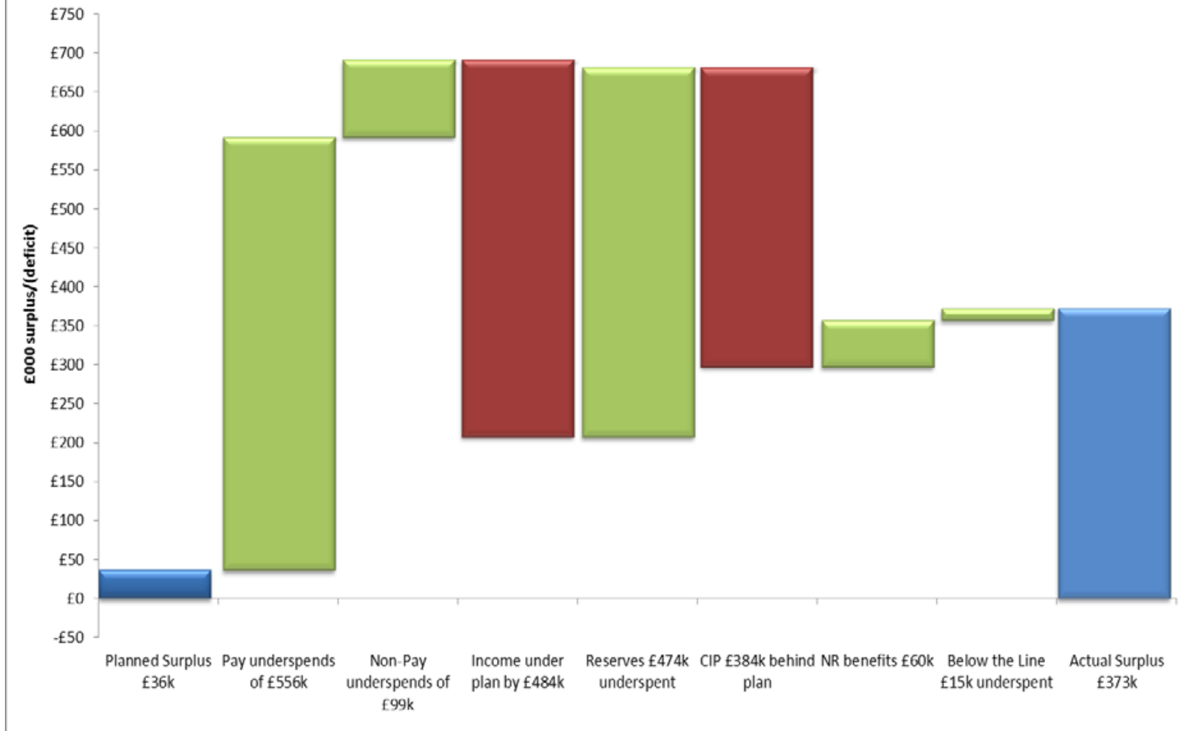
	Current Month			Year to Date			Forecast		
	Plan £000	Actual £000	Variance Fav (+) / Adv (-) £000	Plan £000	Actual £000	Variance Fav (+) / Adv (-) £000	Plan £000	Actual £000	Variance Fav (+) / Adv (-) £000
Clinical Income	10,473	10,208	(265)	20,946	20,425	(521)	126,576	122,457	(4,119)
Non Clinical Income	849	764	(86)	1,698	1,501	(197)	10,190	8,916	(1,274)
Pay	(8,478)	(8,035)	443	(16,957)	(15,981)	976	(101,492)	(96,613)	4,879
Non Pay	(2,194)	(2,225)	(31)	(4,412)	(4,347)	65	(26,330)	(25,824)	507
EBITDA	**650**	**712**	**62**	**1,276**	**1,598**	**322**	**8,944**	**8,936**	**(7)**
Depreciation	(295)	(265)	30	(589)	(578)	12	(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	(172)	(175)	(3)	(384)	(382)	2	(2,109)	(2,104)	5
Dividend	(133)	(126)	7	(267)	(266)	0	(1,600)	(1,600)	0
Net Surplus / (Deficit)	**49**	**145**	**96**	**36**	**372**	**336**	**1,401**	**1,400**	**(1)**
Technical adj - Impairment	0	0	0	0	0	0	(300)	(300)	0
UnderlyingSurplus / (Deficit)	**49**	**145**	**96**	**36**	**372**	**336**	**1,701**	**1,700**	**(1)**

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 £265k less than plan in month and is forecast to be £4.1m worse by the end of the year of which a significant proportion is due to differences in planning assumptions with offsetting expenditure reductions. There is however forecast underperformances on activity related income.

Non Clinical income is less than plan in the month by £86k with a forecast outturn of £1.3m behind plan. £0.4m relates to a miscellaneous income target with no income forecast against it.

Pay expenditure is £443k less than the plan in the month and the year end position is £4.9m more favourable than plan which is due planning assumptions (with offsetting income reductions) but also vacancies and recruitment.



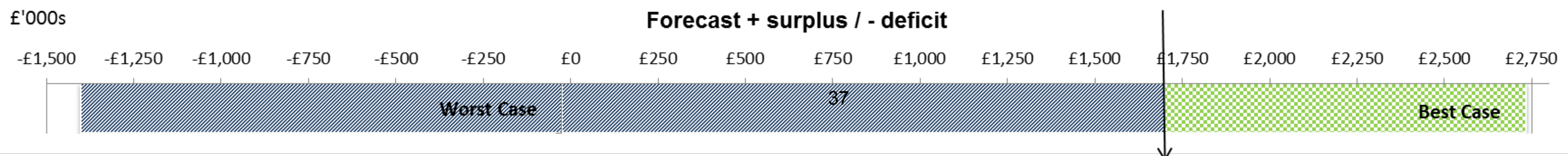
Summary of key points Enc E

Overall favourable variance to plan in the month of £96k 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
£2.7m Surplus	£1.7m surplus	£1.4m deficit



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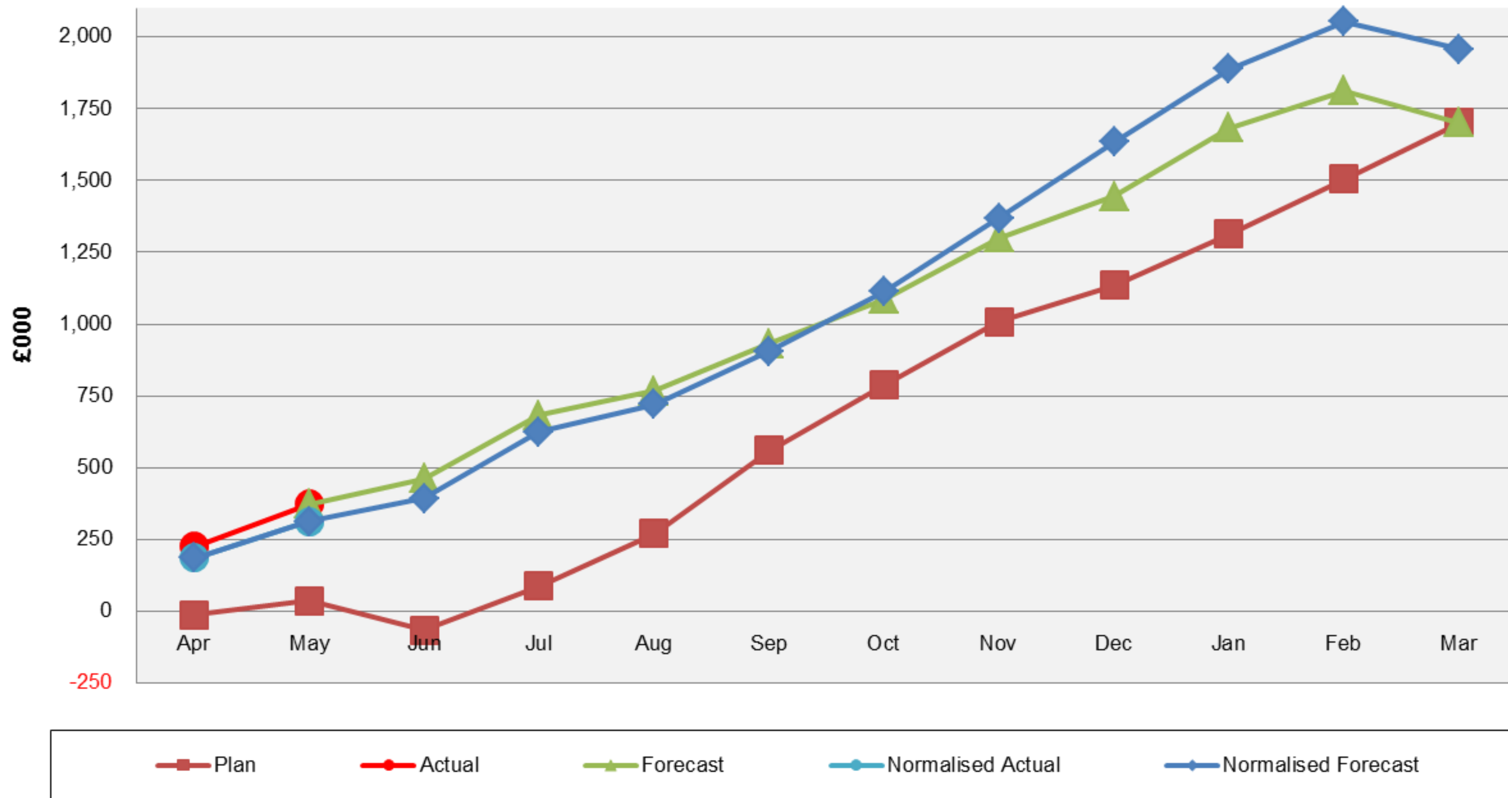
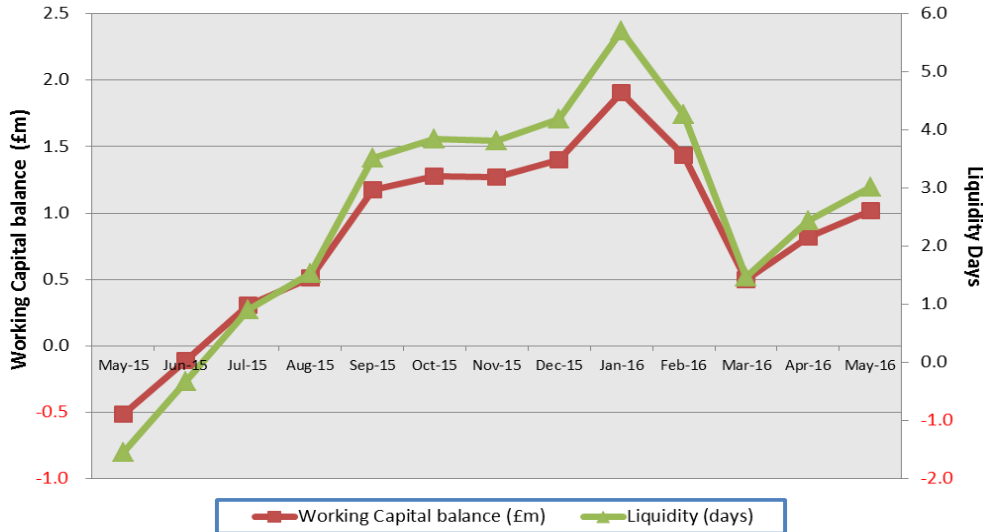
Normalised Income and Expenditure position

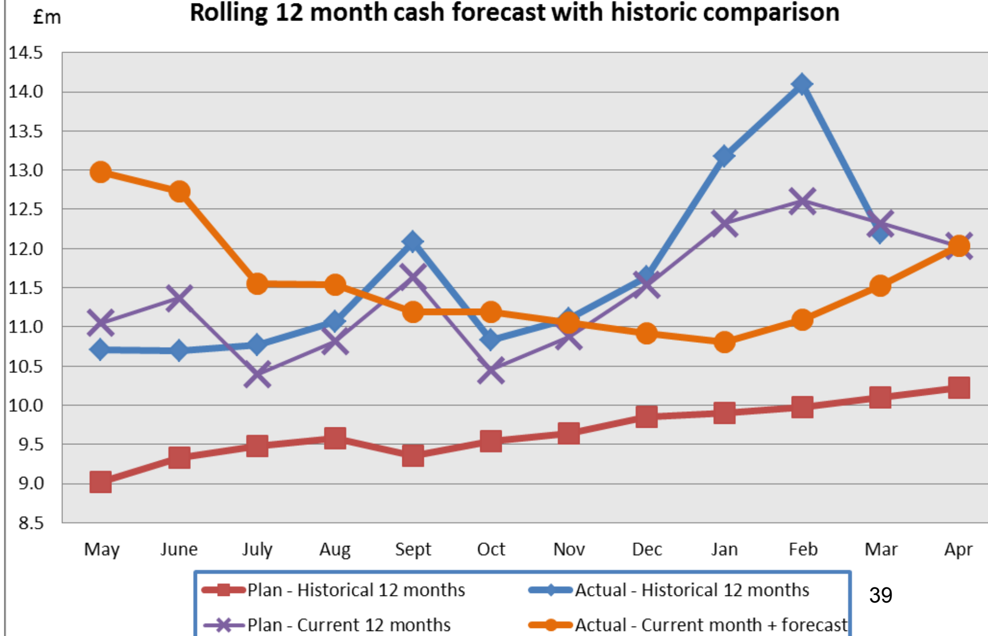


The normalised financial position is referring to the position removing any one off non-recurrent items of cost or income that is not part of the business as usual.

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



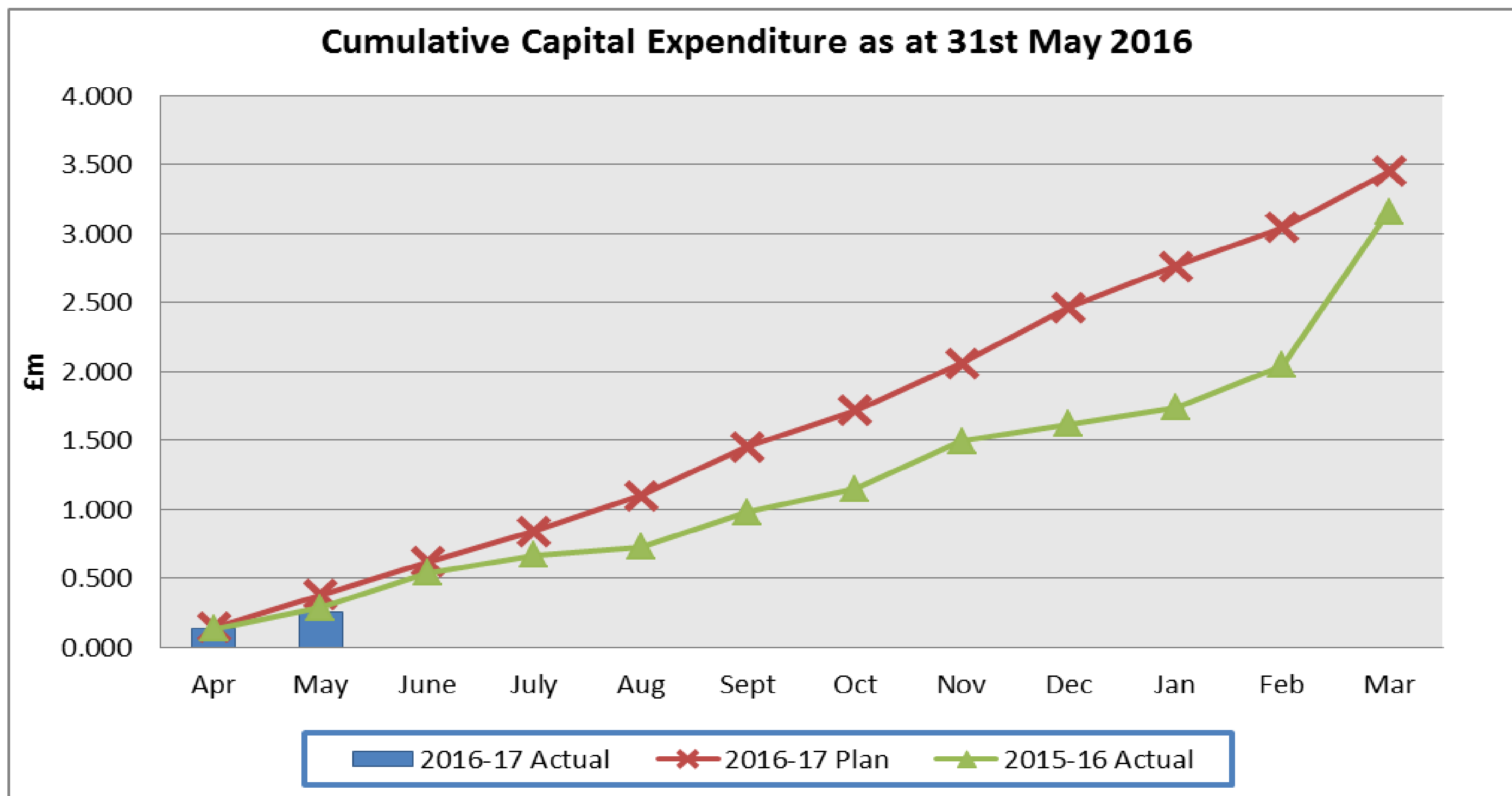


The first graph shows the working capital balance (net current assets less net current liabilities adjusted for assets held for sale and inventories) and how many days of operating expenses that balance provides.

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. May 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.

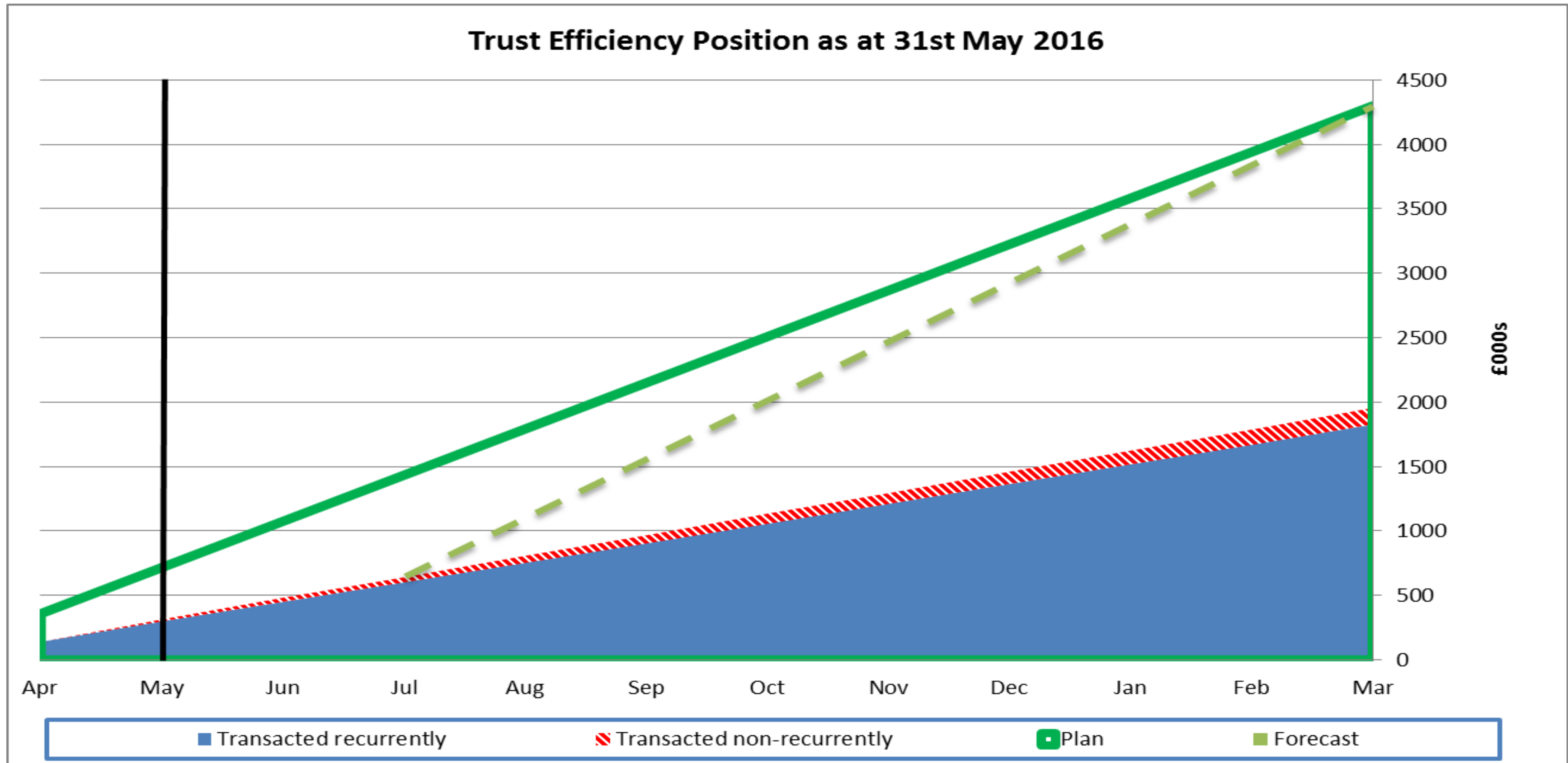
Cash is currently at £13.0m which was £1.9m better than the plan in the month. This is due to cash related Income and Expenditure surplus timing of payables and receivables.



Capital Expenditure is £126k 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)



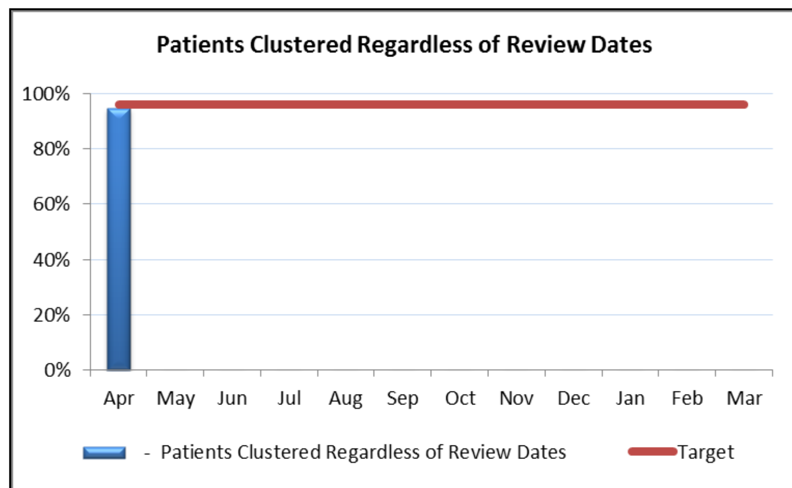
At the end of May there was a shortfall against the year to date plan of £395k. The full year amount of savings identified at the end of May reporting is £2.0m.

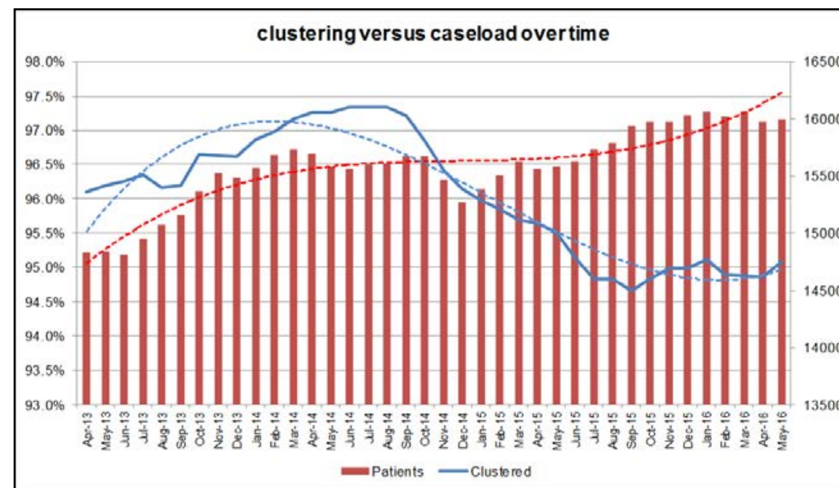
The forecast assumes full achievement of the plan by the end of the financial year.

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

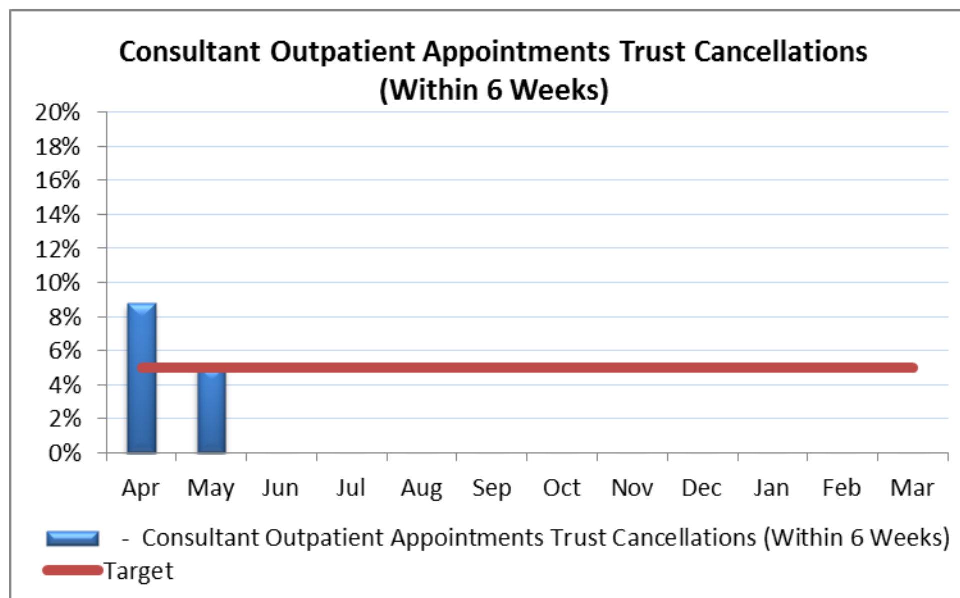




We have seen an increase over time in the number of patients needing to be clustered.

The percentage of patients clustered increased steadily over time up until October 2014 which is when the Trust moved to a new electronic patient record system, Paris. From that point we saw a steady decline in patients clustered. This is no fault of the system: Paris is very different to the previous system and any new system takes time to embed as people learn how to use it. 12 months following the implementation of Paris, the decline stopped. This was mainly as a result of a lot of hard work by the PbR and IM&T teams over the months to resolve any issues identified that were impacting on clustering. The majority of clinicians now successfully manage their PbR caseloads either independently or through positive engagement with available support.

Consultant Outpatient Appointments Trust Cancelations (within 6 weeks)



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

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

IM&T have been asked to explore the possibility of adapting Paris to enable the recording of cancellation reasons for individual appointments, not just whole clinics.

Enc E

WARD STAFFING

Ward name	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
AUDREY HOUSE RESIDENTIAL REHABILITATION	137.1%	81.5%	135.5%	74.2%		
CHILD BEARING INPATIENT	116.4%	145.5%	103.2%	200.0%	Yes	The fill rate tolerances for unqualified staff have been broken due to two long term sickness absences, vacancies and high levels of clinical activity/high observation levels.
CTC RESIDENTIAL REHABILITATION	121.8%	89.8%	100.0%	101.6%	Yes	
ENHANCED CARE WARD	83.6%	104.9%	81.0%	141.0%	Yes	Continue to hold significant vacancies for RNs. All recruitment processes continue. BY 13/06 will have 9.8 RNs only. Continue to maintain NIC cover from ECW nurse and to use bank NAs to uphold shift numbers. Staffing remains on risk register for Radbourne.
HARTINGTON UNIT - MORTON WARD ADULT	101.0%	104.6%	68.5%	161.7%	Yes	We are currently carrying 5.36 Band 5 vacancies on Morton ward, in addition to that I have a further Band 5 acting into a Band 6 position. It is difficult therefore to roster x2 Band 5 nurses on night duty.
HARTINGTON UNIT - PLEASLEY WARD ADULT	101.6%	89.8%	109.3%	92.0%	Yes	None received
HARTINGTON UNIT - TANSLEY WARD ADULT	71.8%	123.7%	51.6%	182.9%	Yes	None received
KEDLESTON LOW SECURE UNIT	112.9%	100.4%	108.1%	118.5%	No	None required
KINGSWAY CUBLEY COURT - FEMALE	86.0%	117.3%	66.1%	151.6%		
KINGSWAY CUBLEY COURT - MALE	105.9%	118.5%	96.8%	158.1%		
LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP	122.6%	62.4%	66.1%	167.7%		
LONDON ROAD COMMUNITY HOSPITAL - WARD 2 OP	112.1%	76.3%	62.9%	196.8%		
RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT	97.1%	98.8%	97.1%	107.1%	No	None required
RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT	94.6%	127.5%	68.9%	190.7%	Yes	Ward 34 continue to have a large number of RN vacancies with staff from other areas being deployed to assist, there is on-going recruitment to address this, also ward 34 have had a high number of engagement levels requiring the use of extra bank staff this however has now reduced.
RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT	84.7%	115.9%	90.9%	124.1%	Yes	We have broken the current fill rates for Qualified due to a combination of Maternity and Sickness
RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT	101.6%	95.3%	95.1%	119.7%	No	None required

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6 MONTH WARD STAFFING REVIEW

Ward Staffing Monthly Fill Rates

> 125%
< 90%

Ward	Shift	Resource	Dec-2015 Complete	Jan-2016 Complete	Feb-2016 Complete	Mar-2016 Complete	Apr-2016 Complete	May-2016 Complete
AUDREY HOUSE RESIDENTIAL REHABILITATION	Day	Average fill rate - registered nurses/midwives (%)	100%	100%	99.09%	99.15%	101.18%	137.1%
		Average fill rate - care staff (%)	100%	98.44%	100%	101.47%	100%	81.45%
	Night	Average fill rate - registered nurses/midwives (%)	100%	100%	97.3%	100%	100%	135.48%
		Average fill rate - care staff (%)	100%	100%	104.76%	100%	104.17%	74.19%
CTC RESIDENTIAL REHABILITATION	Day	Average fill rate - registered nurses/midwives (%)	100.78%	100%	103.2%	101.56%	100%	121.77%
		Average fill rate - care staff (%)	97.78%	98.84%	96.23%	100.52%	100%	89.78%
	Night	Average fill rate - registered nurses/midwives (%)	100%	100%	100%	100%	100%	100%
		Average fill rate - care staff (%)	101.59%	100%	100%	100%	100%	101.61%
ENHANCED CARE WARD	Day	Average fill rate - registered nurses/midwives (%)	104.84%	96.26%	87.5%	80.22%	83.52%	83.61%
		Average fill rate - care staff (%)	85.48%	100.48%	100.97%	97%	102.73%	104.93%
	Night	Average fill rate - registered nurses/midwives (%)	78.33%	96.77%	92.98%	80.33%	83.05%	81.03%
		Average fill rate - care staff (%)	123.19%	116.05%	126.92%	116.9%	112.33%	141.03%
HARTINGTON UNIT - MORTON WARD ADULT	Day	Average fill rate - registered nurses/midwives (%)	97.79%	102.23%	103.45%	94.68%	103.13%	101.04%
		Average fill rate - care staff (%)	108.63%	102.26%	101.59%	105.26%	109.23%	104.62%
	Night	Average fill rate - registered nurses/midwives (%)	82.76%	70%	70%	72.22%	66.07%	68.52%
		Average fill rate - care staff (%)	136.36%	134.09%	144.68%	141.67%	170%	161.7%
HARTINGTON UNIT - PLEASLEY WARD ADULT	Day	Average fill rate - registered nurses/midwives (%)	102.69%	98.91%	108.33%	113.44%	119.34%	101.57%
		Average fill rate - care staff (%)	105.65%	106.98%	86.36%	81.25%	77.31%	89.83%
	Night	Average fill rate - registered nurses/midwives (%)	104.76%	100%	146.67%	157.58%	125%	109.3%
		Average fill rate - care staff (%)	95.31%	100%	79.31%	80.33%	83.67%	92%
HARTINGTON UNIT - TANSLEY WARD ADULT	Day	Average fill rate - registered nurses/midwives (%)	87.97%	88.17%	91.39%	87.5%	80%	71.82%
		Average fill rate - care staff (%)	117.42%	123.81%	113.1%	112.66%	131.62%	123.74%
	Night	Average fill rate - registered nurses/midwives (%)	70%	69.57%	64.71%	52.46%	57.63%	51.61%
		Average fill rate - care staff (%)	148.94%	119.23%	139.47%	188.24%	156.82%	182.93%
KEDLESTON LOW SECURE UNIT	Day	Average fill rate - registered nurses/midwives (%)				110.48%	110.83%	112.9%
		Average fill rate - care staff (%)				91.13%	90%	100.4%
	Night	Average fill rate - registered nurses/midwives (%)				100%	100%	108.06%
		Average fill rate - care staff (%)				104.03%	105%	118.55%
KEDLESTON UNIT - CURZON WARD	Day	Average fill rate - registered nurses/midwives (%)	86.18%	97.54%	98.33%			
		Average fill rate - care staff (%)	106.77%	102.72%	97.3%			
	Night	Average fill rate - registered nurses/midwives (%)	100%	100%	100%			
		Average fill rate - care staff (%)	100%	104.11%	98.28%			
KEDLESTON UNIT - SCARSDALE WARD	Day	Average fill rate - registered nurses/midwives (%)	97.54%	97.58%	97.44%			
		Average fill rate - care staff (%)	100%	100%	93.91%			
	Night	Average fill rate - registered nurses/midwives (%)	100%	100%	100%			
		Average fill rate - care staff (%)	100%	98.36%	98.25%			

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6 MONTH WARD STAFFING REVIEW

Ward Staffing Monthly Fill Rates

> 125%

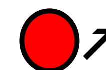
< 90%

Ward	Shift	Resource	Dec-2015	Jan-2016	Feb-2016	Mar-2016	Apr-2016	May-2016
			Complete	Complete	Complete	Complete	Complete	Complete
KINGSWAY CUBLEY COURT - FEMALE	Day	Average fill rate - registered nurses/midwives (%)	101.95%	103.66%	102.01%	102.78%	100%	86.02%
		Average fill rate - care staff (%)	97.54%	93.44%	95.56%	93.31%	95.93%	117.34%
	Night	Average fill rate - registered nurses/midwives (%)	90%	100%	94.74%	91.23%	76%	66.13%
		Average fill rate - care staff (%)	100.81%	99.33%	102.7%	101.79%	110.78%	151.61%
KINGSWAY CUBLEY COURT - MALE	Day	Average fill rate - registered nurses/midwives (%)	99.43%	99.43%	97.66%	96.6%	98.24%	105.91%
		Average fill rate - care staff (%)	98.15%	93.15%	92.89%	93.71%	99.67%	118.55%
	Night	Average fill rate - registered nurses/midwives (%)	90%	96.77%	94.83%	81.97%	91.8%	96.77%
		Average fill rate - care staff (%)	110.53%	97.39%	99.22%	108.26%	101.99%	158.06%
LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP	Day	Average fill rate - registered nurses/midwives (%)	98.78%	100.66%	98.05%	99.24%	106.87%	122.58%
		Average fill rate - care staff (%)	97.41%	89.43%	94.17%	96.71%	92.65%	62.37%
	Night	Average fill rate - registered nurses/midwives (%)	95.74%	92.16%	93.62%	100%	91.3%	66.13%
		Average fill rate - care staff (%)	100%	109.3%	123.53%	100%	101.85%	167.74%
LONDON ROAD COMMUNITY HOSPITAL - WARD 2 OP	Day	Average fill rate - registered nurses/midwives (%)	103.52%	100.75%	103.28%	100.7%	100.74%	112.1%
		Average fill rate - care staff (%)	94.56%	96.62%	95.42%	97.04%	96.45%	76.34%
	Night	Average fill rate - registered nurses/midwives (%)	95.65%	97.87%	93.88%	100%	100%	62.9%
		Average fill rate - care staff (%)	101.45%	98.08%	106.98%	98.41%	95.83%	196.77%
PERINATAL PSYCHIATRY INPATIENT	Day	Average fill rate - registered nurses/midwives (%)	119.3%	107.69%	109.84%	125.37%	113.11%	116.42%
		Average fill rate - care staff (%)	134.65%	151.72%	156.34%	191.76%	160.71%	145.54%
	Night	Average fill rate - registered nurses/midwives (%)	110.34%	103.13%	100%	103.33%	100%	103.23%
		Average fill rate - care staff (%)	148.65%	167.74%	143.75%	154.72%	147.37%	200%
RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT	Day	Average fill rate - registered nurses/midwives (%)	99.49%	99.48%	95.86%	98.84%	96.63%	97.09%
		Average fill rate - care staff (%)	98.66%	101.89%	101.2%	102.38%	98.8%	98.81%
	Night	Average fill rate - registered nurses/midwives (%)	104.88%	97.78%	102.78%	97.5%	100%	97.06%
		Average fill rate - care staff (%)	105.71%	111.11%	101.64%	98.63%	98.31%	107.14%
RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT	Day	Average fill rate - registered nurses/midwives (%)	101.61%	95.21%	91.38%	95.7%	98.33%	94.57%
		Average fill rate - care staff (%)	106.45%	107.26%	120%	113.53%	105.43%	127.48%
	Night	Average fill rate - registered nurses/midwives (%)	51.61%	64.52%	63.16%	63.33%	82.46%	68.85%
		Average fill rate - care staff (%)	231.25%	184.38%	193.33%	228.57%	148.78%	190.7%
RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT	Day	Average fill rate - registered nurses/midwives (%)	121.93%	102.67%	97.7%	93.01%	92.27%	84.7%
		Average fill rate - care staff (%)	114.39%	106.82%	122.95%	110.4%	107.09%	115.91%
	Night	Average fill rate - registered nurses/midwives (%)	90.91%	90.48%	89.13%	94.55%	109.3%	90.91%
		Average fill rate - care staff (%)	131.82%	124.29%	116.47%	122.22%	115.79%	124.14%
RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT	Day	Average fill rate - registered nurses/midwives (%)	101.06%	92.43%	94.89%	92.47%	95.53%	101.6%
		Average fill rate - care staff (%)	107.48%	110.16%	96.64%	106.25%	98.4%	95.35%
	Night	Average fill rate - registered nurses/midwives (%)	77.27%	92.31%	82.93%	79.49%	97.14%	95.12%
		Average fill rate - care staff (%)	155.56%	106.9%	117.39%	117.54%	107.27%	119.67%

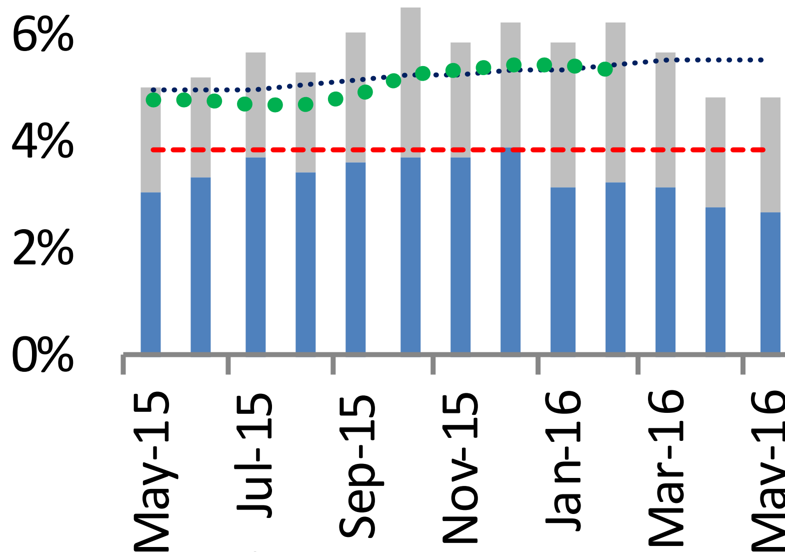
Workforce Section

Wellbeing

Sickness Absence	Mar-16	Apr-16	**May-16**
(Monthly)	5.67%	4.81%	**4.87%**

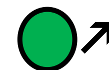


Target 3.90%

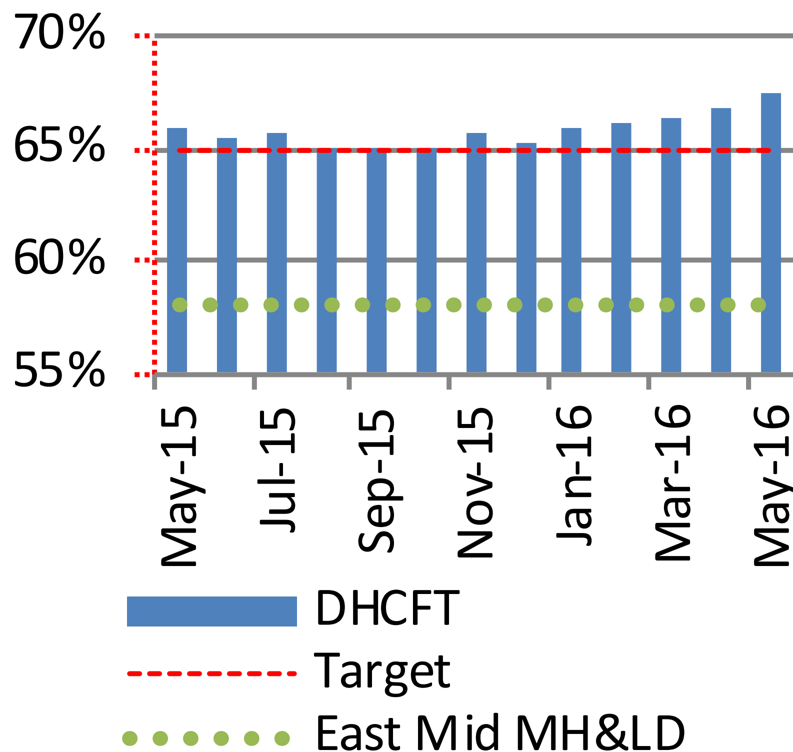


The Trust annual sickness absence rate is currently 5.54% (0.03% increase compared to last month). Anxiety/stress/depression/other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 26.42% of all sickness absence, followed by Surgery at 8.56% and Gastrointestinal

Qualified Nurses	Mar-16	Apr-16	**May-16**
health visitors and healthcare assistants)	66.41%	66.89%	**67.50%**

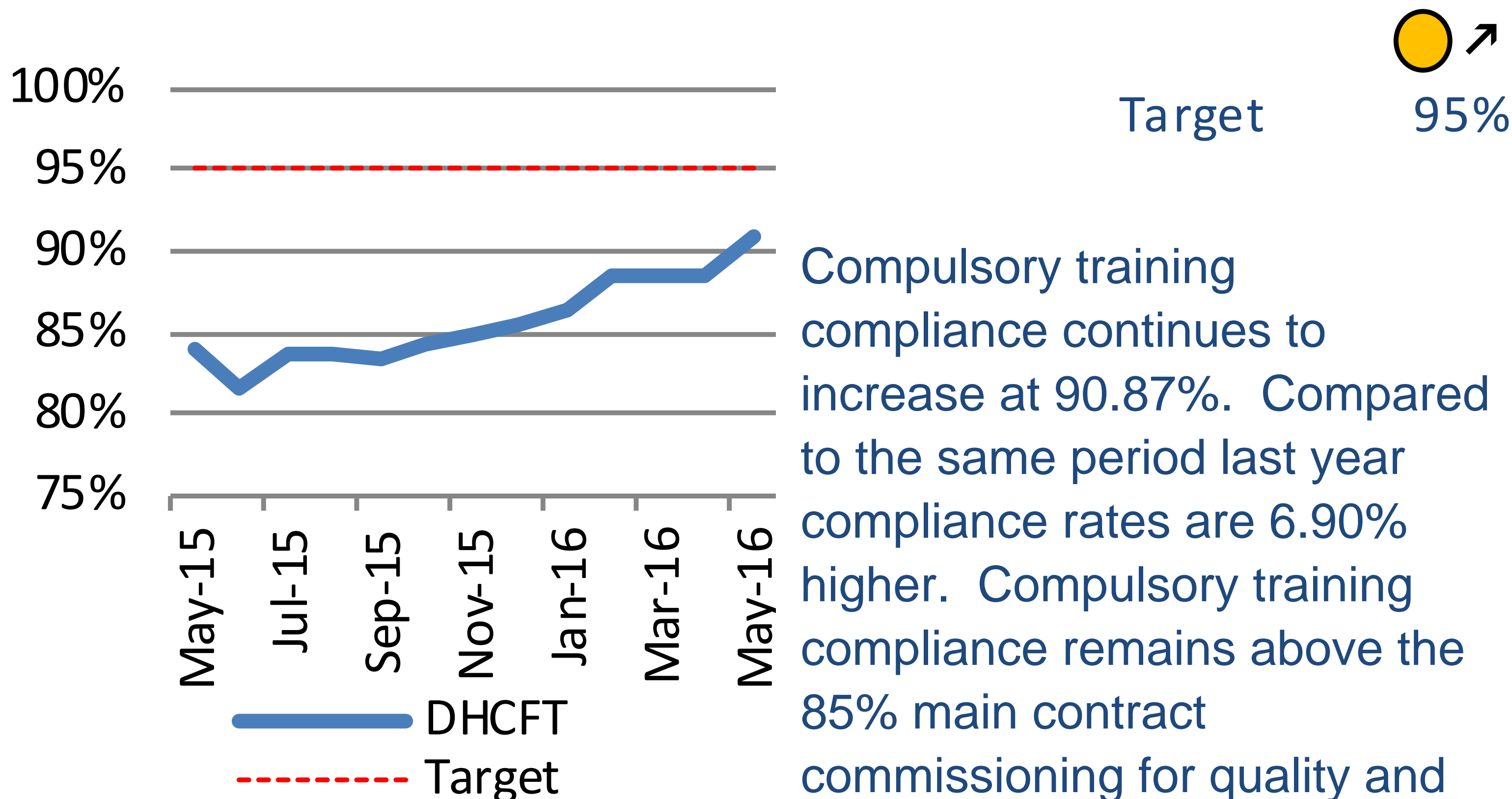


Target 65%



Contracted staff in post qualified nurses to total nurses, midwives, health visitors and healthcare assistants remains within target at 67.50%. Vacancy rates can impact on this measure. The NHS average is 61.38% and the East Midlands Mental Health & Learning Disability average is 58.04%.

Compulsory Training	Mar-16	Apr-16	**May-16**
(Staff in-date)	88.59%	88.58%	**90.87%**



Target 95%

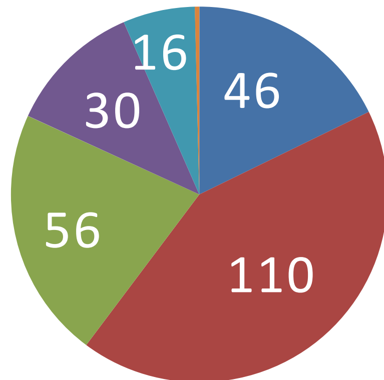
Compulsory training compliance continues to increase at 90.87%. Compared to the same period last year compliance rates are 6.90% higher. Compulsory training compliance remains above the 85% main contract commissioning for quality and innovation (CQUIN) target.

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.

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



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

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

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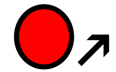
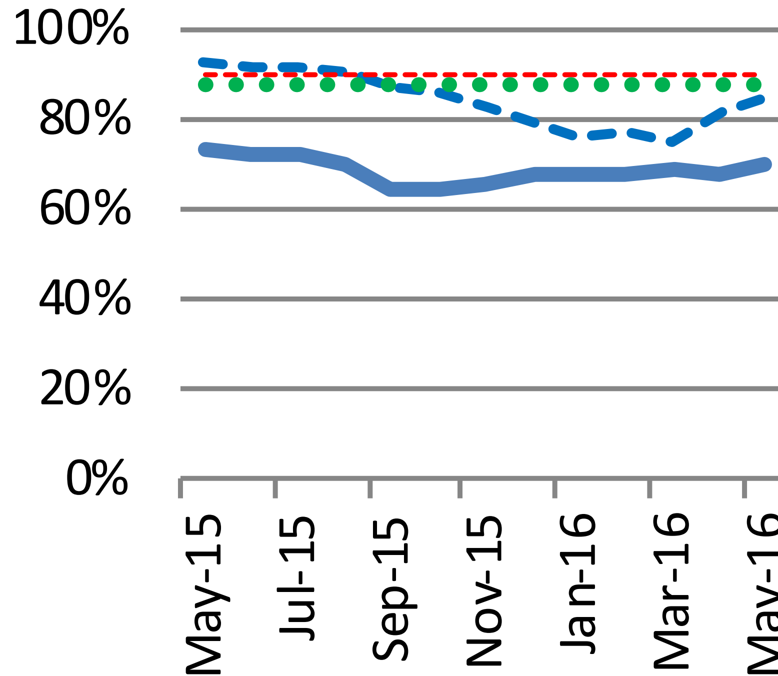
Appraisals

	Mar-16	Apr-16	**May-16**
(All staff)	69.12%	68.12%	**69.59%**



Target	90%



The number of employees who have received an appraisal within the last 12 months has increased by 1.47% during May 2016. Historic Medical appraisals have now been updated. According to the latest staff survey results, the national average for Mental Health & Learning Disability Trusts is 91%.

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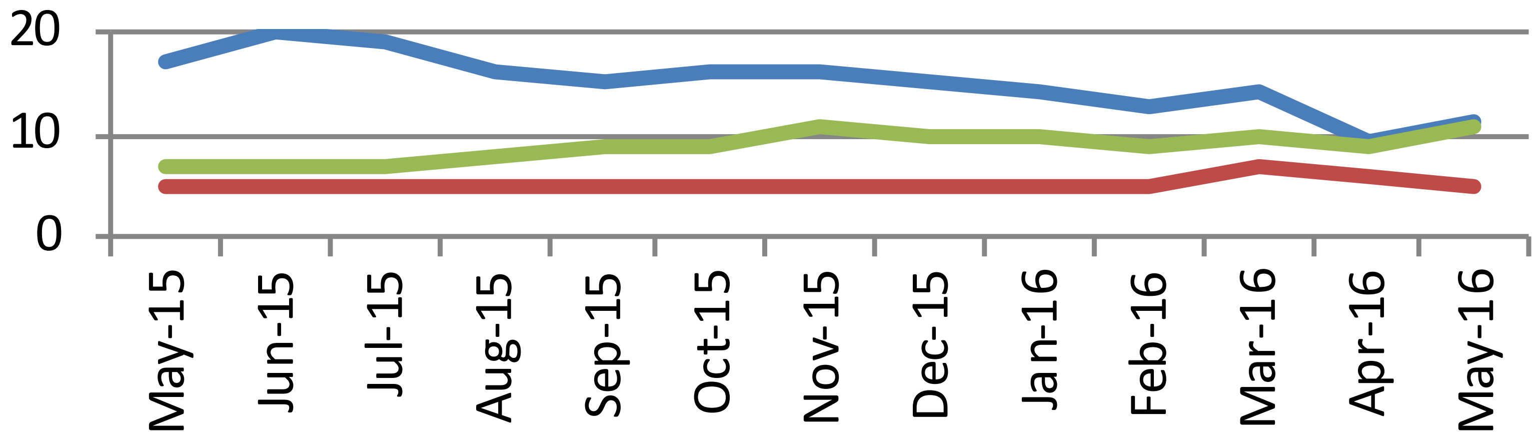
Grievances/Dignity at Work/Disciplinaries as at 31/05/16

Grievances 11

Dignity at Work 5

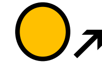
Disciplinaries 11

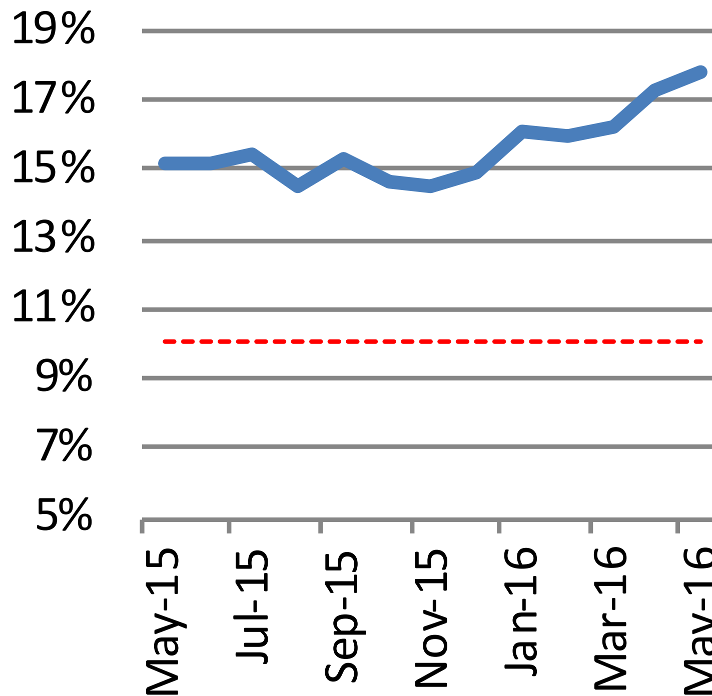
11 grievances currently lodged at the formal stage, 3 new cases received and 1 resolved during May 2016. 5 dignity at work cases currently lodged, no change from previous month. 11 disciplinaries in progress, 3 new cases and 1 resolved during May 2016.



Attendance

Vacancy	Mar-16	Apr-16	**May-16**
(Budgeted full time equivalent)	16.24%	17.30%	**17.75%**

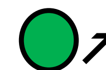


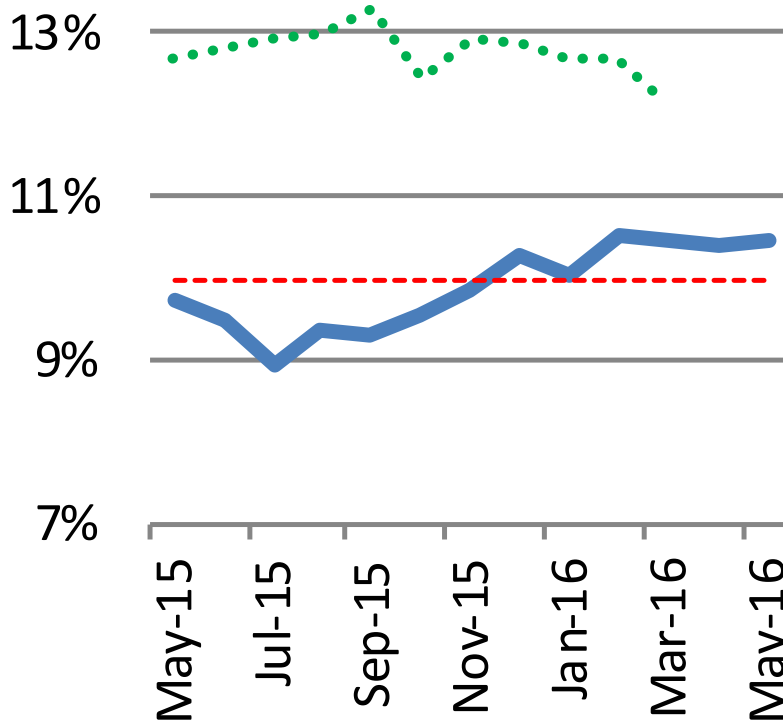


Target 10%

The budgeted vacancy rate has increased by 0.45%. April 2016 included additional full time equivalent investment for 2016/17. Active recruitment during May 2016 was for 91 posts. 65.90% were for qualified nursing, 11% admin & clerical, 9.9% medical, 7.7% scientific & technical, 3.3% allied health professionals and 2.2% additional clinical services.

Turnover	Mar-16	Apr-16	**May-16**
(Annual)	10.45%	10.42%	**10.44%**



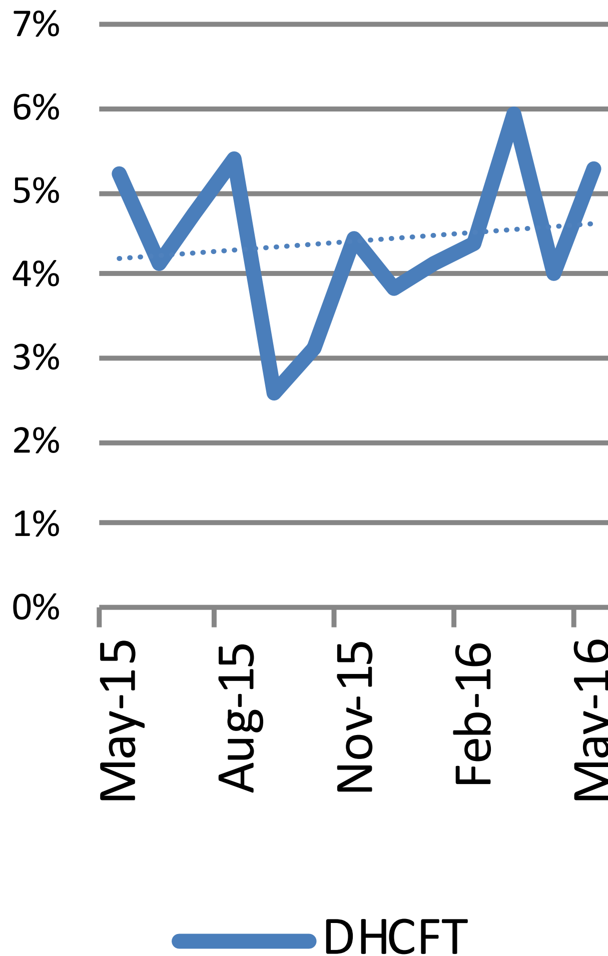


Target 10%

Annual turnover remains within Trust target parameters at 10.44% 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. 17 employees left the Trust during May 2016 which included 6 retirements.

Agency Usage	Mar-16	Apr-16	**May-16**
(Spend)	5.95%	4.03%	**5.29%**

↗



Total agency spend in May 2016 was 5.29%. Of total agency spend for all staff groups, Qualified Nursing represented 0.95%, Medical 3.27% and other agency usage 1.07%. Agency Qualified Nursing spend against total Qualified Nursing spend in May was 2.51%. Agency Medical spend against total Medical spend in May was 17.49%. In May the level of Agency expenditure exceeded the ceiling set by NHSI by £228k of which £190k related to Medical staff.

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 Monitor 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	⟷

The Board has requested that the planned target rating for each risk be identified, together with a target date to achieve. A plan to provide this information is being developed, with reporting to begin from Sept 16.

Clinical Risks (Significant)

Risk Description	Risk rating	Trend
Long waiting lists due to difficulty in recruiting paediatricians	EXTR	→
Non-compliance with medicine management standards. Lack of facilities to assure compliance with medicines management standards	HIGH	↑
Nursing vacancies, leadership and succession planning across Radbourne Unit	HIGH	→
Lack of commissioned services: ADHD, patients discharged from prison	HIGH	→
Waiting times for psychological assessment, neighbourhood teams, pressure from transfer between neighbourhood teams.	HIGH	↑
Lack of parking for clinicians at bases	HIGH	→

Lack of compliance with correct storage temperature of medicines, managed through portable air conditioning units whilst capital bids to install permanent solutions are being implemented.

Further risk re waiting for psychological assessment. Pressure from transfers of patients from neighbouring teams, especially St Marys Gate. Plan to co-ordinate transfers underway.

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

Trust Compliance – Accessible Information Standard

Purpose of Report:
This report provides our compliance update with the Accessible Information Standard.

Executive Summary
- The Accessible Information Standard was published 3 July 2015. Full implementation of the standard is required by 31 July 2016.

Strategic considerations
- To maintain high level of standard compliance within our organisation and also to support partnering organisations.

(Board) Assurances
- Full assurance implementation plan monitoring and completion
- Full assurance for our Accessible Information Standard compliance
- Full assurance post implementation monitoring and audit

Consultation
- Learning Disability Clinical & Professional Reference Group (Derbyshire County Wide)
- This report will be presented to the Information Governance Committee in July

Governance or Legal Issues
- This information standard is published under section 250 of the Health and Social Care Act 2012.

Equality Delivery System
- Successful implementation will lead to improved outcomes and experiences, and the provision of safer and more personalised care and services to those individuals who come within the standard's scope.

Recommendations

The Board of Directors is requested to:
1) Acknowledge progress made with the Accessible Information Standard implementation plan
2) Acknowledge full implementation compliance in advance of 31 July 2016

Report presented by: Carolyn Gilby (Acting Director of Operations)

Report prepared by: Alex Rose (Records Manager)

Accessible Information Standard Report

Introduction

This report provides information on our compliance with the Accessible Information Standard (http://www.hscic.gov.uk/isce/publication/scci1605).

This standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.

The standard applies to service providers across the NHS and adult social care system, and effective implementation will require such organisations to make changes to policy, procedure, human behaviour and, where applicable, electronic systems. Commissioners of NHS and publicly-funded adult social care must also have regard to this standard, in so much as they must ensure that contracts, frameworks and performance management arrangements with provider bodies enable and promote the standard's requirements.

Background

This standard was published 3rd July 2015 with full implementation required by 31st July 2016.

The standard can be broken down into key compliance areas:

- Electronic Patient Record Systems
- Website and supporting material
- Policies and Procedures
- Leaflets
- Staff training and awareness

Action so far

The following key actions have already been completed:

- Electronic Patient Record Systems

PARIS, TPP SystmONE and IAPTUS have all been tested. Systems confirmed to have the capacity to allow staff to record information and communication needs and for these to be highly visible and promoted as alerts.

- Website and supporting material

Trust external website has been updated:
http://www.derbyshirehealthcareft.nhs.uk/accessibility/

This also includes a text reading system for people with visual impairments, called BrowseAloud.

Trust Core Care Standards website has been updated:
http://www.corecarestandards.co.uk/accessibility/

- Buttons to translate the website into other languages
- Includes Easy Read, picture and symbol options in a number of sections, particularly the Keeping Well area, and a section in Learning Disability Services about support with accessible information, links to videos.
- Uses large print to alert people to the viewing options
- Includes a standard on Involvement and choice, and a principle on Information
- Has been written in clear straightforward language, using reading tools to gauge accessibility

Forms:

- Assessment and Care Planning forms include a section on Communication
- Currently publishing a Writing Good Care Plans Guide which gives advice on accessibility of care plans
- The Trust has a translation and Interpreting service for any forms needed

- Policies and Procedures

Trust policies have been reviewed and updated to reflect the need to raise awareness and support compliance for the Accessible Information Standard.

The Minimum Standards for Health Records Policy has been updated and renamed:
Minimum and Accessible Information Standards for Health Records Policy

The Data Quality Policy and Procedure has also been updated to reflect the need to enforce collection and recording of key information related to the Accessible Information Standard:
Data Quality Policy and Procedure

- Leaflets

All public facing leaflets contain a message offering to provide information in other formats. Trust uses Pearl Linguistics to support translations and Braille transcriptions.

Trust has created a suite of easy-read materials on our public-facing website: http://www.derbyshirehealthcareft.nhs.uk/about-us/publications/easy-read-health-information-guides/

- Staff Training and Awareness

User guides available for staff to support Accessible Information Standard compliance when using electronic patient record system.

Learning Disability Services have an extensive collection of forms in easy-read and Widget symbols, and staff trained to use these

http://www.e-lfh.org.uk/programmes/accessible-information-standard/open-access-sessions/

Work in progress
The following actions are underway and will either be completed before 31st July 2016 or will be further enhancements at a later date:

- Electronic Patient Record

Suppliers of: PARIS, TPP SystmONE and IAPTUS to provide dedicated functionality to support the Accessible Information Standard. Although Trust can demonstrate compliance without this, the further development of electronic patient record systems will provide further support.

- Website and Supporting Material

For the Core Care Standards website:

  - Adding tabs to all the standards about accessible information
  - Reviewing the Principle about Information and adding a piece on the main page
  - Updating the ‘accessibility’ banner heading at the top of the home page with more information about translations and interpreting
  - Looking at the feasibility of having the Read Aloud software on the CCS website
  - Adding a slide to the slide show on the home page
  - Planning to add a BSL-signed video to the home page

For Core Care Standards publications:
Although most have a guide to receive in translation:

  - Agreeing a standard approach with Communications
  - Reviewing all our publications to ensure a consistent approach in the next edition
  - Publish a large print contact card (currently out of print)

- Policies and Procedures

Although Trust policies have been updated, these are to be reviewed and updated as part of the post implementation audit and review. Local user guidance documentation to be published and communicated to all staff.

- Leaflets

All new leaflets and communication to include statement about provision in a different format on request.

- Staff Training and Awareness

  - Add a slide about accessible information to the CPA & CCS level 1 block training for staff

  - Add a slide about accessible information to the IG block training for staff

  - When all changes are complete, to survey staff, carers, and service users to gauge effectiveness

Implementation Plan – Accessible Information Standard

Lead: IMT and Records
Sponsor: Carolyn Gilby

Version: 0.1

No.	Recommendation	Action *(If same as recommendation put 'As recommendation')*	Action Lead *(only **one** name for each action)*	Action Deadline Date	Evidence Required	Date completed
1	The standard will be adopted across the Trust by 31/07/16	As recommendation	C Gilby	31/07/16	Audit	On Target
2	Review all electronic systems to ensure compliance	As recommendation	A Rose	01/07/16	Information can be captured on the EPR	On Target
3	Review CCS and forms to ensure compliance	As recommendation	W Slater	30/06/16	Website	On Target
4	Review Policies and add as necessary to ensure compliance	Data Quality and Minimum Standards for Record keeping to be updated	A Rose	10/06/16	Intranet	10/06/2016
5	Review information leaflets and rewrite if needed to ensure compliance	As recommendation	R Eaton	31/07/16	Leaflets	On Target
6	Produce staff briefings and training materials	Clinical line briefings to take place	J Fleeman	31/07/16	Staff training registers/ briefing lists	On Target

Public Session

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 29th June 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. Caring through our work with carers in carer's week.
2. Responsiveness of our services through our Blue Light system.
3. Safe services which includes some of our work which has commenced on seclusion, mental capacity act and physical health checks.
4. Well-led- Our CQC visit inspection week and some next steps.
5. Effectiveness of our Learning Disabilities (LD) Strategic Health Facilitation in winning funding from NHS England and Patient activation bid key aspects of our Quality priorities in Physical Healthcare and Personalised care.

Strategic considerations
To give an insight into our key areas as key questioning by the Care Quality Commission and to provide assurance level information on our services and their performance.

(Board) Assurances
Compliance with the key areas covered by the Care Quality Commission key lines of enquiry.

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
2) Gain assurance and information on its content and seek clarity or challenge on any aspect of the report

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

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

QUALITY POSITION STATEMENT
June 2016

1. SAFE SERVICES

1.1 CQC Inspection

We have had some feedback from our CQC inspection and we are working on some policy work on seclusion pathway and monitoring, our existing quality priority and making improvements in our mental capacity act compliance and monitoring. We will continue to work on our quality priority of physical healthcare monitoring and immediate checks following the use of medicines.

1.2. Shaping the future: CQC's strategy for 2016 to 2021

The Care Quality Commission has published *Shaping the future,* its strategy for 2016 to 2021.

We will:

- Discuss the publication at the Quality Committee.
- Share with Quality Leadership Teams
- Factor into our patient safety and audit plans, including our work with our soon to be appointed mortality technician

1.3. Alan Woods review of role and function of Local Safeguarding Boards

Alan Woods undertook a review of the role and function of local safeguarding boards. His report and the Government response to this was published on 26th May 2016. The report makes a number of recommendations for Boards to consider they include:

- The Child Death overview panels to move from Department for Education to Department of Health.
- To replace the existing statutory arrangements for local safeguarding children's boards (LSCB's) and introduce a new statutory framework for multi-agency arrangements for child protection.
- To introduce a new framework for Safeguarding Children's reviews including both national local elements. An accreditation scheme/ regime for Overview writers.
- More effective local arrangements which could include LSCB if they are effective, but more likely different less structured arrangements
- Adult and Children's Boards should not be integrated, but other board overlaps should be considered (Health and Wellbeing).

We will:

- Consider the outcomes and recommendations of the Wood review and adjust our Safeguarding strategy and work plan in line with any formal changes.

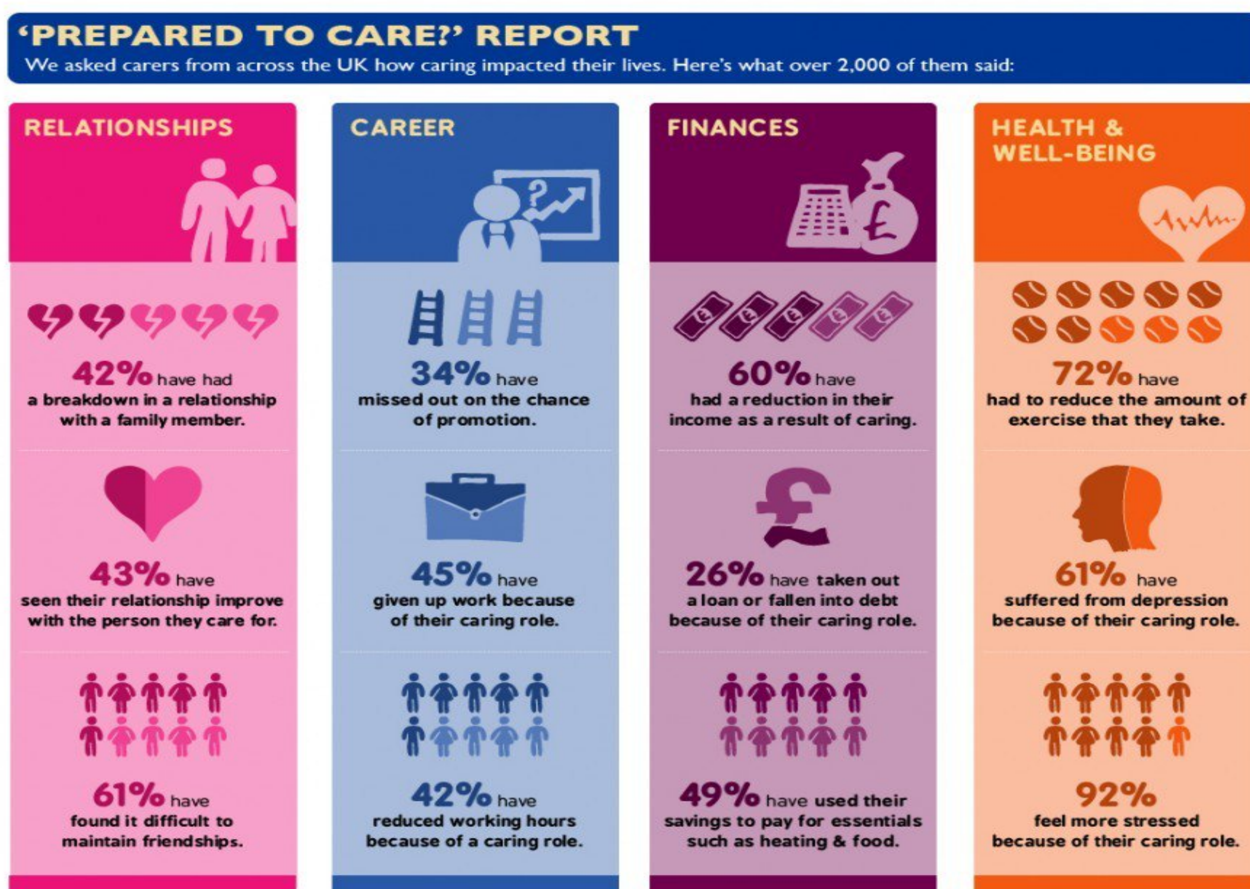
2. CARING SERVICES

This month from the 6th June was Carers week .@CarersWeek asked 2,000 people how caring affected their lives http://www.carersweek.org/get-involved #CarersWeek

This feedback is being displayed in the Trust to promote Family and carers inclusive practice, as well our on-going commitment to Think Family through its associated training, publications, posters and he use of our Family liaison team and SBARD for Families and carers, Publicising and being responsive to the needs of carers.

Later in the year the Trust is contributing to the North Derbyshire carers events through a small contribution to sponsorship and staff attendance at the event.

Since the last Board Carolyn Green attended Derby City and South Derbyshire Mental Health Carers Forum to listen to the views of carers, to promote the use of the Family and Carers handbook and the Family and carers SBARD. The majority of the feedback was about access to services, concerns with regard to our Trust position on its move to a smoke free environment and the impact of council funding reductions on their well-attended and highly regarded forum.



3. EFFECTIVE SERVICES

Our Quality priority of improving Physical health care

Congratulations to our Learning Disabilities (LD) Strategic Health Facilitation team has been awarded £154,746 by NHS England after showing how it would work with GPs in Derbyshire and Nottinghamshire to enable them to promote the NHS bowel, breast and cervical screening programmes amongst their learning disabled patients.

Our Quality priority of improving personalised care planning and person centred care

Congratulations to our across Trust quality circle approach to bid writing with new and novice bid writers who were successful in achieving the NHS England bid on Patient Activation. This bid enables improvements to clinical practice that without external investment would not be achieved. We were informed in June by the Person-centred Care Team, Patients and Public Participation and Insight Division that our bid had been successful.

This model was promoted by recent research in this area, that there was new and emerging evident that individuals receiving care and their care givers, need to move past engagement to a new progressive model of care to be activated as an expert and informed person making choices in their care. This model would be an evidenced based rating scale for clinical practice to activate individuals in decision making and if early research outcomes are fully replicated could be a key pillar of improved individual and family patient experience clinical effectiveness, and the management of clinical demand.

It is mandatory that successful applicants attend one ‘Patient Activation Training Workshop’ provided by NHS England, in collaboration with Insignia Health. This full day session is required supporting sites to understand how patient activation can influence the way in which people are supported to manage their long-term conditions and will provide in-depth training on how to use the PAM tool. Four representatives have attended the Training event on the 14th June 2016, as a train the trainer model to develop this approach in the Trust.

4. RESPONSIVE

4.1 Blue light’ information

Our system of ‘Blue Light’ has been in place for a number of years. This enables us to share learning quickly through an ‘all staff’ e mail process. The blue light information outlines required processes, legal requirements and risks

When the Care Quality Commission raised some areas where further work was needed this process was activated and we are pleased to say that in all instances, staff have risen to the challenge of this. We have issued some blue light information to enable our clinical staff to understand the improvement areas we need to make to ensure we are protecting our patients and ask that all staff access these blue light alerts and are aware of the content.

We will:

- Ask teams to discuss the content of the bulletins in their teams
- Ask teams to discuss at handovers and team meetings.
- Ask teams to think: what does this mean for my practice? What do I need to change in my practice, as part of my team going forward to ensure we are always acting in the best interests of my patients?

We will be monitoring the impact of blue light information in named areas such as our compliance and monitoring of mental capacity act assessments are occurring in clinical services routinely.

5. WELL LED

5.1 Care Quality Commission planned inspection visit

Since the last quality position statement we have now completed our planned inspection week which took place on Monday, 6th June – Friday, 10th June

This consisted of a 5 day plan;
Monday – The CQC based themselves at a local hotel for their planning day. This included a presentation and a welcome to the Trust given from Ifti Majid

Tuesday – Thursday – The CQC visited various locations, teams and wards around the Trust. There was a core team of CQC based at Trust HQ during this time and the conducted 1:1 planned interviews and staff focus groups

Friday – CQC core team spent the day at the hotel summing up and informally feeding back to Ifti Majid, John Sykes and Carolyn Green.

We will:

- Continue to submit requests for data at this point we have received over 300+ data requests in a ten day period.
- Continue to receive follow up visits by the Care Quality Commission inspection team to some teams.
- Wait to receive the draft report – this will be in approximately 12 weeks this could take us up to September before a final outcome is known.
- Hold a CQC sponsor debrief and post inspection feedback session to consider reflection and learning and any other support requirements to teams.
- Act on any immediate feedback and provide additional information or act on any immediate learning or service improvements in the interests of our patients, staff and community.

Report prepared by: Clare Grainger, Head of Quality on behalf of Carolyn Green Director of Nursing and Patient Experience

Derbyshire Healthcare NHS Foundation Trust
Report to Trust Board 30 June 2016

Medical Appraisal/Revalidation 2015-2016

Purpose of Report

To provide assurance that doctors working in DHCFT are fit to practise

Executive Summary

- The Annual Organisation Audit was submitted to NHS England in May 2016
- The Framework of Quality Assurance is due to be presented to the Board in June 2016

Strategic considerations

- A fit for purpose medical appraisal/revalidation system is an essential NHSI requirement

Committee Assurances

Audit results are summarised in Appendices A-E

Consultation

This is the first time these reports have been presented

Governance or Legal Issues

- The Annual Organisation Statement of Compliance needs to be returned by the chairman to NHS England by 30 September 2016

Equality Delivery System

All doctors will be required to "pull in" their appraisal year to stick to a 12 month cycle in 2016/2017. There may be particular challenges for part-time practitioners who are predominantly female.

Recommendations

The Board is requested to:
Consider the report
Scrutinise the contents
Confirm assurance or otherwise seek additional assurance.

Report presented by: **Dr John R Sykes**
Medical Director/Responsible Officer

Annex A – Designated Body statement of compliance – Derbyshire Healthcare NHS FT

The Board of Derbyshire Healthcare NHS Foundation Trust - has carried out an annual organisational audit of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;
2. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations;
3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;
4. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;
5. Medical appraisers will have an ongoing performance review and training / development activities, to include peer review and calibration of professional judgements;
6. All licensed medical practitioners either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;
7. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners, which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;
8. There is a process established for responding to concerns about any licensed medical practitioners' fitness to practise;
9. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work; and
10. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners have qualifications and experience appropriate to the work performed.

Signed on behalf of the designated body

(Chair)

Medical Appraisal / Revalidation 2015/2016
- Framework for Quality Assurance

1. Executive summary

In 2015-16 there were 106 doctors with a prescribed connection to DHCF, 89 of which completed a successful appraisal as required – 14 doctors were able to provide acceptable reasons for postponing their appraisal, the remaining 3 have now completed their appraisals and will seek to perform their next appraisal early to compensate. Based upon subsequent audits and reviews of practice, the following issues are to be addressed by May 2017 by the Responsible Officer and Medical Appraisal Lead as part of the DHCFT Appraisal Action Plan to allow successful completion of the NHS England Annual Organisational Audit for 2016-2017:

- Maintenance of the appraisal data collection and storage systems to facilitate access to information for audit and review
- Realignment of the appraisal calendar to enable all doctors to complete their appraisals within the designated timeframe
- Continuation of the annual cycle of appraiser feedback review/appraisal
- Assurance that the SUI/complaints cross-referencing system ensures these are all addressed in the appraisal process
- Provision of further refresher/support sessions to appraisers and appraisees highlighting the importance of reflection to both in the appraisal process
- An introductory appraisal training package for doctors new to DHCFT

2. Purpose of the Paper

The Framework of Quality Assurance for Responsible Officers and Revalidation (FQA) has been designed to assist responsible officers in providing assurance to their organisation's board that doctors working in the designated body remain up to date and fit to practise. This covers areas including –

- Governance arrangements within DHCFT
- Medical Appraisal Systems
- Recommendations for revalidation
- Recruitment and engagement background checks

It provides a formal record of compliance, which may be helpful should a designated body's systems and processes become subject to challenge at any stage. It also provides details to allow the board to complete the Annual Organisational Statement of Compliance for return to NHS England by 30 September 2016.

3. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

provider boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

4. Governance Arrangements

This report gives annual assurance to the Trust Board. Quarterly returns are made to NHS England. The Quality Committee receives updated policies and audit results.
The Responsible Officer and Appraisal Lead are fully compliant with regional training requirements.

a. Policy and Guidance

The DHCFT Medical appraisal Policy has been updated.

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

- Number of doctors (Full time and DHCFT locum consultants and Speciality Grade Doctors) with prescribed connection to DHCFT = **106**
- Number of completed appraisals = **89**
- Number of appraisals postponed for acceptable reasons = **14**
- Number of doctors in remediation and disciplinary processes = **1**

Details of exceptions i.e. missed appraisals and reasons, incomplete appraisals etc. are included in **Annual Report Template Appendix A;** Audit of all missed or incomplete appraisals audit. All postponed appraisals reviewed and agreed by both the Responsible Officer and the Medical Appraisal Lead.

b. Appraisers

- Number of appraisers = 25. So DHCFT ratio appraisers: doctors = 25:106 =1:4.2. NHS England recommended ratio is between 1:20 and 1:5
- New appraiser training = takes place external to the DHCFT on NHS England recognised/approved courses. Fees for the course paid either through DHCFT study budget or by medical staff themselves.
- Further appraiser training support = provided by Medical Appraisal Lead as part of each appraiser's annual review and appraisal. Immediate advice provided as required during process of individual appraisal by Medical Appraisal Lead on direct contact.

- Content of the training and how this was identified = training offered is a combination of update information disseminated by the Revalidation Team of NHS England, from issues raised on the doctors' post-appraisal feedback forms (as provided by the NHS England Revalidation Team- see attached document) and through issues identified by the appraisers themselves in their PDP during their structured annual Appraiser Assurance Review Template
- The Medical Appraisal Lead attends the quarterly East Midlands Regional Appraisers' Network Meeting and offers feedback to all medical staff both through DHCFT TMAC and by "all-staff" email.
- New developments include the development of DHCFT "in-house" new appraiser training, an "Introduction to Appraisals" course for doctors new to both DHCFT and the appraisal process and a DHCFT Appraisers' Support Group.

c. Appraisal Quality Assurance

For the appraisal portfolio – all the following are audited by the Medical Appraisal Lead and signed off by the Responsible Officer, the Quality Assurance Committee and by NHS England as part of the Annual Organisational Audit (submitted 26/5/2016)

- Review of appraisal folders to provide assurance that the appraisal inputs, the pre-appraisal declarations and supporting information provided are available and appropriate
- Review of appraisal folders to provide assurance that the appraisal outputs, PDP, summary and sign offs are complete and to an appropriate standard
- Review of appraisal outputs to provide assurance that any key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal outputs
- Review of lessons learned from any complaints
- Review of lessons learned from any significant events

For the individual appraiser:

- An annual record of the appraiser's reflection on their own appropriate continuing professional development as an appraiser and the development of a relevant PDP to enhance their appraisal skills (Document attached)
- 360 degree feedback from doctors for each individual appraiser – collected utilising post-appraisal feedback forms (Document attached), reviewed, collated and fed back to the appraiser by the Medical Appraisal Lead during each appraiser's own appraisal. Examples of good practice both from individual appraisers within DHCFT and that obtained from quarterly East Midlands Regional Appraisers' Network Meetings is then shared with all active appraisers for use in future appraisals.

For the organisation:

- The Responsible Officer has already submitted DHCFT's completed Annual Organisational Audit to NHS England in time for the deadline of 31st May 2016

- The report is to be presented to the DHCFT Board within a timeframe that allows it to be ratified and the required Statement of Compliance completed and returned to NHS England by 30th September 2016.

Results of Appraisal Quality Assurance audit are included in **Annual Report Template, Appendix B;** Quality assurance audit of appraisal inputs and outputs. This highlights the success of DHCFT doctors in recording activity and providing appropriate supporting information during their appraisal but also the need for greater involvement in the process of patient and colleague feedback.

d. Access, security and confidentiality

Issues relating to information governance and patient identifiable data within appraisal portfolios are addressed in Section 2 of the DHCFT Medical Appraisal Policy. All appraisers are aware of the need to check for evidence of patient identifiable data in the appraisal inputs and supporting evidence during individual appraisals – if detected then it is the responsibility of both the doctor and the appraiser either to remove or anonymise such details.

The DHCFT Quality Assurance Audit of Appraisal Inputs and Outputs (See **Appendix B**) further scrutinises appraisals for evidence of any breaches of patient confidentiality which may not have been detected during the initial appraisal process - any such breaches will be reported directly to the Responsible Officer and appropriate actions taken. None were detected during the 2015-2016 audit process.

e. Clinical Governance

At present DHCFT does not stipulate the inclusion of any trust-related mandatory supporting evidence within the appraisal **apart** from details relating to SUIs and complaints. The development of a system of clinical dashboards for all doctors, gives the opportunity to utilise this as part of the appraisal process. This would be incorporated into section 14 of the MAG form and could include such measures as HoNoS/PBR recording, waiting list times, patterns of prescribing, etc. and be available on request by each doctor in time for their appraisal. The issues of service commitment/development however are separate from the appraisal process.

6. Revalidation Recommendations

Number of recommendations between April – March - 27
Recommendations completed on time – all on time
Positive recommendations - 25
Deferrals requests - 2
Non engagement notifications - 0
Reasons for all missed or late recommendations – N/A

See **Annual Report Template Appendix C;** Audit of revalidation recommendations

7. Recruitment and engagement background checks

Including pre and post employment checks;
Checks on locums;

See **Annual Report Template Appendix E**

Audit of recruitment and engagement background

8. Monitoring Performance

This is through an annual review of work plans jointly by medical and operational managers.

9. Responding to Concerns and Remediation

The Trust Local Disciplinary Policy is consistent with the national approach to Maintaining Higher Professional Standards.

10. Risk and Issues

Single points of failure could be exposed if the few key individuals concerned with the overview of revalidation were to become unavailable.

11. Board / Executive Team Reflections

A separate report on recruitment and locum use is being provided to the Finance & Performance Committee

12. Corrective Actions, Improvement Plan and Next Steps

The approach to quality improvement of appraisals has been outlined.

NHS England conducted an Independent Verification Visit in February 2016. Feedback was vey favourable although we are awaiting the official report.

Suggestions included:

1. The development of a remediation policy – in preparation
2. Amend the Medical Appraisal Policy as suggested during visit – completed
3. Consider appraiser network meetings – completed
4. Review the recommendation process for revalidation including a Scheme of Delegation to define access to GMC Connect – action for Medical Director for November 2016

13. Recommendations

The Board is asked to:

- accept this report (noting it will be shared, along with the annual audit, with the higher level responsible officer) and to consider any developments/resources
- approve the ‘statement of compliance’ confirming that the organisation, as a designated body, is in compliance with the regulations

Annual Report Template Appendix A
Audit of all missed or incomplete appraisals audit

Doctor factors (total)	**Number**
Maternity leave during the majority of the 'appraisal due window'	3
Sickness absence during the majority of the 'appraisal due window'	4
Prolonged leave during the majority of the 'appraisal due window'	2
Suspension during the majority of the 'appraisal due window'	2
New starter within 3 month of appraisal due date	0
New starter more than 3 months from appraisal due date	0
Postponed due to incomplete portfolio/insufficient supporting information	1
Appraisal outputs not signed off by doctor within 28 days	0
Lack of time of doctor	3
Lack of engagement of doctor	0
Other doctor factors (Commitments to RCPsych)	2
TOTAL	**17**
Appraiser factors	
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	0
Lack of time of appraiser	0
Other appraiser factors (describe)	0
TOTAL	**0**
Organisational factors	
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0
TOTAL	**0**

Annual Report Template Appendix B - QA audit of appraisal inputs and outputs

Total number of appraisals completed		Number 106
	Number of appraisal portfolios sampled (to demonstrate adequate sample size)	**Number of the sampled appraisal portfolios deemed to be acceptable against standards**
Appraisal inputs		
Scope of work: Has a full scope of practice been described?	30	30
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	30	28
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	30	27
Patient feedback exercise: Has a patient feedback exercise been completed?	30	24
Colleague feedback exercise: Has a colleague feedback exercise been completed?	30	25
Review of complaints: Have all complaints been included?	30 examined 20 complaints	30 19 acceptable
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	30 24 SUIs	30 24 acceptable
Is there sufficient supporting information from all the doctor's roles and places of work?	30	27
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)? Explanatory note: For example • Has a patient and colleague feedback exercise been completed by year 3? • Is the portfolio complete after the appraisal which precedes the revalidation recommendation (year 5)? • Has all supporting information been included?	30	30
Appraisal Outputs		
Appraisal Summary	30	29
Appraiser Statements	30	30
Personal Development Plan (PDP)	30	28

Annual Report Template Appendix C - Audit of revalidation recommendations

Revalidation recommendations between 1 April 2015 to 31 March 2016	
Recommendations completed on time (within the GMC recommendation window)	27
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	27
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resources or support for the responsible officer role	0
Other	0
Describe other	
TOTAL [sum of (late) + (missed)]	0

Annual Report Template Appendix D - Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level[2]	Medium level[2]	Low level[2]	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern	2	1		3
Capability concerns (as the primary category) in the last 12 months	1	1		2
Conduct concerns (as the primary category) in the last 12 months	1			1
Health concerns (as the primary category) in the last 12 months		2		2
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2015 who have undergone formal remediation between 1 April 2014 and 31 March 2015				1
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				1
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				0
General practitioner (for NHS England area teams only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				0
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				0
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodiess				0
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies				0
TOTALS				1
Other Actions/Interventions				
Local Actions:				
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included				3
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed				3

[2] http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf

Concerns about a doctor's practice	**High level[2]**	**Medium level[2]**	**Low level[2]**	**Total**
between 1 April and 31 March should be included 6 - 12 months				
Number of doctors who have had local restrictions placed on their practice in the last 12 months?				1
GMC Actions: Number of doctors who:				
Were referred by the designated body to the GMC between 1 April and 31 March				1
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March				1
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March				2
Had their registration/licence suspended by the GMC between 1 April and 31 March				0
Were erased from the GMC register between 1 April and 31 March				0
National Clinical Assessment Service actions:				0
Number of doctors about whom the National Clinical Advisory Service (NCAS) has been contacted between 1 April and 31 March for advice or for assessment				5
Number of NCAS assessments performed				1

Annual Report Template Appendix E
Audit of recruitment and engagement background checks

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	Number
Temporary employed doctors	Number
Locums brought in to the designated body through a locum agency	Number
Locums brought in to the designated body through 'Staff Bank' arrangements	Number
Doctors on Performers Lists	Number
Other Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc	Number
TOTAL	Number

For how many of these doctors was the following information available within 1 month of the doctor's starting date (numbers)

	Total	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC/NCAS investigations	Disclosure and Barring Service (DBS)	2 recent references	Name of last responsible officer	Reference from last responsible officer	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance concerns
Permanent employed doctors																
Temporary employed doctors																
Locums brought in to the designated body through a locum agency																
Locums brought in to the designated body through 'Staff Bank' arrangements																
Doctors on Performers Lists																
Other (independent contractors, practising privileges, members, registrants, etc)																
Total																

For Providers of healthcare i.e. hospital trusts – use of locum doctors: Explanatory note: Number of locum sessions used (days) as a proportion of total medical establishment (days) The total WTE headcount is included to show the proportion of the posts in each specialty that are covered by locum doctors					
Locum use by specialty:	Total establishment in specialty (current approved WTE headcount)	Consultant: Overall number of locum days used	SAS doctors: Overall number of locum days used	Trainees (all grades): Overall number of locum days used	Total Overall number of locum days used
Surgery					
Medicine					
Psychiatry					
Obstetrics/Gynaecology					
Accident and Emergency					
Anaesthetics					
Radiology					
Pathology					
Other					
Total in designated body (This includes all doctors not just those with a prescribed connection)					
Number of individual locum attachments by duration of attachment (each contract is a separate ‘attachment’ even if the same doctor fills more than one contract)	Total	Pre-employment checks completed (number)	Induction or orientation completed (number)	Exit reports completed (number)	Concerns reported to agency or responsible officer (number)
2 days or less					
3 days to one week					
1 week to 1 month					
1-3 months					
3-6 months					
6-12 months					
More than 12 months					
Total					

Derbyshire Healthcare NHS Foundation Trust
Report to Trust Board 30 June 2016

Governance Statements 4, 5 & 6, 2015/16 submission

Purpose of Report

This paper supports the requirement for the Board to submit Governance Statements four, five and six to Monitor by 30th June 2016 (statements one, two and three having been previously submitted in May 2016).

Declarations 1 and 2, which were presented to the Board at the May Board meeting as also attached for information, to inform the Board of a post-submission amendment made as a result of feedback from NHS Improvement.

Recommendations

The Board of Directors is requested:

1) To confirm the following governance statements:

Statement 4: For the Corporate Governance Statement, that it is appropriate to select 'confirmed' for each statement and that the risks and mitigations (as attached) for each statement are correct.

Statement 5: This statement is not applicable because we are neither:

- part of a major Joint Venture or Academic Health Science Centre (AHSC); or
- considering entering into either a major Joint Venture or an AHSC.

Statement 6: The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

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 licence conditions on a quarterly basis through the year when certifying the compliance returns to Monitor (NHS Improvement from 1 April 2016). In addition, the assurances 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 (Audit and Risk Committee from 1 April 2016) independent oversight of the effectiveness of those systems, all indicate that the Board is able positively to self-certify against the declarations.

At their quarterly council meetings the governors take the opportunity to question the directors on the Trust's performance and current governance rating.

It is therefore recommended that the Board approves the signing-off of the declarations (GS6) as 'confirmed'.

Due to the change in phasing of the submission of compliance returns to NHS Improvement that have been notified for 2016/17, the Board is asked to approve delegated authority to the Chair of the Audit and Risk Committee together with the Chair of the Finance and Performance Committee for the sign off of future submissions. Once submitted, these will be circulated to the Board for information at the next Public Trust Board meeting.

Strategic Considerations

As part of APR planning NHS Foundation Trusts are required to make certain declarations to NHS Improvement. The full list of six declarations is detailed with the Governance/legal issues section for context.

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 NHS Improvement. The full list of six declarations is detailed below for context.

Declarations 1& 2: *Systems for compliance with licence conditions – in accordance with General Condition 6 of the NHS provider licence*
Declaration 3: *Availability of resources and accompanying statement in accordance with Continuity of Services condition 7 of the NHS provider licence*
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 have already been submitted to NHS Improvement by 31st May 2016. Further to advice received from NHS Improvement, this self-certification has been amended to confirm that although in breach under section 106 the Trust continues to meet its licence conditions.

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

Declarations 4, 5 and 6 above are set out in this document, and are required to be returned to NHS Improvement by 30th 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 and Affairs and Trust Secretary

CORPORATE GOVERNANCE STATEMENT

CORPORATE GOVERNANCE STATEMENT	RESPONSE	RISKS & MITIGATING ACTION
1. The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirm	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 licence 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 (GIAP) to agreed timescales and through robust ongoing oversight by the Trust Board and NHS Improvement. The GIAP was approved by the Trust Board in March 2016 and provides focus and pace to ensuring principles, systems and standards of good corporate governance are embedded within the Trust.
2. The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time	Confirm	The Board has a scheduled programme of Development Sessions whereby new guidance is presented and discussed, and policy and practice reviewed accordingly. These include both internally and externally facilitated sessions. Board members actively participate in NHS Providers events. In addition the Director of Corporate Affairs and Trust Secretary is responsible for the Trust's Corporate Governance framework and addressing new practice and guidance

CORPORATE GOVERNANCE STATEMENT	RESPONSE	RISKS & MITIGATING ACTION
3. The Board is satisfied that the Trust implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirm	The Trust's Governance arrangements, including Committee terms of reference, are subject to annual review. The Governance Improvement Action Plan includes the requirement to review the full corporate governance framework. This has commenced and includes a full review of Committee structures, escalation and assurance arrangements, roles and responsibilities of the Board and clarifying the Trust's accountability framework.
4. The Board is satisfied that the Trust effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans)	Confirm	The Audit Committee (Audit and Risk Committee from 1 April 2016) as the senior independent committee has an overview of the governance structure with clear forward plans, and maintaining a Board Assurance Framework, which is reported to the Board three times a year.

CORPORATE GOVERNANCE STATEMENT	RESPONSE	RISKS & MITIGATING ACTION
material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.		
5. The Board is satisfied that the systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for	Confirm	The Delivery of the Quality Account and Quality Strategy are overseen by a Board committee, the Quality Committee, which provides exception and escalation reports to Board. The Medical Director and Director of Nursing and Patient Experience are jointly responsible to the Board for quality. All Board members and Council of Governors are invited to quality visits to ensure triangulation of information. The Board on a monthly basis receives a quality position statement and a patient story.

CORPORATE GOVERNANCE STATEMENT	RESPONSE	RISKS & MITIGATING ACTION
escalating and resolving quality issues including escalating them to the Board where appropriate.		
6. The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirm	The Trust, through the People and Culture Committee, is driving leadership and focusing on engagement and workforce planning. The Trust has a clear recruitment and selection policy. The Board has employed a number of senior leaders, one specifically tasked with Organisational Development including succession planning. The Director of Corporate Affairs has operational responsibility for ensuring compliance with the conditions of the NHS provider licence.

Worksheet "Certification G6"

Declarations required by General condition 6 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions

1 Following a review for the purpose of paragraph 2(b) of licence 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 licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution. — **Not confirmed**

AND

2 The board declares that the Licensee continues to meet the criteria for holding a licence. — **Confirmed**

Signed on behalf of the board of directors, and having regard to the views of the governors

Signature	Signature
Name Ifti Majid	**Name** Richard Gregory
Capacity Acting Chief Executive	**Capacity** Interim Chairman
Date 25 May 2016	**Date** 25 May 2016

Further explanatory information should be provided below where the Board has been unable to confirm declarations 1 or 2 above.

A 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 licence conditions FT4 (2), FT4 (4a-c) FT4 (5) a,b,e,f,h FT4 (7)) that were highlighted as part of an Employment Tribunal involving the Trust's Board, and a subsequent Employment Tribunal investigaton. Reviews by Deloitte LLP on governance arrangements and HR related functions and a CQC Focussed 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.

B

Self-Certification Template

FT Name: Derbyshire Healthcare NHS Foundation Trust

NHS Foundation Trusts are required to make the following declarations to NHS Improvement :

1 & 2 *Systems for compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence*
3 *Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence*
4 *Corporate Governance Statement - in accordance with the Risk Assessment Framework*
5 *Certification on AHSCs and governance - in accordance with Appendix E of the Risk Assessment Framework*
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 this template, which is required to be returned to NHS Improvement by 31 May 2016.
Declaration 3 is included in the APR 2016/17 Final Financial Template, which is required to be returned to NHS Improvement per communications on final operational plan submissions.
Declarations 4, 5 and 6 above are set out in a separate template, which is required to be returned to NHS Improvement by 30 June 2016.

Templates should be returned via the Trust portal, marked as a Trust Return with the activity type set to Annual Plan Review.

How to use this template
1) Copy this file to your Local Network or Computer.
2) Select the name of your organisation from the drop-down box at the top of this worksheet.
3) In the Certifications G6 worksheet, enter responses and information into the yellow data-entry cells as appropriate.
4) Once the data has been entered, add signatures to the document, as described below.
5) Use the Save File button at the top of this worksheet to save the file to your Network or Computer - note that the name of the saved file is set automatically - please do not change this name.
6) Copy the saved file to your outbox in your NHS Improvement Portal.

Notes: *NHS Improvement will accept either:*
1) electronic signatures inserted into this worksheet (save signature file locally and use 'Insert - Picture' from the toolbar/ribbon to do this) or
2) hand written signatures on a paper printout of this declaration posted to NHS Improvement to arrive by the submission deadline.

In the event than an NHS foundation trust is unable to fully self certify, it should NOT select 'Confirmed' in the relevant box. It must provide commentary (using the section provided at the end of this declaration) explaining the reasons for the absence of a full self certification and the action it proposes to take to address it.

Board Committee Summary Report to Trust Board
Audit & Risk Committee
24 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
Actions matrix	AUD2016/009	Assurance on completion awaited from Mental Health Act Committee.	None	Sam Harrison to confirm via MHA on 3 June that this action is complete before removing from A&R action matrix	None
Governance Improvement Action Plan	Mark Powell gave an overview of the progress of GIAP actions and recommendations. Committee support for completed actions was considered.	Assurance on progress was noted. Sam Harrison provided an update on work relating to developing a Corporate Governance Framework which covers several GIAP actions. An update on ClinG2 (policies) was requested for the next meeting – Action: Mark Powell.	None – risks to delivery to of GIAP tasks have been mitigated by review of delivery timeline.	Committee agreed completed actions as outlined. The revised Corporate Governance Framework is to be reviewed by ELT and Audit and Risk Committee prior to submission to the Trust Board on 27 July. It will also be discussed by the Board Committee Chairs at their next meeting. The revised timeline as outlined was agreed.	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 reason
Freedom to Speak Up - Whistleblowing Policy	Sam Harrison updated on actions relating to implementing processes and culture to encourage staff to raise concerns.	Update noted. Partial assurance received. Listen, Learn and Lead initiative was welcomed. Developing culture to encourage staff to raise concerns was supported. Further promotion of raising concerns to be undertaken – Action Sam Harrison. Sam Harrison to confirm the process set in place via NHS Whistleblowing helpline	None	Future reports to focus on confidence that correct approach is in place and on monitoring of policy. .	None
Terms of Reference	The updated terms of reference were presented and discussed	Comments noted on risk remit of the Committee – action for C Maley and S Harrison to further review the terms of reference – including covering reference to BAF. Delegated authority to Committee for sign off of annual report and accounts to be revisited, and reference to review by CoG to be incorporated. At 7.19 Quality Account to reference Quality Committee role.	None	The terms of reference were agreed subject to Chairs action re further emphasis of risk remit.	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 reason
Committee Assurance Summary Reports (Quality Committee and Mental Health Act Committee)	Assurance summaries from Board Committees were reviewed and noted.	BAF risks identified within the Quality Report were discussed. Further details were requested and Sam Harrison was asked to follow up with Claire Grainger. It was noted that these have been escalated to Board via integrated governance reporting.	None	Feedback to Committees re ensuring appropriate detail captured on assurance summaries.	None
Review of audited and final Annual Report including Quality Report and Annual Accounts 2015/16 – including summary of key changes from draft	The Committee noted all highlighted changes to the Annual Report, Annual Accounts and Quality Account including the Remuneration report changes. The Chairman raised queries and points of accuracy on content.	Comments from the Chairman were noted for incorporation into the final document by Anna Shaw. Updates to the Remuneration report were reviewed in detail and approved. Areas for emphasis were noted for inclusion in the Annual Review document to be produced over forthcoming weeks.	None.	Annual Report and Accounts, including Quality Account were agreed subject to final minor amendments to be made prior to sign-off and submission to Monitor by 27 May deadline.	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 reason
Letters of Representation	The Letters of representation (for both the Quality Report and Financial Statements) were reviewed.	The Committee confirmed and agreed the content of the letters as stated for signature.	None	The Letters of Representation were agreed for signature by Caroline Maley and Ifti Majid.	
Proposed opinion on the accounts **Proposed opinion on the FTCs (consolidation schedules)** **Audit Findings Report** **Report to Governors on the Quality Report 2015/16** **Quality Report opinion**	External Audit presented their reports and findings to the Committee.	The Committee received assurance that External Audit outlined a 'clean' audit and commented on good working with the Trust. It was agreed that further work should be carried out during 2016/17 audit re asset valuation. Action: Claire Wright. External auditors commented on good internal controls and effective working in relation to economy, efficiency and effectiveness. The qualified value for money opinion was outlined to relate to specific governance weaknesses previously identified within the Trust and are being addressed through the Governance	None	The Committee noted the External Audit opinions and findings.	

		Improvement Action Plan. An unqualified conclusion was given in respect of the Quality Account.			
Internal Audit Report Annual Report and Associated Opinions	The final version of the annual report and associated opinions from internal auditors was discussed.	The Head of Internal Audit Opinion of 'generally satisfactory with some required improvements' was noted and the Committee received assurance from this. This had not changed from the draft report received at the April Audit and Risk Committee.	None	The final Internal Audit Report and Opinion was noted and is reflected in the Annual Governance Statement.	None
Annual Counter Fraud Report	The Counter Fraud, Bribery and Corruption Annual report 2015/16 was discussed.	The Committee obtained assurance on the range of work undertaken and the conclusions that the Trust's counter fraud, bribery and corruption arrangements are embedded.	None	The Report was received and noted.	None
Final Approval of Annual Report and Accounts 2015/16	Caroline Maley confirmed that all documentation which would inform approval of the annual report and accounts had been reviewed by the meeting.	Assurance was received that due process had been followed in informing the decision to approve the annual reporting documents.		The Committee resolved to approve the annual report and accounts (including Quality Account) by delegated authority from the Board of Directors. It was agreed that the annual report and accounts, including quality account be duly signed by the Chairman and Chief Executive.	

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
2016/17 Forward Plan	The forward plan was noted.	It was agreed that Sam Harrison Caroline Maley would review on an ongoing basis.	None	Forward planner noted.	None
Meeting Effectiveness	All present were asked for feedback on the meeting.	John Morrissey, Lead Governor, welcomed that he had attended the meeting as an observer.	None	N/A	None

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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	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 policy.				
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	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	Responsiveness and waiting time. Patient experience and access.	Partial assurance received; require improved performance in this area. ELT to monitor performance via PCOG.	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)
Model		presented for assurance. 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	Addition of this significant risk to the BAF. Request a paediatric clinical strategy for transformation of this service offer and brief next month with estimated date of completion. 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)
			greater assurance.		
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
16 June 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	Some progress made - recognised the recent capacity issues within team Recognised the timing of the committee and the GIAP timeline of 30th June	Partial assurance	Capacity to prioritise GIAP	Review of resources to prioritise	See GIAP report
2.1 Actions from May					
HR2 Resource Plan	Resource Plan Discussion re. sufficient /capable resource to deliver GIAP	Assurance in the resources currently engaged Management trainer interviews to be held w/c 20/6 Jayne Storey Review of resources to support GIAP –Jayne Storey	Sufficient / capable resources to deliver the GIAP	Re-visit the resource plan Review of activities to release capacity	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 reason
PC2/4 People Plan for approval	Positive progress and refinement of the People plan noted. Discussed the project plan approach Discussion - level of detail and identified leads but recognised this did not prevent progress in a number of areas.	Partial assurance KPI's to be included – Rose Boulton Dates on plan to reflect end date not progress/update date – Rose Boulton Link with Remuneration Committee in respect of succession planning – Jayne Storey	Timescale to deliver against plan (recognised previously as a timing due to Trust strategy) and now to prioritise	Refine, add more clarity – leads and specific KPI's - July PC&C	None
PC3 Communications system to record feedback from staff	Following May paper last month - further clarity added (mechanisms) Identified and discussed the key link between communications and the Engagement group	Partial assurance Joined up approach with the engagement group required Anna Shaw/Sue Walters Incorporate within Engagement group and notes from group to be presented in July PC&C Anna Shaw/Sue Walters	Ensure lined up activities between communication and engagement Momentum	ELT discussion for resource Engagement group to meet 21st June	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 reason
W1 Freedom to Speak Up/Raising Concerns Action Plan	Reviewed refined plan discussed -in respect of both process and culture required Recognised the final end date as March 2017 with time lines specific to individual actions	Positive assurance	None	Progress noted and agreed to quarterly updates going forward	None
WOD7 Monitoring of Adherence to the grievance, disciplinary, whistleblowing policies	Positive progress recognised Robust tracker (ER) in place assured to be able to monitor cases Recognised difficulty to assure the 'adherence' to policy	Positive assurance on ER tracker Planned controls in place – training, coaching, reviewing policies but recognising the retrospective concerns to adherence Monthly overview of tracker required on forward agenda	Continued assurance of 'adherence' to policy – controls in place	Receive monthly the over view of the tracker and trajectory. Review outcome of internal audits	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 reason
2.2 Key tasks for delivery in June					
HR3/HR4/HR5 – HR Model, Structure and Metrics	Recognition that April PC&C received outline HR metrics June the model for HR delivery Reference to structure but no assurance on all HR3/HR4/HR5 being a cohesive document	Partial assurance One document to outline HR model, structure and metrics – to be received in July PC&C – Jayne Storey	Failure to deliver HR3, HR4, HR5 as one cohesive plan within GIAP timeline	Present as one paper to July PC&C	None
PC5 Comprehensive Communications plan to ensure Trust values are visible across the Trust	Recognised positive progress and need to align Engagement group	Positive assurance To discuss within the Engagement Group – Sue Walters	Momentum and alignment to the cultural change programme	Ensure a key agenda item on the Engagement group	None
WOD1 HR function to audit compliance against two selected HR policies	Discussion on the policies within internal audit and internal HR audit scope Agreed the Professional Registration Policy would be audited and one other by the end of June	Partial assurance Re-prioritise the Policy review timeline and deliver in line with plan – Owen Fulton Ensure JNCC aware – Rose Boulton	Failure to complete by end of June – mitigated by re-prioritisation	Complete by the end of June by re-prioritising and present in July PC&C	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 reason
WOD2 Review and ensure that recruitment and acting up policies are fit for purpose	No assurance at the time of the Committee offered Discussion of previous recruitment audit in 2015 and progress on streamlining – E-forms/E-DBS	Partial assurance Re-prioritise the Policy review timeline and deliver in line with plan - Owen Fulton Ensure JNCC aware – Rose Boulton	Failure to complete by end of June – mitigated by re-prioritisation	Complete by the end of June by re-prioritising and present in July PC&C	None
WOD6 Implement integrated team meetings	Verbal update that team meetings were in place and proposed integrated team meeting planned to take place in July	Partial assurance Confirmation that Integrated team meeting had taken place was required – Jayne Storey	That circumstances prevent the integrated team meeting to take place	Integrated team meeting to take place	None
WOD7 Ensure backlog of cases made know to CQC are concluded	It wasn't established which particular cases was referred to – however all the cases are on the tracker, the recent CQC inspection reviewed the tracker and specific cases The ER tracker will continue to be received by PC&C on a monthly basis	Neutral assurance Tracker recognised and progress on cases identifiable. Narrative to be provided to support future tracker submissions – Rose Boulton	The length of time cases are on tracker to resolve – mitigate by focussed activity, case management review approach and to feed into overall policy review.	The overview of the ER Tracker to continue to be presented monthly with narrative Consider additional resource to support back log	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 reason
Workforce Plan – progress update	Work in progress recognised and discussion on more depth being added, specific geographic and occupational group challenges and alignment to the refreshed Trust strategy	Partial assurance Completion of plan - Faith Sango / Liam Carrier Engagement with Mark Powell to alignment with Trust Strategy – FS/LC	Resource to complete within timeframe – mitigated with support from Health Education England	Completed plan to be presented at July PC&C	None
Equality and Diversity (EDS2) Update	Positive work recognised EDS2 is in progress and recognised risks identified Discussed the consultation planned, the Quality Committee EDS2 (1&2) and the need to bring together as draft in June for Board sign off in July	Partial assurance EDS2 to be consulted on - Owen Fulton/Paul Beardsley Submitted to board and commissioners –Owen Fulton/Paul Beardsley	Positive action required to address the risks within the EDS2	EDS2 to be approved through Quality Committee and PC&C and sign off in July 2016	None
HR Metrics	Positive discussion on presentation and triangulation Recognised Operational input required for assurance on progress (recruitment)	Positive assurance on HR metrics Operational narrative from TOMM/PCOG required for progress tracking – Carolyn Gilby	Potential risk identified on operational recruitment progress	Present HR Metrics with narrative from Operations on progress Board deep dive to include recruitment update and triangulation	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 reason
AOB	CQUIN – update on physical health	Mindful, health and well-being group tasked with developing the plan and to bring to July PC&C - Rose Boulton	Failure to deliver CQUIN	Overview of CQUIN delivery to be discussed as part of the Mindful, health and well-being group and report in July PC&C	None

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, 12 May 2016

PRESENT:	Maura Teager	Chair and Non-Executive Director
	Phil Harris	Non-Executive Director
	Carolyn Green	Director of Nursing and Patient Experience
	Dr John Sykes	Executive Medical Director
	Carolyn Gilby	Acting Director of Operations
IN ATTENDANCE:	Sue Turner	Board Secretary and Minute Taker
	Wendy Brown	Clinical Director
	Emma Flanders	Lead Professional for Patient Safety
	Carrina Gaunt	Health & Safety Manager
	Lesley Watson	Senior Capital Manager
	Rubina Reza	Research & Clinical Audit Manager
	Chris Fitzclark	North Derbyshire Voluntary Action
	Ruth Hingle	North Derbyshire Voluntary Action
	Nicola Smith	Observer from Hardwick CCG
For item QC/2016/083	Jenna Davies	GIAP Programme Manager
For item QC/2016/087	Allan Johnston	Consultant Psychiatrist and Chair of the DHCFT Suicide Prevention Strategy Group
For item QC/2016/087	Keith Waters	Director of Centre for Self Harm & Suicide Prevention
For item QC/2016/087	Richey Wheatcroft	Service User
For item QC/2016/091	Sam Kelly	Consultant Nurse
APOLOGIES:	Samantha Harrison	Director of Corporate Affairs and Trust Secretary
	Sarah Butt	Assistant Director of Clinical Practice and Nursing
	Rachel Kempster	Risk & Assurance Manager
	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
	Bev Green	Releasing Time to Care Lead (Service Improvement)
	Pam Dawson	Carer Forum

QC/2016/080	**WELCOME AND APOLOGIES** The Chair, Maura Teager, opened the meeting and welcomed everyone. Chris Fitzclark* and Ruth Hingle were particularly welcomed as this was the first meeting they had attended as representatives of North Derbyshire Voluntary Action. Maura Teager also welcomed Nicola Smith from the Hardwick Clinical Commissioning Group. * *Chris Fitzclark was previously a member of the Quality Committee as a representative of Derbyshire Voice.*
QC/2016/081	**MINUTES OF THE MEETING DATED 14 APRIL 2016** The minutes of the meeting held on 14 April 2016 were accepted and agreed.

QC/2016/082	**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. The Policy Actions Matrix was also reviewed and the Committee was pleased to receive a continuously improving level of assurance with the approval of updated policies. **RESOLVED: The Quality Committee was assured by the work that had taken place to update and approve outstanding policies.**
QC/2016/083	**GOVERNANCE IMPROVEMENT ACTION PLAN** Jenna Davies presented a report which updated the Committee with respect to its oversight of GIAP (Governance Improvement Action Plan) actions and provided an overview of the actions the Committee is responsible for seeking assurance on delivery. At the April meeting the Committee was assured by the paper which set out how the Quality Leadership Teams would increase their effectiveness as core quality governance forums and this specific task ClinG1 has been recorded as complete. As part of ClinG3 the Committee is required to review the Terms of Reference to ensure the clear alignment with the quality strategy and associated objectives, and ensuring a clear focus on seeking assurance. These were addressed at the meeting and recorded in item QC/2016/084 below. It was noted that also as part of ClinG3, the Committee is required by the end of June to ensure that the Quality Committee agenda is structured so that it focuses on topics to deliver quality strategy and goals. The Committee noted the actions outlined in the GIAP and was assured that actions are being implemented in a way that reflects the recommendations contained in the GIAP report. **ACTION: Agenda to be structured to focus on topics to deliver quality strategy and goals.** **RESOLVED: The Quality Committee received the report and was assured that actions outlined in the GIAP have been delivered within the timeframes agreed.**
QC/2016/084	**TERMS OF REFERENCE** Carolyn Green presented her report which set out the recommendations on changes to the Quality Committee's Terms of Reference, including membership, assurance and responsibilities. The paper also outlined the requirements of the GIAP, specifically the review of the Quality Committee and how it functions. The Committee carried out a detailed review of the Terms of Reference and agreed to the establishment of a Quality sub-group and the removal of risk management from the Quality Committee to the Audit Committee. The clarity in relation to the Audit and Risk Committee and People and Culture Committee was noted as was the removal of the links with the Mental Health Act Committee and Safeguarding Committee. In addition to Clinical Audit, explicit mention will be made to the Research & Development Governance Committee. Maura Teager expressed her concern that with just two Non-Executive Directors

	(including the Chair of the committee) this would, at times, prove challenging to the quoracy given that this was a monthly commitment. It was proposed that it should be maintained at two Non-Executive Directors plus the Chair role. Quoracy would still be the presence of two out of the three. This could then be reviewed in line with the governance review scheduled for December 2016 to include Safeguarding and Mental Health Act Committees. **RESOLVED: The Quality Committee:** **1) Received assurance on the development of a revisited terms of reference** **2) Scrutinised and challenged the revised terms of reference** **3) Authorised the recommended changes to the Quality Committee terms of in preparation of presentation to the Trust Board of Directors as part of a governance review.**
QC/2016/085	**SERIOUS INCIDENT END OF YEAR REPORT** Emma Flanders, Lead Professional for Patient Safety, provided the Quality Committee with information relating to all Serious Incidents (SIs) occurring during 2015/16. It was noted that there has been an increase of 8 incidents externally reported in April 2016, compared to March 2016. There has been an increase by one for catastrophic incidents, and an increase by two for major. There were no specific patterns or issues arising within the analysis of the major/ catastrophic incidents reported in April 2016. Duty of Candour has been reported on, both in the feedback from individual investigations and there have been no breaches in discharging our statutory Duty of Candour reported to commissioners at the end of April 2015. The matter that there were 21 current overdue actions from SIRI investigations was raised especially as the March report showed all actions resulting from SIs were complete. It was understood that this would change from time to time depending on the flow of incident reports but the Committee felt it was difficult to know how to interpret the flow of incidences and this was very difficult to predict. The single homicide incident when a substance misuse service user injected another substance misuse service user was discussed and it was understood there has been a trend of substance misuse users co-injecting and co-using very potent strains of heroin. Carolyn Green drew attention to the NRLS report and it was noted that the Trust's benchmarking reporting has reduced, and the organisation is in the bottom section of all trusts reporting incidents (there have been 1506 incidents reported over 6 month period per bed days). The Committee discussed the analysis and considered the changes in bed days which amounted to 28.1 per 1,000 bed days. The median for cluster is 38.62. This compares to 26.46 previous 6 months, cluster 31.1. Further scrutiny on whether the bed reduction and changes with Melbourne and Tissington have been formally registered with the NRLS data It was also noted that there has been an increase in access, admission, transfer, discharge (including missing patient. It was noted that NHS England had requested a reporting change and that all Kedleston absconsion information is now reported which is not in line with the NRLS standards. Which may indicate part of this reduction in performance when benchmarked against other trusts. Discussion centred around the NRLS report and death rate, there has been a significant improvement in performance and the data is now suggesting a return to average death rate, against national benchmark.

	Discussion centred around the NRLS report and whether the reporting of bed days was accurate. The Committee asked Emma Flanders to work with Rachel Kempster to carry out a review of NRLS data to establish whether NRLS have been notified of the Trust's reduction in beds and they would also assess whether the increase in admission and discharge issues is related to access to PICU beds. The Committee also discussed the fact that in March it was reported that the Trust was an outlier for sudden unexplained deaths. However, due to confidentiality the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) were unable to share the patient information although it is now understood that this benchmark only related too three patients who fell under this category, between 2011 and 2013 and the national sample size is 25 patients. Maura Teager felt the report provided assurance but that this was limited due to the overdue actions and asked for extra effort of the named leads to be tasked to complete overdue actions. **ACTION: Emma Flanders to work with Rachel Kempster to carry out a review of NRLS data to establish whether we have notified NRSL that we have reduced bed numbers. They will also assess whether the increase in admission and discharge issues is related to PICU beds.** **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 SI Group.**
QC/2016/086	**LIGATURE AUDIT AND ESTATES CAPITAL IMPROVEMENT PROGRESS** Carrina Gaunt presented her report which provided the Quality Committee with an update in relation to Ligature Risk Reduction being of high priority within the Health & Safety portfolio. The Committee noted that £150K was provided by the Trust Capital Action Team in order to undertake the ligature Risk Reduction works during 2015/16. Works have been undertaken in Radbourne Unit – Bedrooms and Bathrooms/toilets, Hartington Unit – Bedrooms and Bathrooms/toilets and Kedleston Unit – Bedrooms and Bathrooms/toilets to reduce a number of Red Risks. It was also noted that that the total cost to eliminate risks completely or reduce them to a satisfactory level, could require financial commitment of a further £300K. Carrina Gaunt drew attention to the development of an environmental hand over which is currently under review. This involves moving to a narrative patient safety assessment to ensure clinical record keeping and assessment to include the patient and their family more actively in line with shared clinical decision making to ensure that the environment is as safe as possible. She would also be meeting with the Head of Nursing to discuss this and how it will be fully embedded in practice. This was seen by the committee as a critical factor in the risk management to achieve safer environments. Carrina Gaunt described the work currently taking place to reduce the ligature point on doors and was asked to include a costing and feasibility study / risk assessment for doors in her next report which is due to be received by the Committee in three months' time. The Committee was assured by the level of progress made and recognised that a substantial amount of work was required to meet the required standard for ligature risk reduction. Maura Teager proposed that the costing for outstanding ligature risk reduction work be escalated to the Finance & Performance Committee to progress

	further risk reduction in these areas. **ACTION: Carrina Gaunt to include in her next report half year report costing and feasibility study/process for a risk assessment for doors. Costings for outstanding ligature risk reduction work to be escalated to the Finance and Performance Committee for consideration.** **RESOLVED: The Quality Committee approved the course of action to progress further risk reduction in these areas.**
QC/2016/087	**<u>SUICIDE PREVENTION STRATEGY</u>** Allan Johnston, Keith Waters and service receiver, Richey Wheatcroft presented the new Suicide Prevention Strategy which set out the aims for reducing the incidence of suicide across the Trust. The strategy sets out key strategic priorities and sought to illustrate why it is important, both in terms of how it relates to the wider national picture and suicide prevention research, and also how it relates to the individual experiences of service receivers. The Committee was pleased to note that the strategy contained significant input from service receivers, Derbyshire Voice and North Derbyshire Voluntary Action and acknowledged that suicide prevention is everyone's business. The Committee also recognised that the strategy contained some genuine challenges that were easily understood and recognisable both locally and against the national agenda. The Committee discussed how the media has a duty to report suicide and was assured that the Suicide Prevention team were working closely with Richard Eaton in the Communications team to ensure reporting is dealt with sensitively and in line with national guidance. Public Health England are leading suicide prevention and mental health trusts are very actively involved in promoting the suicide prevention message. Carolyn Green was concerned that there were some areas in the strategy that are not in part of the Trust's gift due to commissioning requirement which may put the Board at risk if not corrected. To confirm that all children's services would have this training is a significant commitment in light of operational challenges and needs to be revisited with commissioners in line with contractual requirements. Carolyn Green and Carolyn Gilby offered to provide feedback regarding operational aspects, contracting and commissioning directly to Allan Johnston. In addition to this, suggested amendments could also be forwarded from relevant members of the Committee directly to Richard Eaton so corrections can be co-ordinated. These included the removal of a named provider as this would be a breach of Standing financial instructions. To provide all training by 2017 although aspirational is challenging in terms of a pragmatic or achievable goal at this current time with operational and waiting list pressures. The strategy is also not aligned with the newly ratified supervision policy as the supervision requirements are different. It will also need to reflect strategy regarding the ligature reduction and risk policy which describes a minimum of annual checks with additional issues being addressed. It was agreed that key individuals, namely Carolyn Green, Carolyn Gilby and Carrina Gaunt would provide the narrative to support the strategy and provide accuracy on current position to inform the final strategy document. The Committee proposed that the training element of the Suicide Prevention Strategy

	would be referred to the People & Culture Committee. Maura Teager thanked Allan Johnston and his colleagues for taking the initiative and producing the Suicide Prevention Strategy and hoped they found the comments and advice useful. The Committee supported and agreed the strategy in principle and would commend the strategy to the Board. **ACTION: Training element of the Suicide Prevention Strategy to be referred to the People & Culture Committee.** **ACTION: Operational, contracting and commissioning aspects to be fed back directly to Allan Johnston by Carolyn Green and Carolyn Gilby. Ligature amendments to be provided by Carina Gaunt, these amendments will be forwarded directly to Richard Eaton and copied to John Sykes and Allan Johnston.** **RESOLVED: The Quality Committee** **1) Approved the Suicide Prevention Strategy in principle subject to amendments** **2) Agreed to support the launch and roll out of the strategy.**
QC/2016/088	**MENTAL HEALTH COMMUNITY TEAM WAITS FOR CARE CO-ORDINATION AND PAEDIATRICIAN RECRUITMENT** John Sykes presented his report which provided the Committee with an update on Community Paediatrics medical staffing. The Committee was concerned that there are approximately 1,000 children on the waiting list for assessment of possible autism and noted that two specialty doctor posts have been advertised. However, the Committee understood that this type of work was extremely specialised and recognised the challenge to fill these posts, further work was ongoing to review job plans in addition to working closely with Paediatricians at the Royal Derby. It was also noted that commissioners have contributed £300,000 for a 12 month period to help with waiting list pressures and this was seen as a positive solution. Carolyn Gilby pointed out that clinical risk will form part of the Integrated Performance Report submitted to this month's Board and ELT will monitor the waiting list via PCOG and she would discuss the relocation of staff to this area with David Tucker. The Committee requested that a paediatric clinical strategy for transformation of this service offer be the focus of a report received at next month's meeting that will show an estimated date of completion. The management of the waiting lists for care co-ordination with in the community based neighbourhood teams was also discussed. It was accepted that an underlying cause relating to waits is due to funding capacity and this has partially been improved due to an increase in funding. Long term sickness within the teams has been an issue and is mainly due to caseload and work-related stress. The Committee appreciated that a lot of proactive work is being carried on nurse and community practitioner recruitment and with universities and that a recruitment plan is being worked through the People & Culture Committee. It was accepted that long term work force planning needs to be addressed now especially as nursing bursaries will be ceasing imminently. **ACTION: John Sykes to provide a report to the next meeting on paediatric clinical strategy for transformation including an estimated date for completion.**

	ACTION: Carolyn Gilby to discuss the relocation of staff to Paediatrics with David Tucker **RESOLVED: The Quality Committee noted the update on waiting lists hoped to receive assurance on the effectiveness of waiting list management in due course**
QC/2016/089	**PATIENT EXPERIENCE ANNUAL REPORT** In the absence of Sarah Butt, Carolyn Green presented the report that updated the Committee using a range of data to demonstrate how we are learning and improving our services and our patients' experiences of their care. The report also provided an annual narrative position on the themes identified. The Committee considered that the report provided a good level of detail and analysis and was pleased to note the increasing assurance in patient experience. It was also pleasing to note the high standards of medication management applied by newly qualified staff and the Committee suggested that they, with their preceptors, be invited to talk to the Board as part of a Board story. The Committee considered this to be a very coherent report and noted the key themes and increasing level of assurance in a number of areas. The Committee also noted the additional paper that detailed the information for service receivers and their carers and received and approved this approach. **RESOLVED: The Quality Committee** **1) Accepted the Patient Experience Annual Report** **2) Approved the approach for providing information for service receivers and their carers** **3) Requested the Heads of nursing organise a staff focussed 'Ward to Board' story on being a newly qualified nurse in DHCFT.**
QC/2016/090	**FACILITATING THE MAAASTRICT APPROACH** Carolyn Green presented her report that provided the Committee with assurance on the compliance with a pilot project to enable self-care and recovery initiatives to be tested (2014/15 reporting in 2016). The Committee recognised this was an aspirational project and that learning from the pilot and the outcome of the project had been achieved but due to the lack of quality outcomes it was not financially viable to implement it any further without additional funding. **RESOLVED: The Quality Committee:** **1) Noted the complexity of the report and the findings of the pilot model and recommendations.** **2) Received assurance on the Trust's position and completion of the work plan.**
QC/2016/091	**CARE PLANNING AND PERSON CENTRED CARE PROJECT PERFORMANCE UPDATE ON THE TRUST QUALITY PRIORITY** Sam Kelly attended the meeting and provided an update on behalf of the Person-centred Care and Care Planning Task Group. Sam Kelly explained that the care plan group has been exploring the development of a revised approach to care delivery, recording and audit across the varied and

	expansive services of the Trust and was developing a system which is mutually accessible and capitalises on the opportunities of the two EPR (Electronic Patient Record) systems to improve the experience, effectiveness and approach to care delivery – a Universally Accessible Electronic Care Record. Particular attention was drawn to the 'little red book' which provides a reference point for how the care record will function within the EPR. The Committee understand that ease and familiarity of this approach will be pivotal to its success as this will orientate people to how to complete the record. Maura Teager was impressed with the ambition of the Care and Care Planning Task Group and the proposal was agreed on behalf of the Committee. She also asked that the next performance update brought to the Committee should highlight the risks of not carrying out this project. **ACTION: Next Care Planning and Person Centred Care Project Update Report to highlight the risks of not carrying out this project – due November.** **RESOLVED: The Quality Committee noted the contents of the report and approved the proposal.**
QC/2016/092	**POSITIVE AND SAFE POLICY** The Positive and Safe Management of Violence and Acute Psychological Distress Policy and Procedure was presented to the Committee by Carolyn Green. This policy had been re-written to be compliant with the Code of Practice and it was thought that the recent experience concerning an inpatient had an impact on the way the policy had been written, as well as staff feedback on their support and what they wanted to see in a policy, including prosecution where appropriate. The Committee approved the policy and recognised the complexity and statutory requirements, training and skill level required in implementing its requirements. **RESOLVED: The Quality Committee approved the Positive and Safe Policy.**
QC/2016/093	**CLINICAL AUDIT FRAMEWORK POLICY & PROCEDURES** The Clinical Audit Framework Policy and Procedures was submitted to the Committee for approval by Rubina Reza. The Committee identified the significant additions and approved the implementation of the policy. **RESOLVED: The Quality Committee approved the Clinical Audit Framework Policy and Procedures.**
QC/2016/094	**ITEMS INCLUDED FOR INFORMATION** The following items were received and noted by the committee: • Quality Leadership Team draft minutes • Terms of Reference for the Children and Young People's Services
QC/2016/095	**FORWARD PLAN** The forward plan was noted and would be updated in line with today's discussions and would also take into consideration the refocus on the structuring of future agenda in line with GIAP actions.
QC/2016/096	**ITEMS ESCALATED TO THE BOARD OR OTHER COMMITTEES**

	• Costing for outstanding ligature risk reduction work to be escalated to the Finance & Performance Committee • Training element of the Suicide Prevention Strategy would be referred to the People & Culture Committee • Suicide Prevention Strategy to be recommended to Trust Board with agreed amendments.
QC/2016/097	**ANY OTHER BUSINESS** Carolyn Gilby informed the Committee that during recent interviews as part of the recent homicide incident investigation she had been asked how the Trust provided feedback to individuals. She explained that feedback was often invited as part of the process but feedback was not always given to individuals concerned. Carolyn Gilby suggested that best practice going forward should be that if someone is interviewed as part of an investigation process, feedback should be provided to them as an automatic part of the process. This approach was supported and endorsed by the Committee.
QC/2016/098	**EFFECTIVENESS OF THE MEETIING** It was felt that good discussions were held. However, Maura Teager questioned whether this was always at the right level and whether the Committee membership contains the right composition of attendance. Maura Teager also reiterated that the agenda for June will be prioritised to be more structured in line with ClinG3 in the GIAP. The Committee was pleased to note that a commissioner had been in attendance and they confirmed that this gave them a much better understanding of the Trust's services.

Date and Time of next meeting: The next meeting of the Quality Committee will take place on:
Thursday,23 June 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, 18 May 2016

PRESENT:	Phil Harris	Delegated Chair and Non-Executive Director
	Maura Teager	Non-Executive Director
	Jayne Storey	Director of Workforce, OD & Culture
	Mark Powell	Director of Business Development & Marketing
	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
	Rose Boulton	Principal Workforce & OD Manager
	Liam Carrier	Workforce Systems & Information Manager
	Anna Shaw	Deputy Director of Communications
	Robert Quick	Governor, North East Derbyshire
	Sue Walters	Senior Staff Engagement Project Lead
APOLOGIES:	Richard Gregory	Chairman

P&C/2016/043	**WELCOME AND APOLOGIES** In Richard Gregory's absence, Phil Harris opened the meeting, welcomed everyone and introductions were made around the table. Robert Quick was particularly welcomed as this was the first meeting of the Committee he had attended.
P&C/2016/044	**MINUTES OF THE PREVIOUS MEETING, ACTION MATRIX** Minutes of the meeting held on 17 March 2016 were approved with the following amendment: **P&C/2016/034 Sickness and Absence Deep Dive:** This sentence would be amended to read "Due to the large number of agenda items it was agreed to defer this item to the next meeting in May".
P&C/2016/045	**GOVERNANCE IMPROVEMENT ACTION PLAN** Mark Powell presented the People and Culture Committee with an update in respect to its oversight of GIAP actions and provided an overview of the actions the Committee is responsible for seeking assurance on delivery. 1. **GIAP W1 Freedom to Speak Up Action Plan – Raising Concerns Policy:** Sam Harrison the current lead for Raising Concerns identified the work carried out so far on the Freedom to Speak Up Action Plan and informed the Committee that Jim Dixon had been appointed as the Lead Non-Executive Director to receive concerns and that Carrina Gaunt was the Trust's newly appointed Freedom to Speak Up Guardian. The Committee agreed that it was important that Carrina Gaunt should receive the right level of support and training and it was agreed that Lee Fretwell would work with Sam Harrison to develop mechanisms to support her in this role.

	Robert Quick reiterated the role of the Staff Governors as an important link for staff to raise concerns. It was agreed that the Freedom to Speak Up action plan had been superseded by the GIAP and further detail on the action plan would be brought back to the next meeting of the Committee in June in order to assess the robustness of progress made. **ACTION: Further Freedom to Speak Up Action Plan to be an agenda item for June meeting.** 2. **GIAP PC3 Internal Communications Approaches and Plans Going forward:** Anna Shaw presented her report and outlined existing internal communication mechanisms that are in place across the Trust and the internal communications objectives currently agreed for the organisation. She also provided suggestions for further activities going forward, to be developed in line with both the requirements of the GIAP and the final year's plan of activities for the Communications Strategy. The Committee discussed the range of established internal mechanisms that can be consolidated and utilised to their best advantage and it was proposed that Anna Shaw will work closely with Sue Walters, Senior Staff Engagement Lead to develop this perspective further. The Committee was assured that good progress was being made with the Comms plan. The system to record feedback from staff would be developed further. However, it was understood that this could not be delivered with current resource and the need for additional resource or the reprioritisation of the activities of the Comms team would be addressed at ELT. **ACTION: Sam Harrison to address Comms Team resource at ELT** 3. **GIAP PC5 Review of the Trust values including engagement plan:** Sue Walters provided an update on progress and initial plans to support the cultural change programme and engagement. The Committee discussed how behavioural quality tools can be used to ensure behaviour change and considered that in order to facilitate positive behaviour the in-house expertise of psychologists would be useful. The Committee acknowledged that delivery of the engagement plan is in development (tasks 2 and 3) and task 1 (review of the Trust's values) was complete. 4. **GIAP WOD3 HR and OD Development Plan and GIAP WOD6 HR and OD Pulse Check:** Jayne Storey shared with the Committee a high level approach to ensuring the HR and OD functions are effective. She explained that the team had completed an initial 'pulse check' which contained a mixture of responses and feelings. Jayne Storey was assured that sufficient information has been obtained to take this on board and work was under way to develop a development plan. The Committee was satisfied that the report set out a clear measure of the proposed plan and was on track for completion. 5. **GIAP WOD 7 Monitoring of Adherence to the grievance, disciplinary, whistleblowing policies:** Jayne Storey provided a verbal update on plans to produce a monitoring system for the adherence to the grievance, disciplinary and whistleblowing policies. Due to the difficulties with anonymity the data contained in the spread sheet could not be circulated to members of the Committee. The committee was informed that Peter Charlton was in the process of developing an automated tracking system for this data and this would be the basis of a

	document brought to the Committee at a later date. As there was no report provided for this task, it was agreed that in order to obtain confidence that a process is in place to determine a monitoring system, Maura Teager would be given a short demonstration of the on line data at the end of the meeting. In addition the internal auditors would carry out a review of the system. The Committee was assured that a process was currently in place but this process does not currently monitor adherence and further work is required. As a result, the Trust's internal auditors will be tasked with providing the Committee with the assurance that the monitoring system is being developed. In addition this GIAP task would be a standing agenda item to ensure completion of the action. **ACTION: WOD7 Monitoring of Adherence to the grievance, disciplinary, whistleblowing policies would be a standing agenda item to ensure this system is followed up.** **ACTION: The Trust's internal auditors will provide reports containing timelines to provide the Committee with the assurance that the monitoring system is being developed.** **ACTION: Maura Teager to review the tracker and offer the Committee NED assurance** ***Post Meeting Note:*** *Maura Teager established she was assured by the line tracking system demonstrated to her and the data it contained regarding adherence to the grievance, disciplinary, whistleblowing policies. This would be added to the minutes as a post meeting note.* 6. **GIAP CQC2 Recruitment of operational vacancies and communications plan:** Carolyn Gilby's report outlined plans and strategies to improve the Trust's success in recruiting staff. Discussions took place on the approach to be explored to improve recruitment. The Committee was pleased to see evidence that showed that staffing levels in clinical areas had improved due to newly appointed clinical staff and that a significant amount of graduate student nurses would be recruited in September. It was suggested that contact be maintained with student nurses to "keep them warm" and regularly provide them with information. The Committee also acknowledged the importance of focussing on a staff retention strategy. Discussion took place on preceptors. It was considered that more could be done proactively on preceptorships and it was agreed that Lee Fretwell from Staff Side will meet with Carolyn Gilby to resolve this. The Committee acknowledged that the recruitment plan was aspirational and Carolyn Gilby proposed to provide an update report at the September meeting which will give a clearer indication of the achievement of the recruitment plan. It was agreed that this task was complete and the Committee adopted the trajectory to the recruitment plan. In the meantime, a caveat would be applied to this task to stating this is an aspirational task and an early warning system will be applied. Anna Shaw informed the Committee that Task 3 to develop and implement an internal communications plan which supports pro-active recruitment would be extremely difficult within the current resource of the Comms team. **ACTION: Progress report on recruitment to be submitted to the September**

	meeting and an "early warning system" applied to the task. **ACTION: Lee Fretwell and Carolyn Gilby will meet to improve the management of preceptorships.** **RESOLVED: The People & Culture Committee noted the progress made to date on the actions it is responsible for seeking assurance on delivery within the GIAP.**
P&C/2016/046	**<u>TERMS OF REFERENCE</u>** The revised terms of reference were reviewed by the Committee. It was agreed that the membership of NEDs on Board committees would be standardised and a paragraph would be included in the terms of reference to reflect roles in overseeing the Trust strategy and GIAP actions. It was agreed that Sam Harrison would work with Jayne Storey to add reference to the assurance summaries produced for the Board at each meeting. **ACTION: Sam Harrison to amend the TOR to reflect the standardisation required and Jayne Storey would work together to add reference to the assurance summaries produced for the Board.** **RESOLVED: The People & Culture Committee accepted the revised terms of reference subject to the amendments raised.**
P&C/2016/047	**<u>RESOURCE PLAN UPDATE</u>** Jayne Storey provided the Committee with a brief update on the resource plan. It was noted that there are currently six roles that will be appointed to provide additional capacity and Jayne Storey was confident these would be appointed although one role was at risk of not being completed by the end of May. **RESOLVED: The People & Culture Committee noted the verbal Resource Plan Update.**
P&C/2016/048	**<u>DRAFT PEOPLE PLAN</u>** Jayne Storey presented her report which confirmed the supporting People Plan for 2016/17. Following the discussion at the last meeting in April the approach to the People Plan was agreed and it was acknowledged that it would be aligned with the Trust strategy and will change as priorities and measurements develop. For this reason Jayne Storey intended to present the People Plan to the Committee on a quarterly basis. It was agreed that Jayne Storey would hold separate meetings outside of the meeting to discuss with Anna Shaw actions identified for the Comms Team. She would also discuss the operational structure with Carolyn Gilby. The Committee agreed that further work was required on the People Plan and due to the detail and length it was not entirely clear on what was being reported at this meeting. There was more work to be carried out and it was considered that this plan was in danger of being seriously off track. For this reason, the Committee asked that Jayne Storey's next report provide further clarity and define ownership of actions. This would be articulated to the Board through the assurance summary received at next Wednesday's Board meeting. Jayne Storey assured the committee that activities were still being carried out despite not being in a format to track at this stage and would re-visit the plan. Given the timescales and other priorities it was acknowledged that this may not be complete in time for June P&C The Committee agreed the Draft People Plan in principle but acknowledged this was

	not a completed plan and would stay rated as red "off track" on the GIAP. It was noted that a final, detailed People Plan might be received at the next meeting in June. **ACTION: Final People Plan anticipated at next meeting in June.** **RESOLVED: The People & Culture Committee received the draft People Plan and noted that a final version might be received at the June meeting.**
P&C/2016/049	**<u>SICKNESS AND ABSENCE DEEP DIVE</u>** The deep dive into sickness and absence had been due at the last month's meeting and was based on information as at February 2016. It was recognised that matters have moved on since then and the HR metrics in the next item provide evidence of this. The report provided the following: • A Trust wide overview of sickness absence • Detailed analysis of sickness absence by Staff Group and Work Area • Analysis of sickness absence by reason • Focus on three key areas within the Trust Discussion took place on the three key clinical areas within the Trust where sickness absence levels are high (Cubley Male, the Lighthouse and Ward 2) to establish whether the level of sickness absence had had an effect on patient experience. It was noted that some instances of aggression experienced in Cubley Male had been attributed to the stress levels of staff especially as the ward was at full capacity and this has had an impact on staff resilience. It was thought that the closure of Tissington House and the redeployment of staff also had had an impact on patients as redeployed staff were unfamiliar in these areas. The Committee considered this to be a very informative report. It was acknowledged that a deep dive into sickness and absence levels was received by the Board in October and was further scrutinised by the Finance & Performance Committee. A further deep dive in vacancies, sickness and recruitment is due to take place at the June Board meeting. It was agreed that the Health and Wellbeing Group would scrutinise the movement of sickness absence and would report on the consequences to the Committee. Sickness absence in these areas would also be brought to the attention of the Quality Committee due to the impact this was having on patient experience. **ACTION: Health & Wellbeing Group to report on the consequences of sickness absence to the Committee.** **RESOLVED: The People & Culture Committee :** **1) Acknowledged the Deep Dive Report and current position in relation to sickness absence** **2) Provided continued support for preventative work around resilience.**
P&C/2016/050	**<u>HR METRICS</u>** The Workforce KPI Dashboard provided the Committee with the latest key Workforce metrics at Trust level and the next steps to be followed. The Committee noted the following: • The workforce was stable. The number of staff leaving each month remains

	static at an average of 21 employees per month (the reduction in contracted staff to post has caused an increase in recent turnover rates). • The annual sickness absence rate was lower than in the previous month. • The number of employees who have received an appraisal within the last 12 months has decreased overall. • Compulsory training compliance rates have risen significantly during the previous nine months. • Work is underway to develop a hot spot and triangulation focus list that will identify wards/teams most in need of attention. The Committee asked that the term "less than optimum performing" be used rather than "worst performing" when reporting on areas in need of support and attention. Carolyn Gilby informed the Committee that a paper on case load sizes and work related sickness was received by the Quality Committee at the May meeting and focussed on how case loads and waiting lists were managed in the community teams. This piece of work established that three people were absent due to work related stress in the community and there was no correlation between case loads and work related stress contained in 2016/17 data. It was suggested that this report to the Quality Committee be sent to Liam Carrier for reference. **ACTION: Liam Carrier to receive the Operational Management of the Waiting Lists for Care Co-ordination report.** **RESOLVED: The People & Culture Committee scrutinised and noted the information contained in the HR Metrics report.**
P&C/2016/051	**FORWARD PLAN** The forward plan would be updated in line with today's discussions and presented for reference at the next meeting of the Committee. The committee discussed the need for the forward plan to establish when reports from the sub-groups are received.
P&C/2016/052	**ITEMS ESCALATED TO THE BOARD** The following items are to be escalated to the Trust Board meeting: - • The insufficient resource of the Comms team or the reprioritisation of the activities of the Comms team would be addressed at ELT • Levels of sickness absence and the effect on patient experience to be brought to the attention of the Quality Committee.
P&C/2016/053	**IDENTIFIED RISKS** The committee identified the key risks as follows: • Communications team resource and capacity
P&C/2016/054	**EFFECTIVENESS OF THE MEETING** Good discussions were held during the meeting. It was recognised that this was only the fourth meeting of the Committee and it was considered that effective discussions took place, especially during the review of GIAP actions and tasks.

	The agenda for the June meeting would have to be carefully managed to take account of the number of GIAP tasks/actions to be reviewed.
Date and Time of next meeting: The next meeting of the People & Culture Committee will take place on **Thursday, 16 June 2016 at 2.00 pm in *Meeting Room 2 – Albany House, Kingsway, Derby.***	

MINUTES OF THE EXTRAORDINARY INTERIM MEETING OF MENTAL HEALTH ACT COMMITTEE MEETING HELD ON WEDNESDAY, 11 MAY 2016 MEETING ROOM 1, ALBANY HOUSE, KINGSWAY, DERBY

PRESENT:	Maura Teager	Delegated Chair and Non-Executive Director
	Jim Dixon	Non-Executive Director and Deputy Trust Chair
	Dr John Sykes	Medical Director
	Sam Harrison	Director of Corporate Affairs & Trust Secretary
IN ATTENDANCE:	Sue Turner	Board Secretary and Minute Taker
APOLOGIES:	Richard Gregory	Chair

MHA 2016/013	**OPENING REMARKS** This extraordinary and interim meeting was attended by the Committee's Executive Directors and Non-Executive Directors only. The purpose of the meeting was to progress outstanding actions and the approval of policies.
MHA 2016/014	**MINUTES FOM THE MEETING HELD ON 30 MARCH 2015** The minutes of the meeting held on 30 March were agreed and accepted, subject to the details of today's meeting being added to the date of the next meeting section of the minutes.
MHA 2015/015	**MATTERS ARISING FROM THE ACTIONS MATRIX AND THE MINUTES** It was agreed to close all completed actions and updates provided by members of the Committee and were noted directly to the matrix.
MHA 2015/016	**CQC VISIT REPORT AND CQC VISIT PLAN** Christine Henson's report provided the Committee with details of the CQC report in respect of recent unannounced visits to Cherry Tree Close, Morton Ward and the Hartington Unit, together with the action plan produced by the Trust. The Committee recognised that some progress had been made in key areas and the report identified good practice. However the following concerns were raised: • Section 17 leave forms had not been signed by patients and there was no evidence that a copy of the form was given to the relevant people. This was seen as a potential breach of the Human Rights Act and considered a specific risk by the Committee • The same issues are being repeated • Should be one named responsible manager rather than four • Nominated individual to be updated to Ifti Majid, Acting Chief Executive. **ACTION: Report to June meeting to confirm action taken or identify where there are issues with progress.** **RESOLVED: The Mental Health Act Committee noted the report and approved the action plan.**
MHA 2015/017	**SECTION 12 DOCTORS SERVICE UPDATE**

	John Sykes presented his report which set out the proposal for Section 12 Doctor availability. It was recognised that the present system was unsatisfactory as delayed assessments could increase risk in vulnerable individuals. The Committee approved the pilot model service which would run for a one month period and would provide consistency and flexibility along with a net saving to the Trust. It was agreed that John Sykes would provide feedback on the pilot programme at the November meeting. **ACTION: Feedback on the pilot programme to be provided at the November meeting along with feedback on success criteria.** **RESOLVED: The Mental Health Act Committee endorsed the proposal of a pilot service trial.**
MHA 2015/018	**REVIEW OF POLICIES REQUIRED BY THE REVISED MENTAL HEALTH ACT 1983 AND CODE OF PRACTICE 2015** John Sykes presented to the Committee an update on the report previously submitted in November 2015, on compliance of the Trust with the policies, procedures and guidance which the Code of Practice requires should be in place locally. The Committee reviewed the spreadsheet that listed the policies where approval was still outstanding and agreed that Rachel Kempster would be given the authority to pursue the revision of all outstanding policies to ensure they can be submitted to the next meeting on 3 June for ratification. The Committee recognised that significant progress had been made in reviewing policies to ensure they are in line with the Code of Practice but noted that some policies still need to be revised to ensure they are compliant. **ACTION: John Sykes to inform Rachel Kempster of the Committee's support to ensure all outstanding policies are brought to the June meeting for approval.** **RESOLVED: The Mental Health Act Committee** **1) Received limited assurance that significant progress has been made to ensure policies are compliant with the Code** **2) Agreed to receive all outstanding policies at the next meeting**
MHA 2015/019	**MENTAL HEALTH ACT SECTION 132 RIGHTS POLICY AND PROCEDURES** The report set out the guidance contained in the policy provided to Trust staff when explaining the rights to detained patients or patients subject to a Community Treatment Order as defined by the Mental Health Act 1983. The Committee approved the policy in principle and agreed that John Sykes would arrange for the policy to be updated with minor amendments to the informal patient section to state that patient consent and capacity is recorded and their rights are explained to them within 24 hours or as soon as possible, their health allowing. **ACTION: Policy to be amended to state that patient consent and capacity is recorded and patient rights are explained to them within 24 hours or as soon as possible allowing for their health.** **RESOLVED: The Mental Health Act Committee received and ratified the policy, subject to the amendments as outlined.**

MHA 2015/020	**<u>MENTAL HEALTH ACT 1983 HOSPITAL MANAGERS SCHEME OF DELEGATION POLICY AND PROCEDURES</u>** The Mental Health Act 1983 allows the Hospital Managers to delegate certain functions to Officers of the Trust. The report accompanying the policy set out the scheme of delegation agreed by the Trust. The Committee agreed that the following amendments would be made to the policy prior to it being resubmitted to the next meeting on 3 June for ratification: • John Sykes to include paragraph to describe how the duties of the Responsible Clinician are allocated • Jenna Davies to provide a narrative to define the role of the Associate Hospital Managers • Section 2.12 to be amended to show delegation of age appropriate services to the Director of Operations. **ACTION: Policy to be amended and brought back next meeting on 3 June.** **RESOLVED: The Mental Health Act Committee received the policy and agreed it would be amended and resubmitted to the next meeting on 3 June.**
MHA 2015/021	**<u>LOCKING OF DOORS ON OPEN WARDS ALL UNITS POLICY AND PROCEDURES</u>** The Locking of Doors on Open Wards all Units Policy and Procedures was presented to the Committee for ratification. The Committee agreed that the policy would be amended subject to typographical errors and amendments by Sarah Butt as follows: • The summary would be corrected to show it has incorporated issues surrounding the Mental Health Act Code of Practice Mental Capacity Act and DoLs. • The monitoring section would be clarified to demonstrate how lock down is regularly reviewed as John Sykes was of the view that lock down should be reviewed immediately. Once the policy has been amended it will be resubmitted to the next meeting on 3 June for ratification. **ACTION: John Sykes to liaise with Sarah Butt on the detail/amendments to the policy.** **RESOLVED: The Mental Health Act Committee received the policy and agreed it would be amended and resubmitted to the next meeting on 3 June.**
MHA 2015/022	**<u>PROTOCOL FOR CONVEYANCE OF SERVICE RECEIVERS SUBJECT TO THE MENTAL HEALTH ACT 1983</u>** The protocol for conveyance of service users was received for the Trust to adopt as its procedure for transporting patients. The Committee reviewed the protocol and agreed for it to be signed by John Sykes on behalf of the Trust. **RESOLVED: The Mental Health Act Committee adopted the Protocol for Conveyance of Service Users**

MHA 2015/023	**FORWARD PLAN** The Committee agreed that the forward plan would be reviewed by John Sykes and Sam Harrison. Forward plan would also be updated to reflect feedback on the pilot service for Section 12 Doctors received at the November meeting and feedback received on Conveyance Policy in March 2017. **ACTION: Forward Plan to be reviewed by John Sykes and Sam Harrison and updated in line with today's discussions.** **RESOLVED: The Mental Health Act Committee reviewed the Forward Plan.**
MHA 2015/024	**ISSUES ESCALATED TO BOARD, AUDIT COMMITTEE OR OTHER BOARD COMMITTEES** No issues were escalated, although the John Sykes agreed to draw Richard Gregory's attention to the need for a chair to chair discussion regarding the need for Chesterfield Royal being designated as a place of safety.
MHA 2015/025	**MEETING EFFECTIVENESS** The Committee made good progress with closing actions and the ratification of policies and looked forward to holding effective discussions with a full representation of members at the next meeting on 3 June.
DATE OF NEXT MEETING **Friday, 3 June, 2016 at 10.00am, Meeting Room 1, Albany House, Kingsway site.** *If you are unable to attend, please advise your apologies to Sue Turner, Board Secretary, extension 31203, for recording in the minutes.*	

MINUTES OF THE AUDIT & RISK COMMITTEE HELD ON THURSDAY, 28 APRIL, 2016 AT10.30 AM HELD IN MEETING ROOM 1, ALBANY HOUSE, KINGSWAY, DERBY DE22 3LZ

PRESENT:	Caroline Maley	Chair/Senior Independent Director
	Phil Harris	Non-Executive Director
IN ATTENDANCE:	Jim Dixon	Deputy Trust Chair and Non-Executive Director
	Claire Wright	Executive Director of Finance
	Sam Harrison	Director Corporate Affairs and Trust Secretary
	Rachel Leyland	Deputy Finance Director
	Stacey Forbes	Financial Controller
	Rachel Kempster	Risk and Assurance Manager
	Alison Breadon	PricewaterhouseCoopers
	Mark Stocks	Engagement Lead Grant Thornton
	Joan Barnett	Engagement Manager Grant Thornton
For items AUD 2016/041	Clare Grainger	Head of Quality & Performance
For items AUD 2016/041	Anna Shaw	Deputy Director of Communications & Involvement
	Sue Turner	Board Secretary and Minute Taker

WELCOME AND APOLOGIES The Chair, Caroline Maley opened the meeting and welcomed everyone present. She also welcomed Jim Dixon who would be attending Audit & Risk Committee meetings until a replacement Non-Executive Director for Tony Smith is appointed, although he is unable to attend the next meeting in May.	
AUD 2016/035	**MINUTES OF THE AUDIT & RISK COMMITTEE MEETING DATED 16 MARCH 2016** The minutes of the meeting held on 16 March were accepted and approved as an accurate record of the meeting subject to an amendment to item AUD2016/035 Exception Reporting. The sentence "The Committee was assured there were no exceptions to report on Losses and Compensations, Hospitality and Sponsorship or Debtors and Creditors" was substituted with *"The Committee noted there were no exceptions to report on Losses and Compensations, Hospitality and Sponsorship or Debtors and Creditors".*
AUD 2016/036	**ACTION MATRIX** All updates provided by members of the Committee were noted directly to the matrix.
AUD 2016/037	**GOVERNANCE IMPROVEMENT ACTION PLAN (GIAP)** Mark Powell presented his paper which set out the role of the Committee with respect to its oversight of GIAP actions and provided an overview of the actions that the Audit & Risk Committee is responsible for seeking assurance on delivery. However, it was acknowledged that CG12 (Reintroduce short summary reports from Committee chairs to the Board to supplement minutes.) would be re-rated from blue to amber as the Board had suggested that an additional column be included to the assurance

	summary template to request why the Board should address the particular issue being escalated. The Committee noted that some of the timeframes contained in the GIAP relating to the Corporate Governance Framework were not realistic. It was agreed that Sam Harrison will provide a paper for the May Board meeting that will set out the reasons for implementing revised timeframes. This re-planned framework will be received by the Audit & Risk Committee in May prior to the May Board. In the meantime, Sam Harrison would keep Caroline Maley updated as to the programmes and an updated GIAP showing the new time frames will be received at the May meeting. The Committee briefly reviewed all of the 22 GIAP key tasks that it will be responsible for seeking assurance on delivery and noted the progress made, and approved completed actions as outlined.. Mark Powell informed the Committee that the next GIAP paper received by the Committee in May will describe how actions have been completed / progressed and the updated version of the GIAP will show details of the impact of the effectiveness of task progress in the Board Assurance rating column. **ACTION: Sam Harrison will provide a paper setting out revised GIAP timeframe of tasks/actions for the May Audit & Risk Committee and May Board meeting.** **ACTION: Updated report and GIAP to be submitted to the May meeting by Mark Powell.** **RESOLVED: The Audit & Risk Committee received the report and approved the completed actions as outlined..**
AUD 2016/038	**GOING CONCERN ASSESSMENT** The Trust is required to include in the 2015/16 Annual Report a statement as to whether or not the financial statements have been prepared on a going concern basis and the reasons for this decision, with supporting assumptions or qualifications as necessary. Claire Wright presented her paper which summarised the key reasons in support of this assessment which provided the Committee with the assurance to assess the Trust as a Going Concern. Alison Breadon advised that in future the report should contain more evidence of cash headroom which Claire Wright agreed to complete for the next report. Grant Thornton confirmed their acceptance of the detail contained in the report, subject to the completion of their audit work. The Committee was assured on behalf of the Board that it had received sufficient information to assess the Trust as a going concern. **RESOLVED: The Audit & Risk Committee:** **1) Received the going concern assessment for 2015/16** **2) Confirmed that the Committee had sufficient evidence to assess the organisation as a Going Concern** **3) Agreed that the financial statements should be prepared on that basis**
AUD	**2015/16 NHS SBS ISAE3402 EFFECTIVENESS OF CONTROLS REPORTS**

2016/039	Claire Wright presented her paper that provided the Audit & Risk Committee with oversight of the assurance on effectiveness of controls for SBS finance and accounting and employment services. The Committee received strong external assurance that all SBS controls had been tested and were satisfactory. **RESOLVED: The Audit & Risk Committee noted the reports and gained assurance from the unqualified opinions**
AUD 2016/040	**<u>REVIEW OF DRAFT ANNUAL ACCOUNTS</u>** Rachel Leyland presented to the Committee the draft Annual Accounts which had been submitted to Monitor and External Auditors. Observations made by Caroline Maley and members of the Committee were noted directly to the draft by Rachel Leyland. Caroline Maley thanked Rachel Leyland and Stacey Forbes for their good work and looked forward to receiving the final version of the annual accounts at the next meeting in May. **RESOLVED: The Audit & Risk Committee reviewed the draft Annual Accounts.**
AUD 2016/041	**<u>REVIEW OF DRAFT ANNUAL REPORT (INCLUDING QUALTY REPORT) AUDITED ANNUAL REPORT AND DRAFT ANNUAL GOVERNANCE STATEMENT</u>** Anna Shaw presented the working draft annual report to the Committee which shared the progress made to date on the content for the 2015/16 Annual Report. Amendments made to the annual report were noted by Anna Shaw who will present a final report to the next meeting of the Committee. Sam Harrison to review the Remuneration Committee narrative on the activity in the year. Claire Wright, Sam Harrison and Anna Shaw to review the commentary on the remuneration report and where all the information is shown concerning the ET and its outcomes, and to meet with Grant Thornton to clarify compliance with the ARM. Clare Grainger attended the meeting to present the Quality Report which had been written as a stand-alone document. She informed the Committee that helpful comments had been made by governors when the Quality Report was reviewed by governors at the Governance Committee meeting held on 12 April. Jim Dixon felt that the Acting CEO statement was too long and lost some of its impact. Sam Harrison advised caution around slimming down this content as it had been submitted for comment to stakeholders in this format. The final sign off of the Annual Report including the Annual Governance Statement and Quality Report will be carried out on behalf of the Trust's Board of Directors at the next meeting of the Committee on 24 May. **ACTION: Sam Harrison to review the narrative for the Remuneration Committee report.** **ACTION: Claire Wright, Sam Harrison and Anna Shaw to review the commentary on**

	the remuneration report especially concerning the ET and its outcomes and meet with Grant Thornton to clarify compliance with the ARM. **RESOLVED: The Audit & Risk Committee noted the information contained in the report.**
AUD 2016/042	**<u>AUDIT & RISK COMMITTEE SELF ASSESSMENT</u>** The Audit & Risk Committee's self-assessment of its effectiveness was prepared by Alison Breadon of PwC and was noted by the Committee. **RESOLVED: The Audit & Risk Committee noted the Audit & Risk Committee Effectiveness Review.**
AUD 2016/043	**<u>ANNUAL REPORT FROM THE AUDIT & RISK COMMITTEE TO THE BOARD</u>** The 2015/16 Audit & Risk Committee Annual Report was reviewed by the Committee in order to finalise and agree the 2015/16 Audit & Risk Committee Annual Report for submission to the Trust Board. The report summarised how the Committee has discharged its remit during 2015/2016 and is in addition to the reports which have been presented to Board meetings throughout the year. The report would also be presented to the Council of Governors at the next meeting on 1 June to explain the responsibilities of the Committee. The final sentence of the report would be amended to state that the letter of representation will also be signed by the Chair of the Audit & Risk Committee and Director of Finance. **ACTION: Final sentence of Annual Report from Audit & Risk Committee to the Board to be amended to read that the letter of representation will also be signed by the Chair of the Audit & Risk Committee and Director of Finance.** **RESOLVED: The Audit & Risk Committee reviewed the information contained in the 2015/16 report.**
AUD 2016/044	**<u>2015/16 FINANCE & PERFORMANCE COMMITTEE YEAR END REPORT</u>** Claire Wright provided a report to Audit & Risk Committee on the effectiveness of the Finance & Performance Committee for 2015/16 that compared the work of the Committee to its Terms of Reference. The Chair confirmed she was satisfied with the effectiveness of the Finance & Performance Committee throughout 2015/16 and asked that annual reports from the other Board Committees follow the same format. **RESOLVED: The Audit & Risk Committee:** **1) Considered the effectiveness of Finance and Performance Committee against the terms of reference for the Committee that were in place during 2015/16** **2) Confirmed that the Committee was effective during that time** **3) Noted the issues and requirements for the Committee looking ahead to 2016/17**
AUD 2016/045	**<u>REVIEW OF ASSURANCE FROM OTHER COMMITTEES</u>** The Committee noted that the Board had received a first trial of short assurance summaries from Committee chairs which supplemented the Committees' minutes.

	The Chair considered that the Audit & Risk Committee should place a different emphasis than Board on the Committee summary reports and proposed that this be matter that Committee chairs collectively agree on. **ACTION: Committee Chairs to agree the emphasis that the Audit & Risk Committee should place on the assurance summary reports.** **RESOLVED: The Audit & Risk Committee noted the Assurance Summaries received from the Finance & Performance Committee, Quality Committee, Safeguarding Committee and People & Culture Committee.**
AUD 2016/046	**EXCEPTION REPORTING** The Committee noted there were no exceptions to report on Losses and Compensations, Hospitality and Sponsorship or Debtors and Creditors and agreed it would receive reports on an exception only basis twice a year. The Committee also agreed that waivers would be reported to the Audit & Risk Committee and this process would be discussed by Claire Wright and Samantha Harrison outside of the meeting. **ACTION: Forward plan to be updated to reflect Exception Reporting received by the committee twice a year.** **RESOLVED: The Audit & Risk Committee noted there were no exceptions to report.**
AUD 2016/047	**INTERNAL AUDIT** The Internal Audit Charter was noted by the Committee. The Committee considered the draft Annual Report to be a fair assessment of the internal audit work delivered by PwC for 2015/16, with the overall opinion being generally satisfactory with some improvement required. The Chair asked Alison Breadon to discuss the approved clinician status of with John Sykes to ensure the Trust is operating within the required control framework. **ACTION: Alison Breadon to discuss approved clinician status with John Sykes to ensure the Trust is operating within the required controlled framework.** **RESOLVED: The Audit & Risk Committee received the Internal Audit Charter and draft Annual Report and noted the information contained in the reports.**
AUD 2016/048	**EXTERNAL AUDIT** Grant Thornton's report provided a record of the management responses to key areas around Fraud risk, laws and regulations and their impacts, going concern and related considerations, estimates and related considerations. The Committee considered the management responses and confirmed that they were satisfied with them. Phil Harris pointed out that the asset age of the buildings was 95 years and the estimate considerations showed them to be 89, and asked if this assessment was based on asset life. Grant Thornton agreed to check whether there had been any change to the calculation

	they were anticipating. The Committee noted that on site audit work had commenced and Grant Thornton confirmed there were no issues to report to date. **ACTION: Grant Thornton to check calculation of the asset age of the Trust's buildings.** **RESOLVED: The Audit & Risk Committee received the External Audit Report and noted the information contained in the reports.**
AUD 2016/051	**<u>MATTERS TO BE ESCALATED TO THE BOARD</u>** There were no matters required to be escalated to the Board.
AUD 2016/052	**<u>MEETING EFFECTIVENESS AND CLOSURE OF THE MEETING</u>** It was acknowledged that the meeting was challenging due to the full agenda. The Chair thanked all those present for their attention and attendance and closed the meeting at 1:15pm. **<u>Date of next meeting</u>:** Tuesday, 24 May at 10:30am. Venue: Meeting Room 1 – Albany House, Kingsway, Derby DE22 3LZ.

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

Deep Dive Vacancies, Sickness and Recruitment – June 2016

Purpose of Report

A "deep dive" dated 30 September 2015 into the Trust's Sickness Absence information and links to other employee relations activity was presented to the Board, was subsequently updated and presented to the F&P Committee in January 2016 with a view to progress on the Board's forward plan.

This "deep dive" was generated in response to the request by the Trust Board regarding the number of vacancies, sickness levels, and recruitment undertaken within the Trust to be presented in June.

Executive Summary

- This Report highlights the 20 teams on the KPI Hot Spot Triangulation within the Workforce Dashboard for May 2016.
- Focus on the top 6 teams within the Trust on the Board Dashboard for May 2016.
- The approach has also involved joint analysis between Workforce & Organisational Development with Operational Management to develop action plans against the KPIs. The trajectory for recruitment in the updated Operational Recruitment Plan previously presented to the People and Culture Committee has also been taken into account.

Board Assurances

- Triangulation of data to be considered by the People & Culture Committee and acted upon on a quarterly basis with respect to KPIs.

Governance or Legal Issues

There are no governance or legal considerations

Equality Delivery System

The report has been prepared taking into consideration the Equality Act and in particular the impact on Disability.

Recommendations

The Board of Directors is requested to

1. Acknowledge the report and note the progress that is taking place to recruit staff and support areas with staffing challenges.
2. Acknowledge the work taking place to consider those areas that trigger more than one KPI on the Workforce Dashboard, and following analysis by Operational Management and the Workforce & OD Department be assured that appropriate support and assistance are provided to those teams.
3. Consider incorporating data / KPIs against teams that demonstrate excellence in order to encourage the sharing of best practice and supporting other teams who may require assistance through PCOG.

Report prepared by: Rose Boulton, Acting Deputy Director of Workforce & Organisational Development

Liam Carrier, Workforce Systems & Information Manager

Report presented by: Rose Boulton
Acting Deputy Director of Workforce & Organisational Development

Kath Lane
Acting Deputy Director of Operations

Derbyshire Healthcare NHS Foundation Trust

Report for Trust Board – June 2016

Background

This “deep dive” was on the forward plan for the Board following the “deep dive” in September 2015, and F&P Committee regarding the Action Plan in January 2016. Sequentially the P&CC have received the Operational Recruitment Plan and further data has been analysed to triangulate the information by Service Line in response to the request by Trust Board with respect to vacancies, sickness and recruitment within the Trust.

This report will first extrapolate the Trust-wide KPI information, relating to the top 20 teams within the KPI hot spot triangulation of the Workforce Dashboard for May Board i.e. sickness, compulsory training and appraisals across the Trust, and incorporate the vacancy and recruitment aspects as part of this triangulation in order to consider more effectively where the Trust can identify teams requiring additional support and assistance via operational management and WOD.

Spotlight

Further analysis on six teams who have triggered more than one of these KPIs within the Trust is provided within this Report to establish whether there is a correlation where support and assistance is to be offered by Operational Management and the Workforce & Organisational Team.

The approach has also involved joint analysis between Workforce & Organisational Development team and Operational Management, and taking into account the Operational Recruitment Plan previously presented to the People and Culture Committee.

Sickness Absence Position (Target = 3.90%**)

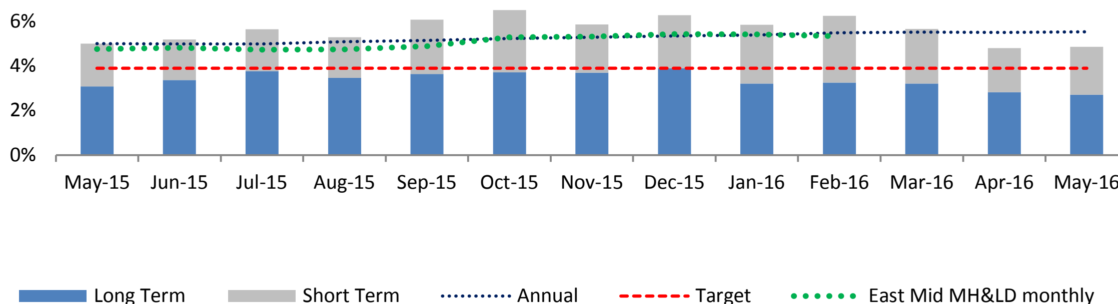
The Trust annual sickness absence rate is currently 5.54% (0.03% increase compared to last month).

Anxiety/stress/depression/other psychiatric illnesses remains the Trust’s highest sickness absence reason and accounts for 26.42% of all sickness absence, followed by surgery at 8.56% and gastrointestinal problems at 8.56%.

The figures also include a comparison to the East Midlands Mental Health and Learning Disability Trusts up to February 2016 (the latest figures available).

The Monthly rates for March to May 2016 remain high (March 5.67%, April 4.81% and May 4.87%). **The RAG rating is red and the trend is increasing.**

Please note ** = targets set for the KPIs will be reviewed by the Workforce Group and to be presented to the P&CC in September.

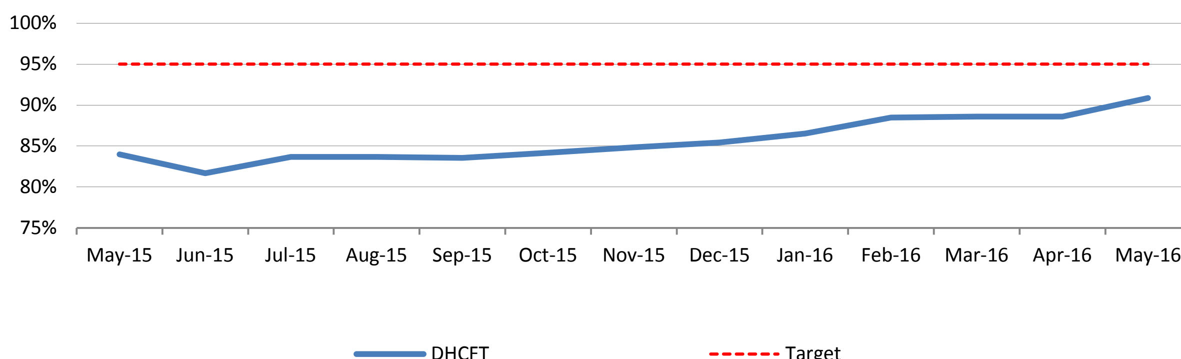


Action: The Mindful Health & Wellbeing Group as a sub-group of the P&CC will review the action plan and report through to the P&CC

Compulsory Training Compliance Position (Target = 95%)

Compulsory training compliance continues to increase at 90.87% in May 2016. Compared to the same period last year compliance rates are now 6.90% higher. Compulsory training compliance remains above 85% which is the main contract for the Commissioning for Quality and Innovation (CQUIN) target.

The Monthly rates for March to May 2016 being; March 88.59%, April 88.58% and May 90.87% **with a RAG rating of amber, and a trend of compliance increasing**.

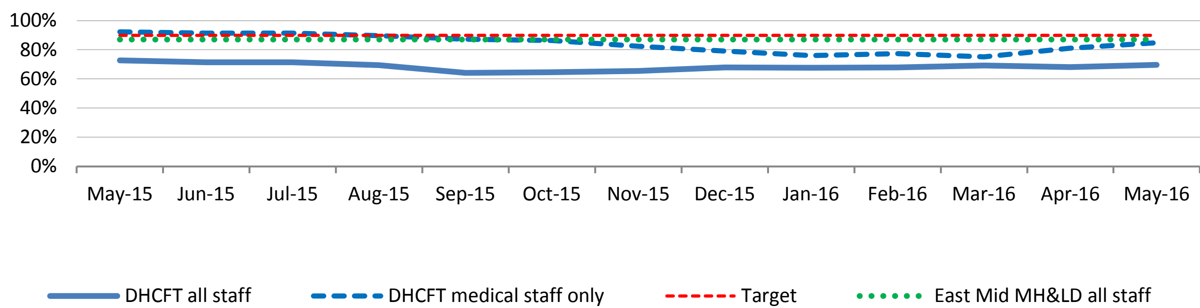


Appraisal Compliance Position (Target = 90%)

The number of employees who have received an appraisal within the last 12 months has increased by 1.47% during May 2016.

Historic medical appraisals have now been updated. According to the latest staff survey results, the national average for Mental Health & Learning Disability Trusts is 91%.

The Monthly rates for March to May 2016, being; March 69.12%, April 68.12% and May 69.59% and is **RAG rated at red, with the trend demonstrating compliance is increasing slightly.**



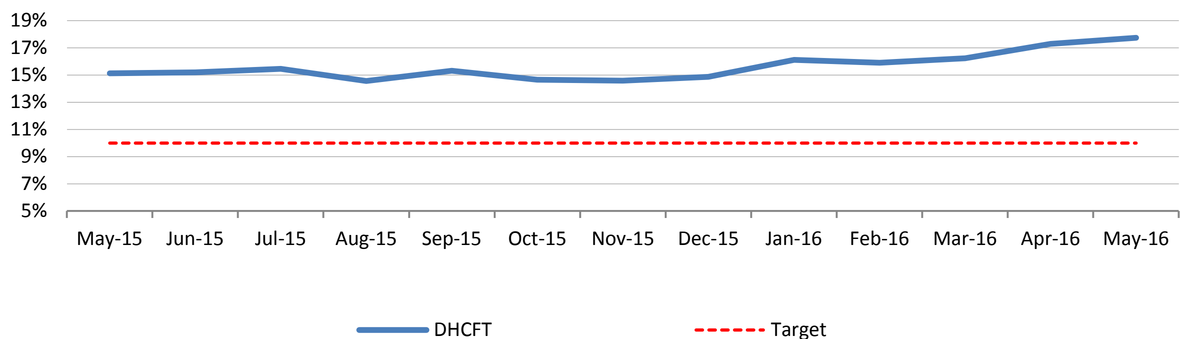
Action: The Engagement Group as a sub-group of the P&CC will review in line with the Trust Values and report through to the P&CC

Vacancy Position (Target = 10%)

The budgeted vacancy rate has increased by 0.45%. April 2016 included additional full time equivalent investment for 2016/17.

Active recruitment during May 2016 was against 91 posts, with 65.90% for qualified nursing, 11% for admin & clerical, 9.9% for medical, 7.7% for scientific & technical, 3.3% for allied health professionals and 2.2% for additional clinical services.

The Monthly rates for March to May 2016, being; March 16.24%, April 17.30% and May 17.75%, and are **RAG rated as amber, with a trajectory of this increasing.**



Action: The Operational Recruitment Plan and trajectory will be monitored and reviewed through the P&CC.

Support and Assistance to Teams

The following teams have been extracted from the KPI hot spot triangulation (May Workforce Dashboard for Board), highlighting six teams with high sickness absence levels, of which five have triggered experiencing challenges in meeting other KPIs, and may require support and assistance. These teams represent 0.66% of total sickness absence during May which was 4.87%.

Kedleston Low Secure Unit (Headcount = 44)
Sickness Absence = 12.82% Appraisal compliance = 83.72% (modest compliance rate given sickness levels) Compulsory Training compliance = 94.79% (good compliance rate despite sickness levels)
Enhanced Care Ward Medics (Headcount = 31)
Sickness Absence = 10.47% Appraisal compliance = 16.13%
County South Early Intervention (Headcount = 10)
Sickness Absence = 11.08% Compulsory Training Compliance = 82.02% Appraisal compliance = 30.00%
Derby City Neighbourhood - Team C (Headcount = 23)
Sickness Absence = 16.30% Compulsory Training compliance = 82.54%
Medics Neighbourhood City (Headcount = 11)
Sickness Absence = 11.29% Compulsory Training compliance = 80.81%
Bolsover+CC Neighbourhood - Team B (Headcount = 19)
Sickness Absence = 18.20% Compulsory Training compliance = 85.80%

On initial analysis of the top three highest reasons for absence there appears to be a range of different reasons; including Anxiety/Stress/Depression/Other Psychiatric illnesses, and Musculoskeletal. There are a number of other reasons for sickness absence for some teams that require further analysis including Headache / migraine for 82 days, Cold, Cough, Flu - Influenza for two teams totalling 146 days, Gastrointestinal problems 53 days, Nervous System Disorders for two teams totalling 122 days, and Not Assigned 86 days.

The Kedleston Unit demonstrates that whilst a team may trigger only one KPI, it may be a sufficiently high percentage in itself to justify the team being considered requiring further support and assistance. In this instance the Unit shows high levels of sickness absence but does not trigger compulsory training compliance or appraisal

compliance. Indeed, further triangulation and analysis demonstrated here that the team has a modest compliance rate for appraisals at 83.72%, and also a good compliance rate for compulsory training at 94.79% which demonstrates despite the high sickness levels these KPIs have been achieved with success. Notwithstanding this, the sickness absence levels are high and may warrant the team receiving additional support and assistance with this aspect of their KPIs.

These areas have been supported by Operational Management and Workforce & Organisational Development Culture Team as follows:

Area	Action
Kedleston Low Secure Unit	An interim manager to the Unit has sought the support from WOD, resulting in an Action Plan to address sickness absence, to be reviewed at the end of June 2016.
	Campus Performance Meeting undertook a Sickness Absence Deep Dive at their meeting on 10 May 2016, and on 14 June the focus was for Supervision and Appraisal in order to further support managers in addressing these issues within their areas of responsibility.
Enhanced Care Ward Medics	WOD supporting managers with short and long term sickness absence at the Radbourne Unit, through regular meetings with managers on ECW and other areas. Actions Plans in place for each case. This is being rolled out across the Unit with the rest of the Ward Managers with assistance in conducting regular monthly review meetings.
	The Staff Liaison Manager undertakes weekly support sessions on the wards at the Radbourne Unit (including ECW).
	Plans are also in place for the Staff Liaison Manager to provide this same level of support at the Hartington Unit (starting July).
	Weekly support sessions offered by the Staff Liaison Manager to two other ward areas across the Campus.
Area	**Action**
County South Early Intervention	Utilising standard Trust processes to address sickness absence, particularly the stresses experienced in this team.
	Ongoing recruitment taking place and process recently developed to enable Fast-Track Recruitment where appropriate.
	PADRs have now been added to people's passports and these are reviewed in supervision with a view to increase appraisal compliance rates.
	There have been difficulties due to absence of a manager for the team, which is now resolved. It is anticipated that there will be an improvement in appraisal compliance trajectory.

Area	Action
	There is a focus on compulsory training compliance through supervision. Hot spots in the team will now improve as team management issues have been resolved.
Derby City Neighbourhood - Team C	WOD attendance at the Neighbourhood Operations meeting to discuss the KPI hotspots. Plans are to be developed to improve the sickness rates where required.
	Some of the sickness absence is believed to be related to organisational change. In addition to the Health & Wellbeing initiatives, the Engagement Lead is meeting with the General Manager and Principal WOD Manager to plan how to address this.
	As well as sickness review meetings with managers, a Post-Organisational Change Action Plan will be developed along the same format as that for the Bolsover Team.
Medics Neighbourhood City	Plan as above
Bolsover+CC Neighbourhood - Team B	Post Organisational Development Action Plan has been developed with the WOD Manager and Service Manager to address sickness at Bolsover which will include Individual Stress Risk Assessments.

It should be noted that in addition to the above there are numerous initiatives being undertaken to support teams and individuals generally a number of which relate to health and wellbeing, training, and support through various processes within the Trust.

So what are the other KPIs telling us from a Recruitment perspective?

Recruitment

Recruitment is on the increase, however, turnover is fairly static at 10% within variables, and agency spend increases are mainly due to medical staffing requirements. A medical recruitment paper was presented to F&P. This has been considered recently by F&P Committee with a number of subsequent actions agreed. The impact of the agency cap by NHSI is a possible correlation to the increase in recruitment activity except for the medical staffing, which requires further analysis.

The year-on-year Recruitment Services activity is provided in the table below:

Year		Recruitment activity (posts advertised)
2014		306
2015		278
2016	(6 months to June)	242

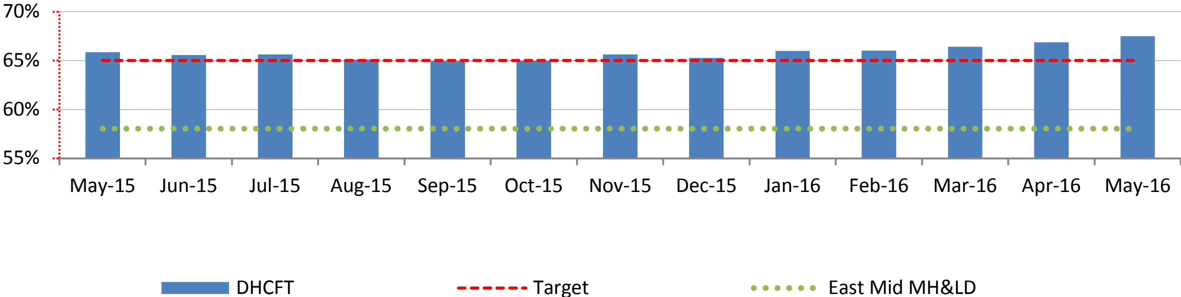
This demonstrates that in the first six months of 2016 the Trust's recruitment activity has almost reached its performance levels for the totals in the previous two years.

This may correlate to the impact of the NHSI caps on the usage of bank and agency, and as a result of new funding for posts.

The recruitment KPI is based on budgeted FTE - 90% of staff in post target, with a 10% vacancy rate to cover for inpatient annual leave, sickness, etc. The true vacancy figure and what the Trust would recruit to is the difference between staff in post and 90%.

The Trust also reports on the number of vacancies actively being recruited to as this gives a more realistic idea of current recruitment activity. It should also be noted that the vacancy rates also include new FTE investment from April 2016.

<u>Qualified Nurses</u> (Target = 65%)
(Total nurses, midwives, health visitors and healthcare assistants)



Contracted staff in post qualified nurses to total nurses, midwives, health visitors and healthcare assistants remains within target at 67.50%. However, vacancy rates can impact on this measure. The NHS average is 61.38% and the East Midlands Mental Health & Learning Disability average is 58.04%.

The Monthly rates for March to May 2016, being; March 66.41%, April 66.89% and May 67.60%, and **are RAG rated as green, with a trajectory of this increasing**.

<u>Operational Recruitment Plan</u>

Due to the Trust operating within a context of a national shortage of registered nurses and the Trust has had difficulty in recruiting doctors to substantive posts, especially in specialised areas such as Child and Adolescent Mental Health, Paediatrics and Learning Disabilities, an "Operational Recruitment Plan" was approved at the People and Culture Committee (P&CC) in April 2016.

As part of this, it was agreed that "Fast Track Recruitment" would be introduced in order to reduce the time required to recruit by advertising posts prior to current post holder having left the role since 9 May, and there have been a number of posts which have been processed in this way which is being monitored and reviewed via the P&CC.

Operationally detailed plans are in place on recruitment progress against safer staffing. Waiting lists are still very high and create significant pressure, as does the pace required to develop new ways of working to support better management of the

waiting lists. Recruitment so far has been against the trajectory within the Operational Recruitment Plan, however, it anticipated this will become trickier given the volume of posts required to recruit to across the Trust as a whole. Neighbourhoods and Campus operational management are working closely together to ensure internal competition for filling vacancies is kept to a minimum. The increase in recruitment activity in Neighbourhood directly relates to new funding. Posts are being identified to work as rotations between Campus and Neighbourhoods which will help this situation and also offer a good development package to newly registered staff – i.e. as they rotate between Neighbourhood and Ward placements.

New recruitment KPI's are currently being developed in order to understand the whole "recruitment journey", which will form part of the analysis of the Fast Track approach and be reviewed with Operational Management and the Workforce & Organisational Development Department.

Report prepared by	Rose Boulton, Acting Deputy Director of Workforce & Organisational Development
Data produced by	Liam Carrier, Workforce Systems & Information Manager
With support from	Paul Beardsley, WOD Manager Claire Biernacki, General Manager Neighbourhoods Liz Corcoran, Acting Principal WOD Manager Kully Hans, WOD Manager Pete Henson, Performance Manager, Operations Kath Lane, Acting Deputy Director of Operations Tim Slater, General Manager Campus Susan Spray, Principal WOD Manager Julieann Trembling, Staff Liaison Manager Joe Wileman, General Manager Central Services

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

Report from the Council of Governors meeting held on 1 June 2016

Purpose of Report

To update the Board on discussions at the Council of Governors meeting held on 1 June 2016

Executive Summary

- The Council of Governors meets formally on a bi-monthly basis and conducts business relating to its role. The meetings are attended by the Chief Executive, Chairman, and several Non-Executive and Executive Directors. Agendas are developed in liaison with the Chairman and Lead Governor, with all governors given the opportunity to suggest items for inclusion in future agendas.

Strategic considerations

- Good communication between the Trust Board and Council of Governors is important for effective relationships and operation of the Trust. This enables both the Council of Governors and the Board of Directors to carry out their statutory duties.

Board Assurances

- The Board can receive assurance that key items of Trust business are covered at the Council of Governors meetings, that the meetings provide an opportunity for governors to scrutinise the Trust's work, learn more about the Trust's activities and hold the Trust Board to account, through the Non-Executive Directors.

Consultation

The paper reflects discussion held at the 1 June meeting of the Council of Governors, and is a summary of the minutes of the meeting.

Governance or Legal Issues

- The role of the Council of Governors is outlined in the Trust's constitution, with duties to hold the Non-Executive Directors to account for the performance of the Board of Directors and to represent the interests of the members as a whole and the interests of the public.

Equality Delivery System

- None

Recommendations
The Board of Directors is requested to note the discussions at the Council of Governors meeting held on 1 June 2016

Report presented by: **Richard Gregory**
Chairman

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

Derbyshire Healthcare Foundation Trust

Report from Council of Governors 1 June 2016

The Council of Governors met on 1 June 2016 at The Postmill Centre, South Normanton. This report provides a summary of issues discussed for noting by the Trust Board. Thirteen governors were in attendance.

The Council of Governors discussed agenda items including:

ACTING CHIEF EXECUTIVE'S REPORT

The report updated governors on changes within the national health and social care sector as well as providing local updates within the health and social care community. The report aimed to support the Council in its duty of holding the Board to account by way of informing members on internal and external developments.

Demand and operational performance of the Trust was noted to be in line with similar Trusts nationally and in terms of other NHS Improvement mental health performance trends, the Trust continues to perform well. The Derbyshire Health and Social Care Community has completed its first short submission of the sustainability and transformation plan (STP). The plan aims to address the help and wellbeing gap in Derbyshire, the quality gap and the financial and efficiency gap and will be submitted in June 2016. Governors outlined their strong support for the sustainability and transformation plan quality model.

Ifti Majid highlighted the level of increased visibility of Board members with 23 visits undertaken within the last three months. This was recognised to represent a significant shift in culture and has been successful in that concerns have been raised and issues shared with Board members directly.

TRUST STRATEGY

Lynn Wilmott-Shepherd, Associate Director of Strategy and Development, presented the new Trust strategy 2016–2021 which was approved by the Board on 25 May 2016. This had been developed through engagement with staff, service users and governors over recent months. Next steps were outlined with regard to communication and implementation which will be linked to the values work as part of the Trust's People Strategy.

PEOPLE STRATEGY

Jayne Storey, Director of Workforce, OD and Culture, presented the draft People Strategy approach noting that this was a key enabling strategy for the Trust. The draft strategy sets out the overarching approach and ambition and the supporting people plan that is required in order to continue to develop the Trust and improve its effectiveness. Governors were encouraged to feed back on the draft strategy approach which will be reviewed again by the People and Culture Committee at their June meeting. The future impact of the national policy to remove nursing bursaries

was discussed and the proposed action in terms of the development of the nurse associate role, return to practice and apprenticeship schemes were outlined.

WORKFORCE AND STRATEGY

Carolyn Gilby, Acting Director of Operations, updated governors on processes to review recruitment and retention within the Trust. Proactive steps to address the potential impact of nurse training funding and analysing the profile of staff due to retire were outlined. Governors raised questions on staffing ratios on wards and the use of overseas staff with responses provided by Executive Directors.

GOVERNANCE IMPROVEMENT ACTION PLAN (GIAP) - UPDATE ON PROGRESS WITH COUNCIL OF GOVERNORS RELATED ACTIONS

Ifti Majid presented the GIAP update report which outlined progress to date on those actions listed for Council of Governors' oversight. Good progress had been made in implementing the actions and further updates are to be reported to each Council of Governors meeting. Governors said that they were satisfied with the level of detail within the report and noted that the Governance Committee would also review progress in further detail at their monthly meetings. Governors would be presented at future meetings with overall progress on the wider GIAP with a focus on completion of tasks and delivery of agreed outcomes and organisational benefit. Governors are to pursue the potential for representation from secondary education on the Council of Governors and the scheduling of governor elections is to be reviewed by Samantha Harrison, Director of Corporate Affairs. Several governors welcomed the positive steps made by the Trust in progressing the GIAP actions relating to the work of the Council of Governors.

FINANCE DIRECTOR'S REPORT

Claire Wright, Director of Finance, highlighted details of the Trust's current financial position. At month 1 of 2016/17 the Trust is ahead of its financial plan by £240k, but as costs come in through the year, it is not expected that the position will remain ahead of plan by the year end. The Trust is forecasting to meet the planned control total of £1.7m surplus, but there is a forecast range of possible outturns ranging from £2.9m surplus to £0.9m deficit. The biggest single risk to the achievement of the financial plan was noted to be the Cost Improvement Programme (CIP) which has a current planning gap of about £2m. The Trust is forecasting to close about half of that gap.

Caps on Agency spend and possible ways for the Trust to address the ongoing above-plan agency expenditure were discussed. Claire Wright updated governors that NHS Improvement had written to all non-acute providers offering system transformation funding. For our Trust this was £830,000 and the Trust had agreed not to accept this at this stage as the terms of conditions of acceptance were not fully clear.

REPORT FROM GOVERNANCE COMMITTEE

The report from the Governance Committee highlighting issues discussed at meetings held on 12 April and 25 April was received and noted.

ANY OTHER BUSINESS

Governor questions - Governors noted that questions had been raised with Non-Executive Directors at the informal Governor/Non-Executive Director session held prior to the meeting.

Non-Executive Director Recruitment – governors were provided with an update on the recruitment process underway for the three Non-Executive Director posts.

Other issues raised including ensuring feedback from quality visits was reported to the Council of Governors, further discussion on support to governors in engagement with their constituents to be scheduled for the Governance Committee, and that a protocol for governor visits to Trust services is to be developed.

ANNUAL REPORT FROM THE AUDIT COMMITTEE

The Annual report from the Audit Committee for the year 2015/16 was presented by Caroline Maley, Senior Independent Director and Chair of the Audit Committee. The role and remit of the Committee was noted along with the change of name of the Committee from 1 April 2016 to the Audit and Risk Committee, to reflect the emphasis on the risk oversight role of the Committee.

NON EXECUTIVE DIRECTOR REPORTS AND KEY THEMES RAISED

The reports from Caroline Maley, Jim Dixon and Phil Harris were noted for information.

The Board is asked to:

Note the summary report from the Council of Governors

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 30 June 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 June is the third 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 June. The Board should be aware that there has been limited opportunity to look beyond this in any great detail due to significant resource being directed towards the Trust's recent CQQ inspection.

- Owing to the timing of meetings only the 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.

- Quality Committee and Remuneration Committee are due to meet after the deadline for completing Board papers.

Board Members will see that the far right hand BRAG rating column continues to be 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 remains 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 continue to evolve, alongside the developing KPI's and external assurance that is being sought for a number of GIAP recommendations.

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 third month.

- ***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.*

- ***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.*

- ***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.*

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*

- ***WOD1****- 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

- ***WOD2-*** *The trust should ensure that recruitment processes for all staff are transparent, open & adhere to relevant trust policies*

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

Key Performance Indicators

Over the last 2 weeks the Responsible Director and the GIAP programme manager have refined the KPIs and demonstrable outcomes related to the successful delivery of GIAP recommendation. In line with NHSI feedback the Trust is plotting the trajectory and baseline for the achievement of each indicator. These will be finalised at the Board development session in July and provided to Trust Board in July for final sign off.

Feedback from NHSI on the GIAP

The Trust and NHSI met as part of planned meetings on the 2nd June. Following on from the meeting NHSI have written to the Trust and asked that focus is given to a number areas, mainly the development of KPIs and outcomes and consideration as to how the Board is assured that the actions are having the necessary impact. NHSI have requested that the Trust review the KPIs and ensure there is a clear description and definition of each target and metric, which also includes both a baseline and a trajectory for achievement of each target.

In addition to the transactional KPIs, NHSI also discussed ways in which the Trust might also be able to measure and evidence core qualitative outcomes, and in particular those relating to the effectiveness of the Board and Committees. Further consideration is being given to this, particularly regarding external assurance and peer support.

Strategic considerations

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

Assurances

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

Consultation

- This report 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. 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 of Strategic Development)**

	Issue Raised/ Action	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
	CORE 1- REUNIFICATION OF THE HR AND ASSOCIATED FUNCTIONS																		
HR2	Ensure external resources for the newly appointed Director of Workforce, OD and Culture are obtained in order to drive the transformation of HR and related functions through a combination of coaching, buddying, and mentoring support.				**R25**		1) Develop and agree a plan which identifies additional resources to ensure successful delivery of HR, Workforce and OD GIAP actions	18th March 2016	**Some Issues**	1) Availability of competent staff in areas required within timeframe and budget 2) Acceptance and integration of additional staff into existing teams 3) Internal Process will have a negative impact of the timescales of recruitment to the interim roles 4) There is a risk that the Director of Workforce, OD and Culture will be unable to identify sufficiently experienced interims with the appropriate skills to undertake the roles 5) There is a risk that the high number of interims within the HR and OD team may cause further relationship issues 6) There is a risk that the high number of interims within the HR and OD team may lead to inconsistency and issues with sustainability.	1) Lack of extra external resource to support delivery of actions will significantly impact on successful delivery of the GIAP 2) Further Regulatory Action if there is not enough progress against the GIAP deliverables. 3) External and internal audit will be unable to provide assurance against the GIAP deliverables.	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. 9) At the June meeting of People and Culture Committee the Director of Workforce provided an update on the recruitment of the outstanding post. noting that the Trust had been out to advert twice and no candidate was appointed. Agency's have now been instructed and 9 CVs have been received, with 5 being identified for interview.	1) Sickness absence rate (3.9%) 2) Vacancy rates (10%) 3) Staff appraisals (90%) 4) Staff turnover (10.45%) 5) Mandatory training (95%) 6) Agency spend (£3.03 Million) 7) HR policies in date (100%) 8) Time to recruitment 9) Headcount per employee	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) Approved of internal HR metrics in place 4) Approved set of organisational HR metrics in place 5) Integrated Performance report	**Some Issues**
							2) Deliver the Resource Plan	31st March 2016	**Some Issues**				Director of Workforce, OD and Culture	People and Culture Committee					
HR3	Undertake an exercise to update the model for HR. Utilising the model as a guide, expertise and best practice across the LHE, and beyond. As a priority the Trust should focus on establishing clear foundations, utilising key building blocks to create sustainability in the long term.				**R27**		1) In consultation with the team develop and deliver the new model for HR	30th June 2016	**Off Track**	1) Inability to deliver HR service model due to staff sickness and lack of engagement from existing staff 2) The high levels of interims in the HR department may decrease the level of engagement of permanent staff to adequately consult on the changes to the HR model	1) Function not 'fit for purpose' to support the organisation in delivery of the Trust strategy 2) Failure to integrate into wider Derbyshire system plans 3) HR function will not be sustainable moving forward	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 4) A revised HR model based on the one suggested by Deloitte was presented to the People and Culture in June. The Committee acknowledged the current capacity issues in HR and noted the progress but agreed that the proposal only gave partial assurance and that further detail about the model and how it would work in practice was required before the Committee could be assured. It was agreed that a further paper would be presented to the Committee which set out this detail.			**Off track**

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HR4	Define a new structure for HR and its related functions with a priority on operational efficiency and strategic impact taking into account the refreshed People Strategy and revised model for HR and related functions.				**R28**		1) Develop and implement a new structure for HR and its related functions with a priority on operational efficiency and strategic impact	30th June 2016	**Off Track**	1) Inability to deliver HR service model due to staff sickness, lack of engagement and capacity 2) The high levels of interims in the HR department may decrease the level of engagement of permanent staff to adequately consult on the changes to the HR model 3) The high level of interims may cause confusion about the overall HR structure	1) Function not 'fit for purpose' and inefficient to support the organisation in delivery of the Trust strategy 2) The OD and HR functions will not be co-ordinated and not be able to deliver the necessary OD change.	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 4) A revised HR model based on the one suggested by Deloitte was presented to the People and Culture in June. The Committee acknowledged the current capacity issues in HR and noted the progress but agreed that the proposal only gave partial assurance and that further detail about the model and how it would work in practice was required before the Committee could be assured. It was agreed that a further paper would be presented to the Committee which set out this detail. The paper would include an outline of the SLA and customer charter.			**Off track**
HR5	As part of the development of the People strategy and developing the model for HR, the function should define how it measures and evaluates the impact of HR, particularly around securing organisational development. A clear set of metrics demonstrating the impact of the function should be a focus on the newly created People and Culture committee.				**R35**		1) Develop a suite of metrics to measure impact of interventions at an organisation and service line level	30th June 2016	**Some Issues**	1) Failure to recognise and accept the need to change by exciting teams 2) Failure to ensure capacity within the team to deliver the proposed actions 3) Failure to deliver an appropriate People Strategy will impact on the 4) Lack of partnership agreement with staff side, to deliver the People Strategy	1) Lack of focus in key areas, inefficient use of resources 2) Function not 'fit for purpose' and inefficient to support the organisation in delivery of the Trust strategy 3) The People Committee are unable to receive the appropriate assurance that the changes to the HR model are having the appropriate impact 4) The Board will not be sufficiently sighted on the on workforce improvements.	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 4) Revised Metrics were presented to People and Culture on the 16th June, the people and Culture Committee agreed further work was required to define the KPIs based on the revised HR model and Structure			**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	**HR 11.2 HR 11.4 HR 11.7 WL Q4**	**Gov2**				1) Terms of Reference Developed	29th January 2016	**Completed**	1) Failure of the People and Culture Committee to remain strategic and be well supported by functioning sub-groups will reduce its efficiency and ability to maintain oversight of the GIAP actions	1) Failure to ensure appropriate governance and accountability to deliver the People Strategy	None Required	Director of Workforce, OD and Culture	People and Culture Committee	27th January 2016	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	1) Improvement in monthly Pulse Check scores 2) People plan metrics to be reflected once agreed 3) A reduction in work based stress	1) people and Culture Committee minutes 2)Evidence of the delivery of the People plan 3) Audit assurance of the effectiveness of the People and Culture Committee 4) Evidence of the delivery of the Communications Plan	On Track
							2) Terms of Reference approved by Board	29th January 2016	**Completed**										
							3) First Committee meeting	17th February 2016	**Completed**										

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PC2	Develop and undertake a clear programme of work around culture, utilising the expertise of other NHS Trusts in the LHE, and where necessary beyond, to inform the programme of activities.				R9		1) Develop a programme of work against the delivery of the people strategy	30th June 2016	off Track	1) Consultation fatigue and lack of belief that the organisation is willing and able to change. 2) Outcomes of the pulse checks are not adequately considered and change embedded. 3) Staff do not have the capacity to attend engagement events due to operational pressures, 4) Due to the high level of change on the organisation there is limited opportunity for innovation. 5) Due to capacity the team are unable to deliver the leadership development programme	1) Failure to articulate expected values and behaviours 2) Failure to engage staff impacting on productivity and patient care	Resources required to be identified within People plan.	Director of Workforce, OD and Culture	People and Culture Committee	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. 8) A revised People Plan was presented to the People and Culture Committee in June, unfortunately due to capacity linked to the CQC inspection the paper was only received by members on the day and therefore members did not gain assurance on the updated paper. The Committee requested, at its July meeting, a revised plan to be developed which would provide clarity on ownership of actions, clearly defined KPIs, timescales and deliverables.			Off 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	Off Track				Director of Workforce, OD and Culture						
							6) Develop and implement a leadership development programme	31st July 2016	On Track				Director of Workforce, OD and Culture						

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PC3	Supplement the current mechanisms to engage with staff through the inclusion of more informal activities across both clinical and corporate areas. Develop clearer reporting of information and trends from these activities in order to triangulate with other information, for example, through the CEO report and Quality Position Statement.				R10		1) Develop a comprehensive internal Comms plan, which clearly articulates engagement approaches both formal and informal	31st May 2016	Completed	1. Capacity of the communications team to support the delivery of the plan 2. lack of mechanisms are in place to record and feedback to staff 3) lack of capacity within the OD and workforce function to support effective engagement	1. Failure to support the delivery of the Trust strategy 2. Failure to engage staff impacting on productivity and patient care	Comms resource may be required	Director of Corporate Affairs	People and Culture Committee	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. 3) At June's meeting of the People and Culture Committee a revised report was presented which outlined the comms approach to recording feedback. The Comms team have developed a SharePoint database which will be held on Connect. The database will be visible only to members of the communications and workforce teams and allow for a single system to be updated and maintained by both teams. The Committee noted the progress but it was agreed that the Engagement group would provide feedback to July's P&CC on how the feedback would be used.			Some Issues
							2) Develop a clear system to record feedback received from staff	31st May 2016	Off Track				Director of Corporate Affairs	People and Culture Committee					
PC4	Prioritise the development of the People Strategy and ensure the agenda and focus of the newly formed People and Culture Committee is clearly aligned the Trust's overall strategy.				R26		1) Refresh People Strategy including reporting metrics	29th April 2016	Off Track	1) Capacity to deliver an agreed People Strategy 2) Lack of partnership agreement with staff side, to deliver the People Strategy 3) Delays in the development of the Trust strategy will impact on the development of the people strategy 4) The People plan lacks the required detail to deliver the required change. 5) The people plan is not aligned to the Trust Strategy	1) Failure to support the delivery of the Trust strategy 2) Failure to engage staff impacting on productivity and patient care 3) Failure to establish distributed leadership and detrimental impact on ED's	Identified within the resource plan	Director of Workforce, OD and Culture	People and Culture Committee	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. 4) A revised People Plan was presented to the People and Culture Committee in June, unfortunately due to capacity linked to the CQC inspection the paper was only received by members on the day and therefore members did not gain assurance on the updated paper. The Committee requested, at its July 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					

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PC5	Undertake an exercise to refresh the Trust values. As part of this exercise engage with staff to ensure that values are meaningful and expected behaviours are clear. Prelaunch revised values across the Trust.				R8		1) HR and OD to undertake a review of the Trust values	31st May 2016	Completed	1) Failure to articulate expected values and behaviours	1) Failure to engage staff impacting on productivity and patient care 2) There is a risk that the pace required may impact on sustainable change 3) There is a risk in term of communications support due to capacity within the team.	Investment in external consultants to support culture change programme	Director of Workforce, OD and Culture	People and Culture Committee	10th August 2016	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 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. 6) A further update was presented to the People and Culture Committee in June, noting that proactive Communication was underway, ensuring that the values are referenced in all communications. It was also noted that the Comms around the values was being aligned to the communications around the new Trust strategy.			On track
							2) Set a programme of engagement with staff to consultant on the refresh of the values	31st May 2016	Completed				Director of Workforce, OD and Culture	People and Culture Committee					
							3) Ensure a comprehensive Comms plan in place to ensure values are visible across the Trust; and	30th June 2016	Completed				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					
PC6	Expand the current Chair and CEO reports to provide a greater depth of information regarding key priorities for stakeholder engagement, feedback provided and any barriers to progress.				R11		1) Chairman and CEO reports to include information about stakeholder engagement and feedback from commissioners	31st March 2016	Completed	1) None identified at this time	1) None identified at this time	None Required	Acting Chief Executive	Board of Directors	20th April 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) Trust Board confirmed its assurance on the delivery of Chair and CEO reports at April 27th Board meeting and agreed closure of this recommendation			Complete

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	CORE 3 CLINICAL GOVERNANCE																		
ClinG1	Refresh the role of Quality Leadership Teams to increase their effectiveness as core quality governance forums.				R24		1) Agree and implement a QLT forward plan process to ensure all required papers are received at each meeting	30th April 2016	Completed	1) Clinicians will not deliver quality priorities 2) QLTs do not meet sufficiently in order to meet there TOR 3) QLTs do not receive the adequate level of support to enable them to be effective. 4) QLTs are not reporting to the appropriate operational group within the executive leadership governance structure	1) The Trust will not deliver the Quality Framework	Resource required to support time out days for QLT and CRG leadership teams	Director of Nursing	Quality Committee	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. 2) The Director of Nursing has met with the Chairs of the QLTs, and there are plans in place for further collective and individual development. 3) At a GIAP meeting the Director of Nursing requested support from Education to construct a 12 month development programme for Nurses and QLTs.	1) Trust Policies that are in date (100%) 2) Reduce the overall number of Trust policies (10%)	1) Revised Polices for Policies 2) Internal Assurance report on policy compliance 3) External Assurance report on effectiveness of QLTs 4) Quality Committee TOR 5) Policy dashboard in place and monitored through Board governance structures 6) External assurance received on the effectiveness of Quality Committee and its alignment to the Quality Strategy 7) Quality Sub group in place	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.				R30		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	1) Inability to review and update policies with necessary pace due to capacity 2) Lack of partnership working with staff side may cause delays in approving and implementing HR policies 3) Failure to implement policies due to insufficient policy implementation processes.	1) Employees will not adhere to policies if there are too many or if there are not clear	Resource will be required to increase capacity within the risk management function	Director of Nursing	Audit 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 3) Policy tracker to be presented to the Audit Committee in July to provide assurance on the process 4) The Risk Manager has reviewed the number of Trust policies and benchmarked against other organisations. There is room to consolidate a number of policies but due to changes to professional clinical practice there are a number of new policies required.			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.				R18		1) Board Development to focus on NED challenge of overdue actions and reports (see RR2)	31st March 2016	Completed	1) There is a risk that the Quality Committee agenda is to broad, and doesn't sufficiently focus on the delivery of the Quality Strategy 2) The quality TOR do not adequately reflect the quality strategy and priorities	1) Trust will not deliver Quality strategy and goals 2) The Board will not gain assurance from quality Committee 3) Non delivery of actions will result in the failure to achieve clinical quality standards required by our regulators which may lead to harm to service users and/or staff (BAF risk	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 3) The Agenda for the June meeting of the Quality Committee has been drafted to reflect the CQC domains and also align to the Quality Priorities. Further work is required to address the capacity of the Committee.			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					
							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					

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	CORE 4; CORPORATE GOVERNANCE																		
CorpG1	The Trust should consider how its governance arrangements could better match its strategy and plans.	**WL Q6**	**Gov1**				1) Develop and approve a Corporate Governance Framework which supports the delivery of the Trust strategy ensuring that the Board of Directors and Board Committee agendas adequately reflect the strategic objectives of the Trust	31st May 2016	**Some Issues**	1) There is a risk that the Board of Directors and Board Committees are not focused on the correct issues	1) Failure to deliver the Trust Strategy 2)Failure to receive assurance around strategy delivery 3) Increased bureaucracy within Organisation 4) Clinical disconnect from the Strategy 5) Failure to embed the Strategy 6) Capacity Issues within the current Board may impact on delivery of the Strategy	None Required	Director of Corporate Affairs	Board of Directors	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.	1) 100% of Board Committee ToRs reviewed annually 2) 90% papers circulated 5 days prior to meeting 3) 80% of actions on the Integrated action matrix are on track 4) Each Board member will attend 80% of the Board Development programme 5) 100% of Board Members have undergone a 360 appraisal	1) Well led External review 2) Committee TOR 3) Completed actions matrix 4) Board Development programme agendas 5) 360 feedback reports and associated actions	**Some Issues**
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.				**R14**		1) Develop and approve a Corporate Governance Framework	31st May 2016	**Some Issues**	1) Failure to allocate sufficient resource to deliver this	1) Lack of clarity around roles may lead to failure to deliver key functions resulting in breach of regulatory conditions. 2) Clinical risk may increase due to lack of clinical ownership within governance structure. 3) Operational performance and operational performance assurance could deteriorate leading to a breach of regulatory or contractual requirements. 4) Inability to articulate corporate risks may lead to further breaches of statutory/ regulatory compliance targets	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.				**R15**		1) Board Development programme to be updated to include a session on holding to account which will include holding to account for agreed actions.	30th June 2016	**Completed**	1) Board development session does not take place in a timely manner	1) Increased risk of non delivery of Trust Strategy or contractual/regulatory requirements 2) Loss of confidence in the Trust Board by regulators and Stakeholders 3) Staff confidence in the Board will not improve	External Support needed in order to facilitate Board Development session	Director of Corporate Affairs	Audit and Risk Committee	14th July 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	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
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				R16		1) Undertake a comprehensive review of the Board Committee structures including TOR	31st May 2016	Some Issues	1) Capacity of NED's 2) Lack of clarity of attendance of Committees 3) Turnover of Board members	1) Board does not have sufficient capacity to service all committees 2) Appropriate assurance on performance, quality and finance is not able to be provided to the Board. 3) Lack of clarity may result in increased bureaucracy and reduced pace of action implementation.	None Required	Director of Corporate Affairs	Audit and Risk Committee	14th July 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					
							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				R19		1)Undertake a comprehensive review of the Committee aligned to the TOR of the Committee	31st May 2016	Completed	1) Capacity of F&P Committee	1) Committee not able to meet requirements of ToR 2) Failure to provide assurance to Board 3) Key statutory reporting is not completed in a timely way	None Required	Director of Corporate Affairs	Audit and Risk Committee	14th July 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					

	Issue Raised/ Action	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
CorpG6	The Audit Committee should reaffirm its role in seeking assurance over systems, controls and processes and not matters of operational or managerial detail.				R20		1) Ensure processes are in place for Audit Committee to undertake a review of its effectiveness	30th April 2016	Completed	1) Audit Committee agenda does not reflect TOR 2) Capacity of Audit Committee 3) NED Capacity	1) Inability to provide assurance to the Board 2) Failure to meet ToR	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					
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.				R21		1) Aligned to the Corporate Governance Framework develop and approve an organisational accountability framework	30th June 2016	Some Issues	1) Capacity within teams and their ability to cope with competing priorities 2) Lack of clarity about the Executive Governance Structures 3) Senior leaders unable to engage due to capacity	1) Failure to deliver the Trusts Transformational change programme at the required pace. 2) Staff morale and engagement will reduce leading to a reduction in clinical quality. 3) Operational performance could reduce leading to failure to meet required contractual and regulatory outcomes.	None Required	Director of 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					
CorpG8	The Board needs to introduce an integrated performance report which encompasses key operational, quality, workforce and finance metrics				R22		1) The Trust will revise the integrated performance report which will include: •key operational metrics; •a workforce dashboard; •the Quality Dashboard, updated to show the refreshed Quality Priorities; •a finance dashboard; and •a summary of performance of groups to highlight any underlying themes.	31st May 2016	Completed	1) Lack of clear KPIs identified by Director leads 2) Issues with embedding the Quality Metrics into the integrated performance report will negatively impact the Boards ability to triangulate all organisational performance information and KPIs	1) Poor information leading to sub optimal decision making by the Board. 2) The Board not being sighted on key risks or poorly performing areas leading to delays in resolution. 3) Lack of clear KPIs for each section of the integrated performance report will result in trends not poor performance not being identified and improvements not monitored	None Required	Director of Operations	Board of Directors	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

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	Issue Raised/ Action	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
CorpG9	Formalise the role of PCOG as a key forum in the Trust's governance structure				R23		1) As part of the Governance Framework review the Trust will formalise the role of PCOG	31st May 2016	Some Issues	1) Lack of ED engagement in PCOG 2) Failure to clarify individual and collective roles within PCOG 3) Failure to clarify the role of PCOG within the executive governance structures 4) Failure to clarify the roles of PCOG and TOMM to avoid duplication 5) lack of clear escalation of operational issues from PCOG to the Board.	1) Performance and contract information is not able to be triangulated through the governance structure leading to increased risk of reduced quality, financial inefficiency or reduced operational performance.	None Required	Director of Operations	Audit and Risk Committee	19th July 2016	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 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 their 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
							2) Increasing ED attendance at PCOG	31st May 2016	Some Issues				Director of Operations	Audit and Risk Committee					
							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					
							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.				R2		1) Ensure ELT agenda focuses on agreed key priorities and items appropriately escalated through the Governance Structures. Agenda and papers will be circulated on a Thursday	31st March 2016	Completed	1) Failure of ELT to take on board change	1)Pace of change and delivery of required outcomes reduced. 2) An effectiveness of executive team leads to increased organisational risk 3) Ensure the Board Secretariat function has resourced sufficiently	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	1) Failure of Board Members to engage with this change 2) Failure of the Board to be visible 3) Failure of the Board to gain adequate assurance.	1)The Board is not able to deliver the Organisational strategy 2)The Board breaches its regulatory requirements 3)The Board does not recognise and respond to increasing governance or clinical risks that are emerging		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	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
CorpG11					R3		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.				R17		1) Reintroduce short summary reports from committee chairs to the Board which identify key risks, successes and decisions made / escalated from the meeting.	30th April 2016	Some Issues	1. Failure to provide appropriate escalation processes to Board 2. inconsistent approach to summary reports fails to provide necessary assurance	1)There is a danger that key escalations from committees to board are missed resulting in increased clinical or organisational risk	None Required	Director of Corporate Affairs	Audit 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.	WL Q7	C1, C2 Gov7				Develop and Agree BAF 16/17	31st March 2016	Completed	1) None identified at this time	1) Board is not sufficiently aware of confidential risks	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
							Schedule BAF Deep dive reviews for Board Committees	31st March 2016	Completed				Director of Corporate Affairs						

	Issue Raised/ Action	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
CORE 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.	WL Q3 WL Q4	Gov 4, Gov 5, Gov 6,			CQC 4- Should	1) The Board and Council of governors will co-write a policy on how the Board and council of governors will work in partnership	30th June 2016	On Track	1) The ongoing negative press and detail of the investigations may result in further distrust between the Board and Council of Governors 2) Turn over of Governors and Board Members will negatively impact on the relationship 3) Lack of clarity in relation to the role of SID	1) Failure to rebuild trust and confidence between the Board of Directors and CoG will impact on delivery of the Trust Strategy 2) Failure to progress the development of a positive and constructive relationship	None Required	Director of Corporate Affairs	Board of Directors & Council of Governors	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. 5) Key principles and a draft policy has been identified from best practice for discussion at the next Governance Committee on 6 June. This encompasses arrangements already set in place including the twice yearly Council of Governors and Board session, the regular Non-Executive Director and Council of Governor sessions. Governors have also been invited to attend Board Committee meetings to observe the work of Committees and further understand the role and hold Non Executive Directors to account. 6) A proposal for an evaluation of the effectiveness of the Council of Governors has been drawn up and is to be discussed at the Governance Committee on 6 June 2016. Subject to discussion and approval, it is planned that this will be carried out in July 2016, the result reviewed by the Governance Committee and the findings used to develop an action plan for the governors to take forwards. 7) Revisions to the Code of Conduct have been discussed as part of the Governance Committee agenda on 12 April 2016 and 25 April 2016. A further draft has been circulated to governors prior to discussion at the Governance Committee meeting on 6 June 2016.	1) New Governors induction completed (100%) 2) 90% positive feedback received on the induction	1) Well led External review 2) Engagement Policy 3) Code of Conduct 4) Lead Governor role description	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					

	Issue Raised/ Action	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
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		**Gov 4, Gov 5, Gov 6,**		**R12**	**CQC 3- Should**	1) Develop a new induction programme for the Council of Governors and roll out its delivery	31st May 2016	Completed	1) Governors will not hold NED's to account in an effective way 2) Governors may not be able allocate sufficient time to undertake induction and external training	1) Failure to rebuild trust and confidence between the Board of Directors and CoG will impact on delivery of the Trust Strategy 2) Failure to progress the development of a positive and constructive relationship 3) Failure to provide Governors with the necessary skills and knowledge for them to effectively discharge there duties	Requirement for external governance training	Director of Corporate Affairs	Council of Governors	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. 5) There is a planned induction event on 31 May to cover the areas of the role of governors, their context within the organisation and personal conduct as outlined by the Code of Conduct. The Chair, chief executive and wider Board members will attend and present at the event. New governors are invited to attend along with existing governors to refresh knowledge and to meet new governors. Those new governors who are unable to attend the session will have a bespoke 1:1 induction session with the Director of Corporate Affairs. 6) At the Council of Governors meeting on the 1st June 2016, the Governors confirmed that the actions were complete. All but one new Governor undertook Induction on the 1st June 2016, the remaining Governor will undertake a one to one induction with the Director of Corporate affairs on the 22nd June 2016.			On Track
							2) Develop a CoG development plan for 2016/17 to include Governwell and other external training	30th April 2016	Completed				Director of Corporate Affairs	Council of Governors					
							3) Ensure that a schedule of the plans are made available to all Board members and members of the Council of governors and the plan is delivered	31st March 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.				**R12**		1) Chairman will engage stakeholders to ensure representation on the Council of Governors	31st May 2016	Completed	1) Incomplete CoG impacting on its effectiveness 2) Failure to ensure a Broad range of experience on the Council of Governors	1) Carrying vacancies will add additional pressure to existing Governors, who may resign due to capacity	Electoral reform services will manage the Governor Elections	Director of Corporate Affairs	Council of Governors	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	Completed				Director of Corporate Affairs	Council of Governors	22nd July 2016				

	Issue Raised/ Action	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
	CORE 6- ROLE AND RESPONSIBILITIES OF BOARD MEMBERS																		
RR1	Implement proposals to improve succession planning at Board level, including ensuring that Governors are adequately engaged in this process. Alongside this, develop processes for succession planning for Senior Leader positions				**R4**		1) Develop and approve Board level, key divisional and corporate leaders succession plan	30th September 2016	**On Track**	1)Inability to identify key components of the succession plan 2) Due to sickness and vacancies may not adequately succession plan	1) Trust performance could deteriorate due to capacity and single points of failure 2) Risk to Business continuity	None Required	Director of Workforce, OD and Culture	Rem Com	1st April 2017		1) Each Board member has attended 80% of the Board Development programme 2) 100% of Board Members have undergone a 360 appraisal 3) Exec Directors have attended at least 80% of the executive development sessions 4) All Directors 100% compliance with their training requirements	1) Board Development programme agendas 2) 360 feedback reports and associated actions 3) Succession plans 4) Well led External review 5) Board Effectiveness Review	**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)	**WL Q2 WL Q3 HR Q11**	**G1, G2a**		**R5**	**CQC 3- Should**	1) Develop a Board Development plan for 2016/17	31st March 2016	**Completed**	1) Conflicting Priorities 2) Availability of external presenters 3) Perception of Value of the delivery of the Board Development Plan	1) Failure to develop as a Unitary Board which will impact on delivery of strategy 2) Failure to effectively challenge will impact on Board accountability and decision making 3) Non Achievement of development objectives	External resource will be required to facilitate Board Effectiveness sessions	Director of Corporate Affairs	Board of Directors	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.				**R6**	**CQC 8- Should**	1) Develop a 360 feedback process for BM's with forms and expectations on what and how to feedback	30th June 2016	**On Track**	1) Failure to provide clarity over Director portfolios 2) Failure to identify development needs of Directors which may impact on individual and collective performance 3) Failure of Directors to understand the role of Corporate Directors.	1) Capacity staff do not have the capacity to complete multiple 360 feedback forms 2) Capacity of Managers to effectively analyse the feedback required	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 (this paper was not provided and will need to be provided at July's meeting)			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					
							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.				**R1**		1) Develop and agree Executive Team development programme which will include; team dynamics and agreed ways of working; •clarity of purpose and vision; •effective challenge and leadership; and •individual coaching.	31st May 2016	**Completed**	1) Conflicting Priorities and capacity within the Executive team may impact on the availability of Directors to attend Exec Development Sessions 2) Availability of external presenters 3) Perception of Value of the delivery of the ELT Development Plan	1) Failure to work cohesively as a team which will impact on performance	Support required from external organisations	Acting Chief Executive	Rem Com	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.				**R5**	CQC 7- **Should**	1) Training requirement for all ED's and NEDS are agreed by CEO and Chair, with passports updated accordingly	30th June 2016	**On Track**	1) Failure to ensure Directors have the required knowledge and skills to undertake their roles 2) Failure to identify the training requirements for individual directors based on individual roles,	1) Failure to continually develop will impact on Board performance 2) BMs ability to challenge may be impacted without the appropriate training and knowledge	Resource may be required for individual development	Acting Chief Executive / 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	**Completed**				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					

	Issue Raised/ Action	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
CORE 7- HR AND OD																			
WOD1	**DR34**- Define and agree a process to regularly monitor the consistent application of HR policies and procedures for the full range of Employee Relations cases. **CQC 1** - The trust must ensure HR policies and procedures are followed and monitored for all staff	HR Q11			R34	CQC 1- Must	1) To undertake a review of HR policies and procedures to ensure all are in date and are compliant with expected HR practice	30th September 2016	On Track	1) Failure to identify capacity to review HR policies 2) Failure of JNCC to approve policies in a timely manner 3) Failure to have robust HR leadership to support this work 4) Failure to effectively monitor adherence to HR policies 5) Failure to effectively implement and train staff on HR policies	1) If HR policies are not followed this will continue negative impact on Governance systems of assurance 2) There will be further Employment Relationship issues if managers fail to follow policies 3) Ongoing issues with the HR department may impact on staff morale 4) negative impact of the ET and enforcement action may impact on recruitment and retention	Additional senior HR capacity is required to lead on this work. HR Resource plan to identify this is needed	Director of Workforce, OD and Culture	People and Culture Committee	18th January 2017	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 4) A timeline is in place to ensure all HR policies are reviewed by the end of September. 5) The People and Culture Committee were made aware that the HR team had not had chance to audit 2 policies. The Committee therefore agreed that the HR team will Audit the Acting up Policy and the professional registration policy, a report on the outcome will be presented to the Committee in July.	1) Compliance with Mandatory Training (90%) 2) Improvement in the following areas of the staff survey KF 14, KF 27, KF 15, KF 21 3) 90% of Managers trained on HR policies before 31st December 4) Improvement in monthly Pulse Check scores 5) Managers completing Grievance, Disciplinary, and Whistleblowing policies training (85%)	1) Integrated Performance report 2) HR SLA delivery 3) Board and Committee minutes	**Some Issues**
							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				Director of Workforce, OD and Culture	People and Culture Committee					
							3) A training programme on HR policies and process is designed, available and accessible	31st December 2016	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	Off 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					
WOD2	The trust should ensure that recruitment processes for all staff are transparent, open & adhere to relevant trust policies					CQC 9- Should	1) Review and ensure that Trust recruitment and acting up policies are fit for purpose	30th June 2016	Off track	1) Failure to identify capacity to review HR policies 2) Failure of JNCC to approve policies in a timely manner 3) Failure to have robust HR leadership to support this work 4)Failure to release managers to attend training	1) Inconsistency of recruitment process leading to challenge and litigation. 2) Failure to recruit competent and capable staff	Additional senior HR capacity is required to lead on this work. HR Resource plan to identify this is needed	Director of Workforce, OD and Culture	People and Culture Committee	15th July 2016	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 2) The People and Culture Committee were made aware that the HR team had not had chance to audit the acting up or recruitment policies. The Committee therefore agreed that the Acting up and Recruitment Policies would be audited for July's meeting.			**Some Issues**
							2) Agree a plan and deliver recruitment training to all appointing officers	31st March 2017	On Track				Director of Workforce, OD and Culture	People and Culture Committee					
							3) Deliver a peer audit of recruitment policies compliance to demonstrate improvement	31st December 2016	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.				**R29**		1) Develop and implement a HR and related function Development programme, which includes building good working relationships	31st May 2016	Completed	1) Staff groups choose not to engage in the development process 2) Inconsistency of policy application leading to Employment Relation issues	1) Inability to deliver an effective HR service into the organisation presenting significant organisational risk	External resource and support required	Director of Workforce, OD and Culture	People and Culture Committee	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					

	Issue Raised/ Action	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
WOD4	As part of its review programme, the Trust may wish to consider a mandatory programme for line managers in order to embed the revised policies and procedures.				R31		1) A training programme on HR policies and process is designed, available and accessible	31st December 2016	On Track	1) Capacity of managers to be released in order to attend training	1) Inconsistency of recruitment process leading to challenge and litigation. 2) Failure to recruit competent and capable staff	Additional capacity to develop core management training is required	Director of Workforce, OD and Culture	People and Culture Committee	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.				R32		1) As part of the wider HR development programme (WOD 3) deliver specific interventions on employment law	30th September 2016	On Track	1) Inability to deliver team development programme 2) Failure to identify the risks associated with potential ETs 3) Failure to escalate risk relating to ETs	1) Failure to have the required knowledge and skills in the HR team	Specialist HR Employment law specialist request	Director of Workforce, OD and Culture	People and Culture Committee	19th October 2016				On Track
WOD6	Consider mechanisms to regularly seek feedback from the HR function on the extent to which the candour, openness, honesty, transparency and challenge to poor performance are the norm, e.g. through monthly pulse checks				R33		1) Introduce a monthly pulse check for the HR team	31st May 2016	Completed	1) Failure to improve culture and behaviours 2) Members of the function will not accept joint team meetings 3) Effective management of HR ineffective due to interim arrangements	1) Failure to deliver an effective HR function 2) Failure to provide HR support to managers across the organisation may result in further employee relations issues	None required	Director of Workforce, OD and Culture	People and Culture Committee	17th July 2017	1) 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. 3) A verbal update was delivered to the People and Culture Committee. it was noted that both teams have agreed in principle to an integrated team meeting, it was highlighted that there are delays in progressing this due to internal issues which are outside of the control of the Director of HR.			On Track
							2) Integrated Team meeting implement	30th June 2016	Some Issues				Director of Workforce, OD and Culture	People and Culture Committee					
WOD7	The trust should monitor the adherence to the grievance, disciplinary, whistle-blowing policies and the current backlog of cases concluded.					CQC 6- Should	1) Implement a proactive system which monitors adherence to the grievance, disciplinary, whistle-blowing policies, including a robust case tracking system.	31st May 2016	Some Issues	1) Failure to review the policies will result in further backlog of cases 2) Failure to deliver Speak up action plan at the required pace will lead to staff unable to raise issues 3) Lack of visibility of senior HR leaders 4) Failure to effectively Monitor adherence to HR policies 5) Failure to ensure backlog of cases are completed due to delays in the process outside of the Trusts control.	1) Failure to deliver effective HR process could lead to reduced staff morale	Resource Plan	Director of Workforce, OD and Culture	People and Culture Committee	19th October 2016	1) 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. 6) An update was provided to the People and Culture Committee in June. the Director of Workforce and OD noted that the Audit of the policies and the case tracker was underway and she is due to meet internal audit on the 5th July 2016 to review the feedback from the Audit. In addition work was underway to review a number of cases and implement a lessons learnt approach to cases. Work is also underway to align whistleblowing cases to the HR tracker. 7) The Director of Workforce, OD and Culture noted that the backlog of cases had not been completed, noting that CQC spent a day in HR reviewing the current cases. As part of the CQC interview the Director of Workforce, OD and Culture explained the delays and mitigations relating to the outstanding cases.			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					
							3) Ensure the backlog of cases made known to the CQC at the time of the inspection are concluded.	30th June 2016	Some Issues				Director of Workforce, OD and Culture	People and Culture Committee					

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WOD8	The trust should continue to make improvements in staff engagement and communication					CQC 11- Should	1) Develop a clear staff engagement plan that takes account of listen, learn	30th June 2016	**On Track**	1) lack of clarity around the ownership of engagement actions 2) Capacity of the Comms team to effectively support the engagement plan 3) Failure to align the engagement plan to the people plan.	1. Failure to articulate expected values and behaviours 2. Failure to engage staff which will have a negative impact productivity and patient care 3. Failure of the Board and Senior Managers to be visible 4. Failure of JCNCC to approve policies 5. Failure to articulate outcome measures for the delivery of the engagement plan	1) Resource may be required for Pulse Check	Director of Workforce, OD and	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																		
W1	As part of the Trusts Well Led Self assessment we identified the need to take further action around the recommendations from the Francis report relating to whistleblowing in order that staff, patients and stakeholders feel confident to raise concerns	WL 3 WL 2					1) Freedom to speak up action plan will be refreshed and approved	31st March 2016	**Completed**	1) Capacity within teams and their ability to cope with competing priorities 2) Failure to deliver the freedom to speak up action plan due to capacity 3) Failure to identify the necessary leads to deliver the action plan	1) Action plan will not deliver culture change required		~~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. 6) The Committee received an updated Freedom to speak up / Raising Concerns action plan, which had been updated in line with comments received the previous month by the Committee. The Committee received positive assurance and agreed that the plan would be added to the committees forward plan for quarterly updates.	1) 95% of Managers have completed whistleblowing training 2) 100% compliance against the whistleblowing policy 3) Improvements in the following staff survey results a) Q13b improve the score from 67% to 71% b) Q13c improve the score from 52% to 59%	1) Refreshed raising concerns at work policy and process approved by Board 2) Freedom to Speak up action plan delivered 3) Internal Audit to provide assurance on compliance with the Whistleblowing policy	**On Track**
							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					

	Issue Raised/ Action	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
	CORE 9- FIT AND PROPER PERSON TEST																		
FF1	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.					CQC 2 must	1) Develop fit and proper persons policy and have it ratified by Board of Directors	24th February 2016	**Completed**	1) Delays in receiving clear DBS checks	1) Failure to fulfil a statutory requirement 2) Failure of the Fit and Proper person process may result in Directors not undergoing to necessary checks	None required	Director of Corporate Affairs	Board of Directors	29th June 2016	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 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 5) At the May board meeting the Chairman confirmed that all directors were fit and proper and he had been assured by the necessary paper work.	1) 100% of Directors are fully compliant with the Fit and Proper person test 2) 100% of Directors personal files evidence fit and proper persons requirements	1) Board Minutes 2) Fit and Proper person evidence files	**On Track**
							2) Ensure that HR maintain the Fit and Proper Persons tracker	30th April 2016	**Completed**				Director of Workforce, OD and Culture	Board of Directors					
							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	**Completed**				Director of Corporate Affairs	People and Culture Committee					
							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	**Completed**				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					CQC 5- Should	1) The CQC targeted report is used as a key guide in Trust strategy development days	30th June 2016	**Completed**	No significant risks identified	1) Failure to develop a new Strategy which supports cultural change	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'	1) Reduction in t vacancy rate to 10% (16.24% March) 2) Increase the recruitment to operational Vacancies as per recruitment trajectory		On Track

	Issue Raised/ Action	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
CQC2	The trust should continue to proactively recruit staff to fill operational vacancies.					CQC 10- Should	1) Develop and agree a proactive operational recruitment plan, including in reach to the local University and wider health community	30th April 2016	**Completed**	1) Lack of capacity and capability in the HR team in order to support operational Staff 2) there is a risk that recruiting managers do not follow policies 3) Inadequate supply of experienced staff 4) Poor retention levels of staff 5) Regulatory action has a negative impact on recruitment and retention	1) Failure to recruit could impact on patient safety 2) Staff confidence in the Board will not improve 3) Sustainability of workforce	None Required	Director of Operations	People and Culture 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 4) The recruitment plan was discussed at the people and culture Committee in June, it was agreed that a progress update would be provided to the meeting in July			**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					

	Issue Raised/ Action	well led self assessment	Reference to AY Governance Review	HR investigation	Deloitte Report	CQC report	Key Tasks	Key Task Date	Progress Rag Rating	Associated risks to delivery of Action	Associated Risks of non-implementation	outline of any key resources required;	Owner	Responsible Committee	Issue/ Action completion sign off by Body	comments on progress	KPIs and success measures;	Evidence of demonstrable outcomes and assurance	Board Assurance Rag Rating
	CORE 11- MONITOR ENFORCEMENT UNDERTAKINGS																		
M1	The Trust will deliver a Governance Improvement Action Plan (GIAP) to address the findings and recommendations from the Employment Tribunal Investigation, Deloitte report, and the CQC focused inspection DR13; Further iterations of the governance action plan should include a greater depth of detail, including summary of progress and clearer insight into priority actions required. the action plan should include: •priority ratings for each action; •key tasks required for each recommendation / action area; •associated risks with non-implementation; •outline of any key resources required; •completion of KPIs and success measures; •comments on progress comments; and •links to demonstrable outcomes		X		**R13**	X	1) Governance Improvement Action plan approved by Board of Directors	30th March 2016	**Completed**	1) Failure to create sufficient capacity within the key group of officers responsible for delivering the Plan 2) do not adhere to the roles and responsibilities set out in the governance arrangements of the improvement plan 3)The roles and responsibilities relating to programme governance are not understood 4) Executive Team focus on what is urgent rather than what is important, inability to prioritise	1) Risk of further enforcement action 2) Risk to the viability of the organisation 3) Risk of reputational damage	Programme Manager to be appointed PMO admin support appointed responsible Director identified	Responsible Director	Board of Directors	31st March 2017	1) GIAP and Governance and delivery Framework agreed by Board in March 2) GIAP delivery framework implemented during April, with updates made to the plan accordingly	1) 80% of Actions are on Track or Completed 2) 80% of rag ratings in the Board Assurance Colum are on Track or Completed 3) 80% of deliverables are presented to committees within timeframes 4) 80% of risks identified are scored as 15 or below (after mitigation)	1) External assurance reports on the GIAP and governance Framework 2) Enforcement notice removed 3) External well led governance review 4) Board minutes	On Track
							2) GIAP and Governance and Delivery Framework sent to Monitor	18th March 2016	**Completed**				Responsible Director	Board of Directors					
							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**	1) Failure to gain external assurance in a timely manner	1) Failure to deliver enforcement undertakings 2) Failure to provide assurance to regulators may result Further Regulatory action	External Assurance from professional service consultancy e.g. Deloitte resource will be required	Acting Chief Executive	Board of Directors	31st March 2017	1) A scope of work is being agreed with internal auditors to provide assurance in a number of specific areas of the plan.	1) External assurance process undertaken in a timely manner	1) External positive assurance report	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**	1) Failure to allocate sufficient resources	1) Failure to deliver enforcement undertakings	None Required	Acting Chief Executive	Board of Directors	31st March 2017	1) April and May reports provided to NHSI and CQC	1) Positive Formal correspondence with monitor on the delivery of the plan 2) Positive and credible relationship with Monitor	1) Enforcement notice removed	On Track

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									

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
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								