Derbyshire Healthcare NHS
NHS Foundation Trust

Meeting of the Board of Directors

5 October 2016

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

Better together

Derbyshire Healthcare NHS
NHS Foundation Trust

NOTICE OF BOARD MEETING - WEDNESDAY 5 OCTOBER 2016
TO COMMENCE AT 1.00 PM IN CONFERENCE ROOMS A&B, FIRST FLOOR,
RESEARCH & DEVELOPMENT CENTRE, KINGSWAY, DERBY DE22 3LZ

	TIME	AGENDA	ENC	LED BY
1.	1:00	Deputy Chairman's welcome, opening remarks and apologies for absence	**-**	Jim Dixon
2.	1:05	Service Receiver Story	**-**	Jim Dixon
3.	1:30	Declarations of Interest	**A**	Jim Dixon
4.	1:30	Minutes of Board of Directors meeting held on 7 September 2016	**B**	Jim Dixon
5.	1:35	Matters arising – Actions Matrix	**C**	Jim Dixon
6.	1:40	Chairman's Verbal Update	**-**	Jim Dixon
7.	1:50	Acting Chief Executive's Report	**D**	Ifti Majid
OPERATIONAL PERFORMANCE, QUALITY AND STRATEGY				
8.	2:10	Integrated Performance and Activity Report	**E**	Mark Powell Claire Wright Amanda Rawlings Carolyn Green
9.	2:20	Position Statement on Quality	**F**	Carolyn Green
10.	2:30	Board Committee Escalations: Audit & Risk Committee (19 July), Mental Health Act Committee (26 August), Quality Committee (8 September), Ratified Minutes of Quality Committee held 8 September and People & Culture Committee held 15 July (for information only)	**G**	Committee Chairs
11.	2:45	NHSI Single Oversight Framework	**H**	Claire Wright
12.	2:55	NHS Operational Planning and Contracting Guidance 2017 - 2019	**I**	Mark Powell
13.	3:05	Equality and Diversity – To follow	**J**	Amanda Rawlings
3:15 B R E A K				
14.	3:25	Recovery Outcomes – Learning from Patient Stories	**K**	Carolyn Green
GOVERNANCE				
15.	3:35	Governance Improvement Action Plan	**L**	Mark Powell
16.	3:45	Report from Council of Governors	**M**	Samantha Harrison
17.	3:55	Revision of Engagement with the Board of Directors and Council of Governors Policy	**N**	Samantha Harrison
CLOSING MATTERS				
18.	4:10	Any other business	**-**	Jim Dixon
19.	4:20	2016/17 Board Forward Plan	**O**	Jim Dixon
20.	4:30	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Meeting effectiveness	**-**	Jim Dixon

Questions that are applicable to the agenda, and at the Chairman's discretion, can be sent by email to the Corporate Office up to 48 hours prior to the meeting for a response provided by the Board at the meeting. Email: Alison.Tuckley@derbyshcft.nhs.uk

In the absence of the Interim Chairman, Richard Gregory, this meeting will be chaired by Jim Dixon, Deputy Trust Chair and Non-Executive Director.

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 will be held at 1.00 pm on 2 November 2016
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)
Margaret Gildea	Director, Organisation Change Solutions Limited Non-Executive Director, Derwent Living	(a, b)
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)
Samantha Harrison	Nil	-
Ifti Majid	Nil	-
Caroline Maley	Director – C D Maley Ltd Trustee – Vocaleyes Ltd.	(a) (a, d)
Mark Powell	Nil	-
Dr 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)
Dr Julia Tabreham	Non-Executive Director, Parliamentary and Health Service Ombudsman Director of Research and Ambassador Carers Federation Board member, RESTORE (supporting older offenders in the criminal justice system) Lay Member - National Institute for Health and Care Excellence, Guideline Development Group, National Collaborating Centre for mental Health of Adults in the Criminal Justice System	(a, d)
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, 7 September 2016

MEETING HELD IN PUBLIC

Commenced: 1pm Closed: 4:50pm

PRESENT:	Richard Gregory	Interim Chairman
	Caroline Maley	Senior Independent Director
	Maura Teager	Non-Executive Director
	Margaret Gildea	Non-Executive Director
	Julia Tabreham	Non-Executive Director
	Ifti Majid	Acting Chief Executive
	Claire Wright	Executive Director of Finance
	Carolyn Green	Director of Nursing & Patient Experience
	Dr John Sykes	Executive Medical Director
	Carolyn Gilby	Acting Director of Operations
	Mark Powell	Director of Strategic Development
	Amanda Rawlings	Director of Workforce, Organisational Development and Culture
	Samantha Harrison	Director of Corporate Affairs & Trust Secretary
IN ATTENDANCE:	Anna Shaw	Deputy Director of Communications & Involvement
	Sue Turner	Board Secretary and Minute Taker
For item DHCFT 2016/1	Libby Runcie	Professional Leader, Commissioning Differently
For item DHCFT 2016/1	Karen Billyeald	Area Service Manager, Learning Disability Services
APOLOGIES:	Jim Dixon	Deputy Chair and Non-Executive Director
VISITORS:	John Morrissey	Lead Governor
	Gillian Hough	Public Governor, Derby City East
	Rosemary Farkas	Public Governor, Surrounding Areas
	Mark McKeown	Derbyshire Mental Health Alliance
	Owen Fulton	Principal Employee Relations Manager

DHCFT 2016/128	**INTERIM CHAIRMAN'S WELCOME, OPENING REMARKS AND APOLOGIES** The Interim Chairman, Richard Gregory, opened the meeting and welcomed everyone who was present. Apologies were noted as above. Richard Gregory was delighted to welcome and introduce the two new Non-Executive Directors, Margaret Gildea and Julia Tabreham. He also introduced Amanda Rawlings in her role as Interim Director of Workforce, Organisational Development and Culture. Whilst Amanda will retain her substantive role of Director of People and Organisational Effectiveness at Derbyshire Community Health Services NHS Foundation Trust (DCHS) she will provide interim support to the Trust in the light of our recent initiatives about working in greater collaboration with DCHS. The Board noted the declaration of interest made by Amanda Rawlings in respect of her

	association with DCHS. Richard Gregory confirmed he was content with her declared interest in view of the dual role she will be performing.
DHCFT 2016/129	**MINUTES OF THE MEETING DATED 27 JULY 2016** The minutes of the meeting held on 27 July were accepted and agreed.
DHCFT 2016/130	**MATTERS ARISING AND ACTIONS MATRIX** The Board agreed to close all completed actions. Updates were provided by members of the Board and were noted directly on the actions matrix.
DHCFT 2016/131	**CHAIRMAN'S VERBAL REPORT** Richard Gregory updated the Board on a positive meeting he, Ifti Majid and Mark Powell recently had with NHS Improvement's (NHSI) enforcement team on the Governance Improvement Action Plan. Good progress continues to be made to deliver the plan and NHSI confirmed that the Trust had made good progress and they were satisfied with the underpinning process we have adopted which supports delivery of the planned actions. A great deal of the Board's time has recently been taken up with the Board of DCHS (Derbyshire Community Health Services Foundation Trust) exploring a range of options for potential future collaboration and Richard Gregory looked forward to the recommendations that would be contained in the Strategic Options Case (SOC) report that would be received by both Boards at the end of October, and then shared with staff and governors. As part of the development of this case an engagement event was held for key stakeholders on 31 August that was well attended by Board members, governors from Trusts, clinical leaders and representatives from other Derbyshire organisations which provided the opportunity for good strategic discussions and the chance to examine the different options. Richard Gregory made it clear that he and the Board recognised the impact and the destabilising nature that constant change within the NHS has on staff and stressed that he and the Board would make sure that every attempt to alleviate these impacts would be made. **RESOLVED: The Board of Directors noted the Interim Chairman's verbal update.**
DHCFT 2016/132	**ACTING CHIEF EXECUTIVE'S REPORT** The Board received Ifti Majid's report which provided 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 fact that NHSI have put the 2017/18 and 2018/19 tariff out to consultation, within that is the guidance to move away from block contracts for Mental Health services and use either episodic or capitation methods or other local contractual agreements. He felt this remains a risk to the Trust if we want to contract in a different way within the system and he hoped the Trust would receive support from regulators with regard to the organisation's contract agreements. Ifti Majid felt it was important to recognise the pressure the Trust is under particularly in inpatient services. The last few months have seen an increased pressure on bed availability for adults with mental health problems. The impact of this is that patients presenting at Emergency Departments have had to wait longer for a bed whilst one was sourced. This has led to an increasing number of people waiting longer than 12 hours and this is not an acceptable experience for those individuals. Ifti Majid informed the

	Board that Carolyn Gilby and the clinical teams have been working closely with counterparts in acute trusts in order to improve this situation and with NHS England. It was noted that Carolyn Gilby would report on progress through the Quality Committee and he hoped this reporting structure would assure the Board that we are working to resolve this. Julia Tabreham commented that she felt the 12 hour wait within Emergency Departments was a key indicator of how the system is not working. As incoming Chair of the Quality Committee she proposed to ensure that some very robust analysis of these services would take place on behalf of patients, carers and families. It was recognised that people are anxious to learn the outcome of the CQC visit which took place in June. Ifti Majid assured the Board that work was still taking place completing factual accuracy checks on the reports that will be returned to the CQC. He wished to make it clear that there will be a period of time when the CQC will review these reports before the final comments can be released into the public domain. On a positive note Ifti Majid was pleased to say that during his visits with staff he had noticed that staff felt able to talk to him and members of the Board about their concerns and this was a significant improvement from how it had been in the past. Point 3 of the report talked about funding in the system and Julia Tabreham felt this would cause anxiety for service receivers and asked for assurance regarding the funding mechanisms going forward. In his response Ifti Majid said that the Trust's current transformation process has been running for three years and people who use our services were heavily involved in this process. Service user complaints and the quality impact on people is scrutinised by the Quality Committee to ascertain how we can improve our services. The next phase of the transformation plan will be to consult with the general public who use our services to help our services move forward. Carolyn Green added that we also consult with service user groups and they are helping with our work with care planning. Governors and organisations such as Healthwatch Derby and the Carers Association also contribute to the improvements we will make to our services. **RESOLVED: The Board of Directors noted the contents of the Acting Chief Executive's report.**
DHCFT 2016/133	**<u>INTEGRATED PERFORMANCE AND ACTIVITY REPORT</u>** The Board received the integrated overview of performance as at the end of July 2016 with regard to workforce, finance and operational delivery and quality performance. Claire Wright updated the Board on the financial aspect of the report and described the Trust's continuing trend of performing well against plan financially for the year to date. She was pleased to report that the organisation's current risk rating was sound and that the Trust was still in a position to meet the control total although risks remain, not least the CIP gap and run rate changes. Ifti Majid asked how NHSI would view the Trust's performance in achieving the control total whilst leaving some CIP (Cost Improvement Programme) unmet. Claire Wright replied that she had discussed this with them and it was her opinion that achieving our control total is NHSI's prime focus. Julia Tabreham asked whether services had stopped where developments weren't funded. Claire Wright explained the variance related to timing of contract negotiations compared to submitting the plan, which had been difficult this year and the plan showed the total picture that had been requested. In the analysis there are ongoing variances to both the income side of the plan and costs side of the plan which are equal opposites for the developments not funded. Mark Powell reiterated that the CIP programme is still a considerable challenge and plans are being developed to deliver this programme or close the gap in other ways. He wanted to make the Board aware that we are striving to close this gap and the Finance and Performance Committee monitors CIP performance to gain assurance that the control total will be achieved.

	Amanda Rawlings drew attention to the Workforce section of the report and stressed that recruitment will be prioritised to ensure the Trust is positioned as an employer of choice. She pointed out that there are different generations of the workforce who want different things out of the workplace and this would be considered within the plans for retention. Another big area of focus will be staff appraisal completion. Amanda Rawlings would also be focussing on the reasons for the rise in sickness levels and would ensure that managers would take responsibility for managing sickness levels of their staff. Carolyn Green took the Board through the Quality aspect of the report. She drew attention to the issue of supervision and compliance and talked about the work taking place to review the Early Interventions in Psychosis Performance data alongside the Workforce and Organisational Development indicators. A key feature of integrated performance reporting is triangulation and identification of themes. This prompted a review of supervision rates for that service to see if this was contribution to a dip in quality service a provision and staff experience. She explained that supervision rates were low compared to the target of 90% and she is considering how this can be reported in the future and what other aspects of quality could demonstrate the performance of early interventions. When asked by Maura Teager how additional support could be provided to teams in distress, Carolyn Green answered that a patients and services review is being carried out to establish new ideas for team leadership. New models of group supervision are being brought in to bring supervision levels up and she hopes to report an improvement next month. Carolyn Gilby talked about the Operational perspective of the report and drew attention to the emergency planning procedures that reprioritise our work to provide a safe environment on campus. She reiterated that safety always comes first. Claire Wright was concerned as to how this report will change with regard to the CQC action plan. Carolyn Green said that she hopes to have a dashboard that will show progress with the CQC action plan ready for November report. This will form part of the quality dashboard and the report will develop areas of concern as well as areas of success. Ward staffing was raised by Ifti Majid. He asked what was being done to address night time staffing. Carolyn Gilby replied that the Operations Directorate are carrying out emergency planning but are struggling with the bank staff fill rate and work will take place with Amanda Rawlings to improve staffing rates and to look at how we can attract recruits. Maura Teager commented from the patient perspective that patients feel very vulnerable at night time especially in terms of their psychotic issues. She was pleased to hear that Carolyn Green will take management action to address this through internal control. The Board also discussed the clinical risks associated with work related stress, increased violence and aggression, lone working and workplace stress on the Radbourne Unit and the increased risk of fire identified on some inpatient ward associated with the smoking ban. **RESOLVED: The Board of Directors scrutinised the content of the report and obtained assurance on the current performance across the areas presented.**
DHCFT 2016/134	**<u>POSITION STATEMENT ON QUALITY</u>** Carolyn Green delivered her report which provided the Board of Directors with an update on the continuing work to improve the quality of the organisation's services in line with the Trust's Strategy, Quality Strategy and Framework and strategic objectives.

	She drew attention to the CCG's (Clinical Commissioning Group) and the Safeguarding Board chair's visit to the Trust when they explored our Safeguarding strategy and assurance and wished to thank Tina Ndili and Dr Joanne Kennedy for their diligent work in compiling extensive and detailed evidence during this exercise. She now looks forward to receiving a written report from the CCG and the Safeguarding Board's formal feedback on their visit. Changes are taking place in the clinical services groups. Carolyn Green referred to the retirement in September of Clare Grainger, Head of Quality, and thanked her for her longstanding commitment and contribution to the Trust. She explained that this post has been redesigned and recruitment to this position was supported through an assessment panel with staff, service receiver representatives and a carer's representative from North Derbyshire Carers Association. The panel was skilled and informed in its assessments thorough this approach and members were thanked for their insightful and extensive contributions. Derbyshire Mental Health Alliance gave positive feedback and thanked the Trust for the continued inclusive approach that was taken. Carolyn Green informed the Board that the Quality Visit Programme is well underway for 2016 and to date over 60 visits to clinical and non-clinical teams have been completed. She pointed out the importance of governors and the Board taking part in quality visits and she made it clear that these visits are not intended to provide assurance of clinical quality, they are Board to service area site visits, and allow staff to have discussions with Board members, commissioners and governors and present and showcase their services, ideas and innovations against the sections of the key lines of enquiries. Carolyn Green assured the Board that actions agreed during the visits would continue to be monitored and best practice examples would be recorded following moderation for teams to learn from. This feedback would also be shared with the Quality Leadership Teams to draw from the feedback, and enable staff to take management actions to support teams. Carolyn Green pointed out that some staff have expressed an interest in revisiting the Quality Visit model and a review will be completed after the end of this season. She urged all Board members to reflect upon the current model in the meantime and provide her with any views or recommendations they might have. **RESOLVED: The Board of Directors:** **1) Received the Quality Position Statement** **2) Gained assurance on its content**
DHCFT 2016/135	**<u>BOARD COMMITTEE ESCALATIONS</u>** An assurance summary was received from the Quality Committee which identified key risks, assurance and decisions made. It was noted that assurance summaries had not been received from the Mental Health Act Committee or the Audit & Risk Committee and these would be received at the October meeting. The ratified minutes of the Quality Committee held in July were received for information only and no issues were raised. **RESOLVED: The Board of Directors received the Board Committee escalations and ratified minutes of meetings held in June.**
DHCFT 2016/136	**<u>EQUALITY DELIVERY SYSTEM EDS2 UPDATE</u>** Amanda Rawlings presented to the Board the four outcomes of the EDS2 and explained how the Trust is positioned against its objectives and offered guidance as to next steps in terms of governance.

	It was noted that EDS2 is critical to the Trust's working and Amanda Rawlings thanked Owen Fulton for his work carried out on EDS2 over the last few weeks. Amanda Rawlings explained that her priority would be to ensure the Board was sighted on the 18 outcomes against which NHS organisations assess and grade themselves. It was acknowledged that presently, the Trust does not have a comprehensive plan to deliver on its EDS2 work streams. This has impacted certain groups adversely both from a patient and employee point of view and it was noted that non-compliance with EDS2 will be included in the Trust Board Assurance Framework. Amanda Rawlings assured the Board that excelling in this work would be linked into the Trust's governance framework and she described how the People and Culture Committee and the Quality Committee would monitor EDS2 as we move towards. The People and Culture Committee would be the lead committee and would ensure the Trust is compliant with EDS2 and the Quality Committee will measure the patient outcomes. The Board approved the report but recognised it would be necessary to have the required resource in place to deliver this plan and agreed that resource and capacity would be addressed through the Executive Leadership Team (ELT). **ACTION: Non-compliance with EDS2 to be included in the Board Assurance Framework** **ACTION: ELT to address the Trust's resource to deliver EDS2.** **RESOLVED: The Board of Directors** **1. Endorsed the establishment of the Equalities Forum** **2. Noted progress on the EDS2 goals 1, 2, 3 and 4 including actions to date for implementation** **3. Agreed that the risk is to be included in the Trust BAF regarding non-compliance with EDS2**
DHCFT 2016/137	**<u>DEEP DIVE – LEARNING DISABILITIES – COMMISSIONING DIFFERENTLY</u>** Libby Runcie, Professional Leader, Commissioning Differently and Karen Billyeald, Area Service Manager, Learning Disability (LD) Services attended the meeting and advised the Board as to how the Commissioning Differently for Learning Disabilities programme was driving to change practices 'to do things differently' following the recommendations contained in the Winterbourne Review, which set out a programme of action to transform services for people with learning disabilities or autism and mental health conditions or behaviours described as challenging. The Board noted that within the LD team there are only two specially employed managers, Karen Billyeald and Debbie Hargreaves, other clinical leaders take on management responsibilities. Recruitment is a problem across the service and work is taking place to recruit to teams to enable patients to be treated at home rather than being admitted to hospital. Recruitment of band 4 nurses has been of a high quality but it has been very difficult to recruit qualified nurses and it is also difficult to recruit to speech and language therapy posts. Maura Teager asked if you assumed the right to be creative with recruitment what organisational development action did you take? Karen Billyeald explained that a skill mix review was undertaken across the service line and every vacancy was skill mixed. Recruitment was looked at from all angles as advertising on NHS Jobs does not always attract people with the right skills. She had also liaised and researched how other trusts manage recruitment and she also used social media to attract staff. Amanda Rawlings spoke about training and asked how anyone new was inducted into the service and hoped this could be a programme that DCHS and the Trust can work together on. Offering the right training opportunities and leadership programmes will

	attract people and would help when competing with other organisations. Libby Runcie offered assurance to the Board that the LD team was working hard to support victims of historical abuse who had been detained at Aston Hall and was working with individuals and sharing their medical records. Carolyn Green thanked Karen Billyeald for her sterling work in making safeguarding personal and going beyond the call of duty. Examples of collaborative working with partners to allow personalisation of support for individuals, preventing inappropriate or reoccurring hospital admissions were given. The Board was made aware of how the Commissioning Differently programme works to purchase homes for people in need so they can be cared for in their homes. Libby Runcie talked with enthusiasm about the care they were providing for a particularly difficult LD case. This person had been institutionalised in the private sector in appalling conditions for most of their life and was now being helped to lead a happier life living in a bungalow that had been funded by the Commissioning Differently programme rather than in a hospital. The Board was struck by the enthusiasm and drive of the team in describing the care they have put in place for this particular individual which they used as an example of Commissioning Differently. Some people with learning difficulties are caught up in criminal justice system because this is the only place they feel safe. There is a lack of appropriate treatment which is a national issue. The Board considered action to be taken and heard through Carolyn Green that the case described above by Libby Runcie would be taken to Safeguarding Adults Board as a case study. The CAMHS team will also write a report on Commissioning Differently and examples and concerns will be monitored through the Trust's Safeguarding Committee. The Board thanked Libby and Karen for their informative item on Commissioning Differently and was grateful for their commitment to challenging the practices they are driving to change. Carolyn Green informed the Board that challenges around waiting time, caseloads, capacity, recruitment and dealing with people with an autism diagnosis would be addressed within her directorate. **RESOLVED: The Board of Directors received the deep dive into Learning Disabilities and Commissioning Differently**
DHCFT 2016/138	**<u>STRATEGY IMPLEMENTATION UPDATE</u>** The Board approved the Trust Strategy 2016-21 in May of this year. At that time a brief outline of the strategy implementation process was presented. This latest report appraised the Board of the progress and provided assurance against the agreed timeframes. Risks associated with delivery of the strategy were highlighted by Mark Powell and are listed below: • System wide planning – the draft STP (Sustainability and Transformation Plan) was submitted on 30 June and the strategy implementation process was based on this submission. Clarification was sought in early August following a meeting that Chief Officers attended with Senior NHS officers in late July. Whilst there is a slight reframing of work, this is not significant and will actually make it easier for internal processes. The system-wide planning represents a risk to our process although we are mitigating it by ensuring close alignment to the 'Engine Room' (the central team driving the process) and the Commissioner Leads. The risk is medium. • Clinical and senior management involvement – whilst there is good clinical and

	management involvement the timing and the importance of the CQC inspection and subsequent report will mean that staff have competing priorities. Teams are trying to balance requirements although this will undoubtedly remain a high risk to delivery. • Medical leadership – the need for Associate Clinical Directors (ACDs) and other senior consultants to lead the process is a cultural change and is proving challenging. However, key senior managers are working closely with the Medical Director and ACD's to ensure that there are appropriate levels of involvement. Managers continue to provide support which helps alleviate the time commitment, which still remains considerable. This remains a high risk. Mark Powell pointed out that the report intended to provide assurance to the Board that the process is progressing according to plan and aligned with the STP and that more action would take place over the next few weeks which will be feature in the next report. The Board noted that where we have suitable structures in place, such as Dementia Board, CAMHS Transformation Group, projects are being integrated into their core business to reduce complexity and demand on staff time. There are also some key risks that need to be reflected on in the Board Assurance Framework (BAF). Capacity generally is a real issue and it was noted that risks to the transformation programme and strategy implementation have been captured in the BAF. The next stage for the process is 'Gateway 2' on 16 and 23 September, where proposals will be discussed with a panel consisting of Directors, a representative from the Non-Executive Directors, a staff and public governor representative, Senior Managers and Commissioners. **RESOLVED: The Board of Directors:** **1. Noted the contents of this report** **2. Received assurance that the strategy implementation process is progressing and that appropriate measures are in place to ensure that it is in-line with the system wide STP process**
DHCFT 2016/139	**<u>REPORT FROM COUNCIL OF GOVERNORS MEETINGS HELD ON 12 AND 21 JULY</u>** The Council of Governors met on 12 July for an extraordinary confidential meeting and also on 21 July for a scheduled public meeting. The report provided a summary of issues discussed and was noted by the Trust Board. **RESOLVED: The Board of Directors noted the summary report from the Council of Governors.**
DHCFT 2016/140	**<u>GOVERNANCE IMPROVEMENT ACTION PLAN (GIAP)</u>** Mark Powell delivered his report which provided Board members with an update on progress on the delivery of the GIAP, including the identification of tasks and recommendations that are off track. The report also provided assurance on the delivery and risk mitigation received from Board Committees and lead Directors and enabled constructive challenge to establish whether sufficient evidence has been provided for completed actions and to decide whether tasks and recommendations can be closed and archived. The Board noted the need to amend the way in which the GIAP is reported to provide the Board and its Committees with a greater emphasis on specific, difficult to deliver tasks and also to place much greater focus on how actions are being embedded across the organisation. Mark Powell pointed out the responsibility for developing an organisational accountability framework sits with the Executive Leadership Team which will allow wider debate on any further adaptations and this will be agreed and implemented by the end of October.

	Mark Powell referred to the Blue Action Form and explained how this had been designed to provide final assurance to the Board that each core area within the GIAP has been concluded.. He pointed out that the Board should receive 53 blue forms over a period of time and this will ensure the Board has assurance of each completed action and the Board meeting agenda will be structured accordingly to capture each completed action. The Board recognised that the GIAP is now far more focused on assurance of completion of actions. All areas that are off track will be monitored through the Board Committees and the accountability framework will be addressed at ELT and implemented by the end of October. The Board was satisfied with the evidence contained in the report that actions have been evaluated which constituted good governance. **RESOLVED: The Board of Directors:** **1) Noted the progress made against GIAP** **2) Reviewed the content of this paper and KPIs** **3) Discussed the areas rated as 'off track' and 'some issues'** **4) Approved the revised reporting process and templates for each Core area and blue completion forms**
DHCFT 2016/141	**<u>AUDIT & RISK COMMITTEE - GOVERNANCE IMPROVEMENT ACTION PLAN</u>** At the Audit and Risk Committee meeting on the 19 July, members of the Committee were not assured on the progress of the GIAP actions which Audit and Risk Committee has oversight. The Board noted the detail contained in the report and was assured by the evidence of progress against each of the actions for which the Committee has oversight. Caroline Maley, as Chair of the Audit and Risk Committee was satisfied with the progress detailed in the report but said her only concern was that the Audit and Risk Committee would not be meeting until 11 October and then again in December. **RESOLVED: The Board of Directors:** **1) Received the report and noted the update of the actions.** **2) Noted and agreed that ClinG3 (2), CorpG4 (1) and CorpG (12) are complete.**
DHCFT 2016/142	**<u>TRUST COMPLIANCE – ACCESSIBLE INFORMATION STANDARD AND INFORMATION GOVERNANCE REPORT</u>** This report presented by Carolyn Gilby provided the Board with an update on the Trust's compliance with the Accessible Information Standard since the previous update was update reported to the Board in June. The Board noted the key actions that had been completed. Carolyn Green challenged how the audit plan and compliance checks would be evidenced to show this was in place. Carolyn Gilby explained that this is very important area of our work which is evidenced through the Information Governance Committee. This Committee has a comprehensive programme for continuous review and improvement and the Information Governance Committee reports to the Quality Committee every six months. Examples of completed audits and the work plan are included in the report and an annual report is received by the Board and this will be reflected in the Board's forward plan. **ACTION: Timing for the Annual Report on Information Governance to be captured in the forward plan.** **RESOLVED: The Board of Directors:** **1) Acknowledged full implementation and Trust compliance with the Accessible Information Standard**

	2) Acknowledged post implementation monitoring and audit.
DHCFT 2016/143	**ANY OTHER BUSINESS** **Carolyn Gilby's Retirement:** Richard Gregory reminded the Board that this would be Carolyn Gilby's last attendance at Board. He thanked her for her tremendous contribution to the Trust throughout her career and wished her well in her retirement. **Security and Safety:** Carolyn Green asked for input from a Non-Executive Director as Lead Security NED to look at standards of security and safety. Sam Harrison and Richard Gregory agreed to discuss this outside of the meeting with Non-Executive Directors as part of a wider portfolio review.
DHCFT 2016/144	**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 2016/145	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK OR GIAP** • Trust's non-compliance with EDS2 will be included as a risk in the BAF. • The capacity of Non-Executive Directors and Executive Directors will be reflected in the BAF. • Risks associated with delivery of the Trust' Strategy as identified in Strategy Implementation Update
DHCFT 2016/146	**BOARD PERFORMANCE AND CONTENT OF MEETING** The Board felt that today's deep dive into Learning Disabilities was a remarkable account of the worthwhile work carried out through the Commissioning Differently programme. The Integrated Performance Report stimulated good discussion

The next meeting of the Board held in Public Session will take place at 1pm on Wednesday, 5 October 2016.

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

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - OCTOBER 2016		Enc C
Date	**Minute Ref**	**Action**	**Lead**	**Status of Action**	**Current Position**	
25.5.2016	DHCFT 2016/080	Deep Dive - Neighbourhoods	Claire Wright	Building requirements of Neighbourhood teams in STP developments and as part of the Estates strategy to be considered by Claire Wright.	The next 6 monthly progress update of the Estates Strategy to Finance and Performance Committee will cover neighbourhood estate requirements and will also include a section summarising progress with the Derbyshire STP estates workstream. Will be agenda item at November F&P meeting.	Yellow
27.7.2016	DHCFT 2016/108	Service Receiver Story	Carloyn Green	Hayley Darn will discuss how service receiver stories can be carried forward in future board meetings with Carolyn Green	Carolyn Green is exploring and designing a new model and will discuss requirements and expectations with Quality lead/NED.	Green
27.7.2016	DHCFT 2016/112	Acting Chief Executive's Report	Sam Harrison	Engagement programme to be received at the September Board meeting and by the Council of Governors	Engagement Programme has since been deferred to November Board.	Yellow
27.7.2016	DHCFT 2016/113	Integrated Performance And Activity Report	~~Carolyn Gilby~~ Amanda Rawlings	Carolyn Gilby to check whether the Trust is an outlier with regard to grievances/dignity at work/disciplinaries	This has been difficult to ascertain as other organisations do not publish this information in their Board reports. The HR team have reported that this has been discussed at HR networks but that it is difficult to make comparisons as different organisations have different policies and procedures and every case is individual and some are simple to resolve others very complex. It was felt by the HR team that this would benefit from further discussion at People and Culture Committee and ongoing review of our own processes via our case tracker and through continued dialogue with other organisations. 7.9.2016 This will now be progressed by Amanda Rawlings	Amber
7.9.2016	DHCFT 2016/136	EDS2 Update	Amanda Rawlings	Non-compliance with EDS2 to be included in the BAF as a separate risk		Amber
7.9.2016	DHCFT 2016/136	EDS2 Update	Amanda Rawlings	ELT to address the Trust's resource to deliver EDS2		Amber
7.9.2016	DHCFT 2016/142	Trust Compliance – Accessible Information Standard and Information Governance Report	Sam Harrison Sue Turner	Timing for the Annual Report on Information Governance to be captured in the forward plan	Forward plan can be updated once the timeline for annual report to be received at Board is confirmed.	Amber

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

Derbyshire Healthcare NHS Foundation Trust
Report to Public Board of Directors 5th October 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. Mental health problems during pregnancy and the first year after birth are often under-reported, under-diagnosed and under-treated. The Royal College of General Practitioners recognises the importance of better detection and treatment of mental health problems during this perinatal time and it has developed a Perinatal Mental Health Toolkit. Our specialist perinatal teams within our Trust are aware that up to one in five women and one in ten men are affected by mental health problems in the perinatal period. Unfortunately, only 50% of these are diagnosed. Without appropriate treatment, the negative impact of mental health problems during the perinatal period is enormous and can have long-lasting consequences on not only women, but their partners and children too. This toolkit is a set of relevant tools to assist members of the primary care team to deliver the highest quality care to women with mental health problems in the perinatal period. As well as offering a diverse collection of resources, the Perinatal Mental Health Toolkit gives details of additional learning for individual practitioners. As a provider of secondary perinatal interventions this toolkit provides an opportunity for intervening earlier to improve outcomes

2. Expanding the children and young people mental health workforce - Health Education England has received funding from the Department of Health to support NHS England in meeting national targets to expand the workforce providing children and young people's mental health services. There is currently an opportunity for providers to express their interest in accessing the fully-funded scheme to employ and train new staff to provide evidence-based treatment for children and young people with mental health issues. To encourage expansion of the children and young people's mental health workforce, HEE is commissioning two training routes and offering 100% financial contribution to salary and training costs in the first year of employment. The access to funding is available for two roles:
    - Psychological Wellbeing Practitioners (PWP)
    - Recruit to Train (RtT)

   Our Trust is already part of a Children and Young People Improving Access to Psychological Therapy collaborative and we already use the PWP role however we will evaluate this opportunity to understand how it could support further improving our clinical outcomes and our service transformation.

3. To deliver the recommendations following Lord Carter's report earlier this year

Operational productivity and performance in English NHS acute hospitals: there has been recognition of the need for NHS organisations to work together and standardise specifications and catalogues to reduce ranges and ensure best value prices are secured using full volume leverage. The first tranche of 12 rationalised products have been detailed. We have been asked to confirm our commitment to this collaboration and agree to take advantage of this procurement. As a provider of community and mental health services many of the items procured through this scheme are not ones we require to deliver services but as the list expands we commit to using the nationally secured procurement items to avoid undermining the purchasing power of the national scheme.

4. NHSI have launched a set of tools to support the setting up of a culture and leadership programme. This is of specific interest for our Trust as this is one of the key areas of improvement required in the governance improvement action plan. The guide covers setting up a culture and leadership programme along with helping to diagnose our current culture using existing data, board, staff and stakeholder perceptions, and workforce analysis. The resources have been developed through the real life experiences of three pilot trusts and are based on national and international evidence that identifies elements and behaviours needed for high quality care cultures. This programme is something our engagement team will consider using moving forward

Local Context

5. The Derbyshire STP is now entering a triple phase of

    a. Detailed planning to ensure completion of the 30 page national submission due 21st October. This submission will expand on the April short return with more detail around the transformational changes and underpinning enabling schemes that will support Derbyshire to close the health and wellbeing quality and finance gaps. The Board should note that as with all strategic plans the STP submission will continue to grow and develop beyond the October submission. AT our extra-ordinary Board in October we are required to receive this detailed plan for consideration.
    b. Preparation for this year's contracting round to be managed in a way that supports the direction of travel for the STP. The system has agreed a set of contracting principles and intentions that have been shared with NHS England. These principles support shared accountability, investment in line with the STP year one requirements (including the GP and Mental Health Five Year Forward View requirements) and revised monitoring arrangements via the STP's new governance processes.
    c. The development of a communication and engagement plan for deployment after the 21st October submission, this plan will include planned local engagement events for the public and stakeholders.

6. The collaboration work between ourselves and Derbyshire Community Healthcare Services continues and we are on track for the Strategic Outcome Case to be presented to the Board and then the Council of Governors at the end of October.

7. The drive towards improving the efficiency of our support services functions continues in line with both the STP and the collaboration work. The current focus is to develop new models of function delivery that will enable support services to be delivered at greater scale in Derbyshire initially spanning our Organisation and DCHS but with a

recognition and expectation that in the medium term the functions will also support other Derbyshire Organisations.

Within our Trust

6. During September I attended the Trusts Medical Advisory Committee. During the committee we were able to focus on learning from the recent CQC visit, anticipated outcomes and the medical leadership contribution to resolving some of the core issues around capacity and consent and the Mental Health Act in general. I was particularly impressed by a presentation I heard (in the earlier Medical Staff Committee) about clinical variation associated with prescribing behaviours given by Dr Simon Taylor. We know that this is an area where as a Trust and health community we need to improve the consistency of practice leading to better outcomes for people who use our services.

7. September the 22nd was our Annual Members meeting at Ilkeston. It was well attended by Board members, Governors and some members of the public. I would like to again extend my thanks to Jonny Benjamin for his thought provoking opening address that provided us with some vital insights about living with a mental health problem. From the presentations in the market place to the questions we received it is clear that the passion and commitment to supporting improvements in outcomes for all the groups of people we work with remains very strong. Thanks to all those people who I know worked so hard to plan for the event.

8. One of the things I have enjoyed most in this acting up role is having the opportunity to meet staff and people who use our services and hear first-hand feedback from them. I wanted to share with the Board a note I received from Sukhi Katkhar who was a specialist nurse in North Derbyshire's Liaison Team. She said……

I would just like to share my experience with you and whilst I have been working within the Liaison Team (north). I am now moving into a different role within the Trust but I wanted to highlight the amazing work that goes on within the Liaison Team. I joined the liaison team with a forensic background, so this role was a complete different change for me. But in the last 2 years I have been supported immensely and this has enabled me to develop and enhance my clinical skills further. The support that I have received from my colleagues whether this be a consultant psychiatrist or nurse has helped me to develop this and have made me feel a part of the team. Without their support and continuous encouragement I don't think I would be as confident in undertaking a good clinical assessment within all the specialties of the team. I think that the work we do is paramount to the service user, and our Chesterfield Royal colleagues . Whilst we have challenging situation's and decision to make, the collaborative working that we do is amazing. The support you get within the team is brilliant. Although you are an autonomous clinician – you are classed an important member of the team. You are included in decision making and if there are any complex cases this will be discussed on multi-disciplinary.

The team will always look at ways in which we can improve our service and always think "outside the box". I have seen compassion and enthusiasm from my colleagues that has made me proud to have been a part in this team.

Just wanted to share my thoughts about this amazing team that works very hard to make sure that Trust standards are met.

9. During September I attended team sessions with Wards 1&2 and Derby City Neighbourhood Team (not included due to paper submission dates). The key issues arising included
    - Opportunities to create more time for frontline staff to spend face to face with patients
    - Good local morale but some concerns about the visibility of more senior managers
    - Interested in the collaborative work but didn't feel it would directly impact on the day to work.

Strategic considerations

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

Board Assurances

- The Board can take assurance that Trust level of engagement and influence is high in the health and social care community
- 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

Report presented by:

Ifti Majid
Acting Chief Executive

Report prepared by:

Ifti Majid
Acting Chief Executive

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 5th October 2016

Integrated Performance Report Month 5

Purpose of Report

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

Recommendations

The Board of Directors is requested to:

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

Executive Summary

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

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

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

The report continues to be 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 provides assurance across several BAF risks related to workforce, operational performance, quality performance, financial performance and regulatory compliance.

Consultation

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

Governance or Legal issues

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

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

Equality Delivery System

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

Report presented by:	**Mark Powell, Acting Chief Operating Officer** **Claire Wright, Director of Finance** **Amanda Rawlings, Acting Director of Workforce, OD & Culture** **Carolyn Green, Director of Nursing**
Report prepared by:	**Peter Charlton, General Manager, Information Management** **Rachel Leyland, Deputy Director of Finance** **Liam Carrier, Workforce Systems & Information Manager** **Hayley Darn, Nurse Consultant**

Highlights
- FSRR (based on current metrics) on plan and forecast on plan for year end
- Surplus better than plan in month and forecast to achieve plan at year end
- Cash better than plan

Challenges
- CIP forecast to deliver further but not to full target
- Mitigations of Financial risks during 16/17
- Containment of agency expenditure

Highlights
- % 6-8 Week Breastfeeding coverage has improved

Challenges
- 18 week incomplete RTT compliance
- Initial cluster of patients
- Outpatient Cancellations and DNAs

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

Challenges
- Monthly and annual sickness absence rates continue to rise.
- Budgeted Fte vacancies remain high.
- Appraisal compliance rates have decreased.

This is a report section in phased development.

Highlights
- Significant improvement in Fire warden training for campus services

Challenges
- Maintaining levels of supervision
- Commencement of Flu vaccination for staff

FINANCIAL OVERVIEW – AUGUST 2016

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Governance	FSRR	Overall Financial Sustainability Risk rating	YTD	4	4	G	→	As at the end of August the FSRR is 4 which is in line with 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. The ratings quoted are under the Risk Assessment Framework. This will be replaced by the new Single Oversight Framework with effect from 1st October and will result in different ratings and segmentation of providers.
			Forecast	4	4	G	→	
		Debt Service Cover	YTD	3	3	G	→	
			Forecast	3	3	G	→	
		Liquidity	YTD	3	4	G	→	
			Forecast	4	4	G	→	
		Income and Expenditure Margin	YTD	4	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	Control Total position £'000	In-Month	252	447	G	↑	The Control Total shows the position including the Sustainability Transformation Fund (STF) and the Underlying Income and Expenditure position excludes the STF. Surplus is better than plan in the month and due to changes in the run rate is forecast to achieve plan at the end of the financial year. The Normalised Income and Expenditure shows the financial performance adjusting for any non-recurrent costs or benefits that will not continue.
			YTD	616	1,453	G	↑	
			Forecast	2,531	2,531	G	→	
		Underlying Income and Expenditure position £'000	In-Month	183	378	G	↑	
			YTD	271	1,107	G	↑	
			Forecast	1,701	1,701	G	→	
		Normalised Income and Expenditure position £'000	In-Month	183	356	G	↑	
			YTD	271	1,188	G	↑	
			Forecast	1,701	1,673	R	↑	
	Profitability	Profitability - EBITDA £'000	In-Month	855	900	G	↓	
			YTD	3,670	4,380	G	↑	
			Forecast	9,806	9,694	R	↘	
		Profitability - EBITDA %	In-Month	7.5%	8.1%	G	↘	
			YTD	6.4%	7.9%	G	→	
			Forecast	7.1%	7.2%	G	→	
Liquidity	Cash	Cash £m	YTD	11.022	12.748	G	↑	Cash is currently above plan but is forecast to be below plan at year end due to the forecast release of some provisions. Capital is slightly behind plan YTD but is forecast to fully spend by the end of the financial year.
			Forecast	13.153	12.355	R	→	
	Net Current Assets	Net Current Assets £m	YTD	4.065	6.667	G	↑	
			Forecast	7.570	5.779	R	↑	
	Capex	Capital expenditure £m	YTD	1.101	0.912	R	↑	
			Forecast	3.450	3.450	G	→	
Efficiency	CIP	CIP achievement £m	In-Month	0.358	0.209	R	↑	CIP is currently behind plan and is forecast not to deliver the full plan at the end of the financial year. This is compensated for by other cost avoidance and underspends in the overall position.
			YTD	1.792	0.927	R	↓	
			Forecast	4.300	2.749	R	↓	
			Recurrent	4.300	2.026	R	↘	

Key:

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

Plan In-month or Year end Trust plan

Achieving plan
Not achieving plan

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

OPERATIONAL OVERVIEW – AUGUST 2016

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	NHSI	CPA 7 Day Follow-up	Month	95.00%	97.14%	G	→	Compliant with NHSI targets except incomplete RTT where the number of new referrals received per week has exceeded the number of available new outpatient appointment slots for quite some time.
			Quarter	95.00%	97.33%	G	→	
		CPA Reviews in Last 12 months	Month	95.00%	95.83%	G	→	
			Quarter	95.00%	95.13%	G	→	
		Delayed Transfers of Care	Month	7.50%	2.76%	G	→	
			Quarter	7.50%	2.55%	G	→	
		Data completeness - Identifiers	Month	97.00%	99.51%	G	→	
			Quarter	97.00%	99.56%	G	→	
		Data completeness - Outcomes	Month	50.00%	93.49%	G	→	
			Quarter	50.00%	93.49%	G	→	
		Community Care Data Activity - Completeness	Month	50.00%	93.36%	G	→	
			Quarter	50.00%	93.27%	G	→	
		Community Care Data - RTT Completeness	Month	50.00%	92.31%	G	→	
			Quarter	50.00%	92.31%	G	→	
		Community Care Data - Referral Completeness	Month	50.00%	75.85%	G	→	
			Quarter	50.00%	75.92%	G	↓	
		18 Week RTT incomplete	Month	92.00%	90.73%	R	↓	
			Quarter	92.00%	90.79%	R	↓	
		Early Interventions New Caseload	Month	95.00%	163.20%	G	↓	
			Quarter	95.00%	163.20%	G	↓	
		Clostridium Difficile Incidents	Month	7	0	G	→	
			Quarter	7	0	G	→	
		Crisis Gatekeeping	Month	95.00%	100.00%	G	→	
			Quarter	95.00%	100.00%	G	→	
		IAPT RTT within 18 weeks	Month	95.00%	99.74%	G	→	
			Quarter	95.00%	99.59%	G	→	
		IAPT RTT within 6 weeks	Month	75.00%	88.63%	G	→	
			Quarter	75.00%	88.07%	G	↓	
		Early Intervention in Psychosis RTT Within 14 Days	Month	50.00%	52.78%	G	↓	
			Quarter	50.00%	57.14%	G	↓	

Key:

Period

Month — Current Month

Quarter — Current Quarter

Achieving target

Not achieving target

↑ → ↓ Trend compared to previous month/quarter

OPERATIONAL OVERVIEW – AUGUST 2016

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Locally Agreed	CPA Settled Accommodation	Month	90.00%	96.36%	G	→	The majority of clinicians now successfully manage their PbR caseloads either independently or through positive engagement with available support.
			Quarter	90.00%	96.49%	G	→	
		CPA Employment Status	Month	90.00%	97.15%	G	→	
			Quarter	90.00%	97.32%	G	→	
		Data completeness - Identifiers	Month	99.00%	99.51%	G	→	
			Quarter	99.00%	99.56%	G	→	
		Data completeness - Outcomes	Month	90.00%	93.49%	G	→	
			Quarter	90.00%	93.49%	G	→	
		Patients Clustered not Breaching Today	Month	80.00%	80.57%	G	→	
			Quarter	80.00%	80.63%	G	→	
		Patients Clustered regardless of review dates	Month	96.00%	94.59%	R	→	
			Quarter	96.00%	94.66%	R	→	
		7 Day Follow-up - all inpatients	Month	95.00%	96.43%	G	→	
			Quarter	95.00%	96.76%	G	→	
		Ethnicity coding	Month	90.00%	90.57%	G	↓	
			Quarter	90.00%	90.29%	G	↓	
		NHS Number	Month	99.00%	99.98%	G	→	
			Quarter	99.00%	99.98%	G	→	
	Schedule 4	Consultant Outpatient Trust Cancellations	Month	5.00%	6.64%	R	→	The main reasons given for cancellation were consultant sickness and clinician on annual leave.
			Quarter	5.00%	6.47%	R	→	
		Consultant Outpatient DNAs	Month	15.00%	15.77%	R	→	
			Quarter	15.00%	16.44%	R	↓	
		Under 18 admissions to Adult inpatients	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Outpatient letters sent in 10 working days	Month	90.00%	91.11%	G	→	
			Quarter	90.00%	91.60%	G	→	
		Outpatient letters sent in 15 working days	Month	95.00%	95.87%	G	→	
			Quarter	95.00%	96.01%	G	→	
		Inpatient 28 day readmissions	Month	10.00%	0.70%	G	↑	
			Quarter	10.00%	3.68%	G	↑	
		MRSA - Blood stream infection	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Mixed Sex accommodation breaches	Month	0	0	G	→	
			Quarter	0	0	G	→	
		18 weeks RTT greater than 52 weeks	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Discharge Fax sent in 2 working days	Month	98.00%	99.09%	G	→	
			Quarter	98.00%	99.60%	G	→	

OPERATIONAL OVERVIEW – AUGUST 2016

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Fixed Submitted Returns	18 weeks RTT greater than 52 weeks	Month	0	0	G	→	Compliant with Fixed Targets except incomplete RTT here the number of new referrals received per week has exceeded the number of available new outpatient appointment slots for quite some time.
			Quarter	0	0	G	→	
		18 Week RTT incomplete	Month	92.00%	90.75%	R	→	
			Quarter	92.00%	90.28%	R	↓	
		Mixed Sex accommodation breaches	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Completion of IAPT Data Outcomes	Month	90.00%	96.38%	G	↑	
			Quarter	90.00%	95.59%	G	→	
		Ethnicity coding	Month	90.00%	90.11%	G	↓	
			Quarter	90.00%	90.78%	G	→	
		NHS Number	Month	99.00%	99.99%	G	→	
			Quarter	99.00%	99.99%	G	→	
Other Dashboards	Health Visiting	% 10-14 Day Breastfeeding coverage	Month	98.00%	100.00%	G	→	
			Quarter	98.00%	100.34%	G	→	
		% 6-8 Week Breastfeeding coverage	Month	98.00%	98.00%	G	→	
			Quarter	98.00%	98.70%	G	→	
	IAPT	Recovery Rates	Month	50.00%	53.62%	G	↓	
			Quarter	50.00%	54.14%	G	→	
		Reliable & Recovery Rates	Month	65.00%	74.56%	G	→	
			Quarter	65.00%	74.20%	G	↑	
	Safer Staffing	Inpatient Safer Staffing Fill Rates	Month	90.00%	104.1%	G	→	Detailed ward level information shows specific variances
			Quarter	90.00%	104.4%	G	↓	

WORKFORCE OVERVIEW – AUGUST 2016

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance		Trend	Key Points
Workforce Dashboard	NHSI Key Performance Indicator (KPI)	**Turnover** (annual)	**Aug-16**	10%	**10.72%**	↘	G	↑	Annual turnover remains within the Trust target parameters and is below the regional Mental Health & Learning Disability average of 12.65% (as at June 2016 latest available data). The monthly sickness absence rate is 0.24% lower compared to the previous month, however it is 0.79% higher than in the same period last year (August 2015) causing the annual sickness absence rate to increase further by 0.13%, to 5.83%. The regional average annual sickness absence rate for Mental Health & Learning Disability Trusts is 5.04% (as at May 2016 latest available data). Anxiety/stress/depression/other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 32.21% of all sickness absence, followed by Surgery at 11.58%, other musculoskeletal problems at 10.67% and Injury/Fracture at 8.79%. Vacancy rates have decreased by 1.23% compared to the previous month. The number of employees who have received an appraisal within the last 12 months has decreased by 0.90% to 66.29%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £809k of which £466k related to Medical staff. Compulsory training compliance has decreased slightly this month by 0.08% but still remains above the 85% main contract non CQUIN.
			Jul-16		10.86%		G		
		Sickness Absence (monthly)	**Aug-16**	5.04%	**6.08%**	↘	R	↑	
			Jul-16		6.32%		R		
		Vacancies (including 10% funded fte cover)	**Aug-16**	10%	**16.60%**	↘	A	↓	
			Jul-16		17.83%		A		
		Vacancies (actual)	**Aug-16**	0%	**6.60%**	↘	A	↓	
			Jul-16		7.83%		A		
		Appraisals (all staff - number of employees who have received an appraisal in the previous 12 months)	**Aug-16**	90%	**66.29%**	↘	R	↓	
			Jul-16		67.19%		R		
		Appraisals (medical staff only - number of employees who have received an appraisal in the previous 12 months)	**Aug-16**	90%	**79.46%**	↘	R	↓	
			Jul-16		82.24%		R		
		Qualified Nurses (to total nurses, midwives, health visitors and healthcare assistants)	**Aug-16**	65%	**68.36%**	↗	G	↑	
			Jul-16		67.95%		G		
		Agency Usage (£ year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Aug-16**	£0	**£809k**	↗	R	↑	
			Jul-16		£650k		R		
		Agency Usage (% year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Aug-16**	0%	**63.90%**	↘	R	↓	
			Jul-16		64.00%		R		
	Other KPI	**Compulsory Training** (staff in-date)	**Aug-16**	90%	**90.23%**	↘	G	↓	
			Jul-16		90.31%		G		

Key:

Period Current month and previous month

Plan Trust target

↗ Variance to previous month

Achieving target/within target parameters

Approaching target/approaching target parameters

Not achieving target/outside target parameters

Trend based on previous 4 months

Turnover parameters (8% to 12%)

Vacancy parameters (10% to 20%)

QUALITY OVERVIEW – AUGUST 2016

Enc E

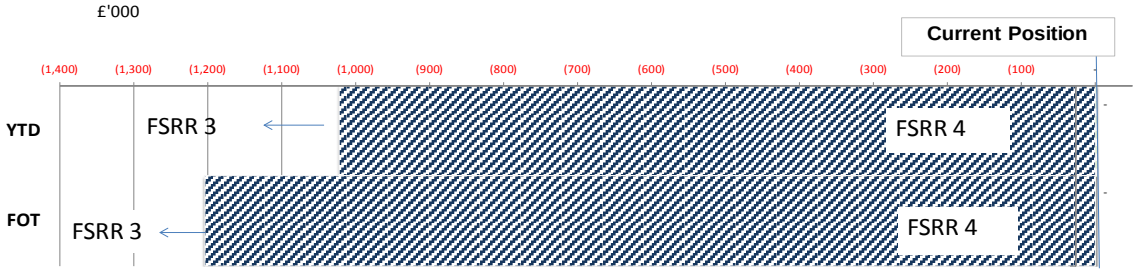
Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Quality	Quality Strategy	Percentage of current Inpatients with a recorded Capacity Assessment	Month	100.00%	64.80%	A	↓	Awaiting FSR roll out (data from PARIS), Capacity assessments now recorded on PARIS as per 'Blue Light' June 2016. Monitoring underway on this indicator in advance of full FSR. Awaiting further development of FSR amd reporting capability to demonstrate care planning.
			Quarter	100.00%		A	↓	
		Percentage of all patients with a care plan in place which has been reviewed with 12 months	Month	90.00%	N/A		→	
			Quarter	90.00%	N/A		→	
		Seclusion incidents	Month	20	22	G	→	
			Quarter	60	54	G	→	
		Physical Restraint incidents	Month	55	60	G	↑	
			Quarter	165	127	G	↓	
		Clinical Supervision	Month	90	33.22%	A	→	Sampling audit of care planning undertaken July 2016.
		Management Supervision	Month	90	48.90%	A	→	Supervision continues to increase, how
		Safeguarding Supervision	Month	90	50.20%	R	→	Metric for safeguarding supervision requires refinement as frequency is less.
		Professional Supervision	Month	90	17.90%	R	→	Exploring combining with managerial. 3 sessions per year
		Safeguarding Childrens Level 3 Training	Month	90	61.82%	A	→	Provided as internal & external course
		Fire Warden Training (Campus services)	Month	90	92.40%	G	↑	
	CQUINs or contractual levy	Flu Jab Up-take	Month	45.00%	N/A		→	Flu, see Quality Position Statement. Staff Vaccinations commence 6th Oct 2016. Think Family training increased by 1%, Safety Planning increased by 8%, now almost at target. New data collection system for CTR commenced August 2016, data not available.
			Quarter	45.00%	N/A		→	
		Think Family Training	Month	90.00%	66.59%	A	↑	
			Quarter	90.00%	N/A	A	→	
		The safety plan training	Month	90.00%	85.95%	A	↑	
			Quarter	90.00%	N/A	A	→	
		The number of LD or Autism admissions without a CTR before admission	Month	0	N/A		→	
			Quarter	0	N/A		→	

Financial Section

Governance – Financial Sustainability Risk Rating (FSRR)

The FSRR at the end of August is a 4 which is in line with plan. The forecast continues to be a rating of 4 as per the plan.

The headroom down to a FSRR of 3 year to date and forecast is £1.0m and £1.2m respectively. The headroom is shown in the graph below:



The year to date FSRR at the end of each of the quarters is shown in the table below:

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

NHS Improvement have recently published the Single Oversight Framework which includes new financial metrics to measure financial sustainability, efficiency and controls which will come into effect from quarter 3. It is important to note that the new metrics have been reversed and the best rating is a '1' as opposed to a '4'.

	YTD @ Quarter 1		YTD @ Quarter 2		YTD @ Quarter 3		YTD @ Quarter 4	
	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual
Capital Service Capacity rating	2	3	3	3	2	2	2	2
Liquidity rating	3	4	4	4	1	1	1	1
I&E Margin rating	3	4	4	4	1	1	1	1
I&E Margin Variance rating	4	4	4	4				
Difference to plan					1	1	1	1
Agency distance to cap					1	3	1	2
FSRR	3	4	4	4	1	2	1	1

Income and Expenditure

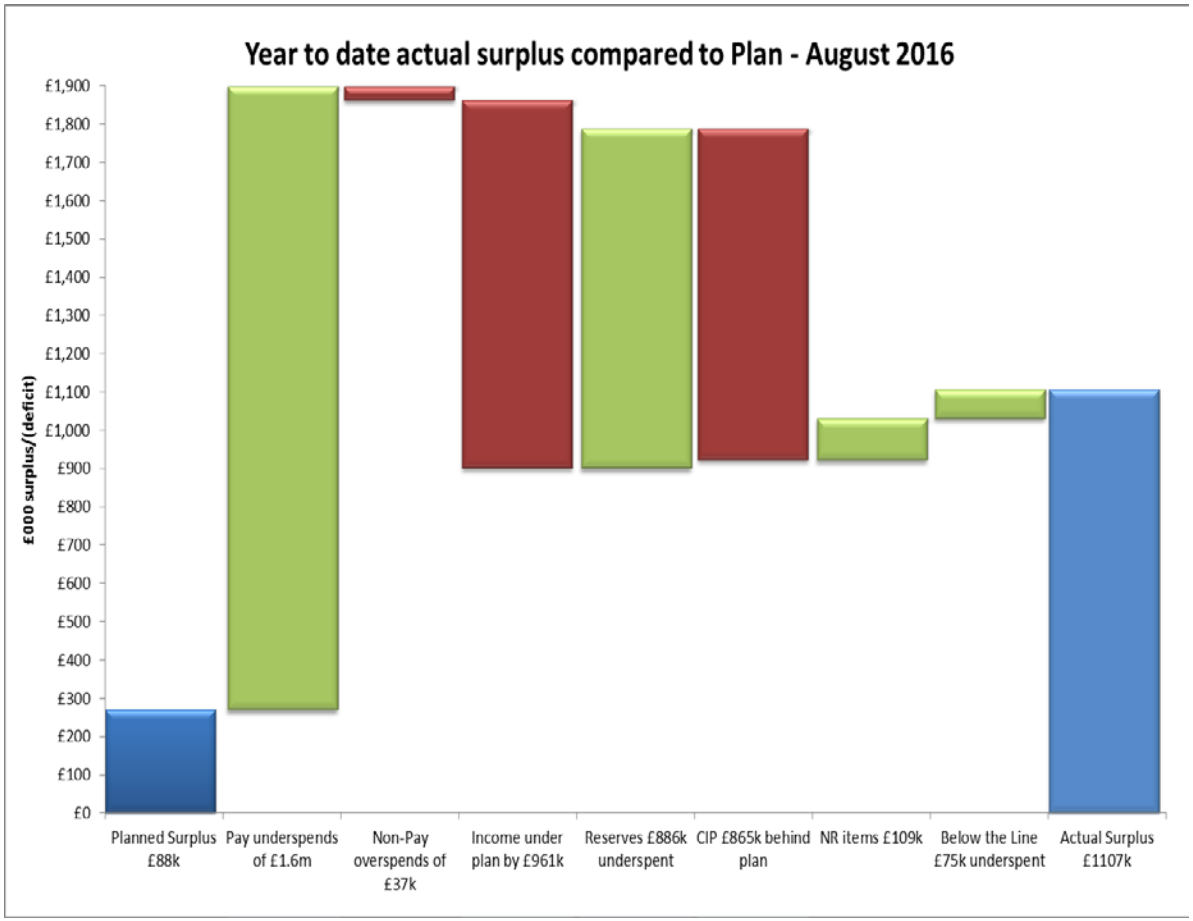
Statement of Comprehensive Income — August 2016

	Current Month			Year to Date			Forecast		
	Plan	Actual	Variance Fav (+) / Adv (-)	Plan	Actual	Variance Fav (+) / Adv (-)	Plan	Actual	Variance Fav (+) / Adv (-)
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical Income	10,548	10,310	(238)	52,905	51,616	(1,289)	127,406	124,429	(2,977)
Non Clinical Income	849	758	(91)	4,246	3,862	(384)	10,190	9,437	(753)
Employee Expenses	(8,376)	(8,117)	259	(42,573)	(40,118)	2,455	(101,492)	(96,882)	4,610
Non Pay	(2,167)	(2,051)	116	(10,908)	(10,980)	(71)	(26,298)	(27,291)	(992)
EBITDA	**855**	**900**	**45**	**3,670**	**4,380**	**710**	**9,806**	**9,694**	**(112)**
Depreciation	(295)	(145)	150	(1,473)	(1,360)	112	(3,534)	(3,452)	83
Impairment	0	(36)	(36)	0	(36)	(36)	(300)	(300)	0
Profit (loss) on asset disposals	0	0	0	0	0	0	0	0	0
Interest/Financing	(175)	(175)	1	(915)	(901)	14	(2,141)	(2,112)	29
Dividend	(133)	(133)	(0)	(667)	(666)	0	(1,600)	(1,600)	0
Net Surplus / (Deficit)	**252**	**411**	**159**	**616**	**1,417**	**801**	**2,231**	**2,231**	**(0)**
Technical adjustment - Impairment	0	(36)	(36)	0	(36)	(36)	(300)	(300)	0
Control Total Surplus / (Deficit)	**252**	**447**	**195**	**616**	**1,453**	**837**	**2,531**	**2,530**	**(0)**
Technical adjustment - STF Allocation	69	69	(0)	346	346	0	830	830	0
Underlying Net Surplus / (Deficit)	**183**	**378**	**195**	**271**	**1,107**	**837**	**1,701**	**1,700**	**(0)**

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

The Statement of Comprehensive Income shows both the control total of £2.5m which includes the Sustainability Transformation Fund (STF) and the underlying surplus / (deficit) against the underlying plan with the STF excluded.

Clinical Income is £238k less than plan in month and is forecast to be £3.0m 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 £91k and has a forecast outturn of £753k behind plan. £0.4m relates to a miscellaneous income target with no income forecast against it.
Pay expenditure is £259k less than the plan in the month and the year end position is £4.6m more favourable than plan which is due to planning assumptions (with offsetting income reductions) but also vacancies and recruitment.
Non Pay is underspent in the month by £116k but has a forecast outturn of £1.0m behind plan which mainly relates to Drugs and PICU expenditure.



Summary of key points

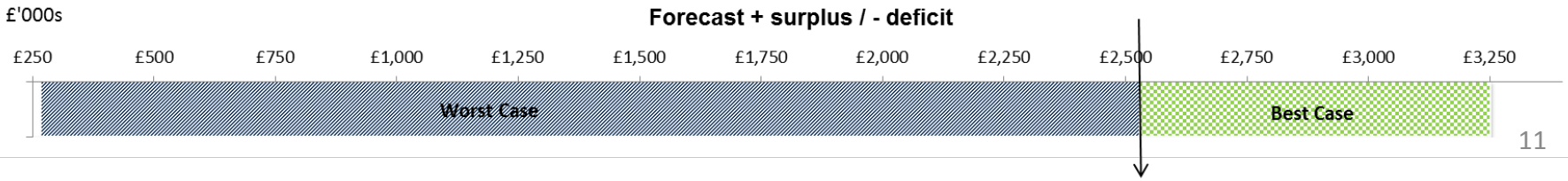
Overall favourable variance to plan year to date which is driven by the following:

- Pay budget is significantly underspent which is mainly driven by vacancies across the Trust. Some of this relates to planning assumptions which are different to final contract negotiations (which is offset by corresponding income reductions), new service developments that are in the process of being recruited to. These also have associated non-pay underspends.
- Reserves are underspent in month as expenditure is forecast over the coming months and spans across the financial year, so is in a different phasing to the original plan.
- This is helping to offset the CIP which is behind plan year to date.

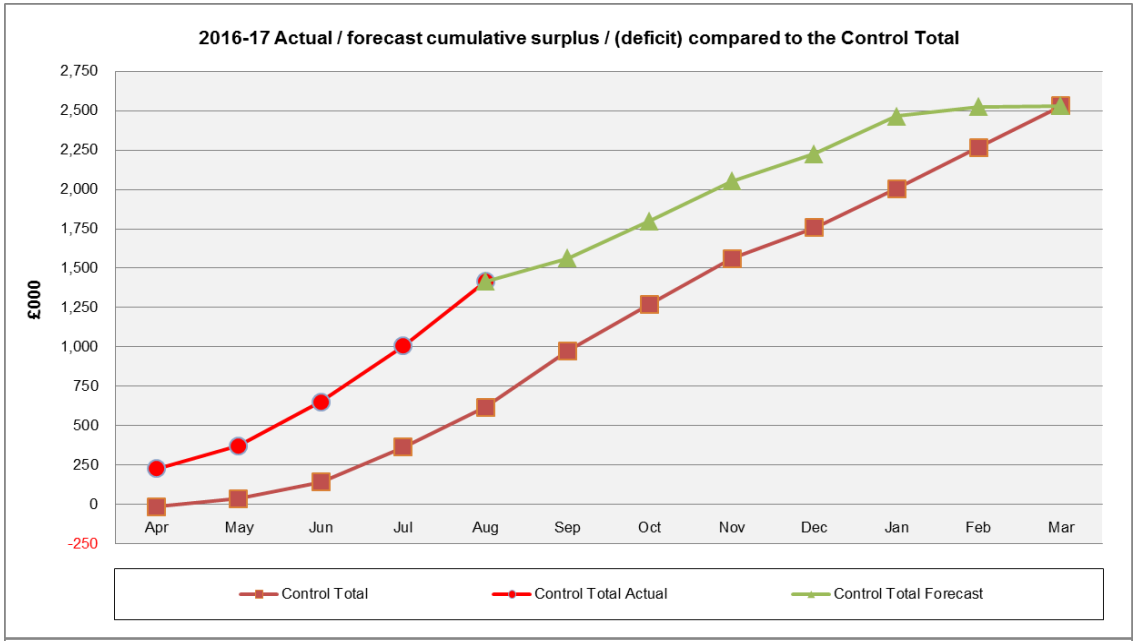
The forecast includes a set of assumptions based on knowledge and expectations at this point in time. There remains a large performance range from worst-case to best-case outturn which is primarily dependant on the mitigation of risks as well as factors such as recruitment, retention and agency expenditure levels.

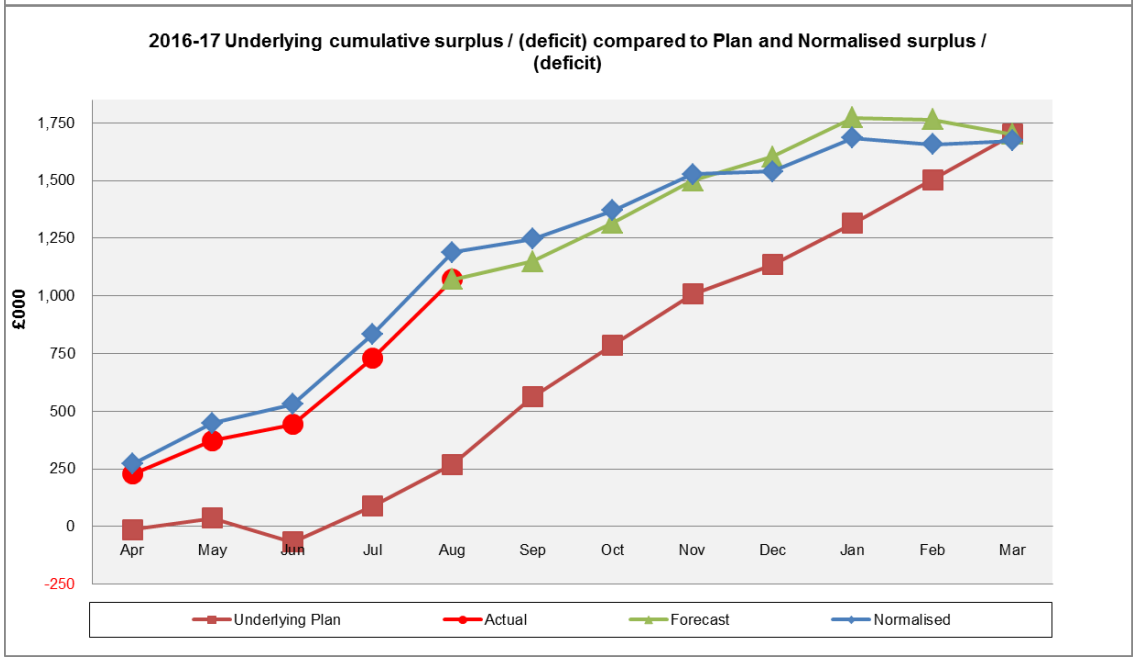
Forecast Range

Best Case	Likely Case	Worst Case
£3.3m Surplus	£2.5m surplus	£0.3m deficit



Normalised Income and Expenditure position





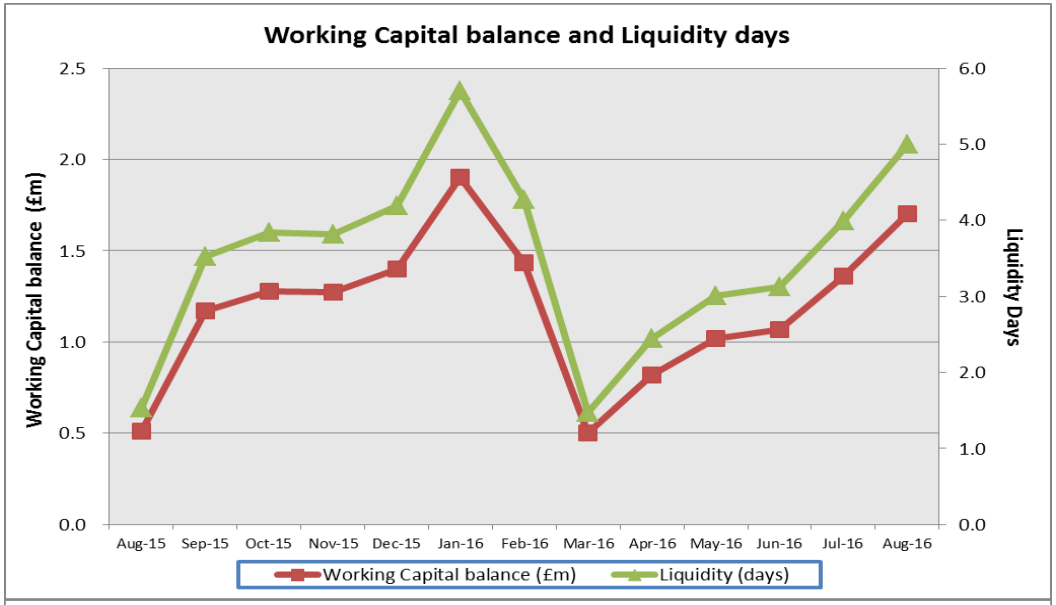
The first graph shows the actual and forecast cumulative surplus against the control total (including the Sustainability Transformation Fund (STF). The surplus is forecast to remain ahead of plan in the first part of the financial year and then slowly reduce back down to the planned control total.

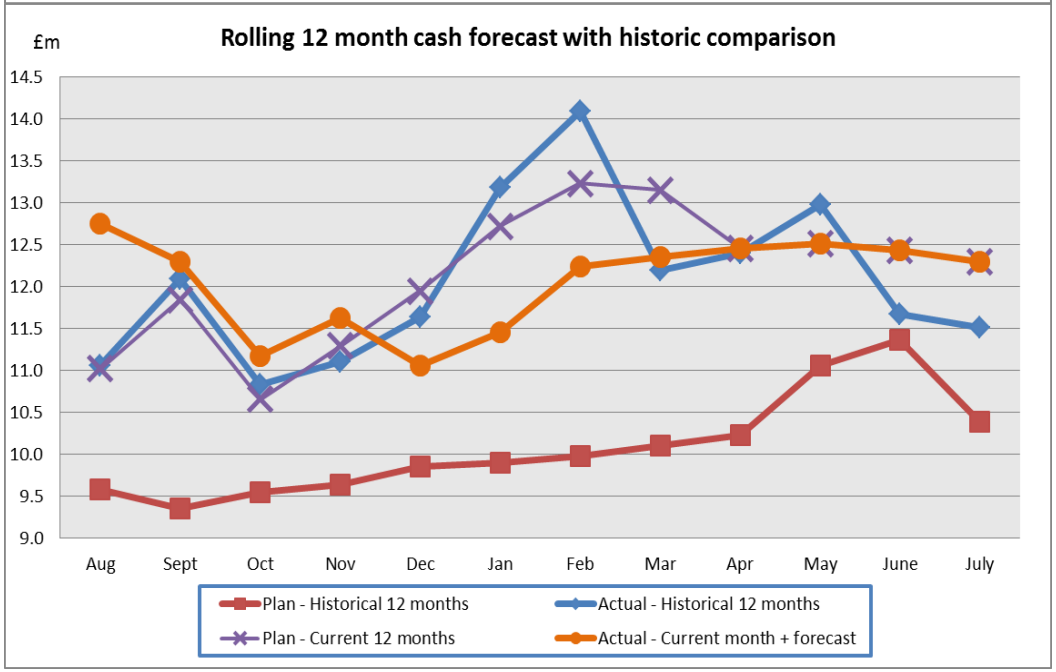
The second graph shows the underlying actual and forecast surplus against the underlying plan excluding the STF.

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

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

Liquidity





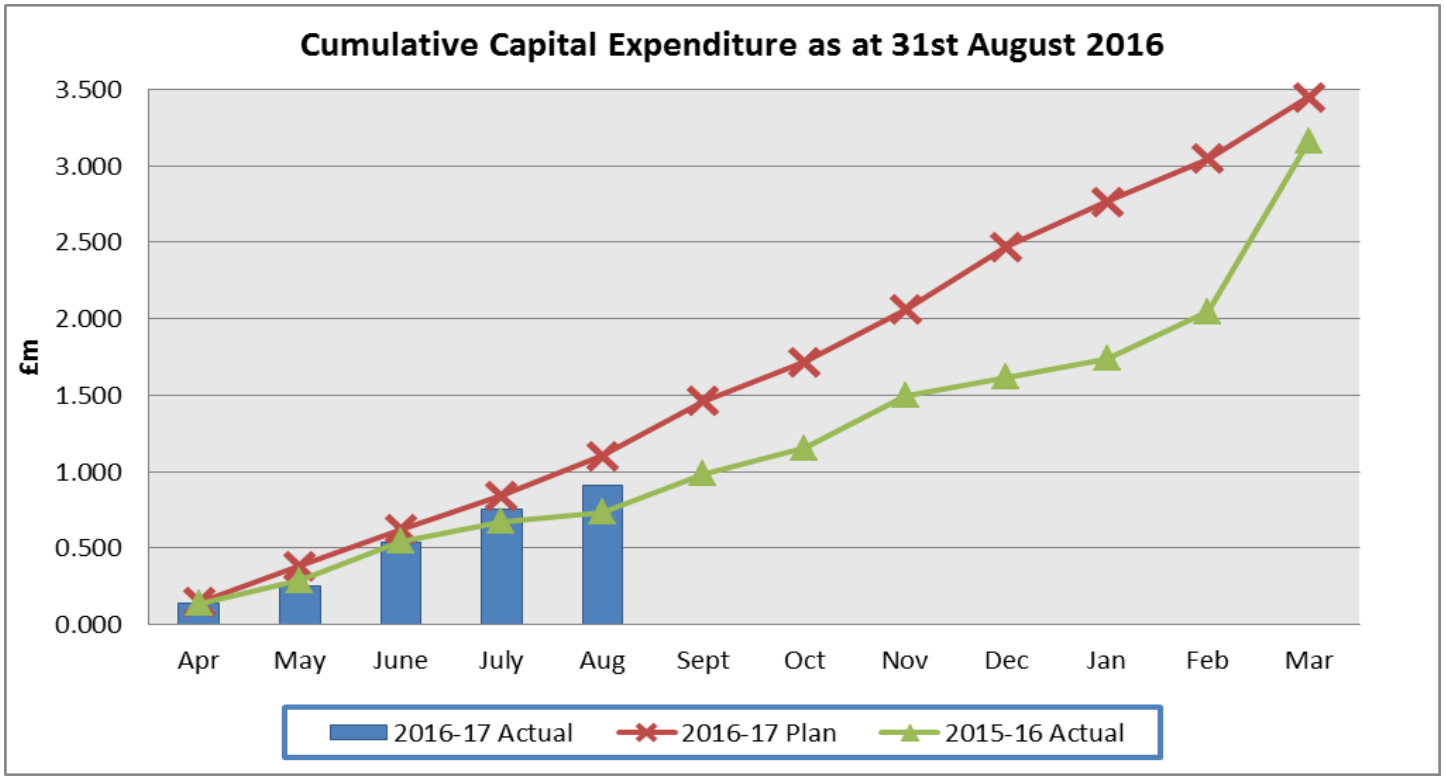
The first graph shows the working capital balance (net current assets less net current liabilities adjusted for assets held for sale and inventories) and how many days of operating expenses that balance provides.

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. August continues to show a further improvement up to 5 days which still gives a rating of 4 on that metric (-7days drops to a rating of 3).

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

Cash is currently at £12.7m which was £1.7m better than the plan at the end of August. This is mainly driven by the Income and Expenditure surplus.

Capital Expenditure

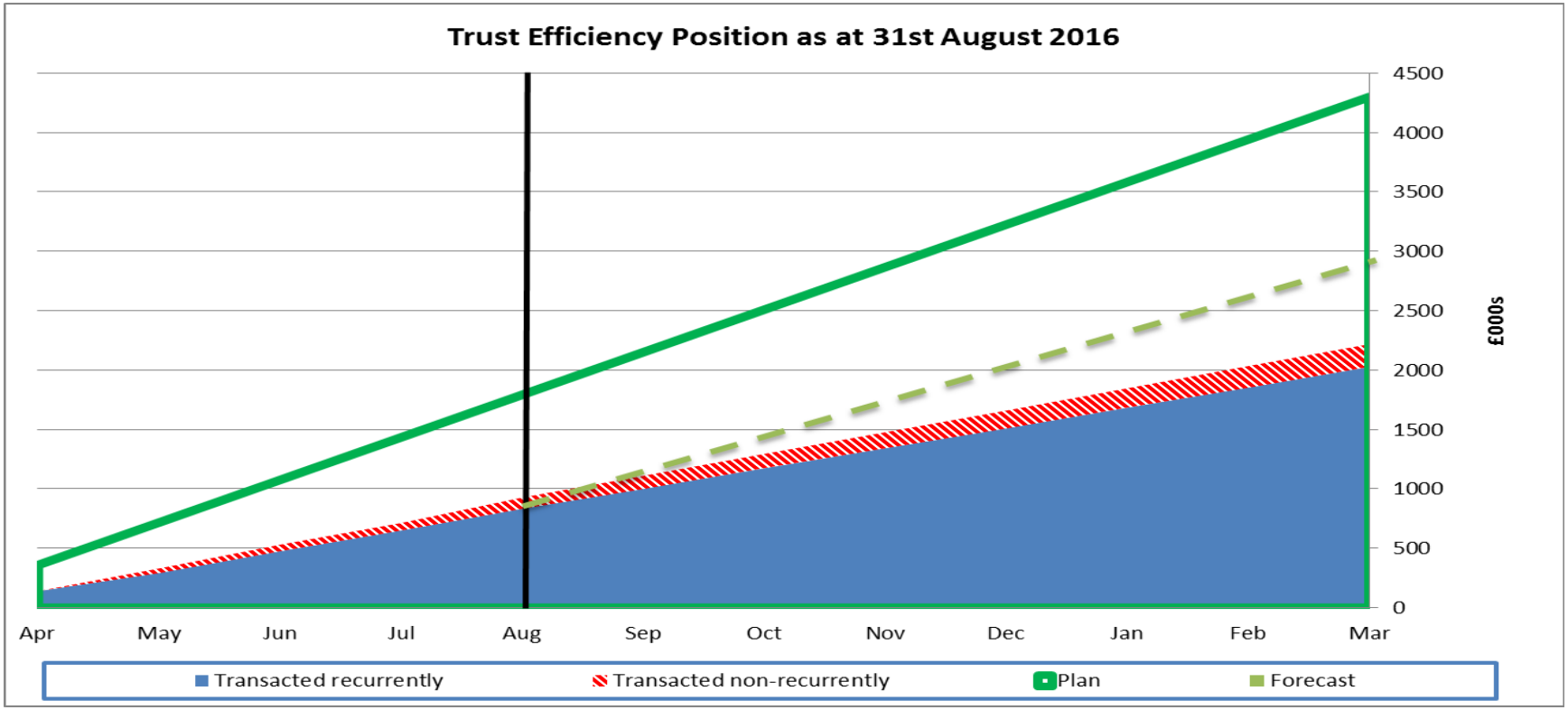


Capital Expenditure is £188k behind plan year to date but is forecast to spend to the plan of £3.45m by year end.

The 2016/17 schemes are regularly reviewed by Capital Action Team (CAT) including the reprioritisation to fund any new schemes. Some reprioritisation of schemes has already taken place to date this year in order to fund more urgent schemes. Capital Action Team members are currently collating a list of all CQC-related capital requirements in order to inform the prioritisation for the remainder of the year.

Efficiency

Cost Improvement Programme (CIP)



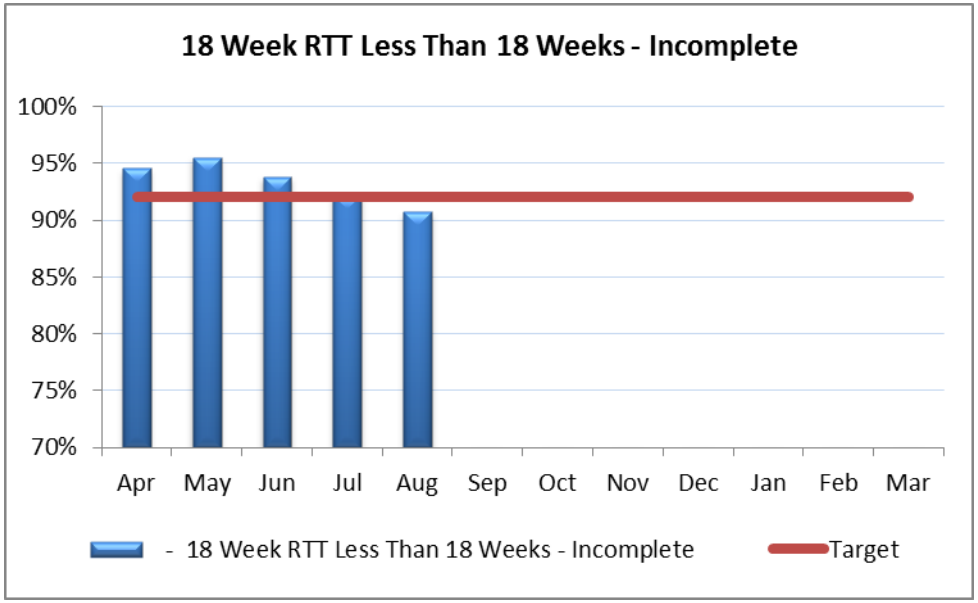
At the end of August there was a shortfall against the year to date plan of £865k. The full year amount of savings identified at the end of August reporting is £2.2m leaving a gap of £2.1m.

The forecast assumes that a further £0.5m will be achieved by the end of the financial year leaving unfound CIP of £1.5m. This underachievement is compensated for by cost avoidance and other underspends in the overall position.

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

Operational Section

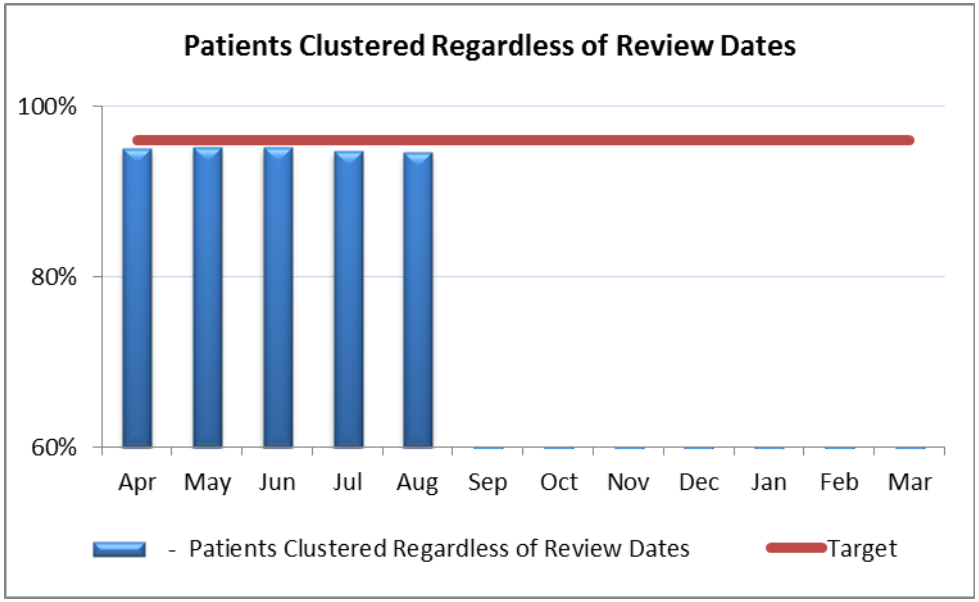
18 Week RTT Less Than 18 Weeks - Incomplete



The number of new referrals received per week has exceeded the number of available new outpatient appointment slots for quite some time. The number of available slots has also consistently been below the average number of new referrals. The median waiting time for patients currently waiting to be seen is 6.8 weeks. This is close to the national median of 6.5 weeks
(data source: https://improvement.nhs.uk/uploads/documents/BM1666_Sector_performance_report_.pdf)
The rate of DNAs also impacts on capacity and if a patient does not attend their appointment it does not stop the RTT clock. (See DNA section below for action being taken).
The following actions are being undertaken;

- ACDs to lead on the creation of urgent assessment slots in areas needed.
- To review the number of first appointments all medics are offering
- To establish whether any treatment has been provided during contacts with the Trust's interface services prior to onward referral to outpatients. Records will be corrected if applicable.
- To review Resource Centre outpatients opening hours.
- To produce a protocol for the interface services around providing treatment

Clustering

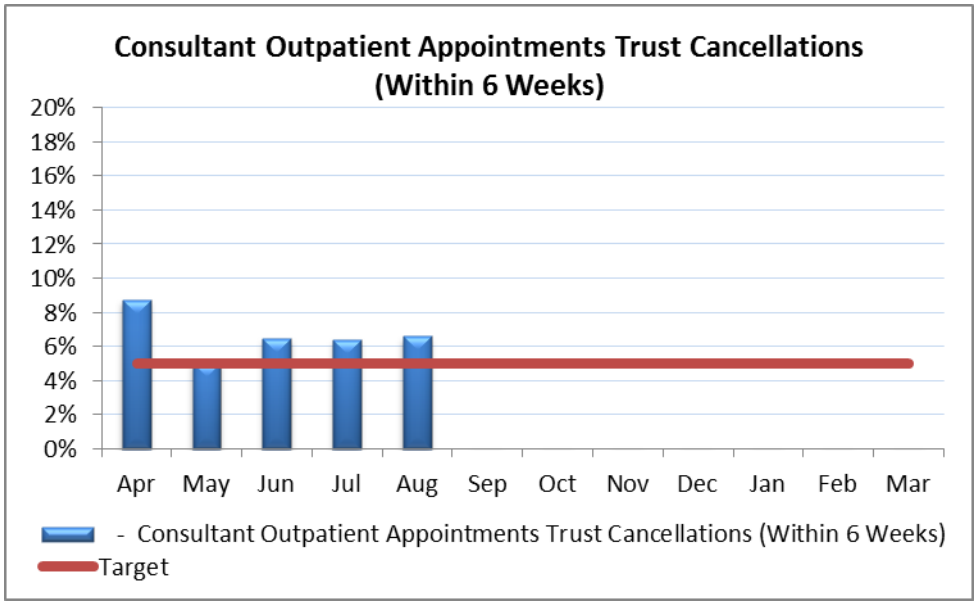


The majority of clinicians now successfully manage their PbR caseloads either independently or through positive engagement with available support.

Solutions being deployed on an ongoing basis:

- to data cleanse
- to make improvements in practitioner clustering
- to highlight to staff responsible for clustering the issues needing to be resolved
- PbR Advisors continue to target support to those clinicians with the largest clustering backlogs.
- Taught Course “Understanding HoNOS and Care Clusters – Flustered About Clusters?” has now been introduced.

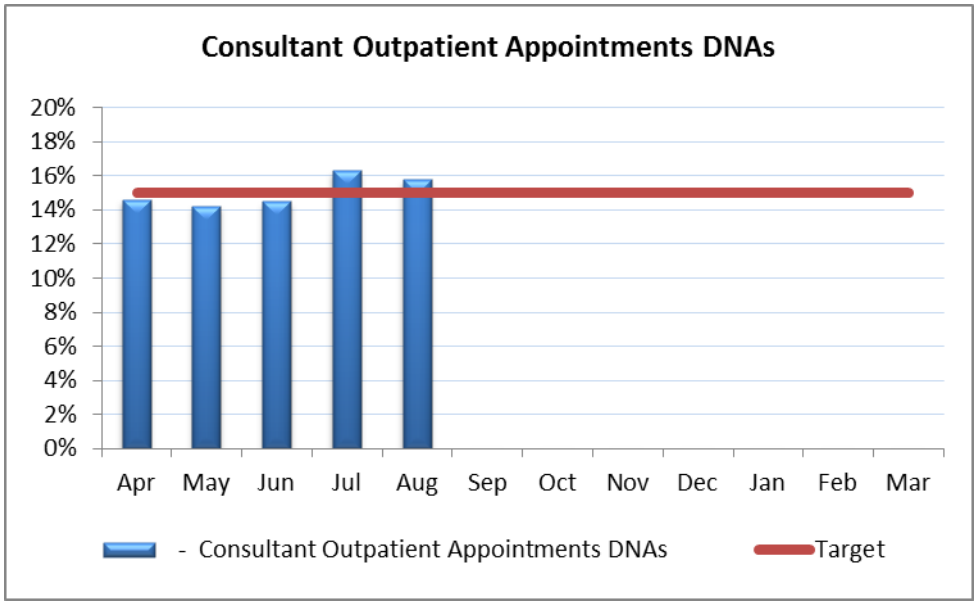
Consultant Outpatient Appointments Trust Cancelations (within 6 weeks)



The main reasons given for cancellation were consultant sickness, annual leave, having to attend an inquest and junior doctors on nights.

- 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 by IM&T to enable easier reporting and monitoring. IM&T have adapted Paris to enable the recording of cancellation reasons for individual appointments, not just whole clinics.

Consultant Outpatient Appointments DNAs



The rate of DNAs was above the target threshold for the second time in 6 months. Where mobile numbers are recorded on Paris we send out text message reminders, however these will only prove to be effective if the mobile numbers held on file are current.

- The Divisional Admin Coordinator and Professional Lead has been requested to review outpatient administration processes.
- PCOG to consider the option of writing to all patients asking them to update their details, to ensure that we have the correct mobile numbers for sending text message reminders. This would include asking for their ethnicity.
- To continue to monitor

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	174.8%	56.4%	106.5%	93.5%	Yes	We ensure that our ward is safely managed and times this as meant where we have had sickness we cover with a qualified if unable to get unqualified cover. We are also working towards ensuring we have 2 qualified staff on all shifts and only 2 qualified at night so we will no longer be working to 1 qualified and 1 NA
CHILD BEARING INPATIENT	113.4%	143.9%	100.0%	140.6%	Yes	No comment received
CTC RESIDENTIAL REHABILITATION	100.1%	98.7%	100.0%	100.0%	No	
ENHANCED CARE WARD	86.6%	112.8%	54.1%	145.8%	Yes	Enhanced Care Continues to carry RN vacancies which are being addressed through the recruitment programme. We have two new starters in September and a third nurse who has come out of retirement that will be commencing shortly.
HARTINGTON UNIT - MORTON WARD ADULT	107.9%	102.6%	61.8%	196.4%	Yes	Morton ward are currently carrying a significant amount of Registered nurses vacant posts and these are back filled by HCAs – on night duty we are rostering x1 qualified nurse rather than the desired x2.
HARTINGTON UNIT - PLEASLEY WARD ADULT	109.1%	72.6%	94.4%	105.1%	Yes	In August the ward has carried some short term HCA sickness, there has been difficulty covering this with HCA's, as a result these shifts have been covered by Registered Staff accounting for the breach in fill rate tolerances.
HARTINGTON UNIT - TANSLEY WARD ADULT	75.5%	121.1%	50.0%	225.8%	Yes	Currently carrying significant number of band 5 vacancies, recruited into some of the vacancies and awaiting them starting. In addition this this we have one staff nurse unable to undertake clinical duty.
KEDLESTON LOW SECURE UNIT	104.8%	94.9%	103.2%	100.0%	No	
KINGSWAY CUBLEY COURT - FEMALE	95.4%	97.7%	82.3%	128.0%	Yes	Ward has R/N vacancies, and are actively looking to recruit
KINGSWAY CUBLEY COURT - MALE	80.0%	125.3%	91.9%	155.9%	Yes	Ward has R/N vacancies, and are actively looking to recruit
LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP	126.5%	70.8%	69.4%	232.2%	Yes	No comment received
LONDON ROAD COMMUNITY HOSPITAL - WARD 2 OP	110.3%	91.8%	106.4%	140.3%	Yes	The increased use was due to the levels of increased observations on the ward which required an increase of x1 staff per shift to meet the needs of the patients (2) who required 1-1 support.
RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT	100.7%	99.4%	95.5%	103.2%	No	
RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT	86.7%	112.4%	51.6%	251.6%	Yes	Ward 34 continue to carry a high level of vacancies, which is being addressed with in recruitment but this is a slow process, also there continues to be a high level of clinical activity and increased engagement levels resulting in an increased use of nursing assistants and bank staff.
RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT	68.5%	154.9%	78.0%	132.8%	Yes	We have broken current fill rates due to a number of unfilled vacancies.
RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT	93.0%	107.3%	72.1%	154.7%	Yes	increased use of bank staff due to staff vacancies not being filled

Workforce Section

WORKFORCE DASHBOARD

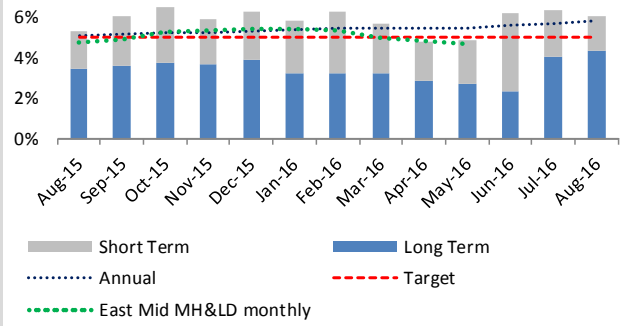
Wellbeing

Sickness Absence

(Monthly)

Jun-16	Jul-16	Aug-16
6.20%	6.32%	**6.08%**

Target 5.04%



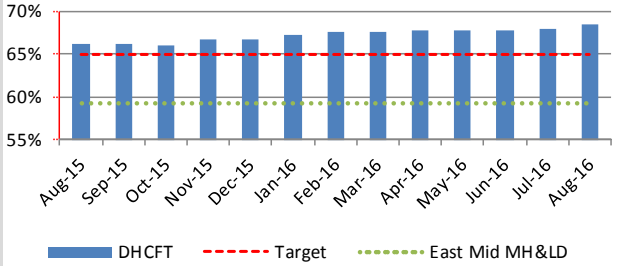
The Trust annual sickness absence rate is currently 5.83%. Monthly sickness absence is 0.24% lower than the previous month, but is 0.79% higher than the same period last year. In June 2016 there was a large increase in short term absence caused by traditional long term absence reasons which has now developed into long term sickness. Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 32.21% of all sickness absence, followed by surgery at 11.58%, other musculoskeletal problems at 10.67% and injury/fracture at 8.79%.

Qualified Nurses

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

Jun-16	Jul-16	Aug-16
67.81%	67.95%	**68.36%**

Target 65%



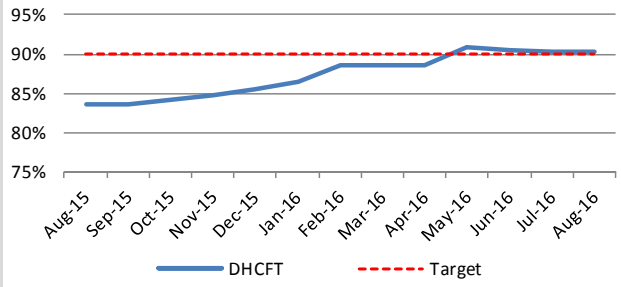
Contracted staff in post qualified nurses to total nurses, midwives, health visitors and healthcare assistants is running at 68.36%. Vacancy rates can impact on this measure. The average for East Midlands Mental Health & Learning Disability Trusts is 59.25%. Health Visitors represent 5.58% of the Trust total and are not included in the Qualified Nurses calculation. Healthcare Assistants and Nursing Support staff represent 26.06% of the total.

Compulsory Training

(Staff in-date)

Jun-16	Jul-16	Aug-16
90.49%	90.31%	**90.23%**

90%



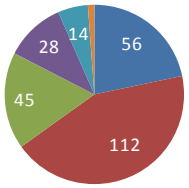
Compulsory training compliance continues to remain high running at 90.23%, a slight decrease of 0.08% compared to the previous month. Compared to the same period last year compliance rates are 6.57% higher. Compulsory training compliance remains above the 85% main contract commissioning for quality and innovation (CQUIN) target and remains above the Trust target.

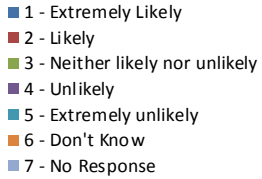
WORKFORCE DASHBOARD

Motivation

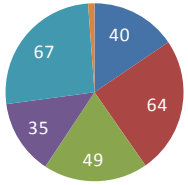
Staff FFT Q1 2016/17 & Staff Survey 2015

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





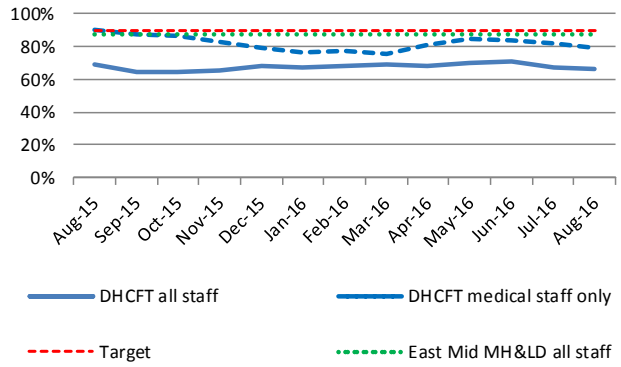
How likely are you to recommend this organisation to friends and family as a place to work.



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

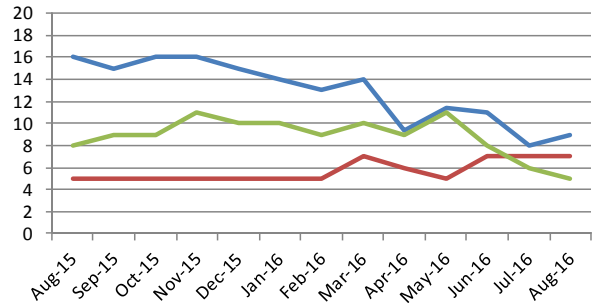
Appraisals	Jun-16	Jul-16	**Aug-16**
(All staff)	71.29%	67.19%	**66.29%**

Target 90%

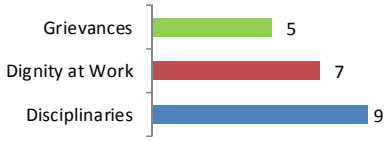


The number of employees who have received an appraisal within the last 12 months has decreased by 0.90% during August 2016 to 66.29%. Compared to the same period last year, compliance rates are 3.24% lower. Medical staff appraisal compliance rates are running at 79.46%. According to the latest staff survey results, the national average for Mental Health & Learning Disability Trusts is 91%. Local benchmarking data for a range of Trusts in the East Midlands shows an average completion rate of 77.33%.

Grievances/Dignity at Work/Disciplinaries as at 31/08/16



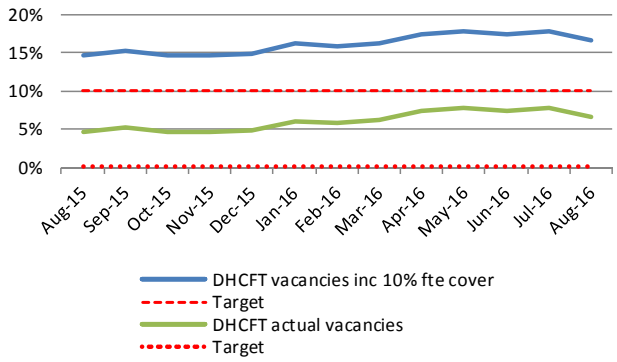
5 grievances currently lodged at the formal stage, one long term case concluded in August 2016 and no new cases received. 7 dignity at work cases currently lodged, no new cases and efforts continue to bring existing cases to a conclusion. 9 disciplinaries in progress, 1 new case received in August 2016 and efforts continue to bring existing cases to a close.



Vacancy

		Jun-16	Jul-16	Aug-16
(Budgeted full time equivalent)	Including 10% funded fte cover	17.48%	17.83%	**16.60%**
	Actual	7.48%	7.83%	**6.60%**

Target 10%/0%

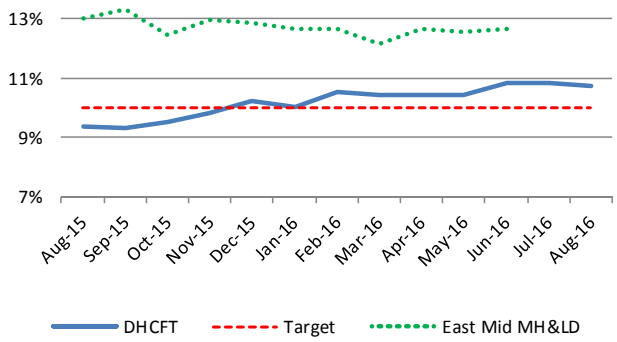


The Trust target for contracted staff in post is 90% which allows 10% funded full time equivalent (fte) surplus for sickness and annual leave cover in In-Patient areas. The budgeted fte vacancy rate has decreased by 1.23%. April 2016 included additional full time equivalent investment for 2016/17. New recruitment activity during August 2016 was for 117 posts. 58% were for qualified nursing, 15% admin & clerical, 11% additional clinical services, 11% medical, 3% scientific & technical and 2% Allied Health Professionals.

Turnover

	Jun-16	Jul-16	Aug-16
(Annual)	10.86%	10.86%	**10.72%**

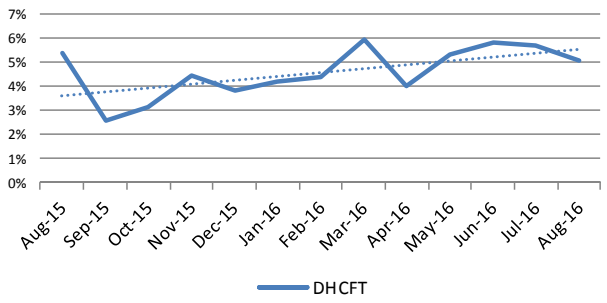
Target 10%



Annual turnover remains within Trust target parameters at 10.72% and is below the average for East Midlands Mental Health & Learning Disability Trusts. The average number of employees leaving each month remains static at 22. During August 2016 20 employees left the Trust which included 3 retirements. A key factor still remains for the increase in recent turnover rates, which is a reduction in overall contracted staff in post caused by unfilled vacancies.

Agency Usage

	Jun-16	Jul-16	Aug-16
(Spend)	5.79%	5.71%	**5.05%**



Total agency spend in August was 5.05% (6.18% including medical locums). Of total agency and locum spend for all staff groups, Qualified Nursing represented 1.0%, Medical 3.4% and other agency usage 1.8%. Agency Qualified Nursing spend against total Qualified Nursing spend in August was 2.7%. Agency Medical spend against total Medical spend in August was 12.2%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £809k of which £466k related to Medical staff.

Quality Section

Strategic Risks (Board Assurance Framework)

Risk Description	Risk rating	Trend
1a) Failure to achieve clinical quality standards	HIGH	⟷
2a) Risk to delivery of national and local system wide change.	HIGH	⟷
3a) Loss of public confidence due to Monitor enforcement actions and CQC requirement notice and adverse media attention	HIGH	⟷
3b) Loss of confidence by staff in the leadership of the organisation at all levels	HIGH	⟷
3c) Risk that turnover of the Board members could adversely affect delivery of the organisational strategy	MED	**NEW**
4a) Failure to deliver short term and long term financial plans	EXTR	⟷
4b) Failure to deliver the agreed transformational change at the required pace	HIGH	⟷

A new risk, 3c, has to been proposed to reflect the risks identified by current level of Board turnover. This risk will be considered by the Audit and Risk Committee as part of the BAF review in Oct 16 and then by Board in Nov 16.

Clinical Risks (Significant)

The list below relates to themes from across a number of risk assessments recorded on Datix

Risk Description	Risk rating	Trend
Long waiting lists due to difficulty in recruiting paediatricians	EXTR	⟷
Nursing vacancies, leadership and succession planning across Radbourne Unit	EXTR	⟷
Non-compliance with medicine management standards. Lack of facilities to assure compliance with medicines management standards	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	⟷
Increased risk of fire, violence and aggression, lone working and workplace stress on Radbourne Unit.	HIGH	⟷

Themes continue as previously identified:
Significant staffing level risks across a number of service areas;
Associated increases in work related stress;
Increased risks of violence and aggression identified on Radbourne Wards in relation to the number of staff vacancies;
Increased risk of fire identified on some inpatient wards associated with the smoking ban

Quality & Safety of Services - Focus on Safeguarding Children Training – 23rd August 2016

Training Name	Target Group	Compliant	Non Compliant	Compliant %
C Safeguarding Children Level 1 (3 yearly)	601	555	46	92.35%
C Safeguarding Children Level 1 (once only)	1765	1720	45	97.45%
R Safeguarding Children Level 2 (3 yearly)	211	182	29	86.26%
R Safeguarding Children Level 2 (once only)	1522	1382	140	90.80%
R Safeguarding Children Level 3 (3 yearly)	1218	753	465	61.82%
R Safeguarding Children Level 3 (annual)	291	199	92	68.38%
R Safeguarding Children (Paediatricians) Level 3 (annual)	11	8	3	72.73%
R Safeguarding Children Level 4 (annual)	8	2	6	25.00%
R Think Family (Once Only)	1706	1128	578	66.12%

The above table shows the Safeguarding Children Training Data, in context of all of the types of training, along with the frequency required.

Quality & safety of Services – Focus on Fire Warden Training – Campus Services

Team	Fire Responsible Person			Fire Warden			Fire Safety Level 1			Total Staff
	Red	Green	% Compliant	Red	Green	% Compliant	Red	Green	% Compliant	
383 Audrey House Residential Rehabilitation 'IP' (OSER) (G61104)		2	100.0%	0	4	100.0%		19	100.0%	19
383 Cherry Tree Close Residential Rehab 'IP' (OSER) (G61103)	1	4	80.0%	0	2	100.0%		23	100.0%	26
383 County South Older People Day Hospital 'DH' (OSER) (G61877)	1	2	66.7%	1	1	50.0%		6	100.0%	7
383 Dovedale Older People Day Hospital 'DH' (OSER) (G61876)	1	2	66.7%	2	0	0.0%		6	100.0%	10
383 Enhanced Care Ward 'IP' (OSER) (G61113)	1	2	66.7%	0	4	100.0%		25	100.0%	30
383 Hartington Unit Morton Ward Adult 'IP' (OSER) (G61377)	1	2	66.7%	0	3	100.0%		22	100.0%	25
383 Hartington Unit Pleasley Ward Adult 'IP' (OSER) (G61378)		3	100.0%	0	2	100.0%		26	100.0%	29
383 Hartington Unit Tansley Ward Adult 'IP' (OSER) (G61376)	2	3	60.0%	0	5	100.0%		20	100.0%	25
383 Kedleston Low Secure Unit 'IP' (OSER) (G61053)	1	5	83.3%	0	2	100.0%		42	100.0%	45
383 Kingsway Cubley Court OP Female 'IP' (OSER) (G61734)		3	100.0%	0	4	50.0%		34	100.0%	35
383 Kingsway Cubley Court OP Male 'IP' (OSER) (G61731)		5	100.0%	0	5	100.0%		36	100.0%	37
383 LRCH Ward 1 OP 'IP' (OSER) (G61726)		5	100.0%	0	6	100.0%		26	100.0%	28
383 LRCH Ward 2 OP 'IP' (OSER) (G61727)	1	5	83.3%	0	5	100.0%	1	30	96.8%	35
383 Perinatal Psychiatry 'IP' (OSER) (G61110)		2	100.0%	2	0	0.0%		16	100.0%	16
383 RDH Clinical & Night Co-ordinators 'DH' (OSER) (G61111)	1	2	66.7%	0	2	100.0%		3	100.0%	3
383 RDH Ward 33 Adult Acute Inpatient 'IP' (OSER) (G61107)	1	3	75.0%	0	2	100.0%		25	100.0%	31
383 RDH Ward 34 Adult Acute 'IP' (OSER) (G61118)	1	3	75.0%	0	4	100.0%		24	100.0%	28
383 RDH Ward 35 Adult Acute Inpatient 'IP' (OSER) (G61108)	2	2	50.0%	0	3	100.0%		28	100.0%	32
383 RDH Ward 36 Adult Acute Inpatient 'IP' (OSER) (G61109)	1	3	75.0%	0	4	100.0%		24	100.0%	28
383 The Lighthouse 'DH' (OSER) (G61618)	1		0.0%	0	2	100.0%		7	100.0%	13
TOTAL	16	58	78.4%	5	61	48.8%	1	442	99.8%	502
	78.4%			92.4%			99.8%			

CQC Comprehensive Inspection – Action Planning

	NUMBER OF ACTIONS PER SERVICE, GROUPED BY REGULATION											
	REGULATION											
	REGULATION 08 - GENERAL	REGULATION 09 - PERSON CENTRED CARE	REGULATION 10 - DIGNITY AND RESPECT	REGULATION 11 - CONSENT	REGULATION 12 - SAFE CARE AND TREATMENT	REGULATION 13 - SAFEGUARDING	REGULATION 15 - ENVIRONMENT AND EQUIPMENT	REGULATION 16 - COMPLAINTS	REGULATION 17 - GOOD GOVERNANCE	REGULATION 18 - STAFFING	REGULATION 22 - STAFFING	TOTAL
LEAD FOR ACTION PLAN	Clare Biernacki	Joe Wileman	Owen Fultom	Tracey Holtom	Hayley Darn/Sarah Butt	Tina Ndili	Carolyn Green	Anne Reilly	Sam Harrison	Kath Lane	Kath Lane	
SERVICE												
ACUTE - ADULTS	4	2	1	1	7		6		5	6		32
ACUTE - OLDER ADULTS	1	1		5	3		1		4			15
CRISIS			1	1	4		4		1	4		15
FORENSIC		3	1	2	8	2	4	1	7	5		33
REHAB	1	5			1				2	2		11
CAMHS		1					3		2			6
CHILDREN + YP		1			4	1	1		8	2		17
LEARNING DISABILITIES		2		1	1		1		3			8
COMMUNITY - ADULTS		4	1	1	2		6		1	5		20
COMMUNITY - OLDER ADULTS		2							3			5
TRUST-WIDE											1	1
TOTAL	6	21	4	11	30	3	26	1	36	24	1	163

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 5th October 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. Strategic and clinical developments of Safeguarding Adults and Children with Derby City Local authority and partners
2. Executive Director of nursing attendance at Quality Leadership team sub groups to explore and seek assurance on their value, attendance and level of functioning and whether issues are being escalated and resolved through a quality governance system
3. Feedback on quality priorities. Think Family and family inclusive practice, particularly with regard to the Triangle of care and dissemination of practice to other Trusts.
4. Quality visits and Quality priorities of the Nursing and Quality team
5. Quality governance senior staff changes
6. CQUIN developments including Staff Health and Well being
7. Involving Service receivers and carers in Trust developments and briefing on Trust wider system developments
8. Care Quality commission comprehensive inspection action planning, reporting and the Quality summit.

Strategic considerations

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

(Board) Assurances

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

Consultation

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

Governance or Legal issues

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

Equality Delivery System

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

Recommendations:

The Board of Directors is requested to:

- Receive this quality position statement.
- Gain assurance and information on its content and seek clarity or challenge on any aspect of the report.

Report prepared and presented by:

Carolyn Green
Executive Director of Nursing and Patient Experience

QUALITY POSITION STATEMENT
August 2016

1. SAFE SERVICES

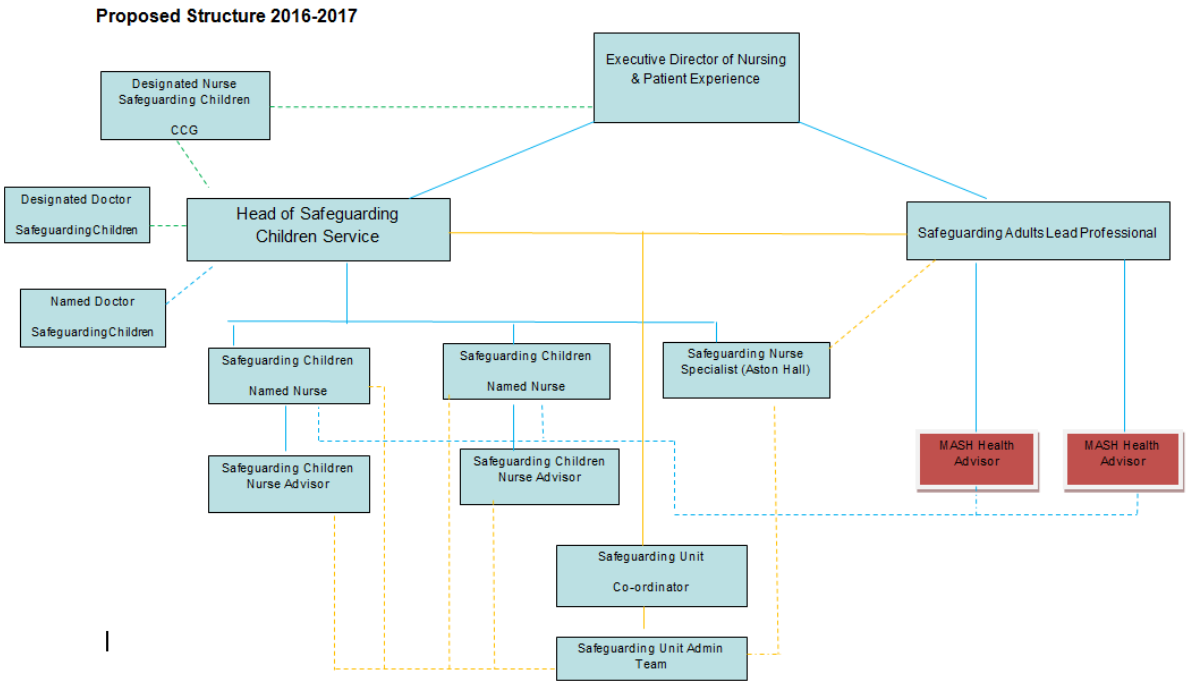
1.1 Safeguarding Adults Assurance framework quality site visit

The Trust has completed its Safeguarding Adults Assurance framework review with commissioners and our four CCGs lead Safeguarding adults lead and the Chair of the Adult Safeguarding Board for Derbyshire in August.

The clinical commissioners agreed to delay our meeting to one of the last interviews in Derbyshire due to the extensive additional clinical pressure the Trust is providing on behalf of our community partners and our local community and wider region and national areas for individuals requiring psychological support as they raise concerns about their experiences in a complex enquiry.

An up-date from our commissioners on our CQC report and factual accuracy agreed statement.

Multi-agency Safeguarding hub. Derby city partners in the local authority and police have invested in a Safeguarding Childrens and Adults hub in the council house. This MASH development in Derby City is service development and investment provided by Southern Derbyshire CCG for a six month pilot, of two additional Band 7 workers in the team and this will substantially change the Safeguarding service and how it operates and will provide additional resource to the team. An outline of the revised structure following this investment is outlined below.



2. CARING SERVICES

2.1 Nursing and Quality, quality visit

2.2 Triangle of care- Think Family and Family inclusive practice, a Trust quality priority

On the 29th of July 2016 clinical staff hosted the Triangle of Care Midlands Regional Group This has been chaired by Ruth Hannan Carers Trust - Policy & Development Manager (Mental Health). There was representation from Mental Health Trust including

3. Nottinghamshire Healthcare NHS Trust
4. Birmingham and Solihull Mental Health NHS Foundation Trust
5. South Staffordshire & Shropshire Healthcare NHS Foundation Trust
6. 2gether NHS Foundation Trust
7. Coventry & Warwickshire Partnership NHS Trust
8. Dudley and Walsall Mental Health Partnerships NHS Trust.

This is the 6 monthly progress update meeting from providers who are participants within the Triangle of Care Membership Scheme. Today's event covered the Stage One submission by Nottinghamshire Healthcare NHS Foundation Trust.

The event also included in the event were updates from the providers, DHCFT at the last presentation in April 2016 had presented the SBARD for Families and carers, this tool allows carers to be able to raise questions they wish to ask in particular at times of crisis . The team representing DHCFT today received feedback from providers at the event which was positive and supportive with regards to the tool. 2gether NHS Foundation Trust has presented the tool to carers and their own Trust and has sought the Trust agreement today that they can adopt the tool for use across their services.

DHCFT have reported back that since the last regional group that we had undertook a successful event in the North of the County with carers with regards to "Looking after yourself", where advice on healthy eating, blood pressure monitoring, etc had taken place. The event had been well received by carers and staff.

We had also undertaken a Carer Lead event to update our carer leads in the organisation.

That we have organised training dates arranged to support the roll out of the stage 2 self-assessment submission for our community Neighbourhood teams, we updated that this will be ready for submission and presentation at the regional meeting in March 2017.

The feedback on Trust progress was well received.

Ruth acknowledged the work that has been completed by the Trust and had no on-going concerns with regards to ownership at a Senior Organisational Level and confirmed that progress had been made by the Trust. The Trust today was supported by Tracey Holtom Safeguarding Lead, Wendy Slater Care Core Care Standards and CPA Manager & Carers Lead, Bev Green Head of Nursing for Hartington Unit, Brenda Rhule Acting Head of Nursing for Community, Lynn Dunham Core Care Standards and CPA Co-ordinator and representation from both North and South Derbyshire Carers Forums

Strategic considerations and potential changes for the Safeguarding committee to consider in its Family and carer leadership for the Trust

1. There will be changes from October with regards to the Triangle of Care assessment process. Level 2 will be given a fixed timeframe for completion, level 3 will be formalised but this will not be by utilising the gold star but how this is formalised has yet to be agreed by the TOC steering group.
2. There will be a revocation of membership for organisations who do not meet the timeframes or standards- this is to ensure that the TOC remains to deliver high standards.
3. There will be a process put into place for renewing membership on a yearly basis.
4. There was a discussion in relation to Trusts working more closely and potential merging and acquisitions where only one of the Trusts are active TOC members (this appears to be across the country at the moment), the lead has not finalised how this would work but the triangle of care leads is considering utilising the stage 3 process to meet the requirements.

3.0 RESPONSIVE AND EFFECTIVENESS OF OUR SERVICES

3.1 The Director of nursing attending the Childrens and CAMHS Clinical Reference Groups and listened and observed the meeting. This is part of the quality priorities of supporting and developing the Quality leadership team and their clinical leadership. The group had representation from both Childrens and CAMHS, and multidisciplinary and operational representation. It was positive to hear clinical risks and mitigations being reviewed and escalation of issues and the use of the risk register in raising concerns re clinical practice and opportunities to reduce risks through the effective use of system one in an integrated communication aid across Childrens and CAMHS and the risks associated with clinical staff requiring access to both System One and PARIS when working at a primary care level.

In addition the Childrens services had raised on their quality visit and escalated formally to the QLT that they had concerns that the Trust transition policy was focusing upon CAMH services and did not fully focus upon transition issues for Childrens services. It was positive to be briefed that the chair of the QLT Richard morrow had written to the Childrens and CAMHS Clinical Reference Groups members to have a named working party representative from this group to join the QLT in October to actively contribute to revisions to the transition policy. To find a solution to issues raised.

Action:

To receive assurance from the General management team that licences will be issued for CAMHS staff to have rapid access to System one and licences are made available to support safe clinical practice.

4. WELL LED

4.1 Quality Leadership

The Trust has seen the retirement of one of most organisationally committed staff our Head of Quality Clare Grainger who has now retired at the end of September.

This post was advertised and the recruitment to the position was supported through an assessment panel process with staff, service receiver representatives from Derbyshire Mental Health Alliance and a carer's representative from North Derbyshire Carers association as key members /expert by experience advisers to the panel. The Deputy Director of Nursing and Quality Governance post was not recruited too in the first round and a second panel was successful at the end of September in appointing a very experienced Mental Health Nurse from another Trust who has extensive clinical and quality experience who accepted the position.

4.2 Findings from Quality visits

The Quality visit programme is well underway for 2016 and the programme will be completed by mid-October. To date we have completed over 70+ visits to clinical and non- clinical teams.

The Nursing and Quality service had a quality visit and presented information on the following.

1. Improving the Physical Healthcare of those in our care. Raising concerns with regard to commissioning gaps for Dieticians and the impact on raising these issues and outcomes from concerns raised in 2015 and the impact in 2016 on patient care.
2. Think! Family – working with the whole family and co-ordinating all aspects of support to address their full needs.

The team focused upon their impact in supporting

- Individual carers and families
- The 4 E's Carers Sub-Group
- Mental Health Carers Forums
- Staff (including colleagues in Nursing and Patient Experience)
- Partner agencies: Making Space, Derbyshire Carers Association, Creative Carers, Think Carer etc.
- Health and Social Care Commissioners
- Carers Champions
- National forums: Care Co-ordination Association etc.

We will reflect on the Quality visit feedback to date that some staff would like to revisit the Quality visit model and would like to consider revisions to the operating model this year; A review of the model will be completed after the end of this season. All Board members and Quality visit chairs are requested to reflect upon the current model and the added value and reflections on these seasons' visits and feed into the Director of Nursing on their views and recommendations in writing. Verbal feedback form governors and board members to-date has included, removing the CQC scoring system, and removing the platinum and non-podium awards for tracking progress.

Family Liaison has three primary functions

1. to provide support independent of clinical teams and services to families in distress following a serious incident/or death
2. to provide support and reassurance to staff when working with families in distress
3. to provide assurance to boards of directors regarding being open and duty of candour

This service is enabling to families and independent auditors from Mazars who undertook the investigation at Southern Health, visited the Director of Nursing and Medical Director in September to share thee learning from Southern Health NHS England investigation and commended the Family liaison service and model and the Quality directors have been invited to present the work we have undertaken and continue to progress at a regional sharing event.

1. Improving experience for service users, carers and families, minimising distress
2. Enable families to share their views and experiences, along with any concerns in any investigations
3. Give families a voice
4. Provide practical and emotional support and signposting into more specialist services
5. Streamlined process for families where there is a serious incident investigation and a complaint
6. Provides assurances to Board that both Duty of Candour and principles of Being Open are consistently fulfilled with families independently form the clinical team in line with Mazars recommendations.

Feedback

Thank you card received: "We would like to thank you for your help and support both before and at the inquest. You were a great help and support. You pitched the level of support and understanding perfectly and you are perfect for the job which you do."

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

4.3 Staff Health & Wellbeing – CQUIN

As part of the 2016/17 CQUIN requirements, there is a focus on staff health & wellbeing. One component of this is to focus support for the annual Staff Influenza vaccination programme, which has been a mainstay of the staff health offer in the NHS for many years.

In past years, the uptake from our staff has been low, with 22% of the target group attending for a vaccination. This year, in addition to the – clinics we have on offer across a number of locations where we have services based, we are for the first time committing to a 'peer vaccination' service. This entails support for some of our clinical staff (6) to be released to attend training to enable them to safely deliver vaccinations to their colleagues, to help support flexibility and uptake. They have undergone training and will have support and supervision from the Infection Control Support Nurse. The aim is for these staff to compliment the existing clinic offer, for example by having a peer vaccinator in a campus setting, this helps staff access a vaccine when there is a safe opportunity at ward level, rather than leaving the ward to access a clinic, or having to attend at the end of the working day.

Once they have undergone training, the staff will be licensed to administer a vaccine, with a signed consent form, under the terms of a Patient Group Directive (PGD). We are also exploring with our Occupational Health Colleagues the possibility of some in-reach visits to wards settings; this is being negotiated with local leaders to ensure safety of all, and the maintenance of the correct medicine storage standards.

We have negotiated with Commissioners that the target of frontline staff we are aspiring to achieve is 45%, that a local agreed target in line with the historical baseline achievement which is stretch but more realistic target for the Trust.

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

The Trust runs a service receiver and carer forum to enable direct access to the Director of nursing and other quality team members to influence Trust developments and information. The group requested the attendance of the Lead mental Health commissioner to meet the group and give a briefing and provide information to the Group on commissioning, the Systems transformation plan, and open questions on the Engagement service model and wider service issues.
The groups did feedback that the back office sharing of services between named NHS providers appears to be eminently sensible and could be seen as good housekeeping.

An evening session of the group was held on the 27th September and had attendance from Mental Health Alliance, Making Space, North Derbyshire Carers and South Derbyshire Carers. The group

feedback their thanks to Dave for his time and his briefing on the developments, the national context and the future potential solutions. The Trust Director of Nursing and lead Mental Health commissioner have agreed to provide on-going dialogue to support community groups in direct access and briefing on significant changes in the system and this is being scheduled as a routine offer to this group, as the rapid pace of change and developments is concerning and they respectfully request involvement and information on the impact it will have on their groups and the individuals they support and represent in Trust and community forums. Bothe engagement and carer lead provider groups are being retendered at this time by Derbyshire local authority and Hardwick commissioners. This coupled with systems changes is adversely affecting specific groups in their ability to retain system changes, their ability to influence and be involved in such a significant period of service changes.

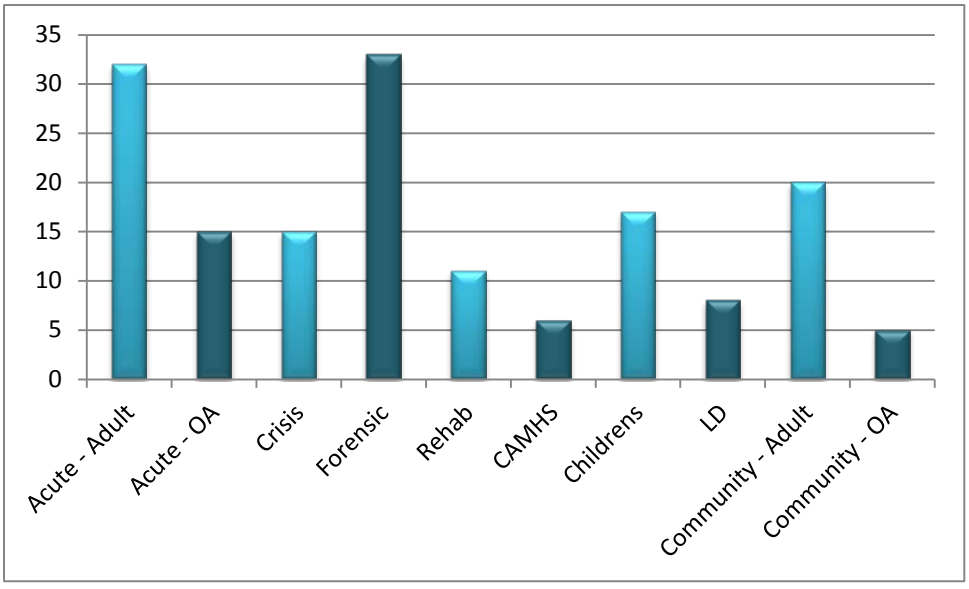
4.5 Care Quality commission comprehensive inspection

The CQC full inspection report was published on the 29th September 2016

Prior to this period a number of planning events were held to review draft actions and regulation level action plans were already in development when the CQC draft report was received. On 30 and 31 August workshops were held with representatives from all areas with senior and middle management levels clinicians and managers to also further develop service level action plans. The workshops also scrutinised all the reports for factual accuracy from the perspective of staff that were inspected.

As a result of the factual accuracy checks and the action plan development evidence was also identified to support the trust response to some of the actions. This evidence, along with the action plans themselves, will be uploaded to the portal in readiness for the first CQC submission of action plans and evidence after the Quality summit visit which is scheduled for the 21st of October.

The breakdown of actions per service is as follows:



Some high level actions that have been progressed since receiving the comprehensive report and immediate feedback on areas of improvement already in progress or completed are as follows:

1. Fire warden compliance training is a key aspect of our regulatory compliance and the detailed information is included in the integrated performance reports, signing in sheets of training attendance is available for independent scrutiny.
2. Safeguarding children Level 3 training for all services is increasing in line with original targets of full compliance by March 2017; the full detailed breakdown is included in the integrated performance report.
3. Safeguarding knowledge and responses to security and safety of property, and action plan to consider as a trust how the organisation is able to learn from losses and can put

in place systems and structures to analyse clusters of issues, has been put in place to enable the Safeguarding Adults Lead professional and Safeguarding named Dr to reflect and identify potential clusters of incidents. All information related to this issue has been shared with the Safeguarding adult manager for the CCG, Local authority and other bodies.

4. The Equalities Act and our EDS2 submissions have an action plan and significant work led by our Human resource team under the scrutiny and leadership of our Director of Human Resources Amanda Rawlings.
5. Our Mental Health Act team have been revisiting all community treatment orders and rights that have been issued and ensuring all rights forms are correctly completed and file. A compliance report with full assurance on the rights of individuals is in final stages of report writing and completion and will be provided to the Mental health act committee
6. Heads of nursing assurance visits to the Kedleston unit have been completed and a review of Physical health checks, care planning. A detailed report has been scheduled to the Quality leadership team with a summary of this planned for the October Quality committee to provide assurance on progress and exploring potential solutions for a new clinic room and medicines trolley has been issued. This may result in the reduction of a bedroom to create a clinic room and this issue will be explored with NHS England.
7. Kedleston - Seclusion room has planning permission. A detailed plan and outlined were reviewed by the Quality committee on the 11th August 2016. Full planning permission was issued on Tuesday 2nd of August 2016. Tender and development plan in progress. Builders on site to build the full extension and then the new seclusion suite to be operational in March 2017. Please note this is not a standard seclusion room and it requires a building extension and to raise the roof due to the ceiling height not being in line with the new seclusion specification.
8. Complaints posters and leaflets re issued to Kedleston, to not just in pt. rooms and reception, but in the main ward.
9. Clinical skills tutors being recruited for rapid improvement of Mental capacity act knowledge, and a new Mental Capacity administrator has been appointed, starting imminently
10. Security incidents and safe property management/Safeguarding, independent investigation completed and action plan, in final sign off, to confidential board. All safety and security incidents sent to Safeguarding adults Dr and nurse each month, from last two months with review.
11. All Community Treatment Orders community paperwork be fully revisited to ensure rights are issued and forms completed,
12. Fire wardens - 60 plus staff trained and growing, final compliance percentage for in-pt. areas is being reconfirmed and will be reported routinely in the integrated performance report.
13. Safeguarding Level 3- at end of August, still on trajectory for March 2017 and a further 10 additional course commissioned. Please note target group and intercollegiate guidance stating target group is not restricted in DHCFT. It has been proposed that the target group is reduced in line with other Trusts training levels. This is not being completed in the Trust.
14. Equalities work in progress and led by new director of HR and OD – Amanda Rawlings
15. BME network members are invited members of People and Culture committee, which was revised prior to the issuing of the warning notice.
16. All policy improvement revisions highlighted in the comprehensive review are in sign off or in draft status for revision. This includes the Positive and safe related clinical policies.

17. A Deputy Director of nursing and Quality governance has been appointed and awaiting start date, 12 weeks' notice may be required, due to the appointment of an external candidate.
18. Safeguarding adults named Dr appointed. Safeguarding adults SAAF review submitted at the agreed extension period and was confirmed as good. Two Band 7 posts as a 6 month proof of concept invested by Southern Derbyshire Safeguarding hub (MASH) to support safeguarding adults and children agenda
19. Emergency equipment an oxygen cylinder that had expired at the time of the CQC comprehensive inspection was replaced on inspection week. The review and provision of ligature cutters for a 136 suite to have the emergency equipment labelled has been rectified. Further exploration of ligature cutters for community teams is being reviewed.
20. The older adults service has redesigned a clinical post to be dedicated to Older adult in-patient areas and will lead on clinical compliance issues specifically with regard to Personalised care planning for mental health conditions in in-patient areas, the knowledge acquisition and clinical practice improvement of staff in applying the mental capacity act in all decision making and in best interest decisions. Whilst this post has been advertised and is being appointed to a Learning Disability best interest assessor has been in-reaching into the services to support clinical audit and expectations.
21. Three clinical skills tutors' posts have been advertised and are in recruitment phase for clinical staff to work across the seven day per week period to improve staffs knowledge on the Mental Capacity Act. Personalised Care planning and embedding I statements, Physical health checks in the use of rapid tranquilisation and the Positive and safe strategy and ensuring that knowledge of seclusion and segregation is embedded.
22. Capital investments and additional changes to the programme post the CQC comprehensive visit have been scheduled for the Capital planning group to consider re-prioritising the capital investments in line with required actions including re-prioritising planned ligature works from acute ward areas to older adult's specific named areas and the Kedleston unit. Priority areas had been mental health acute areas bedroom and bathrooms, these service improvements will now be deprioritised until immediate actions have been completed.
23. The Audrey House service currently housed at a grade 2 listed building with significant improvement works was scheduled to be relocated form the Audrey House site to the empty ward formally known as Melbourne house at the Kingsway site. This development is due to Trust concerns with regard to the environment and safety issues and this service changes enable rapid achievement of CQC requests for improvements in the environment and self- catering facilities. This service will remain, Audrey House at the Kingsway site.

CQC plan

The findings and the recommendations of the report have been designed into a CQC portal which is a repository for all named leads to review their actions, and acts as a shared holding area for monthly reports to the CQC both on recommendations progress and this contains review and analysis of the service areas, themes and regulations. This report will be produced monthly both for the Quality committee and a report will be sent to the CQC to provide initially reassurance and assurance on the Trust implementing all learning and recommendations. This portal will have an export function which enables a briefing report and the actual evidence to be uploaded directly to a secure CQC nhs.net account. An extract of the high level regulations and themes report is provided in the integrated performance report.

In addition the Trust will be providing a monthly provider report to the CQC on information and this data will used by the CQC to inform them of provider intelligence and this intelligence will be used to consider unannounced visits to the service, focus inspection visits and wider issues for probing or analysis.

Sarah Bennett and Judy Davis are the inspectors for the Trust and their work is overseen by Surrinder Kaur, as a regional lead for the CQC.

The Trust will be required to submit a monthly report in the newly issued Provider intelligence template on progress, in addition to the monthly CQC report against recommendations. These monthly reports will be supplemented with face to face quarterly meetings with our inspection team to review the CQC comprehensive inspection reports and the monthly provider intelligence reports.

Report prepared and presented by

Carolyn Green

Director of Nursing and Patient Experience

Board Committee Summary Report to Trust Board
Audit & Risk Committee - 19 July 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)
Corporate Governance Framework **Board Committee Terms of Reference**	The Committee reviewed the Corporate Governance Framework and terms of reference.	Assurance was received that GIAP actions as outlined relating to the development of the Corporate Governance Framework were complete. Minor amendments to be made.	None	Agreed to forward to Trust Board for ratification.	Board to ratify completion of relevant GIAP actions as part of overall GIAP reporting.
Review changes to standing financial instructions	R Leyland outlined the areas updated. Minor amendments noted.	Amendment to be made and then SFIs to be published on Trust intranet.	None	Updated SFIs were approved.	None
Governance Improvement Action Plan	Deferred. .	S Harrison to clarify with M Powell and J Davies on issues outstanding with GIAP actions	None	Update on GIAP actions for Audit and Risk Committee oversight to be reported direct to Trust Board meeting as part of full GIAP report, due to next Audit and Risk Committee not until October	Board to receive update on Audit and Risk GIAP actions directly
Committee Assurance Summary Reports (Mental Health Act 3 June) People & Culture Cmmttee (16 June) Quality Committee 7 July	The Committee assurance report was noted from Quality Committee.	Tabled assurance reports from People and Culture Committee and Mental Health Act Committee to be carried forward to October meeting agenda	None	Assurance Reports from June Mental Health Act Committee (June) and People and Culture Committee (June) to be on agenda for October Audit and Risk Committee meeting	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)
Overview of complaints and themes for assurance	Carolyn Green presented an edited review of assurance of service performance arising from Quality Committee's review of the Complaints, Concerns and Compliments Annual Report.	Significant assurance received from Quality Committee review of Complaints, Concerns and Compliments that effective processes are in place. Partial assurance against policy standard of response within 3 days.	Capacity of the team to reply to complaints within 3 working days – team resource is under national benchmarks – additional resource or STP shared service will be explored going forwards	None	None
Annual Reports from Board Committees (Quality Committee, Mental Health Act Committee, Safeguarding Committee and Remuneration Committee)	2015/16 year end annual reports from Board Committees were noted.	Assurance received on effectiveness of Committees through review of work of the Committees. Future years to be more aligned in structure and focus on assurance.	None	Agree that Committee Chairs ensure alignment of reports for 2016/17.	None
Quarterly Review Board Assurance Framework 2016/17	Review of second presentation of BAF report for 2016/17	Assurance received of ongoing update and in management of risks as outlined	As identified on the BAF itself – increased risk ratings and mitigating actions noted	BAF to be the subject of a future Board Development Session	None
Overview of Risk Management Controls and Assurance	Overview of current assurances and challenges in the Trust's risk management systems and processes	Assurance received on the effective functioning of risk management systems	Some backlog in prompting of risk reviews and challenges of reporting deadlines.	Risk management strategy to be developed to support coordination of risk processes and reporting across the Trust – to be brought to October A&R meeting.	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)
Deep dive BAF Risk 2a Transformation	Presentation of key controls/systems in place to mitigate the risk to delivery of national and local system-wide change.	Positive assurance received relating to strong partnership and influencing system change. Action plan to be developed to align to BAF	Gaps in assurance were discussed and mitigation outlined.	BAF risks 2a System Change and 4b Transformation to be merged for next BAF update.	None
Update on External Audit progress: Receive the external auditors annual audit letter	Presentation of annual audit letter and update report on external audit progress	Assurances as outlined as part of the Annual Audit Letter. Assurance received on value for money conclusion re economy, efficiency and effectiveness (excepting known governance issues).	None	Agreed Annual Audit letter to be forwarded to Trust Board as per established process	None
Update on Internal Audit Plan progress	Update on PWC activity in delivering the 2016/17 internal audit plan	Assurance on progress received	Potential slippage in HR policies audit – staff to be prompted to ensure swift completion	Audit plan to be changed in light of work on GIAP implementation now to be undertaken by Deloitte LLP.	None
Review Counter Fraud progress report	Update report presented.	Assurance received that work continues to plan. Agreed that Fraudulent times would be circulated to Committee members Agreed that Counter Fraud to be involved in future policy reviews going forwards	None	None	None
Review the	John Sykes and Rubina	Assurance received that	Potential duplication	Future reporting to Audit and	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)
Annual Clinical Audit Plan - report from Quality Com	Reza updated on clinical audit framework, policy and processes	good progress has been made with respect to the number of projects signed off. Sign off process through QLTs is also working well. To agree a process for commissioner requests via ELT.	between Quality Committee and Audit and Risk Committee remit on clinical audit – Caroline Maley and Maura Teager to maintain dialogue	Risk Committee agreed to be twice per year (July for end of year report and new plan for Jan/Feb meeting).	
2016/17 Forward Plan	Noted.	To be reviewed by S Harrison and C Maley on an ongoing basis	None	None	None
Meeting Effectiveness	Discussion on the effectiveness of the meeting noted that it is essential for key presenters/owners of papers to be present. Absences due to unforeseen circumstances meant that for some items this was not possible.	N/A	N/A	N/A	None
Internal Audit and Local Counter Fraud Services Tender (Private) **Held in private session – commercial – in confidence**	The procurement process and tender specification for the re-procurement of these services was outlined and discussed.	Assurance was received on the proposed process including quality, weightings and scoring methodology to be followed by the Bid Board.	None	Agreed to proceed as outlined with maximum expected bid price to be outlined in tender documentation to encourage bids within the Trust's financial envelope.	None

Board Committee Summary Report to Trust Board
Mental Health Act Committee - meeting held on 26 August 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)
Mental Health Act Committee Report including seclusion monitoring and equality data	The MHAC report is developing into a more dynamic description of how the MHA/MCA are being applied in the Trust	1. Executive summary required for future reports – CH 2. Capacity to consent data to be submitted at MHAC – JRS 3. Equality data to be expanded and interpreted – CH 4. Seclusion/Segregation to be further devised and verified. Report on current practice required for next meeting – SB/TH 5. Rapid tranquillisation to be audited	There could be confusion around seclusion/segregation and reporting of such	To define and verify good/actual practice for next meeting	N/A
Section 136 Group	Terms of Reference and work plan have been agreed	Partial – S136 forward plan to be formulated	RK to report back to next meeting of MHAC	Further assurance required	N/A
Position Statement on wards visited by the CQC prior to inspection	Greater focus is required on compliance	To ask ELT to consider a case for an independent CQC inspector to be appointed	Lack of compliance demonstrated by repeated CQC visits	ELT to consider deploying extra resources	Escalated to confidential Section of Trust Board August 2016
Areas of Non-	CQC inspection has identified gaps in	Further assurance and	RK to update BAF risk register	Further report on approach to	As above

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Compliance identified by CQC Action Report	compliance	quantification of risks required		improving compliance required at next meeting – JRS	
Derby City AMHP Update including quarterly DOLS report Derbyshire County Council AMHP Update	Concern expressed re availability of Section 12 doctors and delays due to bed availability	To agree an approach to quantify risks	Delays could expose patients to risk	Report required for next meeting – JRS	N/A
Mental Health Act/Mental Capacity Act Training	Training is underway but resources limited	Action plan and time scales required – AC	Lack of training resource	ELT to identify training resource – JRS	Confidential section of August Board
Policy Update	Full assurance received	-	Nil	-	N/A
Any other business	-	-	-	-	-
Issues escalated to Board, Audit Committee or other Board Committees	-	-	-	-	-
2015-2016 Forward Plan	To be further populated	-	-	To update – JRS/RK/CH	N/A

Board Committee Summary Report to Trust Board

Quality Committee - meeting held on 8 September 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)
Specific actions re compliance standards for Seclusion unit	Confirmation of CQC guidelines service receivers involvement confirmed in the decoration and operational policy design for Kedleston developments	Assurance received that Kedleston unit has service receiver involvement in the capital investment programme to build an extension and a new seclusion area	Confirmation of inclusivity and engagement	Continue with implementation of this investment scheme in line with CQC regulations and Positive and Safe Strategy	None
Serious incident report	Report given on serious untoward incidents during July 2016.	Assurance received The SIRI report contained data validation and audit of compliance to policy check was undertaken in reviewing old data from 2011 to 2015. Categories of reporting and types of investigations were analysed for compliance with policy. This is a complex area of analysis and final information relating to cause of death due change following coroners and investigation.	None Gaps in compliance and assurance were established pre 2014. 2014 and 2015 substantially improved compliance and lower error rate in 2015. No known errors in 2016.	Exploration and consideration of NRLS data and any indicators that transition is an emerging or increasing issue. This report and validation was presented to commissioners with the CCG patient safety lead, they commended the diligence in further analysing practice in addition to the initial MAZARS analysis which was reported in January 2016	None
Safety Ligature reduction programme	Written report on ligature reduction programme.	Partial and limited assurance received progress noted in some areas However, significant delay in progress relating to environmental handovers, further compounded by the nursing standards team re-	The pace of the programme of work for specific delivery items Specific action has not been implemented and embedded within agreed timescale	Additional scrutiny of the ligature reduction programme. Additional assurance on the environmental handover will be scrutinised until full assurance is achieved – named lead RM to provide written report to October meeting	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)
		prioritising work to direct clinical support and emergency planning.			
Single Patient Care System	Carolyn Gilby presented the developments in a Single Patient Care System	Some evidence of progress. However still some significant delivery and technological developments to deliver this.	Requires full roll out of EPR to in-patient areas. Progress delayed by emergency planning Delivery of SI and wider external recommendations	To revisit risks again, to receive further project reports from the FSR, full service records Board	None
Positive & Safe Monthly Update	SB presented the report and improvements made	Continued scrutiny to ensure progress, policy adjustment and sustained improvements are made.	No new issues. Continued delivery of work plan	Partial assurance, the full period of the strategy is not completed. This work will require continued monitoring.	None
Quality Leadership Team Update	Deferred to October meeting. Was planned for the September agenda, neither QLT chair attended the meeting Discussion with one of the deputy QLT members, on progress to date	Lack of assurance	Attendance of chairs or nominated deputy	Deferred to October meeting	Escalated as part of the GIAP down grading to amber
Governance improvement plan	Written report of GIAP evidence. Scrutiny and challenge on whether the actions are embedded	Assurance reduced to partial as there has been completion of actions but these issues are not embedded such as more formal structured escalation from QLTS. Diligence in use of the revised agenda template to confirm papers relation to strategy and in ensuring completion of	None Central QLT to provide terms of reference and oversee work plan for Children's and CAMHs and provide assurance to the September Quality Committee was not provided Administration support	Downgraded GIAP actions from GREEN to AMBER, until further evidence is achieved. Summary report to confirm downgraded GIAP actions from GREEN to AMBER, until further evidence is achieved. QLT chairs or designated representatives not always in	Down grading of actions due to lack of evidence through the QLT reporting processes/escalations to QC and inconsistency of presence at the QC monthly meetings

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
		actions to the forward plan Minutes were not available to QC from QLT as meetings held the same week (Mon for a Thurs QC)	for annual leave cover	attendance	
Information Governance Update	This report provides information on our Version 14 Information Governance Toolkit submission. The annual cycle begins in April and we have submitted our Baseline on 29th July 2016 at 62% and Not Satisfactory.	Assurance received Maintenance of our current level of attainment, reaching 92% and satisfactory by March 2017.	Continued focus in this area to meet required standards are on trajectory	None	None
Central Alert System (CAS) Policy and Procedure	This policy outlines the process for receiving, acknowledging, assessing and actioning alerts from the Central Alerts System. Policy was ratified	Brief summary of main themes Sponsor to be revised Policy ratified	None	Revisions to front sheet to change author and governance reporting	None
Any other business	Review of forward plan to adjust and revisit required areas. Meeting closed				None
Confidential section	Information presented on embargoed draft CQC report, pre-factual accuracy amendments	Deep dive for risk 1a to be moved to go to Audit and Risk Committee in December after it has been presented to Quality Committee in October due to timing of CQC report			Reporting to confidential board

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE QUALITY COMMITTEE

HELD ON THURSDAY 8 SEPTEMBER 2016
MEETING ROOM 1, ALBANY HOUSE

PRESENT	Maura Teager	Chair and Non-Executive Director
	Julia Tabreham	Non-Executive Director
	Carolyn Gilby	Acting Director of Operations
	Carolyn Green	Director of Nursing & Patient Experience
	John Sykes	Medical Director
IN ATTENDANCE	Sandra Austen	Derby City & South Derbyshire Mental Health Carers Forum
	Sarah Butt	Assistant Director Clinical Professional
	Petrina Brown	Consultant Clinical Psychologist
	Donna Cameron	Corporate Services Officer (minutes)
	Chris Fitzclark	Derbyshire Mental Health Alliance
	Carinna Gaunt	Health & Safety Manager
	Emma Flanders	Lead Professional for Patient Safety
	Mark Powell	Director of Strategic Development
	Rob Morgan	Health & Safety Advisor
	Rubina Reza	Research & Clinical Audit Manager
APOLOGIES	Sam Harrison	Director of Corporate Affairs & Trust Secretary

QC/2016/150	**WELCOME AND APOLOGIES** The Chair, Maura Teager, opened the meeting and welcomed attendees. Julia Tabreham was welcomed officially in her capacity as Non-Executive Director. Julia will be taking over the Chair of Quality Committee formally in October. Apologies for absence were noted as above.
QC/2016/151	**MINUTES OF THE MEETING HELD ON 11 AUGUST 2016** The minutes of the previous meeting, held on 11 August 2016, were accepted with the following amendments: **QC2016/137 PATIENT EXPERIENCE REPORT** Paragraph three to be amended to reflect that the *"deep dive had been presented to the Commissioner's Quality Assurance Committee".* **QC2016/146 MEETING EFFECTIVENESS** Minute to be amended to read *"The Committee noted the feedback from Julia Tabreham. It was felt there had been a lot of operational discussion and the Committee would benefit from a more strategic dialogue. Julia had been impressed by the hard work and analysis to support the Committee. It was agreed to consider the suggestion that if confidential discussions are required a separate, confidential meeting of Quality Committee may be held at the end of the meeting, which is documented"*
QC2016/152	**ACTIONS MATRIX AND MATTERS ARISING** The Committee reviewed the Actions Matrix and agreed updates and

	amendments. It was agreed to add due date information to the matrix for all actions. **Policies:** The Quality Committee policies dashboard was noted. **ACTION: Carolyn Green is to review, with Rachel Kempster, the option to RAG rate out of date policies, according to risk impact, at the request of Julia Tabreham.** **ACTION: An update on the completion date for the Equality Impact Assessment Policy to be discussed by Amanda Rawlings/Carolyn Green.**
QC2016/153	**SERIOUS INCIDENT REPORT** Emma Flanders, Lead Professional for Patient Safety, presented to report to update the Committee on information relating to serious incidents (SIs) that had occurred during August 2016. The Chair sought further detail on the three Mental Health Act errors recorded in August. Emma Flanders advised that the errors had been made on admission to Royal Derby and were received with those errors on transfer. Sarah Butt advised a "blue light" was issued advising staff of immediate actions required to rectify this practice in future. Julia Tabreham queried the SIs where missed grading had occurred. Emma Flanders advised that the SI Group had been commissioned to investigate and provide assurance to the Committee that wrongly graded incidents are being picked up. It was noted that only categories where major/catastrophic incidents occur are reported in the SI report. Julia Tabreham and Carolyn Green to discuss any potential changes in the presentation of this material in order to provide assurance and strategic direction. Julia Tabreham sought assurance on the management of overdue actions. Emma Flanders advised that overdue actions are escalated on a monthly basis to responsible individuals and their managers. Extensions can be requested for actions but the risk and vulnerabilities to patients will be factored into any such approvals. Chris Fitzpatrick expressed his concern regarding incident W22809 (2015/34375) and his frustration, from a service user's perspective, at the circumstances which had led to the patient's suicide. John Sykes assured the Committee that the investigation had reviewed the standard of care provided, lessons learned and improvements made. The Trust had been very open with the family and taken on board the response from the Coroner. The Trust continues to progress the suicide prevention. Julia Tabreham noted the incidence of points of transition and asked members for input to improve on this. Following discussion, Emma Flanders agreed to review transition data, using NRLS statistics, to reflect on patterns. Feedback will be given to the next meeting. The outcome of this will determine any next steps. The Committee noted that work continues on the data review of the 34

	deaths previously recorded on Datix as suicides but not reported on STEIS. As previously reported, the Commissioners have been notified of this and the impact on historical data. As requested at the last meeting, a brief outline on the progress of each investigation death is provided. The level of these retrospective reviews exceeds that required but is being undertaken for good practice and to maximise learning. **ACTION: Presentation of data on major/catastrophic incidents to be reviewed.** **ACTION: Transition data to be reviewed to reflect on patterns for presentation to the October meeting.** **RESOLVED: The Quality Committee noted the report. The data review of STEIS reportable incidents will be escalated to the Board for information.**
QC2016/154	**ANTI LIGATURE AUDIT** Carrina Gaunt, Health & Safety Manager, joined the meeting to provide the Quality Committee with an update on ligature risk reduction, an area of high priority within the Health Safety portfolio. The plan to identify, reduce or remove risks in the Radbourne, Hartington and Kedleston Units in bedrooms, bathrooms and WCs is on target. Resolutions have also been formed for three issues identified by the CQC outside of bedrooms, bathrooms and WCs. A detailed report on the programme will be presented to Quality Committee in the next report, scheduled for December. The report will also include an update on seclusion doors. Carinna advised the Committee that the area of environmental handover is still outstanding. A high level of concern was expressed by the Quality Committee regarding the lack of completion or implementation on this. Richard Morrow will be invited to present an urgent update report to the October meeting. Sarah Butt will provide an interim update, between meetings, to Carolyn Green. **ACTION: Interim update on environmental handover from Sarah Butt to Carolyn Green between meetings.** **ACTION: Richard Morrow to be invited to present urgent update on environmental handover to the October meeting. Pending the update, the Committee will consider escalation to the Trust Board.** **RESOLVED: The Quality Committee noted the report and had limited assurance in respect of the work on environmental handover.**
QC2016/155	**POSITIVE AND SAFE UPDATE** Sarah Butt, Assistant Director of Clinical Practice, presented her monthly report to advise Quality Committee on the progress of the reducing restrictive interventions action plan. The following points were highlighted: The Positive and Safe Steering Group and its sub-committees continue to

	drive delivery on key objectives in the strategy. The challenges, as set out in the Executive Summary, were noted. The Chair, when recently attending the Mental Health Act Committee, observed differences in understanding of segregation. Following discussion, it was agreed that Sarah Butt would revisit the policy to provide clarifications, in agreement with John Sykes. Safe wards had been fully implemented within the Radbourne and Kingsway Units. The feasibility for an exchange programme is being reviewed for next year. GAP analysis on inpatient rules has been undertaken and an action plan developed to address practices which constitute blanket rules. A monthly audit programme will be implemented and shared with Quality Committee for assurance. A Mental Health Capacity Act Lead has been recruited. A start date is to be agreed. Access to independent advocacy services had been made available since April for post-incident debriefs but uptake had been observed to be low. Heads of Nursing are now auditing every seclusion and use is being reviewed. John Sykes raised the issue of restrictive interventions, adding that, anecdotally, there are concerns around the expectations of and from medical staff in challenging seclusions. Following discussion it was agreed that Sarah Butt would lead a 'table top review', incorporating a cross reference to staffing levels, to see if any improvements can be identified. Petrina Brown also suggested some reflective practice (with bleep holders) around challenging decisions. In relation to the Safeward exchange with representatives from Denmark, Julia Tabreham sought information on how staff are able to access national and international forums, summits, opportunities and grants. Carolyn Green advised that such activities are promoted to staff and knowledge sharing encouraged. Further discussion will be held outside the meeting. **ACTION: Segregation Policy wording to be reviewed with Sarah Butt and John Sykes** **ACTION: Table top exercise on restrictive interventions to be led by Sarah Butt.** **RESOLVED: The Quality Committee received and noted the report.**
QC2016/156	**<u>QUALITY LEADERSHIP UPDATE</u>** The Chair noted the lack of representation from the Quality Leadership Team (QLT) for the second consecutive meeting. Petrina Brown confirmed that a QLT meeting had been held earlier in the week and summarised discussions. However, due to timescales and lack of admin support it had not been possible to produce minutes or a report for the Quality Committee today.

	The Chair thanked Petrina Brown for the update but expressed her concern on the progress of and maturity of governance infrastructure, which is part of delivery of the Quality Improvement action Plan. QLTs exist to provide structure to Quality Committee and are pivotal to releasing the Senior Leadership and Executive Team from operational management. The QLTs had been in place for some time now but there had been inconsistency, lack of representation and absence of feedback. In discussing next steps, Quality Committee acknowledged that the work of the QLTs is a fundamental part of the Trust's governance. Mark Powell expressed his concern that as a smaller Trust the organisation may not have sufficient size and resource to support these arrangements. Key to underpinning this is the accountability framework, which ELT aims to have in place by end of October. The framework will allow, enable and support the infrastructure and leadership support. Julia Tabreham requested Mark Powell raise the QLT matter at ELT with a view to identifying obstacles to success. **ACTION: QLT to be requested to attend next meeting.** **ACTION: Issue of attendance/capacity/support to be raised at ELT.**
QC2016/157	**<u>GIAP UPDATE</u>** Mark Powell, Director of Strategic Development, presented Quality Committee with an update against Core 3 of the GIAP to provide an overview of key tasks that the Committee is responsible for seeking assurance on delivery. The paper is as presented to the Trust Board on 7 September. Core Area Three is responsible for delivery of nine recommendations. Mark Powell sought the Committee's opinion on the current status of those recommendations, as presented to the Trust Board. And also asked members if they had any questions about the process itself. The Committee proceeded to review and discuss each element of Core 3 as follows: ***Refresh the role of the Quality Leadership Teams to increase their effectiveness as core quality governance forums (four actions) ClinG1:*** Reflecting upon the discussion as per item QC2016/156 above, the Committee did not think this was on track to deliver by the target date. There are obvious issues preventing delivery. Carolyn Green offered support in planning and scheduling meetings. Ad-hoc NED attendance had been discussed previously and the Chair offered to make herself available for this. The Chair noted concerns had been raised regarding lack of administrative support for the QLTs, which Mark Powell is asked to feedback to ELT. Minutes have not been regularly provided from QLT to Quality Committee, which would benefit from improvement. ***The Trust would benefit from a robust and thorough policy review programme (one action)ClinG2:*** Audit and Risk Committee has received an assurance on the policy review programme and it is on track for delivery by end of December. The Committee suggested this would be On Track/Green, which Mark Powell supported. ***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 (four actions)ClinG3*:** The Chair considered this a work in progress and not Green. Transition of the Chairmanship is expected to positively impact on strategic discussion and effectiveness. Mark noted that the agenda for this meeting did not reflect the forward plan and suggested the Committee refocus on links to the quality priorities. The Committee agreed that the rating is Amber, which would be flagged through the escalation template to board. **ACTION: Mark Powell to book some time with Julia Tabreham to discuss assurance processes and major quality imperatives as soon as possible.** **ACTION: Agenda to be revised to reflect links to quality imperatives and forward plan.** **RESOLVED: Quality Committee discussed the content of the paper and agreed risk ratings for the delivery of this core area.** Sarah Butt left the meeting.
QC2016/158	**<u>INFORMATION GOVERNANCE (IG) UPDATE</u>** John Sykes, Medical Director presented the Q2 IG update, detailing progress towards meeting the requirements of the 2016/17 Version 14 IG Toolkit as well as the work of the IG Committee and IG breach monitoring. Mark Powell noted the ambition to achieve 92% attainment by 2017. John Sykes assured the Committee of his high level of confidence in the personnel and department in achieving this. **ACTION: Workplan to reflect six monthly updates.** **RESOLVED: Quality Committee acknowledged the initial IG toolkit baseline and progress made with the IG Workplan. IG Committee Terms of Reference, IG Work Plan, IG Management Framework and IG Specialist Training Plan were confirmed as fit for purpose.**
QC2016/159	**<u>CENTRAL ALERT SYSTEM</u>** Emma Flanders, presented the revised Central Alert System (CAS) Policy & Procedure. The policy was approved subject to minor alternations (location and author to be amended). **RESOLVED. Quality Committee approved the policy.**
QC2016/160	**<u>SINGLE PATIENT CARE SYSTEM</u>** Carolyn Gilby, Acting Director of Operations, delivered a verbal update on single patient care system. A full progress review on the Paris Single Record Project was reviewed by ELT on 22 August where the retention of the Project Team was approved until the end of March. Also approved the

	purchase of integration software tool to resolve connectivity issues between systems and develop integration facilities between internal and external services. The Chair noted that this would be Carolyn Gilby's final Quality Committee prior to her retirement and thanked her, on behalf of the Committee for her contribution.
QC2016/161	**ANY OTHER BUSINESS** Noting that this would also be Chris Fitzpatrick's final meeting, the Chair thanked him for his meaningful contributions to the meeting and representing service users to so well. Sangeeta Bassi, Chief Pharmacist, noted that the forward plan does not reflect the pharmacy strategy and medical management report. Carolyn Green to advise dates. Forward plan will be amended. Noting that the minutes of the Drugs & Therapeutics Committee were included on today's agenda for information, the new Chair will consider if minutes of the Medicines Safety Committee are required in future.
QC2016/162	**ESCALATION ITEMS TO THE BOARD** • Data review of STEIS reportable incidents • GIAP change of category and rating • Anti-ligature - Estates capital improvement programme • Quality Leadership Team
QC2016/163	**FORWARD PLAN** In light of earlier conversations, the forward plan will undergo a review. **ACTION: The forward plan to be reviewed.**
QC2016/164	**MEETING EFFECTIVENESS** The Chair sought feedback on time allocation, contributions and quality of papers. Mark Powell observed that discussions had been very good. The report on the anti-ligature work had contained an escalation to the Committee, which may not have been the appropriate route for escalation. Conversations on the GIAP had been extremely helpful and honest. The meeting would benefit from the presence of the QLT representatives. Carolyn Gilby added that with the departure of Chris Fitzclark it is important to ensure continued representation from a service receiver group. Carolyn Green agreed to follow this up. New representatives are required to have an induction with Carolyn Green to discuss boundaries and safeguarding prior to attending the meetings, which Carolyn will also follow up on for Sandra Austen. The meeting closed at 16.55. A confidential meeting with members only followed.

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DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE PEOPLE & CULTURE COMMITTEE

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

Friday, 15 July 2016

PRESENT:	Richard Gregory	Chairman
	Phil Harris	Delegated Chair and Non-Executive Director
	Carolyn Gilby	Acting Director of Operations
IN ATTENDANCE:	Sue Turner	Board Secretary & Minute Taker
	Mark Powell	Director of Business Development & Marketing
	Jenna Davies	GIAP Programme Manager
	Rose Boulton	Principal Workforce & OD Manager
	Lee Fretwell	Chair, Staff Side
	Liam Carrier	Workforce Systems & Information Manager
	Sue Walters	Senior Staff Engagement Project Lead
	Richard Eaton	Communications Manager
	Owen Fulton	Principal Employee Relations Manager
	Faith Sango	Head of Education
APOLOGIES:	Jayne Storey	Director of Workforce, OD & Culture
	Dr John Sykes	Executive Medical Director

P&C/2016/ 067	**WELCOME AND APOLOGIES** Richard Gregory welcomed everyone and opened the meeting.
P&C/2016/ 068	**MINUTES OF THE MEETING HELD ON 16 JUNE 2016** Minutes of the meeting held on 16 June 2016 were approved, subject to page 5 being corrected to show that the People Plan would be revised and submitted to the July meeting and not the June meeting.
P&C/2016/ 069	**ACTIONS MATRIX AND MATTERS ARISING** It was agreed to close all completed actions. Updates were provided by members of the Committee and were noted directly on the actions matrix. **P&C/2016/045 GIAP2 Recruitment of operational vacancies and recruitment plan:** It was agreed at the last meeting that a verbal update would be provided by Carolyn Gilby in July and a formal report received in September. Carolyn Gilby informed the Committee that recruitment is being fast tracked but more staff are leaving than being recruited. Newly qualified nurses will commence in September but we are losing experienced nurses through retirement and staff leaving which is causing issues in inpatient areas. A recruitment KPI is being formulated to show time to recruit. Carolyn Gilby assured the Committee that the Trust is safely staffed and regular meetings are taking place to ensure this remains the case and she and Carolyn Green are working to ensure staffing level remain safe. The Committee noted that retired staff have made it known that they felt devalued by

	the organisation as they were never thanked for their service on retirement. It was agreed that a process would be put in place immediately to ensure thank you letters are sent to people on their retirement. It was also agreed that more emphasis will be placed on managers to ensure exit interviews are offered to all staff leaving the organisation. **ACTION: Rose Boulton to ensure letters are sent to all retirees from Chair and CEO and ensure that managers are sent a communication about ensuring exit interviews for staff that leave the organisation.**
P&C/2016/ 070	**<u>GOVERNANCE IMPROVEMENT ACTION PLAN</u>** 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. The Committee wished it to be acknowledged that although some progress had been made, staffing capacity and demands on time spent during the recent CQC inspection had impacted on the progress of GIAP tasks and actions. The GIAP timeline of 30 June was recognised and actions reported as "off track" or rated as having "some issues" were discussed. Actions from the June meeting were scrutinised and noted as follows: **1. HR2 Resource Plan:** Management Trainer will commence 1 September working with OD and Leadership. This action is on track. **2. HR3/HR4/HR5:** Since the last meeting more detail had been provided on the HR Model diagram. The Committee approved the model and were assured that the model would support the organisation further. Mark Powell requested that for the next meeting actual outcomes and targets are populated in the HR metrics. It was agreed this action is completed and updates would be submitted to the Committee every quarter to show progress made and this will be reflected in the forward plan. **ACTION: HR3/HR4/HR5: Update report HR model to be received on a quarterly basis and is to be reflected in forward plan.** **3. PC2/4 People Plan for approval:** Since the last meeting in June the People Plan had been revised and is now linked to the strategic objectives outlined in the Trust Strategy. The Committee approved the People Plan and agreed this action is now complete. It was also agreed that the Committee's agenda will reflect the structure of the People Plan and the People Plan will be a standing agenda at each meeting. Dialogue with key stakeholders from Communications and Operations Teams and Staffside is to take place in order to deliver the plan. **ACTION: PC2/4 People Plan to be a standing item on the Committee's agenda** **4. PC3 Communications system to record feedback from staff:** A system to record feedback from staff has now been developed. The Engagement Group will now take oversight of this system and will report ongoing matters to the Committee and Lee Fretwell and Staffside every three months. It was agreed this action is completed.

5. WOD1 HR Function to audit compliance against two selected HR Policies:

- **Acting Up Policy:** It was agreed this policy would be revised to ensure it includes an equitable process. The language will be improved so it reflects skills/expertise of staff and the policy will be submitted to the next meeting of the Committee for ratification.

  ACTION: Acting Up Policy to be revised and submitted to the next meeting for ratification.

- **Professional Registration and Re-Registration Policy:** It was agreed that this policy will be reviewed to incorporate the new Qualified Nursing Re-validation programme at TOMM and would be monitored every six months.

  ACTION: Carolyn Gilby to ensure the Professional Registration and Re-Registration Policy is on the next TOMM agenda and is monitored by TOMM on a six monthly basis.

  Mark Powell confirmed he was satisfied that audit compliance against these two policies was now complete.

6. WOD2 Review and ensure that recruitment and acting up policies are fit for purpose: The Committee received partial assurance at the June meeting that the Recruitment and Acting Up Policy is robust and that examples of acting up positions have been followed correctly and have been complied with – please see WOD1 above.

7. WOD6 Implement Integrated Team Meetings: These meetings will bring together various areas of workforce and organisation development but circumstances have so far prevented integrated team meetings taking place. This action is now 'off track' and would be escalated to the Board in September.

8. WOD7 Ensure backlog of cases made known to CQC are concluded: Cases are being reviewed and are now captured and tracked on the ER Tracker. The Committee was satisfied that this process is now in place and that the ER tracker along with a brief narrative will be overviewed by the Committee at each meeting. This action is now complete.

ACTION: ER Tracker to be standing agenda item for each meeting. Rose Boulton and Liam Carrier to provide narrative to support future tracker submissions at each meeting.

Key tasks for delivery in July:

Sue Walters' provided an update on progress to support cultural change and engagement.

1. PC2 Develop a clear plan which outlines an ongoing focus on pulse surveys to enable targeted activity: Sue Walters presented the tool kit for engagement, together with a video which was positively received by the Committee. Richard Gregory asked Sue Walters to present the same video to the Board, together with a paper on Leadership and Culture at the September meeting. He also requested that the video be shown to the Council of Governors on 6 September.

	It was noted that data from the pulse survey is being used to prepare for the annual staff survey. The Committee approved this approach and asked that updates be reported to each meeting to maintain impetus. It was agreed that in the absence of Jayne Storey, Carolyn Gilby will act temporarily as co-chair of the Engagement Group. **ACTION: Board and Council of Governors to receive video and paper on Engagement in September.** **ACTION: Updates on pulse surveys to be reported to the Committee at each meeting.** 2. **PC2 Develop and implement a leadership development programme:** Work is taking place with Training & Education Group to develop leadership and talent management framework for implementation at end of October. An action plan is also being developed which will be submitted to the next meeting so progress can be reviewed. The Committee approved the action plan and asked that updates be provided at each meeting on specific actions to provide assurance on progress. This item is currently 'off track'. **ACTION: Leadership Development Action Plan to be reported to the Committee at each meeting.** 3. **PC5 HR and OD to undertake a refresh of the behavioural framework:** Sue Walters informed the Committee she was working with Board directors to develop a behaviour framework tool for implementation in September. The immediate priorities and objectives required to take place between July and December were noted and concerns were raised as to who would be responsible to lead specific actions. This item is currently 'off track'. 4. **WOD1 Develop an internal compliance monitoring process for HR policies and procedures including case management and tracking. This will be monitored by the Trust Board and will be integrated into its performance reporting:** A tracker has been developed for monitoring HR policies and procedures and are tracked on the ER Tracker as shown in WOD 7 above. This Action is completed **ACTION: Rose Boulton to circulate the front sheet of the ER Tracker to show progress and trajectory** **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/ 071	**<u>WORKFORCE PLAN</u>** Liam Carrier highlighted amendments and additions that had been made to the Workforce Plan since it was last reviewed at the June meeting. The Committee noted that the Trust's EDS2 will be consulted upon within various stakeholder groups including JNCC where it was favourably received, the BME Network, the Board and Council of Governors and it was agreed that the next version of the Workforce Plan would show the timeline for this scale of work to be undertaken.

	Discussion took place on using newly qualified nursing staff and developing programmes for clinicians and apprenticeships as it was recognised that the Workforce Plan contained challenges regarding the medical workforce although it was noted that work was underway to provide assurance that recruitment was taking place. The Committee approved the Workforce Plan and agreed it would continue to be refined with the latest thinking and scale of work to be undertaken and will be received regularly for review. **ACTION: Workforce Plan to be received regularly for review.** **RESOLVED: The People & Culture Committee received and noted the revised Workforce Plan**
P&C/2016/ 072	**EDS2 UPDATE** Owen Fulton attended the meeting and provided a verbal update on the equality and diversity aspect of the Trust's workforce. The Committee was advised that EDS2 has been very well received by the BME Group and a representative from this group will participate in the newly set up EDS2 working party. It was agreed that the Equality and Diversity consultation paper will be presented to the Council of Governors on 21 July and a final version presented to the Board in September. The Committee was concerned that a named person should be identified to drive equality and diversity forward within the Trust. It was agreed that further updates would be received on a quarterly basis and this would be reflected in the forward plan. **ACTION: Forward Plan to reflect EDS2 received on a quarterly basis.** **RESOLVED: The People & Culture Committee acknowledged the EDS2 Update for 2016/2017 and agreed to receive quarterly updates on progress.**
P&C/2016/ 073	**WORKFORCE KPI DASHBOARD** The KPI Dashboard provided the People & Culture Committee with the latest key Workforce metrics at Trust level for June 2016 with historic data for the previous 12 months. General observations were highlighted by Liam Carrier, along with hotspots and triangulation with data for May 2016. The high level of sickness rates were noted by the Committee and it was proposed that these would be analysed by Rose Boulton and reported to the next meeting to establish if there are any links to unusual reasons, or whether there is a correlation to the recent difficulties experienced at the Radbourne Unit. The Committee was pleased to note that work is taking place to ensure appraisals are more meaningful. The appraisals process is being reviewed and will be relaunched through the engagement process and evidence of an improvement in the quality of appraisals is expected to be seen next year; the aim is for staff to value their appraisal process.

	The Committee noted the detail contained in the KPI Dashboard and asked that more narrative feedback be contained in the next report. **ACTION: Rose Boulton to provide a report on analysis of sickness rates to the next meeting. More narrative feedback will be contained in the next Workforce KPI report.** **RESOLVED: The People & Culture Committee scrutinised and noted the information contained in the HR Metrics report.**
P&C/2016/ 074	**FORWARD PLAN** The forward plan would be updated in line with today's discussions and presented for reference at the next meeting of the Committee.
P&C/2016/ 075	**ITEMS ESCALATED TO THE BOARD OR OTHER COMMITTEES** It was agreed that items escalated to the Board will be identified through the GIAP.
P&C/2016/ 076	**IDENTIFIED RISKS** The Committee identified the key risks as follows: **HR2 - Resource Plan:** Programme of leadership and training being developed and to complete in 6 months (February 2017) **PC2/4 People Plan:** Timescale to deliver against plan (recognised previously as a timing due to Trust strategy) and now to prioritise **Acting Up Policy:** Outcome that Policy not fit for purpose, to be updated and circulated and agreed in advance of the next PCC **Professional Registration and Re-Registration Policy:** Policy to include nurse revalidation and compliance monitored through TOMM **WOD6 Implement integrated team meetings:** Circumstances have so far prevented integrated team meetings taking place. **WOD7 Ensure the backlog of cases made known to the CQC are concluded:** The length of time cases are on ER tracker to resolve – to be mitigated by focussed activity, case management review approach and to feed into overall policy review. **PC2 Develop a clear plan which outlines an on-going focus on pulse surveys to enable targeted activity:** Resource to complete within timeframe. Review of resources to prioritise against plan. **PC2 Develop and implement a leadership development programme:** Clarity regarding the responsible people to lead this **PC5 HR and OD to undertake a refresh of the behavioural framework:** Clarity regarding the responsible people to lead these actions **WOD1-Develop an internal compliance monitoring process for HR policies and procedures including case management and tracking:** The length of time cases

	are on ER tracker to resolve – to be mitigated by focussed activity, case management review approach and to feed into overall policy review. **Workforce Plan:** Update with latest thinking with the scale of work to be undertaken, including new roles required for the future. **EDS2:** Named person should be identified to drive equality and diversity forward within the Trust **Workforce KPI Dashboard:** Rise in short-term absences may develop into long-term sickness
P&C/2016/ 077	**EFFECTIVENESS OF THE MEETING** The Chair, Richard Gregory was pleased with the outcome of the meeting and felt that good progress had been made through the discussions held.
Date and Time of next meeting: The next meeting of the People & Culture Committee will take place on **Friday, 20 September 2016 at 2.00 pm in *Meeting Room 1 – Albany House, Kingsway, Derby.***	

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors 5th October 2016

NHS IMPROVEMENT (NHSI) OVERSIGHT FRAMEWORK: EFFECTIVE FROM 1 OCTOBER 2016

Purpose of Report

To summarise for Trust Board the key elements and risk areas relating to the new NHSI oversight framework.

Executive Summary

On 13t September 2016 NHSI published its Single Oversight Framework which is effective from 1 October 2016. For Foundation Trusts this replaces the Risk Assessment Framework. It will impact on reporting and regulation for October 2016 performance onwards. (Performance Reports reporting to this meeting of the Board are reported under the Risk Assessment Framework as they relate to month five, August)

It provides one framework for overseeing providers, irrespective of their legal form with the objective of identifying potential support needs, by 'theme', as they emerge. It outlines an approach to tailored support packages to the specific needs of providers in the context of their local health systems, drawing on expertise from across the sector as well as within NHSI and is based on the principle of earned autonomy.

It segments providers into one of four categories that indicates their level of autonomy and regulatory support from NHSI.

'Shadow' segmentation has been undertaken for providers, at the time of writing we had not been notified of ours, although this has been requested. Segmentation-proper for the provider sector will be notified in November, based on month 7 (October) performance.

Performance is assessed across these five themes:
1. Quality of care
2. Finance and Use of Resources
3. Operational Performance
4. Strategic Change
5. Leadership and improvement capability (Well Led)

Ratings are the opposite way round in the new framework – currently 1 is worst and 4 is best. In the new ratings 1 is best with highest level of autonomy and 4 is for trusts in special measures.

For us there is a likelihood of the risk of triggering regulatory scrutiny/action under the themes for:
Quality (due to CQC inspection findings) and
Leadership (due to Well Led, CQC findings, NHSI enforcement action, staff indicators, Board churn) and also potential risk in:
Finance (caused by agency spend)

There is therefore a significant likelihood that taking those factors together the Trust's current performance against the various indicators will place the Trust in segment 3 which is for trusts that are in actual or suspected breach of their licence. This triggers a mandated support package from NHSI.

Strategic considerations

Compliance with Regulatory obligations and acceptable performance to Regulators is a fundamental strategic requirement and adverse performance can result in non-achievement of strategic priorities as well as regulatory intervention which can also adversely impact on strategic delivery.

Board Assurances

Because the Oversight Framework is so comprehensive in scope this report should be considered in relation to all risks contained in the Board Assurance Framework 2016/17:

1a Failure to achieve clinical quality standards required by our regulators which may lead to harm to service users and/or staff

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

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

Furthermore, failure to deliver the Governance Improvement Action Plan could lead to a risk of further breaches in licence regulations with NHSI and the CQC and further regulatory action.

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

3c There is a risk that turnover of the Board members could adversely affect delivery of the organisational strategy due to loss of specialist organisational knowledge, capacity and stability

4a Failure to deliver short term and long term financial plans could adversely affect the financial viability and sustainability of the organisation

4b Failure to deliver the agreed transformational change, at the required pace could result in reduced outcomes for service users, failure to deliver financial requirements and negative reputational risk.

Consultation

This paper has not been considered elsewhere, although aspects of the Oversight Framework and performance against it have been discussed at the September 2016 meeting of the Finance and Performance Committee.

Governance or Legal Issues

This report describes the updated and emerging requirements of the NHSI and Care Quality Commission as Regulators.

Equality Delivery System

This report and the regulatory framework have no differential impact on REGARDS groups.

Recommendations

The Board of Directors are requested:

1. To scrutinise and become familiar with the new Oversight Framework
2. To note the key risk areas for this organisation and to consider the likelihood and implications of segmentation into segment 3
3. To receive information regarding any future updates or iterations of the framework

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

1. Summary of oversight areas

Figure 1 below summarises the areas being measured and what sources of information are used by NHSI

Figure 1 Summary of information used

	In-year	Annual/ less frequently	Ad hoc
Quality of care	In-year quality information to identify any areas for improvement (see Appendix 2)	Annual quality information	Results of CQC inspections CQC warning notices, fines, civil or criminal actions and information on other relevant matters
Finance and use of resources	Monthly returns	Annual plans	One-off financial events (eg sudden drops in income/ increases in costs) Transactions/mergers
Operational performance	Monthly/quarterly(in some cases weekly[2]) operational performance information (see Appendix 3)		Any sudden and unforeseen factors driving a significant failure to deliver
Strategic change	Delivery of sustainability and transformation plans (STPs) Progress of any new care models, devolution plans	STPs	Any sudden and unforeseen factors driving a significant failure to deliver
Leadership and improvement capability	Third-party information with governance implications[1] Organisational health indicators - staff absenteeism - staff churn - board vacancies	Staff and patient surveys Third-party information with governance implications[1]	Findings of well-led reviews Third-party information with governance implications[1]

[1] eg reports from quality surveillance groups (QSGs), GMC, ombudsman, CCGs, Healthwatch England, auditors, Health and Safety Executive, patient groups, complaints, whistleblowers, medical Royal Colleges

[2] Where necessary

Risk areas and areas to note with regard to the 'themes' of oversight:

Quality:

- The CQC full inspection report published on 29th September highlights factors that will impact on this area and trigger concern. Action-planning for CQC findings are reported elsewhere to board so are not repeated here. Note that where CQC's assessment identifies a provider as 'inadequate' or 'requires improvement' against any of the **safe**, **effective, caring** or **responsive** key questions, this will represent a potential support need. (CQC inadequate or requires improvement against **well led** triggers concern under the leadership theme)

Finance and Use of Resources:

- Our main risk area here is against the agency spend metric – currently we are operating with a level of spend that is in the worst metric score and would result in the override rule applying. Measurement commences on 1st October so action planning, particularly with regard to reduction in expenditure on agency medics is key.
- Board are also aware from separate reports about the range of risks and assumptions within the financial position and forecast including delivery of the control total (notably CIP/cost avoidance gap closure requirement)
- The five financial metrics are described in the table below

Area	Weighting	Metric	Definition	Score			
				1	2	3	4[1]
Financial sustainability	**0.2**	**Capital service capacity**	Degree to which the provider's generated income covers its financial obligations	>2.5x	1.75-2.5x	1.25-1.75x	< 1.25x
	0.2	**Liquidity (days)**	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	>0	(7)-0	(14)-(7)	<(14)
Financial efficiency	**0.2**	**I&E margin**	I&E surplus or deficit / total revenue	>1%	1-0%	0-(1)%	≤(1)%
Financial controls	**0.2**	**Distance from financial plan**	Year-to-date actual I&E surplus/deficit in comparison to Year-to-date plan I&E surplus/ deficit	≥0%	(1)-0%	(2)-(1)%	≤(2)%
	0.2	**Agency spend**	Distance from provider's cap	≤0%	0%-25%	25-50%	>50%

- Where providers have a score of 4 or 3 in the financial and use of resources theme, this will identify a potential support need under this theme, as will providers scoring a 4 (ie significant underperformance) against **any** of the individual metrics.
- Providers in financial special measures will score a 4 on this theme.

Broader value-for-money considerations will be taken into account if they suggest a provider is failing to operate effective systems and/or processes for financial management and control, and not operating economically, efficiently and effectively. Eg national benchmarking, management consultancy spend, paybill growth, consolidation of back office and pathology services, and the extent to which providers are addressing unsustainable services through consolidation, and change or transfer to a neighbouring provider.

Operational performance

- Generally speaking, as reported in the Integrated Performance Report, operational performance against standards is meeting all requirements measured by NHSI.
- One area that has potential to underachieve is RTT.
- If trajectories are not met for two consecutive months that triggers a concern.

Strategic Change

- This is an theme which is still being developed by NHSI but we should be reasonably well-placed with regard to this measure because of our involvement in the system strategic change in STP for Derby/Derbyshire

Leadership

- NHSI look at three main characteristics within this theme: effective boards and governance, continuous improvement capability and effective use of data.
- Risk issues for us here include achievement of Well led/GIAP, CQC inspection well led rating, EDS/WRES delivery staff absence rates, retention rates, board churn, staff friends and family surveys.

The SOF guidance includes appendices with the full lists of what information is used to inform the segmentation and that is not replicated here.
This link takes the reader to the full document: Single Oversight Framework

Triggering support from NHSI

Where providers have a potential support need, based on the triggers, NHSI will consider the circumstances to determine the level of support required. Practically, they will consider:

- the extent to which the provider is triggering a Single Oversight Framework measure under one, or more, of the five themes
- any associated circumstances the provider is facing
- the degree to which the provider understands what is driving the issue
- the provider's capability and the credibility of plans it has developed to address the issue
- the extent to which the provider is delivering against a recovery trajectory.

2. Segmentation

Depending on the extent of support needs identified through its oversight process and performance against the above measures, NHSI will segment providers into four. Table 1 below summarises the impact of various levels of segmentation

Table 1

Segment	Description	Support packages	Reporting and review frequency
1 – Maximum autonomy	No potential support needs identified across five themes. Is lowest level of oversight and expectation that providers in segment 1 will support providers in other segments	**Universal** support	Providers in segment 1 will only reviewed on a quarterly basis (unless there is evidence that a provider is in breach of its licence, or equivalent for NHS trusts)
2 – targeted support	Potential support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/or formal action needed	**Universal** support **Targeted** support as agreed by provider: • To address issues • Help provider move to segment 1	Ongoing – Where in-year, annual or ad-hoc monitoring flags a potential support need, NHSI will review the provider's situation and consider whether it needs to change its allocated segment.
3 – mandated support	The provider is in actual/suspected breach of the licence (or equivalent for NHS trusts) and/or requires formal action	**Universal** support **Targeted** support **Mandated** support as determined by NHSI: • To address specific issues and help provider move to segment 2 or 1 • Compliance is required	Ongoing – as above
4 – special measures	The provider is in actual/suspected breach of its licence (or equivalent for NHS trusts) with very serious/complex issues that may mean that they are in special measures	**Universal** support **Targeted** support **Mandated** support as determined by NHSI: • To help minimise the time the provider is in segment 4 • Compliance is required	Ongoing – as above

Segmentation will be based on:

- All available information on providers – both obtained directly and from third parties
- Identifying providers with a potential support need in one or more of the above themes
- Using NHSI's judgement, based on relationship knowledge and/or findings of formal or informal investigations, or analysis, consideration of the scale of the issues faced by a provider and whether it is in breach or suspected breach of licence conditions.

3. Support packages

Individual support packages will be provider-specific, and tailored to the support needs identified, but comprise one or more of three levels of support:

Universal support offer: tools that providers can draw on if they wish to improve specific aspects of performance – its use is voluntary.

Targeted support offer: support to help providers with specific areas – eg intensive support teams to help in emergency care or agency spend. Programmes of targeted support will be agreed with providers. This support is offered to providers – its use is voluntary.

Mandated support: where a provider has complex issues, we may introduce a mandated series of improvement actions, e.g. appoint an improvement director, or agree a recovery trajectory and support providers to deliver this. In these serious cases, providers are required to comply with NHS Improvement's actions/expectations.

4. Alignment with CQC ongoing work and developments in Carter requirements

NHSI say they will continue to work with CQC to align approaches more fully as they move towards a single combined assessment of quality and use of resources. They will work with CQC to develop the well-led framework, to help identify support needs for leadership and improvement capability. They will work together to share data and develop common data sets where possible. They will also continue to develop close operational working, for example aligning the way NHSI and CQC work together in engaging with individual providers.

In line with Carter recommendation, NHSI are working with the CQC, NHS England and the provider sector to ensure that they draw on a single, shared set of metrics both to review performance and to decide where to target support or oversight.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors 5th October 2016

NHS Operational Planning and Contracting Guidance 2017 - 2019

Purpose of Report

The purpose of this report is to provide Trust Board with a summary of the recently published NHS Operational Planning and Contracting Guidance for 2017 - 2019.

Executive Summary

The 2017–2019 planning guidance outlines the expectations of the national bodies for system level planning over the next two years, focussing on contracting and sustainability and transformation plans (STPs) as well as introducing a range of new national business rules.

Alongside the planning guidance the draft standard contract has also been published as well as the draft National Tariff prices and draft national CQUINs.

The key proposals from the planning guidance focus on several areas;

- changes to contracting processes
- STP financing measures
- performance metrics
- further details on sustainability and transformation funding

Underpinning this is a clear, but very challenging delivery timetable.

2 documents have been attached for Board members to review and discuss.

The first is NHS Providers' 'on the day briefing' which summarises the key points within the planning guidance along with their views on its content.

The second is the full document published by NHS England on the 22nd September 2016.

Strategic considerations

The organisation faces significant challenges over the next few years in terms of the transformation of clinical services and with the wider challenges facing the Trust from a financial, clinical and operational perspective.

The planning process aims to support the successful delivery of plans both at organisation and system wide level to meet those challenges; however, consideration needs to be taken of the capacity of the organisation to meet these challenges in such a demanding and complex working environment.

(Board) Assurances

This report should be considered in relation to the financial risk contained in the Board Assurance

Framework 2015/16:

- 1a Failure to achieve clinical quality standards required by our regulators which may lead to harm to service users
- 2a Risk to delivery of national and local system wide change. If not delivered this could cause the Trusts financial position to deteriorate resulting in regulatory action
- 4a Failure to deliver short term and long term financial plans could adversely affect the financial viability and sustainability of the organisation

Consultation

Owing to the timing of the release of the guidance this paper has not been considered at any other Committee

Governance or Legal issues

There are no governance or legal exceptions to note.

Equality Delivery System

This report has a neutral impact on REGARDS groups.

Recommendations

Board members are requested to discuss and note the content of the attached documents.

Report presented by: **Mark Powell, Director of Strategic Development**

Report prepared by: **Mark Powell, Director of Strategic Development**

22 September Month 2016

on the day BRIEFING

2017-2019 OPERATIONAL PLANNING & CONTRACTING "PLANNING GUIDANCE" – ON THE DAY BRIEFING

Today the national bodies NHS England (NHSE) and NHS Improvement (NHSI) have published their "planning guidance" *2017-2019 NHS Operational planning and contracting*. This briefing paper summarises the proposals, and gives NHS Providers view on them.

The planning guidance outlines the expectations of the national bodies for system level planning over the next two years, focussing on contracting and sustainability and transformation plans (STPs) as well as introducing a range of new national business rules. Alongside the planning guidance the draft standard contract has also been published today (summarised in a separate briefing document, to follow on our website) as well as the draft National Tariff prices and draft national CQUINs.

WHAT HAS BEEN PUBLISHED TODAY?

- 2017-2019 Operational planning & contracting "planning guidance"
- Technical guidance for NHS planning 2017/18 and 2018/19
- Draft standard contract for consultation
- Draft Tariff prices for 2017/18 and 2018/19
- Specialised services commissioning intentions and Specialised CQUIN Scheme Guidance for 2017-2019

KEY PROPOSALS

The key proposals from the planning guidance focus on several areas – changes to contracting processes, STP financing measures and performance metrics, and some further details on sustainability and transformation funding.

The key deadlines and information on publication dates relating to these items can be found in Annex 2.

STP planning, control totals and performance metrics

STP areas are required to submit local financial plans showing how their systems will achieve financial balance within the available resources, with NHSI and NHSE expecting both the commissioner sector and the provider sector to each be in financial balance in both 2017/18 and 2018/19.

The position of each provider's plan (on finance, activity and workforce) has to be consistent with the STP footprint financial plan for 2017/18 and 2018/19 that will be submitted on 21 October 2016 and with the system control for that STP area (see below for more detail), with the aggregate of all operational plans in a footprint needing to reconcile with the overall STP position. All organisations will be held accountable for delivering both their individual control total and the overall system STP control total.

From April 2017 each STP will have a financial control total derived from all the individual control totals for CCGs and provider organisations in that geography. It will be possible to flex individual organisation's control totals within that system control total via an application to NHS England and NHS Improvement, the purpose being to allow better balance, integration and planning across different organisations.

STPs can also propose to NHS England and NHS Improvement a subdivision or cross-STP boundary arrangements of their geography, with separate system control totals (and governance arrangements) for each sub-division, if they feel it is better suited to operational collaboration and risk management.

The document notes STP leaders "will have strong governance processes to ensure clarity as to how different organisations are contributing to agreed system working, how progress will be tracked, and how organisations will work together to manage cross-cutting transformational activity."

Drawing on existing data collections from the assurance frameworks, NHSI and NHSE will also publish core baseline STP metrics in November, encompassing, as a minimum, the following metrics:

- *Finance*
  - Performance against system control totals
- *Quality*
  - Operational Performance
  - A&E performance
  - RTT performance
- *Health outcomes and care redesign*
  - Progress against cancer taskforce plan
  - Progress against mental health FYFV implementation plan
  - Progress against the General Practice Forward View
  - Hospital total bed days per 1,000 population
  - Emergency hospital admissions per 1,000 population

STP areas will need to agree trajectories against these areas for 2017-19.

Sustainability and transformation funding (STF)

The planning guidance and its technical annex outline the following on future allocations of the STF funding:

- £1.8bn of *sustainability* funding will again be available in 2017/18: a £1.5bn general fund allocated on the basis of emergency care; a £0.1bn general fund allocated to non-acute providers; and a £0.2bn targeted fund.
- NHSE and NHSI have reviewed the approach to the STF for 2017/18 to 2018/19 in the light of experiences in 2016/17, and made changes based on an impact assessment model at an individual provider level. Based on this work they have allocated individual providers an indicative share of the STF and a provisional control total for 2017/18 and 2018/19. These are being communicated in a letter to each provider on 30 September 2016.
- The operating rules will be subject to agreement with the Department of Health and HM Treasury. However, as in 2016/17, the payment of STF will depend on providers meeting their financial control totals and meeting the core access standards.
- The baseline for 2017/18 trajectories will be the same as the agreed trajectories for 2016/17. Any provider whose plan for 2016/17 did not deliver one or more of the national standards for operational performance will not be able to reduce this baseline, and will have a trajectory to reach the national standards during 2017/18.

- If a provider does not deliver its performance trajectory during 2016/17 as a result of "exceptional circumstances outside of its control", it can use an appeals process to NHS England and NHS Improvement.

From 2017/18 onwards, the guidance states streams of *transformation* funding will increasingly be targeted towards "the STPs making most progress". This funding will be focused on delivery of specific national programme objectives "rather than spread thinly everywhere". To minimise the administrative burden, NHSE and NHSI will "ensure that the different application processes for different programmes are more co-ordinated."

Contracts and the contracting round

The document reaffirms that the contracting round will be completed by the end of this calendar year, and the contracts signed within this contracting round will last two financial years, starting from April 2017.

With regard to the process for signing off contracts, the document states:

- "We expect all contracts to be signed by 23 December".
- "Access to formal arbitration must be a last resort… and [resorting to arbitration] will be seen as a clear failure of collaboration and good governance."
- "NHS Improvement and NHS England will intervene where necessary, using their oversight and regulatory powers to resolve any cases where organisations refuse to do."
- "To enable a more collaborative approach to contracting [there will be] increased access to technical advice on contract and tariff issues… [and] escalation to NHS England and NHS Improvement Chief Executives (or delegated national directors) for commissioners and providers that do not agree their contracts" on time.
- "Where a provider refuses to follow the NHS arbitration process, they may forfeit a proportion of their Sustainability and Transformation Fund (STF) monies, and where a CCG fails to comply with the process, quality premium and transformation monies may be forfeited."

Regarding the content on the contracts, the planning guidance outlines the following:

- The 2017-19 planning and contracting round "will be built out from STPs". Two-year contracts will reflect two-year activity, workforce and performance assumptions that are agreed and affordable within each local STP. They must include "how they support delivery of the local STP, including clear and credible milestones and deliverables"
- It also requires that plans include:
  - The planned contribution to savings at an STP level,
  - How risks have been jointly identified and mitigated
  - The impact of new care models, including where appropriate how contracts with secondary care providers will be adjusted to take account of the introduction of new commissioning arrangements (MCPs, PACs)
  - The technical guidance published alongside the main planning guidance states that providers plans must be "stretching from a financial perspective: planning to deliver (or exceed) the financial control total agreed with NHS Improvement, thus qualifying the provider for receipt of STF; taking full advantage of efficiency opportunities including those identified by the Carter review and the agency rules."

Where providers accept their financial control totals and any associated conditions and are therefore eligible for payments from the Sustainability and Transformation Fund, contract sanctions for key performance standards will continue to be suspended until April 2019.

Nine 'must dos' for 2017-19

These are the same as outlined in 2016/17 planning guidance, and they remain for the priorities for 2017/18 and 2018/19. Commissioner and provider plans need to demonstrate how they will deliver these nine 'must-dos'.

2017/18 and 2018/19 'Must dos'
1. STPs – includes: Implement agreed STP milestones, on track for full achievement by 2020/21, and achieve agreed trajectories against the STP core metrics set for 2017-19.
2. Finance – includes: Deliver individual CCG and NHS provider organisational control totals and achieve local system financial control totals. Also implement local STP plans, moderate demand growth, increase provider efficiencies, including Carter proposals
3. Primary care – includes: Implement the General Practice Forward View., ensure local investment meets or exceeds minimum required levels., Increasing the number of doctors working in general practice, improve weekend and evening access, and Support general practice at scale and the expansion of MCPs or PACS,.
4. Urgent & emergency care – includes: Deliver the four hour A&E standard and standards for ambulance response times. By November 2017, meet the four priority standards for seven-day hospital services for all urgent network specialist services. Implement the Urgent and Emergency Care Review.
5. Referral to treatment times and elective care – includes: Deliver the NHS Constitution standard that more than 92 per cent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment. Deliver patient choice of first outpatient appointment, and achieve 100% of use of e-referrals by April 2018 in line with the 2017/18 CQUIN. Implement the national maternity services review
6. Cancer – includes: Implement the cancer taskforce report. Deliver the NHS Constitution 62 day cancer standard. Make progress in improving one-year survival rates and ensure all elements of the Recovery Package are commissioned.
7. Mental health – includes: Deliver in full the implementation plan for the mental health five year forward view for all ages. Ensure delivery of the mental health access and quality standards including 24. Increase baseline spend on mental health and eliminate out of area placements for non-specialist acute care by 2020/21.
8. People with learning disabilities – includes: Deliver Transforming Care Partnership plans with local government partners, reduce inpatient bed capacity. Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability or autism.
9. Improving quality in organisations – includes: Implement plans to improve quality of care, particularly for organisations in special measures.

Other key items

National Tariff

Draft Tariff prices for the next two years have been published today and are available here.

Subject to consultation, cost uplifts in the national tariff will be set at 2.1% for 2017/18 and 2.1% for 2018/19. As previously announced, the efficiency deflator will be set at 2% in both years.

The proposal for follow up outpatient activity to move to a single block payment was not widely supported by either commissioners or providers during the Tariff Engagement over the summer. As a result NHSI and NHSE "intend as an alternative to increase the percentage of follow-up costs bundled into first attendances as follows:

- 30% - adult surgical specialties and some medical specialties e.g. diabetes, cardiology and general paediatric medicine;
- 20% - other medical specialties;
- 10% (i.e. no change) – oncology, haematology, paediatric specialties and areas where Best Practice Tariffs apply e.g. transient ischaemic attack."

Education and Training Tariffs

To "provide stability to providers", Health Education England (HEE) will not be introducing changes to the education and training tariff currency design before April 2019. There are three possible exceptions to this:

- The non-medical placement tariff. The Department of Health consultation on education funding reforms could lead to structural changes from September 2018;
- Dental undergraduate tariff, where the Department of Health is proposing changes to the structure of the tariff from April 2018; and
- The potential expansion of the standardised education and training tariff for primary care placements.

CCG Business Rules and Allocations and "Risk reserve"

In 2016/17 CCGs had to ensure the 1% non-recurrent investment was uncommitted at the beginning of the year in order to create a risk reserve for the NHS worth c£800m. For 2017/18 and 2018/19 both commissioners and providers are required to help create the risk reserve. As in 16/17, release of the risk reserve to each local system will be dependent on delivery of its control total, subject to a satisfactory national risk profile. The risk reserve will be created from three components, totalling c. £830m:

- CCGs will again be asked to ensure that 1% of their allocation is planned to be spent non-recurrently, but only half of this – equivalent to £360m – has to be uncommitted at the start of the year, with the other half being available for immediate investment;
- NHS England will add c.£200m to this;
- 0.5% of the local CCG CQUIN scheme will also be held within the risk reserve, contributing £270m. Where systems are delivering their control total, this element of the risk reserve will be released for investment by the providers to whom the CQUIN is payable, with no other conditions attached.

Other salient items include:

- Commissioner allocations may be refreshed to reflect the impacts of new tariff pricing and updated Identification Rules for specialised services. Any adjustments will be published on 30 September.
- In deficit CCGs are expected to achieve at least breakeven position in-year and plan for return to cumulative underspend over the Spending Review period. Where this is not possible, they will be required as a minimum to improve their in-year position by 1% of allocation per year plus any above average allocation growth until the cumulative deficit has been eliminated and the 1% cumulative underspend business rule is achieved.

CQUINs

The current CQUIN scheme enables providers to earn up to 2.5% of annual contract value if they deliver objectives set out in the scheme. For 2017/18 and 2018/19, the full 2.5% will continue to be available to providers. NHS England is intending to make two changes to the scheme.

Continuing the arrangement of the current year, 1.5% of the 2.5% will be linked to delivery of nationally identified indicators. The indicator set has been streamlined, and with different indicator sets for different provider types. For acute and community services, the proposed national indicators cover six areas; there are five in mental health, and two in ambulance services. The national indicators include:

- NHS staff health and wellbeing (all providers)
- proactive and safe discharge (acute and community providers);
- reducing 999 conveyance (ambulance providers)
- NHS 111 referrals to A&E and 999 (NHS 111 providers);
- reducing the impact of serious infections (acute providers)
- wound care (community providers);
- crisis liaison (acute and mental health providers);
- physical health for people with severe mental illness (community and mental health providers);
- transition for children and young people with mental health needs (mental health providers);
- advice and guidance services (acute providers);
- e-referrals (acute providers, 2017/18 only;) and
- preventing ill health from risky behaviours (acute providers 2018/19 only; community and mental health providers, both years)

The remaining 1% will be assigned to support providers locally. 0.5% of this will be available subject to full provider engagement and commitment to the STP process. To support the introduction of system-wide risk pooling at STP level, the remaining 0.5% will be held as a reserve to cover risks in delivery of the relevant system control total. Where the system as a whole is on track to deliver within its system control total, this 0.5% will be payable to providers.

Specialised Services commissioning intentions and CQUINs

NHS England's commissioning intentions for specialised services are published today alongside the planning guidance. These set out national priorities for the six programmes of care, and region-specific priorities, as well as priorities for clinical and service reform, quality improvement and peer review including the payment system for secure mental health and critical care.

The specialised services CQUIN scheme will remain as now with 2% of contract value for all acute providers, 2.5% for mental health providers, and 2.8% for Hep C lead providers.

The scheme provides a limited number of CQUINs per contract, proportionate to the financial value of CQUIN investment. The largest acute and mental health provider will have between ten and five CQUINs respectively, with an average three CQUINs per contract. NHS England will seek further views on the proposed specialised CQUIN indicators as part of the wider CQUIN engagement exercise in October, and will publish any changes to the final scheme at the end of October.

NHS PROVIDERS VIEW ON THE PLANNING GUIDANCE

We welcome the action NHS England and NHS Improvement have taken to create a more effective planning cycle for 2017/18-2018/19. There are clear themes in the planning guidance of:

- Setting a more realistic, though stretching, ask on provider efficiency with a 2% headline efficiency requirement
- Providing greater planning certainty and stability through a two-year tariff, contract and consistent list of 'must do' performance commitments
- Supporting collaboration between providers and commissioners to reduce the time spent on transactional contractual disagreements and coming to earlier agreement on contracts
- Signalling further moves towards system-based working, including the development of STP metrics and control totals.

We acknowledge the aims of this new approach in reducing the transactional costs in the system and creating more time and focus on the delivery of longer-term transformation of services. However, there are several significant practical and policy issues to address if the aims of the planning guidance are to be realised.

Deadlines for agreeing contracts

The aim to have contracts signed off earlier is laudable and many providers are already accelerating their internal planning process to meet this new deadline. However, there is a clear trade-off between developing a plan quickly, and developing a well thought-through plan that has appropriate clinical input and board oversight. We would not wish to see providers or commissioners penalised for following good governance and planning processes where this entails missing a brought-forward deadline.

Many providers are also exploring complex new contracting arrangements that involve alliances between social care, primary care and third sector providers. Developing these contracts requires considerable time and resource, and partners in these alliances may not always be bound by the requirements of the NHS planning timeline. We welcome the assurance that commissioners will still have the ability to let new longer-term contracts and revise existing contracts accordingly, but contracting teams have finite time available and will be developing both these longer term contracts and the standard annual or biannual contract in parallel. It would be helpful if NHS England and NHS Improvement could provider a clearer signal on whether resources should be prioritised in developing the standard contract over the next three months, or these longer-term contracts that may have greater benefits for patients.

There is welcome recognition in the guidance that less time should be spent in adversarial and transactional contracting disagreements between CCGs and providers in the forthcoming contracting round. It would be helpful to see how NHS England will provide oversight on whether opening offers from CCGs in the contracting round are credible and supportive of a good faith negotiating process. It must also be recognised that many of the challenges in agreeing contracts between CCGs and providers in 2016/17 did not always arise from local issues but sometimes from seemingly conflicting guidance from the national bodies. We will be seeking greater clarity from NHS England

and NHS Improvement on how we will avoid issues where CCGs and providers simply can not agree a contract due to their commitments to organisation control totals and risk reserves.

Finally, while the planning guidance is clear in its view that failure to avoid arbitration is a failure of collaboration and good governance, we would argue that it would be a greater failure of governance for autonomous provider boards to sign-up to contracts that are neither fair nor deliverable, and this must be respected as part of the dispute resolution process and wider discussions with NHS Improvement and NHS England.

National tariff and standard contract

As noted earlier we welcome the retention of a more credible 2% efficiency factor.

We strongly opposed the introduction of a single block payment for outpatient activity, and welcome the changes that have been made to this policy. However, the proposed changes to the payment system are still relatively blunt and will potentially penalise providers offering outpatient follow-ups at clinically appropriate levels.

Provider finances and control totals

The planning guidance sets out how sustainability and transformation funding and control totals will operate over the next two years. We will be continuing our discussions with NHS Improvement over the longer-term strategy for control totals and how providers will be supported to return to greater autononomy in financial decision-making and control.

We will also be working closely with Health Education England to understand how changes to education and training funding will affect provider income over the course of the parliament. Although there is initial stability to provider income from education and training in 2016/17 from non-recurrent top-up payments, changes to the HEE budget in 2017/18 and 2018/19 may result in significantly increased pass-through costs to providers.

The planning guidance reiterates that the target NHS provider deficit for 2016/17 should be no more than £580m with a goal of £250m, and that any slippage against this target will lead to higher cumulative efficiency asks on providers in 2017/18-2018/19 as we will have 'unrealised and undelivered efficiency opportunity from previous years.' We will continue our influencing work with the national bodies to argue that the planning guidance must-dos must in fact be doable, and there is little to be gained by setting unachievable financial or performance targets that are then missed.

STPs

Following the introduction of STPs in last year's planning guidance, this year's planning guidance potentially cements STPs as a new unit of financial and performance monitoring and management, in addition to their initial primary purpose as a planning vehicle.

Greater clarity is needed on what the long term strategic direction for STPs will be, what accompanying regulatory and legistlative changes are needed, and what support will be provided for the development of clearer and more accountable governance structures. Further information is also needed on what support will be provided to STP leaders who will now see their duties and responsibilities grow.

Allocating STP-wide, or sub-STP-wide, financial control totals may in some areas support the appropriate sharing of financial risk and resource to improve services for patients, and the benefits of system-based working and collaboration are considerable. However, there is significant complexity involved in designing these systems. A given

mental health provider for example may now find itself with an individual control total, an STP control total, a separate contractual arrangement for the specialised services it offers, and on-going negotiations with partner providers and commissioners on transfers of services that will affect all the control totals within the STP as well as the aggregate STP-position. Resolving these issues is not impossible, nor is this the wrong thing to aim for, but it will be a significant challenge for local health systems to achieve this within the next few months.

It is also unclear whether reporting of A&E and RTT performance at STP level is simply additive and an aggregate of individual organisational reporting, or whether this is intended to allow greater flexibility in how services are delivered at individual organisations as long as the STP-wide performance is on trajectory.

Our next steps

Separate details will be circulated on how we will be involving our members in our engagement programme with NHS England and NHS Improvement on specific issues in the planning guidance, such as the longer-term approach to education and training funding and the operation of CQUINS, and wider issues including the governance issues surrounding STPs.

If you have any questions please contact Edward Cornick (Policy Advisor – NHS Finances)
Edward.Cornick@nhsproviders.org

ANNEX 1: NHS Providers press statement

Welcoming the release today of the NHS 2017/19 planning guidance, Chris Hopson, chief executive of NHS Providers, said:

"This year's planning and contracting round was one of the most difficult and frustrating in NHS history. We therefore welcome the desire of NHS England and NHS Improvement to improve and refine this year's process. The much earlier publication of the national planning framework allows frontline organisations to start their planning much earlier in the year, although this will bring some challenges.

"A two year planning and contracting period will help make the best use of resources. The clarity on key elements of the NHS landscape like the tariff, CQUINs, business rules and the standard contract will all help and are to be welcomed. We recognise the hard work of NHS England and NHS Improvement, which have worked at high speed, to get us here.

"The tariff is sensible and will help providers - together with the continuing £1.8 billion support – to eliminate or significantly reduce deficits. This year's quarter 1 results has shown, despite the huge pressure on providers from rising demand and the stretch on social and primary care, that extra investment in providers delivers concrete results for patients.

"We also welcome the recognition that the NHS is in transition from a service focussed on individual organisations to one focussed on local health and care systems.

"We also welcome the recognition that the NHS is in transition from a service focussed on individual organisations to one focussed on local health and care systems. The guidance sets out helpful, but appropriately flexible, guidance on how these two year 2017/19 operational plans interact with Sustainability and Transformation Plans.

"There are some aspects that need further exploration over the next weeks but these should not detract from the positive steps taken so far to help the NHS manage a very challenging financial challenge and plug the gap. In particular, we need to be sure that numbers of small but unfunded commitments are not added later in the year. This is critical as the gap between what the NHS is being asked to deliver and the funding available remains. But this guidance provides a helpful basis to enable the NHS to now plan how to meet the more challenging times we face."

Ends

Annex 2: Planning timeline

Key deadlines for planning and contracting processes and information publication dates	Date
Planning Guidance published + Technical Guidance issued	**22 September**
Draft NHS Standard Contract, national CQUIN scheme guidance and National Tariff draft prices issued	22 September
Initial STF 2017/2018 guidance issued to providers	30 September
Commissioner allocations, provider control totals and STF allocations published	21 October
NHS Standard Contract consultation closes	21 October
Submission of STPs	**21 October**
National Tariff section 118 consultation issued	31 October
Final CCG and specialised services CQUIN scheme guidance issued	31 October
Commissioners (CCGs and direct commissioners) to issue initial contract offers that form a reasonable basis for negotiations to providers	4 November
Final NHS Standard Contract published	**4 November**
Providers to respond to initial offers from commissioners (CCGs and direct commissioners)	11 November
Submission of full draft 2017/18 to 2018/19 operational plans	**24 November**
National Tariff section 118 consultation closes	28 November
Where contract signature deadline of 23 December at risk local decisions to enter mediation	5 December
Contract mediation	5 – 23 December
National Tariff section 118 consultation results announced	w/c 12 December
Final National Tariff published	**20 December**
National deadline for signing of contracts, submission of final approved 2017/18 to 2018/19 operational plans, aligned with contracts (Final contract signature date for avoiding arbitration)	**23 December**
Submission of joint arbitration paperwork by CCGs, direct commissioners and providers where contracts not signed	By 9 January
Arbitration outcomes notified to CCGs, direct commissioners and providers	Within 2 working days after panel
Contract and schedule revisions reflecting arbitration findings completed and signed by both parties	By 31 January

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NHS Operational Planning and Contracting Guidance

2017-2019

Published by

NHS England and NHS Improvement

Published: **Thursday 22 September 2016**
Prepared by: **NHS England and NHS Improvement**

This document is for: commissioners, NHS trusts and NHS foundation trusts
Publication Gateway Reference: **05829**

Contents

Annexes

Introduction and context: implementing Sustainability and Transformation Plans

1. This document explains how the NHS operational planning and contracting processes will now change to support Sustainability and Transformation Plans (STPs) and the 'financial reset'. It reaffirms national priorities and sets out the financial and business rules for both 2017/18 and 2018/19.

2. Our shared tasks are clear: implement the Five Year Forward View to drive improvements in health and care; restore and maintain financial balance; and deliver core access and quality standards.

3. In local STPs, these jobs come together as one. Each STP becomes the route map for how the local NHS and its partners make a reality of the Five Year Forward View, within the Spending Review envelope. It provides the basis for operational planning and contracting.

4. STPs are more than just plans. They represent a different way of working, with partnership behaviours becoming the new norm. What makes most sense for patients, communities and the taxpayer should always trump the narrower interests of individual organisations. That is why, although STPs are relatively new, we see them as having a significant ongoing role in the NHS.

5. Good organisations cannot implement the Five Year Forward View and deliver the required productivity savings and care redesign in silos. Only through a system-wide set of changes will the NHS be sure of being able to deliver the right care, in the right place, with optimal value. This means improving and investing in preventative, primary and community based care. It means creating new relationships with patients and communities, seeing the totality of health and care in identifying solutions, using social care and wider services to support improved productivity and quality as well as people's wellbeing. We need new care models that break down the boundaries between different types of provider, and foster stronger collaboration across services – drawing on, and strengthening, joint work with partners, including local government. The solutions will not come solely from within the NHS, but from patients and communities, and wider partnerships including local government, and the third sector; and effective public engagement will be essential to their success.

6. Right across the country, NHS organisations want to spend less of their time locked in adversarial and transactional relationships. Allocating finite and stretched NHS resources between competing demands will never be easy, and the task gets harder over the next three years. But we do now have the opportunity to settle the numbers earlier and for a longer duration. This will enable us all to devote more of our energies towards getting on with the job of redesigning and delivering better, more efficient care.

7. To support the STP process and embed the 'financial reset', the annual NHS planning and contracting round will now be streamlined significantly. Our aims are to provide greater certainty and stability; simplify processes and ensure they are more joined up; cut transaction costs; and support partnership and transformation.

8. The default will be for two-year contracts in place of those currently negotiated annually. Commissioners will still have the ability to let new longer-term contracts, based on new care models and whole population budgets, revising existing contracts accordingly.

9. The 2017-19 operational planning and contracting round will be built out from STPs. Two-year contracts will reflect two-year activity, workforce and performance assumptions that are agreed and affordable within each local STP. We are issuing a two-year tariff for consultation and two-year CQUIN and CCG quality premium schemes. NHS England is engaging with the sector on the indicators and measurements for these CQUINs. For the first time, a single NHS England and NHS Improvement oversight process will provide a unified interface with local organisations to ensure effective alignment of CCG and provider plans. And, as requested by NHS leaders, the timetable is now being brought forward to provide certainty earlier – with a target deadline of all 2017-19 contracts signed by 23 December 2016.

10. To ensure that organisational boundaries and perverse financial incentives do not get in the way of transformation, from April 2017 each STP (or agreed population/geographical area) will have a financial control total that is also the summation of the individual organisational control totals. All organisations will be held accountable for delivering both their individual control total and the overall system control. It will be possible to flex individual organisational control totals within that system control total, by application and with the agreement of NHS England and NHS Improvement. Further details are contained in paragraphs 25-29 of this document.

Priorities and performance assessment

Nine 'must dos' for 2017-19

11. In 2016/17 we described nine 'must do' priorities. These remain the priorities for 2017/18 and 2018/19. These national priorities and other local priorities will need to be delivered within the financial resources available in each year.

2017/18 and 2018/19 'must dos'

1. STPs

- Implement agreed STP milestones, so that you are on track for full achievement by 2020/21.
- Achieve agreed trajectories against the STP core metrics set for 2017-19.

2. Finance

- Deliver individual CCG and NHS provider organisational control totals, and achieve local system financial control totals. At national level, the provider sector needs to be in financial balance in each of 2017/18 and 2018/19. At national level the CCG sector needs to be in financial balance in each of 2017/18 and 2018/19.
- Implement local STP plans and achieve local targets to moderate demand growth and increase provider efficiencies.
- Demand reduction measures include: implementing RightCare; elective care redesign; urgent and emergency care reform; supporting self care and prevention; progressing population-health new care models such as multispecialty community providers (MCPs) and primary and acute care systems (PACS); medicines optimisation; and improving the management of continuing healthcare processes.
- Provider efficiency measures include: implementing pathology service and back office rationalisation; implementing procurement, hospital pharmacy and estates transformation plans; improving rostering systems and job planning to reduce use of agency staff and increase clinical productivity; implementing the Getting It Right First Time programme; and implementing new models of acute service collaboration and more integrated primary and community services.

3. Primary care

- Ensure the sustainability of general practice in your area by implementing the General Practice Forward View, including the plans for Practice Transformational Support, and the ten high impact changes.
- Ensure local investment meets or exceeds minimum required levels.
- Tackle workforce and workload issues, including interim milestones that contribute towards increasing the number of doctors working in general practice by 5,000 in 2020, co-funding an extra 1,500 pharmacists to work in general practice by 2020, the expansion of Improving Access to Psychological Therapies (IAPT) in general practice with 3,000 more therapists in primary care, and investment in training practice staff and stimulating the use of online consultation systems.
- By no later than March 2019, extend and improve access in line with requirements for new national funding.
- Support general practice at scale, the expansion of Multispecialty Community Providers or Primary and Acute Care Systems, and enable and fund primary care to play its part in fully implementing the forthcoming framework for improving health in care homes.

4. Urgent and emergency care

- Deliver the four hour A&E standard, and standards for ambulance response times including through implementing the five elements of the A&E Improvement Plan.
- By November 2017, meet the four priority standards for seven-day hospital services for all urgent network specialist services.
- Implement the Urgent and Emergency Care Review, ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020 in each STP footprint, including a clinical hub that supports NHS 111, 999 and out-of-hours calls.
- Deliver a reduction in the proportion of ambulance 999 calls that result in avoidable transportation to an A&E department.
- Initiate cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis.

5. Referral to treatment times and elective care

- Deliver the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment (RTT).
- Deliver patient choice of first outpatient appointment, and achieve 100% of use of e-referrals by no later than April 2018 in line with the 2017/18 CQUIN and payment changes from October 2018.
- Streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow-ups.
- Implement the national maternity services review, *Better Births*, through local maternity systems.

6. Cancer

- Working through Cancer Alliances and the National Cancer Vanguard, implement the cancer taskforce report.
- Deliver the NHS Constitution 62 day cancer standard, including by securing adequate diagnostic capacity and the other NHS Constitution cancer standards.
- Make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.
- Ensure stratified follow up pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types.
- Ensure all elements of the Recovery Package are commissioned, including ensuring that:
    - o all patients have a holistic needs assessment and care plan at the point of diagnosis;
    - o a treatment summary is sent to the patient's GP at the end of treatment; and
    - o a cancer care review is completed by the GP within six months of a cancer diagnosis.

7. Mental health

- Deliver in full the implementation plan for the Mental Health Five Year Forward View for all ages, including:
    - Additional psychological therapies so that at least 19% of people with anxiety and depression access treatment, with the majority of the increase from the baseline of 15% to be integrated with physical healthcare;
    - More high-quality mental health services for children and young people, so that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, including all areas being part of Children and Young People Improving Access to Psychological Therapies (CYP IAPT) by 2018;
    - Expand capacity so that more than 53% of people experiencing a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral.
    - Increase access to individual placement support for people with severe mental illness in secondary care services by 25% by April 2019 against 2017/18 baseline;
    - Commission community eating disorder teams so that 95% of children and young people receive treatment within four weeks of referral for routine cases; and one week for urgent cases; and
    - Reduce suicide rates by 10% against the 2016/17 baseline.
- Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals.
- Increase baseline spend on mental health to deliver the Mental Health Investment Standard.
- Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support.
- Eliminate out of area placements for non-specialist acute care by 2020/21.

8. People with learning disabilities

- Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism.
- Reduce inpatient bed capacity by March 2019 to 10-15 in CCG-commissioned beds per million population, and 20-25 in NHS England-commissioned beds per million population.
- Improve access to healthcare for people with learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check.
- Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability or autism.

9. Improving quality in organisations

- All organisations should implement plans to improve quality of care, particularly for organisations in special measures.
- Drawing on the National Quality Board's resources, measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services.
- Participate in the annual publication of findings from reviews of deaths, to include the annual publication of avoidable death rates, and actions they have taken to reduce deaths related to problems in healthcare.

Measuring and assessing performance

12. These priorities do not encompass the full breadth of NHS organisations' responsibilities. A summary of the current Government Mandate to NHS England is attached at Annex 1 and sets out the areas in which the Government expects the NHS to improve by 2020. Should these mandated objectives change for 2017/18 or 2018/19, we will issue supplementary advice as necessary. There is clear read-across from the Mandate to both the new CCG Improvement and Assessment Framework (CCG IAF) indicators and the new NHS Improvement oversight framework for NHS providers. Annexes E and F of the technical guidance list metrics for which commissioners and providers are required to submit planning trajectories. NHS England is publishing its intentions for specialised services commissioning alongside this document – these are outlined in paragraphs 63-67.

13. NHS England, NHS Improvement, Health Education England, the Care Quality Commission, Public Health England, NHS Digital and NICE are committed to working in a joined up way, together with local government, to support STP areas. NHS Improvement will use its new single oversight framework to look at providers' contribution to their STP and any associated support needs, and NHS England will do likewise through the CCG IAF. Wherever appropriate, however, we will ensure that our main point of contact to discuss progress with implementation of STPs and any support needed from national bodies is with the shared STP leadership for each area.

14. Drawing on existing data collections from the assurance frameworks, we will publish core baseline STP metrics in November 2016, encompassing as a minimum these metrics:

Finance

- Performance against organisation-specific and system control totals

Quality

Operational Performance

- A&E performance
- RTT performance

Health outcomes and care redesign

- Progress against cancer taskforce implementation plan
- Progress against Mental Health Five Year Forward View implementation plan
- Progress against the General Practice Forward View
- Hospital total bed days per 1,000 population
- Emergency hospital admissions per 1,000 population

15. STP areas will need to agree trajectories against these areas for 2017-19. The letter sent to STP leaders setting out the expectations for the content of STPs for the October 2016 submission is in Annex 4. These include:

- addressing feedback from the July 2016 conversations, including a crisp articulation of the tangible benefits to patients and communities;
- providing more depth and specificity on implementation;
- ensuring plans are underpinned by the Finance Templates;
- setting out the measurable impacts of the STP;
- describing how they envisage better integration between health and social care;
- describing the degree of local consensus amongst organisations and plans for further engagement; and
- continuing development of the STP's estates strategy.

Developing operational plans and agreeing contracts for 2017-19

16. The detailed requirements for commissioner and provider plans are set out in accompanying technical guidance. Plans will need to demonstrate:
    - how they will be delivering the nine 'must-dos';
    - how they support delivery of the local STP, including clear and credible milestones and deliverables;
    - how they intend to reconcile finance with activity and workforce to deliver their agreed contribution to the relevant system control total;
    - robust, stretching and deliverable activity plans which are directly derived from their STP, reflective of the impact that the STP's well-implemented transformation and efficiency schemes will have on trend growth rates, agreed by commissioners and providers and consistent with achieving the relevant performance trajectories within available local budgets;
    - how local independent sector capacity should be factored into demand and capacity planning from the outset, and local independent sector providers engaged throughout;
    - the planned contribution to savings;
    - how risks have been jointly identified and mitigated through an agreed contingency plan; and
    - the impact of new care models, including where appropriate how contracts with secondary care providers will be adjusted to take account of the introduction of new commissioning arrangements for MCPs or PACS during 2017-19.

17. CCG and provider plans will need to be agreed by NHS England and NHS Improvement, with a clear expectation that they must be fully aligned in local contracts. This is more than a technical process. It requires a genuine commitment for local leaders to run a shared, open-book process to deliver performance and improvement within the growing, but fixed, funding envelope available to that local area. We have seen this approach in the development of STPs and expect to see it carried forward into operational plans. Further details on support, review and assurance are set out in the Technical Guidance document.

Dispute avoidance and resolution

18. We expect all contracts to be signed by 23 December 2016. The earlier timetable for operational planning should give commissioners (CCGs and direct commissioners) and providers greater scope for constructive engagement over contracts. Access to formal arbitration must be a last resort. Our expectation is that commissioners and providers sort out any differences without the need for arbitration, and failure to do so will be seen as a clear failure of collaboration and good governance.
19. To enable a more collaborative approach to contracting, we are making a number of changes to the dispute resolution process as follows:
    - increased access to technical advice on contract and tariff issues to reduce the number of technical disputes;
    - escalation to NHS England and NHS Improvement chief executives (or delegated national directors) for commissioners and providers that do not agree their contracts to the national timetable.
20. It is our expectation that any parties, including foundation trusts, that are unable to agree contracts in line with the national timetable will submit their disputes for timely resolution through the NHS arbitration process. NHS England will also ensure that any disputes regarding its specialised commissioning activities which have not been resolved according to the national timeline will be referred to the NHS arbitration arrangements. NHS Improvement and NHS England will intervene where necessary, using their oversight and regulatory powers to resolve any cases where organisations refuse to do so. In addition, where a provider refuses to follow the NHS arbitration process, they may forfeit a proportion of their Sustainability and Transformation Fund (STF) monies, and where a CCG fails to comply with the process, quality premium and transformation monies may be forfeited.

NHS Standard Contract

21. We are proposing minimal changes to the NHS Standard Contract for the next two years. To support two-year local plans and contracts, the NHS Standard Contract will be set for two years. NHS England is publishing the revised NHS Standard Contract for consultation, alongside this document.

22. To enable more seamless care for patients, and as set out in the General Practice Forward View, we have strengthened the requirement for transmitting letters to GPs following clinic attendance. The current timescale for production (within 14 days of attendance) will reduce progressively to ten days (from 1 April 2017) and seven days (from 1 April 2018). A new requirement for electronic transmission of clinic letters, as structured messages using standardised clinical headings, will take effect from 1 October 2018. NHS England is also proposing:

    - from April 2017, stronger requirements on commissioners to facilitate hospital discharge and on providers to comply with recent NICE guidance;
    - from April 2017 mandated use of the e-Referral system (ERS); and from October 2018, non-payment for activity resulting from non-ERS referrals and the right for providers to return such referrals to GPs. We will work with the GP community to resolve practical issues which currently hinder use and uptake of the e-referral system in general practice;
    - from April 2017, mandatory data-sharing agreements for urgent and emergency care providers, enabling commissioners to access cross-provider data about utilisation and effectiveness of services;
    - from November 2017, the four priority standards for seven-day hospital services for all urgent network specialist services; and
    - compliance with new data security standards (April 2017), new conflicts of interest guidance (June 2017) and new interoperability requirements for clinical IT systems (January 2019).

23. In addition, NHS Digital intends to amend its guidance to support daily submission of electronic Secondary User Service (SUS) data from April 2018. There will be further engagement with providers before introducing these changes. NHS Digital will also shorten the turnaround of data to improve its utility for providers, commissioners and national bodies, which will in turn reduce burden on the system in providing aggregate data and the same data to multiple organisations. This will also improve the quality of data at source and on source systems.

24. Where providers accept their financial control totals and any associated conditions and are therefore eligible for payments from the Sustainability and Transformation Fund, contract sanctions for key performance standards are currently suspended. We propose to extend this suspension until April 2019.

Timetable

Timetable Item (applicable to all bodies unless specifically referenced)	Date
Planning Guidance published	**22 September 2016**
Technical Guidance issued	**22 September 2016**
Commissioner Finance templates issued (commissioners only)	22 September 2016
Draft NHS Standard Contract and national CQUIN scheme guidance published	22 September 2016
National Tariff draft prices issued	22 September 2016
Provider control totals and STF allocations published	30 September 2016
Commissioner allocations published	21 October 2016
NHS Standard Contract consultation closes	21 October 2016
Submission of STPs	**21 October 2016**
National Tariff section 118 consultation issued	31 October 2016
Final CCG and specialised services CQUIN scheme guidance issued	31 October 2016
Provider finance, workforce and activity templates issued with related Technical Guidance (providers only)	1 November 2016
Submission of summary level 2017/18 to 2018/19 operational financial plans	1 November 2016 (noon)
Commissioners (CCGs and direct commissioners) to issue initial contract offers that form a reasonable basis for negotiations to providers	4 November 2016
Providers to respond to initial offers from commissioners (CCGs and direct commissioners)	4 November 2016
Final NHS Standard Contract published	4 November 2016
Submission of full draft 2017/18 to 2018/19 operational plans	**24 November 2016 (noon)**
Weekly contract tracker to be submitted by CCGs, direct commissioners and providers	Weekly from: 21/22 November 2016 to 30/31 January 2017
National Tariff section 118 consultation closes	28 November 2016

Timetable Item (applicable to all bodies unless specifically referenced)	Date
Where CCG or direct commissioning contracts are not signed and contract signature deadline of 23 December 2016 is at risk, local decisions to enter mediation	5 December 2016
Contract mediation	5-23 December 2016
National Tariff section 118 consultation results announced	w/c 12 December 2016
Publish National Tariff	20 December 2016
National deadline for signing of contracts	**23 December 2016**
Final contract signature date for CCG and direct commissioners for avoiding arbitration	23 December 2016
Submission of final 2017/18 to 2018/19 operational plans, aligned with contracts	**23 December 2016**
Final plans approved by Boards or governing bodies of providers and commissioners	By 23 December 2016
Submission of joint arbitration paperwork by CCGs, direct commissioners and providers where contracts not signed	By 9 January 2017
Arbitration outcomes notified to CCGs, direct commissioners and providers	Within two working days after panel date
Contract and schedule revisions reflecting arbitration findings completed and signed by both parties	By 31 January 2017

Finance and business rules

STP system control totals

25. STP areas are required to submit local financial plans showing how their systems will achieve financial balance within the available resources. We expect both the commissioner sector and the provider sector to be in financial balance in both 2017/18 and 2018/19. Operational plans for 2017/18 and 2018/19 are the detailed plans for the first two years of the STP.

26. We expect that:

- the transformation and efficiency plans, including activity growth moderation plans, set out in STPs will be reflected in individual organisational plans;
- there will be aggregate financial activity and workforce plans at STP level, underpinned by financial control totals, and organisational level operational plans will need to reflect those aggregate plans;
- accountability for delivery will sit with individual organisations but they will need to demonstrate how their organisational plans align with STP objectives and planning assumptions; and
- STP leaders will have strong governance processes to ensure clarity as to how different organisations are contributing to agreed system working, how progress will be tracked, and how organisations will work together to manage cross-cutting transformational activity.

27. To support system-wide planning and transformation, we will be setting financial system control totals for all STP or equivalent agreed areas for planning purposes, ongoing monitoring and management. In the first instance, they will be derived from individual control totals for CCGs and provider organisations in that geography. On a by-application basis, there will be flexibility, by agreement with NHS England and NHS Improvement, for STP partners to adjust organisational control totals (both for providers and for CCGs) within an STP footprint, provided the overall system control total is not breached. This process will be managed so that two rules are met: the provider sector achieves aggregate financial balance in 2017/18 and 2018/19, and the commissioning system continues to live within its statutory resource limits. Individual organisations will continue to be accountable for managing within their organisational-level control totals.

28. This approach has a number of potential benefits, including the ability to shift money within systems to support agreed transformation plans or planned changes to patient flows; to manage financial risk across a health economy; and to pool administrative and other functions across organisations. Annex 5 provides further information.

29. Larger STP areas may wish to propose to NHS England and NHS Improvement a subdivision of their geography for these purposes, with separate system control totals (and governance arrangements) for each subdivision, where this is better suited to operational collaboration and risk management.

Approach to efficiency

30. In July 2016, the 'reset' publication 'Strengthening Financial Performance and Accountability in 2016/17 in the NHS' underscored the responsibilities of individual NHS bodies to live within the funding available. Specifically, it confirmed actions to support NHS providers in cutting the annual NHS provider deficit in 2016/17 to no more than £580m with a goal of £250m for 2016/17 and a balanced starting position for 2017/18 based on the full year effect of the measures taken. It also set out measures to sharpen the direct accountability of providers and commissioners to live within the public resources made available by Parliament.

31. As noted above, the provider sector will be expected to achieve aggregate financial balance in each of the two years of the operational plan after taking into account deployment of the £1.8bn STF. Any deterioration in the opening position for 2017/18 set out in the previous paragraph or in delivery during the plan period will require the relevant individual providers to deliver efficiency levels greater than the 2% national requirement to meet the control totals set by NHS Improvement, recognising that by definition they will have unrealised and undelivered efficiency opportunity from previous years.

32. Although there are increased resources available for the NHS in 2017/18 and 2018/19, the level of growth is significantly less than has previously been available to the NHS.

33. Therefore, the expectation is that providers and commissioners have a relentless focus on efficiency in 2017/18 and 2018/19; and that the opportunities set out in the national efficiency programmes and embedded in STPs are further developed in operational plans and delivered by providers and commissioners working together. The national transformation and efficiency programmes – RightCare, Continuing Healthcare, New Models of Care, Urgent and Emergency Care, Self Care and Prevention, Getting It Right First Time (GIRFT), and the Carter productivity programme led by NHS Improvement – will support this process, and learning from early adopters is now available.

34. Improvements in operational productivity need to be accelerated within providers and across STPs to reduce unwarranted variation in quality and costs. Particular focus should be given to:
    - consolidation of pathology services and back office functions across STP footprints (and possibly wider);
    - compliance with the procurement of items on the mandated list and continuing to submit purchase order information for the Purchasing Price Benchmarking Index and taking action to move to best value items;
    - implementing Procurement, Hospital Pharmacy and Estates and Facilities Transformation Plans;
    - improved rostering systems and job planning to reduce the use of agency and increase clinical productivity, with reference to benchmarks and guidance around Care Hour Per Patient Day and Cost Per Care Hour metrics;
    - participating in the specialised commissioning savings programme for high cost drugs and devices; and
    - fully participating in the clinically led Getting it Right First programme by submitting any necessary data and enacting jointly agreed changes to clinical practice to reduce unwarranted variation.

35. Work to roll out Lord Carter's work in to the mental health and community provider sectors begins in autumn 2016, and providers and commissioners of these services are encouraged to participate.

National Tariff

36. The Tariff Engagement Document published in August 2016 proposed two major changes:
    - first, to set a national tariff for two years; and
    - second, to move from using HRG4 currency design to using phase 3 of HRG4+ complemented by an updated system of top-up payments in order to better reflect different levels of complexity and current clinical practice.

37. Subject to consultation, cost uplifts in the national tariff will be set at 2.1% for 2017/18 and 2.1% for 2018/19. The cost uplifts include revised projections for pay drift, the costs of the apprenticeship levy and pass through drugs and exclude HRG-specific uplifts included in tariff prices for Clinical Negligence Scheme for Trusts (CNST). As previously announced, the efficiency deflator will be set at 2% in both years.

38. We proposed in the Tariff Engagement Document that we move all follow up outpatient activity to a single block payment. The rationale was to reduce inappropriate outpatient follow-ups. This proposal was not widely supported by either commissioners or providers. We therefore intend as an alternative to increase the percentage of follow-up costs bundled into first attendances as follows:

    - 30% - adult surgical specialties and some medical specialties eg diabetes, cardiology and general paediatric medicine;
    - 20% - other medical specialties; and
    - 10% (ie no change) – oncology, haematology, paediatric specialties and areas where Best Practice Tariffs apply eg transient ischaemic attack.

39. We encourage local systems to consider more far reaching local payment reform to complement the redesign of first outpatient appointments and introduction of advice and guidance services under the proposed new CCG CQUIN, as well as to reduce inappropriate outpatient follow-ups, through local variations. Where local schemes are not in place, the default will be the approach set out above.

40. As announced in June, we will also publish the first new Innovation and Technology tariffs, drawing on the NHS Innovation Accelerator (NIA) programme, to incentivise take-up of the latest innovations across the NHS.

Education and Training Tariffs

41. To provide stability to providers, Health Education England (HEE) will not be introducing changes to the education and training tariff currency design before 1 April 2019. There are three possible exceptions to this:

    - The non-medical placement tariff. The Department of Health (DH) consultation on education funding reforms could lead to structural changes from September 2018. HEE will continue to fund the non-medical placement tariff on the same basis as 2016/17, provided there are no material changes to placement numbers;
    - Dental undergraduate tariff, where the Department of Health is proposing changes to the structure of the tariff from April 2018; and
    - The potential expansion of the standardised education and training tariff for primary care placements.

42. The Spending Review settlement means that there will be no increase to the education and training tariffs in both 2017/18 and 2018/19, both for clinical placement settings and the salary contributions that HEE currently pays for each post graduate placement (eg F1 doctors in training). Study leave course fees may be removed from the education and training tariff for postgraduate medical placements subject to the outcome of DH proposals currently under consideration.

43. Transition to national education and training tariff price, which has limited provider gains and losses on a year by year basis, will continue in line with original transition plan. The cap on annual losses will remain at £2m or 0.25% of income. In addition, the non-recurrent supplementary tariff relief provided by DH this year will not be repeated for 2017/18. That relief effectively negated for 12 months the 2% reduction across all education and training tariffs in 2016/17. The Department of Health intends to provide further guidance on the education and training tariffs for 2017/18 and 2018/19 in due course[1].

Sustainability and transformation funding

44. The provider sector is required to return to aggregate financial balance in 2017/18, including through use of the £1.8bn STF. This is again being made available to providers in 2017/18 and 2018/19. Our expectation is that sustainability funding must deliver at least a pound-for-pound improvement in the aggregate financial position.

45. It is intended that the overall disposition of the £1.8bn will be as follows: a £1.5bn general fund allocated on the basis of emergency care; a £0.1bn general fund allocated to non-acute providers; and a £0.2bn targeted fund. The operating rules of the existing £1.8bn STF are subject to agreement with the Department of Health and HM Treasury, and we will set out further details in due course.

46. The baseline for 2017/18 trajectories will be the agreed trajectories for 2016/17. Any provider whose plan for 2016/17 did not deliver one or more of the national standards for operational performance will not be able to reduce this baseline, and will have a trajectory to reach the national standards during 2017/18. All other providers will be expected to deliver the national standard and will submit assurance statements to this effect to NHS Improvement. If a provider does not deliver its performance trajectory during 2016/17 as a result of exceptional circumstances outside of its control, it can use the appeals process to NHS England and NHS Improvement and, if successful, NHS England and NHS Improvement may jointly agree to adjust its trajectory, but this will only very rarely be the case.

[1] The Department of Health and Health Education England are currently in discussion with NHS Improvement about the impact of the proposed changes to Education Tariffs

47. The 2016/17 Spending Review provided additional dedicated funding streams for core priorities, including mental health, cancer care, general practice, and technology, building up over the next five years:

    - **Primary Care:** For 2017/18, NHS England has allocated around £8bn in primary medical care allocations (central and local), an increase of £301m over the previous year, and around £8.3bn in 2018/19 a further £304m increase. CCGs should also plan to spend approximately £3 per head (totalling £171m non-recurrently) in 2017/18 and 2018/19, from their existing allocations, for practice transformational support, as set out in the General Practice Forward View. Additional information is available in the General Practice Forward View Planning Requirements in Annex 6.
    - **Mental Health:** To support the transformation of mental health services, dedicated funding will be available. This includes centrally-held transformation funding of £215m in 2017/18 and £180m in 2018/19.
    - **Cancer:** Most of the extra funding needed to improve and expand cancer services is contained within CCG and specialised commissioning growing core budget allocations. However, there are several specific elements of the Cancer Taskforce which will be "kick started" with national funds, and these will be announced shortly.
    - **Technology:** £4.2bn of additional transformation funding for technology programmes will be subject to a consolidated approvals process which brings together NHS England, DH and NHS Digital funding as part of the National Information Board and associated new Digital Delivery Board (DDB). Programme plans for the period from 2017/18 to 2020/21 have been developed at a national level, and are subject to confirmation and challenge by DDB. During 2016/17, health economies organised themselves into digital footprints and developed Local Digital Roadmaps which are their plans of how they will digitise the providers in their area and achieve integration of information across care boundaries over the coming years. During the next period, NHS England and NHS Digital will work with STPs to agree allocation of transformation funding to support delivery of their Local Digital Roadmaps.
    - **Diabetes:** The NHS Diabetes Prevention Programme will be scaled up in 2017/18 and 2018/19 in two further phases of expansion, with appropriate national funding to support this. Additionally, we intend to launch a wider programme of investment in supporting the treatment and care of people who already have diabetes, for which CCGs will have the opportunity to bid for additional national funding of approximately £40m per year to promote access to evidence based interventions - improving uptake of structured education; improving access to specialist inpatient support and to a multi-disciplinary foot team for people with diabetic foot disease; and improving the achievement of the NICE recommended treatment targets whilst driving down variation between CCGs.

48. From 2017/18 onwards, the different streams of transformation funding will increasingly be targeted towards the STPs making most progress. However, this funding will need to be focused on full delivery of specific national programme objectives, rather than spread thinly everywhere. To minimise the administrative burden, we will ensure that the different application processes for different programmes are more co-ordinated, following the submission of STPs in October 2016. This will enable NHS England's Investment Committee to make investment decisions in time for the beginning of the 2017/18 financial year. Transformation funding will only be available to systems whose operational plans meet their required control total and performance trajectories.

49. Improving value in the NHS is at the heart of the Five Year Forward View. Over the course of this year NHS England has used the Best Possible Value (BPV) framework to make investment decisions for year two of vanguard funding and for transformation funding for mental health, cancer and maternity. The BPV framework is a structured approach to assessing the value of a particular project. It uses logic models and success hypotheses to estimate both quality benefits as well as financial return on investment and provide a robust mechanism for tracking the delivery of these benefits. For 2017/18 and 2018/19, the BPV framework will be used to assess all applications for transformation investments that are available for the NHS. We expect all STPs to have adopted value-based decision making processes based on the BPV framework, embedded from April 2017.

50. The capital environment remains very challenged with capital resources severely constrained. STPs will enable a clearer view of how capital funding can help deliver transformation. Provider capital plans will need to be consistent with clinical strategy and clearly provide for the delivery of safe, productive services with business cases that demonstrate affordability and value for money. Providers will need to continue to procure capital assets more efficiently, maximise and accelerate disposals and extend asset lives. We will shortly issue guidance on commissioner and provider capital processes for 2017/18 and 2018/19.

Risk reserve

51. In 2016/17 we asked CCG and primary care commissioners to ensure the 1% non-recurrent investment was uncommitted at the beginning of the year in order to create a risk reserve for the NHS, which could then be spent later in the year if commissioners and providers are on track to deliver their financial plans. In total this was worth circa £800m. To make sure we can manage the risks that both commissioners and providers face in 2017/18 and 2018/19, we will require a similar level of risk reserve, whilst nevertheless maximising purchasing power available to frontline services early in the year.

52. For 2017/18 and 2018/19 we will be looking to both commissioners and providers to help create the risk reserve, as part of a more collaborative and system-wide approach, and to complement the introduction of system control totals at STP level. As in 2016/17, release of the risk reserve to each local system will be dependent on delivery of its control total, subject to a satisfactory national risk profile. The risk reserve will be created from three components, totalling circa £830m:

    - CCGs will again be asked to ensure that 1% of their allocation is planned to be spent non-recurrently, but only half of this – equivalent to £360m – has to be uncommitted at the start of the year, with the other half being available for immediate investment.
    - NHS England will add circa £200m to this, funded from drawdown.
    - 0.5% of the local CCG CQUIN scheme will also be held within the risk reserve, contributing £270m. If a provider delivers its control total in 2016/17, the CQUIN will be paid at the beginning of 2017/18 to the provider, who will be required to hold it as a reserve until release is authorised (with CQUIN for 2018/19 linked to delivery in 2017/18). For providers that do not accept or deliver their control totals in the prior year the 0.5% CQUIN will be held by the CCG prior to potential release. In both instances this element of the risk reserve will be released for investment by the relevant providers when it is demonstrated that the system in question is delivering its control total.

CCG Business rules and allocations

53. The business rules for commissioners for 2017/18 and 2018/19 are set out in full in Annex E of the technical guidance. The key requirements are:

    - all CCGs are required to aim for in-year breakeven, with expectations set for the minimum level of improvement in deficit CCGs;
    - as in previous years, CCGs should plan for 1% non-recurrent spend:
        - 0.5% to be uncommitted and held as risk reserve (see above)
        - 0.5% immediately available for CCGs to spend non recurrently, to support transformation and change implied by STPs;
    - as was the case for 2016/17 and previous years, CCGs should also plan for 0.5% contingency to manage in-year pressures and risks; and
    - £0.4bn drawdown will be available supplemented by an increasing level of repayment of cumulative deficits, which will be used to fund:
        - a contribution to the risk reserve;
        - in-year CCG deficits (subject to the financial improvement rules set out in Annex E); and
        - drawdown for CCGs and primary care budgets, which have built up cumulative underspends above 1% in previous years.

54. Commissioner allocations may be refreshed to reflect the impacts of new tariff pricing and updated Identification Rules for specialised services. Any adjustments will be published on 21 October 2016.

55. The commissioner sector needs to continue to achieve a balanced position, and within this those CCGs that are currently in cumulative deficit need to recover their position as rapidly as possible. Deficit CCGs are expected to achieve at least breakeven position in-year and plan for return to cumulative underspend over the Spending Review period. Where this is not possible, they will be required as a minimum to improve their in-year position by 1% of allocation per year plus any above average allocation growth until the cumulative deficit has been eliminated and the 1% cumulative underspend business rule is achieved. Any variation from this to reflect exceptional circumstances will need to be agreed with the relevant NHS England regional team. Annex E of the technical guidance sets out further details of the expectations for CCGs in deficit.

56. In addition centrally held transformation funding to support delivery of the General Practice Forward View and Mental Health Forward View will be allocated to CCGs for 2017/18 and 2018/19. More details of the approach to this are set out in Annexes 6 and 8 of this document.

CQUIN and Quality Premium

57. The current CQUIN scheme enables providers to earn up to 2.5% of annual contract value if they deliver objectives set out in the scheme. For 2017/18 and 2018/19, the full 2.5% will continue to be available to providers. NHS England is intending to make two changes to the scheme.

58. First, continuing the arrangement of the current year, 1.5% of the 2.5% will be linked to delivery of nationally identified indicators. The indicator set has been streamlined, and with different indicator sets for different provider types. For acute and community services, the proposed national indicators cover six areas; there are five in mental health, and two each in ambulance services, NHS 111 and care homes. The indicators and their rationale are set out in Annex A of the technical guidance. NHS England will seek views over the next month on the measures and thresholds proposed for each indicator, through a new engagement exercise.

59. The national indicators include:
    - NHS staff health and wellbeing (all providers)
    - proactive and safe discharge (acute and community providers);
    - reducing 999 conveyance (ambulance providers)
    - NHS 111 referrals to A&E and 999 (NHS 111 providers);
    - reducing the impact of serious infections (acute providers)
    - wound care (community providers);
    - improving services for people with MH needs who present to A&E (acute and mental health providers);
    - physical health for people with severe mental illness (community and mental health providers);
    - transition for children and young people with mental health needs (mental health providers);

- advice and guidance services (acute providers);
- e-referrals (acute providers, 2017/18 only;) and
- preventing ill health from risky behaviours (acute providers 2018/19 only; community and mental health providers, both years)

60. Secondly, the remaining 1% will be assigned to support providers locally. 0.5% will be available subject to full provider engagement and commitment to the STP process. In effect, this will be a cost free indicator for providers with clear scope for earning the full amount. The remaining 0.5% is discussed in paragraph 52 above.

61. The Quality Premium scheme will continue to be offered to CCGs. This will also become a two-year scheme. The 2017/18 to 2018/19 scheme has evolved from the 2016/17 scheme, in that NHS England has streamlined the indicator set and:
    - retained indicators on Cancer Stage of Diagnosis and Patient Experience of Accessing their GP;
    - evolved the existing Anti-Microbial Resistance measure into a measure on Bloodstream Infections;
    - retained a locally selected indicator towards delivering the aims of the RightCare programme; and
    - introduced two new indicators, one to be selected from a Mental Health menu, and one focused on delivery of Continuing Healthcare.

62. The previous Gateway tests will continue to operate for the scheme, covering Finance, Quality and measures within the NHS Constitution. More detail is set out at Annex A of the technical guidance.

Specialised services and other direct commissioning

63. NHS England's commissioning intentions for specialised services are being published alongside this document. These set out national priorities for the six programmes of care, and region-specific priorities. Reviews that will impact in 2017/18 include Hyperbaric Oxygen Therapy, Prosthetics, Spinal Cord Injury, Paediatric Burns, Children's Epilepsy Surgery, Metabolic Medicine, Intestinal Failure and Paediatric critical care, transport, surgery and extra corporeal membrane oxygenation. The document also sets priorities for clinical and service reform, quality improvement and peer review including the payment system for secure mental health and critical care.

64. The new specialised services framework will enable STPs to include the contribution of specialised care to population based health services and outcomes. Through the continuation of the existing gain-share arrangements, CCGs will also be encouraged to unlock efficiencies across whole patient pathways. The national adoption of information rules by all providers will enable clearer identification and action on unwarranted variation in utilisation, efficiency and outcomes.

65. The contracting approach for specialised services is aligned to implementation of the Carter review. It includes: locally priced services reform, to reduce cost per weighted activity unit; a comprehensive multi-year medicines optimisation approach underpinned by CQUIN; and further reforms to the medical device supply chain, high cost drugs reimbursement and data flows.

66. The specialised services CQUIN scheme has been simplified and updated following engagement with providers over the summer. The multi-year approach introduced after dialogue in 2016/17 was supported and is continued. The overall funding structure for the scheme will remain as now with 2% of contract value for all acute providers, 2.5% for mental health providers, and 2.8% for hepatitis C lead providers. Furthermore, the incentive payment will be increased from "typical provider cost + 25%" to "typical provider cost + 50%". The scheme provides a sufficient range of CQUINs to be relevant to the service diversity of specialised providers whilst setting a limited number of CQUINs per contract, proportionate to the financial value of CQUIN investment. The largest acute and mental health provider will have ten and five CQUINs respectively, with an average three CQUINs per contract. NHS England will seek further views on the proposed specialised CQUIN indicators as part of the wider CQUIN engagement exercise in October 2016, and will publish any changes to the final scheme at the end of October 2016.

67. The approach outlined in this planning guidance will also apply to NHS England's other areas of direct commissioning as appropriate, including public health services, services for the armed forces, and healthcare for people in secure and detained settings.

Commissioning in the evolving system

68. Over half of CCGs now have delegated responsibility for commissioning primary medical care. CCGs indicate that this number will increase very significantly by April 2017, with almost all having delegated responsibility by the end of 2018/19. CCGs are also playing a bigger role in specialised services commissioning through the regional collaboration hubs. As part of devolution policy, joint working with local government is being strengthened across the country.

69. CCGs and Upper Tier Councils will need to agree a joint plan to deliver the requirements of the Better Care Fund (BCF) from 2017/18 via the Health and Wellbeing Board. The plan should build on the 2016/17 BCF plan, taking account of what has worked well in meeting the objectives of the fund, and what has not. CCGs will be advised of the minimum amount that they are required to pool as part of the notification of their wider allocation. BCF funding should explicitly support reductions in unplanned admissions and hospital delayed transfers of care. Further guidance on the BCF will be provided later in the autumn.

70. CCGs' role will continue to evolve. As new care models are established, the boundary between what is done by CCGs and by new integrated care providers will shift. However, there will continue to be a need for an effective commissioning function in the NHS. This includes acting as funder, setting local priorities and incentives, oversight of contracts, ensuring best value for the taxpayer, and ensuring the provision of a comprehensive local NHS within the available resources.

71. As part of this operational planning process, and within the context of STPs, CCGs will need to consider the opportunities for establishing new care models, the likely timetable for this and the implications for contracting. CCGs have a key role here in defining the scope of services for MCPs and PACS, engaging with local communities and providers over proposals, and running procurement processes. In particular, where the scope of MCP services includes services previously provided in hospitals, CCGs will need to agree revised contracts with the providers of these services. As part of the process for setting up new care models, NHS England will work with CCGs to ensure they have the capability and capacity to operate effectively in the changing provider landscape. This will include building on locally-led initiatives up and down the country for CCGs to work together across larger geographical footprints, for example, through joint appointments, integrated management and governance arrangements.

Annex 1

The Government's Mandate to NHS England, 2020 goals

1.	**Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities.**
1.1: CCG performance	Overall 2020 goal: • Consistent improvement in performance of CCGs against new CCG assessment framework.
2.	**To help create the safest, highest quality health and care service.**
2.1: Avoidable deaths and seven day services	Overall 2020 goals: • Roll out of seven day services in hospital to 100% of the population (four priority clinical standards in all relevant specialities, with progress also made on the other six standards), so that patients receive the same standards of care, seven days a week. • Achieve a significant reduction in avoidable deaths, with all trusts to have seen measurable reduction from their baseline on the basis of annual measurements. • Support NHS Improvement to significantly increase the number of trusts rated outstanding or good, including significantly reducing the length of time trusts remain in special measures. • Measurable progress towards reducing the rate of stillbirths, neonatal and maternal deaths and brain injuries that are caused during or soon after birth by 50% by 2030 with a measurable reduction by 2020. • Support the NHS to be the world's largest learning organisation with a new culture of learning from clinical mistakes, including improving the number of staff who feel their organisation acts on concerns raised by clinical staff or patients. • Measurable improvement in antimicrobial prescribing and resistance rates.

2.2: Patient experience	Overall 2020 goals: • Maintain and increase the number of people recommending services in the Friends and Family Test (FFT) (currently 88-96%), and ensure its effectiveness, alongside other sources of feedback to improve services. • 50-100,000 people to have a personal health budget or integrated personal budget (up from current estimate of 4,000). • Significantly improve patient choice, including in maternity, end-of-life care and for people with long-term conditions, including ensuring an increase in the number of people able to die in the place of their choice, including at home.
2.3: Cancer	Overall 2020 goals: • Deliver recommendations of the Independent Cancer Taskforce, including: o significantly improving one-year survival to achieve 75% by 2020 for all cancers combined (up from 69% currently); and o patients given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP.
3.	**To balance the NHS budget and improve efficiency and productivity.**
3.1: Balancing the NHS budget	Overall 2020 goals: • With NHS Improvement, ensure the NHS balances its budget in each financial year. • With the Department of Health and NHS Improvement, achieve year on year improvements in NHS efficiency and productivity (2-3% each year), including from reducing growth in activity and maximising cost recovery.
4.	**To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.**
4.1: Obesity and diabetes	Overall 2020 goals: • Measurable reduction in child obesity as part of the Government's childhood obesity strategy. • 100,000 people supported to reduce their risk of diabetes through the Diabetes Prevention Programme. • Measurable reduction in variation in management and care for people with diabetes.

4.2: Dementia	Overall 2020 goals: • Measurable improvement on all areas of Prime Minister's challenge on dementia 2020, including: o maintain a diagnosis rate of at least two thirds; o increase the numbers of people receiving a dementia diagnosis within six weeks of a GP referral; and o improve quality of post-diagnosis treatment and support for people with dementia and their carers.
5.	**To maintain and improve performance against core standards**
5.1: A&E, Ambulances and RTT	Overall 2020 goals: • 95% of people attending A&E seen within four hours; Urgent and Emergency Care Networks rolled out to 100% of the population. • 75% of Category A ambulance calls responded to within eight minutes. • At least 92% of patients on incomplete non-emergency pathways to have been waiting no more than 18 weeks from referral; no-one waits more than 52 weeks.
6.	**To improve out-of-hospital care.**
6.1. New models of care and general practice	Overall 2020 goals: • 100% of population has access to weekend/evening routine GP appointments. • Measurable reduction in age standardised emergency admission rates and emergency inpatient bed-day rates; more significant reductions through the New Care Model programme covering at least 50% of population. • Significant measurable progress in health and social care integration, urgent and emergency care (including ensuring a single point of contact), and electronic health record sharing, in areas covered by the New Care Model programme. • 5,000 extra doctors in general practice.
6.2: Health and social care integration	Overall 2020 goals: • Achieve better integration of health and social care in every area of the country, with significant improvements in performance against integration metrics within the new CCG Improvement and assessment framework. Areas will graduate from the Better Care Fund programme management once they can demonstrate they have moved beyond its requirements, meeting the Government's key criteria for devolution. • Ensure the NHS plays its part in significantly reducing delayed transfers of care, including through developing and applying new incentives.

6.3: Mental health, learning disabilities and autism	Overall 2020 goals: • To close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole (defined ambitions to be agreed based on report by Mental Health Taskforce). • Access and waiting time standards for mental health services embedded, including: o 50% of people experiencing first episode of psychosis to access treatment within two weeks; and o 75% of people with relevant conditions to access talking therapies in six weeks; 95% in 18 weeks.
7.	**To support research, innovation and growth.**
7.1: Research and growth	Overall 2020 goals: • Support the Department of Health and the Health Research Authority in their ambition to improve the UK's international ranking for health research. • Implement research proposals and initiatives in the NHS England research plan. • Measurable improvement in NHS uptake of affordable and cost-effective new innovations. • To assure and monitor NHS Genomic Medicine Centre performance to deliver the 100,000 genomes commitment.
7.2: Technology	Overall 2020 goals: • Support delivery of the National Information Board Framework 'Personalised Health and Care 2020' including local digital roadmaps, leading to measurable improvement on the new digital maturity index and achievement of an NHS which is paper-free at the point of care. • 95% of GP patients to be offered e-consultation and other digital services; and 95% of tests to be digitally transferred between organisations.
7.3 Health and work	Overall 2020 goals: • Contribute to reducing the disability employment gap. • Contribute to the Government's goal of increasing the use of Fit for Work.

Annex 2

The CCG Improvement and Assessment Framework

NHS England introduced a new Improvement and Assessment Framework for CCGs (CCG IAF) from 2016/17 onwards, to replace both the previous CCG Assurance Framework and separate CCG performance dashboard. In the Government's Mandate to NHS England, this new framework takes an enhanced and more central place in the overall arrangements for public accountability of the NHS.

The Five Year Forward View (5YFV), NHS Planning Guidance and the Sustainability and Transformation Plans (STPs) for each area, are all driven by the pursuit of the "triple aim": (i) improving the health and wellbeing of the whole population; (ii) better quality for all patients, through care redesign; and (iii) better value for taxpayers in a financially sustainable system. The new framework aligns key objectives and priorities, including the way we assess and manage our day-to-day relationships with CCGs.

The CCG IAF has been designed to supply indicators for adoption in STPs as markers of success. In turn those plans will provide vision and local actions that will populate and enrich the local use of the CCG IAF.

The NHS can only deliver the 5YFV through place-based partnerships spanning across NHS commissioners, local government, providers, patients, communities, the voluntary and independent sectors. To ask CCGs to focus solely on what resides exclusively within their own organisational locus would miss out what many are doing, and artificially limit their influence and relevance as local system leaders. In both the CCG IAF, and STPs, we give primacy to tasks-in-common over formal organisational boundaries.

The CCG IAF is available on the NHS England website.

Annex 3

NHS Improvement Single Oversight Framework

In September 2016 NHS Improvement published the Single Oversight Framework which has five themes:

- Quality of care (safe, effective, caring, responsive): we will use CQC's most recent assessments of whether a provider's care is safe, effective, caring and responsive, in combination with in-year information where available. We will also include delivery of the four priority standards for seven day hospital services.
- Finance and use of resources: we will oversee a provider's financial efficiency and progress in meeting its financial control total, reflecting the approach taken in strengthening financial performance and accountability. We are co-developing this approach with CQC.
- Operational performance: we will support providers in improving and sustaining performance against NHS Constitution standards and other, including A&E waiting times, referral to treatment times, cancer treatment times, ambulance response times, and access to mental health services. These NHS Constitution standards may relate to one or more facets of quality (i.e. safe, effective, caring and/or responsive).
- Strategic change: working with system partners we will consider how well providers are delivering the strategic changes set out in the 5YFV, with a particular focus on their contribution to sustainability and transformation plans (STPs), new care models, and, where relevant, implementation of devolution.
- Leadership and improvement capability (well-led): building on the joint CQC and NHS Improvement well-led framework, we will develop a shared system view with CQC of what good governance and leadership look like, including organisations' ability to learn and improve.

By focusing on these five themes NHS Improvement will support providers to improve to attain and/or maintain a CQC 'good' or 'outstanding' rating. Quality of care, finance and use of resources, and operational performance relate directly to sector outcomes. Strategic change recognises that organisational accountability and system-wide collaboration are mutually supportive. Leadership and improvement capability are crucial in ensuring that providers can deliver sustainable improvement.

The Single Oversight Framework is available on the NHS Improvement website

Annex 4

October Guidance on STPs

The Five Year Forward View set out our shared ambition to improve health, quality of care and efficiency within the resources given to us by Parliament. This 'triple aim' will only be achieved through local health and social care organisations working together in partnership with the active involvement of patients, stakeholders, clinicians and staff. Sustainability and Transformation Plans are the means of delivering these objectives in each local health and care system.

In June, each STP area shared its emerging thoughts on the three to five critical issues in its locality. As discussed in our conversations during July, we now expect to see plans with more depth and specificity. We recognise that each area is at a different starting point and that you will be able to provide more detail in 17/18 than later years but the October submission should build on the previous STP guidance issued in April and:

- Set out your plan to address the feedback from our July conversation. We don't need another lengthy narrative. It would be helpful if you could provide a summary sheet or 'plan on a page' to set out your overall aims, highlighting key changes between the June and October submissions. This should also include a crisp articulation of the tangible benefits to patients and communities.
- Provide more depth and specificity on how you plan to implement the proposed schemes as annexes. Illustrative PIDs and templates that other footprints have developed will follow to support you in this process. Any proposed shifts in activity from the acute sector should be accompanied by a clear plan to build strong primary care and community based services to provide the appropriate alternative care. Whatever format you choose, your plan will need to set out a clear set of milestones, outcomes, resources and owners for each scheme, as well as overarching risks, governance and interdependencies. This should include which organisation is involved in each initiative to allow you and us to triangulate your STP with local operational plans. We recognise that your plans will be more detailed for 17/18 and 18/19 and more high-level thereafter and subject to the normal rules around consultation and engagement.
- Ensure your plan is underpinned by the finance template and shows the impact on activity, benefits (costs and returns), capacity, workforce and investment requirements over time. We expect calculations to build from a whole-system view developed in collaboration with local government colleagues. Further guidance will be provided separately.

- Set out the measurable impacts of your STP. These will reflect local priorities and show how your local metrics link to the three to five key issues identified in your June submission as well as national metrics agreed with the Department of Health. These are likely to include measurements already captured in the CCG Improvement and Assessment Framework and NHS Improvement's Single Oversight Framework such as emergency admissions, bed days per 1000, A&E and RTT performance as well as delivery against elements of the cancer, mental health and primary care plans. Further information will follow.
- Include a brief statement setting out how you envisage better integration between health and social care commissioning and services could support the overall objectives of your STP and proposals for working between the leadership of the STP and the health and social care integration plan if these are different. The LGA have also produced a tool to support integration (to follow).
- Set out the degree of local consensus amongst organisations and plans for further engagement. It would be useful to know the degree of support your proposals command, the extent that you have engaged stakeholders and the public so far, and your plans for further engagement with patients, stakeholders, clinicians, communities, staff and other partners and how you have held meaningful strategic conversations with both NHS boards, CCG governing bodies and local government leaders (Local Authority arrangements will vary across the country so you should seek the advice of your LA CEO on who best to involve and when). We have produced guidance on engagement and consultation to support you in this (published 15 September 2016).
- Continue to develop your estates strategy to deliver your service strategy; identifying and valuing the opportunities for estates rationalisation and land disposal (as well as funding sources) and any key interdependencies. The strategic estates advisers that supported CCGs in the preparation of their initial Local Estates Strategies will continue to be available to support you.

In order to plan effectively you will need to know the business rules and planning assumptions going forward, including how transformation funds and control totals will be agreed. We will therefore publish the Planning Guidance for your operational plans today – three months earlier than previous years – and we will be in touch to arrange a briefing in advance of publication.

STPs will be system-wide and set out how to deliver locally agreed objectives, how activity will flow between care settings and what each organisation needs to do to deliver the system-wide plan. Operational plans will be at the level of individual CCGs and NHS providers and capture each organisation's plans for quality improvement, activity and operational performance, including the reconciliation of finance, activity and workforce plans. This year, operational plans will cover 2017/18 and 2018/19, i.e. years two and three of the STP. The aggregate of all operational plans in a footprint need to be consistent with the STP. Operational plans will be expected to reconcile to STPs.

As you will need to move swiftly from STP to contract agreement, it is important that the key metrics in terms of activity trajectory and outline finance allocated are addressed within the STP.

Producing system wide STPs and earlier operational plans and contracts will be challenging for us all. Nevertheless, this offers a real opportunity to ensure that operational plans reflect our strategic intent rather than simply rolling forward last year's business model and to free up headroom in 2017 so that we can focus on delivering our plans rather than negotiating them.

Our Regional directors will continue to support you in this process and will provide feedback on your STP in November so you can feed this into the planning round. The role of the STP and the Footprint leader is a vital and evolving one and we will work with you to understand how we can best support each other as we move towards implementation.

Further information on available support will follow separately including a timeline of key milestones.

Submission

Plans need to be submitted by Friday, 21 October by 5pm to england.fiveyearview@nhs.net, copying in your Regional directors.

Annex 5

NHS England and NHS Improvement approach to establishing shared financial control totals

Contents

1. Introduction

This annex covers the development and implementation of system control totals for 2017/18 and 2018/19.

The intent of system control totals is threefold:

- To sustain the commitment to collaboration developed across health economies through the STP process and reduce the incentives for individual organisations to optimise their own financial position at the expense of the wider system as the focus moves to operational planning and delivery;
- To create the flexibility for local systems to implement transformational change without being constrained by any resulting shifts in financial performance as between individual organisations;
- To maximise the likelihood of success in managing overall financial delivery risk in the system by fostering shared risk management approaches across health economies.

System-wide control totals are intended to complement rather than replace individual organisational control totals, and all organisations will therefore be held accountable for delivering both their individual control total and the relevant overall system control total.

The degree of flexibility offered to individual systems will depend on their appetite for collaborative financial management and the maturity of the processes and governance they put in place to support it. For 2017/18 this will be on a 'by application' basis. Flexible system controls will become the default from 2018/19, though each area will still be required to demonstrate that it has the appropriate mechanisms in place to ensure successful functioning of a shared control total.

2. Setting control totals

System control totals for each STP area are being developed and will be communicated to STP leaders to ensure that STP submissions in October deliver financial balance on a national basis in 2017/18 and 2018/19 and in each system by 2020/21. For 2017/18 and 2018/19 these system control totals will be derived from NHS England and NHS Improvement draft requirements of individual organisations (including direct commissioning on a basis consistent with the STPs) but will also take into account insights from the modelling undertaken to date by individual areas. These control totals should then be reflected in final STPs.

We expect individual operational plans to be a direct disaggregation of the agreed STPs to the component organisations, and the resulting individual control totals for operational planning and delivery should add up to the agreed STP control totals.

3. Scope and geography for system control totals

Control totals will be applied across providers and CCGs together.

For operational purposes, the system control total will exclude direct commissioning (other than delegated primary medical care) at least for the next two years. Ambulance trusts and highly specialised organisations with predominantly national remits will also be similarly excluded, as will local authorities. However, systems will need to consider the financial impact of their decisions on these other organisations.

The default is for operational control totals to apply to the same geography as the STP. However, larger STP areas may wish to propose to NHS England and NHS Improvement a subdivision of their geography for these purposes, with separate system control totals (and governance arrangements) for each subdivision, where this is better suited to operational collaboration and risk management. The subdivisions must cover the entire STP area between them, and each must be of a demonstrably sufficient size to provide appropriate risk pooling. System control totals are not expected to operate over a wider footprint than an STP.

4. Flexibility

Systems will also be able to apply for in-year flexibility to vary individual control totals whilst maintaining the overall system control total. System control total flexibilities can be applied within a given financial year only, not across financial years.

Shifts can only be made prospectively, for example to allow for the financial impacts of an agreed transformation plan or planned changes to patient flows. Systems may apply for changes to control totals at the planning stage and then quarterly thereafter.

Any changes will be subject to joint approval by the NHS England and NHS Improvement regional teams. As well as the inherent merits of individual proposals this will need to take into account the need for the provider sector to achieve aggregate financial balance in 2017/18 and 2018/19 and for the NHS England Group – comprising NHS England and CCGs – to live within its statutory resource limits.

The system control total approach will routinely apply to the planned underspend or deficit of the control group, but areas may also wish to explore combined arrangements for contingency, 1% non-recurrent spend, or other specific business rules. Where this option is taken, areas must ensure that such agreements are clearly documented and transparent.

Local system leaders should also give consideration to joint approaches to the accessing and deployment of national transformation resources, collaboration arrangements and pooled budgets with local authorities and gain share arrangements with specialised commissioning.

5. Local management arrangements

Areas will need to articulate the monitoring and management arrangements that will be put in place to ensure that a system control total can operate effectively. This is particularly important where they are seeking to apply the flexibilities outlined above. The arrangements will need to include the following:

- An oversight group comprising the leaders across the health economy with a named chair and including senior financial representation;
- Terms of reference which clearly articulate the limit of the group's decision making and how any escalation and dispute resolution will be managed;
- Arrangements for the operation of the group which have been approved by the boards or governing bodies of the constituent organisations;
- Reporting arrangements to receive timely financial and performance information to allow monitoring of performance against the control total and other related factors such as delivery of efficiency savings and CIPs plans; and
- Scenario planning which has been discussed and agreed by the group showing how delivery of the system control total will operate in various scenarios, where individual organisations fall short of their control total.

These arrangements will form a key part of any application for additional flexibilities and will also be subject to NHS England and NHS Improvement assurance processes.

6. Reporting

Reporting requirements for system control totals will be multi-level.

Each individual organisation will continue to report financial performance through its own governance route and in addition as part of the system control group.

NHS England and NHS Improvement will continue to monitor and report the financial performance of individual organisations against their agreed plans.

The system control total will provide a mechanism for monitoring the financial performance of an STP compared with its agreed strategy, and thus whether the STP's progress towards financial sustainability is being delivered. NHS England and NHS Improvement will put additional reporting mechanisms in place to allow us collectively to monitor performance against system control totals.

7. Benefits realisation

Establishing flexible system control total processes is not an end in itself but should be seen as a means for seeking improvement across the system that could not otherwise be achieved.

In designing their arrangements and applying for flexibilities, areas should consider how tangible benefits will flow from establishing the control total. Benefits may arise in the following ways:

Direct financial improvement – establishing a system control total may allow for greater certainty over income and expenditure within the health economy which may in turn allow for a more positive system control total than the sum of the individual control totals.

Improved risk management – working collaboratively across a control group may lead to an enhanced ability to manage financial risk across the health economy and hence improved risk management. This may then allow for earlier and greater release of risk reserves for investment.

Improved use of/reduction in admin resources – collaborative working across the health economy may yield benefits from a resource perspective, for example by combining programme offices, reducing the amount of resource dedicated to generating and challenging provider income claims, or negotiating contracts and disputes. Health economies may also wish to look at collaboration on common resources such as drugs purchases and call centre arrangements.

Behavioural change – in combination with the STP process, the establishment of a system control total approach may provide a better platform for medium term change by breaking through organisational barriers and helping to align the leaders of the health economy behind a common purpose. Behavioural change may provide short term measurable benefit if conflicting incentives are removed from the system and organisations are therefore acting in a goal congruent manner.

8. Application processes

Any systems wishing to manage system control totals over smaller operational footprints than the STP area should set out their proposals, including the rationale and supporting information in relation to the criteria set out above. This should be sent to NHSCB.financialperformance@nhs.net by 31st October 2016 for review and discussion with regional teams, leading to confirmation by 30th November 2016.

Those systems wishing to apply for flexibility in operating their operational control totals for 2017/18 should submit a proposal covering the following:

- A description of how the control total will operate, including the planned footprint, any initial flexibility proposals and the likely further flexibility required during the financial year;
- The accountability proposals;
- The oversight and monitoring arrangements for the operation of the control total;
- The additional reporting arrangements that will be required;
- An explanation of the expected benefits, including how these will be measured; and
- Any considerations for specialised services commissioning or provision, and any other cross border issues relevant to the application.

Annex 6

General Practice Forward View planning requirements

1.1 Introduction

This technical annex outlines the planning requirements of CCGs to support implementation of the General Practice Forward View (GPFV)

The GPFV, published on 21 April 2016, sets out our investment and commitments to strengthen general practice in the short term and support sustainable transformation of primary care for the future. It includes specific, practical and funded investment in five areas – investment, workforce, workload, practice infrastructure and care redesign.

Many of the actions in the GPFV are for NHS England, Health Education England and the Care Quality Commission to take forward. This guidance focuses on the actions needed to implement the more local aspects.

Strengthening and transforming general practice will play a crucial role in the delivery of STP plans, and already many STP footprints are integrating the aims and more local elements of the GPFV into the system wide plans. To complement this, CCGs should similarly translate the aims and key local elements of the GPFV into their more detailed local operational plans. This technical annex distils the priorities that CCGs should consider as they develop these local plans. Some of these are for CCGs to consider alone; others are for CCGs to consider working in collaboration.

CCGs will need to submit one GPFV plan to NHS England on 23 December 2016, encompassing the specific areas outlined in this guidance. Plans will need to reflect local circumstances, but must – as a minimum – set out:

- How access to general practice will be improved
- How funds for practice transformational support (as set out in the GPFV) will be created and deployed to support general practice
- How ring-fenced funding being devolved to CCGs to support the training of care navigators and medical assistants, and stimulate the use of online consultations, will be deployed.

1.2 Investment

The NHS England allocations for primary care (medical) were published for five years.

This sets out that in 2017/18 and 2018/19 there will be an increase in funding for core local primary medical allocations of £231 million and then a further £188 million on top respectively. In addition to those allocations, other primary care funding is available for specific purposes as part of the £500 million plus sustainability and transformation package announced in the GPFV, as detailed below, as well as specific extra funding to support improvements in access to general practice, and improvements in estates and technology.

1.2.1 Elements of the sustainability and transformation package

a) Transformational support 2017/18 and 2018/19 from CCG allocations

CCGs should also plan to spend a total of £3 per head as a one off non-recurrent investment commencing in 2017/18, for practice transformational support, as set out in the GPFV. This equates to a £171million non- recurrent investment. This investment should commence in 2017/18 and can take place over two years as determined by the CCG, £3 in 17/18 or 18/19 or split over the two years. The investment is designed to be used to stimulate development of at scale providers for improved access, stimulate implementation of the 10 high impact actions to free up GP time, and secure sustainability of general practice. CCGs will need to find this funding from within their NHS England allocations for CCG core services.

b) Online general practice consultation software systems

The £45 million funding for this programme (over three years), announced in the GPFV, will start to be deployed in 2017/18 with £15 million devolved to CCGs along with rules and a specification, and a further £20 million in 2018/19.

The allocations to each CCG will be based upon the estimated CCG registered populations for 2017/18 and 2018/19, which can be found in the "GP Registration Projections" tab of Spreadsheet file B.

CCGs can calculate their share of the funding in 2017/18 by multiplying the £15 million total by their registered population figures in column X within the "GP Registrations Projections" tab of the Spreadsheet file B, and then dividing by the total number of registered patients in England of 58,173,725.

Likewise, CCG shares for 2018/19 can be calculated by multiplying the £20 million total by their registered population figures in column Y, and dividing by the total number of registered patients in England of 58,592,211.

CCGs will be accountable for this spend to deliver the specification outlined. Further details on the specification and monitoring arrangements will be shared in due course.

c) Training care navigators and medical assistants for all practices

The £45 million funding for this programme (over five years) announced in the GPFV, totals £10 million in 2017/18 and £10 million in 2018/19, with £5 million already allocated in 2016/17. Again, this funding will be devolved to NHS England local teams or delegated CCGs based on their share of registered patients as a percentage of the England total.

The allocation for 2017/18 for each CCG area will be their total estimated registered population for that year, shown in column X of the "GP Registration Projections" tab of Spreadsheet file B divided by the total estimated registered patients in England, of 58,173,725 multiplied by the £10 million total.

Likewise, the allocation for each CCG area is the estimated CCG registered lists figure in column Y of the "GP Registration Projections" tab of Spreadsheet file B divided by the total of patients in England of 58,592,211 multiplied by the £10 million total.

CCGs will be accountable for this expenditure to deliver the specification outlined for this work, with details on the specification and monitoring arrangements being shared in due course.

d) General Practice Resilience Programme

The £40 million non-recurrent funding for the General Practice Resilience Programme (over four years) announced in the GPFV, has already begun to be deployed, with £16 million already allocated in 2016/17. Funding for this programme in 2017/18 totals £8 million, and a further £8 million in 2018/19.

This funding will be delegated to NHS England local teams on a fair shares basis as set out in the published guidance document , which contains the details of the allocations. NHS England local teams should ensure these amounts are included in their plans.

A number of other elements of the package are being held centrally. Some schemes have already started and announcements will be made in due course as to how further funding for these will be spent and distributed, or how centrally commissioned arrangements can be accessed. Commissioners of GP services should not currently factor any of the funding for these schemes into their plans.

1.2.2 Funding to improve access to general practice services

This funding is being targeted at those areas of England which had successful pilot sites in 2015/16, known as the "Prime Minister's Challenge Fund" or "General Practice Access Fund" sites.

CCGs should plan to receive £6 per weighted patient for each of these sites in 2017/18 and £6 per weighted patient in 2018/19.

The programme will expand in 2017/18, bringing the total investment up to over £138m million. This funding will be recurrent. There will be further funding coming on stream in 2018/19, totalling £258 million. This additional funding will be allocated across all remaining CCGs to support improvements in access, as £3.34 per head of population and as set out in the 'improved access' section of this document.

It has been agreed that, given some of the unique characteristics of London, the funding for London schemes will be available to be deployed to support improvements across the whole of the geographical area. Further information will be available through NHS England (London).

Further background details on improving access to general practice are available here.

1.2.3 Estates and Technology Transformation Fund (primary care)

CCGs were invited to bid for funding from 2016/17 onwards as set out in guidance issued in May 2016. Details of the process and milestones are also included in that guidance.

CCGs will receive confirmation that a bid has been successful shortly.

1.2.4 Other funding for general practice

There will also be some non-recurrent funding held nationally to support GPFV commitments in a number of areas, including growing the general practice workforce, premises and the national development programme. In addition, there will be increases in a number of national lines to support the promised increase in investment in general practice set out in the GPFV. This includes:

- increases in funding for GP trainees funded by Health Education England;
- Increases in funding for nationally procured GP IT systems;
- Increases in the section 7A funding for public health services, which support payments to GPs for screening and immunisation services; and
- 3,000 new fully funded practice-based mental health therapists to help transform the way mental health services are delivered.

The GPFV also assumes that there will continue to be increases in CCG funding to general practice (currently totalling around £1.8 billion in 2015/16) at least equal to, and ideally more than, the increases in CCG core allocations which are 2.14% in 2017/18 and 2.15% in 2018/19.

1.3 Care redesign

As part of their GPFV plan, CCGs should have a clear, articulated vision of the care redesign that will deliver sustainable services today and transformed services tomorrow. This will be part of their STP's vision. This should include details of the changes to be made to redesign services for improved outcomes, including the ways in which greater use will be made of selfcare, technology and a wider workforce, and other actions to address challenges with general practice capacity.

CCGs should agree a plan for implementation of these changes across all member practices and other providers, with an indication of how this has been developed in co-production with primary care providers themselves.

1.3.1 Improved access

As outlined in the investment section, NHS England will provide additional funding, on top of existing primary medical care allocations to enable CCGs to commission and fund extra capacity to ensure that everyone has access to GP services, including sufficient routine and same day appointments at evenings and weekends to meet locally determined demand, alongside effective access to other primary care and general practice services such as urgent care services.

CCGs will be required to secure services following appropriate procurement processes.

Recurrent funding to commission additional capacity and improve patient access will increase over time. In 2017/18 CCGs with General Practice Access Fund Schemes, and a number of additional geographies identified across the country which will accelerate delivery of improving GP access, will receive recurrent funding of £6 per head of population (weighted) to commission improved access. In 18/19, this will expand to enable remaining CCGs to improve access, with £3.34 available in 2018/19 for those remaining CCGs. In 2019/20 all CCGs will receive at least £6 per head extra recurrently for those improvements in general practice.

In order to be eligible for additional recurrent funding, CCGs will need to commission and demonstrate the following:

Timing of appointments:

- commission weekday provision of access to pre-bookable and same day appointments to general practice services in evenings (after 6:30pm) – to provide an additional 1.5 hours a day;
- commission weekend provision of access to pre-bookable and same day appointments on both Saturdays and Sundays to meet local population needs;
- provide robust evidence, based on utilisation rates, for the proposed disposition of services throughout the week; and
- appointments can be provided on a hub basis with practices working at scale.

Capacity:

- commission a minimum additional 30 minutes consultation capacity per 1000 population, rising to 45 minutes per 1000 population.

Measurement:

- ensure usage of a nationally commissioned new tool to be introduced during 2017/18 to automatically measure appointment activity by all participating practices, both in-hours and in extended hours. This will enable improvements in matching capacity to times of high demand.

Advertising and ease of access:

- ensure services are advertised to patients, including notification on practice websites, notices in local urgent care services and publicity into the community, so that it is clear to patients how they can access these appointments and associated service;

- ensure ease of access for patients including:
  - all practice receptionists able to direct patients to the service and offer appointments to extended hours service on the same basis as appointments to non-extended hours services
  - patients should be offered a choice of evening or weekend appointments on an equal footing to core hours appointments.

Digital:
- use of digital approaches to support new models of care in general practice.

Inequalities:
- issues of inequalities in patients' experience of accessing general practice identified by local evidence and actions to resolve in place.

1.3.2 Effective access to wider whole system services

- Effective connection to other system services enabling patients to receive the right care from the right professional, including access from and to other primary care and general practice services such as urgent care services

During 2017/18 CCGs should ensure 100% coverage of extended access (evening and weekend appointments) is achieved in GP Access Fund sites and a number of additional geographies identified across the country which will accelerate delivery of improving GP access.

In 2018/19 and 2019/20, we expect this roll out to continue. Remaining CCGs will be required to start access improvement in 2018/19, with funding at £3.34 per head of population for the year, and achieve 100% coverage from April 2019, when funding will reach at least £6 per head of population in 2019/20.

CCGs will need to provide plans outlining their approach to improved access by 23 December 2016 as part of their GPFV plan. This should include trajectories on improved access coverage for their local population.

There are currently significant inequalities in different groups' experience of access. Whilst making changes designed to improve access, CCGs should ensure that new initiatives work to reduce inequalities as well as improve overall access.

1.3.3 Time for Care Programme

In July 2016, NHS England set out plans to establish a new national development programme for general practice – Time for Care. CCGs will want to consider identifying a senior person to lead local work to release staff capacity in general practice. They will be an important part of championing the 10 High Impact Actions to release time for care, support the planning of care redesign programmes and act as a link with NHS England development leads. Where appropriate, they will also support local practices in submitting expressions of interest for the Time for Care and General Practice Improvement Leaders programmes.

CCGs should have clear plans for how they will support the planning and delivery of a local Time for Care development programme, to implement member practices' choice of the 10 High Impact Actions. This could include details of:

- how this piece of practice development is being aligned with other developments locally such as technology and estates investment, workforce development and improved collaboration between providers, and
- the investment being made by the CCG to create headroom for practices to engage in development.

1.3.4 Deployment of funding for reception and clerical staff training, and online consultation systems

CCGs are not required to submit a plan to the national NHS England team prior to beginning to spend funds allocated for training in active signposting and document management, or supporting the purchase of online consultation systems. However, they will be required to report on their use of this funding on a regular basis, as part of wider arrangements for monitoring GPFV activity.

The funding will be allocated equally between all CCGs on a capitated basis. The first tranche of funds were transferred in September 2016, but future allocations will be made near the beginning of each financial year.

It will usually be preferable for practices to undertake training or innovation adoption in local cohorts, rather than on an ad hoc basis. CCGs may wish to consider pooling funding with others in their STP footprint. Reporting of GPFV activity will allow CCGs to indicate where this is being done.

As part of their GPFV plan, CCGs should describe how these two new funds will be used for member practices, and may wish to do this collaboratively across the STP footprint. This should include evidence that the plan:

a) has been developed in consultation with general practices themselves;
b) will be delivered in alignment with other development activities such as local Time for Care programmes, and wider workforce and technology strategies;
c) includes plans to use early adopters to help spread innovations in workforce and technology; and
d) provides assurance that this funding is ring-fenced for the intended purposes.

1.4 Workforce

In their GPFV plans, CCGs will want to include a general practice workforce strategy for the local system that links to their service redesign plans. These should be clear about the current position, areas of greatest stress, examples of innovative workforce practices, the planned future model and actions to get there.

For example, the plans could include:

- a baseline that includes assessment of current workforce in general practice, workload demands and identifying practices that are in greatest need of support;

- workforce development plans which set out future ways of working including the development of multi-disciplinary teams, support for practice nursing and establishing primary care at scale;
- commitment to develop, fund and implement local workforce plans in line with the GPFV and that support delivery of STPs;
- initiatives to attract, recruit and retain GPs and other clinical staff including locally designed and nationally available initiatives;
- actions to ensure GPs are operating at the top of their license, for example through use of clinical pharmacists in a community setting and upskilling other health care professionals to manage less complex health problems;
- actions which facilitate an expanded multi-disciplinary team and greater integration across community services to optimise out of hospital care for patients including access to premises, diagnostics, technology and community assets.

NHS England has retained some national funds to support workforce developments as indicated in the investment section. This includes:

a) **International recruitment**: NHS England will produce a framework for CCGs along with other partners to recruit doctors internationally and will fund several overseas recruitment projects for up to 500 doctors nationally. Further information will be available by the end of December 2016.

b) **Clinical pharmacists in general practice:** in addition to the clinical pharmacist recruited in phase one, additional funding will be available (as set out in the GPFV) for providers over the next three years to assist in costs of establishing the role in practices. Further information will be made available by December 2016.

c) HEE and NHS England will produce frameworks and models to support the expansion of physician associates, medical assistants and physiotherapists.

1.5 Workload

Guidance for the General Practice Resilience Programme sets out indicative funding allocations of £8 million each year for 2017/18 and 2018/19 for NHS England Regional teams to deliver a menu of support to help practices become more sustainable and resilient. Local teams should work in partnership with STPs and CCGs to ensure this funding is used to target support at areas of greatest need and work in line with the processes set out in the operational guidance to deliver upstream support for practices. Local teams will keep their assessments of practices to be selected for support under six-monthly review and by July and January of each financial year will be able to confirm their list of practices prioritised for support and that agreed action plans for delivery of support to these practices are in place.

For people living with long term conditions, self care is usual care. STP footprints should ensure that people living with long term conditions reporting low levels of support or confidence to self care (or for those STPs using the Patient Activation Measure, low levels of activation) undertake regular personalised care and support planning and are signposted to tailored support. Personalised care and support planning should take place in general practice and should produce a single care plan, which is owned by the patient and shared with the system.

Commissioners should also have established pathways of care that integrate with community pharmacy. For example, we would expect CCGs to have considered the value provided by a community pharmacy based minor ailments service and also the contribution to better medicines use by patients with long terms conditions – both of which are expected to have a positive impact on patient experience and practice workload.

1.6 Practice infrastructure

CCGs should have clear local estates and digital roadmaps which lay out the plans to create the infrastructure to support new models of care. These should deliver against the requirements set out in recent guidance (Local Estates Strategies: A Framework for Commissioners and the GP IT Operating Model 2016/18).

Estates and technology schemes funded or part funded by the Estates and Technology Transformation Fund must meet the specified core criteria. NHS England will work with CCGs to agree the pipeline of investments.

Digital Roadmaps, as highlighted in the GP IT Operating Model 2016/18, should set out priorities and deliverables for each year. Interoperability must feature as must the pursuit of innovative technologies to transform triage and consultations with patients to alleviate workload pressures.

Annex 7

Cancer services transformation planning requirements

2017/18	2018/19	Metrics
Strengthen existing tobacco controls and smoking cessation services, in line with reducing smoking prevalence to below 13% nationally by 2020	Strengthen existing tobacco controls and smoking cessation services, in line with reducing smoking prevalence to below 13% nationally by 2020	Smoking prevalence in adults in routine and manual occupations (PHOF 2.14; annual; PHE)
Increase uptake of breast, bowel and cervical cancer screening programmes	Increase uptake of breast, bowel and cervical cancer screening programmes	Cancer screening uptake rates (PH Outcomes Framework 2.20i-iii; annual; PHE) Stage at diagnosis
Drive earlier diagnosis by: A. Implementing NICE referral guidelines, which reduce the threshold of risk which should trigger an urgent cancer referral B. Increasing provision of GP direct access to key investigative tests for suspected cancer	Drive earlier diagnosis by: A. Implementing NICE referral guidelines, which reduce the threshold of risk which should trigger an urgent cancer referral B. Increasing provision of GP direct access to key investigative tests for suspected cancer	A. Stage at diagnosis B. GP direct access to tests used for suspected cancer in Diagnostic Imaging Dataset (official statistics; monthly; NHS England statistics)

2017/18	2018/19	Metrics
Commission sufficient capacity to ensure 85% of patients continue to meet the 62 day standard by: A. Identifying any 2017/18 diagnostic capacity gaps B. Improving productivity or implementing plans to close these immediate gaps	Commission sufficient capacity to ensure 85% of patients continue to meet the 62 day standard and to begin to meet the 28 day faster diagnosis standard by: A. Identifying any 2018/19 diagnostic capacity gaps. B. Improving productivity or implementing plans to close these immediate gaps	62-day cancer waiting times (official statistics, monthly, NHS England statistics) Stage at diagnosis A. Submission of planning trajectories for activity (diagnostic tests; endoscopy tests) (annual, NHS England) B. Diagnostic Waiting Times (official statistics; monthly; NHS England Statistics)
Ensure all parts of the Recovery Package are available to all patients including: A. Ensure all patients have a holistic needs assessment and care plan at the point of diagnosis and at the end of treatment B. Ensure that a treatment summary is sent to the patient's GP at the end of treatment C. Ensure that a cancer care review is completed by the GP within six months of a cancer diagnosis	Ensure all parts of the Recovery Package are available to all patients including: A. Ensure all patients have a holistic needs assessment and care plan at the point of diagnosis and at the end of treatment B. Ensure that a treatment summary is sent to the patient's GP at the end of treatment C. Ensure that a cancer care review is completed by the GP within six months of a cancer diagnosis	Local data collection Currently piloting collection of HNA data using COSD (PHE) Developing national quality of life metric
Ensure all breast cancer patients have access to stratified follow up pathways of care and prepare to roll out for prostate and colorectal cancer patients	Ensure all breast, prostate and colorectal cancer patients have access to stratified follow up pathways of care	Local data collection Exploring how data may be collected nationally Developing national quality of life metric
Ensure all patients have access to a clinical nurse specialist or other key worker	Ensure all patients have access to a clinical nurse specialist or other key worker	CNS question in CPES (Q17 Cancer Patient Experience Survey, annual, NHS England Statistics)

Annex 8

Mental health transformation planning requirements

1 Mental health transformation

1.1 Overview

Local areas must plan to deliver in full the implementation plan for the Five Year Forward View for Mental Health, including commitments to improve access to and availability of mental health services across the age range, develop community services, taking pressure off inpatient settings, and provide people with holistic care, recognising their mental and physical health needs. As part of this, local areas must also ensure delivery of the mental health access standards for Improving Access to Psychological Therapies (IAPT), Early Intervention in Psychosis (EIP) and eating disorders.

Additional funding underpinning the delivery of the Five Year Forward View for Mental Health must not be used to supplant existing spend or balance reductions elsewhere. This new money builds on both the foundation of existing local investment in mental health services and the ongoing requirement to increase that baseline by at least the overall growth in allocations to deliver the Mental Health Investment Standard. Savings arising from new services (such as integrated Improving Access to Psychological Therapies/Long Term Conditions and Mental Health liaison in A&E) resulting from this new investment need to be reinvested to maintain services and ensure delivery of the commitment to treat an additional one million people with mental illness by 2020/21.

CCGs should commit to sharing and assuring financial plans with local Healthwatch, mental health providers and local authorities. Details of deliverables and actions are summarised below but areas should make reference to fuller guidance set out in Implementing the Five Year Forward View for Mental Health.

1.2 Transformation funding

Mental health transformation funding is available for the specific deliverables within the implementation plan. For 2017/18 and 2018/19 the new commitments which are supported by identified funding are:

- Commission additional psychological therapies from a baseline of 15% so that at least 25% of people with anxiety and depression access treatment by 2020/21, with the majority of the increase integrated with physical healthcare.
- Increase access to evidence-based specialist perinatal mental health care, in line with the requirement to meet 100% of need by 2020/21, and ensure that care is in line with NICE recommendations.
- Deliver 'core 24' standard liaison services for people in emergency departments and inpatient wards in at least 50% of acute hospitals by 2020/21.

Small amounts of transformation funding may be available locally, if not nationally delivered, in 2018/19 against the following sets of deliverables:

- Deliver community based alternatives to secure inpatient services such that people requiring services receive high quality care in the least restrictive setting.
- Deliver increased access to Individual Placement Support for people with severe mental illness in secondary care services by 2020/21; increase access to IPS by 25% on 2017/18 baseline in 2018/19.

Details of amounts of funding available both from the transformation fund and within CCG baselines are set out in Implementing the Five Year Forward View for Mental Health.

1.3 Summary table of key deliverables for mental health transformation

Deliverable	Key actions for commissioners and providers	How this will be measured
Increase access to high quality mental health services for an additional 70,000 children and young people per year.	• Implement local transformation plans to expand access to CYP services by 7% in real terms in each of 2017/18 and 2018/19 (to meet 32% of local need in 2018/19). • Ensure that all areas take full part in the CYP IAPT workforce capability programme and staff are released for training courses. • Commission 24/7 urgent and emergency mental health service for children and young people that can effectively meet the needs of diverse communities, and ensure submission of data for the baseline audit in 2017.	• Access to evidence based treatment for children and young people will be measured through the MHSDS (number of CYP who have started and completed treatment) and NHSE finance tracker to monitor additional funding. • Data will be provided from HEE and the CYP IAPT programme at CCG and provider level. • 24/7 urgent and emergency response times will be measured through a baseline audit and, subsequently through the MHSDS.
Community eating disorder teams for children and young people to meet access and waiting time standards.	• CCGs should commission dedicated eating disorder teams in line with the waiting time standard, service model and guidance. • Commissioners and providers should join the national quality improvement and accreditation network for community eating disorder services (QNCC ED) to monitor improvements and demonstrate quality of service delivery.	• Waiting times and access to evidence based care will be measured through UNIFY from 2016/17 and the MHSDS from 2017/18.

Deliverable	Key actions for commissioners and providers	How this will be measured
Increase access to evidence-based specialist perinatal mental health care.	• Commission additional or expanded specialist perinatal mental health community services to deliver care to more women within the locality. • Ensure staff are released to attend training or development as required.	• Provision of specialist community services will be monitored through MHSDS and NHSE finance tracker. • Baseline provision against treatment pathway and outcomes will be measured through CCQI self-assessment and subsequent validation.
Commission additional psychological therapies for people with anxiety and depression, with the majority of the increase integrated with physical healthcare.	• CCGs should commission additional IAPT services, in line with the trajectory to meet 25% of local prevalence in 2020/21. Ensure local workforce planning includes the number of therapists needed and mechanisms are in place to fund trainees. • From 2018/19, commission IAPT services integrated with physical healthcare and supporting people with physical and mental health problems. This should include increasing the numbers of therapists co-located in general practice by 3000 by 2020/21.	• Increased access rates: through quarterly publications and other reports within the IAPT data set. • Therapists working in general practice: through the annual IAPT workforce census.

Deliverable	Key actions for commissioners and providers	How this will be measured
Expand capacity so that more than 50% of people experiencing a first episode of psychosis start treatment within two weeks of referral with a NICE-recommended package of care.	• Commission/provide an early intervention service that provides NICE-concordant care to people aged 14-65 years, meeting the relevant access and waiting time standards in each year. • At least 25% of EIP teams should meet the rating for 'good' services in the CCQI self-assessment by 2018/19.	• The RTT component of the standard will be measured through the UNIFY collection in 2017/18, moving to MHSDS as soon as possible. • The NICE-concordant component of the standard will be measured in the CCQI provider self-assessment.
Reduce suicides by 10%, with local government and other partners.	• CCGs and providers should contribute fully to local multi-agency suicide prevention plans, following the latest evidence and PHE guidance.	• Suicide rates will be published by CCG in the MH dashboard, using ONS statistics.
Commission effective 24/7 Crisis Response and Home Treatment Teams as an alternative to acute admissions.	• Commissioners must have conducted a baseline audit of CRHTTs against recommended best practice and have begun to implement a funded plan to address any gaps identified. • Providers must routinely collect and monitor clinician and patient reported outcomes and feedback from people who use services.	• Plans for CRHTTs to be monitored through the CCG Improvement and Assessment Framework. • Delivery of effective CRHTTs in line with standards to be assessed and validated by CCQI. • CCG funding for crisis services to be monitored through NHSE finance tracker

Deliverable	Key actions for commissioners and providers	How this will be measured
Eliminate of out of area placements for non-specialist acute care.	• Commissioners and providers must deliver reductions in non-specialist acute mental health out of area placements, in line with local plans, with the aim of elimination by 2020/21 • Commissioners must ensure routine data collection and monitoring of adult mental health out of area placements, including bed type, placement provider, placement reason, duration and cost.	• Plans for reducing OAPs to be monitored through milestone indicator in the CCG IAF. • Out of area placements to be measured through an interim CAP collection (from autumn 2016), moving to the MHSDS (from April 2017).
Deliver integrated physical and mental health provision to people with severe mental illness.	• CCGs should commission NICE-recommended screening and physical health interventions to cover 30% of the population on GP register with severe mental illness (SMI), and 60% in 2018/19. • Providers to meet the physical health SMI CQUIN requirement.	• NHS England to measure physical health checks in primary and secondary care through a clinical audit of people with SMI to have received a cardio-metabolic assessment and treatment within inpatient settings, EIP services and community-based teams.

Deliverable	Key actions for commissioners and providers	How this will be measured
Ensure that 50% of acute hospitals meet the 'core 24' standard for mental health liaison as a minimum, with the remainder aiming for this level	• Commissioners and providers must implement funded service development plans to ensure that adult liaison mental health services in local acute hospitals are staffed to deliver, as a minimum, the 'Core 24' service specification. • Funding will be made available for mental health liaison via a two-phase bidding process. The first phase of bidding will be run in autumn 2016 for funding in 2017/18 (wave 1) and 2018/19 (wave 2). The second phase of bidding will be run in autumn 2018 for funding in 2019/20 (wave 3) and 2020/21 (wave 4). A&E Delivery Boards (formerly known as System Resilience Groups) will be invited to bid in late October.	• Health Education England will commission an annual workforce survey of liaison mental health services to monitor compliance with workforce elements of the 'core 24' standard. • Access and waiting times for liaison services will be assessed and monitored through CCQI, and in due course the MHSDS. • Outcome measures in line with RCPsych standards will also be collected and monitored through CCQI assessment against standards and the MHSDS.
Increase access to Individual Placement Support for people with severe mental illness	• Using local findings from the national IPS baseline audit, CCGs should plan for improving access to IPS employment support for people with SMI across their STP area from 2018/19. • STP footprints will be invited to bid for transformation funding in autumn 2017, with bids submitted by December 2017.	• NHS England will commission a national baseline audit for IPS services in Q3/4 2016, supported by regional assurance of CCG plans.

Deliverable	Key actions for commissioners and providers	How this will be measured
CCGs will continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.	• Achieve and maintain a diagnosis rate of at least two-thirds, making sustained gains towards the national ambition with a view to halving the number of CCGs not meeting the ambition by March 2019. • Increase the number of people being diagnosed with dementia, and starting treatment, within six weeks from referral; with a suggested improvement of at least 5% compared to 2015/16 (subject to local agreement).	• Monthly monitoring and reporting of CCG diagnosis rates using QOF data. • Regular monitoring and reporting of referral to treatment times using MHMDS data and self-report data from the new CCQI tool. • Annual monitoring of care plan reviews using QOF data.
Ensure data quality and transparency.	• Commissioners must assure that providers are submitting a complete, accurate data return for all routine collections in the MHSDS, IAPT MDS and to any ancillary UNIFY collections. • Providers must engage with CCQI to complete and submit self-assessment tools and subsequent validation in relation to all evidence-based treatment pathways. • Ensure a locally agreed suite of quality/outcome measures is in place which reflects mental, physical and social outcomes, in line with national guidance.	

Deliverable	Key actions for commissioners and providers	How this will be measured
Increase digital maturity in mental health.	• Commissioners should support full interoperability of healthcare records ensuring mental health services are included in local digital roadmaps, plans and sufficient investment is made in functionalities and capabilities • Commissioners should support further expansion of e-prescribing across secondary care mental health services.	• Next and subsequent iterations of the digital maturity index. • Next and subsequent iterations of the digital maturity index.

Derbyshire Healthcare NHS Foundation Trust
Position paper to the Board 5 October 2016.

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Equality and Diversity Update

Purpose of Report

The purpose of this paper is to present to the Board a summary of where the Trust is presently with the equalities agenda.

Executive Summary

The Care Quality Commission (CQC) inspection of June 2016 indicated that the Trust was not ensuring compliance with our Equality and Diversity obligations. The Board Assurance Framework and Risk Register did not include any equality related risks. Directors and staff responsible for equality and diversity were not aware of any equality risks relating to their non-compliance.

Position to date.

- The Trust has complied with its legal obligations in terms of publishing its Workforce Race Equality Standard.

- The Board Assurance Framework and risk register has been updated to reflect the current position on equalities and inclusion and to focus the action and controls for making progress.

- Equality Delivery System2 (EDS2) comprises 18 outcomes, against which NHS organisations assess and grade themselves. They are grouped under four goals, namely; Better health outcomes; Improved patient access and experience; A representative and supported workforce; and Inclusive leadership. As an organisation the Trust has graded itself in 11areas as being underdeveloped, 6 areas as developing and 1 as achieving. The trust will be seeking an independent review of self evaluation.

- The Trust has produced a Public Sector Duty (PSED) report the relevant data to be published on the Trusts website detailing the analysis of Demographics – Patients versus Population June 2014 versus June 2016.

- The Trust Board have agreed the establishment of an Equalities Forum to ensure that an overarching detailed equality and diversity strategy is developed. The Equalities Forum will act as the vehicle by which the equalities agenda will become embedded into the organisation both from a service user, employee and management point of view.

- Trust has been approved as a Disability Confident Employer (previously known as two ticks).

- A detailed DHCFT Equalities Action Plan 2016 -17 has been drafted for Board

consideration.

Strategic Considerations

The detailed action plan takes into account the concerns raised by the CQC report and addresses these concerns under the following objectives (see appendix 1for details) :

Objective 1:
Consider the impact of what we do (or are planning to do) on all sections of the community / protected characteristics).

Objective 2:
Increase and improve DHCFT' awareness and understanding of equality, diversity, inclusion and Human Rights issues – improve organisational culture.

Objective 3:
Better understand, and more effectively meet, the needs of all our service users / patients.

Objective 4:
Better understand the profile and experiences of our employees and achieve a diverse workforce.

Objective 5:
Progress the equalities agenda within DHCFT.

Risks

As a Trust the risks associated with not taking forward the above considerations could result in the following:

Objective 1

Equality Impact Analysis (EIA) failure to undertake this essential work will put the Trust at risk of not identifying the likely detrimental impact on service users, employees and the community at large by not taking into their protected characteristics.

Objective 2

Failure to increase and improve awareness and understanding of equality, diversity, inclusion and Human Rights issues could result in a worsening equalities position, possibly leading to staff disengagement and poor service delivery, and a worsening organisational culture.

Objective 3

Poor data quality may lead to poor analysis, resulting in poor understanding of service user needs and staff experience as well as the inability to identify new opportunities.

Objective 4

Failure to understand the profile and experiences of our employees may lead to poor employee relations and reputation. Impacting adversely on organisational culture and service delivery and our reputation.

Objective 5

Failure to progress the equalities agenda will prevent the Trust from taking an important step forward in becoming and employer and service provider of choice.

Recommendations

The Board is requested to:

- **Accept and approve the DHCFT Equalities Action Plan 2016 – 17.**

Paper prepared by: Owen Fulton, Principal Employee Relations Manager.

Paper presented by: Amanda Rawlins, Director of People and Organisational Effectiveness.

Enclosure J

DHCFT Equalities Action Plan 2016-17 DRAFT

Appendix 1

Equality Objective	DHCFT Equalities Framework Ref	EDS Goal	WRES (Y/N)	Priority	PSED	Action	Target	Responsibility of…	By when	Evidence of outcome	RAG rating (Red/ Amber/ Green)
Objective 1: Consider the impact of what we do (or are planning to do) on all sections of the community / protected characteristics	Compliance / System and procedure	1,2,3,4	N	H	1,2,3	**Ensure that Equality Impact Assessments (EIAs) are undertaken on all key decisions, proposals, policies, procedures, services and functions that are relevant to equality**	Audit of committee papers to determine EIA completion rates	Equality and Diversity Lead	From Nov 2016 and ongoing		
							Quality/ Risk Committee to receive copies of all completed assessments	All	From Nov 2016 and ongoing		
							Sample of completed EIAs to be quality assured on a quarterly basis; to include consideration of outcome	Equality and Diversity Lead / Equality Forum	From Nov 2016 and ongoing		
							All completed and quality assured EIAs to be published on the Trust website	Communications Team	From Nov 2016 and ongoing		
	Compliance	1,2,3	Y	H	1,2,3	**Use monitoring information to identify and analyse:** • **Complaints** • **Incidents** • **DNAs** • **Satisfaction with services** • **Effectiveness / accessibility of workforce initiatives**	Monitoring reports produced and used proactively by service areas / divisions	IM&T Team / General managers/ Equality and Diversity Lead/ Head of Education/ Complaints Manager	From Nov 2016 and ongoing		
Objective 2. Increase and improve DHCFT' awareness and understanding of equality, diversity, inclusion and Human Rights issues – improve	Board capacity / Leadership capacity / Staff capacity	1,2,3,4	N	H	1,2,3	**Raise the profile of equalities and diversity throughout the organisation and develop Board, staff and service user awareness**	Organise, promote and run events to mark national NHS Equality and Diversity Week	Equality Forum (or nominated sub-group)	Nov 2016, and then annually		
							Wide range of equalities-related events marked annually	Equality and Diversity Lead	From Nov 2016 and ongoing		

organisational culture	capacity Board / Leadership capacity / Staff capacity	1,2,3,4	Y	H	1,2,3	**Increase cultural competence / awareness and understanding of equalities**	Review learning and Develop provision so that equalities is embedded and explicit	Learning and development / Equality and Diversity Lead	Nov 2016		
	Board capacity / Leadership capacity / Staff capacity	1,2,3,4	Y	H	1,2,3	**Implement and grow the Board Mentoring Programme for under-represented staff groups**	Recruit mentors and mentees	Equality and Diversity Lead	Jan 2017 and ongoing		
	Board capacity / Leadership capacity / Staff capacity	1,2,3,4	N	H	1,2,3	**Develop 'Equality Allies' programme across the Trust**	Produce paper to Board on proposed way forward	Equality and Diversity Lead	Jan 2017		
							Create campaign to recruit 'Equality Allies'	Communications Team	Jan 2017 and ongoing		
	Board capacity / Leadership capacity / Staff capacity	1,2,3,4	N	H	1,2,3	**Identify staff and patient stories with an equalities angle for governance committees**	Timetable of equality-related stories developed for all directorates to contribute to	Equality Forum	Jan 2017		
	Board capacity / Leadership capacity / Staff capacity	1,2,3,4	N	H	1,2,3	**Draw and bring to life the equities aspects of the DHCFT 'Better Together so that it clearly communicates the Trusts equalities requirements**	Use the DHCFT 'Better together' for all staff	Amanda Rawlings and Anna Shaw (Deputy Director of Communications and Involvement)	Jan 2017		
							Build consideration of equalities more effectively into the Appraisal process	Learning and development / Equality and Diversity Lead	Feb 2017		
	Board capacity / Leadership capacity / Staff capacity	1,2,3,4	N	M	1,2,3	**Review the whole Trust environment and utilise it to positively promote equalities**	Sites identified for display of materials and exhibitions	Integrated Facilities Management Team	Nov 2016		
							Materials / exhibitions sourced	Equality and Diversity Lead	Nov 2016		
Objective 3: Better understand, and more effectively meet, the needs of all our service users / patients	Leadership capacity / Staff capacity	1,2,3,4	Y	H	1,2,3	**Raise awareness , knowledge and understanding of Equality Monitoring**	Amend the monitoring questionnaire on TPP to include all required fields, including requirements of Accessible Information Standard and recording of reasonable adjustments, and roll out across the Trust	IM&T Team	Nov 2016		

							Analysis of service users equalities data available on all DHCFT systems undertaken, reported on and published	IM&T Team	January 2017		
							Review the guide to equality monitoring and produce revised version	Equality and Diversity Lead /	Dec 2016		
							Promote the guide to equality monitoring and DVD across the Trust	Communications Team / All services	From June 2016 and ongoing		
	Compliance	1,2,3	N	M	1,2,3	**Ensure that all DHCFT services and buildings are accessible to all**	Establish a mechanism for undertaking access audits (buildings and services)	Equality and Diversity Lead / Estates	Nov 2016		
							Regular translation and interpretation usage / performance reports produced and reported to the Equality Forum	Communications Team	March 2017		
	Compliance / Systems and procedures / Leadership capability / Staff capability	1,2,3,4	Y	T	1,2,3	**All services / divisions to develop an equalities action plan based on the outcome of their EDS self-assessment, equality monitoring evidence and patient experience feedback**	All services / divisions to have action plans in place	All services	Jan 2016		
							Progress on service / divisional action plans to be monitored through Governance meetings	All services	Jan 2016 and ongoing		
							Regular performance management of action plans with reporting to Equality, Diversity and Inclusion Leadership Forum	All services	Jan 2016 and ongoing		
Objective 4: Better understand the profile and experiences of our employees and achieve a diverse workforce	Compliance / System and procedure	3,4	Y	H	1,2	**Produce equalities analysis of workforce data on six-monthly basis (including Workforce Race Equality Standard WRES and Disability Equality Standard DES)**	Comprehensive, easy to read analysis published on the DHCFT website, analysed and actions identified	Workforce Systems and Information	Nov / Dec 2016		
	Leadership / Compliance	1,2,3,4	Y	H	1,2,3	**Establish action plan to achieve workforce diversity**	Increase our BME workforce at all levels across the organisation				
							Further investigate the differences in shortlisted to appointment of BME applicants				

							Investigate reasons why BME staff fared less favourably than white staff across most areas measured by the equality standard				
							Achievement of all actions in the People Services Equality, Diversity and Inclusion Action Plan 2016/17				
	Compliance / System and procedure	3,4	Y	H	1,2	**Undertake benchmarking of DHCFT' workforce equality data with other comparator organisations**	Benchmarking report received by Equality, Diversity and Inclusion Leadership Forum	Workforce Systems and Information / Equality and Diversity Lead	Nov 2016		
	Staff capacity	3	N	H	1,2	**Improve declaration of sexual orientation, disability and religion or belief**	Undertake additional data verification and validation exercises	Workforce Systems and Information	Nov 2016		
	Compliance / Systems and procedures	3	Y	H	1,2	**Undertake equality analysis of Staff Surveys and act on results**	Produce analysis of data by 6 'Protected Characteristics' – age, gender, disability, race/ethnicity, religion or belief and sexual orientation	Communications Team	Jan 2017		
							Produce report to Equality Forum and Quality Committee on results	Equality and Diversity Lead	Feb 2017		
							Embed actions arising from equalities analysis into main Staff Survey Action Plan	Communications Team / Equality and Diversity Lead	May 2017		
	Staff capacity	3	Y	H	1,2	**Raise profile of, and use to better effect, DHCFT' Employee Network Groups:** • **LGB&T (Myriad Voices)** • **BME** • **Disability and long-term conditions**	Employee Network Groups are supported, enabled and empowered to achieve their objectives	Equality and Diversity Lead	Jan 2017 Ongoing		
Objective 5: Progress the equalities agenda within DHCFT	Compliance	1,2,3,4	N	T	1,2,3	**Undertake EDS2 Audit on annual basis**	Audit completed, externally validated and verified and outcome reported to PCC and QC	Equality and Diversity Lead / Equality Forum	Nov 2017		

	Governance	1,2,3,4	Y	T	1,2,3	**Co-ordinate and facilitate the achievement of all actions in Corporate Equalities Action Plan**	100% of actions completed	Equality Forum / Equality and Diversity Lead	March 2017		
	Governance	1,2,3,4	Y	T	1,2,3	**Co-ordinate and facilitate the achievement of all actions in Board Equalities Action Plan**	100% of actions completed	Board / Equality and Diversity Lead	March 2017		
	Systems and processes / Governance	4	Y	H	1,2,3	**Ensure that regular Equality, Forum meetings are arranged, held, well attended and appropriately supported**	Meetings arranged etc.	Equality and Diversity Lead	Bi-monthly from Nov 2016		
	Governance	4	Y	H	1,2,3	**Ensure that monthly Equality Forum Summary Reports are prepared and submitted to both the PCC and QC as appropriate**	Papers prepared, submitted and presented etc.	Equality and Diversity Lead	Ongoing		
	System and procedure	1,2,3,4	N	M	1,2,3	**Continue to contribute towards the work of the Regional NHS Equalities Leads Group and other associated partnership meetings or projects**	Attend and contribute towards meetings as and when they are held	Equality and Diversity Lead	Ongoing		
	Compliance	1,2,3,4	Y	T	1,2,3	**Publish information to evidence equalities best practice and compliance with the Public Sector Equality Duty (Equality Act 2010)**	Information produced and made available publicly on the website	Communications Team / Equality and Diversity Lead	Jan 2017		
	Systems and processes / Governance	4	Y	H	1,2,3	**Support the Board-level Equalities Forum**	Meetings arranged and held; attendees supported	Equality and Diversity Lead	July 2017 and ongoing		

EDS Goals:
Goal 1: Better health outcomes for all
Goal 2: Improved patient access and experience
Goal 3: Empowered, engaged and well supported staff
Goal 4: Inclusive leadership at all levels

Priority: **Top (T), High (H) or Medium (M)**

PSED (Public Sector Equality Duty) reference:
1 = Eliminate Discrimination, harassment
2 = Advance Equality of Opportunity
3 = Foster Good Relations

Protected Characteristics:
Age
Disability
Gender Reassignment
Marriage and Civil Partnership

Pregnancy and Maternity
Race
Religion or Belief
Sex
Sexual Orientation

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 5th October 2016

Reflecting and learning on Patient and Carer stories at Board
A two year review of their stories and the impact upon the Trust Board strategy and planning

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 a key aspect of Board governance

Executive Summary

This document attached is the Board to ward stories. To inform and influence the Board on the voice of our service receivers, children, families and staff.

Our duty as a Board is to serve our community and provide the very best services we can provide to our communities.

It is required licence to operate as a provider, our contracts and our regulatory duties how they are discharged

This booklet is a two year review of Board stories and is the reflections of the services we provide and demonstrates one aspect of how the Board are listening to the voice of the most important people in our communities.

This Board commitment and time given to the people and families and carers who use our service.

The board has listened to their feedback and be influenced and set the direction of the Trust both on their experiences, and has building on positive and difficult experiences, to create a culture of learning, reflection and action based upon the accounts of people that we serve.

Recommendations

1. Repeat this analysis at annual intervals and consider the voice of the voluntary sector and other representative groups in addition to service receivers and carers views.
2. Increase the number of Children service stories to be more representative of the service provision
3. Schedule the voice of the service receivers from the criminal justice and forensic services.
4. Consider the voice of individuals in primary care with regard to access to the service and or the voice of representation from IAPT services.

Strategic considerations
To give an insight into our Quality management and focus our reporting to the key areas as key lines of enquiry and questioning by the Care Quality Commission as our Quality regulator and to provide assurance level information on our services and their performance. To have overview responsibility for the fundamental standards of care as described by the Care Quality Commission and ensure that a mechanism exists for these standards to be Monitored.

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

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

Governance or Legal issues

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

Equality Delivery System

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

These stories and feedback, have representatives from all of our clinical services and no key groups have been included, there is a mix of children, gender, carers, and sexuality and disability in line with our responsibilities and duties to pay due positive regard

Recommendations:

The Board of Directors is requested to:

- Receive this review of Board stories.
- Gain assurance and information on its content and seek clarity or challenge on any aspect of the report.

Report prepared and presented by:

Carolyn Green
Executive Director of Nursing and Patient Experience

Enc K

Derbyshire Healthcare NHS
NHS Foundation Trust

Opportunity

Recovery

Personal strengths

Optimism

Hope

PATIENT STORY OUTCOMES 2014 -16

Series 2: September 2016

Better together

July 2014

Attention Deficit Hyperactivity Disorder

Mr B gave a moving and powerful account of their family's experience of receiving care for their son who suffered with attention deficit hyperactivity disorder (ADHD). The family benefitted from the 123 Majic training which produced marvellous results. The family also embarked on a 10 week programme of RAPID training that gave them and their son the skills to understand and to deal with his condition through the different stages of his life. A major benefit of RAPID training was that the family met and talked to other parents with the same problems and experiences and this was extremely helpful to them. Their son has now completed his first year of secondary school and achieved average and above national grades and he is now able to deal with situations with peers and family members.

In response to the Chairman asking what improvements could have been made to the service the family received, Mr B added that it would have made things much easier if nurses were able to prescribe. Mr B also thought 123 Majic Training had been invaluable but it is not really suitable for a 16 or 17 year old. A structured RAPID training programme should be readily available to equip teenagers with the tools and knowledge they need to cope with the different phases of their life as they mature. The best outcome of this process has been meeting and speaking to other children and families affected by ADHT.

The Chairman, on behalf of the Board, thanked the family for their openness and bravery in giving an emotional account of their experience of receiving care and was delighted that their comments complimented our services.

ACTION: Carolyn Green would like to use this family's story to help other cases and the family readily gave their permission.

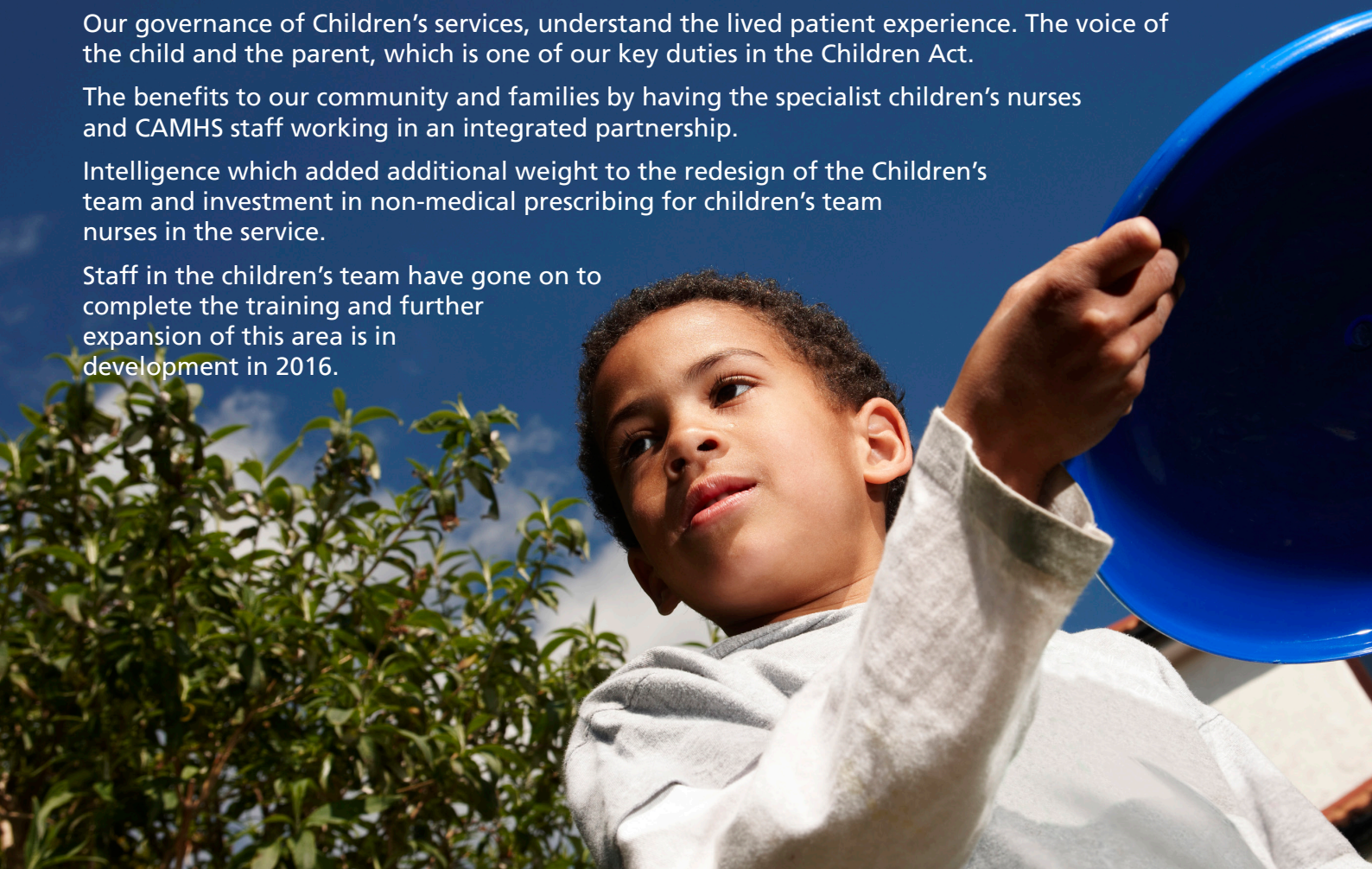
Impact on our Trust strategy and clinical practice

Our governance of Children's services, understand the lived patient experience. The voice of the child and the parent, which is one of our key duties in the Children Act.

The benefits to our community and families by having the specialist children's nurses and CAMHS staff working in an integrated partnership.

Intelligence which added additional weight to the redesign of the Children's team and investment in non-medical prescribing for children's team nurses in the service.

Staff in the children's team have gone on to complete the training and further expansion of this area is in development in 2016.



September 2014

Experience at the Beeches mother and baby unit and the post-natal impact

The Board welcomed a patient (referred to as "G") who was in attendance to share her experience of using Trust services. G provided a frank and detailed account from her admission to The Beeches in December 2012 to the present date. She described the process she had experienced for assessment for possible Asperger's Syndrome. She had found her inpatient stay unsettling, and had been confounded by the failure of her assessment to result in a timely referral for specialist treatment. She believed her initial assessment to be incorrect but was now on a waiting list for treatment.

G explained that she had been through the complaints process and now finally felt she was being listened to.

In response to Carolyn Green, G outlined the ways she felt the Trust could learn from her story and the positive steps that could be taken.

Steve Trenchard acknowledged G's sense of injustice and dissatisfaction and thanked G for providing her personal story to the Board. Every experience, even an uncomfortable one, is an opportunity to learn and improve.

The Chairman said that the elements of G's story would be reviewed, including amongst other aspects, the way in which judgements were made with referrals. The board was advised that there was a general issue of access to assessments from autistic spectrum disorder and Asperger's which had been recognised by the Clinical Commissioning Group.

Carolyn Green said that the complaints team had maintained a good relationship with G and Linsey Thomas had made positive progress in dealing with the points G had raised.

Carolyn Green agreed to review current key indicators in conjunction with the service line manager. Ifti Majid also suggested a visit by some members of the board.

The Chairman thanked G for attending the meeting and assured her that appropriate action would be taken to explore the issues raised.

The Board noted that individuals named by G were not in attendance to respond to the issues raised however relevant follow-up support would be offered to those involved.

RESOLVED: To express thanks to G for sharing her story; to ask the executive to seek the necessary assurance regarding the current service; and to ask the Quality Committee to give further consideration to the gap in service provision.

Impact on our Trust strategy and clinical practice

Our governance of Women's specialist services, understand the lived patient experience

Feedback on the experience of clinical professionals which resulted in feedback to the team on their practice and how it was experienced

Board modelling, in acting on concerns with regard to clinical practice.

Reflective session with the named practitioner.

Reflection and further intelligence gathering to explore whether this was a one off episode of care or an emerging pattern

Feedback on the impact of the complaints service, in listening and impacting positively on an individual's personal negative experience of care.

This resulted in a review by the Quality committee and the Director of nursing met individuals and families who had experience an unsatisfactory patient experience and listened to their concerns.

Management action was taken in result of this feedback

October 2014

Photography Project Experience in Erewash

The Board welcomed Mr D who explained that he was a carer for his wife and service user, Ms B who had been a patient, and Brenda Rhule who had provided them both with support as a Service Manager. Both Mr D's wife and Ms B had been diagnosed with personality disorder and had been admitted to hospitals to receive care for their mental health on a number of occasions and Ms B had been admitted to a hospital out of the area.

As part of their recovery, Mr D and Ms B had taken part in the Photography and Personal Development course delivered to Erewash Recovery Team service users and had learnt practical photography skills as a new way of expressing their thoughts and emotions. The course had developed their confidence and social and personal development skills and provided them with a new interest.

Ms B had sought treatment for borderline personality disorder and had undertaken various types of therapy, as had Mr D's wife, but were disheartened by the waiting lists and gaps they experienced when consultants and mental health staff had either retired or left the service.

They eventually came into contact with Brenda Rhule who encouraged them to take part in the photography course. Feeling invigorated by being in Brenda Rhule's care and attending the course made the biggest advance in Mr D and Ms B's recovery and had a marked improvement on their relationships with family and friends. Taking part in the photography project opened their eyes to the beauty in the world and the support of the group was in itself a therapy that should not be underestimated.

When asked what it felt like to be on the waiting list for treatment and whether he was communicated with, Mr D replied that it would have been good to have had a care plan system as he and his wife had a lot of questions. Information had not been easy to find and he felt that GPs did not have enough training in mental health awareness. Community Psychiatric Nurse support workers were a huge help. However, the workload of the staff was too great.

Ms B added that borderline personality disorder was now called emotional instability and it was a difficult diagnosis to overcome but it made her realise she did not just have a problem; it meant there was definitely something wrong with her. Having her disorder identified helped get the right support but it was important to get an early diagnosis in order to get the right therapy.

Tony Smith commented that the Trust was developing a specialised trauma service and a paper written by local authority colleagues would be presented to the Overview and Scrutiny Committee explaining that there was insufficient therapy across Derbyshire and for the provision of this service to be explored.

Steve Trenchard commented that 'deep dives' were taking place to discover the causes for waiting list delays and there was an expectation in parity of esteem that people with mental health issues should get help within a specific waiting time.

The Chairman acknowledged Brenda Rhule's valuable front line work and thanked her for support and help towards people in her care. He also thanked Mr D and Ms B for attending the meeting and for sharing their beautiful photographs throughout their story and it was hoped that these could be used within the Trust.

RESOLVED: To express thanks to Mr D and Ms B for sharing their story; to ask the Executive Directors to seek the necessary assurance regarding the current service.

ACTION: Carolyn Green and the Quality Committee to give further consideration to the gap in service provision.

Impact on our Trust strategy and clinical practice

This story had an impact on the Trust design and thinking of the impact of social recovery on a person's wellness and illness levels, this example of model formed part of the Trusts strategy and setting recovery at the heart of the clinical strategy. This was one of the session that started clarity on the need for our clinical strategy to be redefined to two goals – Symptom recovery and social recovery

Assurance on a well-rounded community offer of service provision and a holistic offer from our services

Directors attended this group and award ceremony to celebrate this success.

Sources of funding to search for additional bids to support these initiatives were explored.

November 2014

Volunteering

The Board welcomed Mr M and Mr A and Joanna Downing, Volunteer Manager/Social Inclusion OT Patient Experience Team. Both gentlemen had benefited from carrying out volunteer work for the Trust whilst recovering from their illness and were invited to speak about their experience.

When diagnosed with schizotypal personality disorder Mr M was referred to the Early Intervention Service and received help in understanding his difficulties which increased his ability to cope. When the opportunity arose for him to volunteer he jumped at the chance to join the Trust because he felt the Trust was non-judgemental. Mr M explained that the benefits of volunteering were working in a friendly, open-minded atmosphere with professional people who took an interest in him and his work. Mr M was very proud to have been nominated for a Chairman's award at the Trust's annual Delivering Excellence Awards ceremony on 27 November.

Mr A started work as a volunteer in the Trust's Headquarters at Bramble House about eight months' ago. He explained that he had suffered from a psychotic disorder and his counsellor arranged for him to meet Anna Shaw, Deputy Director of Communications. He was soon assigned a desk in the communications office and worked using his photographic and graphic design skills to produce communications literature and also collated and documented art work within the Midlands area. Mr A felt that his work within the communications team had helped him gain confidence in himself both in the workplace and in his personal life.

Tony Smith asked if there was a networking group for volunteers to discuss common interests and encourage their personal development. Joanna Downing replied that she was in the early stages of setting up a network/developmental session.

When asked by Maura Teager if any celebration events had been planned, Steve Trenchard said this should be encouraged and that the Trust would like to develop and improve the volunteering scheme and Joanna Downing and Mr M and Mr A could play a part in influencing how this could be done.

When asked by the Chairman what their ambitions were beyond volunteering, Mr M replied that he would like to develop his skills and become a peer support worker as he felt his work and the experience he acquired whilst recovering from his illness would be helpful. Mr A added that he would continue working as a volunteer to help him get back into the workplace and he wanted to draw attention to the value of art being beneficial to people's recovery.

The Chairman and members of the Board thanked Mr M and Mr A for the valuable work they were providing and were pleased that their volunteer work had played a part in their recovery.

RESOLVED: To express thanks to Mr M and Mr A for sharing their story; to ask the Executive Directors to seek the necessary assurance regarding the current service.

Impact on our Trust strategy and clinical practice

This was one of the second sessions that started clarity on the need for our clinical strategy to be redefined to two goals – Symptom recovery and social recovery.

This really crystallised our thinking on the need to focus on employment strategies and developing personal resilience as well as opportunities to volunteer, be valued and the need to develop occupational strategies and the gap in Occupational therapy strategic leadership in a far more sophisticated manner than purist clinical professional leadership

The need to expand the volunteering service and lobby for an employment intervention strategy and employment/ vocational strategy was born; influence on the AHP in particular the occupational therapists to develop a clinically focused and enabling strategy rather than a pure professional strategy.

The need to design the quality priorities to consider recovery principles but to measure actual difference in the proposed hub developments and neighbourhood developments through the recovery lead. The quality committee set the recovery lead a target piece of work to develop social and employment recovery measures, and in developments to measure difference.

The need to invest or source additional income for apprenterships, a number of bids to HEE and other investors have been made but a successful bid has not been secured

In 2016 an additional patient experience apprenticeship and an internship were piloted, results not reported to date. (not due)

The maintenance of the service and no disinvestment.

January 2015

My family and their experience of CAMHS

The Board welcomed Ms J the mother of a 19 year old girl with Atypical Autism alongside sensory processing difficulties who described her experience of the Trust's mental health service for young adults with autism and how the service failed to provide appropriate help once her daughter reached the age of 18.

Ms J explained that verbal communication is always difficult with people who have autism. Her daughter was anxious about her appointment with the clinician and had prepared written information to help her converse but this information was refused and she was told by the clinician that if she couldn't talk she couldn't be helped. Ms J felt that people with communication difficulties should be treated with compassion and be provided with the same level of support for interpretation as people who are deaf or who have language difficulties. Clinical staff should adapt their style to help people communicate and that people with autism should be asked how they would like to be communicated with during their appointments. Ms J further reported that other staff in the assessment service had not adjusted their assessment or communication skills based upon her daughter's diagnosis and specific needs. She had a similar care experience with the Eating Disorders service; this had been coupled with restricted access on entry to the service. Ms J suggested simple and effective communication methods that would have worked for her daughter that should and could have been routinely employed. She gave a detailed summary of a NHS service which had made adjustments with great success and impact upon her daughter.

Patient confidentiality became a problem once Ms J's daughter reached 18. Chronologically she was an adult but her development meant she was still a child but Ms J was no longer allowed to accompany her daughter for treatment or be consulted with regarding her treatment. However, since Ms J had been involved with Carolyn Green and Gary Stokes following an open meeting at a Healthwatch event, her daughter was receiving better support and access and a specialist Nurse Consultant, Gaynor Ward and Specialist Nurse, Julie Sankey had communicated with her daughter using a method of her daughter's choice. The impact of using alternative communication needs,

giving extra time with no limit had transformed her daughter's experience of care and engagement. Giving guided and additional information on how to access services and what to expect had been really helpful and this had also been experienced when Ms J had met staff form the Crisis team.

The Chairman commented that he had found Ms J's story very humbling to listen to and that the Trust had a duty of care to offer service users with autism appropriate and adjusted services. He proposed that Hospital teams would be coached / given feedback on this specific family's patient experience so they could use the appropriate level of care and consideration when dealing with people who had difficulties with communication.

Ms J made the point that she had to fight for proper care for her daughter and she felt sad that some people with an autistic child would not be in a position to be able to do this. She believed the system was costing lives as people with autism have a high tendency to commit suicide and her daughter was always at risk of taking her own life. Ms J compared services within mental healthcare with A&E where she would have quick and rapid access for a life threatening heart attack in A&E but she felt mental healthcare was treated differently. She stated there was no parity of esteem. To restrict access to a service and to have a waiting list for autism service and no specialist service was unacceptable.

Maura Teager felt dismayed that communication had not been adjusted to meet Ms J's daughter's needs and that a specific approach to sharing information and confidentiality had been taken. Carolyn Green confirmed that the Divisional / Head of Nursing for the area had been given a copy of the letter from Ms J and would be feeding back to the team and developing with the wider nursing team some additional training to support, together with refreshing of core skills. Clinicians' relationships with families should be so robust that they could helpfully care for people who find communication difficult. Also, the person or carer who understood how communication should be conducted must be included in all of the multi-professional consultations. Maura Teager pointed out that there was a chasm between autism and people with learning difficulties and clear learning into family inclusive practice and confidentiality. She was pleased Ms J would be meeting with Dave Gardner and commissioners to tell her family story to address the needs for young people with autism.

John Sykes said he agreed with everything Ms J had expressed. He agreed with Maura Teager's observations that if someone could not communicate verbally imagination should be used to find a way of communicating with that individual. Clinicians have a duty of care to make their appointments work well and they must communicate with individuals appropriately and understand that specialist intervention is sometimes required. Doctors receive regular development and learning and he would ensure that appropriate coaching on working with people with communication difficulties would form part of their professional development.

Carolyn Green said changes to the confidentiality issue relating to age should be considered as a starting point for improvement and she wanted to assure Ms J that the head of nursing would spend time with the staff who dealt with her daughter to reflect on their practice and would ensure that the Trust would appropriately address the relationship between young people, autism and mental health. Ms J added that a key issue was the gap between her positive experience in CAMHS and the falling off a cliff edge experience when entering Adult Mental Health. She expressed the need for a 0-25 children and youth service rather than traditional age 18 boundaries.

Ms J confirmed that both her children's psychosis had been treated by the early intervention service as this had been the closest and most appropriate service. The loss of social care support for her daughter had produced a devastating impact and had resulted in a more high cost service offer. She felt this could have been avoided, instead a support worker could have provided weekly support for a few hours at a very small cost.

The Chairman said it was important that Ms J shared her family's experience with the Board. He would ask the Quality Committee to pursue the matter of inequalities within the autism service so the Trust could address the issues she raised. He felt some good constructive actions would take place because Ms J had told her story and he assured her that he and members of the Board would read the transcript she had prepared.

The Chairman and members of the Board thanked Ms J for attending the meeting and sharing her story and assured her that immediate actions would be taken with the Trust's commissioners to improve the level of service provided to young people with autism.

ACTION: Quality Committee to pursue inequalities within autism services.

ACTION: Coaching in communication difficulties within autism to form part of medical staff's professional development programme.

RESOLVED: The Board expressed thanks to J for sharing her story and asked the Executive Directors to seek the necessary assurance regarding the current service.

Impact on our Trust strategy and clinical practice

To highlight the strategic gap in services for Autism

To discuss the statutory duty for Autism this requires an assessment and treatment service.

This powerful story started further conversations and challenge with regard to this commissioning gap and resulted in additional funding in the 2015/16 funding round for a partial solution.

The quality committee received a brief on autism and the gap

This issue was raised at the Commissioners quality assurance group and some partial mitigation through investment, education and a spotlight ion this key group.

The family member went on to meet commissioners at the strategic autism board.

This commissioning gap remains significant. There is no commissioned treatment service.

APRIL 2015

My recovery journey

The Board welcomed Ms N who described her recovery journey centred in Amber Valley.

Ms N first became unwell after the birth of her second child and was admitted to the mother and baby unit in Kingsway. She found this difficult as she also had a 22 month old son and was not able to have her son with her. She felt the unit was a very negative place and it had a high turnaround of staff. She was later transferred to an adult ward in Burton and was unable to have either child with her on the ward. She was later transferred to Amber Valley, Derbyshire.

Ms N recounted her difficulties with CPNs (Community Psychiatric Nurse), including staff sickness, issues relating to information governance, and general professional mistrust. Ms N explained that Ann North became her CPN and this was the key to her recovery as Ann North spent time building a relationship with her.

Ms N went on to explain her experience at the Radbourne Unit and shared her concerns and offered ideas for improvement:

- All staff should be aware that each patient is on a journey through the process of their own recovery.
- Layout of wards is so important – staff desks cause a mental and physical barrier
- High turnaround of staff prevents the building of relationships and has a very negative impact on recovery
- Staff need to create relationships with patients
- Queueing for medication should not be necessary and causes a breach of confidentiality and was a degrading experience
- Seclusion takes away the emphasis of what needs to be done on the wards. Give patients things to do and focus on their recovery

Ms N also shared her experience of the CAHMS service as her son was receiving treatment. Ms N explained that she had a number of concerns relating to her sons mental health, she felt that there was a delay in diagnosis of autism due to staff relating his issues with her mental health problems. Ms N felt she and her son should have been treated as a family and not separately.

The Chairman was struck by the problem of confidentiality when queuing for medication and was disturbed by the issue of confidentiality of the CPN leaving patient notes behind. Mr Majid agreed there was no need for patients to be queuing for medication and that discussions should take place with patients to establish if there are any side effects or any other factors impacting a patient's recovery. The Chairman explained that Mr Majid and Ms Green were addressing the issue of the layout of wards and staff desks were in the process of being removed.

The Chairman clarified that feedback from Ms N's experience of the organisation would be undertaken by Ms Green. The Trust intended to transform how integration takes place with families and the staff aspect and relationship with the family unit is being investigated. This work was just beginning and the Chairman hoped Ms N would help and provide feedback and return to a future board meeting and report on improvements.

ACTION: Mr Majid would provide feedback to Ms N relating to the missing telephone help number on the webpage and Ms Green would provide feedback on other points raised

ACTION: Ms Green and Mr Majid would look at creating a link within the PARIS system to connect family service users.

RESOLVED: The Board expressed thanks to Ms N for sharing her story and thanked Ms N for accompanying her and for the fantastic work she was providing

Impact on our Trust strategy and clinical practice

This story was to focus on the quality priority of recovery and personalised care.

The need for the Board to put in place to develop stability in teams, reduce turnover and establish ways of ensuring individuals do not continually retell their story to lots of clinical professionals

The need to reduce agency and back staff was very clear and the need through the neighbourhood restructures to maintain continuity.

The lived experience of in-patient care reinforced the need to carry on eith personalised care planning, setting mutual expectations and delivering and rolling out the Safe ward interventions and planning nursing conference events that champion effective personalised purposeful care planning and interventions that shift the power balance form being professionally led but enabling the individual to take control of their experiences.

The reinforcement of maintaining the Trusts approach to think family and pushing forward with family inclusive practice.

The reinforcement of the need to revisit information on line, the information leaflets we give out in the service and how we promote what you should expect from the service. This and other feedback led to the redevelopment of the Your care leaflets, the recovery web pages and a different approach to information.

The need to make headway in the Positive and safe strategy and work plans to reduce restrictive practices, and negative practices such as queuing for medication and seclusion

MAY 2015

My recovery journey

Kate introduced herself and informed the Board she was an award winning children's illustrator and designer. She explained that she had been diagnosed with Acute and Transient Psychotic Disorder and since 2005 she had suffered four severe psychotic relapses and several minor episodes. During these episodes she forgets how to eat and loses all track of time, instead her sense of creativeness is heightened and becomes highly stimulated. She copes with this by drawing and recording every moment in a doodle diary and with photography. She wanted to share with the Board how drawing and creativity helps her and suggested using drawing and creativity to help develop the Trust's services.

Kate described things and events that made her feel safe and emphasised how drawing, writing and photography helped calm her down and speeded up her recovery. She also uses art as a tool to prevent her becoming ill and records positive things that have happened to her.

Kate had many ideas that might improve the Trust's services and help service receivers feel safe. She stressed that feeling safe was very important. She wanted to make the point that service receivers should be reassured by staff and be told they are being looked after and that in time their condition will improve. Kate also believed the use of gentle signs would put patients at ease and suggested the Trust displayed signs to say there are no cameras on the ward or around the hospital as the use of cameras can be very disturbing to some patients.

Kate felt that a quiet expressive room where patients could draw and paint on black board or wipe board walls would be an extremely helpful aid to recovery. This would also allow people time off the ward and it would give structure to their day, allow them to relax and pass time in a sociable way. She also provided evidence of a an idea of offering new patients a journal to use so they have something to write or draw in to express their feelings and this could be a good way to help people start to talk to nurses and professionals. Kate also shared other ideas of treatments such as holistic style treatments. She added that she really enjoyed helping and being with people who have suffered similar problems to her and this had helped her recovery. She now wanted to pass on and share what she has learnt through her mental health condition.

Steve Trenchard was very taken with the idea of creating spaces for people to draw and express themselves in different ways and suggested that the Innovation Fund could perhaps be used to pursue funding. He thought Kate had some good ideas about creating a safe environment for patients. Carolyn Green agreed it would be good to look at different ideas for using art as part of the Trust's core business.

The Chairman was struck by the interaction between art and music and he thought this was a very useful area of therapy. He felt that the messages Kate relayed about safety and wellness definitely resonated with the Board and he hoped she could help the Trust learn how to make people feel safe and help people have an easier and quicker journey to wellness. Ifti Majid was keen to take this message forward and suggested that Kate's presentation be shared with Sara Baines the Lead in Recovery and Wellbeing.

The Chairman thanked Kate for her presentation and for the work she was carrying out and for the support she was providing for the recovery services.

ACTION: Kate's presentation to be sent to Sara Baines, Recovery and Wellbeing Lead.

RESOLVED: The Board expressed thanks to Kate for sharing her story and for the ideas she had proposed.

Impact on our Trust strategy and clinical practice

This story had an impact on the Trust design and thinking of the impact of social recovery on a person's wellness and illness levels, this example of model formed part of the Trusts strategy and setting recovery at the heart of the clinical strategy.

How do we reach individuals who are not able to communicate their needs that small investments can impact on the ability of the service to connect with a person, to draw, doodle or just to put pen to paper to express their mood.

In 2016, all ward areas, received a professionally designed, service designed, doodle pad with a personal message from Kate. This was funded from the Trust innovation network.

Taking an idea into mainstreamed practice.

JUNE 2015

Volunteering and training and resource

Robert introduced himself and explained some of his life history. He had travelled around the world as an ex-serviceman and returned to the area to care for his parents when they became ill and he supported them both to the end.

Robert told the story about his wife who had been diagnosed with a brain tumour two and half years ago. Nothing could be done for her and he cared for her in their home for a period of 12 months. Robert found this hard as he had very little help until the final stage when a nursing team helped him to care for his wife. Although the nurses were there to help he and his wife found it difficult as they had many different nurses caring for her from the District Nursing team (non-Trust service).

When Robert's wife died Robert spent seven weeks in a day care centre. He thought the mental health team carried out some tremendous work with him and helped build his confidence but this help stopped when he was discharged and he felt very isolated after he was sent home. The social network available to him outside of the Trust following a bereavement was non-existent.

Eventually Robert was put in touch with the Community Psychiatric Nurse (CPN) who suggested he did volunteer work. Robert felt this was the best thing he could have done as it gave him a reason to go out and meet new people and it made him feel valued. Robert's volunteer work consists of helping to organise room bookings in the Research & Development Centre and because of his background in IT he carries out computer support work and he also volunteers in a centre in Ilkeston.

Carolyn Green felt Robert's story was very positive and gave the Board the opportunity to learn about volunteering and she felt it would be a good idea if Robert could help the Trust improve its services. Robert replied immediately that consistency and compassion were the most important things that could improve the services he received while caring for his wife. Having the same nurse in the community team would have helped enormously. He had the same CPN while he was being treated and this enabled him to build a relationship with the CPN who recommended he carried out volunteer work. Volunteering also gave Robert the opportunity to sign up to e-learning and this has provided him with additional qualifications.

Carolyn Green thanked Robert for his comments. She acknowledged that the Board had listened to his story and would bear in mind the points he made and will strive to help people who are bereaved, especially as bereavement is a leading cause of depression and for people coming into the Trust's service to gain help. The Chairman added that he could see that volunteering was a very important part of Robert's life and it was good for the Trust to have people like him with real life experience providing such vital support. The Chairman thanked Robert for sharing his story and for his commitment and support as a volunteer within the Trust's service that is sincerely valued and appreciated.

RESOLVED: The Board expressed thanks to Robert for sharing his story and for the ideas he had proposed.

Impact on our Trust strategy and clinical practice

The huge impact of loss on a person's wellness, assurance on the patient experience and an example of how the trust can impact on a person's health through its clinical support but also through its ability to be a mindful employer.

The missed opportunity of the health service to support a carer and the opportunity of integrated care to be increasingly psychologically minded it its approach to individuals.

A further reinforcement of the need to promote symptom and social recovery and how the trust will influence other organisations to be mindful employers.

This case was used as an example with Business partners session through the Chamber of commerce events, as examples of what has worked for the Trust for other Derbyshire employers to consider

JULY 2015

Service user feedback – "your service your say"

Claire Farnsworth, Recreation Co-ordinator at Chesterfield Royal and Hilary a volunteer support worker were invited to share their story with the Board.

Claire informed the Board how her role in the supervision and training for volunteers had emerged. She explained that since the Trust had opened up volunteer membership to ex-service receivers, volunteer recreation support workers had enabled the service to expand from 5 to 7 services and had enabled the hub to open at weekends. The volunteer service had developed further and a job role was created. An interview process took place and Claire was pleased that Hilary accepted the role and started to help with the service.

Hilary explained she is an ex paediatric nurse and had left the job she adored when she became ill. She had been an inpatient and also had community experience and is able to bring this knowledge to the team. She found the patient volunteer role very interesting and it has helped her own mental health and the support she has received from the hub enabled her to feel part of the team.

The role Hilary plays has been very interesting to develop. She produces leaflets and manages an information board that she receives responses from. She works in fairly loose discussions with patients and passes on comments, complaints and suggestions. Some improvements have been made from suggestions from patients and the biggest feedback she has received is that patients say that if they tell Hilary about a problem she finds a solution as she is able to get answers to patients' queries quickly and helps them in ways they cannot help themselves. Hilary also explained that she receives supervision from Claire which is of great benefit to her and at the end of every session she and Claire review what they have gained. Hilary feels that the Trust supports her as a volunteer and she feels people trust her and she is part of the team.

Maura Teager asked Hilary how it would have been if she had had someone like her to help with her problems when she was in hospital. Hilary felt this would have been of great benefit as there are some things that you cannot talk to staff about and she often helps get things moving more quickly for patients because she knows who to talk to get help. It is little things that make such a difference to patients.

Jayne Storey asked Claire and Hilary if the board could help with any matters they could not resolve and Claire was very quick to ask for better outdoor space for patients. Outdoor space is used for OT practice and it would be good to have a safe outdoor space for patients who are non-smokers to use and enjoy. Claire added that going out into the fresh air and growing vegetables and fruit and taking it into the kitchen is very rewarding. The Chairman commented that outdoor space has to have a dual use and also be for smokers and an area for smoking in our environment is a difficult thing to approach. It was suggested that Bev Green might be interested to help and the Trust's Innovation fund could also be approached for help.

John Sykes felt it was important to improve the engagement of male service receivers in different

types of projects and was pleased to hear that male volunteers were starting to come through the recruitment process and bringing their interests with them.

Ifti Majid was glad to hear that Hilary had clearly been accepted in her role and wondered how she could be incorporated into the wider clinical team. Hilary felt this would be difficult as she had been an inpatient recently. Claire felt Hilary's role was developing within the team and on the ward and that volunteer support work was becoming accepted as an established service with ward managers.

The Chairman thanked Claire and Hilary for sharing their experience and for the valuable work they were engaged in that showed ways of connecting with the Trust's service receivers.

RESOLVED: The Board expressed thanks to Claire and Hilary for sharing his story and for the ideas he had proposed.

Impact on our Trust strategy and clinical practice

The need to focus on meaningful activity in the service, the impact of having service receivers reaching other service receivers on the wards and how powerful that can be in, the improvement of the patient experience,

The need to expand the volunteering service and lobby for an employment intervention strategy and employment/ vocational strategy was born; influence on the AHP in particular the occupational therapists to develop a clinically focused and enabling strategy rather than a pure professional strategy.

The positive contribution of occupational therapists in improving the patient experience, evidence and assurance of the impact of a platinum teams impacting upon our acute wards.

SEPTEMBER 2015

Service receiver story

Service receiver visitors today were Norman and his partner and main carer Steven. Steven described how following the trauma of Norman losing his sight and diagnosis of cancer, Norman's mental health deteriorated. The Chesterfield Mental Health Team for Older Adults (CMHT) became involved in his care and throughout the journey Norman has taken, the team have supported both him and Steven.

Steven was full of praise for the team, especially their main CPN in the CMHT, who had on many occasions promptly stepped in with the help they needed. He explained how he and the team had helped when Norman was admitted to hospital for an operation when he was diagnosed with cancer. The nursing staff in the acute trust did not understand the problems associated with Norman's sight loss. Being in the dark at night was distressing for Norman and the CMHT arranged for the lights to be left on at night. The CPN designed and placed a notice above Norman's bed to remind nursing staff as changes in staff had sometimes led to the lights being switched off.

Unfortunately complications arose from Norman's surgery and his chances of survival were small. He recovered but his mental health had deteriorated. Steven knew that Norman needed to have visitors with him throughout the day and night and the CPN quickly arranged with the hospital for Norman to have visitors at any time.

Norman's mental health deteriorated even further when he returned home and Steven gave up his job to care for Norman full time. The CMHT supported them both and gave Norman a "Boom Box". This is a device used for visually impaired people which plays audio files and also contains a radio. Norman's CPN recorded Norman's care plan and a relaxation therapy session to enable him to take control of his anxiety which worsens when Steven goes out of their home. Therefore the results are two-fold, supporting Norman to manage his symptoms and enabling Steven to have some time for respite. The "Boom Box" has been a great success and is very easy for Norman to use and Steven

demonstrated to the Board how it allows Norman to play a relaxation breathing exercise whenever he feels anxious and listen to his care plan. Norman is veteran of the armed forces and receives weekly newspapers on a memory stick which he also plays on the "Boom Box".

Members of the Board were pleased to note the care provided by the CMHT and the good progress and performance of our Trust staff and acknowledged their good work. The difficulties Norman had experienced while in an acute general hospital ward due to the lack of understanding from the staff was observed by the Board and members of the Board considered that Norman's and Steven's story could be anonymised and used for training staff in being psychologically aware of the additional specific sensitivities and nuances to care required with individuals with sight loss.

The Chairman thanked Norman and Steven for sharing their very moving and personal story which would allow improvement and learning about how the NHS can work with a person's needs.

ACTION Ifti Majid to write to the named CPN to feedback on Norman and Steven's story and forward their compliment and extend the Board's thanks

RESOLVED: The Board of Directors expressed thanks to Norman and Steven for sharing their story which allowed them to understand the difficulties they have faced and consider the innovative practice of the "Boom Box", unique solutions to personalised care planning and receive a compliment for our North Older Persons Service, and in particular a named CPN.

Impact on our Trust strategy and clinical practice

The need to think about individuals and all of their needs as a holistic package of care. The links between effective cancer care, mental health needs and the need to have a personalised inclusive package of care.

The needs of carers and the importance of our staff in advocating across the health system in meeting individual are needs.

The positive experience of connection between our staff listening, planning and using innovations to meet the needs of individuals.

Personalising care planning through audio, the need to explore the use of audio and possibly video, PODCATS in the roll out of EPR. PARIS to influence practice across agencies

Assurance and quality of nursing inventions in the Older persons section of the Neighbourhoods.

OCTOBER 2015

Service receiver and carer story

The family and service receiver visitor today was PJ who described her family's experience of the Crisis Team. She was accompanied by Lesley Bryant and Fiona White from the Chesterfield Crisis Team.

PJ defined the care her family received from the Crisis Team as second to none. She apologised that her husband E was not able to join her. She explained that in the African culture stigmatisation attached to mental health issues is very prevalent. Men are expected to be silent if they are suffering otherwise they are not considered "man enough". PJ felt it was a good sign that E felt able to tell her that it would be too difficult for him to meet with the Board today.

PJ described the traumatic time she and her family experienced when her husband had his breakdown. She had called the emergency services and E was taken to Chesterfield hospital. E was seen by Dr Johnson who was able to talk to him and calm him and he was referred to the Crisis Team. The Crisis Team gave PJ and E courage and confidence and supported them and made them both feel they could face things together.

PJ told of her disappointment with professional members of other agencies who threatened to take their children away from them. Throughout this time the Crisis Team focussed on the whole

family and the family's wellbeing and understood that this would result in an improvement in E's mental health. PJ related her experience from other statutory services and the impact of safeguarding interventions, education and social care and how that had impacted upon family life. These experiences were not positive and the family were desperate for support and the Crisis team had reached them and supported them in a critical period. PJ pointed out she had logged formal complaints with those bodies for their actions.

PJ thought there were two exceptional members of the Crisis Team, Lesley and Cheryl but she felt all members of the team were wonderful. The Chairman thanked PJ for the tributes she paid to the Crisis Team. He was intrigued with the connection Lesley had with the family and how she gave the family courage. The Crisis Team understood the family were victims of the circumstances they found themselves in and helped the family look on the positive side and look to the future. They saw PJ as a mother and a friend and they connected with the children too. PJ felt cultural adaptations and sensitivities to E his ethnicity, culture and respect as head of the family had been provided.

Ifti Majid acknowledged the Crisis Team's role was not purely about E's mental health, they had also taken a holistic approach to his and the family's recovery. He recognised they had experienced barriers when trying to get the help they needed from other agencies. The Crisis Team was determined to keep E safe and social workers were adding to his trauma by trying to make E leave the family home. Lesley from the Crisis Team had pleaded with social workers to let her and the team support E and the family and keep him at home as she did not believe he would harm his wife or children.

Maura Teager highlighted the bravery of Lesley and the professional risk she took and felt this was possible because she had a strong team behind her and this helped with the courageous decisions she and the team had made.

The Chairman thanked PJ for sharing her story and thanked Lesley Bryant and Fiona White and the Crisis Team that delivered this service to PJ and her family. He felt there was learning that could be taken from this case regarding co-ordination with other services and how mental health issues are seen within the African culture. This required further work especially as it is not purely confined to African men.

The Board met the junior members of PJ's and E's family, their three daughters, and welcomed them and thanked them for their attendance.

ACTION: Ifti Majid to write to the Crisis Team and extend the Board's thanks and appreciation for their work.

RESOLVED: The Board of Directors expressed thanks to PJ for sharing her family's story which allowed them to understand the difficulties they faced and the responsive and effective work of members of the Crisis Team.

Impact on our Trust strategy and clinical practice

The need to think about individuals and all of their needs as a holistic package of care. The links between effective cancer care, mental health needs and the need to have a personalised inclusive package of care, that is considering the ethnicity, cultural values and gender issues for individuals and families from a BME background.

The impact upon a family of positive risk taking, undertaking a family inclusive approach and considering the needs of the children,

Assurance on the impact of the crisis team from a patient experience perspective.

The need to consider cultural competency in routine clinical work and how this will be increasingly model in education provision.

NOVEMBER 2015

Service receiver story

The service receiver visitor today was Kirsty who first came under the Trust's mental health care at the age of 18 within the adolescent service. She had been diagnosed with borderline personality disorder and she also had a history of self-harm. Kirsty had experience with various mental health teams within the Trust and had been admitted as an inpatient both as a volunteer and after being sectioned.

Kirsty gave her impression of life as an inpatient and felt strongly that wards were very under staffed, although her last admission to the Trust' service was nearly five years ago. She felt nurses have so much to do it makes it difficult to talk to them in the wards if you were experiencing a crisis. Kirsty acknowledged that every effort is made to make the wards as comfortable as possible and t more activities carried out now, but she found it depressing being an inpatient and not having enough to do. Getting outside to have a walk and have some fresh air was difficult because of the lack of staff and was always seen as a "risk management" issue. Being outside and having a change of scenery helps with people's moods and calms them down and Kirsty was so desperate to get out of the ward that she started smoking and 10 years on she is still a smoker, now.

Kirsty described the food on the ward as terrible. She believes having food that is stimulating and attractive would really help people on the wards who have a poor appetite or an eating disorder. Having a hot breakfast a few times a week would give service receivers something to look forward to. She suggested that fruit, dips and crudities would be a good addition.

Kirsty listed other factors that would improve life on the wards. Having a quiet space where you can sit quietly, read a book or listen to music. Having a named nurse who is approachable who you can form a relationship with is important as well as being able to change your named nurse if needed. Kirsty had a lot of praise for the health care assistants who she felt were the back bone on the wards and the ones who take you for a smoke and sit and hold your hand and she didn't think they received the credit they deserved.

The Chairman remarked that part of Kirsty's story was about testing whether the Trust had improved since she was last in hospital as an inpatient some four and a half years ago and the Board was keen to know how the Trust could work with people like Kirsty in the community to implement the improvements she would like to see.

Maura Teager felt Kirsty gave a good account of being an inpatient and wondered if she ever saw things happening on the wards that didn't make sense Kirsty replied that she couldn't understand why nurses congregate and sit at the nurses' station. Rather than have them sitting around they should be walking round the wards and seeing if patients have what they need. She appreciated that sometimes they are completing paperwork but she thought they should be more active around the wards and check on patients behind curtains or sat and watched television with people. She also felt intimidated approaching the nurses' station and that it would be less intimidating if just one nurse was sitting there that you could approach if you needed to talk to someone. Getting to the activities hub was important and engaging in group scrabble games or word searches and doing things as a group helped conversation start to grow.

Ifti Majid asked Kirsty what things have changed over the years? Kirsty replied that the Trust had become extremely "risk conscious". Everything was seen as a risk, even simple things like having a bath. Having more talking therapies would really help.

Carolyn Green thanked Kirsty for telling her story. She could recognise the historical themes and would like to ensure continuous improvement on every point she raised. She confirmed she was in full agreement on therapeutic activity, quiet time, having a therapeutic and caring environment. She assured Kirsty that the Trust will continue to improve and provide patients with fresh air, such as evening or weekend walking groups, which could really help. The Trust had rolled out Safe wards which stimulates group activity and provides calming spaces. Ten research interventions have been introduced in Derby and these aspects would be extended throughout in-patient services. Calm down boxes which are used for massage sessions and relaxation groups and community groups

have been replaced with mutual expectation meetings and one to one discussions are carried out to discover what is working and what isn't working in the drive to create improvements. Self-care and shared care are being introduced to the neighbourhoods which are all models in keeping with Kirsty's feedback on the Trust's services. There is still a lot of work to do and Carolyn Green would like to ask Kirsty to help as there is still a lot of work to be done.

The Chairman thanked Kirsty for sharing her experience with the Board and thanked Kate Heardman for accompanying her. The Board would carry out a reflection of Kirsty's observations and will write to her setting out some recommendations for improvement.

RESOLVED: The Board of Directors expressed thanks to Kirsty for sharing her story and for her observations of the Trust's services.

Impact on our Trust strategy and clinical practice

The lived experience of our in-patient care settings, to gain assurance on our services and how they are experienced.

For the board to listen to the lived experience of how are service are received and consider this in the Boards strategic planning.

The need to consider therapeutic and occupational activity on wards. The experience of individuals whom have a diagnosis of personality disorder the stigma experience of receiving this diagnosis.

The Trust had rolled out Safe wards which stimulates group activity and provides calming spaces. Ten research interventions have been introduced in Derby and these aspects would be extended throughout in-patient services. Calm down boxes which are used for massage sessions and relaxation groups and community groups have been replaced with mutual expectation meetings and one to one discussions are carried out to discover what is working and what isn't working in the drive to create improvements.

The need to develop a community based trauma/ personality disorder service for individuals as an alternative to hospital care.

The need to increase talking therapies across neighbourhoods and within a specialised service

Lack of assurance in the lived experience of in-patient care and the possible risk of unhelpful and harmful episodes of care, with the real potential lack of any added value over and above immediate safety needs.

JANUARY 2016

Service receiver story

Covering Head Nurse at the Hartington Unit, Bev Green, introduced service receiver Phil and Community Drug Worker, Doro Moore who has been working with Phil and his partner Claire (unfortunately Claire could not attend the meeting).

Phil described how he and Claire first came into the Trust's service and how they were originally supported as individuals and then as a family by the substance misuse team. When Phil was first involved with the Trust things did not start very well, he was in a dark place and he felt he received a very one sided experience. Phil explained that he and Claire had a baby girl who unfortunately had a heart problem which was operated on when she was just 10 days old but she very sadly died the following day. Phil and Claire have two other two children who were taken away from them at this point which left them feeling as if their lives had ended.

Phil and Claire had not progressed very well with social services who they felt made judgements against them. Doro Moore, the clinician started working with Phil and Claire and was very understanding and put Phil and Claire in contact with all the services they needed. Doro made appointments for treatment and support for Phil and Claire and set them in the right direction so they now feel quite well. Phil strongly believed that without Doro, he and Claire would not be where they are today as Doro and the substance misuse services took a family approach to their treatment which was so important to them.

Ifti Majid asked Phil if there was anything the Trust could have done better. Phil explained that when you start to work with people who are caring for you it's important to feel comfortable with them. Some people aren't so lucky and have to change support workers or their support worker moves away into other areas and they have to start to build a relationship with someone else. Agency workers only stay for a few months and patients get moved to another person. Phil and Claire refused to change from Doro as they didn't want to start a new relationship with another clinician. They have now been working with Doro for five years and would not want to work with anyone else and although this wasn't the service model, this had been respected by the team and stability in the named worker had been agreed.

Richard Gregory understood Phil's message was that it is important to have a relationship with someone you can trust. Doro Moore explained that she and her team carry out a high and low intensity service which in itself can create problems because some clients are more stable and others have a high dependency on drugs and are passed to other workers. Phil and Claire refused to allow this to happen. Doro also described how nice it was for her to have consistency and see the progress achieved with the people she worked with.

Maura Teager was interested to know how clients could change their care workers if they were unable to establish an effective relationship with them. Doro explained there are various ways of doing this and it is never seen as an issue if clients request a change of key worker. Doro Moore explained that tension between clients and workers can sometime happen due to the nature of boundary setting in substance misuse management and a balance has to be struck of change and continuity.

Richard Gregory felt it took courage for Phil to attend today's meeting and share his story and he hoped Phil's family's progress would continue. Members of the Board offered condolences for Phil's and his partner's loss and thanked Phil for his compelling story and his comments which would serve as a valuable contribution to improving the Trust's services.

RESOLVED: The Board of Directors expressed thanks to Phil for sharing his story and for providing his observations of the Trust's services.

Impact on our Trust strategy and clinical practice

The lived experience of our substance misuse services and the importance of continuity of care, therapeutic relationship and the service model.

The Substance misuse services have been tendered by public health and discussions with regard to the viability of the Trust being able to maintain these services against other competitors who are able to offer a different service model which at times may off public health cost efficiency.

This case presented the strategic case for maintaining the substance misuse services the key alignment of offering a completed care pathway and the ability to offer mental health support to individuals with misuse needs who are very likely to have experienced extensive adverse childhood events leading to substance dependence as a self-treatment model for distress and the clear overlaps of this service in preventing mental illness.

This patient experience story reinforced the need to retain his service in the Trusts portfolio.

FEBRUARY 2016

Profound and multiple learning disabilities

Richard Gregory warmly welcomed Kim, her parents, Derek and Jean, and Sharon Wright, a carer from the home where Kim lives. He also welcomed Katie, her parents, Kay and Clive, and Tonia Simpson carer for Katie. Also in attendance was Debbi Cook, Highly Specialised Clinical Community Physiotherapist, Covering Head Nurse at the Hartington Unit, Kim West, Speech and Language Therapist and Bev Green, Service Improvement/Covering Head Nurse Hartington Unit.

Kim is a lady in her 50s and has profound and multiple learning disabilities (PMLD) as a product of contracting meningitis as a baby. She left home at 21 and went to live in a social services hostel and moved when that closed to Wright Home Care. She still returns home to her parents every weekend who are very involved in her care.

Katie is a young lady of 22, she has PMLD as a result of Rett Syndrome. She also left home aged 21 and went to live at Leigh House. Katie's parents are still very involved in her care and visit often. Katie's story is similar to Kim's, just 30 years behind.

Debbi Cook, Highly Specialised Clinical Community Physiotherapist, referred to the services being run in Southern Derbyshire for people with PMLD. Both ladies have had multiple interventions by the Community Learning Disability Team, particularly Physiotherapy, Occupational Therapy, Nursing and Speech and Language. Many of these interventions have been on-going for a considerable length of time as their needs are so complex and ever changing. She explained that the numbers of people with PMLD are increasing because children are surviving with far greater issues than ever before and are starting to transition through to adult services. The service the Trust provides at the moment for people with complex needs is very good and helps people live healthier for longer in South Derbyshire. The team give a good service but the service needs to prepare for the wave of children brought through to the adult services with PMLD. Debbi Cook stressed the importance of bringing this to the Board's attention as well as commissioners and to realise how many people will be coming through the service in the future.

Richard Gregory asked how the Board could help on a day by day basis. Kim's parents, Jean and Derek felt they are in the prime position of being able to get help for Kim. Access to the team is very important to them and help has been made available for them. The care and comfort people with PMLD need is different for each person. Kim is happy living at Wright Care and with all the other people who live there who all support each other. Kim calls this her home and it gives Jean and Derek great pleasure that Kim wants to live there.

Kay and Clive talked about their daughter Katie who was at school and college until she was 19 and has been living in an independent home for 18 months. They feel the care and service they receive from Debbi Cook and the Learning Disabilities (LD) team is outstanding. They described

how having access to the specialised team and access to the hospital without having to go through their GP means a lot to them. They praised the work of the specialists who work together with the expert team who teach the staff how to look after Katie and this is a great comfort to them. Having the level of knowledge that people are concerned about Katie and know how to look after her is so important to them and they would not have moved Katie to this home if they had not had the certainty that Katie would have had the support of the Trust's service team.

Debbi Cook and the service team raised with the Board that people with PMLD do not have a voice. Debbi Cook further explained how over the coming years there would be further pressure on the service and the Trust should act now to enable capacity.

Richard Gregory and the Board acknowledged that the care described by Katie's and Kim's parents does not exist in various parts of the country or within the NHS. Richard Gregory specifically highlighted one of the messages he was taking away was understanding the needs of carers but also a better transition is required from paediatric into adult services.

Board members were reminded that the Learning Disabilities Showcase event is taking place on 22 March and it is hoped commissioners will attend this event so they can see for themselves what the service is providing and understand what needs to be provided for the future. Ifti Majid assured the team that he was working with commissioners so they can recognise that improvements to this service can't wait. Carolyn Green was closely involved with the Learning Disabilities Showcase event and would be inviting national leaders to attend.

The Board gave thanks to Debbi Cook and the team who provide a very valued service. The Board considered this to be an area of opportunity and strategic change which would be considered within the overall Trust strategy driven forward through the national programme.

RESOLVED: The Board of Directors expressed thanks to Katie and Kim and their families and carers for attending today's meeting and sharing their humbling and heartfelt story.

Impact on our Trust strategy and clinical practice

The lived experience of our Learning disability services and the importance of continuity of care, therapeutic relationship and the service model.

The future changes in the LD workforce and the need to plan for the Trusts experience workforce retiring and the need to develop new banding models to develop the workforce.

The need to plan and monitor the potential changes in the children's population with complex needs graduating into the learning disability service pathways and monitor the referral patterns and plan for future service pressures.

To share this work with commissioners and for the Trust to host a showcase of good practice to the community to take stock of what we are getting wring in the services and with significant change emerging from the Transforming care agenda to consolidate our good practice and stimulate our clinicians through son what we are doing well and where we need to go to improve

The LD teams have often feedback that they sometimes feel the Trust does not understand their service line and there pressure, this board story was to allow the team a platform in addition to the showcase event to demonstrate their practices and be heard.

MARCH 2016

Early Intervention and the internship programme

Richard Gregory and the Board welcomed service receiver Michael who was accompanied by Joanne Downing, Volunteer Manager Occupational Therapist and introduced by Bev Green, Release and Time to Care Lead and Divisional Nurse for the North Campus.

Michael explained that he had been suffering from anxiety and depression and was referred by his GP to the Early Intervention Team. He is well now and has been involved in the Trust's internship scheme since October. Michael is particularly interested in IT and has worked well with the IT team. He has also worked as an administrator for ward managers recording training and qualifications and has carried out other administrative work. Michael described the support and guidance he has received from the internship team as very reassuring. Everyone he has worked with has been very welcoming and helpful. He was particularly impressed with the encouragement he received while working with Peter Charlton and the IT team and he found it extremely rewarding knowing the support he offered benefitted the IT team and other areas within the Trust. Michael also felt working within the internship programme gave him the confidence to learn to drive which has been very beneficial with his daily commute from Chesterfield.

The internship scheme supports people and helps them get back into work. This is a new programme for the Trust and Joanne Downing is supporting Michael through his internship and looking at sourcing external areas for him to move into. She has also helped Michael with ideas for the future and he is hoping to progress to another placement in a technical role and is looking forward to getting back into full time work.

Joanne Downing explained that the internship scheme works alongside the early intervention team and she would like to see the programme expanded as more work needs to be done in house to help and support other service receivers. She would also like to involve other organisations and businesses to help with this initiative. Richard Gregory agreed the internship programme could have more potential and suggested that organisations such as the Princes' Trust and Business in the Community could be approached for support.

Occupational therapy intervention supports Michael and organises his work-based placements and provides him with contacts externally and internally. Each individual coming through the internship scheme has their skills mapped and these are matched with different functions. Michael has been impressed with the structure of the programme which has given him the opportunity to acquire new skills. The programme has also helped him integrate back into society and has given him the opportunity to enjoy mixing with people again and has given him a purpose in life. Essentially the most important thing about the internship scheme has been the people he has worked with who have helped him and made him feel confident to get back into work and he would now like to move onto something more challenging. Richard Gregory recommended to Michael that he should update his CV to mention that he presented his story very articulately and eloquently he would be happy to offer him further support and encouragement.

The Board gave thanks to Michael for agreeing to tell his story and commended the way he presented his experience of the internship programme so articulately which allowed the Board to hear at first hand the service this new initiative provides.

RESOLVED: The Board of Directors expressed thanks to Michael for sharing his inspiring story and appreciated the opportunity to hear at first hand the services the Trust has to offer.

Impact on our Trust strategy and clinical practice

The lived experience of our Early intervention services and the importance of the service model with emerging national changes from the 1st April 2016 in the EI standards and the operating framework, the changes to the model of care, and the service model.

The ability of EI team to intervene and change the trajectory of a person's ill health and start a path to symptom and social recovery.

Assurance on the service model and the links to opportunities for social and occupational recovery.

APRIL 2016

Mr Grundy's group

Richard Gregory welcomed six service users from a group called Mr Grundy's who were accompanied by Senior Occupational Therapist Therese Vecsey and Richard Holford who is a student Occupational Therapist.

Mr Grundy's has been running as a group for over a year as a community facility. Therese Vecsey explained that she became aware that through her assessments that there should be an occupational therapy focus within the recovery teams and there was a need for this type of group to help reduce social isolation. The group takes place on a Wednesday evening in the pub in the centre of Derby from which the group takes its name.

The Board heard how the group was originally set up as a pilot scheme, is now permanent and has links into other groups and activities. There are several members in the group of various age and backgrounds who meet and share their skills and experiences and support each other. Taking part in different activities has encouraged them to progress with other social activities such as bingo, visits to the theatre, art and music classes etc. Friendships have developed between the members who also meet on other evenings. One member appreciated going to the theatre for the first time so much that he is now enjoying attending drama groups. Taking part in Mr Grundy's group gave him confidence and has opened up a brand new world to him.

Members of the Board wondered if this was a model that could be set up in other areas. It was obvious that the success of the group could be attributed to the fact that they meet outside of a hospital environment. Members of Mr Grundy's group thought it should be an essential service as it has been a lifeline for them. It has helped some of them manage their mental health condition more efficiently.

The Board recognised this was a very cost effective model and there were probably other venues in other areas that might be interested in providing space for a similar group. It would be ideal to roll out the ethos of what Mr Grundy's has started across Derbyshire.

Richard Gregory gave thanks to the group for agreeing to tell their story which allowed the Board to hear at first hand the service this initiative provides.

RESOLVED: The Board of Directors expressed thanks to the Mr Grundy's group for sharing their experiences and appreciated the opportunity to hear at first hand the benefits they had received through this initiative.

Impact on our Trust strategy and clinical practice

The lived experience of our Neighbourhood service and the potential to redesign the service to promote social aswell as symptom recovery through social interactions and peer support in a non-stigmatising setting.

The launch of the neighbourhood model and the need to consider the Derbyshire wedge and showcase the opportunities for all neighbourhoods to consider more contemporary model of community mental health practice.

Increasing development of bottom of solutions to the challenge of the neighbourhood model and undertaking community mental health practice from a different perspective. Showcasing personalised recovery orientated practice. Positive reinforcement to service of the board's value of this model, a Trust award winning service. in the Quality account 15/16.

Board promotion of good practice, which was generated after a Quality visit, of a team under significant clinical pressure and challenge that has experience, difficult periods.

MAY 2016

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 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 service the Trust had provided.

Impact on our Trust strategy and clinical practice

The lived experience of in-patient care setting, an example of the North campus and the potential to redesign the service to feedback form a ward that has experienced significant challenges in recruitment, and has required additional support.

To gain assurance on the lived experience and challenged of in-patient care, to highlight the limitations and benefits of dormitory accommodation from a patient experience perspective.

To influence the Trust strategy and planning for the bed stock at the Hartington unit, the long term capital investment needs.

To highlight practices in restrictive practices and in family inclusive practice.

JUNE 2016

The Lighthouse

Carolyn Green introduced Jackie and her son Max who were accompanied by Louise Jenkins, Senior Nurse at the Lighthouse. Jackie very kindly agreed to talk about her experience of the Lighthouse service and described day to day life caring for Max's complex health needs. Max is a pleasure to look after and has a beautiful smile, he was disabled at birth and has a rare form of epilepsy for which he is prescribed medication as well as rescue medication. Max is also non-verbal, he has had a tracheotomy and is fed via gastrostomy, he also has brittle bones and uses a wheelchair.

Max has had several operations and cannot do much for himself and is prescribed considerable medication that needs to be administered correctly. Jackie has three other children and since receiving support from the Lighthouse when Max was eight, Jackie and her family are now managing to live a fuller life and are far happier.

Louise explained that the Lighthouse's main priority is to keep Max safe and provide family respite. He has complex needs which are quite difficult to manage. To stabilise Max's care Louise set up training sessions for all the staff to learn how to meet Max's needs and this has provided Jackie and her family with comfort knowing that Max and other children like him can receive respite care which enables families to spend time together to function normally. Max is always happy at the Lighthouse and has access to sensory rooms and fun equipment.

Carolyn Green asked Jackie what improvements in the support and care for Max she and her family could have received. Jackie wished Max could have accessed the Lighthouse at a much earlier age as caring for him has been very difficult. Staff at the Lighthouse know Max very well and Louise makes sure that any new staff are trained to care for his needs. Jackie suggested that photographs showing how Max likes to sleep or sit could be used as useful guidance to staff who care for children like Max. Carolyn Green pledged to supply the Lighthouse with a camera so photographs can used to inform staff of not just Max's needs, but those of other children in the Lighthouse's care as a patient safety improvement under the Trust's innovation network.

The Board asked to know more about staff training for children with such complex needs. Louise described the enormous element of care involved looking after children like Max and stressed that the complex needs of these children is ever increasing. Tracheotomy and rhesus training is something that needs to be looked at to enable the right level of training to be continuous with the staff who join the Lighthouse team on an ongoing basis. Training has been concentrated on nursing staff and Louise has set up a system to ensure staff undergo training so they are compliant, but she has noticed there has been reluctance / as well as skills competence and the ability to retain this skill set from social care staff to take on training within their roles. Louise was keen for the training packages to be completed and ratified and Carolyn Green suggested that Louise be invited to attend the Physical Care Committee which would help and support her in her endeavours.

The Board considered Jackie's story to be truly inspirational and felt gratified to hear how Louise and the Lighthouse team cared for Max had responded to Jackie's and her family's needs.

ACTION: Bev Green and Carolyn Green to arrange for a camera to be provided for use at the Lighthouse through the Trust innovation network.

RESOLVED: The Board of Directors expressed thanks to Jackie for sharing her experience and appreciated the opportunity to hear at first hand the service the Trust had provided.

Impact on our Trust strategy and clinical practice

The lived experience and family experience of our Children's services an example of the City service and the voice of the child and family in our service.

The trust has been challenged historically by commissioners and other services that the Trust is a mental health trust and that the children's services are not a key part of its service offering.

on its commitment to children's services

This story really showcased the impact on having integrated health and mental health services , the family support the Trust can offer, the positive impact on respite services and the need for the Trust to be psychologically minded in its operation of the children's services in the needs of the individual and the family

Good practice was evidence and some practical and helpful service improvements were agrees, funded by the board to promote clinical solutions and innovations.

The Trust innovation network, offered funding for the equipment and the board were assured and all touched by the impact of our staff on this family.

The staff were engaged into the physical healthcare committee to promote trust wide learning on the good practices they had put into place.

JULY 2016

Dementia and the Dovedale Day Hospital

Bev Green, Releasing Time to Care Lead, introduced Mr and Mrs S who kindly agreed to talk to the Board about their recent experience of care received from the Trust.

Mr and Mrs S described the difficulties they experienced when Mr S was diagnosed with early vascular dementia and the devastating affect this had on them. Mrs S went on to describe how hard it had been caring for her husband, given his significant memory loss.

Life was a struggle for the couple until they were put in touch with the right people who could offer support which eventually enabled Mr S to attend open sessions at the Dovedale Day Hospital. During these visits staff undertook therapy and taught him exercises which kept his brain active. He was also encouraged to look at photographs, and learnt how to keep a book about his life which he can refer to and this has been a tremendous help to him. These activities helped rebuild his confidence so much so that he was able to get back to doing things he enjoys such as reading again. The open sessions at the Dovedale Hospital also allowed Mr and Mrs S to learn about dementia and they also received support from experts who have taught them how to cope so they can continue to live an independent life together.

The couple also attended question and answer sessions at Oaklands Village in Swadlincote and due to the activities and therapy he received from the Dovedale Day Hospital Mr S felt able to contribute to discussions. Mr S has also been invited to the Trust's Living Well sessions to talk to recently diagnosed patients about his own experience and the activities that have helped him and these have been very well received. Mr and Mrs S were very positive about the support they have received from the Trust's mental health team and felt they were lucky to live in an area where support has been available to them.

In response to the couple's account, Richard Gregory said that listening to this story had shown there is a clear need for more facilities to help people suffering with dementia, their carers and their family. He felt Mr and Mrs S's story will help influence decisions made by the caring and dedicated mental health teams working with families in the community. He hoped that in future the Trust can work more effectively and help people to access the help they need and he looked forward to holding discussions with the Board at subsequent meetings to establish how this service has developed since their story was told.

ACTION: Hayley Darn will discuss how service receiver stories can be carried forward in future Board meetings with Carolyn Green.

RESOLVED: The Board of Directors expressed thanks to Mr and Mrs S for sharing their experience and appreciated the opportunity to hear at first hand the service the Trust had provided.

Impact on our Trust strategy and clinical practice

The lived experience and family experience of our Older adults service and showcasing the lived experience and our need to put in place our newly redesigned Dementia strategy and measure progress through the quality committee

The impact on moving from a traditional day hospital model to a self-care shared care cotemporary model of practice in line with the Trust strategy and the need to embed Trust's Living Well sessions, and recovery and living well education into mainstream practice. This should increase across the organisation and model therapeutic activities across services that promote independence and model the retention of skills in line with the Dementia strategy

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Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 5th October 2016

Governance Improvement Action Plan

Purpose of Report

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

Therefore, the purpose of this paper is as follows;

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

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

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

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

5. To discuss the preliminary recommendations provided by Deloitte following their review of the robustness of GIAP project management and assurance structures.

Executive Summary

This paper provides the Board with an update on the progress of delivering the GIAP and preliminary recommendations from Deloitte's recent review of the Trust's GIAP project management and assurance structures.

An amended Board summary GIAP table focused on recommendations, rather than specific tasks, and a slightly more detailed GIAP report (attached as an appendix to this report) have been provided as part of this paper, giving Board members a more detailed overview of performance against key tasks and the overall recommendations in each core area.

There have been a number of changes in the RAG rating of some tasks and subsequently this has resulted in a number of Board RAG ratings for the overall recommendations also changing. The current status of all 53 recommendations is provided in the table below.

Core	Number of Recommendations	Off Track	Some Issues	On track	Completed
Core 1 - HR and associated Functions	5	0	0	4	1
Core 2 - People and Culture	6	0	1	4	1
Core 3 - Clinical Governance	3	0	2	1	0
Core 4 - Corporate Governance	13	2	0	10	1

Core 5 - Council of Governors	3	0	0	3	0
Core 6 - Roles and Responsibilities of Board Members	5	1	3	1	0
Core 7 - HR and OD	8	2	1	5	0
Core 8 - Raising concerns at work	1	0	0	1	0
Core 9 - Fit and Proper	1	0	0	1	0
Core 10 - CQC	2	1	0	1	0
Core 11 - NHS improvement undertakings	6	0	0	3	3
Total	53	6	7	34	6

The core areas and associated recommendations which have changed since last month are set out below under the headings below.

Improvement from last month

Core area 2 – People and Culture (PC2) Board assurance rating improved from 'Off track' to 'On track' following scrutiny of a report provided at September's People and Culture Committee.

Deterioration from last month

Core area 3 – Clinical Governance (ClinG1 and 3) Board assurance rating moving from 'On track' to 'Some Issues' following discussion of the GIAP tasks at September's Quality Committee.

Core area 6 – Roles and Responsibilities of Board members (RR1, 2, 3 and 5) Board assurance ratings moving from 'On track' to 'Off track' for RR1 and 'Some issues' for RR2, 3 and 5.

Core area 10 – CQC (CQC 2) Board assurance rating moving from 'On track' to Off track' following discussion of a recruitment plan update at September's People and Culture Committee.

The body of the report provides more detail on all recommendations that are currently rated as 'off track' or 'some issues'

Board members should note that Audit and Risk and Remuneration Committees have not met since the last Board meeting and therefore the recommendations that they have oversight for have not been formally reviewed.

In addition, due to issues regarding data provision for GIAP KPI's these are not available this month.

Strategic considerations

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

(Board) 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 NHSI enforcement action and associated license undertakings

Equality Delivery System

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

Recommendations

The Board of Directors is asked to;

1. Note the progress made against GIAP
2. Discuss the areas rated as 'off track' and 'some issues', seeking assurance where necessary on the mitigation provided
3. Discuss Deloitte's preliminary recommendations and agree to the suggested 6 month review of GIAP set out in this paper
4. Agree at the end of the Pubic Board meeting whether any further changes are required to the GIAP following presentation of papers, outcomes of item specific discussions and/or other assurances provided throughout the meeting

Report presented by: Mark Powell (Director of Strategic Development)

Report prepared by: Mark Powell (Director of Strategic Development)

1. Introduction

An amended Board summary GIAP table focused on recommendations, rather than specific tasks, and a slightly more detailed GIAP report (attached as an appendix to this report) have been provided as part of this paper, giving Board members a more detailed overview of performance against key tasks and the overall recommendations in each core area.

2. Summary Report

There have been a number of changes in the RAG rating of some tasks and subsequently this has resulted in a number of Board RAG ratings for the overall recommendations also changing. The current status of all 53 recommendations is provided in the table below.

Core	Number of Recommendations	Off Track	Some Issues	On track	Completed
Core 1 - HR and associated Functions	5	0	0	4	1
Core 2 - People and Culture	6	0	1	4	1
Core 3 - Clinical Governance	3	0	2	1	0
Core 4 - Corporate Governance	13	2	0	10	1
Core 5 - Council of Governors	3	0	0	3	0
Core 6 - Roles and Responsibilities of Board Members	5	1	3	1	0
Core 7 - HR and OD	8	2	1	5	0
Core 8 - Raising concerns at work	1	0	0	1	0
Core 9 - Fit and Proper	1	0	0	1	0
Core 10 - CQC	2	1	0	1	0
Core 11 - NHS improvement undertakings	6	0	0	3	3
Total	53	6	7	34	6

2.1 Red Rated ‘Off Track’ recommendations

There are 6 recommendations rated as Red as detailed in the table below.

Board members should be assured that each of these will be discussed in detail at the respective Board committee, with Committee members expected to seek assurance on the mitigations that are put forward.

Core Area	Recommendation	Action(s)	Mitigation
Core 4 - Corporate Governance	CorpG7 - In light of the changing governance and accountability structures (such as neighbourhoods, campuses and QLTs), an accountability framework should be designed to fully engage staff in how these changes will affect ways of working, performance management structures and desired behaviours moving forward	1. Aligned to the Corporate Governance Framework develop and approve an organisational accountability framework 2. Develop and fully engage senior staff in an accountability framework	The responsibility for developing an organisational accountability framework sits with ELT. ELT will be discussing a draft framework on the 22nd August. It is expected that the outcome of this discussion will inform a wider debate with the senior leadership team for any further adaptations to it. It is expected to be agreed and implemented by the end of October 2016.
	CorpG9 - Formalise the role of PCOG as a key forum in the Trust's governance structure	1. As part of the Governance Framework review the Trust will formalise the role of PCOG 2. Clarifying the role of PCOG in light of the move to neighbourhoods and campuses	See above
Core 6 - Roles and Responsibilities of Board Members	RR1 - Implement proposals to improve succession planning at Board level, including ensuring that Governors are adequately engaged in this process. Alongside this, develop processes for succession planning for Senior Leader positions	1) Develop and approve Board level, key divisional and corporate leaders succession plan	Mitigation plan to be discussed and agreed at October's Remuneration Committee
Core 7 - HR and OD	WOD3 - Address the relationship issues identified within the function, and alongside this agree a development programme for HR and its related functions that starts by building relationships at a senior level before seeking to develop an effective and efficient function	1) Develop and implement a HR and related function Development programme, which includes building good working relationships	This will be a key objective of the new Director for Workforce, OD and Culture
	WOD 6 - Consider mechanisms to regularly seek feedback from the HR function on the extent to which the	1) Implement Integrated Team meeting	Director of Workforce, HR and OD has led 1 full integrated team meeting during September

	candour, openness, honesty, transparency and challenge to poor performance are the norm, e.g. through monthly pulse checks		
Core 10 - CQC	CQC 2 - The trust should continue to proactively recruit staff to fill operational vacancies	1) Implement the recruitment plan and monitor effectiveness against an agreed vacancy rate trajectory	People and Culture requested revised recruitment plan at its next meeting to seek assurance that a challenging trajectory can be delivered

2.2 Amber rated 'some issues' rated recommendations

There are 7 recommendations rated as Amber as detailed below.

Core Area	Recommendation	Action(s)	Mitigation
Core 2 - People and Culture	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. Relaunch revised values across the Trust.	1. HR and OD to undertake a refresh of the behavioural framework	It has been agreed that the NHS Employees framework will be adopted, using focus groups with staff to implement. This will be delivered between September and December 2016
Core 3 - Clinical Governance	ClinG1 - Refresh the role of Quality Leadership Teams to increase their effectiveness as core quality governance forums	1) Agree and implement a QLT forward plan process to ensure all required papers are received at each meeting 2) Develop and implement a standard escalation template to be used by QLT's 3) For a 6 month period Don and MD to attend QLTs to provide coaching and oversight of meeting effectiveness	QC requested that in order to address the issues that QLT chairs were required to attend QC, QLT's should provide minutes and escalations via the agreed escalation template and that the wider issue of QLT effectiveness be incorporated as part of the Trust wide accountability framework which is set for agreement by the end of October
	ClinG3 - Increase the effectiveness of the	1) Ensure that Quality Committee	QC agreed that there needed to be more focus

	Quality Committee by ensuring clear alignment of the committee with the quality strategy and associated objectives, and ensuring a clear focus on seeking assurance	agenda is structured so that it focuses on topics to deliver quality strategy and goals	on revising the agenda template to confirm how papers supported delivery of the Trust strategy, in ensuring completion of actions and having a clear forward plan
Core 6 - Roles and Responsibilities of Board Members	RR2 - 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	1) 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.	Board development programme to be reviewed in light of new Board recruits and priorities and challenges for the Trust
	RR3 - Complete the full process of 360 feedback for all BMs and utilise the outcome to set clear objectives in relation to portfolio areas (for EDs) as well as in relation to the role of the corporate director and contribution to the Board	1) Implement 360 degree feedback for all BM's	Mitigation plan to be discussed and agreed at October's Remuneration Committee
	RR5 - The trust should ensure that training passports for directors reflect development required for their corporate roles	1) Provide BM and NED training update reports to Rem Com to demonstrate completion in line with mandatory and CPD requirements	This report is delayed, but will be provided to November's Remuneration Committee
Core 7 - HR and OD	WOD7 - The trust should monitor the adherence to the grievance, disciplinary, whistle-blowing policies and the current backlog of cases concluded.	1) Ensure the backlog of cases made known to the CQC at the time of the inspection are concluded	Progress continues to made resolving all cases in line with Trust policy

3. External Assurance of Board GIAP project management and assurance

As part of the agreed external assurance process for the delivery of GIAP, the Board commissioned Deloitte to undertake a review of the robustness of GIAP project management and assurance structures in place to understand the extent to which progress is being made and reported to the Board and its Committees.

Since the last meeting of the Board the Trust has received the preliminary findings from Deloitte regarding their review of the robustness of GIAP project management and assurance structures.

Overall the summary findings from Deloitte are contained within the following 8 recommendations.

R1: Ensure that the GIAP provides a full and accurate representation of action progress to reflect the BRAG rating provided. This is particularly important where an action is recorded as complete.

R2: There is a need to ensure that oversight of the ratings of tasks and recommendations considers both actions which are due, as well as ensuring that longer term actions are on track.

R3: Ensure that the progress column in the GIAP is kept up to date to fully document the current position.

R4: As part of the introduction of the blue form, revisit all blue rated recommendations to ensure that there is sufficient evidence to support this rating. As part of this process also review a sample of blue rated tasks to confirm that these are fairly stated.

R5: Aligned to the role of the corporate director, ensure that all BMs contribute to the debate around progress, assurance and any risks identified.

R6: Continue to develop committee escalations to the Board in relation to the GIAP to ensure that assurances received and risks identified are consistently reported.

R7: As part of the review of progress against actions outlined in the GIAP, ensure that there is consideration of the broader, more qualitative aspects, outlined in the initial recommendation.

R8: The Board should agree and define how recommendations are transitioned to business as usual as actions are implemented. We would envisage that this should be on a risk based approach with greater levels of assurance and scrutiny applied as required.

Deloitte's summary findings need to be considered by Board members, with consideration and agreement as to how these are taken forward.

The Executive Team has recently been discussing the current status of GIAP delivery and was considering a full review of all aspects of the GIAP given that the Trust is now 6 months into delivering this extensive programme of work and because of changes in personnel across the whole Board. It now seems opportune that following Deloitte's recommendations and the aforementioned Executive discussions that a full review of GIAP is implemented.

It is proposed that this is facilitated through current corporate governance structures, with Board Committees thoroughly reviewing each recommendation that they have oversight for. In last month's GIAP report the following reporting arrangements were approved and it is therefore suggested that the proposed full review process uses this framework.

Core	Committee	Lead Director
Core 1 - HR and associated Functions	People and Culture	Director of HR, OD and Culture
Core 2 - People and Culture	People and Culture	Director of HR, OD and Culture
Core 3 - Clinical Governance	Quality	Director of Nursing
Core 4 - Corporate Governance	Audit	Director of Corporate Affairs
Core 5 - Council of Governors	Council of Governors	Director of Corporate Affairs
Core 6 - Roles and Responsibilities of Board Members	Remuneration Committee	Acting Chief Executive
Core 7 - HR and OD	People and Culture	Director of HR, OD and Culture
Core 8 - Raising concerns at work	People and Culture	Director of Corporate Affairs
Core 9 - Fit and Proper	Remuneration Committee	Director of Corporate Affairs
Core 10 - CQC	People and Culture	Acting Director of Operations
Core 11 - NHS improvement undertakings	Board of Directors	Director of Strategic Development

	Issue Raised/ Action	Key Tasks	Progress Rag Rating	Owner	Responsible Committee	Board Assurance Rag Rating
	CORE 1- REUNIFICATION OF THE HR AND ASSOCIATED FUNCTIONS					
HR1	The HR and OD departments should be under the management of one Executive Director	1) Recruitment of Director of Workforce, OD and culture	**Completed**	Acting Chief Executive	Rem Com	Complete
		2) Job Description approved at Rem Com	**Completed**	Acting Chief Executive	Rem Com	
		3) Inform staff effected by the change	**Completed**	Acting Chief Executive	Rem Com	
		4) Formal recruitment to the post	**Completed**	Acting Chief Executive	Rem Com	
		5) Communicate the change to affected departments	**Completed**	Director of Workforce, OD and Culture	Rem Com	
		6) Communicate the change to the organisation	**Completed**	Acting Chief Executive	Rem Com	
HR2	Ensure external resources for the newly appointed Director of Workforce, OD and Culture are obtained in order to drive the transformation of HR and related functions through a combination of coaching, buddying, and mentoring support.	1) Develop and agree a plan which identifies additional resources to ensure successful delivery of HR, Workforce and OD GIAP actions	**Completed**	Director of Workforce, OD and Culture	People and Culture Committee	**On Track**
		2) Deliver the Resource Plan	**Completed**	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.	1) In consultation with the team develop and deliver the new model for HR	**Completed**	Director of Workforce, OD and Culture	People and Culture Committee	**On Track**
HR4	Define a new structure for HR and its related functions with a priority on operational efficiency and strategic impact taking into account the refreshed People Strategy and revised model for HR and related functions.	1) Develop and implement a new structure for HR and its related functions with a priority on operational efficiency and strategic impact	**Completed**	Director of Workforce, OD and Culture	People and Culture Committee	**On 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.	1) Develop a suite of metrics to measure impact of interventions at an organisation and service line level	**Completed**	Director of Workforce, OD and Culture	People and Culture Committee	**On Track**
		2) Develop an internal suite of metrics to measure functional effectiveness	**Completed**	Director of Workforce, OD and Culture	People and Culture Committee	
	CORE 2- PEOPLE AND CULTURE					
PC1	The Trust should adopt an Organisational Development and Workforce Committee	1) Terms of Reference Developed	**Completed**	Director of Workforce, OD and Culture	People and Culture Committee	On Track
		2) Terms of Reference approved by Board	**Completed**			
		3) First Committee meeting	**Completed**			

	Issue Raised/ Action	Key Tasks	Progress Rag Rating	Owner	Responsible Committee	Board Assurance Rag Rating
PC2	Develop and undertake a clear programme of work around culture, utilising the expertise of other NHS Trusts in the LHE, and where necessary beyond, to inform the programme of activities.	1) Develop a programme of work against the delivery of the people strategy	Completed	Director of Workforce, OD and Culture	People and Culture Committee	On Track
		2) Develop a clear plan which outlines an on-going focus on pulse surveys to enable targeted activity	On Track	Director of Workforce, OD and Culture		
		3) Based on Pulse Checks develop a focused coaching within teams	Off Track	Director of Workforce, OD and Culture		
		4) Implement events focused on staff health and well-being	Completed	Director of Workforce, OD and Culture		
		5) Ensure there is an agreed approach to extensively share good practice and innovation	Completed	Director of Workforce, OD and Culture		
		6) Develop and implement a leadership development programme	Off Track	Director of Workforce, OD and Culture		
PC3	Supplement the current mechanisms to engage with staff through the inclusion of more informal activities across both clinical and corporate areas. Develop clearer reporting of information and trends from these activities in order to triangulate with other information, for example, through the CEO report and Quality Position Statement.	1) Develop a comprehensive internal Comms plan, which clearly articulates engagement approaches both formal and informal	Completed	Director of Corporate Affairs	People and Culture Committee	On Track
		2) Develop a clear system to record feedback received from staff	Completed	Director of Corporate Affairs	People and Culture Committee	

	Issue Raised/ Action	Key Tasks	Progress Rag Rating	Owner	Responsible Committee	Board Assurance Rag Rating
PC4	Prioritise the development of the People Strategy and ensure the agenda and focus of the newly formed People and Culture Committee is clearly aligned the Trust's overall strategy.	1) Refresh People Strategy including reporting metrics	Completed	Director of Workforce, OD and Culture	People and Culture Committee	On Track
		2) Ensure the people Strategy places greater emphasis at divisional and service lines to support our leaders to deliver the strategic objectives	Completed	Director of Workforce, OD and Culture	People and Culture Committee	
PC5	Undertake an exercise to refresh the Trust values. As part of this exercise engage with staff to ensure that values are meaningful and expected behaviours are clear. Relaunch revised values across the Trust.	1) HR and OD to undertake a review of the Trust values	Completed	Director of Workforce, OD and Culture	People and Culture Committee	Some Issues
		2) Set a programme of engagement with staff to consultant on the refresh of the values	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	Completed	Director of Workforce, OD and Culture	People and Culture Committee	
		4) HR and OD to undertake a refresh of the behavioural framework	Off 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.	1) Chairman and CEO reports to include information about stakeholder engagement and feedback from commissioners	Completed	Acting Chief Executive	Board of Directors	Complete
		2) Chairman to provide updates to Board from Council of Governors	Completed	Acting Chief Executive	Board of Directors	
	CORE 3 CLINICAL GOVERNANCE					
ClinG1	Refresh the role of Quality Leadership Teams to increase their effectiveness as core quality governance forums.	1) Agree and implement a QLT forward plan process to ensure all required papers are received at each meeting	Some issues	Director of Nursing	Quality Committee	Some issues
		2) Develop and implement a standard escalation template to be used by QLT's	Some issues	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	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.	Some issues	Director of Nursing	Quality Committee	
ClinG2	The Trust would benefit from a robust and thorough policy review programme.	1) Undertake a review of Trust policies in order to; a)Revise the number of policies; b) update to ensure for plain English; c) ensure consistency and clarity in how policies are presented , e.g. managers guide, policy or procedure.	On Track	Director of Nursing	Audit and Risk Committee	On Track
ClinG3	Increase the effectiveness of the Quality Committee by ensuring clear alignment of the committee with the quality strategy and associated objectives, and ensuring a clear focus on seeking assurance.	1) Board Development to focus on NED challenge of overdue actions and reports (see RR2)	Completed	Director of Corporate Affairs	Board of Directors	Some issues
		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	Completed	Director of Corporate Affairs	Audit and Risk Committee	
		3) Introduce a Quality Governance Group that will report to Quality Committee	Completed	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.	Some issues	Director of Nursing	Quality Committee	
	CORE 4; CORPORATE GOVERNANCE					
CorpG1	The Trust should consider how its governance arrangements could better match its strategy and plans.	1) Develop and approve a Corporate Governance Framework which supports the delivery of the Trust strategy ensuring that the Board of Directors and Board Committee agendas adequately reflect the strategic objectives of the Trust	Completed	Director of Corporate Affairs	Board of Directors	On Track
CorpG2	The Governance Framework should be updated to give greater clarity regarding roles of key individuals and governance forums, including: all EDs, the SID and Vice Chair, PCOG, QLTs and the Safeguarding Committee.	1) Develop and approve a Corporate Governance Framework	Completed	Director of Corporate Affairs	Board of Directors	On Track
CorpG3	The Board and its committees need to have a greater focus on capturing, recording and holding to account for agreed actions.	1) Board Development programme to be updated to include a session on holding to account which will include holding to account for agreed actions.	Completed	Director of Corporate Affairs	Audit and Risk Committee	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	Completed	Director of Corporate Affairs	Audit and Risk Committee	
	Review the operation of all committees seeking to minimise duplication, revising membership, ensuring a focus on capturing and tracking actions, and increasing contribution to the debate. -a review of forward plans against ToR to ensure clarity of purpose; -minimise duplication of papers; -committee chairs should also meet quarterly to ensure effective co-working; -ensure robust attendance of all key EDs at committee meetings; -ensure a consistent focus on summarising debate and capturing actions. (feedback on this should be sought in annual effectiveness reviews); -review appropriateness of membership and provide a focus on members and attendees contributing equitably and effectively; and -timely submission of papers and consistent use over cover sheets	1) Undertake a comprehensive review of the Board Committee structures including TOR	Completed	Director of Corporate Affairs	Audit and Risk Committee	

	Issue Raised/ Action	Key Tasks	Progress Rag Rating	Owner	Responsible Committee	Board Assurance Rag Rating
CorpG4		2) Arrange for Committee Chairs to meet on a quarterly basis	Completed	Director of Corporate Affairs	Audit and Risk Committee	On Track
		3) Review ED attendance at Committees	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	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	Completed	Director of Corporate Affairs	Audit and Risk Committee	
CorpG5	Undertake a review of the Finance and Performance Committee outlined below -a review of forward plans against ToR to ensure clarity of purpose; -minimise duplication of papers; -committee chairs should also meet quarterly to ensure effective co-working; -ensure robust attendance of all key EDs at committee meetings; -ensure a consistent focus on summarising debate and capturing actions. (feedback on this should be sought in annual effectiveness reviews); -review appropriateness of membership and provide a focus on members and attendees contributing equitably and effectively; and -timely submission of papers and consistent use over cover sheets	1)Undertake a comprehensive review of the Committee aligned to the TOR of the Committee	Completed	Director of Corporate Affairs	Audit and Risk Committee	On Track
		2) Finance and Performance Forward Plan approved by F&P	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	Completed	Director of Corporate Affairs	Audit and Risk Committee	
CorpG6	The Audit Committee should reaffirm its role in seeking assurance over systems, controls and processes and not matters of operational or managerial detail.	1) Ensure processes are in place for Audit Committee to undertake a review of its effectiveness	Completed	Director of Corporate Affairs	Audit and Risk Committee	On Track
		2) Review reporting and monitoring process to ensure Audit Committee is receiving required assurance on systems, controls and processes	Completed	Director of Corporate Affairs	Audit and Risk Committee	
		3) Review Audit committee TOR in line with best practice from across the NHS	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.	1) Aligned to the Corporate Governance Framework develop and approve an organisational accountability framework	Off Track	Director of Operations	Audit and Risk Committee	Off Track
		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.	Off Track	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	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.	Completed	Director of Operations	Board of Directors	On Track
CorpG9	Formalise the role of PCOG as a key forum in the Trust's governance structure	1) As part of the Governance Framework review the Trust will formalise the role of PCOG	Off Track	Director of Operations	Audit and Risk Committee	Off Track
		2) Increasing ED attendance at PCOG	On Track	Director of Operations	Audit and Risk Committee	
		3) Improving the quality of minutes and action trackers and the timeliness of papers to this forum.	Completed	Director of Operations	Audit and Risk Committee	
		4) Clarifying the role of PCOG in light of the move to neighbourhoods and campuses	Off Track	Director of Operations	Audit and Risk Committee	
CorpG10	Further improve the function of the ELT by improving the timeliness of papers and quality of debate.	1) Ensure ELT agenda focuses on agreed key priorities and items appropriately escalated through the Governance Structures. Agenda and papers will be circulated on a Thursday	Completed	Acting Chief Executive	Board of Directors	Complete
CorpG11	The Board needs to address the quality of debate and dialogue, focussing on increasing contributions across all BMs, displaying greater leadership and vision, ensuring an appropriate balance between strategic and operational debate, and pushing for increased momentum around key issues.	1) Ensure a Board development programme which is linked to the Trust Strategy	Completed	Director of Corporate Affairs	Board of Directors	On Track
		2) Ensure all Board Members have completed 360 appraisals which focus on development	On Track	Director of Workforce, OD and Culture	Rem Com/ Nominations and Remuneration Committee (CoG)	
		3) Ensure that there is the appropriate balance of strategic and operational items on the Board Agenda	Completed	Director of Corporate Affairs	Board of Directors	

	Issue Raised/ Action	Key Tasks	Progress Rag Rating	Owner	Responsible Committee	Board Assurance Rag Rating
CorpG12	Reintroduce short summary reports from committee chairs to the Board to supplement minutes. These should identify key risks, successes and decisions made / escalated from the meeting.	1) Reintroduce short summary reports from committee chairs to the Board which identify key risks, successes and decisions made / escalated from the meeting.	Completed	Director of Corporate Affairs	Audit and Risk Committee	On Track
CorpG13	The Board should re-establish the Board Assurance Framework as one for all risks including risks which it is involved in and when that risk has an element of confidentiality how it is handled. It should write and implement a plan for BoD development which includes these objectives.	Develop and Agree BAF 16/17	Completed	Director of Corporate Affairs	Audit and Risk Committee	On Track
		Schedule BAF Deep dive reviews for Board Committees	Completed	Director of Corporate Affairs		
CORE 5- COUNCIL OF GOVERNORS						
CoG1	The relationship between the BoD and the CoG is poor. Both parties should adopt a conciliatory approach rather than continuing with the antagonism which inflicts the current relationship.	1) The Board and Council of governors will co-write a policy on how the Board and council of governors will work in partnership	Some Issues	Director of Corporate Affairs	Board of Directors & Council of Governors	On Track
		2) The Trust will expand the role of lead governor to ensure greater collaborative working with the Chairman and SID	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	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	Completed	Director of Corporate Affairs	Board of Directors & Council of Governors	
		5) Implement a Code of Conduct for all Governors	Completed	Director of Corporate Affairs	Board of Directors & Council of Governors	
CoG2	**Deloitte 12** - Formal training should be required for all current members of the CoG and to future members as they join. This training should include the role of the Governors, the context of organisational governance and the personal conduct expected of Governors. **CQC 3** - The trust should ensure that all board members and the council of governors undertake a robust development plan	1) Develop a new induction programme for the Council of Governors and roll out its delivery	Completed	Director of Corporate Affairs	Council of Governors	
		2) Develop a CoG development plan for 2016/17 to include Governwell and other external training	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	Completed	Director of Corporate Affairs	Council of Governors	
CoG3	Prioritise the recruitment to the Council of Governors, ensuring that the role of the governor and vacancies are publicised.	1) Chairman will engage stakeholders to ensure representation on the Council of Governors	Completed	Director of Corporate Affairs	Council of Governors	
		2) Hold Governor elections	Completed	Director of Corporate Affairs	Council of Governors	
	CORE 6- ROLE AND RESPONSIBILITIES OF BOARD MEMBERS					
RR1	Implement proposals to improve succession planning at Board level, including ensuring that Governors are adequately engaged in this process. Alongside this, develop processes for succession planning for Senior Leader positions	1) Develop and approve Board level, key divisional and corporate leaders succession plan	Off Track	Director of Workforce, OD and Culture	Rem Com	Off Track
		2) Implement and embed succession plan	On Track	Director of Workforce, OD and Culture	Rem Com	
RR2	**Deloitte 5** - Agree a programme of Board development work which includes a mix of internal and externally facilitated sessions, is clearly aligned to the combined governance action plan. the Board development plan should consider: •more detailed consideration of the governance action plan; •a focus on Board challenge, including assurance, reassurance and the role of the corporate director; •facilitated 360 feedback; •Board cohesion and dynamics; •use of external speakers to add insight and prompt debate; •joint sessions governors ; and •engagement from senior Trust leaders. **CQC 3** - The trust should ensure that all board members and the council of governors undertake a robust development plan (Link to CG2)	1) Develop a Board Development plan for 2016/17	Completed	Director of Corporate Affairs	Board of Directors	Some Issues
		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.	Some Issues	Director of Corporate Affairs	Board of Directors	
RR3	**Deloitte 6** - Complete the full process of 360 feedback for all BMs and utilise the outcome to set clear objectives in relation to portfolio areas (for EDs) as well as in relation to the role of the corporate director and contribution to the Board. **CQC 8** - The trust should introduce and effectively monitor 360 degree feedback all senior managers and directors.	1) Develop a 360 feedback process for BM's with forms and expectations on what and how to feedback	Completed	Director of Workforce, OD and Culture	Rem Com/ Nominations and Remuneration Committee (CoG)	Some Issues
		2) Implement 360 degree feedback for all BM's	Some Issues	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	On Track	Director of Workforce, OD and Culture	Rem Com/ Nominations and Remuneration Committee (CoG)	
		4) Implement 360 degree feedback for all senior managers	On Track	Director of Workforce, OD and Culture	Rem Com	

	Issue Raised/ Action	Key Tasks	Progress Rag Rating	Owner	Responsible Committee	Board Assurance Rag Rating
		5) Integrate 360 feedback into senior manager appraisal objectives and personal development goals	On Track	Director of Workforce, OD and Culture	Rem Com	
RR4	Implement a programme of Executive Team development which focuses on team dynamics, effective challenge and leadership and is supported by individual coaching where necessary.	1) Develop and agree Executive Team development programme which will include; team dynamics and agreed ways of working; •clarity of purpose and vision; •effective challenge and leadership; and •individual coaching.	Completed	Acting Chief Executive	Rem Com	On Track
		2) Implement development programme and monitor effectiveness through 360 feedback	On Track	Acting Chief Executive	Rem Com	
RR5	The trust should ensure that training passports for directors reflect development required for their corporate roles.	1) Training requirement for all ED's and NEDS are agreed by CEO and Chair, with passports updated accordingly	On Track	Acting Chief Executive / Chairman	Rem Com	Some issues
		2) Developmental training requirements are discussed and agreed with Board members in their Appraisals	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	Some issues	Acting Chief Executive / Chairman	Rem Com	
CORE 7- HR AND OD						
WOD1	**DR34**- Define and agree a process to regularly monitor the consistent application of HR policies and procedures for the full range of Employee Relations cases. **CQC 1** - The trust must ensure HR policies and procedures are followed and monitored for all staff	1) To undertake a review of HR policies and procedures to ensure all are in date and are compliant with expected HR practice	On Track	Director of Workforce, OD and Culture	People and Culture Committee	On Track
		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	Completed	Director of Workforce, OD and Culture	People and Culture Committee	
		3) A training programme on HR policies and process is designed, available and accessible	On Track	Director of Workforce, OD and Culture	People and Culture Committee	
		4) HR function to Audit compliance against two selected HR policies	Completed	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	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	1) Review and ensure that Trust recruitment and acting up policies are fit for purpose	Completed	Director of Workforce, OD and Culture	People and Culture Committee	On Track
		2) Agree a plan and deliver recruitment training to all appointing officers	On Track	Director of Workforce, OD and Culture	People and Culture Committee	
		3) Deliver a peer audit of recruitment policies compliance to demonstrate improvement	On Track	Director of Workforce, OD and Culture	People and Culture Committee	
WOD3	Address the relationship issues identified within the function, and alongside this agree a development programme for HR and its related functions that starts by building relationships at a senior level before seeking to develop an effective and efficient function.	1) Develop and implement a HR and related function Development programme, which includes building good working relationships	Completed	Director of Workforce, OD and Culture	People and Culture Committee	Off Track
		2) Implement Development Programme	Completed	Director of Workforce, OD and Culture	People and Culture Committee	
WOD4	As part of its review programme, the Trust may wish to consider a mandatory programme for line managers in order to embed the revised policies and procedures.	1) A training programme on HR policies and process is designed, available and accessible	On Track	Director of Workforce, OD and Culture	People and Culture Committee	On Track
WOD5	Consider a range of development interventions for the operational HR team to ensure employment law risks are mitigated.	1) As part of the wider HR development programme (WOD 3) deliver specific interventions on employment law	On Track	Director of Workforce, OD and Culture	People and Culture Committee	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	1) Introduce a monthly pulse check for the HR team	Completed	Director of Workforce, OD and Culture	People and Culture Committee	Off Track
		2) Implement Integrated Team meetings	Off Track	Director of Workforce, OD and Culture	People and Culture Committee	
WOD7	The trust should monitor the adherence to the grievance, disciplinary, whistle-blowing policies and the current backlog of cases concluded.	1) Implement a proactive system which monitors adherence to the grievance, disciplinary, whistle-blowing policies, including a robust case tracking system.	Completed	Director of Workforce, OD and Culture	People and Culture Committee	Some Issues
		2) Internal audit compliance against named policies and the defined timescales against cases identified on the tracker.	Completed	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.	Some Issues	Director of Workforce, OD and Culture	People and Culture Committee	
WOD8	The trust should continue to make improvements in staff engagement and communication	1) Develop a clear staff engagement plan that takes account of listen, learn and lead, wider open staff forums and enhances existing good practice	Completed	Director of Workforce, OD and Culture	Board of Directors	On Track
		2) Publish and implement agreed engagement plan	On Track	Director of Workforce, OD and Culture	People and Culture Committee	

	Issue Raised/ Action	Key Tasks	Progress Rag Rating	Owner	Responsible Committee	Board Assurance Rag Rating
		3) Monitor delivery of the plan at P&C Committee using feedback mechanisms such as pulse checks and staff survey.	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	1) Freedom to speak up action plan will be refreshed and approved	Completed	~~Director of Workforce, OD and Culture~~ Director of Corporate Affairs	People and Culture Committee	On Track
		2) Freedom to Speak up action plan will be delivered and monitored through the People and Culture Committee	On Track	~~Director of Workforce, OD and Culture~~ Director of Corporate Affairs	People and Culture Committee	
	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.	1) Develop fit and proper persons policy and have it ratified by Board of Directors	Completed	Director of Corporate Affairs	Board of Directors	On Track
		2) Ensure that HR maintain the Fit and Proper Persons tracker	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	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	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	Completed	Director of Corporate Affairs	Board of Directors	
		6) Formal confirmation to Board by Chair of full compliance with fit and proper persons requirements	Completed	Chairman	Board of Directors	
CORE 10- CQC						
CQC1	The trust should ensure that the outcome of this focussed inspection impacts directly upon the organisational strategy	1) The CQC targeted report is used as a key guide in Trust strategy development days	Completed	Director of Business Development	Board of Directors	On Track
CQC2	The trust should continue to proactively recruit staff to fill operational vacancies.	1) Develop and agree a proactive operational recruitment plan, including in reach to the local University and wider health community	Completed	Director of Operations	People and Culture Committee	Off Track
		2) Implement the recruitment plan and monitor effectiveness against an agreed vacancy rate trajectory	Off Track	Director of Operations	People and Culture Committee	
		3) Develop and implement an internal communications plan which supports pro-active recruitment	Completed	Director of Corporate Affairs	People and Culture Committee	
	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	1) Governance Improvement Action plan approved by Board of Directors	Completed	Responsible Director	Board of Directors	On Track
		2) GIAP and Governance and Delivery Framework sent to Monitor	Completed	Responsible Director	Board of Directors	
		3) Governance and Delivery Framework developed and approved	Completed	Responsible Director	Board of Directors	
		4) Governance Action plan delivered	On Track	Responsible Director	Board of Directors	
M2	The Governance Improvement Action Plan will be updated to reflect material matters arising from the HR investigation	1) The HR Investigation report relating to the overall HR function will be reviewed for lessons learnt and incorporated into the Action Plan	Completed	Director of Corporate Affairs	Board of Directors	Complete
		2) Action Plan approved by Board of Directors	Completed	Director of Corporate Affairs	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	On Track	Acting Chief Executive	Board of Directors	On Track
M4	The Trust will implement Programme management and Governance arrangements to ensure the delivery of the Governance Action Plan	1) Governance and Delivery Framework developed and approved	Completed	Responsible Director	Board of Directors	Complete
		2) A programme manager will be appointed to support Responsible Director to hold Directors to account for the delivery of the programme	Completed	Responsible Director	Board of Directors	
M5	The Trust will provide regular reports to Monitor	1) The Trust will report on a monthly basis on the delivery of the action plan	On Track	Acting Chief Executive	Board of Directors	On Track
M6	The Licensee will, by 18th March 2016 or such other date as agreed with Monitor, develop and submit to Monitor a timetable for making permanent appointments to all director roles which are currently vacant and/or filled on an interim basis. It will, by a date to be agreed with Monitor, revise that timetable in response to any comments made on it by Monitor.	1) Develop a timetable for making permanent appointments to all director roles which are currently vacant and/or filled on an interim basis	Completed	Acting Chief Executive	Board of Directors	Complete

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 5th October 2016

Report from Council of Governors 6 September 2016

The Council of Governors met on 6 September at St Thomas Centre, Chatsworth Road, Brampton Chesterfield. This report provides a summary of issues discussed for noting by the Trust Board. Twelve 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 supports the Council in its duty of holding the Board to account by way of informing members on internal and external developments.

Ifti Majid updated on ongoing streams of work around the Sustainability and Transformation Plan (STP) and the work taking place to explore collaboration with Derbyshire Community Health Services NHS Foundation Trust (DCHS). NHS Improvement's recently announced expectations for collaboration on back office functions was also outlined. Discussion covered issues of succession planning on the Board given Ifti Majid's secondment from the Trust, and ensuring that mental health was prioritised in future collaboration with DCHS. The Chair and Chief Executive gave assurances that they were working to ensure that mental health expertise and skills were taken forward in the partnership working arrangements and that the Strategic Options Case (SOC) under development would encompass this principle.

21c PROPOSALS – BETTER CARE CLOSER TO HOME

Gareth Harry, Chief Commissioning Officer from Hardwick Clinical Commissioning Group, outlined the context and detail of the current public consultation process underway which focusses on better care closer to home.

Gareth explained how the 21c partnership has been working closely with patients and the public to establish a new model of care built around the needs of individuals to improve care for people in north Derbyshire that is cost effective, with care being provided in people's own homes rather than in hospital.

A broad range of questions were raised by governors, responses given and feedback is to be fed into the consultation process.

STRATEGY IMPLEMENTATION

The Board of Directors approved the Trust Strategy 2016-2021 in May and an outline of the strategy implementation process was presented to governors at the June meeting. The report presented at the meeting provided governors with assurance of the timeframes in respect of delivery and implementation of the Trust strategy.

Mark Powell advised governors of the next stage of the process and how this would be developed in terms of care pathways, noting the associated challenges presented by delivery of the Governance Improvement Action Plan and response to issues raised from the recent CQC inspection.

Governors received assurance that the strategy implementation process is progressing and that appropriate measures are in place to ensure that it is in- ine with the system wide STP process.

INTEGRATED PERFORMANCE REPORT

Carolyn Gilby highlighted key areas contained in the report which gave governors an overview of performance as at the end of July 2016 with regard to workforce, finance and operational delivery and quality performance. The main financial challenge was the focus on the Cost Improvement Programme (CIP) which was now focussing on cost reduction and cost avoidance.

NON EXECUTIVE DIRECTOR UPDATES

The verbal reports from Caroline Maley and Maura Teager on their activities in their role as Non- Executive Directors were noted for information.

GOVERNANCE IMPROVEMENT ACTION PLAN (GIAP)

Mark Powell presented his paper which provided an update on the delivery of the GIAP and an overview of the actions that the Council of Governors is responsible for seeking assurance on delivery.

Governors were informed that good progress continues to be made to deliver the plan. The Trust had met with the enforcement team from NHSI where progress against the GIAP was discussed in detail. NHSI had confirmed that the Trust had made good progress across the plan and was satisfied with the underpinning process we have adopted which supports delivery of the planned actions.

ACTIONS AND LEARNING FROM PATIENT STORIES

A booklet listing the outcomes of the patient stories received at Trust Board over the past two years is to be circulated to governors. Carolyn Green explained that this will outline the positive impact of these stories and how these have influenced services within the Trust.

TERMS OF REFERENCE AND REPORT OF THE NOMINATIONS AND REMUNERATION COMMITTEE

The report of the Committee meeting held on 3 August was noted and the revised terms of reference were approved.

POLICY FOR ENGAGEMENT BETWEEN THE BOARD OF DIRECTORS AND COUNCIL OF GOVERNORS

Governors agreed to approve the policy which outlined the commitment by the Board of Directors and governors to develop engagement and two-way communication to carry out their respective roles effectively. The policy would also be required to be

approved by the Trust's Board of Directors and this is scheduled for the October Board meeting.

RECOMMENDATION

The Board is asked to:

- **Note the summary report from the Council of Governors.**

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

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board meeting 5th October 2016

Policy for Engagement between the Board of Directors and Council of Governors

Purpose of Report

This paper sets out a proposed policy that has been developed from reviewing best practice and incorporates comments arising from discussion by governors at the Governance Committee at its 6 June and 7 July meeting. The governors subsequently approved the policy at the Council of Governors meeting on 6 September for onward consideration by the Board of Directors.

Executive Summary

The policy covers a range of important areas including:

- Relationship between the Trust Board and the Council of Governors
- Handling of concerns
- Powers & duties, roles and responsibilities of the Trust Board and the Council of Governors
- Role of the Senior Independent Director
- Grounds and procedure for the removal of the Chair or a Non-Executive Director
- Dispute Resolution Procedure

The policy also encompasses those activities which we have developed within the Trust such as the twice yearly Board/Council of Governor sessions and Governor/NED informal sessions. Also referenced are the opportunities recently offered to representative governors to attend Board Committees and other committees to observe discussions, further understand the role of NEDs and learn more about the activities of the wider Trust.

The purpose of this policy is therefore to:

- Set out the systems and structures to promote a constructive working relationship between the Council of Governors and the Trust Board
- Set out a process for dealing with problems that may arise, as recommended by NHS Improvement's Code of Governance

Strategic considerations and assurances

- This policy for engagement clarifies the respective roles and responsibilities of the Board and the Council of Governors
- This policy outlines commitment of the Board and the Council of Governors to uphold to the Nolan principles, which are the foundation of the role of both director and governor

Consultation

- This policy was discussed at the Governance Committee at its 6 June and 7 July meeting and the Council of Governors meeting on 6 September where it was formally approved, subject to Trust Board agreement.

Governance or Legal issues

- This policy outlines the commitment by the Board of Directors and governors to developing engagement and two-way communication to carry out their respective roles effectively
- The development of this policy is an identified action within the Governance Improvement Action Plan (ref CorpG1). Agreement of the policy and subsequent assurance of implementation will enable this action to be deemed completed.

Recommendations

The Board is asked to:

- Approve the revised Policy for Engagement between the Board of Directors and Council of Governors
- Review the implementation of the policy on an annual basis to ensure that it is being effectively used to the satisfaction of both the Board and Council of Governors.

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

Derbyshire Healthcare NHS
NHS Foundation Trust

Policy for Engagement between the Trust Board and the Council of Governors

See also:	Located in the following policy folder on the Trust Intranet

Service area	Issue date	Issue no.	Review date	
Trust wide				
Ratified by	**Ratification date**	**Responsibility for review:**		
Board of Directors	TBC			

Document published on the Trust Intranet under:

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Derbyshire Healthcare NHS
NHS Foundation Trust

Checklist for Policy for Engagement between the Trust Board and the Council of Governors

Name / Title	Policy for Engagement between the Trust Board and the Council of Governors		Working name/title of the policy/procedure
Aim of Policy	To outline the commitment by the Board of Directors and governors to developing engagement and two-way communication to carry out their respective roles effectively.		Brief summary of main aim of the policy
Sponsor	Samantha Harrison, Director of Corporate Affairs and Trust Secretary		Name and job title of person taking through approval and signing off
Author(s)	Samantha Harrison, Director of Corporate Affairs and Trust Secretary		Job titles of those involved in producing the document
Name of policy being replaced	N/A	**Version No of previous policy:**	Name and version number of the previous policy this replaces (If applicable)

Reason for document production:	GIAP Requirement
Commissioning individual or group:	Trust Board and Council of Governors

Individuals or groups who have been consulted:	**Date:**	**Response**
Governance Committee	6 June and 7 July 2016	Approved
Council of Governors	6 September 2016	Formally approved subject to Trust Board agreement

Version control (for minor amendments)

Date	Author	Comment

Derbyshire Healthcare NHS
NHS Foundation Trust

Policy for Engagement between the Trust Board and Council of Governors

1. Introduction

2. Purpose

3. Relationship between the Trust Board and Council of Governors

4. Handling of concerns.

5. Associated documents

Appendix A
Powers and duties of the Trust Board and the Council of Governors

Appendix B
Role of the Senior Independent Director

Appendix C
Grounds and Procedure for the Removal of the Chair or any Non-Executive Director

Appendix D
Disputes Resolution Procedure

Derbyshire Healthcare NHS
NHS Foundation Trust

Policy for Engagement Between the Trust Board and the Council of Governors

1. Introduction

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

The Board leads the Trust by undertaking four key roles:

- setting strategy
- supervising the work of the executive in the delivery of the strategy and through seeking
- assurance that systems of control are robust and reliable
- setting and leading a positive culture for the board and the organisation
- giving account and answering to key stakeholders, particularly Councils of Governors.

The statutory general duties of the Council of Governors are:

- to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and
- to represent the interests of the members of the corporation as a whole and the interests of the public.

The Trust Board recognises that it needs to enable the Council to hold it to account, in the first instance through the Non-Executive Directors. The Trust Board commits to consult governors on all strategic issues and material service developments before decisions are made, recognizing that governor feedback enables a better informed and more effective Board.

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

This policy outlines the commitment by the Board of Directors and governors to developing engagement and two-way communication to carry out their respective roles effectively.

- The Trust Board and Council of Governors are committed to building and maintaining an open and constructive working relationship. Under-pinning such a relationship is the need for clarity on the respective roles and responsibilities.

- NHS Improvement's Code of Governance (2013) recommends that each Foundation Trust should have a Policy for Engagement between the Trust Board and the Council of Governors, which clearly sets out how the two bodies will interact with one another for the benefit of the Trust.

- This policy for engagement clarifies the respective roles and responsibilities of the Board and the Council of Governors, and describes the information flow between the two groups. The policy describes the involvement of governors in forward planning, and the role they plan in respect of holding the Trust Board to account.

- This policy for engagement also sets out a process should the governors have a concern about the performance of the Board, compliance with the licence or the welfare of the Trust. It also describes the process should the governors have significant concerns about the performance of the Chair or Non-Executive Directors.

- This policy is intended to provide clear guidance and a useful framework for both the Trust Board and Council of Governors and has been approved by each respectively.

The policy also encompasses those activities which we have developed within the Trust such as the twice yearly Board/Council of Governor sessions and Governor/NED informal sessions. Also referenced are the opportunities recently offered to representative governors to attend Board Committees to observe discussions.

In developing this policy both the Board and the Council of Governors are keen to maintain commitment to the Nolan principles which are a foundation of our roles:

The Nolan Principles - The Seven Principles of Public Life

Selflessness
Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

Integrity
Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness
Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership
Holders of public office should promote and support these principles by leadership and example.

2. Purpose

2.1 The Board is committed to building and maintaining an open and constructive working relationship with the Council of Governors. The Board believes that it is important that the respective powers and roles of the Trust Board and the Council of Governors are clear, and are followed in practice.

2.2 There may be times where the Council of Governors has concerns about the running of the Trust. NHS Improvement's Code of Governance recommends that the Council of Governors should establish a Policy for Engagement with the Trust Board for those circumstances when they have concerns about the performance of the Trust Board, compliance with its licence or the welfare of the Trust.

2.2 The purpose of this policy is therefore to:

- set out the systems and structures to promote a constructive working relationship between the Council of Governors and the Trust Board
- set out a process for dealing with problems that may arise, as recommended by NHS Improvement's Code of Governance.

2.3 This policy complements the Trust's arrangements for governor communication with NHS Improvement and the Care Quality Commission (CQC) where governors have concluded that a Trust has failed, or is failing, to act in accordance with its constitution, or Chapter 5 of the Health and Social Care Act (2006) and where it is considered that the intervention of NHS Improvement or the Care Quality Commission may be appropriate. That is, it is the role of the Lead Governor to contact regulators in this instance.

3. Relationship between the Trust Board and the Council of Governors

3.1 Powers and Duties, Roles and Responsibilities

3.1.1 The respective powers and roles of the Trust Board and the Council of Governors are set out in their Standing Orders and the Trust Constitution.

3.1.2 The Trust Board and the Council of Governors should understand their respective roles and seek to follow them in practice. Any concerns or queries should be raised with the Chair, Director of Corporate Affairs/Trust Secretary or Lead Governor.

3.1.3 The Trust will provide induction and ongoing training regarding roles and responsibilities.

3.2 Trust Board and Council of Governors

3.2.1 In order to facilitate communication between the Trust Board and Council of Governors, there will be an opportunity for governors to raise questions linked to the agenda of each public Trust Board meeting. As per established arrangements for questions to the Trust Board, these should be submitted to Board Secretary at least 48 hours prior to the Board meeting.

3.2.2 The Council of Governors will have the opportunity to submit formal questions/concerns to the Trust Board, and will receive a response within seven working days of the meeting.

3.2.3 Governors may, by informing the Chair, request an item to be added to the agenda of the Council of Governors for discussion, or via the Governance Committee, or raise as 'any other business' at the Council of Governors meeting.

3.2.4 Governors will have the opportunity to raise questions about the affairs of the Trust with any Director present at a meeting of the Council of Governors. Wherever possible, questions should be submitted to the Chair in advance of the meeting, to enable a reasonable time to be allocated during the meeting. Where this is not possible, a written response will be provided within seven days of the meeting.

3.2.5 Whilst a confidential part of Board of Director meetings will be held in private the agenda from these meetings will be made available for governors. The public Trust Board papers will be sent to governors electronically and are also available from the Trust website prior to the meeting.

3.3 Role of the Chair

3.3.1 The Chair is responsible for leadership of the Trust Board and the Council of Governors, ensuring their effectiveness on all aspects of the role and setting

their agenda. The Chair is responsible for ensuring that the two groups work together effectively, and that they receive the information they require to carry out their duties.

3.3.2 In the Chairman's absence meetings of the Council of Governors will be chaired by the Deputy Chair of the Trust Board.

3.3.3 The Chair will ensure that the views of governors and members are communicated to the Trust Board and that the Council of Governors is informed of key Trust Board decisions.

3.3.4 The Chair will meet with the Lead Governor, and will have 1:1 meetings with individual governors as reasonably requested.

3.4 Role of the Trust Board

3.4.1 The Trust Board will formally meet with the Council of Governors twice a year to review the Trust's performance against the annual objectives, the Quality Accounts and compliance with the Monitor licence.

3.5 Role of Non-Executive Directors and the Senior Independent Director

3.5.1 Non-Executive Directors will be invited to attend meetings of the Council of Governors, make presentations and answer questions as appropriate.

3.5.2 Non-Executive Directors will commit time to build effective relationships with governors and governors and Non-Executive Directors will agree to spend time together to understand each other's perspectives and build good levels of mutual understanding. Non-Executive Directors will schedule to meet informally with governors on a regular basis.

3.5.2 The Senior Independent Director will be available to the Council of Governors and individual governors if they have concerns which contact through the normal channels of Chair has failed to resolve or for which such contact is inappropriate. The Senior Independent Director should attend sufficient meetings of the Council of Governors Council to listen to their views in order to help develop a balanced understanding of the issues and concerns of the governors and members.

3.5.3 The role of the Senior Independent Director is set out in Appendix B.

3.5.4 The process to be followed in dealing with concerns is set out in Section 4.

3.6 Role of Executive Directors

3.6.1 Executive directors (including the Chief Executive or deputy) will be invited to attend Council of Governors meetings, and be asked to facilitate discussions and answer questions as appropriate.

3.7 Role of the Governors

3.7.1 Governors are required to meet the statutory duties as set out in Appendix A.

3.8 Role of the Lead Governor of the Council of Governors

3.8.2 As Lead Governor:

- Act as a direct link between the governors and NHS Improvement in situations where it would be inappropriate to go through the Chair
- Act as the point of contact between the Council of Governors and the Care Quality Commission
- Prioritise agenda items for the Council of Governors and ensure action plans are followed
- Maintain regular communication with the Chair, conducting regular reviews of the performance of the Trust
- Member of the Nominations and Remuneration Committee
- Member of the Governance Committee
- Represent concerns that governors may have (either as a body, or individually) to the Chair
- Together with the Chair address inappropriate action by any governor subject to Nominations and Remuneration Committee approval
- Lead the appraisal process for the Council of Governors, and facilitate the Council of Governors review of effectiveness
- Maintain a close working relationship with the Senior Independent Director (SID) of the Board of Directors
- Together with the SID carry out the appraisal of the Chair
- Agree the format of regular Council of Governor/Non-Executive Director meetings
- As representative of the Trust's Council of Governors establish and maintain working relationships with NEDs, the Board of Directors and forge links with external bodies such as CQC, Health and Wellbeing Board and Council of Governors of other foundation trusts.

3.9 Council of Governors involvement in forward planning

3.9.1 When the Trust Board is engaged in strategic planning (e.g. annual planning, strategic direction) governors will be involved in the process so that the views of members can be properly canvassed and fed into the process.

3.10 Accountability

3.10.1 The Council of Governors has a role to hold the Non-Executive Directors individually and collectively to account for the performance of the Trust Board, including ensuring the Trust Board acts so that the Trust does not breach its licence. In order to carry out this role, the Council of Governors will be provided with high quality information that is relevant to the decisions they have to make. The information needs of the Council of Governors will be discussed as part of the induction process and subject to ongoing review, and the governors will be consulted in the planning of agendas of Council of Governors Council meetings.

3.10.2 NHS Improvement's Code of Governance provides that the Trust Board will notify the Council of Governors of any major new developments or changes to the Trust's financial condition, performance of its business or expectations as to its performance, that if made public would be likely to lead to a substantial change to the financial well-being, healthcare delivery performance or reputational standing of the Trust.

3.10.3 The Health & Social Care Act 2012 places a mandatory duty on the Board of Directors to consult with and seek the agreement of the Council of Governors on 'significant transactions' including mergers, acquisition, dissolution, separation, raising additional services from activities other than via its principal purpose and raising the threshold of funds raised from private patients as outlined in the Trust's Constitution.

3.10.4 The Council of Governors have the powers to call an Executive Director to the Council of Governors for the purpose of obtaining information about the Trust's performance of its functions or the Director's performance of their duties.

4. Handling of Concerns

4.1 A concern, in the meaning of this policy, must be directly related to either:

- The performance of the Trust Board, or
- Compliance with the licence, or
- The welfare of the Trust

Other matters that do not constitute a concern can be raised with the Chair to be discussed at the appropriate forum (see para 3.2.2-3.2.4).

4.2 Stage 1 – Informal

4.2.1 In the event that the Council of Governors has a concern of the type described above, every attempt should be made to resolve the matter firstly by discussion with the Chair. Where it affects financial matters, the Director of Finance should be involved. The Lead Governor should normally represent the Council of Governors in these matters, and they will consider whether additional representation is required.

4.2.2 Every attempt should be made to resolve concerns in an appropriate way, and as quickly as possible. This may involve the Chair convening a meeting with governors, and/or requesting reports from the Chief Executive, Director of Finance or another director or officer of the Trust, or a report from the Audit and Risk Committee or other committee, and providing comments on any proposed remedial action.

4.2.3 The outcome of the matter will be reported to the next formal meeting of the Council of Governors, who will consider whether the matter has been resolved satisfactorily.

4.3 Stage 2 – Formal

4.3.1 This is the formal stage where stage 1 has failed to produce a resolution and the services of an independent person are required. In this case the Senior Independent Director assumes the role of mediator, as recommended by the Code of Governance, and conducts an investigation.

4.3.2 The decision to proceed to Stage 2 and beyond will always be considered by the full Council of Governors, at an extraordinary, private meeting. This is to ensure that any decision is a collective Council of Governors decision. The decision to proceed to Stage 2 must be collectively agreed by a majority of the Council of Governors present at a meeting which is quorate. In the event that the Council of Governors does not agree to proceed to Stage 2, that decision is final.

4.3.3 Evidence requirements
Any concern should be supported by relevant evidence. It cannot be based on hearsay alone, and should meet the following criteria:

- Any written statement must be from an identifiable person(s) who must sign the statement and be willing to be interviewed under either stage of this process.

- Other documentation must originate from a bona fide organisation and the source must be clearly identifiable. Newspaper articles will not be accepted as prima facie evidence but may be admitted as supporting evidence.

- Where the concern includes hearsay, e.g. media reports, the Council of Governors may require the Trust Board to provide explanations and, if necessary, evidence to show that the hearsay reports are untrue.

4.3.4 Investigation and Decision of the Senior Independent Director.

4.3.4.1 The Senior Independent Director's role is to seek to resolve the matter in the best interests of the Trust.

4.3.4.2 The Senior Independent Director will produce a written report of their findings and recommendations and present it to the Council of Governors and Trust Board. The report will address the issues raised by the Council of Governors, and will also consider whether action is required to repair any breakdown in the relationship between the Trust Board and the Council of Governors.

4.3.4.3 The decision of the Senior Independent Director will be final in resolving the matter in the best interests of the Trust.

4.3.4.4 In the event that the Council of Governors' remain dissatisfied with the Senior Independent Director's decision, the options in paragraph 3.4 may be considered.

4.4 Action in event of Stage 2 failing to achieve resolution

4.4.1 If the Council of Governors does not consider that the matter has been adequately resolved, they have four options:

- Accept the failure to reach a resolution of the matter and consider the matter closed; or

- Seek the intervention of another independent mediator (i.e. a Chair or Senior Independent Director from another NHS Foundation Trust) in order to seek resolution of the matter, or

- Inform NHS Improvement if the Trust is at risk of breaching its licence.

- Follow the Dispute Resolution Procedure (as outlined at Appendix D).

4.5 Removal of the Chair or any Non-Executive Director

4.5.1 In relation to concerns raised in accordance with this policy, the Council of Governors should only exercise its power to remove the Chair or any Non-Executive Directors after exhausting all other means of engagement with the Trust Board.

4.5.2 The procedure for removing the Chair or a Non-Executive Director is set out in Appendix C.

Derbyshire Healthcare NHS
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Appendix A

Powers and duties of the Trust Board and the Council of Governors

Trust Board:	Council of Governors:
All the powers of the Trust are to be exercised by the Trust Board. The Trust Board may do anything which appears to it to be necessary or desirable for the purposes of or in connection with the functions of the Trust, subject to any restrictions in its licence. The powers of the Trust Board include, but are not limited to, the ability to borrow and invest money, acquire and dispose of property, enter into contracts, accept gifts of property (including property to be held on Trust for the purposes of the Foundation Trust or for any purposes relating to the health service), and employ staff.	The Council of Governors cannot veto decisions made by the Trust Board.
The Trust Board must submit forward planning information and annual reports and accounts to NHS Improvement, after consulting with the Council of Governors and having regard to their views.	The Council of Governors is to be consulted on forward planning by the Trust Board, and the Trust Board must have regard to their views.
The Trust Board will present the annual report and accounts and the auditors report to the Council of Governors and will lay a copy of the annual accounts, and any report of the auditor on them before Parliament, and once it has done so, send copies of these documents to NHS Improvement, along with the annual report.	The Council of Governors is to be presented with the annual report and accounts and the report of the auditor on them, at a general meeting of the Council of Governors.
It is for the non-executive directors to appoint and remove the Chief Executive. The appointment of the Chief Executive requires the approval of the Council of Governors.	The Council of Governors is to approve the appointment of the Chief Executive by the non-executive directors. The appointment requires the approval of a majority of the Council of Governors.

Trust Board:	Council of Governors:
It is for a committee consisting of the chairman, the chief executive and the other non-executive directors to appoint or remove the executive directors	The Council of Governors is to appoint the chair and other non-executive directors of the NHS Foundation Trust at a general meeting of the Council of Governors. The appointment requires the approval of a majority of the members of the Council of Governors. If the Council of Governors is to remove the chair or non- executive directors of the NHS Foundation Trust, such removal must occur at a general meeting of the Council of Governors and it requires the approval of three quarters of the members of the Council of Governors.
The Trust Board must establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors	The Council of Governors is to decide the remuneration and allowances, and the other terms and conditions of office, of the non-executive directors. The decision requires the approval of a majority of the members of the Council of Governors.
The Trust Board must establish a committee of non-executive directors to act as an Audit Committee	The Council of Governors is to appoint or remove the external auditor at a general meeting of the Council of Governors. The appointment and removal requires the approval of a majority of the members of the Council of Governors.
Provide active leadership of the Trust within a framework of prudent and effective controls which enable risk to be assessed and managed.	Represent the interests of the Trust's members and partner organisations in the local health economy.
Set the Trust's strategic aims, taking into consideration the views of the Council of Governors, ensuring that the financial and human resources are in place for the Trust to meet its objectives, and review management performance.	Regularly feedback information about the Trust, its vision and its performance to the constituencies and the stakeholder organisations that either elected or appointed them.

Trust Board:	**Council of Governors:**
Ensure compliance by the Trust with its licence, its Constitution, mandatory guidance issued by regulators, relevant statutory requirements and contractual obligations.	Act in the best interests of the Trust and adhere to its values and governor Code of Conduct.
Ensure the quality and safety of healthcare services, education, training and research delivered by the Trust and apply the principles and standards of clinical governance set out by relevant NHS bodies.	Hold the Non-Executive Directors individually and collectively to account for the performance of the Trust Board including ensuring the Trust Board acts so that the Trust does not breach its licence.
Ensure that adequate systems and processes are maintained to measure and monitor the Trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery.	Acknowledge the overall responsibility of the Trust Board for running the Trust and should not try to use the powers of the Council of Governors to veto decisions of the Trust Board.
Regularly review the performance of the Trust in these areas against regulatory requirements and approved plans and objectives.	Establish a policy for engagement with the Trust Board for those circumstances when they have concerns about the performance of the Trust Board, compliance with its licence or the welfare of the Trust.
Establish the values and standards of conduct for the Trust and its staff in accordance with NHS values and accepted standards of behaviour in public life, and operate a Code of Conduct that builds on the values of the Trust and reflects high standards of probity and responsibility.	Inform the Independent Regulator if the Trust is at risk of breaching its licence if these concerns cannot be resolved at a local level.
Ensure that there is a formal, rigorous and transparent procedure for the appointment or election of new members to the Trust Board, and satisfy itself that plans are in place for orderly succession of appointments to the Trust Board so as to maintain an appropriate balance of skills and experience within the Trust and on the Trust Board, and ensure planned and progressive refreshing of the Trust Board.	Agree a process for the evaluation of the Chair and the non-executive directors, with the Chair and the non-executive directors, and agree the outcomes of the evaluations.
Present a balanced and understandable assessment of the Trust's position and prospects.	Agree with the Audit and Risk Committee of the Trust Board the criteria for appointing, reappointing and removing external auditors.
Maintain a sound system of internal control to safeguard public and private investment, the Trust's assets, patient safety and service quality.	Work with the Trust Board on such other matters for the benefit of the Trust as may be agreed between them.

Trust Board:	**Council of Governors:**
Establish formal and transparent arrangements for considering how they should apply the financial reporting and internal control principles and for maintaining an appropriate relationship with the Trust's auditors.	Assess its own collective performance and its impact on the Trust, and communicate this to the members of the Trust.
Consult and involve members, patients, clients and the local community, and monitor how representative the Trust's membership is and the level of effectiveness of member engagement.	Hold constituency meetings to ensure Member's interests are represented and Trust information is fed back.
Ensure that the Trust co-operates with other NHS bodies, local authorities and other relevant organisations with an interest in the local health economy.	
Work with the Council of Governors on such other matters for the benefit of the Trust as may be agreed between them.	Raise issues and matters for discussion: Contact Chair/Involvement Manager to identify an appropriate forum and to submit items for meetings, eg ☐ Request items to be included in the Council of Governors (or Governance Committee) agenda or raise matters under Any Other Business ☐ Raise formal questions for response by the Trust Board ☐ Ask questions of the Chief Executive at Council of Governors meetings.
Follow the principles of openness and transparency in its proceedings and decision making unless this conflicts with a need to protect the wider interests of the public or the Trust (including commercial in confidence matters) and make clear how potential conflicts of interests are dealt with.	
Undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors.	

Derbyshire Healthcare NHS
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Appendix B

Role of the Senior Independent Director

The Senior Independent Director (SID) will be a Non-Executive Director of the Trust Board.

The SID's role will be

- To be available to the Trust Directors if they have concerns which cannot be resolved through the normal channels (or is inappropriate) of the Chair or Chief Executive.

- To support the Chair in resolving disputes between individual Trust Board members in respect of their role as a director of the Trust.

In respect of the Council of Governors

- To be available to members and governors if they have concerns which cannot be resolved through the normal channels (or is inappropriate) of the Chair or Chief Executive. To maintain sufficient contact with governors to understand their issues and concerns, including building an effective relationship with the Lead Governor.

- To help resolving disagreements between the Council of Governors and Trust Board in accordance with the policy setting out the approach to be taken in these circumstances

- To agree a process for evaluating the performance of the Chair and to agree appropriate processes for reporting such evaluation annually to the governor Nominations and Remuneration Committee.

- To work with the Chair to establish a policy for engagement of the Council of Governors with the Trust Board.

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APPENDIX C

Grounds and Procedure for the Removal of the Chair or any Non-Executive Director

Introduction

The Council of Governors has the power to remove the Chair and any Non-Executive Director of the Trust. Such removal must occur at a general meeting of the Council of Governors and requires the approval of three quarters of the members of the Council of Governors.

In relation to concerns raised under the Policy for Engagement, the Council of Governors should only exercise its power to remove a Non-Executive Director after exhausting all other means of engagement with the Trust Board, as set out in that policy.

Grounds for removal

The removal of a Non-Executive Director should be based on the following criteria. Grounds for removal can include the following:

a) s/he is not qualified, or is disqualified, from becoming or continuing as a Non-Executive Director under the Constitution
b) s/he has failed to attend meetings of the Trust Board for a period of six months
c) s/he has failed to discharge his/her duties as a Non-Executive Director
d) s/he has knowingly or recklessly made a false declaration for any purpose provided for under the Constitution or in the 2006 Act
e) s/he has knowingly or recklessly failed to declare a conflict of interest
f) his/her continuing as a Non-Executive Director would be likely to:
I. prejudice the ability of the Trust to fulfill its principal purpose or other of its purposes under the Constitution or otherwise to discharge its duties or functions
II. harm the Trust's work with other persons or bodies with whom it is engaged or may be engaged in the provisions of goods or services
III. adversely affect public confidence in the goods and services provided by the Trust; or otherwise bring the Trust into disrepute
g) s/he has failed or refused to comply with the regulatory framework, the Standing Orders, or any Code of Conduct which the Trust shall have published from time to time
h) s/he has refused without reasonable cause to undertake any training which the Trust requires all Non-Executive Directors to undertake
i) s/he purports to represent the views of any professional body, political party or trade union of which he is a member
j) it is not in the interests of the Trust for the Non-Executive Director to continue to hold office
k) s/he does meet the criteria as outlined in the Trust Fit and Proper Persons Test policy.

The following list provides examples of matters which may indicate to the Council of Governors that it is no longer in the interests of the Trust that a Non-Executive Director continues in office. The list is not intended to be exhaustive or definitive; the Council of Governors will consider each case on its merits, taking account of all relevant factors.

a) If an annual appraisal or sequence of appraisals is unsatisfactory
b) If the Non-Executive Director loses the confidence of the Trust Board
c) If the Non-Executive Director loses the confidence of the public or local community in a substantial way
d) If the Non-Executive Director fails to monitor the performance of the Trust in an effective way
e) If the Non-Executive Director fails to deliver work against pre- agreed targets incorporated within their annual objectives
f) If there is a terminal breakdown in essential relationships, e.g. between a Chair and a Chief Executive or between a Non-Executive Director and the Chair or the rest of the Trust Board.

Procedure

a) Any proposal to remove a Non-Executive Director can be proposed by a Council member, the Chair, or the Trust Board.
b) The Non-Executive Director will be notified in writing of the allegations, and be invited to submit a response.
c) The Non-Executive Director is entitled to address the Council of Governors at the meeting considering the proposal to remove him/her.
d) The Trust Board may make representations to the Council of Governors whether they are for, or against the resolution, or even if they are divided.
e) The Council of Governors may consider any relevant evidence, e.g. appraisal documentation or witness statements.
f) The Council of Governors should take professional advice, via the Director of Corporate Affairs/Trust Secretary, prior to removing a Non-Executive Director.
g) In relation to concerns raised in accordance with the Policy for Engagement, the Council of Governors should only exercise its power to remove a Non-Executive Director after exhausting all other means of engagement with the Trust Board.

Chair of meetings

The Chair may normally express an opinion on the appointment and removal of a Non-Executive Director, but does not have formal voting rights at the Council of Governors.

The Chair should also consider, however, whether in particular circumstances a conflict of interest arises in dealing with the removal of a Non-Executive Director, and if so, stand aside for that part of the meeting.

For the removal of the Chair, the Senior Independent Director will preside at meetings of the Council of Governors.

Removal and disqualification of governors

The process for the removal and disqualification of governors is covered in Annex 5 of the Trust's constitution.

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Appendix D

Dispute Resolution Procedure

In the event of dispute between the Council of Governors and the Trust Board, where the above policy has been followed as appropriate through informal (Stage 1) and formal (Stage 2) procedures at outlined at 4.2 and 4.3, the dispute resolution procedure can be considered as a further option should Stage 2 procedures fail to achieve a resolution:

1. In the first instance the Chairman on the advice of the Director of Corporate Affairs/Trust Secretary, and such other advice as the Chairman may see fit to obtain, shall seek to resolve the dispute.

2. If the Chairman is unable to resolve the dispute he shall appoint a special committee comprising equal numbers of Directors and Governors to consider the circumstances and to make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute.

3. If the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the Chairman may refer the dispute back to the Trust Board who shall make the final decision.

4. Under the 2006 Act, as amended, NHS Improvement has appointed a Panel for Advising Governors (the Panel) to which governors of NHS foundation trusts may refer a question concerning whether their trust has failed, or is failing, to act in accordance with its constitution, or Chapter 5 of the 2006 Act.

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REGARDS EIRA (Equality Impact Risk Analysis) Screening Template (Stage 1)

To be completed and attached to any policy document or framework when submitted to the appropriate committee for consideration and approval.

Name of activity/proposal/policy/function	
Date screening commenced	
Name and role of person undertaking this REGARDS EIRA	

Step 1: Give an overview of the aims, objectives, intended outcomes and who will benefit from the activity or proposal (equality relevant and succinct)?

Step 2 Evidence & Engagement – What early data or evidence have you used to substantiate your decisions? Please provide details of who you have engaged, dates and add links to research and data

Step 3: Impact - What impact does this activity/policy or changes in function have on those within the REGARDS/protected characteristic groups?

Area of potential impact REGARDS Impact Positive or Negative (- or +) Not sufficient to just tick please provide details	Reduce discrimination -/+		Promote/increase equality of opportunity or access -/+		Reduce inequalities -/+		Promote good community relations -/+	
Race (Ethnicity)								
Economic Disadvantage								
Gender/Sex & Gender Reassignment								
Age								
Religion or Belief								
Disability								
Sexual Orientation								
Pregnancy & Maternity								
Marriage & Civil Partnership								
Other equality groups/people e.g. carers, homeless, substance misuse, unemployed, offenders, veterans & sex workers								

Step 4 : Risk Assessment

Does this activity propose major changes in terms of scale or significance for DHCFT? YES: is there a clear indication that, although the policy is minor it is likely to have a major affect for people from REGARDS equality groups e.g. service design, delivery, reoccurring issues of inequality or unequal access. Please tick appropriate box below

YES		No	
High Risk : Complete Full REGARDS EIRA		**No Impact/Low Risk**: Go to step 5	

Step 5 : REGARDS Completion Statement

If this proposal has No impact/equality neutral/low impact - please spell out/ provide evidence/links and justification for how you reached this decision. Please remember that a REGARDS EIRA can be called upon at any time to justify decision making or asked for as part of audit.

Sign off that this is low risk and does not require a full EIRA

Name Reviewer/Assessor: Date

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

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	Apr-16	May-16	Jun-16	Jul-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
SH	Whistleblowing Policy - annual nomination of NED role (one year rotation)	Francis Report		X									
SH	Committee Assurance Summaries (following every meeting) - Audit & Risk - Finance & Performance (Confidential) - Mental Health Act - Quality Committee - Safeguarding - People & Culture	Strategic Outcome 3	X	X	X	X	X	X	X	X	X	X	X
MP	Governance Improvement Action Plan	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X	X
SH	Fit and Proper Person Declaration	Licence Condition FT4		X									X
OPERATIONAL PERFORMANCE													
CG, CW, AR, CGi	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
AR	HR Investigation Action Plan				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/JS	Safeguarding Children Annual Report	Children Act Mental Health Standard Contract						X					
CG/JS	Safeguarding Adult Annual Report	CQC Mental Health Standard Contract							X				
CG	Control of Infection Report	Health Act Hygiene Code		X									
CG/JS	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				

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	Apr-16	May-16	Jun-16	Jul-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
CG	Annual Community Patient Survey	Clinical Practice CQC							X				
JS	Re-validation of Doctors	Strategic Outcome 3			X								